

**Gender, Sexuality and Vulnerability to HIV Infection
among the Borana Pastoral Community of Southern Ethiopia**

INAUGURAL DISSERTATION

Zur

Erlangung der Würde eines Doktors der Philosophie

Vorgelegt der

Philosophisch-Naturwissenschaftlichen Fakultät

der Universität Basel

Von

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Ethiopia

Basel, September 2012

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Basel, den 20. September 2011

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Treatment
CARE	Collaborate American Relief Effort
CSA	Central Statistical Agency
DHS	Demographic and Health Survey
EMSAP	Ethiopian Multi-Sectoral AIDS Program
FHAPCO	Federal HIV and AIDS Prevention and Control Office
GOAL	An International humanitarian organization
HAPCO	HIV and AIDS Prevention and Control Office
HIV	Human Immuno Virus
II	In-depth Interview
NACS	National AIDS Council Secretariat
NGOs	Non-Governmental Organizations
PAs	Peasant Associations
PAMS	Partnership Against Mitigation of Syndromes
PI	Principal Investigator
PPS	Probability Proportion to Size
SNNPR	Southern Nations Nationalities and people's Region
STPH	Swiss Tropical and Public Health
UNAIDS	Joint United Nations program on AIDS
WHO	World Health Organization

Dedication

This Ph D Dissertation is dedicated to
my late grandma Dinkitu Garbi Bulcha
who showed me the way and encouraged me
to follow my dreams

Acknowledgements

This final dissertation has benefitted from the contribution of several people at different level of the process. I would like to acknowledge some of those whose contribution was immense during the field work and finalization of the dissertation.

My utmost gratitude goes to my supervisor Prof. Dr. Marcel Tanner who supported and guided me in my endeavor to find my niche in public health. Your support in defining my research questions, reading versions of my thesis and your valuable comments has shaped the thesis to take its current shape. Thank you indeed Professor Marcel for all your support. I wish to extend my acknowledgement to Prof. Dr. Jakob Zinsstag who encouraged and guided me on how best I could cope with expectations during data collection, analysis and write up. My heartfelt thanks goes to Prof. Dr. Brigit Obrist whose comments were crucial in defining the research questions at the beginning. Latter Prof. Brigit read the different versions of the paper and provided valuable comments that shaped the thesis tremendously. I humbly appreciate for your time and useful comments!

My sincere gratitude goes to Prof. Mitchell Weiss, Dr. Jan Hattendorf and Prof Leickness Symbayi who helped in the choice of methods and applications. Prof. Michel walked me through the application of MAXQDA software for qualitative data analysis while Dr. Jan assisted me in the use of STATA 10 for the survey data analysis. Both of the tools were applied for data analysis for this thesis. Prof. Symbayi shared with me his insights by way of sharing his own experiences in the field which I found was quite useful both during data collection and analysis. Thank you indeed!

Several other colleagues read the different version of the manuscript and provided me with their comments that helped in revising the different versions. Accordingly, I would like to thank Drs. Abeba Bekele, Mitike Molla, Tewabech Bishaw, Alemmaya Mulugeta, Demeke Assefa, Sabin Bieri, Anne Zimmerman and Tibebe Kasawmar for their valuable comments.

I am indebted to Dr. Ibrahim Ame, Sr.Fatuma A/Fita, Tsegaye Gudeta, Girma Getachew who made my stay in Borana smooth and successful. I wish to thank Borbor Bule and Jatani Dida for their unreserved support and guidance during the field work. My appreciation to the staff members of GOAL Borana for their warm and friendly welcome during my field work.

Amena Briet of Swiss TPH spare her precious time not only in editing the entire document but also commenting on coherence, consistency and completeness of the entire document which I found was very important in finalizing the thesis. Sincere acknowledgement to you Amena. Without your support the paper would not have taken this final shape.

During my stay at Swiss TPH, I feel homely with the support and guidance from the passionate staff members of the institute. Thanks to all the staff members. I would however acknowledge Christine Mensch, Christine Walliser and Rebekka Hirsbrunner whom I turn to for specific administrative and library related advices. Their warm welcome and responses to my queries were helpful.

My appreciation also goes to the School of Public Health, Addis Ababa University, especially Dr. Fikre Enquselaasie and Prof. Damen Hailemariam for their unreserved support to get me registered at Addis Ababa University although this was not materialized due to the unexpected change of the university's policy for enrollment of candidates coming from non-governmental institutions.

Thanks also to the office of JACS HoA particularly the coordinator, Ato Berhanu Debele and W/t Rahel who were quick in responding to my demands related to logistic support while I was in the field. I would also like to take this opportunity to thank Prof. Hans Hurni who was keen to see me done with my study and his curious follow up on my progress which I found was encouraging.

I wish to sincerely thank my wife Birtukan Hirpassa, my son Abdi and daughter Jalene Mirgissa who spared the time I should owe them and sacrificed their possible joy if I were with them. The study wouldn't have been completed if you did not stand on my side and consistently encouraged me. Thanks and be blessed my joy and happiness definitely is yours as well.

Finally, I would like to acknowledge NCCR North-South through IP4 for the financial support to this study.

Summary

Background

During the last three decades, most HIV prevention interventions were guided by behavioural models that focused on awareness creation through information provision. Similarly, HIV vulnerability studies argued that risky sexual behaviour, and lack of messages about HIV and related services, especially among women, were factors increasing the chances of HIV infection. While current literature on HIV and AIDS maintains that risky sexual behaviour increases exposure to HIV infection, there is growing agreement that previous studies and interventions designed as described above missed the underlying factors that anchored those prevailing behaviours.

More recent studies show that gender-based violence, women's relatively weak decision-making power, poverty, and concurrent sexual partnerships are factors facilitating the spread of HIV, especially in Sub-Saharan Africa. It is also argued that these factors have specific attributes that may vary dramatically from one culture to another, making it difficult to draw general conclusions about which segments of the population are more affected and why. Failure to recognize this challenge has resulted in HIV and AIDS interventions falling short of expectations to reduce the threat of HIV.

In Ethiopia, after thirty years of interventions, HIV remains a major concern. Recent studies show that although HIV rates are declining or levelling off in some urban settings, it is picking up in small market places and some rural settings. Although literature on HIV among the Borana pastoral community is limited, the few studies available indicate that the community lacks relevant information about HIV and AIDS and extramarital sexual practice were documented to contribute to the spread of HIV. However, there are limitations to these studies that were either not aimed at Borana community in particular or were not specific to HIV and AIDS or were not community based which prevents them from giving a clear assessment of the level of HIV awareness and factors of vulnerability present in the community.

Objectives

The objective of this study is to explore HIV awareness among the Borana pastoral community in Ethiopia and to identify gender-specific and related sexuality attributes that may contribute to increasing vulnerability to HIV infection in the community.

Specifically, the study aims to: a) determine the current level of HIV awareness and misconceptions in Borana, b) identify which gender attributes (role, participation and decision making over resources) facilitate vulnerability to HIV infection and to what extent, c) assess the extent to which the local community is engaged in extramarital concurrent sexual practices d) determine perceived vulnerability to HIV infections and e) identify local opportunities and resources that could be exploited to improve HIV prevention interventions in the community.

The outcomes of this study can contribute to improved design of short- and long-term HIV intervention in the community and help to define further public health research questions of relevance to Borana.

Materials and methods

Study area: Borana is one of 14 zones in the Oromia regional state in Ethiopia. The zone is located at the southern tip of the country, bordering Kenya and Somalia. A recent census report estimates the total population of Borana to be one million. Social services are poorly distributed in the community.

Methodology: A cross-sectional exploratory design was applied to the study whereby quantitative and qualitative methods were used to collect data that responded to the objectives of the study. Surveys were employed to collect data on HIV awareness and misconceptions from both men and women in 502 sampled households throughout three selected districts in the Borana zone. Nine separate focus group discussions (FGDs), including both men and women, and 69 in-depth interviews were carried out to collect data on gender attributes, extramarital concurrent sexual practices and reasons for such practices, perceived vulnerability to HIV infection and potential local resources to improve HIV prevention interventions. Furthermore, as a participant observer in the community, there were opportunities to informally interact with community leaders, which

helped to consolidate the data. Survey data was analysed using STATA version 10, while data from in-depth interviews and FGDs was summarized and coded using the MAXQDA qualitative data analysis tool.

Key Findings

Survey findings showed that only 18% of the respondents could mention abstinence, faithfulness, condom use and avoidance of contact with blood as prevention methods, while the greater majority of respondents sustained incomplete information on prevention methods. Only 9% of survey respondents cited the three modes of HIV transmission (unsafe sexual practices, sharing contact with blood, and from pregnant mother to the foetus) while the majority could identify 'sex' and sharing skin piercing materials. In addition, 85% of the respondents were found to hold three or more misconceptions about HIV transmission, where eating with HIV positive persons, buying food items from a HIV positive shopkeeper, and eating raw meat were mentioned as ways to transmit HIV. Data revealed a growing interest, by both men and women, in knowing more about condoms and how they work as a tool for HIV prevention.

Health Extension Workers (HEWs), school teachers, youth AIDS clubs and to a lesser extent, radio were found to be major sources of information on HIV and AIDS in the community. Apart from information broadcasted on the radio (which the majority of families do not have), research participants expressed mistrust of the information coming from HEWs, school teachers and youth club members who are considered as yet too young to teach the community on such important issues of public concern.

Regarding gender-specific attributes such as roles, participation in public forums and decision-making power over resources, it was found that men are believed to be more exposed to HIV, relative to women, due to their mobility in search of pasture, water and markets for livestock that brings men into contact with women other than their regular sexual partners. Neither participation nor decision-making authority was believed to have any connection with HIV infections.

Although research participants unanimously stated that extramarital concurrent sexual practice is not culturally approved, it was found to be a common and tolerated practice in the community. The practice is considered to be proof of desirability and of fulfilling prescribed gender roles. Extramarital sex is reinforced by individual interest and peer influence in the community, although economic transactions between partners, which at times extend to the family, ensure the continuation of extramarital concurrent sexual practices.

All members of the community believe the community at large to be vulnerable to HIV infection and there is a concern over the future of Borana. In recognition of the seriousness of the problem and the dilemma they face given the favoured status of extramarital concurrent sexual practices, research participants suggested strong involvement from local Gada leaders, the family, government sectors and NGOs operating in the area would rescue the community.

Discussion and conclusions

The findings clearly demonstrate that the community lacks the means to protect themselves from HIV infection, due to weaknesses in the design of interventions that did not pay attention to local contexts. In addition, men's mobility and engagement in extramarital concurrent sexual practices subjects the community to HIV and increases the spread of infection. Although the local health department in Borana claims to have reached the public with relevant prevention interventions, the present study shows that there is a very long way to go toward equipping the community with relevant information and to erasing existing misconceptions.

Although gender-specific attributes such as roles, participation and decision-making power over resources appear to shed a positive light on the fact that women in Borana have some spaces for and rights to action, the fact that women's participation in public forums is passive would make it difficult to reach women with improved HIV interventions through such forums. Another important finding is that extramarital concurrent sexual practices are not likely to end in the near future, given that the practice is interwoven with the social fabric of the community, despite consistent denial of cultural approval. This result calls for a systematic approach to find ways of overcoming such a challenge.

Despite the gloomy picture of HIV and AIDS in Borana, there are opportunities to improve the situation by drawing on local resources. In the short-term, prevention and awareness interventions could capitalize on the influence of Gada leaders and on the community's interest in condoms. A comprehensive long-term empowerment program related to gender and sexuality in connection to HIV and AIDS is also an important consideration.

Areas that deserve further study include ascertaining the acceptability of condoms in view of the strong interest in fertility and reproduction. Such a study may also generate information on acceptable condom distribution channels in pastoral communities. Additionally, more in depth study on gender stereotypes and sexual values among the Borana would help to refine public health interventions for women in pastoral communities.

Chapter 1: Introduction, Literature, Rationale and Methods of the study



Figure 1: Borana girl at Bedhassa village, March 2009, photo by MK

This article is submitted to The Ethiopian Journal of Health Development for publication

1.1. Introduction

Sub-Saharan Africa is known to be the worst affected by HIV pandemic. According to UNAIDS annual report of 2010 the region homes more than two-third of HIV infections the same proportion of new HIV infections among adults and children (1). In the same report, it was indicated that HIV incidence has fallen by 25% in 33 countries of the world during 2001-2009. Although UNAIDS hails the accomplishments that led to the declining trends of HIV infection, there is a strong fear that such gains are yet ‘fragile’ and require more proactive interventions (1). The continued challenge of HIV in this part of the world implies consequences to the precarious development endeavors in the countries of Sub-Saharan Africa. Literature shows that, during the last several years, the pandemic is has reversed demographic, health and economic gains which made it difficult to sustain service provision for those affected and infected members of the community on the other (2–4).

In Sub Saharan Africa, it is also documented that women are disproportionately affected by HIV. On top of their physiological characteristics which provide favorable condition for the virus, women’s relative exposure to HIV infection is attributed to such factors as poverty, gender based violence and women’s weak decision making (5–7). Furthermore, multiple heterosexual partnerships, low rate of male circumcision and inconsistent/incorrect use of condom were identified as factors that explain the unprecedented level of HIV infection in the region (8,9).

In response to this, over the last decades, anecdotal evidence attests that policies, research and programs have been engaged to halt the spread of infection. Yet, endeavors did not stop the spread of the virus. Various explanations have been put forward for such persistence. The first line of argument attributes persistence of HIV infection to the prevention interventions which were informed by behavioral models that target individuals with a focus on the promotion of abstinence, faithfulness and condom use (10–12). Such interventions however were recognized to help in the decline of the pace at which HIV spreads as was shown in the 2010 annual report of UNAIDS. Behavioral

models tend to override the structural foundations of prevailing behaviors (3,11,13) that the virus has continued to spread especially in Sub Saharan Africa (1,3,14). Further evidences show that the behavioral interventions remain generic without due consideration of diversities and often designed by experts at central level for application at community level (2,3). Deterring further infections and meeting UNAIDS's goal of 'zero infection' (1) is suggested to pay attention to structural factors and the design of HIV prevention interventions in reference to specific socio-cultural, economic and political contexts of the target population and with a focus on most affected group especially women (11,13,15,16).

In Ethiopia since the first report of HIV in the early 80's, interventions were put in place. Nevertheless, these interventions were generic ABCs (Abstinence, Faithfulness and condom use) across the country. The Ethiopian Behavioral Surveillance Survey (BSS) of 2005 has further elaborated that, in Ethiopia, comprehensive knowledge about HIV was generally found to be low estimated at (19.3%) but particularly as low as 4.4% among pastoral communities (18). This shows that while the problem of HIV is stabilizing and declining in urban centers (1,17), there are still communities where the problem is still mounting. Pastoral communities in Ethiopia are always in the periphery far from information and are bound to live with their own tradition where the center do not seem to pay attention to and consequently they suffer from such 'emerging' problems as HIV.

This particular study focuses on the Borana pastoral community of Southern Ethiopia. The community is located across the Ethio-Kenya border. In as much as it is physically far from the center, it appears to be far from HIV information and services too. The few available studies conducted in the community documented low level of awareness about HIV and maintain beliefs that are not conventional regarding the routes of HIV

transmission¹ (18,19). This, together with the practice of extramarital sexual partnership is believed to increase the community's vulnerability to HIV infection. This study thus aims to generate evidence on the current status of HIV awareness, gender attributes and sexual values and practices and consequent perceived vulnerability to HIV infection in the community. The study will further identify local opportunities that could be tapped for improved interventions to halt further spread of HIV infection in the community.

1.2. Review of related literature

1.2.1. HIV, Gender and Sexuality

Gender constructs have long been recognized and anonymously reported to determine the status, role and expectations from a person as a man and a woman. It has also been widely recognized that a community's socio-cultural and economic environment shape gender identities, gender relations, and roles including how daily life is organized at family and community levels.

Gender constructs have been well recognized to disproportionately expose women to HIV infection and creating variations in the level of effect HIV has on women and men (7,20–22). The unequal social status of women, their limited access to resources, and lack of decision making authority over resources expose women to HIV infections and places them at a disadvantaged position for accessing HIV and AIDS information and services (15,16,20,22). Specifically, in Sub-Saharan Africa, gender based violence, discrimination; rape and abduction are widespread (20,22,23) where more women living with the virus than men as reflected in the recent UNAIDS report (1).

While gender is fairly comprehensively studied in its connection to HIV and AIDS, sexuality studies focused mainly on sexual knowledge, attitude and practices and associated risks (24–26). However, since recently, sexuality as a broad biological, social

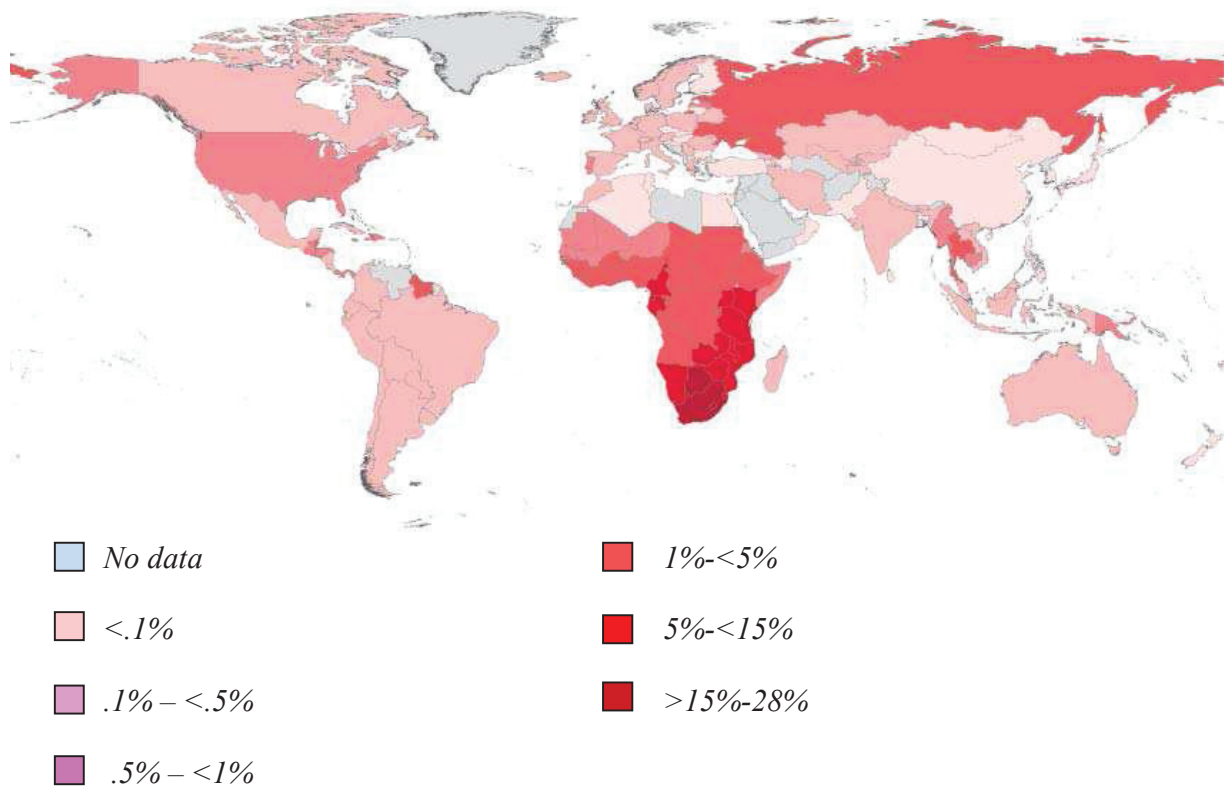
¹ Literatures generally refer to beliefs and understanding that are not conventional as misconceptions while the emic perspective shows that such conceptions and beliefs are normal for the local community. Thus, attempt is made to refrain from using misconceptions in this document

and psychological construct has emerged. WHO clarified that sexuality covers sexual values, identities, pleasure, expression of desire and sexual act itself. The experience of sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural factors that are constructed by the society (27). Furthermore, sexuality is about how sexual engagements and relations are formed and what governs such relations including who has relations with whom, in what ways, why and under what circumstances within the framework of continuously unfolding desire (29–31). Although discussing about sex and sexuality as open as it is today is only a recent phenomenon, it has not stopped the public from thinking, living and experiencing it as an important part of being human and living a full life (13,32,33).

Thus, sexuality is a comprehensive concept linked to gender stereotypes which is considered to be natural and normal given this is about identities, roles and rights (34,37,38). And within these lies opportunities to understand the dynamics of HIV at a community level and design appropriate interventions.

The problem of HIV is more pronounced in parts of the world where poverty, economic and gender inequality is extensive. Different studies show that gender discrimination, rape abduction, widow inheritance and extramarital concurrent sexual practices are widespread in Sub-Saharan Africa (7,15,20,22). Women in Sub-Saharan Africa carry the brunt of HIV infection because of their husbands who are engaged in extramarital concurrent sexual relations on the one hand and because of their own engagement in sex for exchange of financial resources (4,20). The consequence is well reflected in the level of HIV infection in the region where two-third of all infections is documented to be found (1) as shown in fig 1 below.

Fig 2: Global HIV prevalence, 2009



Source: UNAIDS Annual Report, 2010

HIV and AIDS researchers are repeatedly questioning on why HIV intervention in Sub-Saharan African countries fails to meet expected results despite extensive behavior change campaigns and why people continue to place themselves at risk of encountering HIV (2,3,11,14).

Several studies show that prevention interventions did not result in deterring further infections as was expected for interventions were guided by behavior change models (13,15,38) that failed to consider structural factors that anchor individual risk behaviors.

Recent studies on HIV prevention underline the need to pay sufficient attention to the broader socio-cultural contexts of a particular community, including gender, sexuality and behavioral attributes (35,80,126).

Over the course of the last decade, the focus of research on sexuality in relation to HIV and AIDS has moved from behavior, in and of itself, to the broader contexts within which behavior takes place (13,16). Studies show that sexuality comprises biological desires and satisfaction on the one hand and cultural constructs that influence values and norms that govern why, when and how to satisfy sexual desires on the other (34,79,80). An individual's sexual practice thus is informed and modified by an individual's internal biological drive, gender roles, power relations, age, and social and economic conditions. Sexuality thus is a comprehensive concept that goes beyond individual interest and it is biologically shaped and is embedded within the socio-cultural framework of a community (34–36). Helen Epstein in her recent book, *the Invisible Cure*, drew evidences where failure of HIV interventions was attributed to lack of or slow responses to the structural factors that encouraged continued risk taking (40).

The contexts within which sexual values and practices operate, life circumstances of the communities where such practices prevail and the diverse meanings attached to sexual practices in different cultures are important to consider in endeavors to mitigate the spread of HIV infection (15,41,42). And that is why UNAIDS puts forth that meeting its vision of zero new infections will require proper attention to the societal structures and its elements, beliefs and value systems including poverty, gender inequity, inequity in health and the education system that presents obstacles to effective HIV prevention efforts (1)

In Ethiopia sexuality studies in its broadest is yet “Virgin field” of enquiry (43). Although sexuality has been widely studied in the field of public health in terms of sexual behavior particularly awareness and practices related for example to STIs, unwanted pregnancy and now to HIV infections, it remained to be explored further within the sphere of social and cultural contexts of a community of concern. Tadele argues that researchers in public health employ methods that “... dwell [much] on objectifying and

quantifying [what is rather] a sensitive issue that is difficult to quantify...” (43). This poses a challenge to sexuality studies in Ethiopia where available studies failed to capture the structural basis of sexual behavior. Consequently, it is evident that interventions to address sexual health problems including HIV remained shallow dealing with the tips of the iceberg than the problem itself. In Borana pastoral community studies that focused on gender and sexuality in general and in connection to HIV and AIDS in particular is limited.

1.2.2. Vulnerability to HIV in connection to Gender and Sexuality

Early definitions of vulnerability followed a top-down and reductionist approach that tended to attribute the occurrence of a problem to manifestations, without recognizing the context in which the problem occurred (46,107,24). Chambers defined vulnerability in terms of three interconnected attributes: risk to exposure, lack of necessary resources to cope with the threat and the risk of being subjected to consequences (45). Specifically vulnerability to HIV is attributed to exposure to infections which is evident in view the fact that no one community is immune for HIV infection especially in communities where HIV is recorded as generalized epidemic. The weak means available to cope with the challenge of HIV infection would fuel the spread of infection. Thus, in studying vulnerability to HIV infections, resources to cope with the challenge of infection and what specific factors are there within the community to facilitate vulnerability and local resources that could improve interventions are important to consider. Thus, vulnerability focuses of interventions are suggested to be more on structures that shape behavior in holistic terms (29,39,46,47) instead of risks that focus more on individual persons and their behavior.

1.2.3. HIV and the Pastoral Community

It is difficult to produce reliable population data of pastoral communities in Eastern Africa. However, Morton estimated that about 25 per cent of the population of Kenya, five per cent of the population of Uganda and a significant number of the population of Tanzania are pastoralists. The same study estimated pastoralists in Ethiopia, Somalia and

the Sudan accounts for about 16 million. Although this estimate may not be accurate, it is evident that pastoralists make up a good share of population in Eastern Africa (49).

Pastoral communities occupy lowlands where climate is harsh. Economically, livestock is the mainstay of the community embodying their social capital. Mobility and continuous conflict characterizes pastoral community who are marginalized in multiple ways including environmental, economic, socio-cultural and political aspects (49,50).

Although pastoralists represent a large sector of the population, very little is known about HIV and AIDS in these communities. Yet, there is wealth of evidence suggesting that location and place shape the health, exposure and consequent impact on access to services (51). Studies revealed an apparent sexual value that promote multiple sexual practices, early sexual debut for females, high level of sexual networking within and outside of marriage and non-consensual sex among pastoral communities (52–54). There are evidences where not only pastoral communities but also other tribal communities in Australia and the Arabian countries exercise extramarital concurrent sex (56). In today's world of prevailing HIV such communities are under serious threat (55,57).

In Ethiopia although there is no specific study focusing on vulnerability to HIV especially among pastoral communities, much remains to be known on who are vulnerable, why and to what extent. However few other studies documented lack of information and services coupled with sexual values and practices that favor sexual mixing makes communities more exposed to HIV infection (49,50,52,53).

Although available literature documented HIV prevalence rates of up to 20 per cent for roadside settlements and small towns on the transport corridor that runs between Djibouti and Addis Ababa (58). Similar rates are believed to prevail in Somali Region and among the Borana, although it remains difficult to verify the level of infections. However, anecdotal evidences show that limited information and services about HIV and AIDS, sexual interaction between pastoralists and settlers across the main road, prevailing extramarital sexual partnerships among some pastoral groups and evolving patterns of

mobility facilitate the dissemination of HIV among pastoral communities (50). National studies that included the Borana pastoral community have also shown that married men and women practice extra-marital sexual activity with someone other than their own spouse (59). Such a practice is assumed to make this community more vulnerable to HIV infection.

1.3. Rationale of the Study

Borana is the most senior tribe of the Oromo society. The community is best known in Ethiopia not only for its long pastoral tradition and zebu livestock production but also for maintaining the Gada system. The Gada system is a democratic polity where power transfers from one group to the other every eight years following peaceful electoral process. Although Gada system is the focus of this study, it provides guidance on the routine life of the community (58) that it has implication on gender attributes, sexual values and practices as well as community member's perception of vulnerability to HIV infection. The fact that the community is mobile in search of pasture and water for livestock, provision of services remained precarious.

Since the advent of HIV, persistent references have been made to the Borana's extramarital sexual practices as a factor of vulnerability in public discussions on HIV and AIDS. Yet, there have not been studies to ascertain if such practice is indeed there, if that is the case, why it is practiced and how the community copes with the threat of HIV under such circumstances. The absence of such a study is one main reason for the present lack of viable mitigation strategy targeting the Borana.

Equally important is in as much as gender differentials, poverty and inequalities were documented to exacerbate vulnerability, there is dearth of information on which of the gender attributes are associated to HIV infection, why people behave and practice sex in the way they do and its consequences. Besides, there are not studies showing linkages between level of awareness on modes of HIV transmission and prevention, gender attributes, and sexual values and practices and perceived vulnerability to HIV infection

were not available. Thus, this study intends to explore into what constitutes gender and sexuality and how this is perceived to be associated with vulnerability to HIV infection as detailed in diagram 1 below. The research follows holistic assumption that gender attributes, sexual values and practices and individual awareness and consequent vulnerability are the reflection of the underlying socio-cultural contexts, including policies.

The outcome of this study have far reaching implication where recommendations that will be drawn from the study will be considered to design HIV interventions at least for the Borana pastoral community. The study will also provide prominence to the importance of local contexts in responding to public health problems in general and HIV intervention in particular.

1.4. Objectives of the study

1.4.1. General objective

Understanding of the vulnerability to HIV infections necessitates elucidating gender and sexuality attributes as constructed by the social and cultural domains of the community. As shown in the diagram below, the study thus aims to determine awareness at community level on HIV, gender attributes (roles, participation and decision making over resources); values and practices of sexuality as perceived by local community to make them vulnerable to HIV infections.

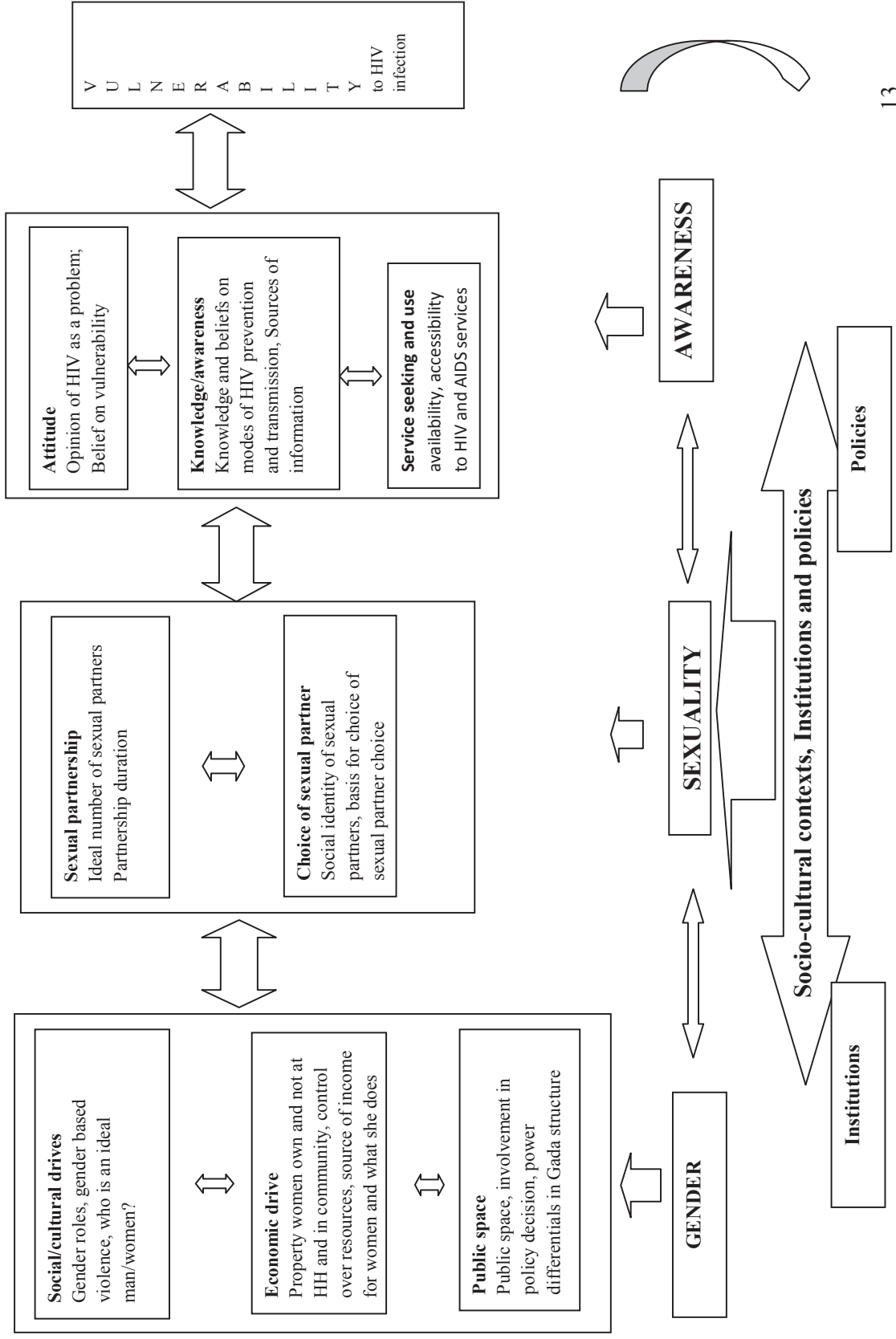
1.4.2. Specific objectives

The study aims to answer the following questions:

1. It is assumed that the practice of extramarital sexual relationships is common and tolerable among the Borana community. If the assumption holds true such basic questions as why extramarital sexual activity is practiced, what reinforces such practices and whether the implications of such practices in terms of exposing the community to HIV infections is recognized by the local community will be answered.

2. Gender role is shaped by the socio-cultural contexts in the community. How is gender role, participation in public forums and decision making over resources instituted in the community's social and cultural life in Borana? Are gender roles, participation in public forums and decision making over resources perceived to have any implication for exposure to HIV infection? What reinforces the prevailing state of gender dynamics in the community?
3. Who is perceived to be vulnerable to HIV infections and why? Are women more vulnerable to HIV infection and why?
4. Furthermore questions on what the community knows on modes of HIV prevention, transmission and whether the community holds understanding that deviates from conventional understanding on HIV and what these are.

Diagram 1 – Problem analysis on perceived vulnerability to HIV infection among the Borana Pastoral community with sexuality component adapted from Dixon’s framework (60)



1.5. Materials and Methods

1.5.1 Background to the study area

The Borana belongs to the Oromo ethnic group of Ethiopia which is the largest single ethnic group in Africa. The Oromo occupies about 40% of the land surface of Ethiopia and population is estimated at nearly 30 million that makes around 40% of the Ethiopian population (61,62). The Borana community is known as the senior Oromo descendants that is known to have maintained the Gada system - core socio-cultural and political framework of the Borana (63). In Borana, Gada as the system of polity is known to have survived at least since the early 13th century which is supported by strong oral history (64) although it is believed to have been weakened in the rest of Oromia zones.

The Gada system is the most sophisticated socio-cultural organization ever known in traditional Africa (63,65). Legesse stated that the Gada-based “Oromo democracy” is one of those remarkable creations of the human mind that evolved into a full-fledged system of government (66). The Gada system was a complex institutional organization that embraced the Oromo peoples’ political, social, economic and religious life . The Oromo had and still have many indigenous systems that govern public wisdom of their own state of life and their worldviews including gender and sexual issues.

1.5.1.1. Location of Borana

Geographically, the Borana pastoral community resides in the southern part of Ethiopia and in Northern Kenya. This community occupies a relatively arid area along the border of Somalia and Kenya. A considerable proportion of the Borana community lives in Northern Kenya while the Ethiopian Borana is estimated at one million (61). Borana zone, one of the fourteen zones of Oromia regions is bounded by Gujii and Bale zones of Oromia to the North and North and east; Somali zone to the east; Kenya to the South and Konso District of Southern Region (SNNP) to the West (See fig2 in green).

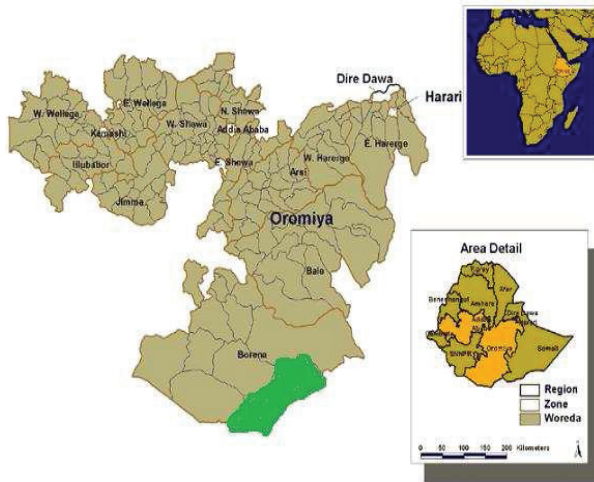


Figure 2: Location of Borana in Oromia region of Ethiopia

1.5.1.2. Borana Economy

As residents of an arid and semi arid environment, the Borana are known as pastoralists. The main means of subsistence among this community is milk and cattle's blood. They also sell their livestock in exchange of food. Possessing many cattle is a source of pride especially under scarce pastureland.

1.5.1.3. Social Services in Borana

While there is a road that connects Borana with Addis Ababa and other Oromia zones, there are gravel roads that connect the seven districts of Borana zone during dry seasons. Social services in Borana are quite limited as evidenced by the number of health and educational facilities in the zone. Although reliable literature is lacking, anecdotal evidence shows that the coverage of literacy and health service in Borana is very low as compared to the neighboring zones of Oromia region. Specifically, HIV related services

are limited to the two hospitals at Bulehora and Negele². During data collection there were couples of health centers that were under construction in the zone.

1.5.2 Methods of the study

The study combined qualitative and quantitative methods. Qualitative methods including observation, in-depth interviews and FGDs were employed to generate information on gender attributes, extramarital sexual values and practices and perceived vulnerability to HIV infection. In addition, through Partnership for Mitigation of Syndrome initiative, awareness creation intervention was launched in six villages with an application of facilitated community conversations every week for three months. This initiative helped to generate data on local understanding related to HIV and AIDS. Quantitative method on the other hand was employed to determine awareness on modes of HIV prevention, transmission and what is considered as misunderstanding about modes of HIV infection among the community.

1.5.2.1. Methods of data Collection

1.5.2.1.1. Qualitative Method

Participants for in-depth interviews and FGDs were identified using snowball technique. The first informant was an elder who served as key informant for the study on Gada system by Legesse in 1973 and recognized as the wisdom power of Borana. This person helped in identifying the next informant. The processes continued until the desired information is generated and data is believed to saturate.

Sixty-nine in-depth interviews and nine sessions of FGDs with sixty eight participants, both men and women, were completed guided by semi-structured questions prepared for this purpose. This method allowed generating rich accounts on local values, practices and norms as regards gender, sexuality, perceived vulnerability to HIV and perceived local mitigation resources from both men and women research participants.

² Following reclassification of Oromia zones currently Negele is the capital of Guji zone

In-depth interviews were carried out at the residence of participants, market places and in towns where it was found to be appropriate for the research participant. Focus Group Discussions were organized in the villages where participants reside. Awareness creation intervention in the six villages engaged over 300 men and women in a weekly facilitated discussion on modes of HIV prevention and transmission, factors facilitating the spread of HIV infection and local resources that could be tapped to improve interventions. In addition to improving participant's awareness on HIV and AIDS, the conversation has also generated relevant data on local understanding of HIV and AIDS and what could be done. Such data was recorded at the end of every conversation using a template developed for this purpose as an input to the data for this study.

1.5.2.1.2. Quantitative Method

The 2007 Ethiopian population and housing census report provided population size at district and kebele³ level. Following probability proportional to size (PPS), twenty four kebeles were selected from three of the seven 'districts' of Borana zone. The three districts were selected based on their distinct characteristics (i.e., residences of typical Borana or mixed residents of Borana, Garri and Gujii. Accordingly, Teltele and Arero representing typical Borana and Liben as district with Borana, Garri and Gujii were selected. The rural sections of these districts were considered for the survey since urban centers are believed to host blends of all cultures in an Ethiopian setting. In each kebele, there were 3-5 locally defined clusters of households (olla) that constitutes at least 50 households. From each kebele one Olla was chosen using random numbers. Enumerators visited each household in the Olla for the interview on socio-demographic features, sexual behavior, awareness about HIV transmission and prevention strategies, source of information, and what is locally believed as modes of HIV transmission. From the twenty-four kebeles, 417 households were selected and 806 married men and women were separately interviewed with a response rate of 97%.

³ The smallest formal administrative unit

1.5.2.1.3. Observation

Staying in the community has offered the researcher with optimal learning opportunities through observation events as they take place. The researcher stayed in the community for a period of two months in 2008, four months in 2009 and short stays of two weeks to one month during 2010. Participation in local cultural events were instrumental to learn more and discuss on specific areas of interest related to the topic at hand with senior local leaders. Specifically, attending the inauguration of the 72nd Gada leaders and the processes that lead to change of leadership was an important opportunity for the researcher to witness the recognition of such leader and the potential role the leader could play in endeavors to mitigate the spread of HIV infection in the community.

1.5.3. Methods of Data analysis

Survey data was analyzed using STATA version 10. Data was summarized using frequencies and associations between outcome and explanatory variables were measured using OR by running uni and multivariable logistic regression.

Qualitative data analysis followed inductive procedure where field notes which were initially written in Afaan Oromo were translated into English and back translated to Afaan Oromo to ensure consistency before it was written in to computer. Development of codes helped to categorize information in to themes guided by the objectives of the study with an application of MAXQDA qualitative data analysis software.

1.5.4. Data Quality Assurance

In order to ensure data quality of both sets (qualitative and quantitative) specific steps were followed. Survey tool which was developed in English was translated into Afaan Oromo and then back translated in to English to ensure consistency. The tool was pretested in the village that was not selected for the study to check if questions are understood and subsequent corrections.

During data collection, field supervisors were checking the completeness of survey data. Raw data was entered into SPSS version 16 by two independent data encoders. Later, this data was transferred into access and was compared using epi info to ensure consistency.

Qualitative data which was collected in Afaan Oromo was transcribed and translated into English. Eight randomly chosen transcribed and translated notes were back translated again into Afaan Oromo to check for consistency.

1.5.5. Ethical Considerations

Ethical clearance for the study was obtained from the school of Public Health, Addis Ababa University, Ethiopia and Swiss TPH Institute. At the study site, research objectives and implications were explained to the zonal administration. The zone administration wrote letter to district administrators introducing the researcher. At data collection level explanation was provided to research participants on the objectives of the research and implications of the findings in an endeavor to improve HIV prevention interventions. Interviewers were advised to read the message to the interviewees in the beginning of each interview session. The message clearly elaborated that participation is based on interest and interviewee were offered the opportunity to quit participation at will if they wished at any point in the interview process. Through Partnership for mitigation of syndrome (PAMS), the community members in six villages were offered an opportunity for participatory learning. Over 300 community members participated on facilitated discussions at community level on the one hand and contributed to the research process on the other hand.

In reporting the results in this dissertation, pseudonyms were used to maintain the anonymity of participants. However, sex, age, source of information (in-depth interviews or focus group discussions) and residence of the participant were shown for easy reference.

1.6. Limitations of the Study

Although most of the points stated as limitations in this study are common in ethnographic studies, I find it useful to reiterate some of them in view of the fact that cross cultural realities would strengthen previous documentation. During the data collection it was found apparent that Borana pastoral community clings to each other and this is an indication of a strong group sentiment. They walk, sit and drink together. As a result, it was not easy to spend several hours with one informant alone. In as much as finding appropriate time with one informant was found challenging, so was getting appropriate private space. Often, a passerby joins the interview, spends some time listening and participating in the process which could as well be an opportunity. This was useful with additional normative information, but it also affected the pace at which a particular interview could be completed. This resulted in returning to the same person several times.

Borana has a very strong oral account, keeping on narrating in much detail about the issues raised for discussion: extramarital sexual partnership, gender roles, position of women, and perceived state of HIV in the community. Among the Borana an issue is discussed with contexts and evidence.

During the field in Borana, it was counterproductive to write and listen at the same time. Active listening is critical among the Borana where one has to follow the flow of the discussions, reassuring listening and understanding by body language (nodding, smiling etc). This has made active field note taking difficult. Equally, taping was also found to be destructive. Intermittent pauses also affect the smooth flow of ideas during discussions. In order to deal with such challenges, research assistants took notes that were developed into details during the night of the day the interview was conducted.

Borana tend to generalize information they provide. They rarely refer to themselves as individuals. Such normative accounts affected efforts to generate specific information that relates to an individual.

HIV prevalence data was collected from available official documents in the zone as well as from the regional Health Bureau which may be difficult to ascertain validity of data. So, that limitation should be kept in mind while reading the text.

1.7. Organization of the thesis

This document is structured into seven different parts. The first part provides background to the study setting and the broader framework around gender, sexuality and vulnerability to HIV infection. Furthermore, this section defines the intended purpose of the study, research questions and methods employed. This section is followed by series of chapters that addresses the specific questions of the research. Chapter two provide an account on the current level of HIV among the Borana pastoral community. It explains research participant's knowledge on modes of prevention, transmissions and if there are deviations from what is considered conventional knowledge on HIV and AIDS, and perceived vulnerability to HIV in the community. Chapter three focuses on the gender attributes in Borana and its association with vulnerability to HIV infections. This chapter shades light on gender roles and how local culture view men and women, and who is perceived to be more vulnerable to HIV in connection to her gender. Chapter four provides evidences on sexual values and practices in Borana, reasons why prevailing practice is sustained and its association with vulnerability to HIV infection. Chapter five elaborates on vulnerability to HIV in Borana shading more light on the different factors that work in tandem to facilitate community's vulnerability to HIV infection. Chapter six provides insights on local opportunities and resources that could be tapped in an endeavor to mitigate the spread of HIV infection in Borana. Finally the last chapter is dedicated to reflect on the findings and provide recommendations following key findings.

Chapter 2: The State of HIV Awareness after Three Decades of Intervention in Ethiopia:

The Case of the Borana Pastoral Community in Southern Ethiopia



Figure 4: Message on HIV at a school in Yabello, November 2008, Photo by MK

2.1 Abstract

Background: HIV continues to be the major challenge to development in Ethiopia. Despite prevention effort during the last three decades, the pandemic has continued to spread to remote pastoral communities.

Objective: The objective of this chapter is to determine what is known on modes of HIV prevention and transmission among the Borana pastoralist community in Ethiopia.

Methods: cross-sectional survey of 403 households, 69 in-depth interviews and nine Focus Group Discussion (FGD) sessions with 68 participants were carried out to generate data. STATA version 10 was applied to analyze survey data while MAXQDA qualitative data analysis software was used to summarize and code qualitative data for further analysis and interpretation.

Results: Survey data revealed that only 10% of the respondents identified all modes of HIV prevention, with significant difference between those who discuss sex with partners and those who do not. Eighty nine percent of the respondents could mention only one or two modes of HIV transmission where those in Arero and Teltele districts (OR=5.3) and those who do not discuss about sex with partners (OR=1.6) were found to have limited knowledge on HIV transmission. Misunderstanding about HIV as compared to conventional knowledge are found to be widespread with 82% of the respondents citing shaking hands, living and eating with someone with HIV, and buying food stuff from an HIV positive shop keeper as ways of transmitting HIV. It was found that those who reside in Arero and Teltele districts (OR=0.4) and those who reported to have no extramarital sexual partners (OR=2.5) were found to have more misunderstandings.

Community conversation facilitated by health extension workers, school teachers, youth AIDS club members and radio are sources of HIV information, although research participants did not always trust credibility of information coming from HEWs, school teachers and youth AIDS club members while radio is not available for the majority.

Discussion and conclusions: After three decades of interventions, the majority of people in Banora people are not well informed about modes of HIV transmission and prevention, and widespread misunderstanding about HIV are apparent. Results of this study will assist HIV/AIDS prevention and control programs tailor their interventions according to local contexts.

2.2. Introduction

Recent Ethiopian behavioral and demographic surveillance surveys show that HIV may be less prevalent but more heterogeneous than previously thought. The surveys show that while HIV infection is rate stabilizing in urban settings and relatively widespread and heterogeneous in rural settings (18,58). The last national HIV surveillance survey report in 2005 shows that more than one million people are estimated to be living with HIV in Ethiopia, with women accounting for 59%. The same report projected that 79,000 pregnant women would be HIV positive by 2008 and that 14,000 HIV positive births would occur that same year (58).

Available literature shows that the epidemic is shifting from urban to rural settings and market centers that were previously not given enough attention by interventions. The studies consider these settings to be emerging hotspots for HIV in Ethiopia (17,18,67).

While rural towns and market centers are becoming hubs for HIV infection, there is evidence of regional variations in the spread of HIV. A study on male army recruits in 2000 shows variations of HIV prevalence in urban settings ranging from 4.3% in the Southern Nations, Nationalities and People's Region (SNNPR) to 10.5% in Amhara. Rural prevalence was found to range from 3.2% in SNNPR to 4.3% in Amhara (68). The recent demographic and health survey and HIV surveillance survey that was carried out by the Ethiopian Ministry of Health has documented regional variations of HIV infection rates with Afar, Tigray and Amhara regions sustaining the highest prevalence, estimated at 10.9%, 10.8% and 9.8%, respectively (17,58).

The state of HIV and AIDS awareness is least studied among pastoral communities in Ethiopia. A published study among the Hamar community in Southern Ethiopia flagged major concerns over expanding HIV infections in this pastoral community due to the prevailing promiscuous sexual practices among members of the community (53). Studies on harmful practices in Borana has revealed that prevailing practices of extramarital sex,

polygamy, marrying the sister of a deceased wife, and widow inheritance are shown to be linked to the spread of HIV infections (19,51,59,69).

Although recent evidence is lacking regarding the prevalence of HIV infections in Borana, a sentinel surveillance survey report indicates that of all pregnant women who visited Moyale health center in a district in Borana, 5.1% tested HIV positive (58). This figure exceeds the national estimate of 3.1% of the adult population. Few unpublished reports from the Borana zone health department revealed higher rates of HIV infection rates among the general population. In 2004, 256 healthy looking individuals were counseled and tested for HIV at Negele Hospital in the Borana zone, of which 104 were reported HIV positive. With the objective of scaling up Anti Retroviral Therapy (ART) in Ethiopia, a series of HIV counseling and testing campaigns run during 2006-2008. Data from the campaign reveals that in Oromia region (of which the Borana zone is a part), about five million individuals were tested and 2.2% were found to be positive while from about 100 thousand individuals in Borana were tested and 3.0% were found to be HIV positive (70). From this prevalence of HIV infection is worrisome in Borana.

The national Behavioral Surveillance Survey (BSS) report of 2005 concluded that comprehensive HIV knowledge, estimated at 14% for the general population, is much lower among pastoral communities, including the Borana; estimated at 4.4% (18). A study carried out by UNDP showed that knowledge of modes of HIV infection was lowest in the Yabello district of Borana zone (59). There were studies that shows widespread misunderstanding about HIV among pastoral communities with at least one form of misunderstanding about HIV constitutes 95% as compared to conventional understandings among pastoralists (17,59).

By way of laying the basis for subsequent chapters, this chapter presents the current state of HIV especially the community's awareness, misunderstandings about HIV and perceived vulnerability to HIV. The outcome of this particular chapter provides evidence that national and local HIV programs could use to tailor interventions that would improve

level of awareness and knowledge on HIV in general modes of prevention and transmission in particular.

2.3. Materials and methods

2.3.1. The study community

The Borana community is recognized as the senior Oromo clan and is best known for maintaining the Gada system, an important system of governance used since the early 13th century (64). While a considerable proportion of the Borana community is believed to live in Northern Kenya, those living in the Borana zone of the Oromia region in Ethiopia account for an estimated one million people (61). The Borana occupies a relatively arid area bordered by the Gujii and Bale zones of Oromia to the North and Northeast, by the Somali zone to the East, Kenya to the South, and the Konso district of the Southern Region (SNNP) to the West. Borana is a pastoral community with an economy based on livestock rearing.

2.3.2. Methods of Data collection

Data was collected from October 2008-April 2009, while subsequent visits to Borana in 2010 helped to substantiate data collected in previous years. Cross sectional surveys, in-depth interviews and FGDs were used to generate data. Survey was employed to measure the level of awareness about modes of HIV transmission and prevention, and prevailing misunderstandings about HIV as compared to what is conventionally known.

Three districts were purposely selected, for the survey, based on the resident pattern: predominantly Borana or a mix of Borana, Gujii and/or Garri. Accordingly, Teltele and Arero were identified as predominantly Borana districts, while Liben was considered for it hosts Borana, Gujii and Garri ethnic groups that are living together. The rural settings of these districts were targeted to avoid an urban bias in the state of awareness and level of misunderstanding about HIV and AIDS. Eighteen kebeles (peasant associations) were randomly selected and from each kebele, one Olla (a cluster of at least 50 households) was chosen using a lottery method. With an application of population proportion to size, 417 households (HHs) were identified for an interview. Trained enumerators interviewed

spouses in the same household separately, using a pre-tested questionnaire. Responses were completed for 403 (97%) households. In-depth interviews and FGDs were held with an objective to determine gender attributes, and extramarital sexual values and practices and associated perceived vulnerability to HIV infections. Nine sessions of separate men and women FGDs and sixty nine in-depth interviews were carried out to generate required information.

2.3.3. Methods of Data analysis

Survey data was entered to SPSS version 16 and analyzed using STATA 10. Data was summarized using frequencies where Odds Ratio was used to measure significance of associations between outcome variables (knowledge on modes of HIV transmission, prevention, and levels of misunderstandings about HIV) and selected explanatory variables.

Qualitative data was analyzed following an inductive analysis approach. Field notes were translated from Afaan Oromo to English and entered in MAXQDA qualitative data analysis software. Codes were developed to categorize information according to theme, in view of the study objectives. Pseudonyms were used to maintain the anonymity of the participants. However, sex, age, source of information (in-depth interviews or focus group discussions) and residence of the participant were shown for easy reference.

2.3.4. Ethical considerations

The study proposal was approved by the Ethical Clearance Committee of the Medical Faculty of Addis Ababa University. Borana zone administration allowed data collection at the district level after being briefed on the purpose of the study. At individual level, full consent was secured before engaging subjects in the study. Making the data anonymous and avoiding personal identifications ensured confidentiality of the study.

2.4. Results

2.4.1. Socio-demographic characteristics

The majority of survey respondents are Oromo (97%), married (96%), can not read and write (78%) and followers of indigenous religion (Waaqeffataa) (43%) as shown in Table 1 below.

2.4.2. Awareness of modes of transmission and prevention

Findings show that 382 (98%) females and 399 (96%) males claimed of hearing about HIV, with no significant variation between male and female. Further questioning of what was heard revealed that study participants do not even know if there is any difference between HIV and AIDS where they were questioning back on if HIV and AIDS are any different “adda addaa?” while all respondents consider HIV to be a *‘killer disease’*.

Only 11% of respondents know all the three modes of HIV transmission (sexual intercourse, sharing skin piercing materials, and from a pregnant mother to the fetus) (Table 2). Most, 89% could mention one to two modes of transmission with over 90% citing sexual activities and sharing of sharp and skin piercing objects.

Univariable logistic regression analysis of association between ‘research participants’ who were found to have limited knowledge on modes of HIV transmission’ and their sex, age, place of residence, religion, whether they discuss about sex with partner, and current engagement in extramarital sex (jaala jaalto) revealed that women, those who believe in other religion than local religion and those who do not discuss about sex with their partner and residents in Arero and Teltele district were found to have known less about the modes of HIV transmission (Table 2). However, multivariate analysis reveals that those who reside in Arero and Teltele districts (OR=5.3), women (OR=2) and those who do not discuss about sex (OR=1.6) were found to have limited knowledge on modes of HIV transmission.

Of the respondents, 10% mentioned all prevention strategies (abstinence, faithfulness, condom use and avoidance of sharing skin piercing materials) with no significant variation between male and female respondents. The majority of respondents, 90% (54% male and 46% female) mentioned as few as one prevention strategies with abstinence and faithfulness frequently mentioned. Univariable logistic regression analysis provides evidence where those over 41 years of age and who do not discuss about sex with partner were found to have limited knowledge about modes of HIV prevention (Table 2). Multivariate analysis confirmed that those over 41 years of age and currently do not discuss about sex with spouses have limited knowledge on modes of HIV prevention (Table 3).

Qualitative findings revealed that avoiding skin-piercing materials, limiting oneself to one partner in addition to the spouse, and use of condoms are common HIV prevention strategies. *“We heard that faithfulness with the spouse and use of condom are important for the HIV prevention of HIV infections” (W56, II Arero)*. However, as explained further in Chapter 4, in practice extramarital concurrent sex is part of Borana’s routine way of life.

Sources of information on HIV and AIDS were reported to come from radio (58%), public gatherings organized by community health workers (34%), school teachers and students, and visiting relatives from urban settings. Qualitative data shows that majority do not own radio which would have provided reliable information. Participants indicated that information from health extension workers; school teachers and children are not trusted though it is the major source of information. One respondent argued that *“We do not have sufficient information about the disease and how it is transmitted. We get mixed information about the disease, some say it is a problem for those residing in towns; others tell us it affects all of us. One thing is clear that it transmits through sexual relation with someone other than one’s own spouse. This, I do not think is acceptable for us in Borana” (W38, FGD Liben)*.

2.4.3. Local Beliefs about HIV transmission

Seven common misunderstandings as compared to conventional modes of HIV transmission were identified. These includes shaking hands, eating, sharing clothes and living with an HIV positive person, mosquito bites, eating raw meat and buying food stuff from a HIV positive shopkeeper were believed to facilitate HIV transmission. As shown in Table 2, eighteen percent of survey respondents were found to have no such misunderstandings about HIV while the wider majority (82%) had lived with at least three of such misunderstandings on modes of HIV transmission.

Univariable logistic regression analysis shows that those who live in Arero and Teltele districts, followers of other religions than local religion (Orthodox, protestant and catholic) and those who currently do not have extramarital sexual partners were found to sustain more misunderstandings about modes of HIV transmission as compared to those who live in Liben district. Further multivariable logistic regression analysis shows that place of residence was found to be associated with more misunderstandings on modes of HIV transmission. As compared to respondents from other study districts, those in Arero and Teltele districts (OR= 0.4) was found to have significantly more misunderstanding about HIV as compared to others (Table 3).

Qualitative data shows that three in four participants (male and female) maintained what are conventionally wrong beliefs about modes of HIV transmission. Duretti pointed out that “...yes it is not safe to eat and live with someone who has HIV”. She emphasized that “... it is always good to keep oneself away from someone who has the virus” (W39, FGD Liben). Huka contends that “While others felt that living, sharing clothes and eating with an HIV sick person may not have any problem, I think living together with such a person would put you at risk since living together would any way lead to sharing materials” (W56, II Arero). Kulule felt that “...those who eat and stays in the same house with someone with the virus are likely to get the virus themselves” (M70, FGD Arero). Some research participants are even scared to speak of the person with HIV. Kura pointed out

that “*I get scared to call the name of an infected person. I feel the disease may jump to me*” (M69, II Yabello).

Lack of awareness about HIV and its associated misunderstanding about HIV are reflected in the zone’s available biological data from Borana zone. The Millennium HIV Counseling and Testing Campaign conducted throughout Ethiopia, including Oromia region, during 2006-2008 shows that the prevalence of HIV in Borana was consistently high as compared to other zones during the three years campaign, with an infection rate of 3%, as shown in Figure 1 below.

2.4.4. Perceived vulnerability to HIV

Survey as well as in-depth interview and FGD participants was asked to assess their own risk of getting HIV and whether they are more or less at risk in comparison to their spouses. Responses indicate that the study group tends to externalize HIV as a problem of those who reside in urban settings, specifically sex workers. The survey data shows that the majority of respondents (68%) do not feel at risk of getting HIV. In depth interviews and FGDs show that women claim to be less at risk of infection compared to men. Women argue that they are not as mobile as men who migrate with livestock in search of water and pasture and visit cities to sell livestock where they meet local women. Women research participants reported that those women who compete to have several extramarital concurrent sexual partners were at a higher risk of encountering HIV like men do.

Men, on the other hand, believe that both men and women encounter HIV, particularly if they have many extramarital concurrent sexual partners. Although survey data found that 84% of the respondents reported having no extramarital concurrent sexual partners, with no variation between male and female respondents, qualitative data shows that extramarital sex is commonly practiced in the community. Gelam stressed that “*Both men and women are at risk of getting HIV since both maintain jaala and jaaltoo in addition to their spouse (W25, FGD Liben)*”. Extramarital concurrent sexual practice has been practiced for generations. Dhadechi explains the desirability of extramarital sex

thus: “...*jaala-jaalto* remains an important mechanism to prove oneself wanted by the opposite sex. One who is not wanted is undermined not only by the community but also by the spouse and this is what maintains the continuous search for an extramarital concurrent sexual partner” (M35, FGD Arero). Such sexual practice is agreed by both men and women research participants to expose both men and women to HIV.

2.5. Discussion

A recent epidemiological synthesis report (2009) documented the reduction of high-risk sexual behavior and consequent decline or leveling off of HIV infection rates in urban settings. However, rural towns and markets are found to be emerging hotspots, although what segments of the rural population are most affected and where needs to be determine (17).

As any other country with a multicultural society, Ethiopia encounters variations in the level of infections and status of awareness about HIV and AIDS. In Borana, the present study found a lack of awareness about modes of HIV transmission and prevention and identified common beliefs about modes of HIV transmission against conventional modes of HIV transmission. The finding reveals that only 10% of all respondents could list the four modes of HIV prevention. The remaining majority (90%) were found to be inconsistent in what they know about HIV prevention. Those who are over 41 years of age and who do not discuss about sex with their partners were found to have low knowledge of modes of HIV prevention. This can be explained by the fact that the older generation tends to stick to available information and may not actively seek new information. It is also possible that these group may not be as actively mixing with others which denies them opportunity for new information.

It was found that only 11% of the respondents cited all modes of HIV transmission, while 89% were found to have incomplete information on how HIV is transmitted. Despite claims of having heard about HIV, what is actually known about transmission and prevention is incomplete and weak. This is consistent with the findings of different

studies that documented a poor level of awareness of HIV and AIDS for the entire country (17,59,67)It was shown that those who are from Arero and Teltele districts and who do not discuss about sex with partners were found to have limited awareness about modes of HIV transmission. This may have to do with the fact that both Arero and Teltele are off the main road and available interventions are weak in these districts. Similarly those who do not discuss about sex with their partners were also less informed showing discussions on sex with partner improves the level of information one would have on HIV and AIDS.

The lack of HIV awareness among the Borana manifests itself through widespread misunderstanding about modes of HIV transmission. Among pastoral communities, there is a tendency to externalize the problem of HIV (7). Similarly, in this study qualitative data reveals that HIV is a problem of urban settings where commercial sex workers are residing. The majority of respondents (nearly 82%) believe HIV could be transmitted through one or more of the following: hand shaking, eating with, sharing clothes and living with a HIV positive person, a mosquito bite, eating raw meat and buying food stuff from a HIV positive shop keeper. Research participants from Arero and Teltele, those who currently do not have extramarital sexual partner and over 41 years of age were found to hold a lot more misunderstanding about modes of HIV transmission. This may have to do with the fact that Arero and Teltel are off the main road which makes it away from information. Those who currently do not have extramarital sexual partners are undermined as explained in chapter 4 and find it difficult to mix with others making it difficult to get access to information. Similarly those who are over 41 years of age often stick to available information than seeking for new ones and they are less likely to mix with others due to their age that they do not have new information.

The lack of HIV awareness and associated misunderstanding about modes of HIV transmission in Borana are supported by the available biological data showing relatively high prevalence of HIV in Borana. HIV prevalence at Moyale health center was 5.1% (37% higher than the sentinel surveillance survey average for the country during the same year) (58). Unofficial data from the Millennium HIV Counseling and Testing Campaign

of 2006-2008 shows that HIV prevalence for Borana is relatively high (3%) compared with the regional rate of 2.2% (70). This clearly shows Borana pastoral community is in a state of looming HIV 'disaster'.

In Borana, radio broadcasts, community gatherings, and relatives who visit from urban settings are major sources of information on HIV. The present study found that radio is trusted as a source of information at the community level. However, most respondents do not have a radio though they reported to get second hand information from relatives who reside in urban settings and get information from the radio. Information disseminated in community gatherings facilitated by community health workers, school teachers and students are least trusted since such the facilitators are considered by most to be young and lacking in experience. Among the Borana, abstinence and faithfulness do not apply as women remain chaste before marriage, and after marriage extramarital sex is tolerated. Thus, the messages provided by health extension workers, school-teachers and youth club members who are least trusted as they lack experiences and information on the one hand and they are also providing information that does not make sense in the Borana context.

Qualitative data shows extramarital concurrent sexual engagement is common in the community, survey data shows most respondents denying engagement in such practices. This has important methodological implication on future research on sexuality. Among the Borana, abstinence and faithfulness may not be the best solution in HIV prevention endeavors since in the community women remain chaste before marriage and after marriage extramarital concurrent sexual practice is tolerable practice. Thus, the messages provided to the community by the providers mentioned above do not acknowledge local contexts. Information on condoms, however, was of interest to the community with demands to know more about how they work and where to obtain them.

Despite UNAIDS' vision of zero discrimination, zero new HIV infections, and zero AIDS-related deaths through universal access to effective HIV prevention, treatment, care and support (16), HIV remains a major challenge in Borana, where incomplete

awareness and beliefs about modes of transmission and prevention and engagement in extramarital sex prevails.

2.6. Conclusion and recommendations

The present study gives evidence that awareness on modes of HIV transmission and prevention is poor among the Borana people. This has contributed to widespread misunderstandings about HIV and its modes of transmission. The study findings are further supported by available biological data, revealing high HIV prevalence in Borana. The interventions at the community level did not help to improve the state of awareness about HIV and AIDS nor did it reduced the overall level of infection. Especially residents of Arero and Teltele, those over 41 years of age and those who do not discuss about sex were consistently found to hold limited knowledge about and beliefs on modes of prevention, transmission about HIV.

In addition to generating evidence on the state of HIV transmission and prevention knowledge in Borana, the present study also draws attention to the government's prevention strategy, which is centrally designed and does not pay attention to local contexts, resulting in differences between the government's claims of successful prevention interventions and the low level of awareness at the community level.

The results of this study call for stakeholders, especially the HIV and AIDS prevention and control programs at national and regional level, to consider local contexts when designing interventions and to consider the local resources including expressed interest to know more about condom and the influences of Gada leader in order to enhance interventions. It is also imperative to build on the community's current interest in knowing more about how condoms work and they can be obtained to design successful prevention intervention.

2.7. Limitations of the study

Study districts were chosen purposively without following proper sampling procedure since the intention was to find out if being Borana or otherwise could make difference in the level of awareness. Thus readers should take this into consideration in interpreting confidence intervals. Secondly, for prevalence data reference was made to unofficial data from the Borana zone and thus may not provide concrete evidence. A parallel biological study to determine the current incidence and prevalence of HIV in Borana would have enriched the behavioral findings and make for a stronger case. Finally, caution should be taken in the application of the findings of from this study to other pastoral communities in view of contextual variations.

Table 1: Socio-demographic characteristics of study participants in Borana. April 2010.

Key variables	Male (n=416)	Female (n=390)	Total
Sex	53%	47%	
Age			
<=18 years	2%	6%	
19-24 years	8%	15%	
25-29 years	15%	21%	
30-34 years	15%	12%	
>= 35 years	60%	45%	
Ethnicity			
Oromo	97%	96%	96.5%
Non Oromo	3%	4%	4.5%
Religion			
Waqefata	43%	43%	43%
Muslim	37%	38%	37.5%
Protestant	9%	7%	8%
Others	11%	12%	11.5%
Educational status			
Cannot read and write	68%	87%	77.5%
Completed elementary	23%	11%	17%
Completed secondary	9%	2%	5.5%
Marital status			
Married	95%	96%	95.5%
Divorced	3%	3%	3%
Widowed	2%	1%	1.5%
Current practice of extramarital sex			
Yes	17%	15%	16%
No	83%	85%	84%

Table 2: Univariable logistic regression of associations between knowledge on modes of prevention and transmission and misunderstandings on modes of HIV transmission and selected independent variables, Borana, April 2010 (n=806)

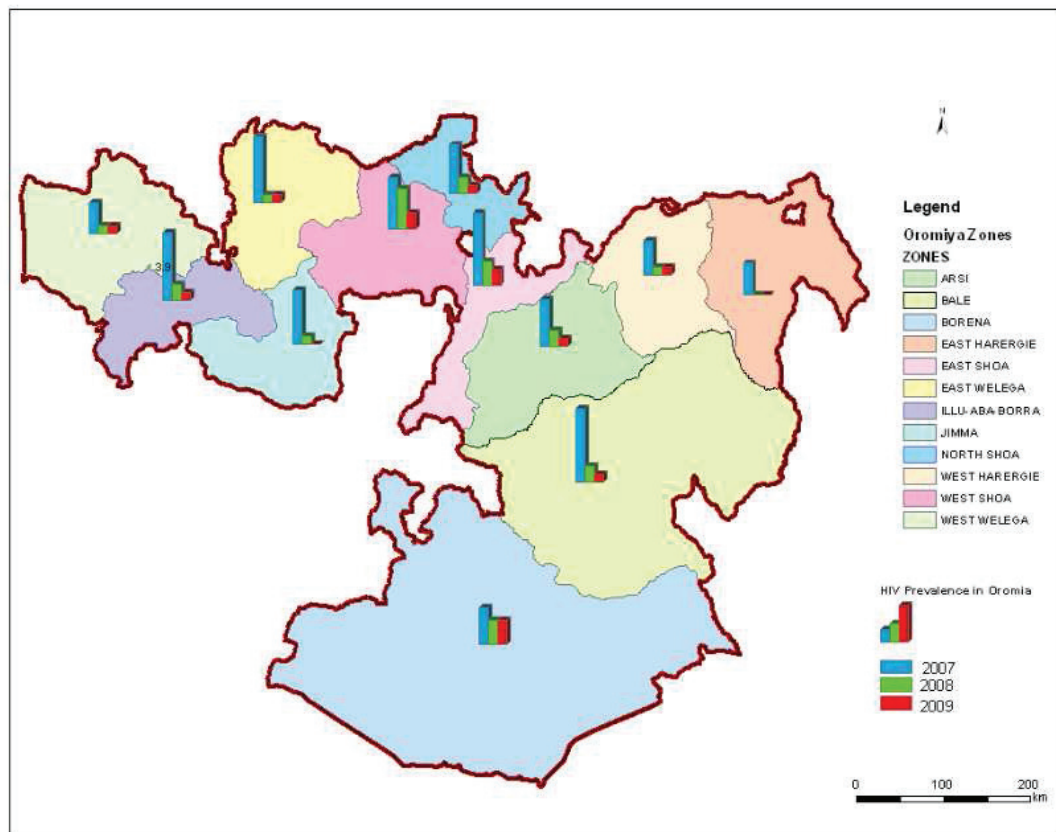
Independent Variables	Outcome variables					
	Knowledge on modes of HIV prevention		Knowledge on modes of HIV transmission		Misunderstandings on modes of HIV transmission	
	%	OR (95%CI)	%	OR (95%CI)	%	OR (95%CI)
Sex						
Male	54.0	Reference	38.9	Reference	51.3	Reference
Female	46.0	0.9 (0.4-1.3)	61.1	1.8 (1.1-2.9)	48.7	0.9 (0.6-1.3)
Age						
<30 years	33.3		16.7		15.4	
30-40 years	42.7	1.1 (0.5-3.5)	16.7	0.8 (0.3-1.8)	18.0	0.9 (0.5-1.9)
>=41 years	23.9	0.7 (0.2-0.9)	12.5	0.7 (0.3-1.7)	14.5	0.9 (0.4-1.9)
					52.1	
Wereda						
Liben	57.5	Reference	18.1	Reference	69.2	Reference
Arero-Teltele	42.5	0.9 (0.5-1.9)	81.9	5.7 (1.0-10.7)	30.8	0.5 (0.3-0.6)
Religion						
Waaqefeta	47.5	Reference	77.8	Reference	65.8	Reference
Muslim	47.5	0.8 (0.4-1.6)	19.4	0.4 (0.2-0.7)	18.8	0.4 (0.2-0.6)
Others	5.0	3.6 (0.8-16.0)	2.8	0.1 (0.02-0.32)	15.6	0.5 (0.3-0.9)
Discuss sex						
Yes	96.9	Reference	96.6	Reference	94.4	Reference
No	3.1	0.6 (0.4-0.9)	3.4	1.8 (1.4-2.3)	5.6	0.5 (0.3-1.02)
Currently have extramarital partner						
Yes	84.7	Reference	83.7	Reference	85.8	Reference
No	15.3	3.4 (0.8-14.6)	16.3	1.1 (0.6-2.1)	14.2	2.2 (1.3-3.5)

Table 3 Multivariable logistic regression analysis of associations between knowledge on modes of prevention and transmission and misunderstandings on modes of HIV transmission and selected independent variables, Borana, April 2010 (n=806)

Selected explanatory variables	Outcome variables		
	Knowledge on modes of HIV prevention	Knowledge on modes of HIV transmission	Misunderstanding on modes of HIV transmission
	OR (95% CI)	OR (95% CI)	OR (95% CI)
Sex Male Female	0.8(0.4-1.3)	2.0 (1.1-3.3)	0.8 (0.5-1.3)
Age <30 years 30-40 years ≥41 years	1.3 (0.5-3.4) 0.4 (0.2-0.9)	1.3 (0.7-2.4) 1.3 (0.6-2.5)	0.9 (0.5-1.4) 0.5 (0.3-0.9)
Wereda Liben Arero-Teltele	a	5.3 (2.8-10.0)	0.4 (0.2-0.6)
Religion Waaqefeta Muslim Others	a	a	a
Discuss sex Yes No	0.6 (0.4-0.9)	1.6 (1.2-2.1)	a
Currently have extramarital partner Yes No	a	a	2.5 (1.5-4.1)

a) Variables omitted due to co linearity

Figure 5: Level of HIV infections in Borana



Source: Unofficial report on Millennium AIDS Campaign 2006-8, Oromia Health Bureau, March 2010

Chapter 3: Gender attributes and perceived vulnerability to HIV infection
among the Borana Pastoral Community



Figure 6: Borana women - hair dressing under the shade close to market place

February 2009, Photo by MK

This article is in preparation for submission to the Journal of Northeastern African Studies

3.1 Abstract

Background: Available literature shows a strong association between gender and level of HIV infection in Sub-Saharan Africa. Specifically, gender based sexual violence; inequality and discrimination are documented to facilitate the spread of HIV. However, such conclusions may not apply across all cultures.

Objectives: The objective of this chapter is to determine if gender attributes such as roles of men and women, level of participation in public affairs, and decision-making power over economic resources at household level are perceived to make men, women or both vulnerable to HIV infection among the Borana pastoral community.

Methods: A total of 69 in-depth interviews and nine FGD sessions with 68 participants were completed. Semi-structured interview guides were employed to collect information on gender roles, participation in public affairs, value of sex at birth, decision-making power over resources and perceived vulnerability to HIV infection. Data was coded and categorized following defined themes. Application of MAXQDA qualitative data analysis software facilitated the analysis.

Key results: Among the Borana, the birth of a son is celebrated and is a source of pride for the family and a mark of identity for the mother. Because daughters marry and join another clan, they are not favored as much as sons. Borana men are responsible for herding livestock, heading the family and representing the family in public affairs, and defending communal territory. Women are responsible for child bearing, household tasks, including building houses and looking after calves. However, women's role could go beyond household chores in supporting men's activities at public forums. While men actively participate in public events and represent their family members, women's participation at major public gatherings with the responsibility to provide catering services to men.

Gender based sexual violence such as: rape and abduction were found to be a taboo and women are protected against those. Yet, women are considered as children deserving to be disciplined and continuously cared for. Decisions over economic resources are jointly made by both husband and wife, and the eldest son at household level. Except for roles that take men away from home, neither participation in public affairs nor decision-making power over neither resources nor preferences for sons are associated with perceived vulnerability to HIV infection. In fact it was argued that both men and women are equally vulnerable to HIV infection.

Discussion and Conclusion: Sons are valued as a thread of clan continuity on the father's side and a mark of identity for mothers. Yet, it is paradoxical that women do not complain for being discriminated and their rights being infringed upon despite being considered as children. In Borana, association between gender attributes and HIV infections is not consistent with the evidence provided by the literature where gender based violence, discrimination, rape and abduction put women at greater risk of infection. The study findings show that to some extent, men, not women, are more vulnerable to HIV infection due to their mobility while male's participation in public events do not make women at a disadvantaged position as regards to vulnerability to HIV infection nor give men more opportunity to access HIV information. This finding calls for women's empowerment and further study on whether women's rights are upheld and continuously protected.

3.2. Introduction

Gender constructs determine to a great extent what men and women can and cannot do in society, how one feels about being a man or a woman, and the types of public affairs in which a man or a woman would participate (9,20,71). Several studies indisputably documented that community's socio-cultural and economic environment shape gender identities, gender relations, and roles including how daily life is organized at family and community levels.

The relationship between gender and HIV infection has been long established. Just as physiological reasons expose women to HIV much more than men, community socio-cultural contexts contribute to variations in the level of vulnerability to infection (9,20,71). Various studies show that the unequal social status between men and women, the limited access to resources, and lack of decision making authority over those resources disproportionately exposes women to HIV infections and places them at a disadvantaged position for accessing HIV and AIDS information and services (15,16,20,22) .

Women living in a state of economic inequality and in a violent and abusive relationships are unlikely to negotiate for use of protective measures, such as condoms and are more likely to contract HIV (12,21,72).

HIV is more pronounced in parts of the world where poverty, economic and gender inequality is extensive. Different studies show that gender discrimination, rape abduction, widow inheritance and extramarital concurrent sexual practices are widespread in Sub-Saharan Africa (7,15,20,22). Women in Sub-Saharan Africa carry the brunt of HIV infection because of their husbands who are engaged in extramarital concurrent sexual relations on the one hand and because of their own engagement in sex for exchange of financial resources (4,20). The consequence is well reflected in the level of HIV infection in the region where two-third of all infections is documented to be found (1).

Ethiopia is a country of over 80 ethnic groups with different cultural backgrounds. Few studies available on gender in Ethiopia show that like other Sub-Saharan African countries, Ethiopia is characterized by disparities in the economic, social, cultural and political positions between women and men. Such disparities are believed to differentially influence women's and men's access to key resources, such as information, education, employment, income, land and credit (59,73,74).

The literature shows that socialization processes play an important role in keeping women in subordinate positions. Sons are socialized to be socially, economically and politically dominant over daughters while women are conditioned to be obedient and submissive (63, 69). A classic study of the Borana people by Largesse (1973) and recently by Ame (2009) documented that while men control military and political activities, (including elections of leaders of villages (olla), naming age-sets⁴ and deciding to go on a raid) and participate in ritual activities, women are responsible for bearing children and household and its surrounding (63,69). However, Legesse (1973) has further commented that the performance of rituals is not an exclusively masculine domain as women also plays important role for the ritual to be successful. It was also documented in his study as well as latter by Ame that though women do not directly participate in major assemblies and make decisions, translation of decisions depends on women's approval. They may express their disapproval through folk songs which they sing in group during public celebrations such as *gubisa* (naming of new born son) (63,75).

Largesse explains that division of labor among the Borana Oromo is such that women and men monitored two large but different economic domains of the family (63). Women are responsible for the household, including hut-building, while men are responsible for livestock, building kraals, and for defending villages, wells, and shrines. While the women have *de facto* power over stationary and semi-mobile resources located close to

⁴ Age-set refers to a cohort of men who are not merely equals, but are also expected to maintain certain norms of behavior, which derive from and express joint membership. The cohort stays together at all the major rites of the community

the domestic sphere, men are more public and mobile. Although Largesse did not elaborate on the implications of these roles on the health and wellbeing of men and women, he alluded to the fact that men were responsible for looking after livestock and that they migrated in search of pasture and water for livestock which gets them in touch with ‘other women’ – women who are not usual partners of the man.

Neither men nor women are ignorant of what goes on in the other’s sphere. As one Oromo folk-proverb indicates: *Dhiirti re’een enelmitu, garuu waan baatu hin wallaaltu* - Males do not milk goats, but still they are not ignorant of how much milk the goats offer (62).

Couple of studies available on Borana did not consider the wider implications of gender attributes in Borana society nor did it explored links between participation in public affairs and decision-making power over economic resources on the spread of HIV.

The objective of this particular chapter is to explore how gender roles, participation in public affairs and decision making power over economic resources are perceived in exposing men and women to HIV infection among Borana pastoralists.

3.3. Materials and methods

3.3.1. The study community

The Oromo occupy about 40% of the land surface of Ethiopia and constitutes the same proportion (40%) of the Ethiopian population (76). The Borana are the senior Oromo clan and are best known for maintaining the Gada system, once believed to be the socio-cultural and political core of Oromo life (63). In Borana, Gada as a system of polity has survived since the early 13th century (64).

Geographically, the Borana community resides in the relatively arid area in the southern part of Ethiopia (along the border of Somalia and Kenya) and Northern Kenya (64). The Borana zone is one of 14 zones in Oromia regional state and hosts a Borana population estimated at one million, based on the recent national census (61). The Borana zone borders the Gujii and Bale zones of Oromia region in the north and northeast, the Somali

zone in the east, Kenya in the South, and the Konso district of the Southern Region (SNNP) in the west. Due to the arid climate, the Borana breed livestock as their economic mainstay. Men are the key players in the economic, social, cultural and political life of the Borana.

3.3.2. Methods of Data Collection and Analysis

Data collection was carried out from October 2008 – April 2009 in Borana. In-depth interview and Focus Group Discussion (FGD) participants were identified using a snowball technique, on the basis of a person's recognized understanding of local knowledge about Borana culture. The next participant was identified based on the same criteria, at the suggestion of the previous participant. The procedure continued until the desired information was generated. A total of 69 in-depth interviews and nine FGDs, with a total of 68 participants, were completed.

The Principal Investigator (PI) stayed in the community during data collection and took part in the community's socio-cultural, economic and political life. This helped to generate further information. The study protocol included structured and semi-structured interviews. The contents of the interview mainly focused on assessing the roles of men and women, participation at the public forums and decision making authority over economic resources.

Interviews were conducted in the local language, Afaan Oromo. Participants were reluctant to be tape-recorded, thus, notes were jotted down by the research assistants during interviews and elaborated and organized as field notes each evening. The notes were translated into English for analysis. In order to ensure consistency of translation with the original data sample, materials were translated back into the original language, Afaan Oromo, for verification.

The data were analyzed using MAXQDA qualitative data analysis software, which helped to summarize and categorize raw data according to coded themes which served to aggregate the data. Data was interpreted without distorting the original meaning.

Pseudonyms were used to maintain the anonymity of the participants. However, sex, age, source of information (in-depth interviews or focus group discussions) and residence of the participant were shown for easy reference.

3.4. Results

3.4.1 Socio-Demographic Characteristics

A total of 69 in-depth interviews and nine FGD sessions with a total of 68 participants were completed. Women constituted 40% of the in-depth interviewees and 56% of FGD participants. The average age of FGD participants among women and men was found to be 40 years and 36 years respectively, while the average age of in-depth interviewees was found to be 50 years for men and 49 years for women. Fertility rates in Borana are high and the number of children born to a family increases with age. All participants are of Oromo ethnicity and more than 75% of them follow the indigenous Oromo religion, Waaqeffannaa (belief in *Waaq* – the Almighty). All research participants were married.

3.4.2. Gender Roles and Expectations

Two out of three research participants (both male and female) explained that everyone is born to play specific roles in the family and in the community based on the sex of the person and that this is considered normal. Study participants revealed that there is a marked distinction between what Borana men and women are expected to do at household and community level.

3.4.2.1 Men's role in Borana

Men are known as the head of a household in Borana. Both men and women study participants unanimously indicated that men are responsible for representing the household in public. At community level, men represent the family in clan affairs and in public gatherings (*Gumii Gaayo*). In addition to the belief that men are responsible to feeding the family, ensuring that family members have clothes to wear, and that their health is taken care of, men are responsible for maintaining livestock, farming and slaughtering animals during holidays. At community level, men commonly participate in arbitrating neighborhood conflicts, digging water wells, and migrating with livestock in search of grass and water. Men are also expected to defend their resources (water and

grass) from encroachment by neighbors, especially from the Garri (Somali clan) living in southeastern Borana.

Two in five male participants argued that men are responsible to discipline and care for women. For these men women are tender and needs care and protection for which men are always responsible. Men battering their wives was found to be common, not only to discipline the wife, but as a sign of love and attention to her. Jatani pointed out that wife battering in Borana is not meant to harm the wife but to show his love and attention. He indicated that at marriage, the son-in-law is reminded, "*Hincabsiin hinbassin dhanni-arabsadhu, nunhanqifadhu, nun hanqadhu*" – "you can discipline her; you can refuse to allow her visit us but do not batter her to the extent of breaking her bones" (M40, II Yabello). If a husband intentionally harms his wife, she can complain to local leaders and her husband could be punished. Contending with the Gada rule, which does not rule out wife battering, Haleke pointed out that "*In the rural setting where you do not come out and say 'I love you to your wife', there should be some other way of expressing your love and attention for your wife and battering is one*" (M47, II Teltele). Gelgelo stated that "*...battering is considered by women as a mechanism to test her husband's level of attention and love to her and at times she instigates the husband to beat her*". He further noted that, "*...given the level of competition between women over a famous and rich man, feeling of neglect at household level could be disturbing and the wife does everything possible to ensure that her husband still cares for and loves her too. So, battering is positively recognized by women in the community, while for men it is a way of disciplining wives*" (M57, II Dillo).

Women research participants did not contest such claims of men. Jedo stated that, "*If a husband does not beat his wife, it means he does not love her and does not care about her. This would give her quite unease*" (W37, FGD Arero). Oshere also argued that "*...if not beaten, women would forget her home, so it is considered normal practice at home level*" (W42, II Liben).

3.4.2.2. Women's role in Borana

All research participants (both male and female) agree that, at household level, women are owners of a household. Dhaki pointed out that *"The household is our domain"*. She further explained that *"...we have full control over the household; we build a house and control what is going on inside the house"* (W43, II Didara). All male participants in the study recognized that a house cannot be a home without women. *"A house without women would not smoke"*, which was a common statement from all male FGD participants and in-depth interviewees – meaning the house is lifeless without women. Women are in charge of household chores and are responsible for bearing and rearing children and looking after smaller animals.

A couple of strong accounts were given about women who were responsible for aiding their husbands, and emphasizing on the idea that behind every successful man is a strong woman. *Maasule Saaqa Wanaaso* and *Tiyoo Walee Waacuu* were mentioned as wise and beautiful women who not only proved to be exemplary in housekeeping and child rearing, but also in advising and guiding their husbands who were recognized as public figures of their time. Yet, two in five men and two in three women argued that women should stay at home and obey their husbands who are expected to set standards and procedures for the household members to observe.

Women's role in the community is limited to supporting other women in preparing feasts for the naming ceremony of first born sons, *'Gubisa'*. During public gatherings (*Gumii*) women also participate in preparing food for the male participants of the assembly.

Although it is said to have declined over the years, women were also responsible for socializing and advising young unmarried men on sexual practices. Dahanba explained that, *"We as women marry much earlier than men, who according to Gada rule, marry much later. Besides, girls are required to remain chaste until marriage. In view of this, it is tolerable if married women are found to have extramarital concurrent sexual relations with unmarried young men"* (W56, FGD Liben). Borbora further indicated that *"Married women were expected to socialize young boys with sexual activity although this is not*

common anymore” (M72, II Dubluk). It was found that young men are now attending schools in urban settings and are not staying much longer in the villages that such practice is declining.

3.4.3. Consequences of failure to fulfill roles

Living up to the expectations of what it is to be a man or woman in Borana society is very important and relates to a long standing socialization starting from childhood. Failure to meet these expectations is often attributed to parents’ failure to socialize their child per family and community level expectations. This is considered a disgrace for the parent. Members of the community keep track of whether or not expectations are being met, as do spouses. Tracking role fulfillment is seen as a means to provide timely support and advice for required improvements. Failure to improve in meeting expectations with the provided support has serious consequences. Tari pointed out that *“In the community we know each other and everybody knows who is doing what? So, when someone is not performing as expected, neighbors tend to help in advising and guiding. But there are few times when some individuals are born weak and could not make use the support provided. I have not seen such a person myself but normally this is what we know from our childhood”* (W46 II Liben). Similarly, Sokora argued that *“the one who consistently fail to meet expectation is considered sick – the family, neighborhood and Gada leaders are all watching you and provides you with support when needed”* (M32, FGD Arero).

If a husband fails to meet expectations, members of his clan will first advise him. If this does not help in the effort to improve, kinsmen may beat the man and in extreme cases, slaughter and feed on his ox as a punishment. Further measures could be taken, including appointing the wife as a head of the household. Female research participants unanimously argued that there have been very few cases where women were given the responsibility of leading the family when a husband is proven weak. Women research participants explained that this was due to the fact that either weak men improve with support from their kinsmen, or that women recognize the problem and decide to accept the situation. Hawo’s point clearly summarizes the arguments on this particular point, *“If a husband*

fails to meet his role, I appeal to his parents (his brother or father) who advice him and help him to improve. If the problem persists other kinsmen and local leaders would advice him to improve and also help him in this regard. If such efforts do not bring differences, women opt accept the problem and live with it” (W54, II Liben).

If a wife fails to meet expectations, the husband would first advise her, followed by a complaint to the mother-in-law who is then expected to help. If that does not bring about improvements, the wife will be battered and eventually the husband will marry another wife. In Borana, failure to bear children is always considered as a problem of women. Duba explained what has been consistently pointed out by research participants, *“If a woman fails to discharge her responsibilities, husband has the responsibility to get her support and advice. Her mother and peers would also advice and assist her. If she fails to improve, he beats her and threaten her to marry another woman. If she fails to improve, he would ultimately marry another woman” (W33 II Arero)*

3.4.4. Sex Preferences at Birth

All research participants agree that having children is a major accomplishment of marital life in Borana. Consequently, reproduction is a primary goal for both men and women and most importantly for women whose identity lies on her ability to bear children especially sons. Men may marry another woman in search of a child, while women may test her fecundity with another man if she cannot get pregnant by her husband. Jedo’s line summarizes what the rest of women research participants argued, *“A woman is always blamed if she does not bear a child but men are not blamed for this.”* She further noted that while men visit other woman, *“we also get engaged with other man to prove ourselves as fecund though this is not always the reason for engagement in extramarital concurrent sexual relations” (W37, FGD Arero).* In Borana children are said to belong to the bed (*ilmeen kan itileeti*), no matter who makes the woman pregnant. Even after the death of the first husband, children born in the house are called after the first husband.

Marked variation was noted in the satisfaction with the outcome of a pregnancy in terms of sex. Among the study participants, birth of a son is considered a great accomplishment

for the family. The family with a son or sons is considered blessed and successful. Sons are proof of continuity of the father's clan. Borbora pointed out that *"A family with a son is considered alive, and even if the father dies his death is not felt much"* (M72, II Dubluk). Producing a son relieves a man of his responsibility to replace himself and find a heir of family property and representation in the clan. A man who has not replaced himself (*daara dabarsu*) would not have a name, as was commonly argued by all participants. For women, bearing a son is a source of pride, respect, marital security and mark of women hood. Female participants argued that birth of a son cements the relationship between spouses and ensures marital security. After bearing a son, a wife becomes the center of attention as in-laws; neighbors and husband provide her with special attention and gifts. Birth of a daughter is not as welcome as that of a son. Study participants shared a saying that goes *'why do you keep silent as if a daughter is born'*. Daughters in Borana are considered 'outsiders' from birth as they will grow up to join another clan upon marriage⁵. All participants in the study unanimously explained that daughters, once married, are members of another clan and take on their husband's name. Several women participants contend that this is a reality in Borana which they do not complain about. Santo explained that; *"I am not with my parents nor do I visit them without my husband's permission. I belong to my husband's clan. I do not have much stake with my natal parents. This is the case for all women in Borana and we do not complain since this is the only way we have come to know throughout our life"* (W38, II Dire).

3.4.5. Participation in Public Meetings

Study participants unanimously explained that men represent the family in public assemblies and clan meetings. Besides, men participate in group hunting, defend communal property (water and pasture) from neighboring non Borana communities and arbitrate conflicts at household and within the community. Women on the other hand do

⁵ Marriage in Borana is exogamous that member of a clan marries to/from other clan. In Borana there are two clans (Sabbo and Gonna) and marriage takes place between the two since inter-clan marriage is considered taboo.

not have roles at these levels although she participate in public assemblies where she is expected to prepare food for men.

Gumii (assembly), which happens every four years, is an important public meeting where all Borana men, women, children and livestock participate. During Gumii, community wide concerns, such as conflict with neighboring communities, issues related to cattle rearing, protection of the rights of women and children, etc. are discussed and decisions are made. Both men and women research participants pointed out that HIV and AIDS has never been discussed at such forums except during the last assembly where for the first time the then Gada leader made a statement. The then Gada leader stated that “*we told the assembly to be careful of HIV, which is a serious disease*”. He further noted that “*... we do not have sufficient information about the disease to provide specific advice on what to do to the public*” (M43, II-Arero).

At the assembly, women's participation is passive. Although women are physically present at the meeting, they do not have space to voice their concerns or contribute to the deliberations. Shege pointed out that, “*Discussions and decisions at Gumii Gaayo are men's domain and this is reinforced by husbands (men) who want us [women] to remain passive at such public forums*”. She further stressed that “*...probably women's limited participation in such forums is attributed to women's refusal to participate when they were invited to take part in decision making at Gumii Gaayo during the reign of Dawee Gobbo [1706-1714] and to the mistreatment of men by the legendary Akko Manoye, who ruled Borana under what was said to be harsh leadership where men were indiscriminately harassed under her reign*” (W40, II Alwaye). At least two in five women participants attributed the current position of women in public affairs to the earlier deeds of the ‘legendary’ woman leader Akko Manoye. Once she was toppled from her position by men who conspired against her, women were denied the space and right to actively participate in public forums or to make decisions of public interest.

Nevertheless, all female participants pointed out that even though women do not have active role at Gumii Gaayo, the outcome of public meetings cannot be translated into

actions if women disagree which they express in the form of songs during social events, such as naming and marriage ceremonies. Haleke contends that “*we discuss with our women on the decisions and convince them to accept. If they resist, the decision is bound to be reconsidered*” (M47, II Teltele). Haleke gave the example of a decision made by *Aba Gada Dawee Gobbo* (1706-1714) who suggested banning extramarital concurrent sexual practices where women disagreed with the decision through song, a verse of which goes as follows “*Dudubbachuun fedha Duubee yaamuun fedha, tan Duubee dubbuma tan Dawee Dalluma; wantti Daween jedhe gurra dhageettuma - I want to talk and refer to Dawee whose talk we heard but cannot go beyond hearing*”. This meant the decision made under the leadership of *abba Gada Dawee* could not proceed beyond announcement that is heard. Dahanba affirmed, “*Even if we do not participate directly in decision making at public forum, we still have a stake on whether or not the decision is put into action. Women tell their husbands her contention and also sing with verses of disagreement with the decision*” (W56, FGD Liben). All research participants noted that women influence decisions made about various aspects of life. Men research participants unanimously pointed out to respect if women insist to disagree with the decisions.

Despite women’s space and level of influence, men were found to argue that women are like children since they lack competence (*gahumsa*), capacity (*dandeetii*), are fearful and shy to stand and speak in public. Boru’s explanation of why women do not actively participate in public sphere summarizes men’s opinion on this “*dubertiin maal beekti? What would woman know?*” (M62, FGD Liben). Although all women research participants did not agree that women are weak as indicated by men research participants, various factors were found to explain women’s weak participation in public forums. While older women accept that women are not as competent as men (W52 II Liben), two in three young married women attribute their weak public position to lack of education (W65, II Arero) and culture denying them the space (W37, II Yabello).

3.4.6. Women's rights in Borana

Interviews and focus group discussions revealed that there are clear and straightforward rules that protect a woman's right. Rape and abduction is very uncommon in Borana. According to Dhaki, *"Sexual aggression towards women by a known or unknown man entails serious punishment in Borana. Especially, sexual aggression towards unmarried girls is considered as serious as killing someone and it is a taboo (cabana) and entails serious punishment"* (W43, II Didara). If a married woman complains to local leaders about sexual aggression or mistreatment, she is trusted without having to offer proof and immediate action is taken against the perpetrator. Abagido pointed out that, *"In our community, if a woman feels mistreated - insulted, harmed from a beating, encounters sexual aggression even in marital life - she appeals to local elders and these results in the immediate punishment of the wrong doer without any further evidence"*. He added, *"Although these days, the elderly are getting corrupted by men to twist decisions, still women's complaints are given due attention and get fast decisions"* (M53, II Liben).

3.4.7. Ownership of resources and decision-making authority

All research participants unanimously agree that neither women nor men have exclusive ownership over shared economic resources or could make unilateral decisions. The role of keeping and rearing livestock provided men with proxy responsibility of selling cattle with the prior consent of the wife and eldest son. If a husband sells cattle without the consent of a wife and eldest son, the wife could complain to local elders, which could result in the subsequent punishment of her husband in the form of buying her cloth. It was found that men in Borana do not take unilateral decision and action on the sale of cattle as this entails punishment. Always sale of cattle follows negotiation and agreement between spouses and the eldest son. The sale usually has a clear purpose: to buy cloth for family members, to pay tax, to pay for children's education, or to support kinsmen (*buusaa gonofaa*) with serious financial problems, such as losing their livestock to disease. Neither the wife nor the eldest son would however track the money a man makes from the sale, as long as the intended purpose is met. Therefore, men may use the sale as

an opportunity to access money for other personal expenses, including invitations and gifts for an extramarital concurrent sexual partner (*jaalto*).

Women have rights over the sale of milk, milk products, chicken and eggs and men do not have control over how she spend such resources. Women may also receive money and/or gifts in the form of cloth or invitations for drinks from an extramarital concurrent sexual partner (*jaala*). All study participants pointed out that if a woman stays with her extramarital concurrent sexual partner for longer than a year, she rightfully expects to receive cattle (often cows) as a gift. The practice still exists although it is not as prevalent as it used to be. According to Tato, “*Your extramarital concurrent sexual partner gives you money, buys you cloth and also gives you cattle which is a public expectation from jaala, although this is more of an exception these days*” (W38, FGD Arero). Although not officially considered the exclusive property of women, a wife tends to consider cattle obtained from her parents and in-laws on her wedding day as her property. As stated by Teno, “*...there is nothing women own unilaterally – what she owns is the joint property of the family* (W47, II Arero)

While joint property is managed through joint decisions, the use of excess resources generated by joint property, such as money from the sale of livestock and money women generate from selling milk and milk products and what she obtains from her jaala, will be considered ‘private property. Hebbo indicated that, “*Men do not care much about consumables at household level. Men save money from the sale of cattle and use it for drinks while we (women) use the money we generate from selling butter and what we get from our jaala to buy consumables such as salt, oil and sugar for the household and sometimes clothes for children and for ourselves*” (W68, II Dubluk).

3.4.8. Perceived Vulnerability to HIV

Two in five women believe that women’s roles are much more extensive than those of men, while three in five women think that men are responsible for tasks that are heavier and riskier. Among male participants, three in five share women’s view that men have riskier and more challenging responsibilities, while the remaining proportion see women

and men as equally busy with their set of responsibilities. However, women strongly believe that both men and women are responsible for sets of tasks that their parents and grandparents were responsible for. They do not feel that one set is any better or more necessary than the other but are complementary. According to Teno, *“We all have tasks that we are expected to meet”*. She further emphasized that, *“In Borana, women are busy with tasks at home while men are busy with out of home tasks which we are all born to find and live with now”* (W47, II Arero).

Study participants were asked if gender roles, decision-making powers over resources and participation in public events would make men and women vulnerable to HIV infection in Borana. At least one in seven women participants and one in ten men argue that men’s roles put them at more risk of getting exposed to HIV infection compared to women.

Women participants pointed out men’s responsibility of travelling far away from home in search of pasture and water for livestock, and especially their propensity for visiting urban centers in connection to cattle sales, men are more exposed to HIV infection. Visiting market places is believed to expose men to “town women” who are believed to have HIV. Teno asserts, *“HIV is a problem of those in town and especially those women who work in drinking places. Our men often encounter such women when they visit market places for sell of cattle”* (W47 II Arero).

Married women’s role of initiating young unmarried men in sex is believed to expose women to HIV infection. However, nowadays such a role is said to have declined mainly since young men are attending schools and may have access to his age mates in town.

Four in five research participants (men and women) did not see any connection between participation in public affairs and vulnerability to HIV infection. It was argued that public forums were not considered as an opportunity to share information on HIV and AIDS. Borbora indicated that *“Gumii Gaayo is a forum where rules and regulations are made and such discussions about HIV do not have space. However, discussions could have*

started at village level and rules could have been made at Gaayo and this has never happened” (M72, II Dubluk).

Participation in public events does not help to access information about HIV and AIDS. Shege noted that *“men as key players in such forums do not have more opportunity to access HIV related information. Men are not different from women in terms of access to information on HIV and AIDS” (W40, II Alwaye).*

The widespread practice of extramarital sex was commonly agreed by research participants to expose both men and women to HIV infection as will be further elaborated in the next chapter. Three out of five men believe that women and youth are more vulnerable to HIV infection since they always tend to have multiple sex partners, while one in seven women believe that men are more vulnerable to HIV infection due to their role. Yet, both men and women interviewees and FGD participants unanimously pointed out that it does not matter who gets HIV first, as the spouses would any way be vulnerable to HIV infection. It is common to hear *“Exposure to HIV is for both men and women as they continue to live together as spouses”*.

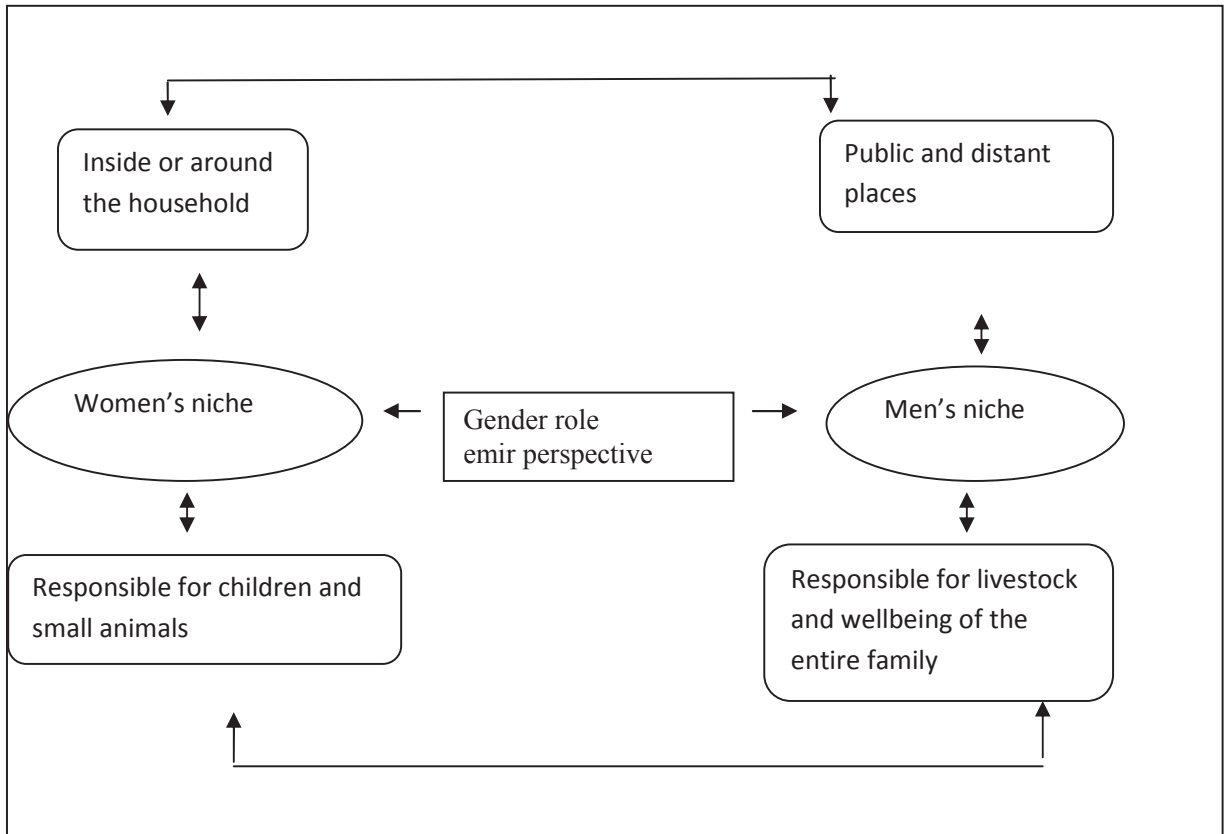
3.5. Discussion

Gender identities, relations and roles are determined by the socio-cultural and economic background of a particular community (15,16,20). Context informed constructs of gender determines what one as a man or as a woman can and cannot do, how one feels as a man or as a woman and in which spheres of public life a man or a woman would participate. Previous studies have shown that the unequal social status of women, their limited access to resources and decision making authority over resources in several African countries put women at a disadvantaged position to access information and services, including those for HIV and AIDS (7,12,21,71). Similarly, it has been argued that women are prone to violent and abusive relationships are less likely to use protective services such as condoms, less likely to negotiate for safer sex and are more likely to contract HIV (20,12).

Although there could be variation in the extent to which women are at disadvantaged position and are obliged to live up to its consequences, it is generally the case that gender based violence, lack of access to resources including information and services, poverty and vulnerability to HIV infection are more pronounced among women in Sub-Saharan Africa (20,22,23).

In Borana men and women have distinct roles and positions in the family and community which has been part of their established life. Women consider the homestead as their niche, while men represent the household in public forums as shown in the diagram below. As such, Borana community is similar to many other communities where men are at the center of the social, cultural, economic and political life of the society (9,20). A girl, in Borana, is expected to join another clan upon marriage and will be socialized at home, by her mother, to fulfill her roles as a woman (ensuring a house is built, cleaning and cooking, nurturing children and rearing small animals). A wife is a member of her husband's family, with limited economic rights and roles in the public sphere. Her primary role is to be a mother and produce sons where her fertility is crucial to her marital security. This clearly shows that Borana women are not any different from other women in the rest of Africa where they have no space in public sphere and their identities protected when and if they bear children (33,77).

Diagram 2: Gender role domains in Borana



A large body of literature argues that traditional societies consider women to be weak, delicate and in need of protection (78,79). Ame and Legesse argued that exclusion of women from leadership role is one of the distinctive features of traditional socio-political institution of the Oromo (63,76) and this may have to do with the fact that they are weak, incompetent and fearful as documented in this study. Ideally, women in Borana are expected to submit to men's authority and supremacy throughout their lives and constantly reminded of such values from childhood. Similarly, a study from Jimma (80) concluded that women were required to be docile, modest and shy in front of men. In view of these, to date, men in Borana regard women as children – socially and culturally inferior deserving to be disciplined. This clearly shows that despite claims that women

have some space in the public sphere and may influence the decisions, women in Borana live under common gender stereotypes.

Although more data is needed to determine if the invisible public role of women in rituals is considered important in the community and if their protection is consistently upheld, this study did not generate convincing evidence to argue the relative level of comfort Borana women has in social, economic and cultural spheres

Several studies assert that culturally sanctioned gender stereotypes put women in a situation that makes it difficult for them to defend their rights (7,20,22). In Borana, it was gathered that rape, abduction, and any form of mistreatment of women by men including by their husbands is considered taboo for which control mechanisms are put in place. While to what extent women's protection is upheld and enforced may need to be further substantiated with more research, one could clearly recognize the fact that women generally are dependent on men to uphold their right. Men in this community holds an ultimate authority and how much of women complaint may have been addressed in 'a right way' remains to be explored.

Lack of access to economic resources is documented to be the basis for engagement in extramarital concurrent sexual relations for women (7,81). Nevertheless, both men and women participants in Borana strongly disagreed with such a conclusion. Extramarital concurrent sexual partnership prevails not for the sake of economic interest alone but as a proof of fulfillment of expectations at family and community levels. Nevertheless, evidence has shown that engagement in extramarital concurrent sexual relations is followed up with transactions of economic interest. Although women exclusive right over specific resources, they tend to spend their 'private' resource to buy items for household consumption, while men tend to spend money they save from sale of cattle for drink and invitation of their sexual partner. This shows that despite claims that women has resources she can decide up on and has a stake in a sale of joint property, there still is economic dominance of men in Borana.

There is evidence that women's vulnerability to HIV infection in most developing countries is increased in situations of poverty, migration, war and civil disturbance where women face increased risk of HIV infection by virtue of their social position, unequal life chances, rigid and stereotypical gender roles, and poor access to information and services (15,34,38). However, among the Borana, women, as well as men, do not perceive their roles to strongly contribute to their vulnerability to HIV infection, though women in the community believe that men's role, requiring them to travel long distances away from home, makes them more vulnerable to HIV due to their sexual encounters with 'other' women living in urban settings. As explained in Chapter 2 above, the Borana community is poorly aware of HIV and AIDS and is living with beliefs that are not common regarding HIV infection. In view of this, it is not surprising if the research participants fail to recognize the relationship between gender roles and participation in public forums would have on HIV infections.

3.6. Conclusions and Recommendations

It is documented that understanding health problems including HIV and AIDS is rooted in gender stereotypes. Designing acceptable solutions thus requires proper understanding of the specific attributes of gender. Gender attributes in Borana, as discussed above, were constructed and shaped by the Gada system and has been practiced for generations. Both men and women research participants recognize that their responsibilities, participation and authorities at various levels are reflections of their traditions. As a result, there is a strong tendency to justify men's and women's roles and positions in the community as normal, natural and acceptable despite the fact that women are passive in community affairs and are not recognized as capable. This needs a long term initiative that aims to empower women and ensure they have a space and recognition in the community which is the basis for public health interventions in general and HIV and AIDS in particular.

It is evident that women in Borana do not have the right to inherit property and resources from either their father or their husband. As long as a husband is alive, he has authority and control over the family's economic resources, which then goes to the firstborn after

his death. This is illustrative of patriarchal characteristics of the Borana community, which was not complained about at least by women research participants. Given women are in the hands of men and men are key actors at family and in the community and this being the case for generation, one may not expect any different opinion from women research participants. It would be an opportunity to expand on the claimed decision making space of women over the sale of joint property at home to ensure women have a grip over economic resources in the community which is believed to be foundation of women's strong position in the community.

Women in Borana do not appear to suffer from sexual violence such as rape and abduction are considered taboo in the community and the fact that Gada system has established mechanisms to ensure women are protected from these types of crimes. It, however remains unclear as to what extent such rights are consistently protected on the one hand and if women have any other way of protecting their right otherwise. Furthermore, it was claimed that rape is a taboo including in marital affairs. This could be a very good finding if substantiated with strong evidence on to what extent this is upheld and enforced. Thus, this may call for further study to determine how strong is the foundation of local rules to keep rape and abduction a taboo and also if marital rape is consistently observed and reported about.

Women's weak social position and men's belief that women require protection, discipline and marginalization from public events is problematic. The rights that women in Borana are claimed to have is secure only insofar as men decide to uphold them. A strengthening of women's position and increased respect for their abilities would help empower women to protect and assert themselves, making any acquisition of rights more sustainable. Further research should consider how to do this.

The present study attempted to determine the association between gender roles, participation in public forums and decision making authority over resources, and perceived vulnerability to HIV infection among Borana. It was noted that both men and women are vulnerable to HIV infection, although men are considered to be more exposed

than women in connection to their roles as rearers and sellers of livestock. This provides an entry point for HIV prevention interventions focusing on men especially at market places. It was also clear that consideration of public forum to impart information on HIV and AIDS is another entry point in an endeavor to facilitate HIV prevention interventions as further elaborated in chapter 6 below.

3.7. Limitation of the study

The study has generated evidences that could contribute to the understanding of gender attributes and their association with HIV infection. Furthermore, the study provided evidences on complacency on gender stereotypes. It was found that women are considered as weak and deserve protection and care on the one hand while it was argued that they have the space to make decisions and or contribute to public decisions. Given gender stereotypes have been integrated into local culture and have been part and parcel of the communities way of life, it was difficult to generate evidences that could help understanding on how genuinely and consistently were women's right protected.

Table 4: Gender roles at different level in Borana, data from the field – 2008-2010

Subjects	Levels	Gender Roles in Borana
Women's role	Family level	<ul style="list-style-type: none"> • Bear children • Care for children and small animals (calves) • Prepare food and feed the family • Milking and dealing with milk products • Fetching water often from distant areas • Collect fire wood • Cleaning the house and compound • Cultural embroidery • Smoke milking materials (qoraasu)
	Public level	<ul style="list-style-type: none"> • House construction (dassi) • Prepare food and drinks during public events (gumii) • Assist fellow women in the neighbor in preparation of foods and drink in connection to naming of a new born son
Men's role	Family level	<ul style="list-style-type: none"> • Ensure family members have enough to eat • Seek care when family member is sick • Herd and water cattle • Take cattle to pasture (during dry season they travel and stay out of home for months) • Build kraal for livestock • Cleaning kraal • Slaughtering animal
	Public level	<ul style="list-style-type: none"> • Hayya qotuu (Digging salty place for livestock) • Participate in public meetings representing the family: <ul style="list-style-type: none"> ○ Gada assembly (Gumii Gaayoo) ○ Yaa'ii – meeting of gossa ○ Conflict resolution ○ Marriage arrangement • Participate in local fighting to defend communal land • Participate in hunting
Property ownership	Men's property	<ul style="list-style-type: none"> • Men do not own property exclusively since property is communal at household level • The entire family belongs to the head of the household • Custody of money generated from sell of cattle
	Women's property	<ul style="list-style-type: none"> • Women do not own property exclusively as property belongs the entire family members

		<ul style="list-style-type: none"> • Saa'a banti fii anuuna (cow given during marriage by in-laws and parents although she cannot take exclusive action)
Participation in public forums	Women	<ul style="list-style-type: none"> • Women freely discuss on various issues with husband at home with no restraint • During Gada assemblies women prepare food and look after children
	Men	<ul style="list-style-type: none"> • In local villages and local administration men are believed to be responsible and have competence • Actively participate in cultural events and ceremonies • Arbitration of conflicts between families (due to mainly marriage related issues), between Borana and other ethnic groups • Raids and fighting • Hunting • Marriage arrangements

Chapter 4: Sexual values, practices and the threat of HIV infection
among the Borana pastoral community



Figure 7: Negotiations at market places in Borana, photo by MK, Sept 2008
This article is in preparation for submission to Journal of the International AIDS Society

4.1 Abstract

Background: HIV continues to be a major public health concern in Africa. It is increasingly becoming clearer that in Africa the virus spreads mainly through unprotected overlapping heterosexual partnerships. The trends and contexts of such overlapping heterosexual activities in pastoral communities and its perceived consequences for the spread of HIV remain to be explored.

Objectives: The objective of this chapter is to build upon the findings of Chapters 2 and 3, indicating that extramarital sex (implying concurrent sexual partnership) is practiced among the Borana pastoral community, by exploring the extent and determinants of such practices. The study will also determine the community's perceived vulnerability to HIV infection in connection to extramarital concurrent sexual practices.

Methods: Information on the extent of extramarital concurrent sexual relationships, reasons for such practices and the perceived consequences of vulnerability to HIV infection was collected from the Borana community of the Oromia region in Ethiopia from November 2008 - April 2009. Sixty eight focus group discussion (FGD) participants and 69 in-depth interview participants were selected through snowball techniques and participated in the research. The data generated was coded, categorized and summarized with an application of MAXQDA qualitative data analysis software.

Key Findings: In Borana, sex before marriage is considered a taboo (*cabana*) for both male and female members of the community. Although local culture does not approve concurrent sex, men are engaged in the practice both before and after marriage, while women start concurrent sex practices after marriage. Extramarital concurrent sex (*Jaalaa-Jaalto*) is attributed to personal, social and economic factors in Borana: A personal interest in feeling wanted by the opposite sex, fulfilment of socially prescribed roles, and reaping the economic values associated with sexual transactions play important roles in sustaining the practice. Extramarital concurrent sexual practices were found to involve as

few as one other partner and as many as ten partners, with relationships lasting anywhere from a few days to life time.

Although extramarital concurrent sexual partnerships are valued and cherished, there is growing concern over its consequences for spreading HIV infection. Reconciling the desire for extramarital concurrent sexual partners with the wish to protect oneself from HIV infection presents a challenge for the Borana community.

Conclusion: Despite widespread recognition of the possible consequences of extramarital concurrent sex as relates to HIV infection, there remains an interest in maintaining extramarital concurrent sexual practice in Borana. The limited availability of accurate and impactful HIV messages in the community, as illustrated in Chapter 2, combined with the prevalence of extramarital concurrent sex poses a serious challenge to HIV prevention strategies among the Borana community and others like it.

Recommendation: The present study shows that extramarital concurrent sexual relations are sustained by context specific personal, social and economic factors that give importance to the practice. In view of this, context informed messages and continuous provision of condoms to the public is believed to facilitate prevention efforts in the short term the sexual values, practices and partnership duration and its association with the pace of HIV spread needs to be further explored.

4.2. Introduction

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, sexual pleasure, and reproduction. While sexuality includes desires, beliefs, values, practices and roles not all of them are always experienced or expressed at community level. The experience of sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural factors that are constructed by the society (27). Further studies conceptualize sexuality as comprising of biological desires, genital stimulation and satisfaction on the one hand and culturally constructed values and norms that govern why, when and how to satisfy sexual desires on the other (34,37,39). An individual's sexual practice thus is informed and modified by an individual's internal biological drive, gender roles, power relations, age, and social and economic conditions. Sexuality thus is a comprehensive concept that goes beyond individual interest and it is biologically shaped and is embedded within the socio-cultural framework of a community (34,38,40).

The available HIV literature lacks relevant information analyzing sexuality in pastoral communities, and its implication for HIV infection (82,83). The few studies dealing directly with sexuality focus on the behavioral aspects of sexual health problems, including sex related knowledge, attitudes toward sex and sex practices (39,43,84). Sexual health problems, including the spread of sexually transmitted diseases, are determined by biological and socio-cultural factors that influence individual behavior. Studies have documented that individual sexual behavior is an important factor in the spread of HIV infection but in view of the definition of sexuality which goes beyond individual behavior, more attention is suggested to be given to the social, economic and cultural factors that set the conditions for sexual behavior, which in turn paves the way for sexually transmitted infections including HIV, in order to control the problem (31,35,79).

There are studies on sexuality that have been theoretical, where mathematical models were employed to track sexual networks (85–87) or were cross-sectional epidemiological studies of multiple partnerships and its consequences (88,89). While these studies provided evidence of the level of threat posed by multiple sex partners, none addressed why people continued to engage in concurrent sexual practices. More recent evidence suggests that it is not only an individual's sexual behavior that drives HIV infection in Eastern and Southern Africa, but engagement in concurrent sexual partnership and the situation in which concurrent sexual partnership takes place has major role (41,90,91).

For women in Africa, engagement in concurrent sexual practices depends on several but intertwined factors which includes but not limited to economic interest, social expectation and peer pressure and mere biological drive (33,39,91,92). In most communities, women are generally expected to remain loyal to their husband, but there are communities where decisions to engage in extramarital concurrent sexual activity is within the domain of women and is accepted. Economically, there could be interest with expectations of gains from such a practice and could as well be due to personal interest. So, various factors determine on why people engage in concurrent sexual partnerships (40).

Studies on sexual behavior in various developing countries cite poverty as the root cause of women's engagement in extramarital concurrent sex (22,81). When sexual engagement is prompted by the need to access food, shelter, or safety, it becomes difficult to advocate and invest in abstinence and faithfulness programs (15,38,93). Commercial sex work is the most well-known means for women to exchange sex for money, but there are other types of 'transactional' sexual partnerships. In Haiti, for example, single mothers, in their struggle to balance the multiple demands of family and economic survival, often engage in a series of sexual relationships to get access to food and housing for themselves and for their children. Research shows that women who enter into concurrent sexual relationships out of economic necessity increase their vulnerability to HIV infections (41,91,94).

A study by Emmanuel and colleagues (2001) on concurrent sexual activity in five urban settings in Sub-Saharan Africa argues that the spread of HIV is not necessarily associated

with concurrent sexual partnerships (95). However, the study shows that protective actions taken by those involved may have important implications in reducing spread of the virus. It is evident though in areas where resistance to accept condom and/or slow uptake of it as protective means in settings where HIV prevention interventions have been far-reaching and weak awareness creation interventions (10,94,96), concurrent sexual partnership will undoubtedly exposes those involved to HIV infection much more than those who are not.

In the field of public health in Ethiopia, sexuality has been widely studied in terms of an individual's awareness and practices as they relate to sexually transmitted infections (STIs), unwanted pregnancy, family planning and now HIV infection. The studies however did not paid sufficient attention to the fact that sexuality is sanctioned by social, economic and cultural domains of a society as discussed above. Methodologically, the studies has also focused on 'objectifying and quantifying a sensitive issue' that may not be understood in quantitative terms (43). In consequence outcomes from such studies fail to answer questions related to why individuals decide to engage in concurrent extramarital concurrent sexual relations and how the practice is reinforced and maintained by the society's social, economic and cultural contexts.

Study on sexuality in its broader is relatively a "virgin field" of enquiry as regards HIV as well as the broader field of public health in Ethiopia (43). A study by Abraham, on the Jimma Oromo, documents that women are often engaged in concurrent sexual activity outside of marriage more often than men do (80). In the Borana pastoral community, anecdotal evidence suggests a high level of concurrent extramarital concurrent sexual practice (see Chapters 2 and 3). This leads to the question of why men and women engage in this concurrent extramarital sex and whether or not the community realizes the potential consequences of the practice.

This chapter, therefore, explores the determinants of extramarital concurrent sexual practice and the perceived consequences of the practice among the Borana pastoral community.

4.3. Materials and Methods

4.3.1. The study community

The Oromo people, of which the Borana is a part, occupy about 40% of the land surface of Ethiopia and constitute 40% of the Ethiopian population (61,62). The Borana are a senior Oromo clan, best known for maintaining the Gada system that was once the core socio-cultural and political system of Oromo society (63). The Borana's oral history suggests that the Gada system of polity has survived since the early 13th century (64).

The Borana community, estimated at some one million people (CSA 2007), occupies a relatively arid area in the southern part of Ethiopia, along the border of Somalia and Kenya (97) and Northern Kenya. The Borana zone is one of fourteen zones in the Oromia Region that borders with the Gujii and Bale zones of Oromia in the north and northeast, the Somali zone in the east, Kenya in the south and the Konso District of the Southern Region (SNNP) in the west. Living in an arid climate, the Borana breed livestock as their economic mainstay. Men are the main participants in the economic, social, cultural and political life of the Borana.

4.3.2. Methods of Data Collection and Analysis

The data for this study was collected between October 2008 and April 2009 in selected communities of the Borana zone. In-depth interview and focus group discussion (FGD) participants were identified using a snowball technique and based on the person's knowledge of Borana culture. The first participant identified suggested a second participant who in turn was asked to identify the third, etc. The process continued in this way until sufficient information was obtained.

Accordingly, a total of 69 in-depth interviews and nine FGD sessions with a total of 68 participants were carried out separately for men and women. Women made up 40% of the in-depth interviewees and 56% percent of the FGD participants.

During the data collection period, the Principal Investigator (PI) stayed in the community and took part in the social and cultural activities of the community. This helped to

generate more information about the community's, socio-cultural, economic and political life.

The study protocol included structured and semi-structured interviews on sex practices, reasons for extramarital concurrent sexual engagement, perceived vulnerability to HIV and which segments of society are most vulnerable to HIV infection.

Interviews were conducted using the local language, Afaan Oromo. Audio-recording interviews were not possible due to the suspicion and discomfort of study participants. Instead, research assistants recorded quick notes during interviews, which were later elaborated and organized as field notes each evening. Field notes were translated into English for analysis. To ensure the accuracy of the translation, sample materials were translated back into Afaan Oromo - the original language of the interview.

Data were analyzed using MAXQDA qualitative data analysis software, which summarized and categorized raw data according to coded themes used to aggregate the data. After carefully interpreting contents without distorting the original meaning, content analysis was applied. Pseudonym was used to maintain the anonymity of the participants. However, age, sex, source of information (interviews and FGDs) and residence of the participants were shown for easy reference.

4.4. Results

4.4.1 Socio-Demographic Characteristics

The average age of FGD participants was 40 among women and 36 among men. Of the 38 women and 31 men selected for in-depth interviews, the average age was 49 years and 50 years respectively. All of the participants are Oromo and more than 75% of them follow the indigenous religion *Waaqeffannaa* (belief in *Waaq* – the Almighty). FGD participants bore on average seven children by the age of 40 years, while in-depth interviewees bore on average ten children by the age of 50 years.

4.4.2. Sexual values and practices among the Borana

It was unanimously documented that spontaneous initiation of sexual intercourse between persons who are strange to one another is a rare occurrence among the Borana. Extramarital sex is negotiable and depends on the interest of both parties involved. However, men often found to start while women choose whether or not to agree. Sexual violence and coercion such as rape, forced marriage, and abduction were found to be taboo among the Borana and there is a mechanism for dealing with such cases (see Chapter 3). For women and girls, sexual activity before marriage is a serious violation of local values of sexual life and is referred to as *cabana* (being wicked). A woman or girl accused of *cabana* is alienated from the community. While girls are expected to remain chaste until marriage, with marriage itself being a prerequisite for women's participation in extramarital sex, boys have the freedom to have sex even before marriage⁶.

⁶ According to the Gada system (local socio-political organization) that governs Borana's social, economic and cultural state of life, sons are expected to go through rituals to qualify for local leadership, which keeps them bachelor much longer than girls. However, they are only allowed to have sex with married women

Concurrent extramarital concurrent sexual activity, locally known as *jaala-jaalto*,⁷ is found to be a common practice in Borana. As a result, marital fidelity is not an expectation of either men or women. Yet, it has been unanimously argued by both men and women research participants that local culture does not prescribe such practice. That is why, as explained all those who participated in the research show that hearing about ones spouse's sexual engagement with another person strikes emotional reaction. Furthermore, if extramarital concurrent sexual partner of one's wife is caught red handed, he would plead "lubu nabaasi" – save my life which was explained that if Borana men plead for life it would only be in such cases related to their sexual life.

4.4.3. Determinants of extramarital concurrent sexual practices in Borana

Evidence obtained from research participants (men and women) reveals that engagement in extramarital concurrent sexual relationships is determined by multifaceted but interrelated factors, including personal interest, and social, and economic expectations at community level.

Most male respondents agreed that extramarital concurrent sexual activity is not as common as it was before five years. The five year mark is associated with the Gumii Gaayo⁸ (the Gaayo assembly) of 2004 when the issue of HIV as a problem was raised in public for the first time by the Gada leader at the time. Haleke commented that "*Although the Gada leader remarked that people should be cautious on HIV infections, he did not comment on extramarital concurrent sexual life of Borana*" (M47 II Teltele). Despite fears and concerns at public leave, still, three in five male and female study participants

⁷ Although I was told that gaarayu is the local term for extramarital concurrent sexual partner, since recently jaala and jaalto has become widely used. Jaala is how women refer to a male sex partner while Jaalto is how men refer to a female sex partner

⁸ In Borana power transfers every eight years following competition among age set cohorts. Four years after coronation of the Gada leader, assembly seats at a place called Gaayo for a mid-term review of accomplishments. Problems encountered during the four year period are discussed and actions for addressing them are tabled. This forum will also review the last four years of previous Gada leader.

were found to favor extramarital concurrent sexual relations and also practice it despite the fear of getting HIV. Shege explained that *“we are quite worried about HIV infection since we heard the disease is contracted through sexual activity. Yet, people do not seem to stop practicing it due to expectations from peers as well as from the community”* (W40, II Alwaye). Gulfo also argued, *“even if we want to stop, we cannot. It is like addiction and there are also expectations from colleagues and the public at large. We also see local leaders who are in it without much worry and we feel it is still acceptable for us as well”* (50M, FGD-Arero). Dhadechi summarized the group’s feelings regarding extramarital sex as an important part of life as follows: *“Although jaala-jaalto is feared since it exposes us to HIV, it remains an important means to prove ourselves as wanted by an opposite sex and equal to others. One who is not wanted is undermined not only by the community but also by the spouse and this perpetuates the continuous search for an extramarital concurrent sexual partner”*(M35, FGD Arero). One in six participants indicated that even spouses would frown upon their husband or wife if they gave up on having an extramarital sex partners. Not having an extramarital sex partner is considered to be indicative of being undesirable, for whom one is undermined both at family and community level. Abagido commented on implications of not having *jaala or jaalto* as follows *“...if your wife is not with any man at one particular moment, friends tease you for having a wife who is unwanted by other men and this is considered to be a disgrace in the community”* (53M II Liben). Similarly, Haleke argues that *“if my wife fails to attract other men, I get worried since this is a sign of her failure to fulfill the roles expected of her both at family and community level and this is known by people or she is not attractive”* (M47, II Teltele).

Personal attractiveness is critical to ensure desirability, as explained by both men and women research participants. Women’s physical beauty is determined by her hair style which has to hair-dressed (*cibrachu*) and her scent (enhanced by taking an herbal smoke bath - *qayya*) as well as her attire. Men’s physical attractiveness depends on wearing a neat cloth, and having combed hair and clean teeth. It was also stated that *jaala-jaalto* is a way of breaking family routines and getting sexual satisfaction that may not be obtained

from the spouse. One in six male and one in eight female study participants believed that extramarital sex is necessary to make life enjoyable. *“Often sexual engagement with my husband is not joyful as he does not pay attention to my interest. So for sexual satisfaction I need to have someone else with whom I have sex leisurely. I think the same is true for men too”* (46W, II Didara). Similarly, Borbora explained that, *“routine life and a consistent relation with just one woman is boring. It is good to have someone else with whom to enjoy sex. This is not only for men, women also have similar feelings although they pretend as if they do not recognize and know them”* (M72, II Dubluk).

Fulfillment of gender roles at family and community levels is another factor that determines attractiveness. Women’s demonstrated ability to prepare delicious food, to bear and nurture children and to keep the homestead clean is important factors ensuring women’s desirability. Rich men, marked by the number of livestock owned⁹ and those known for being public speakers, hunters and fighters draw the attention of women. Qasim explained that *“...competition among peers to have an extramarital concurrent sexual partner and the recognition such a partner would have at community level are critical”* (M40, FGD Liben). Dhadechi contends that *“such sexual relationships have many sides. In Borana, it should not be seen as simple sexual cheating as is the case among the highlanders”* (M35, FGD Liben). *Normally a woman cannot resist having jaala. If a woman does not have jaala, other women blame her that she drinks her own cow’s milk herself “aanan loon ofii ofiif dhugdii”. This is considered shameful as she has to have an extramarital partner to drink the milk.”* (W37, II Didara). This was clarified to have a symbolic meaning that she does not have the skill to prepare delicious food.

Three in five men and two in three women research participants argued that gift exchange naturally follows after having stayed together for years as sexual partners. Yet, economic interest is not believed to be the main driver of extramarital concurrent sexual relationships. According to Kura, *“...a woman is expected to prepare and feed her*

⁹ Wealth level of a household in Borana depends on size of livestock owned. The size is not counted by heads of cattle but by the number of corrals (*yaasa*) one owns

extramarital concurrent sexual partner with porridge, milk and delicious food, which often is much better than what the wife prepares for husband and this is a common practice” (69M, II Yabello). Several research participants agreed with Haleke’s explanation of why men look for other women as it relates to economic interest, “we [men] love to eat something different from jaalto and it is usually something we do not get from our regular wife. Men without extramarital concurrent sexual partners would not have such an opportunity” (M47 II Teltele). Women also get gifts from their jaalto that include money (cash) to buy perfume, and clothes. They also get invitation of drinks during market day and live animals (cattle, goat) once in a while, especially if the woman’s marital family suffers economically. Most participants mentioned that staying together with an extramarital sex partner for at least one year warrants a live animal being gifted to the woman. Lokko pointed out that, “...currently, getting a live animal is not as common as before since the number of livestock one owns has declined due to drought. Although there are still some men who give live cattle to their women sexual partners, many men cannot do so and we [women] do not complain much as we understand the situation” (W37, II Didara).

Some participants doubted that economic interest was associated with extramarital concurrent sexual partnerships. Jedo, for example, pointed out that “*while some argued that women are engaged in extramarital concurrent sexual partnerships with more than one man to earn money, gifts as well as clothes, which is the basis for competition between women, engagement in sexual partnership is more an outcome of desire for sexual satisfaction and proof of desirability than it is for economic benefit” (W37, II Arero).*

In connection to the economic aspect of extramarital concurrent sexual relationships, at least one in three women and two in three men cite market places as spaces for extramarital concurrent sexual negotiations, and for gift exchanges and drinking together. Furthermore, Shege argues that “*our men go to market places to sell livestock. There they meet and invite their jaalto. At market places men could also meet those who are selling*

sex” (W40, II-*Alwaye*). This is a commonly shared view among the majority of the research participants.

4.4.4. Number and duration of Concurrent Extramarital sexual relations

Neither male nor female research participants believe that there is a rule that determines the number of extramarital concurrent sexual partners one could have or how long partners could stay together, citing instead that it depends on the two individuals involved. However, it was revealed that the number of extramarital concurrent sexual partners participants had ranged from one to ten and no one believed that the opposite sex told the truth about the number of extramarital partners they had. The majority of women claimed to keep just one extramarital concurrent sexual partner over a period of a life time, while a few men claimed to have up to 10 extramarital concurrent sexual partners for a limited period of time. However, it was argued that this is not the at least since the last few years due to economic problems and concern over spreading HIV infection.

Currently there is a tendency to limit the number of extramarital concurrent sexual partners due to fear associated to HIV. Malicha noted, “*I do not remember how many sexual partners I had, but for sure they may be more than ten during the last twenty years. Now I am limited to my wife. I know my wife was followed up by several men and I know she had jaala, however I think she is no more with them – she is with me now*” (M46, II *Arero*). According to Huka, “*for the men, I would say they always have many more women as they boast about the number of extramarital concurrent sexual partners they have. As I was saying, women also compete with each other for benefits [gifts from the partner] such that there always are several partners one would have in life*” (W56, II *Arero*). Gelgelo has also noted that, “*... normally women are supposed to have one sexual partner on top of the husband. However, it is now common to find both men and women keep some more in secret*” (M57, II *Dillo*). One out of three women participants accused men of under reporting the number of extramarital concurrent sexual partners they have due to the current concern over HIV infection. Oshore pointed out that “*When asked, men claim to have only 1-2 sexual partners – which are far from the truth as they*

always have more extramarital concurrent sexual partners in secret” (W42, II Liben). Unlike men, women usually stay with one extramarital concurrent sexual partner. Lokko pointed out that *“Most women would not have more than one extramarital concurrent sexual partner. Very few may, however, keep more than one extramarital concurrent sexual partner and those are blamed as ‘hinsharmuxee’ [became sex worker] (W37, II Didara).* Men however accused women of having more extramarital concurrent sexual partners. Dida consolidated what was argued commonly by men research participants *“It is difficult to accept women’s claim of staying with one sexual partner as they are always busy competing for more gifts from extramarital partners” (M69, FGD Liben).* Although it was not possible to estimate the number of extramarital concurrent sexual partners over time, it was evident that both men and women have at least one extramarital concurrent sexual partner in their lifetime.

4.4.5. Reaction of Spouses to Extramarital concurrent sexual relations

There is a common agreement among research participants that *jaala-jaalto* is not culturally approved practice. Male and female study participants described extramarital concurrent sexual partnership is considered as an act of theft (*ishiin waa hanaati*). The previous Gada leader underscored that what is now widely recognized as *‘jaala-jaalto is not what Gada accepts and prescribes but it is a practice individuals carry out in secret. It is not any different from theft (M49, II Yabello)’*. In view of this, the first reaction to hearing or seeing one’s own spouse with another sexual partner is emotional upset and anger by the spouse. Participants explained that if a man knows of his wife’s extramarital concurrent sexual affairs with another man, he would likely beat the wife and threaten to divorce her. A wife who sees her husband with another woman would threaten her husband with retaliation that is to engage in extramarital concurrent sexual activity. Loko summarized women’s feelings that, *“Most of us (women) know who our husband’s jaalto is and our reaction is serious at the beginning. Husband is threatened by the wife who would tell him that she will engage in sexual activity with another man”*. She further explained, *“Husbands would react more seriously to the point where he beats his wife and threatens her with divorce” (W37, II Didara).* Borbora noted that *“Negative reaction*

at the beginning is normal and acceptable and would not go far as you start to rationalize and pretend as if you did not know. However, some men take it further and plan to catch the man red handed to take him to local Gada leader where, in worst case scenario, jaala could be evicted from his usual place of residence". He further clarified on how the decision is made which is commonly described by all research participants, *"Decision on what action to take on a man caught red handed depends on what the husband suggests which Gada leaders approve"* (72M, II Dubluk). According to Dahanba, *"Some men take serious measures against their wives' sexual partner"*. She further explained that *"jealous men would even request the man (jaala) to leave the village so that the two would not continue their extramarital concurrent sexual relations any more"* (56W, FGD-Liben). There have also been instances where a man who had sexual relations with someone's wife was fined and paid heads of cattle to compensate for having an affair with another man's wife. One in six women research participants indicated that in recent times men consider knowing and catching their wives' extramarital partner red-handed as a source of income, though none of the men involved in the study mentioned this to be the case. Shege noted that, *"Some men consider knowing their wife's extramarital partner as a means of getting money or cattle from the man in the form of punishment"* (W40, II Always).

4.4.6. Perceived consequences of extramarital concurrent sexual practices

The study explored the social construction of risk associated with sexual activity in the community. It was found that extramarital concurrent sexual activity is generally believed to expose the community to HIV infection. The threat is understood to apply to both men and women. Yet, there were instances where men accused women for having more extramarital concurrent sexual partners than did the men and more vulnerable to HIV infection. According to Dalacha, extramarital sex is a common practice among both men and women members of Borana community. He further noted that, *"keeping a man and woman faithful to each other is as difficult as keeping an ox or cow from licking their tail. This means both are exposed to HIV infection"* (M65, II Liben).

According to Gelgelo, *“nowadays there is confusion at the community level. While we recognize HIV is here and is challenging us, we find it difficult to stop extramarital concurrent sexual practices due to its association with the way we live”* (57W, II Dillo). Jedo pointed out that, *“We know HIV can be transmitted by extramarital concurrent sexual relationships. However we do not know yet what to do about this – we are all puzzled about this”* (37W, II Arero). Haleke noted that *“Gada leaders, who are models in the community, are continuing to keep jaaltos and this sends the wrong message to the community that respects them”* (47M, II-Teltele). Giving up or changing the practice, he emphasized, would affect the entire Borana community as it is tied to the community’s social life. One in three male and two in three female research participants feel that there has not been much change in people’s sexual activities, despite understanding the implications of the practice for increasing exposure to HIV infection.

The majority of research participants considered condoms as a potential way to reconcile extramarital sex practices and increased vulnerability to HIV. But, there is widespread lack of clarity about condoms and how they work. There is community interest in having more information about condoms and how it prevents HIV infection. Tato argued, *“... this condom may be a solution for the problem, but we do not know about it and our information is limited, as what we know is only hearsay and I think we should be educated about condoms”* (W38, FGD Arero). Kulyee also contends that *“condoms are not known in this community but now a days we are hearing about it as the only solution to prevent HIV infection ‘fala birraa malqabna’ ...what other option do we have except condoms”*(M42, FGD Liben). Kotola on the other hand argued that *“... in our community, condoms are believed to prevent seminal fluids from passing in and may affect conception, or they could also remain in a woman’s body creating problems for her and we do not know how it works. We would like to learn more about it”* (W57, FGD Harobake).

4.5. Discussion

Most studies on sexuality focus on sexual behavior that includes knowledge, attitude and practice as they relate to sex (82). However, there is growing recognition that sexuality is a much more complex subject that goes far beyond behavior alone (83). The steady spread of HIV has prompted researchers to consider the importance of understanding the local contexts in which people practice sex with someone other than the spouse (98).

A study in five urban settings of Sub-Saharan Africa found that the spread of HIV is not so much associated with multiple sexual partnerships (95), since multiple sexual partnerships could be serial where there is no sexual overlapping between those involved and prevention information is available to the public. There are emerging evidences over the last few years that concurrent sexual partnership is the driver of HIV epidemic in Eastern and Southern Africa (41,90,91). The practice of concurrent extramarital sex amongst some communities in Africa increases the risk of HIV infection over those who engage in serial sexual partnerships (41,99). In Borana where awareness is limited it is clear that extramarital concurrent sexual practice widens the opportunity for the virus to spread.

Although concurrent extramarital concurrent sexual practice is not unique to Borana pastoral community, relative tolerance of the practice makes Borana different. Each individual person goes to a great length to make one self acceptable and attractive to the opposite sex and secure an extramarital partner. This finding challenges previous studies that attributed multiple sexual engagement to women's poverty, weak decision making authority and economic interest alone (8,71,79,100–102), Yet, evidence suggests that widespread sexual interconnectedness among the Borana, is rooted in determinants that are not related to gender based sexual violence including rape and abduction and economic interest due to poverty. The social relations, personal desire for sexual satisfaction and to some extent exchange of economic valuables appeared to have played role in driving extramarital concurrent sexual practices among the Borana.

It was clear from the explanations above that there is couple of outstanding issues that appears to be contradicting. One is on the issue of whether extramarital concurrent sexual practice is culturally prescribed or not. Research participants all along insisted that in Gada system, extramarital sex or as it was traditionally referred to (*gaarayu*) are no more than theft. Indeed if one is caught red handed he pleads '*lubu nabaasi*' (save my life). This implies that it is not culturally prescribed. Yet, it was clear that it is widely practiced and there is some level of tolerance. Although it did not come out in the research that among the Borana killing one another among men is uncommon and men considers themselves as brothers. They fight together and hunt together and share bitter life together. So, there could be an evident disinterest to fight over women which could as well imply how women are seen. Secondly, as in any culture, there is a tendency to up keep local culture and protect it from blame. Given the fact that extramarital sex is generally considered as culturally an acceptable, the Borana tends to attribute the continuity of extramarital concurrent sexual practice to individuals instead of culture.

Regarding number of sexual partnership, normally one has to have extramarital concurrent sexual partner which is the mark of wantedness. Nevertheless, the number and duration of such partnership was found to be difficult to track in concrete terms. Before the advent of HIV people continued to have as many as liked for a length of time interested. This has now been questioned in view of the fear and confusion over looming threats of HIV infection. As a result there is growing tendency now to limit oneself to one extramarital concurrent sexual partner. While this is found to be the case, it was found that men often keep more partners which is not seen as a problem while if women has many partners she is blamed for becoming a sex worker.

Although extramarital concurrent sexual practice is widespread in Borana, it is not easy to track the sexual network that results. Previous studies show that sexual networks are shaped by spatial domains that remain undefined due to the constant movement of people from one area to another (86,103). In Borana, there were many accusations and counter-accusations between men and women regarding which sex had more sexual partners. It is common in Africa for men to boast about the number of sexual partners, they have while

women tend to under report (40). A number of studies accused women of a high degree of marital infidelity which is widespread among different communities (80,98,104,105) while there are other studies that claim men are more unfaithful and enjoy more sex partners outside of marriage (88,95,104–106). In the present study, however, despite the finger pointing on the part of both men and women, research participants recognize that extramarital concurrent sex is practiced by both men and women which makes both vulnerable to HIV infection as well. Study participants did not recognize relative vulnerability one group than the other, since both will continue engaging in marital sex anyway.

Concern over the consequences of extramarital concurrent sexual practices lead study participants to show interest in knowing more about condom and considering it for use to contain the spread of HIV infection. This is an important finding in view of the challenges of ensuring consistent use of condoms in various settings. There is evidence of slow uptake of condom usage in settings where HIV prevention endeavors have been wide-ranging (10,94,96). There have been continued resistances to condom with the pretext that it reduces pleasure, affects intimacy and promotes infidelity (92,96,107). Contrary to this, in Borana, there is growing interest to know more about condom and how it works which is positive. Although one may not be able to predict how the community reacts to condom after having equipped with relevant knowledge on condom, it is evident that there is a continued interest at community level to maintain extramarital concurrent sexual practice.

4.6. Conclusions and Recommendations

Among the Borana, girls are expected to remain chaste until marriage, and boys have the freedom to engage in sex before marriage. Yet, once married, women engage in extramarital concurrent sexual affairs at will. While extramarital sex practices are consistently argued to be culturally unacceptable, it remains tolerable. It is paradoxical that there is some level of tolerance despite the fact that local culture does not directly prescribe extramarital sex. Reconciling these seemingly opposed lines of thought was a

challenge for the researcher throughout the study and further study of how tolerance emerges under circumstances where the culture does not prescribe the practice would be of interest.

Extramarital concurrent sexual relations are determined by different but interrelated factors that are based in the social and economic fabric of the community. The findings of the present study show that concurrent sexual practice cannot be attributed solely to personal biological drive or to economic interests in relation to poverty. In Borana, while both personal interest and interest in gifts determine to some extent engagement in extramarital concurrent sexual relations for both men and women, of equal importance is fulfilling the expectations associated with gender roles both at family and community level. Thus, sexuality should always be studied within the socio-cultural and economic context of a society.

It was evident that the Borana recognized the association between extramarital concurrent sexual practices and vulnerability to HIV infection. Yet, abandonment of the practice is not a realistic solution at this point in time, as it is linked with established gender roles, desirability as a mark of identity and consequent competition between individual members of the community. Economic transactions in the form of gifts extend beyond individuals to their families. The importance of this in maintaining social relations between families needs to be studied further.

Gada leaders, who are supposed to be models of behavior in Borana, are also engaged in extramarital concurrent sexual practices as any member of the community. This presents an opportunity for a systematic approach to dealing with the increased risk of HIV infection due to extramarital sex practices. Perhaps it would be wise and cost effective to capitalize on the role of Gada leaders by targeting them and deploying them as change agents in the long run, while empowering them to promote and make available condoms as a prevention tool in the short term.

4.7. Limitations of the study

The sexual dynamics of the Borana community is quite complicated. Engagement in extramarital sex is linked to established personal, social and economic attributes that each deserves to be studied in its own right. While this study captures key aspects of personal, social and economic attributes of extramarital concurrent sexual practices, further exploration would help to generate more insight into the role these attributes play in developing notions of sexuality for both men and women in the community.

The community lamented the lack of information about condoms, and there appears to interest in knowing more about condoms and usage as a potential solution for the spread of HIV. Nonetheless, the paradox of looking to condoms as a potential solution to slowing the spread of HIV infection and the community's continued interest in bearing and nurturing children would be an interesting area of study. The current study did not capture sufficient information on this.

Applying mathematical models to the sexual network of Borana to determine how HIV spreads among the community is a worthwhile line of study. Furthermore, it would be relevant to determine if extramarital concurrent sexual networking also involves the younger generation. Today, young people in Borana are sent to schools in urban settings, away from home and possibly also local culture. This provides them with opportunities to live urban way of life. So, it remains important to explore if these younger generation would also engage in extramarital concurrent sexual practice.

Chapter 5: Perceived Vulnerability to HIV infection among the Borana

Pastoral Community



Figure 8: Social drinking at Beke Market, Sept 2008, photo by MK
This article is in preparation for submission to Journal of the International AIDS Society

5.1. Abstract

Background: Vulnerability to HIV infection is a major challenge in settings where gender based violence, discrimination and power differentials between men and women exist. This is often accompanied by poor awareness about the disease. However, there are gaps in determining the factors that facilitate vulnerability to HIV infection among pastoral communities.

Objectives: The objective of this chapter is to determine factors that are perceived to make the Borana pastoral community vulnerable to HIV infection and which section of the community is more vulnerable and why.

Methods: Information on gender and sexual behaviors of the Borana community, awareness of HIV and local understanding of the association between sexual behavior and HIV infection were collected through FGDs and in depth interviews with selected members of the community. The data generated were coded, categorized and summarized with MAXQDA qualitative data analysis software.

Key findings: Findings show that men's mobility in search of pasture, water and market for livestock puts them in touch with 'other women' other than their regular sexual partners and this is perceived to expose men to HIV infections. Although men are responsible for participating in and representing the family at public forums, findings show that they are not more informed about HIV than women, nor do they protect themselves from infections as a consequence. Despite recognizing the association between extramarital concurrent sexual practices and HIV infection, engagement in extramarital concurrent sexual practices by men and women of the community is not an exception and is perceived to make the community vulnerable to HIV infection. Awareness about HIV and AIDS was generally found to be poor due to lack of consistent and acceptable information from a credible information provider. Available information was found to be generic and did not factor in local context, which made the public doubt the credibility of the messages, thus messages do not seem to have been internalized by the

community. Although men feel that women are more vulnerable to HIV infection due to men's belief that women engage in sex with many partners, women blame men and, to a lesser extent, young people too for having several partners that make them more vulnerable to HIV infection. Despite this debate, study participants share a common understanding that men, women and youth are more or less equally vulnerable to HIV infection.

Discussion and recommendation: Vulnerability to HIV infection in Borana is driven by various factors related to sexuality, gender and awareness that work in tandem. These factors work together in tandem to make the community's vulnerability rather serious.

Interventions to lessen vulnerability should consider all those factors identified to expose the community to HIV infection. This requires concerted and comprehensive interventions by all stakeholders operating in the community, including engagement of local resources for such an endeavor.

5.2. Introduction

Early responses to HIV were guided by the idea that people are rational decision makers when it comes to sex and sexual health concerns, thus equipping them with the right resources would be sufficient to help them to make good choices (11,12,10). This philosophy, according to early development professionals, extended to definitions of vulnerability, which followed a top-down and reductionist approach that tended to attribute the occurrence of a problem to manifestations, without recognizing the context in which the problem occurred (24,45,46). According to Robert Chambers, vulnerability is exposure and defenselessness with an external side denoting exposure to shocks, stress and risk and an internal side reflecting defenselessness due to a lack of means to cope with the problem (108). Failure to cope may take many forms i.e., the individuals may get physically weaker, economically impoverished, and socially dependent, humiliated or psychologically harmed. Chamber defined vulnerability in terms of risk of exposure, risk of lacking necessary resources to cope and risk of being subjected to consequences that are interconnected (45). Gosh further argues that socioeconomic factors create an environment that facilitates exposure to HIV infection and women are at a greater risk of encountering HIV infection (109). These factors include gender based sexual violence, variation in decision-making authority and lack of access to information - all of which are social constructs (15,45,109). It is well documented that women, relative to men, lack opportunities to discuss sex and HIV, have limited access to educational opportunities, and have limited access to information, all of which are known to increase chances of being exposed to HIV infections. Variations between men and women are often attributed to factors that are sanctioned not by individual behavior but by the socio-cultural fabric of the society, which in turn creates a diverse set of coping mechanisms (3,15,110,77). Such variations allow a distinction to be made among those segments of the community that are more vulnerable to a particular problem and determine why (49,77).

Disparities in accessing or generating livelihood assets affects a group's or individual's ability to cope with the problem (107). Who controls and decides over economic

resources determines who is vulnerable to the problem. Similarly, availability of information about HIV and AIDS and services contributes to the coping capacity of a group or individuals. However, this does not mean a given community is passive since communities under all circumstances have their own coping mechanisms (108,111). A recent study on vulnerability recognizes the fact that women are at a disadvantaged positions in social, economic and political spheres, however warned that emphasis on women as victims and men as causes of such victims would jeopardize interventions since both are vulnerable no matter who gets it first (39),

In Ethiopia, there are not many studies on vulnerability in connection to HIV and even fewer targeting pastoral communities. A study on women and HIV/AIDS in Ethiopia sponsored by UNDP documented that women are more vulnerable to HIV due to factors such as female genital mutilation (FGM), abduction, widow inheritance and multiple sexual practices (59). The few available studies on Borana document that extramarital concurrent sexual practices, polygamy and marrying a sister of a deceased wife are critical factors in increasing exposure to HIV infection (19).

While these facts would indicate that HIV is a major concern in Borana, health data from the Borana zone also confirms the seriousness of the problem. According to the health status report of Borana Zone Health Department from 2000-2004, HIV counseling and testing results were found to be high ranging between 40-50% among suspected AIDS cases, blood donors screened for HIV and volunteers who were interested to know their sero status (69). Recent data from a sentinel surveillance site from Moyale health center has also estimated HIV incidence of 5.1% (58). During 2006-8, the government of Ethiopia launched Millennium AIDS campaign to get as many people tested as possible. Although official result from this was not available for Oromia region, draft report shows that Borana stands first with prevalence of 3.0% as compared to the rest zones in Oromia which is estimated at 2%. These figures show an alarmingly high rate in HIV prevalence in Borana.

Despite the high rate of prevalence, prevention interventions continue to lag behind the pace at which the virus is spreading in the community. The 2005 National BSS showed very low comprehensive knowledge about HIV and AIDS for the country at large estimated at (14%). The survey shows that comprehensive knowledge is much lower among pastoral communities with an estimate of 4% (18). The UNDP study in 10 selected districts of Ethiopia which includes Yabello district of the Borana zone, displayed generally weak knowledge on HIV and it was found to be worse in Yabello (59). Another study revealed that among the Borana community, HIV/AIDS risk perception was so low that some people even denied the existence of HIV (69). Similar to many pastoral communities in Ethiopia (53), the Borana practice extramarital sex for reasons explained in Chapter 4, despite widespread recognition of its association with the spread of HIV infections.

This particular study chapter aims to determine perceived vulnerability to HIV infection among the Borana community in connection to specific factors related to gender, sexuality and awareness. The study findings are expected to help design comprehensive and locally sound and feasible strategies to mitigate the spread of HIV.

5.3. Materials and methods

5.3.1. The study community

The Oromo occupy about 40% of the land surface of Ethiopia and make up about the same proportion of the Ethiopian population (61,112). The Borana is a senior Oromo clan and is known for maintaining the Gada system that was once believed to be at the core of socio-cultural and political life in Oromo society (63). In Borana, Gada as a system of polity is believed to have survived since the early 13th century (64).

Geographically, the Borana community resides in the southern part of Ethiopia, occupying a relatively arid area along the border of Somalia and Kenya (97), and in Northern Kenya. The Borana population is estimated at one million (61). The zone borders the Gujii and Bale zones of Oromia in the north and northeast, the Somali zone in the east, Kenya in the south and the Konso district of the Southern Region (SNNP) in the

west. For the Borana, livestock breeding is the economic mainstay in such an arid climate. Men are the key players in the economic, social, cultural and political life of the Borana.

5.3.2. Methods of Data Collection and Analysis

Data collection was carried out from October 2008 – April 2009. Research participants were identified using the snowball technique and on the basis of a persons' locally proven knowledge about the subject matter and their recognition as a credible representative of the Borana. The first identified informant was asked to identify the second informant, etc and this process continued until all relevant information was collected. Accordingly, a series of in-depth interviews and focus group discussions (FGD) were carried out using semi-structured guides and focused on gender roles, sexual practices, awareness of HIV and AIDS and perceived vulnerability to HIV infection. A total of 69 in-depth interviews and 9 FGDs with a total of 68 participants were conducted. 40% of in-depth interviewees and 56% of FGD participants were women.

Interviews were conducted in the local language, Afaan Oromo. Participants were reluctant to be tape-recorded, thus, notes were jotted down by the research assistants during interviews and elaborated and organized as field notes each evening. The notes were translated into English for analysis. In order to ensure consistency of translation with the original data sample, materials were translated back into the original language, Afaan Oromo, for verification.

The Principal Investigator (PI) stayed in the community during data collection and took part in the social and cultural life of the community. This helped to generate additional information about the community's socio-cultural, economic and political life.

The data were analyzed using MAXQDA qualitative data analysis software, which helped to summarize and categorize raw data according to coded themes which served to aggregate the bulk of data. Prior to application of content analysis, the raw data was interpreted without distorting the original meaning. Pseudonyms were used to maintain

the anonymity of the participants. However, sex, age, source of information (in-depth interviews or focus group discussions) and residence of the participant were shown for easy reference.

5.4 Results

5.4.1. Socio-Demographic Characteristics

Forty percent of the in-depth interviewees and 56% of FGD participants were women. The average age of research FGD participants was 40 for women and 36 for men and 49 and 50 years respectively for in-depth interviewees. All participants belong to the Oromo ethnic group. More than 75% of participants are followers of the indigenous religion *Waaqeffannaa* (belief in one *Waaqaa* – the Almighty).

5.4.2. Vulnerability to HIV in Borana

Research participants unanimously acknowledged having heard of HIV before and of understanding it to be a killer disease with no cure and leading to death. Quxulee explained that, *“HIV is a disease that forces people to lose their loved ones to death, like a wood that releases its leaves during the dry season”* (79M, II Yabello). Among the Borana community, HIV is recognized as a serious disease that damages the life of the person and ruins the social fabric of the community. A person infected with HIV is considered to be a burden, as clan members are expected to support the family through their traditional support system (*buusaa gonofaa*). Jilo noted that the Borana have always had a solution for other sexual health problems, but are challenged by HIV, *“Gonorrhea has been and is a common sexual health problem in Borana and yet it has never been scary, as we have locally prepared medicines from such plants as awachoo [Albeiza anthelimetic] and if it becomes chronic, soup made from the bone of an ostrich will absolutely cure the problem. However, we are here with this new disease called HIV, which we can do nothing about. – it could be a curse from Waaqaa”* (35M II, Liben). Although most participants agreed that the disease is everywhere in Borana, there are still many who believe the disease affects mainly those who reside in urban settings. Shege emphasized that, *“Unlike previous times when we heard about the disease from a distance, we are seeing individuals who are getting thinner and thinner in front of our eyes and they are said to have HIV”* (40W II Always). The majority of male and female

research participants felt strongly that *'if measures are not taken by Gada leaders and the government, the Borana community will perish because of HIV'*. Research participants explained vulnerability to HIV in Borana as being facilitated by various factors explained below.

5.4.2.1. Gender and Vulnerability to HIV Infection

As detailed in previous chapters of this thesis, in Borana, men and women have specific roles and expectations attributed to them based on gender, both at family and community levels. While men have more of an external role to play, women's role is by and large limited to the household. In connection to such roles, the majority of women research participants believe that men are much more exposed to HIV since they are involved in fighting, hunting, and travel away from home. In contrast, there is a general notion that women stay near home and are not exposed to as much HIV risk as men. One in seven women and slightly less men respondents reported that men are more vulnerable to HIV in connection to their role that take them out of home in search of pasture and markets to sell livestock. As they travel, it was shown that men may meet 'other women', who are not their regular partner (wife or jaalto). This is believed by research participants to expose men to HIV as compared to women. In explaining the situation, Lokko noted that, *"HIV is a problem that prevails in urban settings where women who work in bars are said to have the disease. Our men are suspected to have sexual relations when they visit towns and we get the problem because of our husbands"* (37W II Didara).

Three in five male research participants, however, argue that women and young people are more vulnerable to HIV than men because of their interest in and engagement with several sexual partners. Although sufficient data was not generated, there were a few participants who mentioned women's role of initiating young unmarried men in sex, which could expose women to HIV infection.

According to Borbora, *"In old days women were expected to socialize young unmarried men in sexual practice since young men marry late due to cultural requirements and expectation of girls to remain chaste which otherwise is cabana. This created a tolerable*

situation where married women have to socialize young unmarried men. This is not the case in today's Borana" (72M II Dubuluk). The finding has consistently found that such a practice has declined mainly since young men stay in urban centers away from family to attend school; and this is believed to give them more opportunity to access sex.

As explained in the previous chapter, women are passive participants in community events and are not given space in the leadership sphere. Similarly, as was documented in the previous chapter, research participants argued that women have decision making authority over joint resources and have right over some resources of their own. In consequence, majority of research participants, both male and female do not believe that participation in public forums or decision making authority over economic resources have any relations with vulnerability to HIV infection. Huka pointed out that *"No, women are not particularly vulnerable to HIV infection because they did not participate in public decision making forums. The discussion is always about communal life, about livestock, about economy, etc. and this is not related to HIV. There has never been discussion about HIV during public assemblies"* (W56, II Arero). Similarly, as regards the economic position of women related to HIV infection, Liben contends that, *"Neither men's nor women's economic decision making nor our participation in public forums has any relation to HIV infection, although lack of information does"* (M75, II Liben).

5.4.2.2. Extramarital concurrent sexual practice and vulnerability to HIV infection

As discussed in chapter 4 above, engagement in extramarital concurrent sexual activity with someone other than one's own spouse is deeply rooted in the daily life of every Borana man and woman and is considered to be part of the social, cultural and economic life of the Borana community. Extramarital engagement is based on is not forced but depends on mutual interest and consent with an established norms controlling partnership. It was gathered that there is no abuse or coercion involved in such partnership.

Extramarital concurrent sexual practice, however, is understood by the community to have implications for exposure to HIV infection. There is a consensus among research

participants that extramarital concurrent sexual practices make the community vulnerable to HIV infection. Gedo (W46, FGD Arero) pointed out that, *“We know HIV can be transmitted through such relationships. However, we do not know what to do about it. It is a major puzzle in the life of the Borana”*. Men share similar concerns, as reiterated by Doyo, *“Although extramarital sex is no more encouraged at community level due to its relation with HIV, the practice is still considered an important mechanism to prove ourselves as successful in our undertakings and expectations as men and women. So, we do not know what to do about this”* (M75, FGD Arero). Data suggest that a compromise has been found in response to the growing unease posed by HIV. Almost one in three research participants (both men and women), indicates reducing the number of extramarital concurrent sexual partner is suggested as a way to respond to the challenge.

Teno (W47, II Arero) argued that, *“Extramarital sex is not encouraged in the community at the moment due to the problem of HIV. However, people still practice it in secret despite so much concern and fear about the disease. The problem becomes serious when the man or the woman gets an additional partner”*. Wuga adds another dimension, where an increased number of partners is associated with competition between peers; *“I think there is a possibility of getting exposed to HIV/AIDS since men are not staying only with a few women. We also compete among ourselves in terms of what our respective jaala has done for his jaalto. So, in order to look good compared to our friends, I may tend to have more sexual partners which exposes me to the disease”* (W47, II Arero). Men share a similar view although there are few men who blame women for keeping more partners than men. *“There is a common understanding that such extra marital sexual affairs facilitate HIV transmission. Especially women are more vulnerable since they keep multiple sexual partners* (M42, FGD Liben).

5.4.2.3. Emerging circumstances and vulnerability to HIV infection

Over the last few years, new market places have been established with opportunities to sell Borana livestock. Within a radius of 100 kilometers from Yabello (capital of Borana), there are four big markets (Harobeke, Didara, Dubuluk, Alawaye). These

markets draw business people, including commercial sex workers, from across Ethiopia. Oshore pointed out that, *“My husband is responsible for selling livestock and I feel this puts him in touch with women who go to Borana on market days. These women, we suspect, have HIV. At market places we [women] also meet our jaala, which is not a problem”* (W42, II Liben). Lokko emphasized that, *“Men do not only meet their extramarital partner as we [women] do, but get involved in sexual activities with them which is a concern for most of us”* (W37, II Didara). Male research participants feel that market is a meeting place for extramarital concurrent sexual partners. However, most men deny encounters with women in such settings with one in six men admitting sexual encounters with women in urban settings. According to Gulfo, *“I come to market to sell cattle and pay various fees. Once I sell, I would invite my jaalto and return back to home. There are of course a few other men who run with women in urban settings but this cannot be generalized for all men”*. Market centers in Borana, are generally considered by women research participants as centers of sexual negotiation and encounters and consequently an opportunity for the spread of HIV.

5.4.2.4. Level of awareness and Vulnerability to HIV infection

Awareness of HIV and AIDS was found to be weak both for men as well as women members of the community (see Chapter 2 for more detail). The majority of respondents claim to have heard about HIV as a disease transmitted through sex. However further probing revealed incomplete information about how HIV is transmitted and how to prevent it. Haleke pointed out, *“There is not enough consistent information on HIV and how to prevent it. The first time I heard about AIDS was from NGOs operating in our area. They did not come back again and I doubted the credibility of the information”* (M47 II Teltele). Research participants commonly questioned the credibility of the information made available to the community through HEWs, school teachers and youth AIDS club members as was elaborated in the different chapters due to their age and the community’s reliance on Gada leaders for important information as that of AIDS which is a major concern in the community.

In consequence to the quality of information, majority of the research participants were found to have limited awareness and widespread misunderstanding on modes of HIV transmission. As shown in Chapter 2 above, only 18% of the respondents mentioned all four modes of transmission, while the wider majority of respondents knew only one or two modes of transmission. Similarly, 82% of the research participants were found to sustain misunderstandings on modes of HIV transmission as explained in chapter 2.

In connection to sustained interest in having extramarital concurrent sexual partners, there was common clear interest among research participants to know more about condom which is said to be a solution to control the spread of HIV infection. Adi emphasized on the need to teach the public about condom; *“I heard about condoms from a relative who lives in Liben town. I was told that it can prevent HIV infection. However, I do not think everyone living in the village knows about this. It would be good to teach the public about condoms. It is also good to make them available”* (52W II Liben). Kotola shared concerns that some research participants held, *“We are confused about condoms, which we heard could protect us from HIV infection - we also hear that it prevents fertility and may block pregnancy, which is a big concern. There are also people who say it may remain in women’s bodies and make them sick. Nonetheless, we wish to know more about condoms and how they work”* (W57 FGD Harobeke).

5.5. Discussion

Vulnerability, as denoted by Chamber, is exposure to risk and defenselessness due to a lack of measures to cope (108). Based on this, Watts and Bohle suggested three interconnected variables that would facilitate the understanding of vulnerability. These are: risk of exposure, lack of necessary resources to cope, and risk of being subjected to consequences (45).

Findings from the study in Borana show that the community is not immune to HIV infection, which supports reports of high prevalence of the virus in the Borana zone (17,69). Gender roles and associated sexual violence, variation in decision-making

authority and lack of access to information are social constructs (113). Gender based violence, discrimination, limited access to information, lack of opportunities and access to educational opportunities make women more vulnerable to HIV infection than men (45,49,109,77). It was evident from the findings that gender attributes and extramarital concurrent sexual practices subjected the Borana community to widespread exposure to HIV infection.

In Borana, although findings suggest that women are not sexually abused, there is clear evidence of discrimination, especially when one considers the treatment of sons and the role of adult men taking part in public events and related tasks. For more details on gender roles in Borana, refer to Chapter 3.

It is clear that men are mobile in search of pasture and water for livestock and to sell cattle at market centers. This offers men the opportunity to connect with ‘other women’, who are not regular sexual partners (either wives or jaaltos). Especially in view of the fact that Borana women invariably argue that women in urban settings have HIV, their men gets the virus from them become more vulnerable to HIV infection. Urban women for Borana women are those who work in drinking places and their assumption holds right since during the first wave of HIV in Ethiopia, commercial sex workers that were more affected (18). Although, women stay at home with household responsibilities in Borana, they are also exposed to infections given that husbands still have matrimonial rights to their wives upon returning home. This perception of vulnerability by the community is consistent with similar findings that show that mobile men are exposed to HIV, which they bring back to their innocent wives (109,114,115).

The consistent extramarital concurrent sexual activities in Borana are recognized by all research participants as a key factor increasing vulnerability. Nevertheless, there is no commitment seen among research participants to abandon it altogether. Instead, there is a new tendency to limit the number of extramarital concurrent sexual partners, suggesting a concerted interest in maintaining the practice while reducing the risks.

Among the Borana, markets were found to be mushrooming due to the demand for livestock species of Borana¹⁰. The proliferation of markets has created more linkages between urbanites and rural residents, buyers and sellers and, often, the linkages, according to Ronald, are both social and commercial in nature (114). The expanding livestock market centers in Broana draw businessmen and sex workers from across the country. They also attract the attention of Borana men who go to sell livestock (116). This study indicates that market places in Borana are not only market centers, but also centers of recreation, drinking and commercial sex contributing to Borana men's relatively increased vulnerability to HIV. In view of the limited knowledge of HIV and AIDS in Borana, Borana men may not take protective measures.

The majority of research participants maintained a shared understanding that HIV is transmitted mainly through sexual relations and is an incurable and killer disease. This is consistent with the connection between vulnerability to HIV and sexual activity as documented, especially in Sub-Saharan Africa, where poverty, violence and limited access to resources are the norm (15,39,24).

Extramarital concurrent sexual practices are an established way of sexual life among the Borana. The practice is in parallel with marital life and is non coercive and/or abusive in nature. Both men and women are involved at will, following an expressed interest and negotiations between those involved. This behavior has been documented in previous studies (51,69), and notably among the Hamar pastoralists of Southern Ethiopia (53). However, what makes extramarital concurrent sexual practices different in Borana is the evident reluctance to abandon it, despite an understanding of its connection to the spread of HIV infection and the relative tolerance of the practice although the local culture does not prescribe it officially.

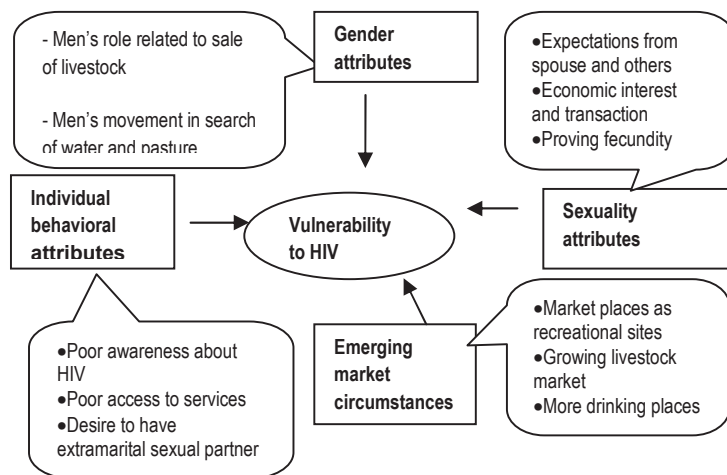
As detailed in Chapter 2 above, in Borana, only 18% of the respondents mentioned all modes of HIV transmission while the most know only one or two modes of transmission.

¹⁰ Borana livestock are mainly zebu, which are considered to be the best in Ethiopia

Furthermore, it was found that only 18% of the respondents claimed to have no misunderstandings on modes of HIV transmission. This finding is consistent with previous studies that show limited comprehensive knowledge and widespread misunderstandings on HIV in Ethiopia in general and among the Borana in particular (17,19,59). This shows that information on HIV and AIDS is inadequate and the majority still feels they do not know much about HIV and AIDS, despite unanimous claims that they have heard about HIV/AIDS as a killer disease.

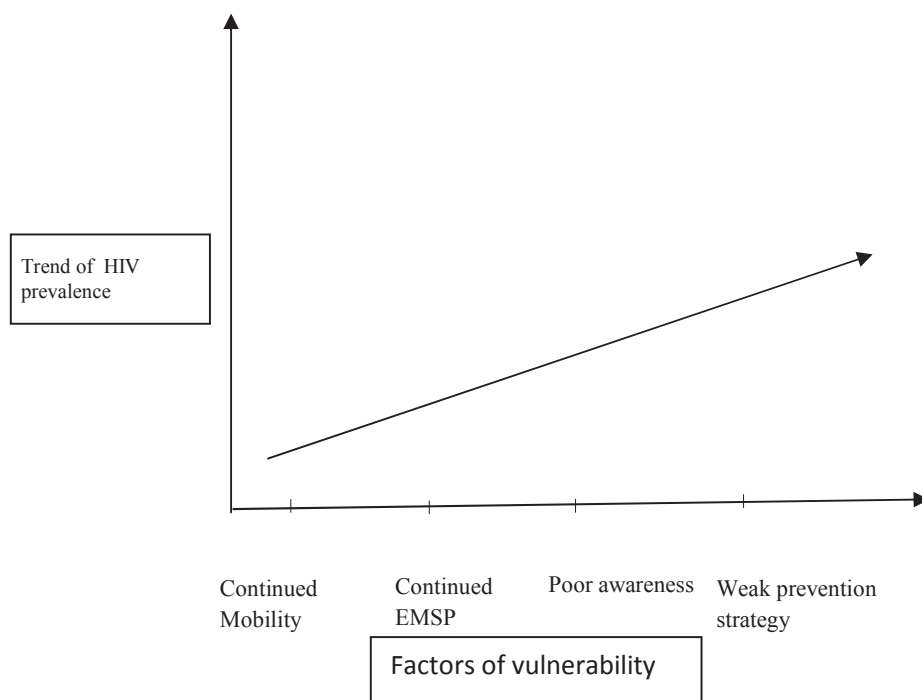
This study underlines that vulnerability to HIV infection in Borana is a cumulative effect of men’s mobility, widespread and tolerated extramarital concurrent sexual practices, limited awareness of HIV, and weak prevention interventions that have not paid attention to local contexts. The latter point will be discussed further in the next chapter. The diagram below summarizes the different factors contributing to vulnerability to HIV infection in Borana.

Diag 3 –Explanation to perceived vulnerability to HIV infection among the Borana



Furthermore, the findings in this chapter suggest that HIV infection will continue to increase steadily so long as extramarital sex is favored, awareness about HIV remains poor and prevention strategies remain generic, as shown in the next chapter, where local contexts are not considered in the design of interventions. These factors work in tandem resulting in a steady increase of HIV infections in Borana as depicted in figure below.

Diag 4: Trend of HIV prevalence in Borana as drawn based on data from the field



5.6. Conclusion and recommendations

This study has generated information showing specific aspects of gender, sexual values and practices and awareness of HIV and AIDS that make both men and women vulnerable to HIV infection.

Gender attributes and extramarital concurrent sexual practices in Borana have their foundations in the community's social and economic state of life. This study underscores that paying specific attention to aspects of gender and sexuality, and which aspects fuel vulnerability would help in the design of reliable and acceptable prevention strategies.

Related to gender attributes, men's role as it pertains to mobility with livestock was found to be associated with vulnerability to HIV infection. The risk is pronounced due to the growing market centers drawing the attention of businessmen and sexual workers from all over the country. Unlike many other pastoral communities, Borana women enjoy the relative freedom to decide with whom and for what reason to engage in extramarital concurrent sexual activities. Sexual violence and coercion is unacceptable in the community. Thus blanket attribution of gender in connection to vulnerability to HIV infection may not make sense and calls for more in depth analysis of which gender components, specifically, are associated with vulnerability.

The findings of the present study have underscored that engagement in practices may not be stopped by mere provision of information. It was interesting to note the interest of research participants in knowing more about condoms, how they work and where to get them. This seems to signify that extramarital concurrent sexual practice will continue to be part of the sexual life of the community. Thus, investing in stopping the practice will take a much longer time. This calls for a short-term solution that capitalizes on the interest in condom. It would also be useful to note that addressing perceived vulnerability to HIV in Borana requires comprehensive intervention where multiple front of prevention intervention would help to mitigate further spread of the virus in the community.

5.7. Limitations of this study

The study has benefitted from the PI's connection with the community and from his being a native Oromo. FGDs and in depth interviews helped generate concrete data related to gender, sexuality and HIV related individual behavior. However, the study has some limitations. These include: a) lack of vulnerability focused studies in Ethiopia in general and in Borana in particular that has it made it difficult to compare the findings b) It is important to note that conclusions reached in this study are specific to Borana and may not be generalized to other pastoral communities, although logical linkages could be made and c) this study is a qualitative one, focusing on factors of vulnerability to HIV infection. Lack of biological data to support the findings is therefore another limitation of the study.

Chapter 6: Local opportunities for HIV prevention among the Borana pastoral community



Figure 9: Community conversation session facilitated by local elder at Cholqassa village, one of PAMS sites, coordinated by GOAL Borana April 2008, Photo by Abdulmalik

This article is submitted to The Ethiopian Journal of Health Sciences for publication

6.1. Abstract

Background: For almost a quarter of a century, responses to the HIV pandemic have advanced and a rich body of knowledge and experiences has been accumulated in its wake. Yet, the pandemic continues to sabotage development efforts, thus there is still a need to explore other opportunities for and experiences of containing the spread of the disease.

Objectives: The main objective of this chapter is to identify local opportunities and resources that could be mobilized to improve HIV and AIDS responses and initiatives in Borana.

Methods: In-depth interviews and focus group discussions (FGD) guided by semi structured questions were used to collect relevant information on available local resources for and experiences in preventing the spread of HIV infections. Data were generated from individual members of the community and institutions that were selected for interviews and FDGs using a snowball technique. Collected data were coded, categorised and summarised with MAXQDA qualitative data analysis software

Key findings: The local health department and non-governmental institutions rely on health extension workers, local teachers and youth groups to impart HIV and AIDS messages to the community. However, these groups are not recognized as credible advisors and sources of information by the Borana people. Consequently, limited awareness and widespread misunderstanding about HIV and AIDS are rife in Borana, as detailed in Chapter 2. Study participants did not feel that local Gada leaders, who are recognized and trusted authorities in the community, were active in HIV prevention endeavors. Study participants believed that HIV prevention is the responsibility of a variety of stakeholders: the family, government, non-governmental organizations, local assembly (*Gumii*) and Gada leaders. Research participants argued that successful HIV prevention interventions would be possible if these different stakeholders could work together to provide the community with consistent and credible information on HIV.

Discussion: The Borana local health department's claim of success in HIV prevention efforts could not be substantiated with evidence obtained from the community. Widespread misunderstandings about HIV and AIDS in the community are rampant, indicating that the community still lacks pertinent information on HIV and AIDS. To address the problem, Gada leaders, local health department, CSOs, and family members must take responsibility and work together to educate and protect their community. This finding is in line with current calls for a comprehensive response to HIV, with all stakeholders playing a vital role.

Conclusion: Designing intervention strategies with the full involvement of stakeholders and giving them the capacity and power to play a role in HIV prevention is believed to bring about concrete results in reducing the level of HIV threat among the Borana community.

6.2. Introduction

The HIV and AIDS epidemic poses serious development challenges to countries around the world. Recent UNAIDS report shows that by the end of 2009, 33.3 million [31.4-35.3] people were estimated to be living with HIV. During the same time an estimated 2.1 million [2.3-2.8] people became newly infected by HIV. The same report also estimated the number of deaths due to HIV related illnesses to be 1.8 million [1.6 - 2.1]. The number of death has declined over the years and number of people living with HIV is growing due to increasingly available anti-retroviral ARVs which have improved the survival of those infected with HIV. Although these figures demonstrate that positive changes over the course of time, there still is a long way to go as prevention strategies, often do not adequately address the patterns of HIV transmission

HIV prevention interventions over the last 30 years have been guided by behavioral change models that target individuals with the objective of increasing awareness, modifying attitudes and improving skills, thereby enabling individuals to take conscious steps to protect oneself from HIV infections (3,117,118). More specifically, HIV prevention interventions emphasized on modifying sexual behavior, such as limiting multiple sexual partners or using condoms during casual sex and persuading individuals to change their behavior in ways that would ultimately reduce their individual risk (2,11,119). A study on concurrent sexual practices in Sub-Saharan African countries concluded that multiple sexual practices alone may not contribute to increased HIV infection (95), but rather whether the partnership is overlapping or serial and the lack of means to protect oneself from infection have implications for the spread of HIV.

Over the last few years, the spread of HIV infections is documented to be declining and new infections have also been dropping in connection with the extensive awareness campaigns and prevention interventions (1). Recent meta-analysis shows that prevention interventions contributed to a remarkable reduction of sexual risk (107) and declining infection in several countries (2,3,11,10). Although UNAIDS recognizes the fact that the

endeavor has improved responses to HIV, (1), Gupta and colleagues argue that behavior change interventions did not achieve consistent results and did not have a broad reach since such interventions were not informed by local contexts (15). Furthermore, the epidemiology of HIV infection shifted from the traditional at risk groups such as long distance truck drivers and commercial sex workers, to married couples and those with long term sexual partners (2,11). These findings reinforce the need to consistently design context informed and appropriate prevention strategies to combat the dynamic nature of the epidemic (2,3,14) and ensure synchrony between the dynamics of the epidemic and policies and strategies developed to address it (15).

In many developing countries, HIV and AIDS interventions have been accused of failing to take local contexts into consideration, but rather remains to be top down in approaches with little regard for the social and cultural context of the targeted beneficiaries. Such realities are believed to have given the epidemic an opportunity to continue threatening people, for several decades to come (3). Global efforts have succeeded in pulling resources together to contain the spread of HIV. Yet, with the same strategies and approaches, mere technical and financial resources may not change the course of the epidemic (89). Interventions must be guided by evidence showing where the epidemic is, who the most affected are and what actions to take. They should also be able to mobilize the resources available in a target community to effectively and sustainably change the course of the HIV and AIDS epidemic (3,11,10). Mobilization of local resources for a comprehensive HIV and AIDS response has been discussed in various literatures and is believed to improve HIV interventions (2,3).

According to the UNAIDS Report 2010, HIV incidence has fallen by 25% between 2001-2009, and Ethiopia is one of the countries where HIV has either stabilized or shown signs of decline during the same period (1). In Ethiopia, during 2010 1.1 million people are believed to be living with HIV in Ethiopia. An estimated 14,000 HIV positive births occurred that year and 58,290 people died due to AIDS (120).

While HIV prevalence appears to have fallen or stabilized in Ethiopia after reaching a peak in the mid-1990s, the absolute number of infected individuals is still very large due to sheer population size (17). Estimates show that in 2010, HIV prevalence in Ethiopia was 2.4%, varying in rural and urban settings. In a country with diverse socio-cultural features, evident economic hardship, expanding urbanization, increased mobility of people in search of employment opportunities and sporadic conflicts, the spread of HIV is assumed to be far reaching and will pose a serious challenge to the country (17,18).

In recognition of the magnitude of HIV related problems and the challenge it poses to development, the Ethiopian government established an HIV and AIDS control program in 1987, under the Ministry of Health (MoH). Eleven years later, in 1998, the government ratified the first comprehensive HIV and AIDS policy, which defined a multi-sectoral approach to HIV prevention and control. The policy and the HIV prevention office have undoubtedly facilitated a coordinated response to mitigate the spread of the pandemic (121). However, the policy which is from 1998 is still the guiding principle of HIV response in the country despite the fact that HIV is a dynamic public health concern.

Since 2001, the federal HIV prevention and Control Office has launched series of HIV and AIDS strategic plans including the recent one 2009-2014. These strategic plans adopted a multi-sectoral approach to prevention that could be implemented at different levels by different stakeholders (18,121,122). The prevention component of the strategic framework, especially the recent ones, focuses on community mobilization, condom promotion and monitoring and evaluation of interventions. In 2006, the HIV coordinating office launched a three year Millennium AIDS campaign that focused on increasing public accessing to HIV counseling and testing. Improving ARV uptake and integrating HIV treatment into health care settings was another component of the campaign (123).

Over the last few years, Ethiopia has received financial and technical assistance from the World Bank, the Global Fund and PEPFAR for its HIV and AIDS program. (17). The resources were used mainly for awareness creation campaigns that followed uniform

behavioral change models neglecting the diversity of Ethiopian socio-cultural features and different local potential that could have augmented interventions.

More recently, in addition to awareness creation endeavors, community mobilization through community conversation and free distribution of ARTs for HIV treatment has succeeded in expanding from hospitals to health centers to reach over 210,000 people. This accounts only for 20% of the people believed to have been living with the virus as of 2009 (124). The wider majority of the population living with HIV is still waiting to be reached by HIV services.

The 2005 National Behavioral Surveillance Survey (BSS) Report stressed that comprehensive knowledge about HIV was found to be low, with less than 25% of communities possessing thorough knowledge. Among pastoral communities, comprehensive knowledge was estimated to be as low as 4.4% (18). This is consistent with this thesis' findings about HIV knowledge and misunderstanding about HIV among the Borana people, detailed in Chapter 2. A UNDP study in Yabello, a district in the Borana zone, documented low levels of knowledge of modes of HIV infection and wide spread misunderstanding about HIV, including denial of the existence of HIV (59,59). Other studies, and this thesis, have documented that the extramarital concurrent sexual practice of *jaala-jaalto* is widely recognized as predisposing the Borana community to HIV infection (51,76).

Although recent biological data on the spread of the virus in Borana is lacking, the little data that is available shows that HIV is a major concern. The last surveillance survey report by the Ministry of Health shows that HIV prevalence among Anti-Natal Care ANC attendees at Yabello Health Center was 5.1% (58); a worrying statistic. Similarly, result from Millennium AIDS campaign shows HIV prevalence of 3% for Borana, which is consistently high compared to overall HIV prevalence for Oromia which was found to be 2%.

Despite such realities, HIV prevention interventions have failed to pay attention to communities in pastoral settings, either due to distance or to urban biases (18). To date, interventions have been uncoordinated and top down, with no cooperation with local actors that have the potential to improve the outcome of interventions.

This chapter assesses prevention interventions currently active in Borana and identifies local opportunities and resources that, if mobilized, could improve HIV prevention interventions in Borana.

6.3. Materials and methods

6.3.1. The study community

The Oromo occupy about 40% of the land surface of Ethiopia and constitute 40% of the Ethiopian population (61,62). The Borana people are a senior Oromo clan and are known for maintaining the Gada system, which has been at the core of socio-cultural and political life of the Oromo society since the early 13th century (63). In Borana, oral history reveals that the Gada system is democratic with elections being held every eight years (64).

Geographically, the Borana community resides in the relatively arid area in the southern part of Ethiopia (along the border of Somalia and Kenya) and Northern Kenya (64). The Borana zone is one of 14 zones in Oromia regional state and hosts a Borana population estimated at one million, based on the recent national census (61). The Borana zone borders the Gujii and Bale zones of Oromia region in the north and northeast, the Somali zone in the east, Kenya in the South, and the Konso district of the Southern Region (SNNP) in the west. Due to the arid climate, the Borana breed livestock as their economic mainstay. Men are the key players in the economic, social, cultural and political life of the Borana.

6.3.2. Methods of data collection and analysis

Data collection was carried out from October 2008 to April 2009 in selected communities of the Borana zone. Data was collection through in-depth interviews and focus group discussions (FDGs) conducted with the aid of semi-structured interview guides. The local health department and two CSOs (GOAL and CARE) were purposely selected due to their role in HIV prevention in Borana. Individual members of the community were identified by applying the snowball technique, whereby first informant identifies the next informant. This process continued until the desired information is generated.

The principal investigator (PI) resided in the community during data collection and took part in social and cultural life, which helped to gather other relevant information.

Interviews were conducted in their local language, Afaan Oromo. Brief notes were taken by the PI and research assistants during interviews and FDGs. The notes were elaborated and organized in to field notes each evening. The field notes were translated into English for analysis. In order to ensure accuracy of translation, sample materials were translated back into the original language, Afaan Oromo.

Field data were analyzed using MAXQDA qualitative data analysis software, which summarized and categories raw data into coded and sub-coded themes. The data was interpreted following the objective of the study. Pseudonyms were used to maintain anonymity of research participants, while age, sex, source of information (in-depth interview or focus group discussion) and residence of the participant were shown in parenthesis for easy reference.

6.4. Result

This section is organised according to: demographic characteristics of the research participants, current HIV prevention activities in Borana, and local resources for HIV prevention.

6.4.1. Socio-Demographic Characteristics

A total of nine FGD sessions with both men and women and totaling 68 participants were carried out, along with 69 in-depth interviews. Average age of FGD female participants was 40 years and 37 years for male participants. Average age of male and female interviewees was found to be 49 years and 50 years, respectively.

All participants were married and belong to the Oromo ethnic group. Eight-in-ten research participants follow the indigenous religion Waaqeffannaa (belief in Waqa – the Almighty).

6.4.2. Current HIV Prevention Activities in Borana

Research participants reported that they have heard about HIV prevention mechanisms including abstinence, faithfulness and condom use. However, the majority of research participants lacked detailed information on how to protect oneself from HIV infection given strong interest in continuing extramarital concurrent sexual practices, as discussed in Chapter 4.

Government health department in Borana is coordinating community mobilization through public conversation which was reported as major HIV prevention strategy in Borana. Both the government and CSOs were found to apply this strategy in their mission to reach the community with HIV and AIDS information. According to information from the health department, community health extension workers, schoolteachers, and youth club members had been trained to facilitate these conversations.

Study participants unanimously doubted the credibility of information received from health extension workers and schoolteachers. Adi argued that *“We do not know much about the HIV disease and how it spreads as we get mixed information about the disease: how it spreads, who is more affected and how to prevent it. We are confused on what to do about this?”* (W52, II Liben). This was a common opinion expressed in both in-depth interviews and focus group discussions.

According to Borbora, *“Messages are not appropriately adapted to the community’s system and way of life. The way messages are shared did not appreciate local cultural communication patterns where Gada leaders’ assistants (mekkala) play role. As a result, we do not feel comfortable with the information we obtain on HIV”*. He further explained that, *“both government and NGOs operating in our area tell us to limit ourselves to our wife and use condoms. For us it would be difficult to accept such message let alone putting it into practice in view of our established tradition of jaala-jaalto”* (M72, II Dubluk). Adi complained about the quality of information, *“I think we [community members] are not getting reliable information about the disease. I do not trust health extension workers, school children and school teachers, who are too young themselves to provide reliable information to the community about the disease”* (W52, II Liben). One FGD participant from Arero summarized the community’s situation thusly: *“What HIV is, how it spreads and what to do to prevent its infection is not well internalized by the community. Some of us claim to know from the little information we get from someone senior we meet either in the community or when we visit town, while the majority still are confused”* (M50, FGD Arero). Dhaki also pointed out that, *“We hear about HIV and how it is transmitted. The concern we have is whether the information we get is reliable. We have not heard about the disease from those we respect and we also notice our Gada leaders continue to maintain their jaalto, which we are told is the source of the problem. This encourages us to maintain our jaala”* (W43 II Didara). Similarly, Kuliye stressed that, *“We do not know enough about the disease since no one has helped us to understand how it is transmitted, what we should do with resources available at our level without compromising jaala-jaalto. Had our local Gada leaders educated us about the*

disease, we would have been better informed about HIV and taken action to protect ourselves from HIV” (42M, FGD Lib).

Research participants unanimously expressed interest in receiving counseling and testing for HIV and in getting more information about condoms - how they work and how to obtain them. The majority of research participants, both men and women want to get services for HIV testing to know their status. Boru stated, *“I heard testing is good and I would be happy to be tested and know my status although I do not have doubts that I am healthy – where would this service is available?”* (M50, II Liben). Huka also emphasized that, *“I do not think my peers and I care much about our HIV status since we feel we are healthy. We can give our blood now if there is such as facility here”* (W56 II Arero). It was gathered that condom is considered to be a tool to prevent HIV infection. At least one in three female and one in five male research participants reported to have heard that condom prevents HIV infection. Kotola pointed out that, *“I heard that condoms prevent HIV infection, but I do not know much about how it works. My friends and myself we want to know about how condoms work and where to obtain them”* (W57, FGD Harobeke).

Related to the low levels of awareness about HIV which is often called the ‘killer disease’ in the community, there is wider recognition of the potential risk of getting infected with HIV. Adi pointed out that *“Although men continue to run after several women, competing over how many sexual partners one has, which is considered to be a symbol of desirability and worthy of recognition in the community, there are also women who do the same such that both men and women in Borana are vulnerable to HIV infection”* (W52, II Liben).

6.4.3. Potential Local Resources for HIV Prevention

The question of who should be responsible for mitigating the spread of AIDS revealed diverse opinions. The majority of female participants argued that everybody has the responsibility to prevent the spread of HIV. However, few also pointed out that the Almighty (*Waaqa*) should save the public from the disaster. At least one in five research

participants believed that, *“prayer to Waaqa is the only solution as there is no other possible way of prevention”*. Kotola noted that *“stopping the practice of jaala-jaalto is very difficult as our social and economic relations would suffer in consequence. So, Waaqa should save us from this disaster which will wipe us all”* (W44, FGD Harobeke).

Several research participants, both men and women, felt that the design of HIV prevention strategy in Borana should involve the Gada leaders. Lokko stressed on the importance of Gada leaders in HIV intervention, *“involvement of Gada leaders at different levels and provision of relevant information on condoms would definitely help in preventing HIV infection”* (W37, II Didara). Xumale has also explained the importance of local Gada leaders in the HIV prevention endeavors where he referred to experiences, *“Abba Gada Liben made a passing remark during the last Gumi Gaayo [five years ago] where he urged the public to be cautious of HIV. He did not however advised the community on what to do about it and if jaala-jaalto practice contributes to the spread of HIV. Since that event, the public in Borana has been in a state of serious fear. If Gada leaders were to advise what to do individually and as a group, there would be a positive response to the advice”* (M55, FGD Yabello). It was consistent throughout the study that Gada leaders should play a lead role in the prevention of HIV infection.

It was also gathered that at family level, husband and wife were cited as responsible for educating and guiding their children while Gada leaders were said to have important role to in educating the public at large on how to prevent HIV infection. It was emphasized by research participants unanimously that *“The family especially men has to advise and educate their children especially sons about HIV the mode of disease transmission”* (M75, II Arero)

It was noted that government is mentioned to have a major stake in providing consistent and reliable information on HIV via the Gada leaders, whose advice is respected in the community. Research participants unanimously emphasized the role of government. Kuto, indicated that *“Prevention is possible if government works with local Gada leaders who are respected and then we all listen to them than what the government comes and*

tell us. We do not trust government people who are not coming with Gada leaders” (M40, II Arero). Tari has also emphasized on the need for collaboration between government and local leaders “government and NGOs should also work with local Gada leaders to prevent the disease” (W46, II Liben).

Although study participants reported to have heard about condom, two in three respondents expressed interest to know more about condom as a tool for HIV prevention. Especially, if such information comes through local Gada leaders, it was consistently reported that the community would take action to as advised to prevent the spread of HIV. According to Dhaki, *“Gada leaders, religious leaders, NGOs and the government have the responsibility to provide resources that help the community to protect themselves. If Gada leaders tell the public about the problem and what to do especially on condom, people would take action accordingly. Yet, I have not seen the Gada leaders paying attention to the disease, at least not to date” (W43, II Didara).*

6.5. Discussions

In Ethiopia, HIV and AIDS continue to threaten the wellbeing of the public and is key public health concern. UNAIDS report show that the number of people living with the virus is increasing, especially in light of the availability of ART that improves longevity for those infected with the virus (1). Over the last few years, interventions to mitigate the spread of HIV have intensified in an attempt to reach ‘the broader public’, but efforts have been uncoordinated and top down in design on the one hand and were not context informed on the other. These interventions were recorded to be guided by behavior change models that focus on individual awareness creation, modification of attitudes and improved skills so as to enable people to reduce their risk of getting HIV (1–3,15). Such models do not consider community dynamics and chains of command. Further, these interventions have not paid enough attention to specific factor of that make communities vulnerable and also failed to mobilize resources at community level (2,14). Furthermore, such approaches did not pay sufficient attention to the variability of infections from place to place and consequent need for calibration.

Thus, it is suggested to shift in favor of understanding what fuels and sustains infections at community level and how to deal with these which strengthens partnership opportunities with the community of concern (15,125,126). Especially in Sub Saharan Africa, HIV prevention interventions are designed without knowing the epidemiology of the epidemic (2). Although there are arguments where community participation has been advocated, this was mere tokenistic where community's participation was not key prevention interventions (125). Interventions thus did not help to fully stop the spread of the epidemic.

In Ethiopia, prevention interventions are designed at central level and follow a similar format and approach throughout the country. While the variation of culture and diverse factors of vulnerability calls for more contexts specific interventions that give attention to local realities and resources. A recent epidemiological survey documented that Ethiopia has made progress in HIV prevention (18,123). This conclusion does not appear to apply to the Borana, where the challenge of HIV remains critical, especially since the Borana community is still poorly informed about HIV and AIDS and continues to engage in extramarital concurrent sexual practices that increase the community's vulnerability. Thus, reported gains do not reflect realities on ground in Borana, and similar peripheral communities.

Current HIV prevention intervention in Ethiopia is organized under the theme of community mobilization where community conversation is considered as a tool (121). The conversation process is facilitated by health extension workers, local teachers and members of youth clubs. It is reported to have improved the level of public awareness on HIV throughout Ethiopia (124), although this assertion is not substantiated by the evidence generated by the present study. Research participants unanimously complained that information that comes from health extension workers and school teachers is not trusted. This is due to the fact that this segment of the population is considered to be as yet learners themselves and is not recognized as providers of information. Thus, it is not only strategy design but also who provides the information at community level that affects the success of interventions to improve community awareness of HIV and AIDS.

Data from this study offers evidence that HIV prevention must consider locally available intervention opportunities that could work in tandem with centrally planned initiatives to produce desired results (2). Building consistent and broad-based coalitions with local resources, including youth, women, the government, CSOs, religious and local leaders and HIV/AIDS activists has long played a proactive role in prevention endeavors (3,11) and can continue to do so, provided local contexts are carefully analyzed and considered beforehand.

In Borana research participants identified several stakeholders who they believe are responsible for HIV prevention. They include Gada leaders, unanimously defined as having a prominent role in view of the respect they command and their recognition as information providers at community level. At family level, parents especially men were said to have a strong stake in educating their children particularly sons about HIV as part of their routine socialization of children as they grow into responsible community members. Furthermore, the government and CSOs were identified as agents capable of supporting the design of information campaigns alongside the community and Gada leaders. Government and CSO partners could help to educate Gada leaders and promote access to services. The study group believes that if these local resources can be mobilized, HIV and AIDS interventions are likely to improve. Gada leaders and its council are believed to have the most important role, as they are very influential and highly trusted by the entire community.

The expressed interest for HIV testing services and to know more about condom as a tool of prevention are important entry points for prevention activities in Borana. Despite resistances and misunderstanding about condom among different communities (10,96,107), this could in addition to the willingness to get HIV counseling and testing and interest would present opportunities to improve HIV response in Borana.

6.6. Conclusion and recommendations

The current state of HIV in Borana is at a critical point where awareness is weak and extramarital sex is widely practiced. The situation, thus, calls for an immediate and focused intervention, guided by realities on ground and tapping into available local resources.

It is notable that the study participants realized the value of partnership for mitigating the spread of HIV. Government, local Gada leaders, spouses at family level and civil society organizations are all seen as having a stake in HIV prevention interventions. This is a positive discovery where the community is not leaving it to the government but feels the solution is within them although government has valuable stake in the process. Such an approach subscribes to global call for a comprehensive approach where the community plays a role in the design and implementation of intervention programs.

The role of Gada leaders in HIV prevention is especially important. Although Gada leaders themselves as members of the community lack information about the pandemic, they should have played important role in the interventions. Yet, the finding shows that interventions have bypassed the Gada leaders and have not recognized them as an authority who commands respect in the community. Instead, community conversations on HIV have been led by younger people who are not taken seriously in Borana society.

The community's interest in receiving HIV counseling and testing and in learning more about condom use, offer valuable entry points that could be used for immediate interventions in Borana.

Summing up, successful HIV interventions in Borana depend on mobilizing and engagement of local Gada leaders as key partner and involvement of the family, government sectors and existing NGOs in the prevention endeavor not only in the design of locally acceptable and effective interventions but also in implementing the interventions. Government is expected to take proactive measures in the initial phases, while eventually Gada leaders and the community should be empowered to take the lead in facilitating and sustain the interventions. Furthermore, making services such as HIV counseling and testing and condom should be taken as immediate interventions at the community level.

Chapter 7: General discussion, conclusions and recommendations



Figure 10: Refresher training of young HEWs to facilitate community conversation

7.1. Introduction

After thirty years of extensive interventions, globally HIV continues to threaten public health. In Sub-Saharan Africa especially, HIV is an outstanding public health and development challenge. This has led to questions on why HIV prevention programs have failed to result in reduction of further infections (13,14,125). Improved levels of awareness and availability of various HIV and AIDS services were reported to have resulted in a leveling off or even a decline in the incidence of HIV in some Sub-Saharan African countries (1). Yet, the problem continues and every day new infections occur, affecting the wellbeing of families and the public at large.

Over the last several years, HIV prevention studies, including those on vulnerability to HIV, have focused on behavioral models that targeted individuals; where changes in an individual's knowledge, attitudes and practices would lead him or her to make informed decisions to protect themselves (2,12,126). It is evident that interventions informed by behavioral change models have contributed to minimizing the magnitude of HIV across the world (1). Yet, there are several studies that show that prevention interventions did not result in deterring further infections as was expected (13,15,35). The model is often blamed for its failure to consider structural factors that anchor individual risk behaviors. Evidence shows that people who received behavioral information continued to expose themselves to HIV infections afterward (28,30,36,110).

Recent studies on HIV prevention underline the need to pay sufficient attention to the broader socio-cultural contexts of a particular community, including gender, sexuality and behavioral attributes (36–38). Gender-specific attributes of community members, for example, are also reflections of the social, cultural, economic and political principles and values of a particular country or community and play an important role in the way HIV is understood and addressed as a public concern (13,16,20)

HIV prevention interventions in Ethiopia followed the same behavioral model, where individuals were targeted and the focus was on HIV and AIDS awareness creation,

modification of attitude regarding sexual values, practices and HIV, and building skills that would help protect oneself from HIV infection (17). Awareness creation interventions were employed uniformly across the country, but neglected to recognize that Ethiopia is home to over 80 different ethnic groups, each with their own specific cultural peculiarities. These idiosyncrasies extend to each group's understanding of HIV and socio-cultural factors, including sexual values, practices and gender-specific attributes. HIV prevention interventions in Ethiopia to date are generic and do not pay attention to specific local contexts (59,122,127).

Although a comprehensive nationwide study is lacking, a recent epidemiological surveillance survey report shows that while HIV infection is leveling off or declining in urban settings, the virus is spreading to small market towns and rural settings that are vulnerable to other development challenges in Ethiopia (17). In circumstances where interventions are not tailored to the local context, interventions may not bring the expected results.

This study was conducted with the objective of exploring HIV and AIDS awareness and gender and sexuality attributes in connection to vulnerability to HIV infection among the Borana pastoral community. Specifically, the study sought to determine the current level of awareness about HIV and associated misunderstanding about HIV, explore gender-specific attributes that facilitate HIV infection, determine to what extent and why extramarital concurrent sexual practices prevail, determine the community's perceived vulnerability to HIV infections, and identify local opportunities for HIV preventions. While the study has addressed the objectives set forth, recommendations on how to improve interventions and further opportunities for research were also identified.

7.2. The current state of HIV in Borana

Survey findings reveal that HIV awareness is generally poor and widespread misunderstandings about HIV prevail among the Borana pastoral community. Although the majority of research participants reported having heard about HIV, knowledge about

the modes of HIV prevention and transmission was found to be inconsistent. Data shows that only 10% of participants know all prevention methods (abstinence, faithfulness, use of condoms, avoidance of contact with blood) and 11% correctly listed three modes of transmission (unsafe sex, mother to child, and through blood contact). In view of the fact that knowledge of modes of prevention and transmission is limited, it was unsurprising to learn that there are widespread misunderstandings about HIV sustained by the community. 82% of respondents were found to have sustained three or more misunderstanding about HIV, especially relating to modes of HIV transmission. Supporting this finding, study participants complained about the lack of appropriate information about HIV and AIDS. HIV was understood to be a 'killer disease with no treatment' that mainly affects sex workers and those who have many extramarital sexual partners. A behavioral surveillance survey in 2005 shows that comprehensive knowledge about HIV was generally low in Ethiopia, estimated at 19%, and much lower among pastoral communities, including the Borana, at 4 % (18). The findings of the present study strengthen and add to the existing evidence of marginal communities being less aware about HIV and AIDS than their urban counterparts.

The finding of poor knowledge of modes of HIV prevention and transmission and consequent misunderstanding about HIV in the community is supported by available biological data on the level of HIV prevalence in Borana. The HIV Surveillance Survey Report of 2005 showed that HIV prevalence at Moyale health center was 5.1% --a staggering 146% more than the national figure of 3.5% (58). Similarly, the HIV counseling and testing campaign of 2006-08 generated evidence shows that HIV prevalence in Borana (3%) is again higher than the regional prevalence of 2% (70). This gives some insight into the magnitude of the problem in Borana.

To contain the spread of HIV, prevention endeavors were found to be ongoing in Borana. These interventions were guided by materials provided by the central HIV Prevention and Control Office (HAPCO). Materials are prepared at central level and focus on imparting generic messages of abstinence, faithfulness and condom use to individuals. These were the key messages cited by some research participants as a means of HIV prevention,

although the messages were not internalized, as explained in chapter 2. Message campaigns did not consider specific local contexts that would have yielded information on how to attract people's interests in knowing more about the problem. It is important to underscore that among the Borana, as discussed elsewhere in this document, abstinence and faithfulness are not realistic solutions due to the prevailing sexual values and practices of the community. The second round Ethiopian Behavioral Surveillance Survey of 2005 also documented similar evidence of HIV prevention strategies in Ethiopia being guided by generic approaches that are not informed by specific contexts of the communities around the country (18). The Borana zone health department, however, claims to have reached the community with HIV and AIDS prevention messages. The office made references to the ongoing community conversation where HEWs, schoolteachers, and youth AIDS club members facilitate community conversations. The information shared by these facilitators was not readily internalized by the community as it did not come from recognized local leaders; trusted and valued sources of important public information. HEWs, schoolteachers and youth club members are considered to be children themselves, as yet learners, and are not expected to be providers of relevant information about a 'killer disease'. This reveals an important gap between the government's strategy, which is generic, top down, and local realities that may not fit with the strategy. In consequence, the government spends scarce resources without achieving a corresponding result and the community will suffer the consequences of a lack of appropriate information about HIV and AIDS. This calls for HIV prevention endeavors to be decentralized away from central level (3,11). In Borana, building a consistent and broad-based coalition of community level stakeholders such as family, public sectors and CSOs, in collaboration with local Gada leadership is believed to have the power to change the course of the pandemic. Thus, the government sector should design HIV and AIDS messages in consultation with local leaders and community stakeholders to achieve a successful prevention intervention.

7.3. Gender attributes and HIV in Borana

The Borana community is a patriarchal society, where men are at the center of social, cultural, economic and political life. The study found that men and women have clearly defined roles both at family and community levels. These roles are believed to be inherited and have been maintained as part of the community's life for several years. As documented in previous studies, such roles are often complementary between the sexes where spouses could not otherwise fulfill all expectations alone (79,92,77). Borana men are responsible for public tasks, including representing the family at community forums, travelling in search of water and pasture, selling livestock and protecting the community's resources (pasture and water). Women are responsible for household and homestead tasks that include bearing and caring for children and rearing small animals such as calves.

Men in Borana are appreciated and recognized publicly for their public speaking skills, as well as fighting and hunting skills. Women are valued for bearing and rearing children, especially sons, making delicious food, constructing houses and keeping the compound clean. One study on the Oromo documents that Oromo women are cherished and celebrated for bearing sons, and that this celebration of bearing a male child is not unique to Borana (128). A study from Ghana also describes a similar experience, where a woman's fertility greatly influences her status and identity as a woman in the community (129). The husband, parents and the community at large expect the women to bear children following marriage. Bearing children is seen as women's primary gender role that determines her identity as a woman and her status in the community. In the Borana community, a couple's failure to conceive is often seen as failure of the woman and justifies a husband's decision to choose another wife. Although data from this study did not directly investigate the claim, there was some evidence showing that women's engagement in extramarital sexual activity may in part be to ensure her fecundity and avoid the label of failure that would apply to her if she was unable to bear a child.

According to Asmarom's classical study of the Borana culture in the 1970's, women do not actively participate in the Borana's socio-political institutions and leadership (63).

The current research confirms that women are still passive participants in public gatherings. Women's passive role has been attributed to a legendary woman, Haadmanoye or sometimes referred to as Akko Maanoye, who led the Borana community in the old days, '*bara durii*'. She is said to have set a bad example as a cruel leader who mistreated men in Borana. The Gada leader, Dawee Gobbo (1830-1838) made an attempt to invite women to actively take part in the Gada system, but is said that women at that time refused to accept the invitation. Although these assertions need to be verified by historical studies, they are enough to serve as an excuse for men to keep women out of the leadership and decision making positions in Borana today. The same reason was offered by women as a way of accepting and justifying their socio-political position in the community, which is limited to food preparation for the elders during the Gada general assembly (*gumii gaayoo*), where important decisions are made by men.

Both men and women research participants consistently argued that women's rights are respected and protected. It was found that if women complain of mistreatment by men, including their husband, in the form of rape, scolding, mismanagement of family resources, or men's failure to meet their expectations, the Gada leader would respond quickly to the charge. Perpetrators would be punished by endowing the woman with a live animal, buying her clothes or, in rare cases, appointing her to head the household with the support of her brother-in-law. In addition, it was revealed that women maintain the right to accept or reject decisions made by men at public forums, which ultimately determines translation of such decisions to actions.

Nevertheless, in a patriarchal community with male dominance clearly established and where a woman herself is considered to be property of her husband, whether such rights are consistently protected and if this makes any major difference in the already precarious position of women remains unknown and should be explored. In this study, it was found that women are thought of as children who deserve to be disciplined. This finding would appear to cast doubt on the extent or importance of women's rights as claimed as well as on women's ability in practice, to influence decisions made by men.

Literature on HIV and AIDS has documented that the unequal social status of women places them at a higher risk of contracting HIV infection. Furthermore, these studies indicate that women in violent and abusive relationships are less likely to negotiate for safer sex and use protective methods and are more likely to be exposed to HIV infection (15,16,20,22). In Borana it is clear that awareness about HIV is limited and misunderstanding about HIV are widespread among both men and women members of the community. The majority of male and female research participants did not believe that exposure to HIV infection could be associated with gender roles. Yet, at the same time, respondents indicated that men who travel away from home in search of water and pasture for livestock and to market places to sell cattle are more likely to encounter 'other' women, thereby increasing men's exposure to HIV infection. Other studies have documented that mobile men are more exposed to HIV infection than women (48,115).

It has been widely reported that poverty, lack of access to economic resources and limited access to services push women into sexual relations that put them at higher risk of infections (20,38,39,24). Both male and female research participants in Borana strongly refuted this conclusion on the grounds that extramarital sexual practices are not initiated for the sake of economic interest. Yet, it is still relevant to note that in Borana, despite claims of women having rights over joint economic resources and her exclusive source of income, it was discovered that she spends such private income for joint household consumption. This could indicate the failure of husbands to fulfill their responsibilities of feeding household members, which may in turn lead women to fulfill this additional task through engaging in sexual activity for economic interest. The finds of the present study suggest further exploration of this economic link is necessary.

To conclude the findings as they relate to gender attributes, it was clear that gender-specific roles, i.e. men's mobility, and the lack of appropriate information about HIV and AIDS, including information about condoms, are associated with increased vulnerability to HIV infection in Borana. Women's passive participation in public forums, and their limited decision making power over joint resources were not recognized as factors contributing to vulnerability to HIV infection. In view of the fact that women are given

weak positions in the community and given the generally poor awareness of HIV and AIDS in the community, it is not surprising that Borana men and women do not understand the association between participation, decision making and roles and vulnerability to HIV infections. This study has shown that men and women share the same information on HIV and AIDS from the same sources. Given that improved HIV messages would most likely be made available at male-dominated forums where important decisions of public concern are made, women's passive participation and limited space for discussion is a major concern.

7.4. Sexual values, practices and HIV in Borana

Over the years sexuality studies were overshadowed by gender studies and the few sexuality studies available, focused on individual sexual knowledge, attitude and skills without much attention to the underlying contexts that shape the state of sexual health problems (11,15,38,130). Sexual health problems are associated with factors that have foundations in gender-specific attributes as discussed above, and in several other studies (31,35,79,80,126). In the case of Borana, for example, husbands visit towns to sell livestock and engage in sex with town women and then return home to demand his matrimonial sexual rights; this behavior goes much deeper than individual deeds. Thus, in as much as individual behavior is important to understanding the epidemiology of HIV, further evidence is needed to explore why women and men alike engage in extramarital concurrent sexual practices and if they recognize the implication of the practice in making them vulnerable to HIV infection.

Among the Borana, evidence shows that extramarital concurrent sexual practices are common and are considered to be an integral part of life. Women were found to have the right to have extramarital sex as do men. Further, sexual violence such as rape, abduction and premarital sex were found to be uncommon and considered taboo in the community. This latter finding was also documented by a cross-cultural study of gender in Ethiopia (59). Other studies have documented the widespread value of chastity until marriage in Ethiopia (59,118,131), consistent with the findings in Borana.

This study describes that while men engage in sexual activity with married women as soon as they become sexually active, even before marriage, women's acquisition of additional sex partners starts only after marriage. This is explained by the fact that sons marry late in connection to cultural requirements where young men have to go through cultural rituals before marriage, while daughters marry as early as 16 years of age. The importance given to women's chastity before marriage, combined with the fact that rape and abduction are taboo makes it acceptable for unmarried young men to have sexual privileges with married women before they take a wife, and which may continue afterwards, although there is no data to substantiate this latter point. In today's Borana, however, this practice is declining now that young men are attending schools located in urban settings.

Extramarital concurrent sexual practice is tolerated, despite gross denial that local culture subscribes to such practices. Although neither men nor women are forced into having extramarital sexual affairs, expectations from the community support the activity. Among the Borana, engagement in extramarital concurrent sexual practice is the reflection of social and cultural expectations of role fulfillment, and in some instances, interest in economic transactions that involves not only the sexual partners, but also the families of both. The practice is further reinforced by peer pressure and personal desire for satisfaction. Yet, in this case, women retain full control over their decision to accept or reject requests for sex, including requests for marriage. Nonetheless, in view of the fact that breaking chastity before marriage is stigmatizing and considered shaming for the family, as well as the father's clan, claims that women have the right to control their sexuality are exaggerated and misguided.

Although having multiple sexual partners has been widely documented as an important factor in the spread of HIV in Sub Saharan Africa (2,5,15), a multi-country study on concurrent sexual partnerships in five Sub-Saharan African communities did not show strong association between multiple sexual partnerships and the level of HIV infection (95). This can be explained by the fact that in the multi-country study, multiple sexual relations studied were serial, where sexual partners are not overlapping at any point, thus

reducing the potential for exposure. Combined with preventive measures, multiple serial sexual partnerships would not be as challenging as concurrent sexual partnership. There is growing evidence that concurrent sexual partnership is rooted in a community's socio-cultural domain and is a driver of vulnerability to HIV infection in Southern and Eastern African countries and could also help explain the higher magnitude of HIV infection in Southern and Eastern Africa (41,91).

Despite widespread practice and continued interest in maintaining extramarital concurrent sexual relations in Borana, it is paradoxical to find strong denial of cultural approval of the practice. All study participants argued that local culture does not allow the practice and that it is kept as secret as possible so as not to be found in public with somebody else's wife or husband. Intentional shunning occurs whenever such secrets break, although in recent times, men tend to treat news of affairs more seriously, which may have to do with the fear of HIV infection.

In response to the dilemma over the recognized threat of HIV infection due to extramarital concurrent sex and reluctance to abandon the practice, research participants showed a high-level of interest in knowing more about condoms as a tool for HIV prevention. While changing the practice will likely require a long-term intervention coupled with a women's empowerment initiative, the interest in condoms is an immediate entry point for efforts to control the further spread of HIV. Otherwise, the practice, coupled with limited awareness and widespread misunderstanding about HIV and weak prevention interventions, allows HIV to pose serious challenges to the wellbeing of the community at large.

7.5. Perceived vulnerability to HIV infection in Borana

There are studies showing that vulnerability discourses did not help to identify pro-poor disease-control strategies that could simultaneously influence specific factors of vulnerability at individual, structural and global levels (24,48,108). Early literature on vulnerability to HIV infection focused more on an individual's susceptibility to HIV

infections due to their risky behaviors. Such studies did not pay much attention to the structural factors contributing to persistent individual behavior (12,29,39).

Based on Chamber's classic definition of vulnerability, Watts and Bohle specified risk of exposure, lacking necessary resources to cope with the risk and risk of being subjected to consequences as important elements for understanding vulnerability (45). Later studies on HIV control programs referred to vulnerability within a broader framework whereby women, due to biological factors and their social and economic positions in the home community, are more vulnerable to infections and also lack the necessary means to cope with the problem (12,29,39). Several recent studies on vulnerability to HIV infection show that exposure to HIV is fueled by, among other things, women's unequal access to social and economic resources, relative powerlessness, greater poverty and inequality (15,20,34,109). Such arguments reinforce the fact that women are at greater risk of encountering HIV than men. However, recently vulnerability paradigm which assumes that women are always vulnerable while men are considered sources of the problem was challenged (39). Though it is evident that given women's position in the social, cultural and political milieu, women are more vulnerable to HIV infections, it must also be acknowledged that men, as sexual counterparts of women, may not be any safer from HIV infection.

The present study has shown that initiatives to help the community cope with the pandemic have been poorly organized and implemented. HIV awareness remains generally poor and prevention interventions are not informed by the local context, missing the opportunity to reach the wider public, as illustrated by Chapter 2 and 6. In Borana, every member of the community is at risk of being vulnerable to HIV infection. The risk of HIV exposure is related to different but interconnected social, cultural, economic and political factors. In the community, extramarital concurrent sexual practices are an important part of life for both men and women for the reasons outlined above and in Chapter 5. Although men and women were found to antagonize each other over the number of extramarital sexual partners they have, it was found that both men and women are aware that the community at large is vulnerable due to sexual connections.

When designing strategies to mitigate vulnerability to HIV infection, it is imperative to understand the specific characteristics of factors that facilitate vulnerability and the coping mechanisms available at the community level (1,24). Other studies also indicate that if HIV interventions are to succeed, underlying structural factors of the epidemic must be defined and given due attention in the design of interventions (2,3,15). This study clarifies the factors that increase vulnerability to HIV infection in Borana. Behavioral factors, combined with limited awareness and widespread misunderstanding about HIV, the social and economic position of women that denies her space in the public sphere, continued extramarital concurrent sexual practice and lack of locally designed prevention interventions are all working together in Borana (see diag 4 and 5 below) to make the problem of HIV serious enough to press for urgent short- and long-term interventions to rescue the community.

7.6. General conclusions and recommendations

7.6.1. Conclusions

1) This study focused on the Borana pastoral community that is found at the tip of Southern Ethiopia, bordering with Kenya. Findings show poor levels of HIV awareness and widespread misunderstanding about HIV, despite the local health bureau's claim of reaching the public with messages on HIV and AIDS. This suggests discrepancies between the government's endeavors to mitigate the problem at community level, but with guidance and tools designed at central level, and realities on the ground. In view of the tolerance of extramarital sexual practices and importance of chastity until marriage, investment in abstinence and/or faithfulness campaigns are not logical in Borana. Although perfect synchrony between the community and government health department is not expected, absolute divergence of approaches and strategies, especially as regards to HIV intervention, is costly.

2) This study provides insight into how community gender stereotypes fuel vulnerability to HIV. Although the situation of women in Borana was not found to be a source of anguish for women and although men's mobility is shown to be associated with increased

vulnerability to infection, it is clear that in a male dominated community, women tend to accept the way things are as they may feel there is little that they can do about it. It was clear that women do not see their vulnerability to HIV infection as related to their absence from local cultural leadership, or to their passive participation in decision making activities at public forums. Women do not ultimately use the resources they are said to have full authority over. This indicates that in Borana, though there are some rights, such as the right to be protected from rape and abduction and the right to choose and engage in extramarital concurrent sexual activity, women still dominated by men and perhaps subject to systematic distancing from important forums. This would affect any HIV prevention endeavors carried out through such public forums.

3) Although the study found that women are protected against sexual violence, abduction, and mistreatment by men and can refuse sexual demands if she is not interested, it was not quite clear to what extent these rights are upheld, especially in view of the fact that the men and women in the study group support and justify a man's 'right' to discipline his wife. This indicates that men decide what is right and wrong in the community. It is assumed that the real state of women in Borana is concealed by claims of women's rights and protection. This makes it difficult to understand if protection for women is consistent and their rights are indeed upheld consistently.

4) It is clear that both men and women engage in extramarital sex and that the practice is used to establish proof of desirability, for exchange of gifts, and to gain sexual satisfaction. As result, there is continued interest in maintaining extramarital sexual practices at community level. In view of this, HIV prevention that focuses on changing individual sexual behavior may not produce the desired results, at least in the short-term. Instead, interventions should focus on promotion and implementation of safe sex with continuous distribution of condoms, in parallel with long-term initiatives to transform gender stereotypes, sexual values and practices in the community.

5) It is important to recognize that vulnerability to HIV infection in Borana is the outcome of several factors working in tandem. These findings would suggest

comprehensive interventions that could address all the different factors instead of focusing on a specific factor and/or group.

6) Finally concerns about HIV and AIDS have dramatically increased the interest in conducting sexuality studies that have otherwise been considered as a taboo in several disciplines. The biomedical approaches to sexuality have been noted, focusing on biological and behavioral connotations while missing social and cultural constructions of sexuality. It is interesting that in this study, sexuality is driven by a number of factors beyond individual behavior, although this also plays an important role. Thus, addressing public health challenges like sexual health problems requires in-depth and focused study to determine the foundations of such problems, other than biological factors alone.

7.6.2. Recommendations

1. Public health interventions

As it stands now, the Borana community is at a crossroads, where HIV infection is on the rise and facilitated by the various factors outlined throughout this document. It is, therefore, imperative to design short- and long-term interventions that respond to the current situation in Borana. Short-term interventions should capitalize on the expressed interest in condoms and on the influence of local Gada leaders who, if empowered, may play an important role in the whole endeavor. Proper promotion of condom and making them available, while at the same time immediate action is required to mobilize community leaders, CSOs and relevant government offices to develop locally suitable prevention interventions.

Regarding long-term intervention, the study has expressed doubts over women's space in the community and their rights. While it is understood that women have rights over their body, to reject or accept decisions made by men, and are protected against mistreatment by men, they are also considered to be as children, deserving to be disciplined. These assertions are contradictory, suggesting that the Borana has set up a subtle way of

excluding women. Changing these attitudes and related practices requires a long-term gender empowerment program.

2. Further scientific research

The study has identified specific areas that deserve further study in Borana, in connection to HIV and AIDS, gender and sexuality issues.

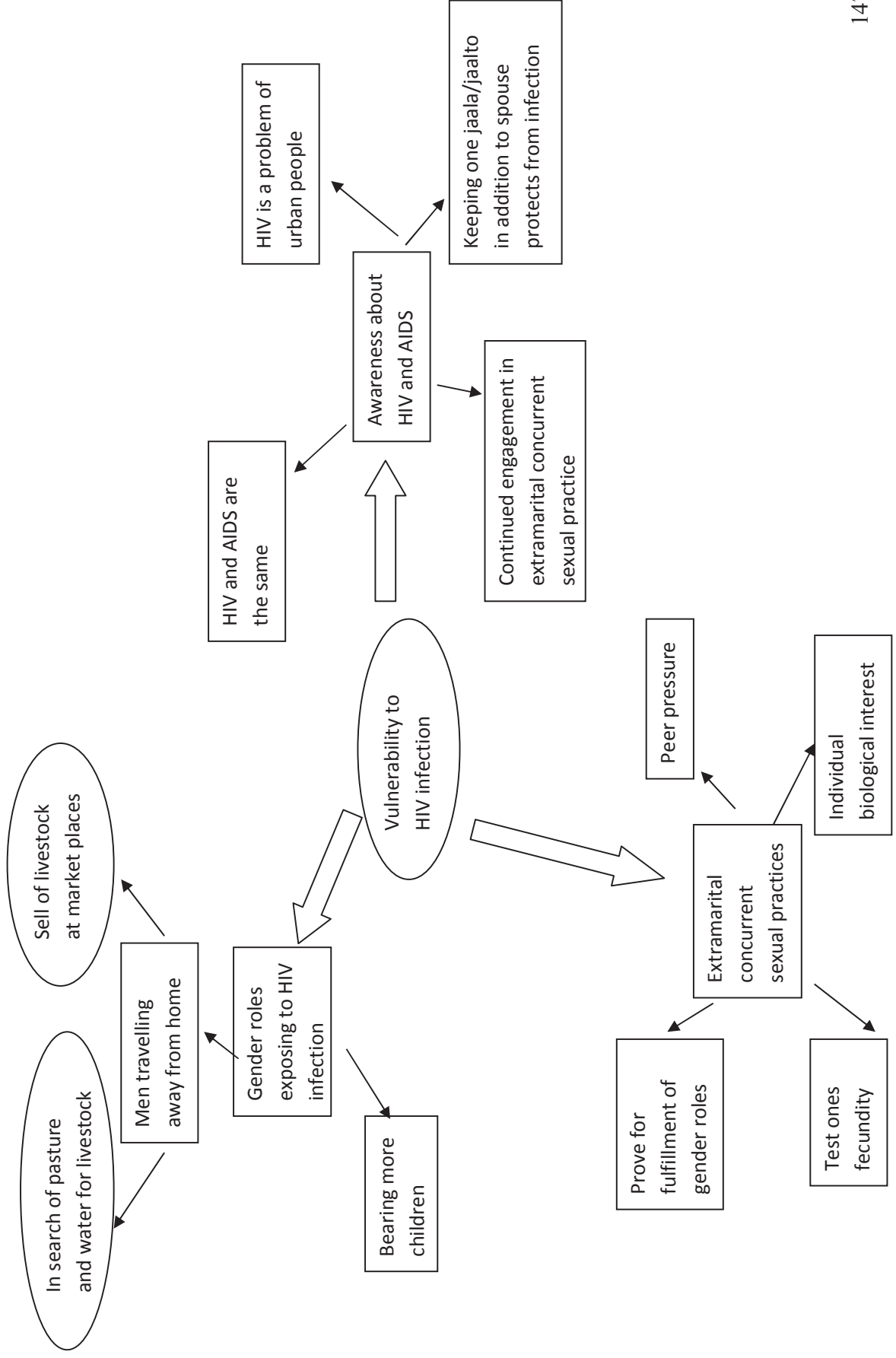
a) Although the community is interested in knowing more about condoms and having access to them, there is also an established interest in having more children, especially sons. These may appear to the Borana community to be incompatible with one another. As one recommendation of this study is to promote and provide condoms to community members, it would be useful to undertake a study that aims to determine the acceptability of condoms on the one hand, and identify acceptable distribution channels on the other.

b) In Borana gender issues are complex, where women have limited space and rights, but men are the drivers of those spaces and rights. In this document, doubts were cast on the proclaimed status of women in Borana, arguing that perhaps the Borana maintain a system that is created to systematically keep women out of the public sphere and keep her happy with what she has. A comprehensive study would help to properly document gender stereotypes and find out how much of the claimed women's rights and spaces are consistently protected and upheld, which would perhaps contribute to a gender discourse related to HIV and AIDS.

c) Extramarital concurrent sexual partnership has emerged as a new area of interest in HIV study. While studies in the field have documented this very well, there are still gray areas with respect to how long partners would stay together in a concurrent partnership. Mathematical models have been used to show the pace at which infections progress with concurrent sexual relations. It would be useful to test the models with concrete data from Borana, which would offer a breakthrough in concurrency studies. Secondly, although findings show that both men and women are engaged in extramarital

concurrent sexual activities and that men and women continue to argue over who has more partners, it would be useful to determine the number of extramarital concurrent sexual partnership one has over the course of lifetime, helping order help refine interventions in the field.

Diag 5: Factors of vulnerability to HIV infection in Borana



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9. Appendix: Curriculum Vitae

A. Personal details

Name: Mirgissa Kaba Serbessa
Sex: Male
Date of birth: May 14, 1964
Marital status: Married and a father of two
Language: Excellent speaking, reading, writing and understanding English and two local languages including natal language Oromiffaa and Amaharic)

Address: P. O. Box 150182; Cell phone +251911213631 and +251118630018 (res) E-mail: mirgissk@yahoo.com

Personal attributes: Goal and result driven; organized; time conscious; adaptable to new environments; cultural sensitive; taking initiatives; confident and self reliant; articulate; analytical and pleasant.

B. Academic qualifications

2008-Sept.2011 PhD student at the Swiss Tropical and Public Health Institute, Switzerland with a doctoral thesis entitled “Gender, sexuality and vulnerability to HIV infection among the Borana pastoral community Southern Ethiopia”
1991-1993 M.A Degree in *Social Anthropology* from Addis Ababa University with a thesis on Traditional Medicine
1984-1987 B.A Degree in *Sociology and Social Administration* form Addis Ababa University
2005 Certificate in a modular course ‘*District Health Planning and Management*’ organized by Swiss Tropical Health and University of Basel,
1997 Certificate on ‘*Gender, Reproductive Health and Fertility*’ – modular course from the University of Amsterdam, the Netherlands
1995 Certificate on *Anthropology of Health and Health Care* from the University of La Salle, the Philippines

C. Short term training received

- Peer service provider training organized by UNICEF, 2009
- Lifeskills and peer education organized by UNICEF, 2007
- Project design, planning and management organized by UNICEF, 2005
- Coaching training organized by UNAIDS, 2005
- Community conversation methodology for communication focusing on social change organize by UNDP and KMG, 2004

- Qualitative research methods for development 2009
- HRAP facilitator's training organized by UNICEF, 2004
- Personal and Professional Development organized by UNICEF, 2004.
- Institutional Capacity Building for young people organized by UNICEF and Save the children in Ghana, 2003.
- Participatory approaches in communication organized by Ireland AID, 1997.

D. Professional career

1. APRIL 2001 to May 2009: HIV prevention and Adolescent development Specialist, UNICEF Ethiopia
2. September 1988 – May 2000, Teaching staff of the Jimma University

E. List of Publications

1. Traditional medicine in Ethiopia, an article in a book entitled “Epidemiology and ecology of health and disease in Ethiopia”, USAID 2006.
2. An ethnographic analysis of the role of religious leaders in the prevention and control of HIV/AIDS prevention in Jimma zone, North Eastern African studies, V2N2, 2004.
3. Ethnographic study of diarrheal disease in Manna district, in the Ethiopian Journal of Health Development, V 14 N1, 2000.
4. Fertility behavior and contraceptive use among women around Jimma town, in a process in Ethiopian Journal of Health Development, V14 N2, 2000.
5. The Jimma Community Based Training Program, in Education for Health, V11, N2, 1999.
6. Hygiene and sanitary behavior of residents of Jimma town, in Ethiopian Journal of Health Development, V13, N1, 1999.
7. Curriculum and a training of trainers (TOT) manual on communication and social mobilization for grass root health and development workers for training use by Jimma University and the Ministry of Health (written along with other colleagues), September 1999.
8. A training guideline on HIV/AIDS and posters for use to train religious leaders and community leaders, written and designed along with a colleague, 1999.
9. Pregnancy prevention: The case of the Surma of Southwestern Ethiopia in proceedings of the conference on Reproductive Health and Communication at the grass roots: the Experience from Africa and Asia, Kenya, Nairobi, 1998.
10. A teaching manual on Introductory Medical Anthropology for Junior Health Workers, 1997.
11. The Utilization of plant materials as medicine among the Oromo of Chora district, in Ethiopian Journal of Health Development, V10, N3, 1996.
12. Land tenure and natural resource conservation, the case of west Shoa Oromo, in land tenure after the Derg, University of Trondeham, 1994, 117-127.
13. A teaching manual entitled ‘Introductory Sociology for Health Professionals, 1989

14. Two articles that focus on cultural anthropology, in *Sociology and Ethnology Bulletin (SEB)* Vol. 1, Nos 1 and 2, 1992.

F. Seminars/Workshops and Papers presented

i. National

- Every year since 1995, Ethiopian Public Health Association (EPHA) with papers on different issues of public health (traditional medicine, diarrhea disease, fertility, STD/HIV e.t.c.).
- 1997, Regional Seminar on Guidance and Counseling in Family Planning organized by FGAE, paper on communication skill to private health care providers.
- 1995, National seminar on Urban Integrated Basic Service organized in Jimma by UNICEF, paper on social mobilization to health workers at the grass root.

ii. International

- Integrated Training course on data management, Co'tdeviore February 2009
- Integrated Training and Capitalising on Experience (ITC) 2008, San José, Costa Rica, 27 Aug - 5 Sep 2008
- 17th international conference on AIDS in Mexico (August 5-11) where I presented a poster on communication social change as a tool for HIV prevention
- October 2006, World congress on communication for development with a paper on "Paradigm shift in communication: youth dialogue experience in Ethiopia"
- An international conference on linking reproductive health and HIV with a paper presented on youth friendly VCT Ethiopian experience, October 2006
- November 2006, African development forum
- December 2000, African Development Forum 2000. AIDS: The greatest Leadership Challenge.
- November 1999, First International Conference on HIV/AIDS in Ethiopia
- 1999, International meeting on Training professionals for future health care: Interaction between health care and education held in **Linkoping/Sweden**, paper presented on 'Community Based Approach in Training Health Professionals.
- 1998, Regional conference on assessment of Vesico-veginal fistulae in eastern Africa held in **Daresalam/Tanzania**.
- 1997, International conference on Reproductive Health and Communication at the grass root: African and Asian experience held in **Addis Ababa/Ethiopia**, paper presented on 'pregnancy prevention among the Surma of Western Ethiopia.
- 1996, International network of Gender, Reproductive Health and Population Policies (GRHPP) held in **Chiapas/Mexico**, project proposal entitled "Socio-cultural aspects of fertility regulation among communities of Jimma zone, Western Ethiopia.
- 1996, First International Medical Olympiad and the thirty-fifth International Congress on the History of Medicine held in **Kos/Greece**, paper entitled "An emic understanding of health and health problem among the Oromo of Chora district, Western Ethiopia.

- 1994, International Seminar on Traditional Medicine held in **Bangkok/Thailand**, paper on current status of traditional medicine in Ethiopia.

G. Recognitions and awards

- Certificate of recognitions for a dedicated service as a board member of the Ethiopian Public Health Association, 2010
- Certificate of recognitions for a dedicated service as a board member of the Family Guidance Association of Ethiopia, 2010
- Certificate of recognitions for a dedicated service to the Addis Ababa youth Association, 2008
- Letter of recognition for support to Afar region HIV and AIDS prevention and control office, 2007

H. References

1. Professor Marcel Tanner – Director, Swiss Tropical and Public Health Institute, Swiss TPH Socinstrasse 57, P.O. Box 4002 BASEL / Switzerland phone: +41-61-2848283 fax: +41-61-2848105 e-mail: marcel.tanner@unibas.ch, web: www.swisstph.ch
2. Prof. Damen Hailemariam, Addis Ababa University School of Public Health hcfp.aau@ethionet.et
3. Dr. Damtew W/Mariam, Former president of Jimma University and current program coordinator of ICAP Ethiopia; Dw2463@columbia.edu Tel. 251911807682
4. Dr. Julie Pulerwitz, Director, HIV/AIDS & TB Global Program PATH, phone: 202-822-0033 jpulerwitz@path.org
4. Dr. Roger Salla ntounga, UNAIDS Geneva, sallantoungar@unaids.org
5. Dr. Judith Bruce, **Senior Associate**, Population Council - One Dag Hammarskjold Plaza New York, NY 10017 USA +1 212 339 0500; jbruce@popcouncil.org
6. Douglass Webb, Chief – Adolescent Development, Protection and HIV prevention, UNICEF Ethiopia, dwebb@unicef.org