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HIV/AIDS in Ethiopia: The Silence Is Broken; the Stigma Is Not

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Introduction

The views on HIV/AIDS contained in this paper are those of a layperson. They represent the thoughts of a political scientist who served for more than three years (1996–1999) as the U.S. ambassador to Ethiopia. During that time he was actively involved in the HIV/AIDS issue. The paper also reflects impressions and information obtained during a recent two-week visit leading a group of medical experts and public health professionals committed to identifying projects that the nongovernmental organization (NGO), People to People, Inc., might undertake to help ameliorate the HIV/AIDS pandemic. The 20-month gap between the author's end of assignment to Ethiopia and first return visit offers a useful perspective to assess the progress achieved and obstacles that remain. This is a revised version of a paper prepared initially for the National Intelligence Council. It reflects comments on the paper at a session hosted by the Center for Strategic and International Studies on July 3, 2001.

How Serious Is the Problem?

Although agreement is widespread that HIV/AIDS is a serious problem in Ethiopia, reliable macro statistics are elusive. In fact, any figure, including those in this paper, that purports to represent the entire country, or even a significant part of it, is an educated guess at best. There are useful micro studies on disease prevalence in Ethiopia. These have been used to extrapolate regional and national statistics. Based on the best information available, between 7 and 10 percent of the sexually active population of Ethiopia is HIV positive. Considerable documentation shows that the rate is notably higher in Addis Ababa, most towns, and along major transportation routes. At the same time, it is lower in rural areas, which still account for most of Ethiopia's population of 64 million.

International experts on HIV/AIDS now list Ethiopia as having the third-highest number of HIV-positive cases in the world after India and South Africa. The total number of people (adults and children) living with HIV/AIDS in Ethiopia today may be as high as 4 million. (The Ethiopian National HIV/AIDS Council uses a lower figure of 2.6 million.) South Africa, with a population of 44 million, has a much higher percentage rate of HIV prevalence. Because of its large population, the problem in Ethiopia is horrific and the fact that it is one of the poorest countries in the world on a per capita basis does not help the situation.

There do not yet appear to be any national studies on the probable impact of HIV/AIDS to development generally or even on specific economic sectors. Nor are there good estimates of the cost for dealing with the issue as a health problem. The evidence that exists is anecdotal. There is not much enthusiasm in any part of society or the donor community for looking beyond efforts to slow down the spread of the pandemic. Ethiopians and foreigners alike continue to use an annual population growth rate of 3.1 percent for the country. Whether deaths due to AIDS and related opportunistic diseases have been factored into this figure is unclear. According to one authoritative study, life expectancy in Ethiopia will fall to 39 years from the current 55 years by the year 2010. Other health experts put the current life expectancy well below 55 years due in large part to the impact of HIV/AIDS.

Is Ethiopia Engaged with the Issue?

Except for a handful of NGOs, virtually no one in Ethiopia was taking the HIV/AIDS problem seriously as recently as 1996, although it was on the radar screen of the local World Health Organization office. A few

partners, including the U.S. Agency for International Development (USAID), tried to elicit more interest in confronting what was clearly a growing problem. The government, however, had extremely limited resources and other health priorities. One ministerial-level official, in response to the author's ministrations on the subject, responded that malaria was the real killer in Ethiopia, not AIDS. HIV/AIDS may well have been responsible for more deaths in 1996; it certainly contributes to more today. Unlike Uganda, Ethiopia was a late bloomer in facing this growing threat.

As it became increasingly obvious that HIV/AIDS was taking a serious toll on Ethiopians, interest in doing something about it increased. More indigenous NGOs organized themselves around the HIV/AIDS issue. More international NGOs added the problem to their portfolio. By 1999 President Negasso Gidada had become an active governmental spokesman for HIV/AIDS and the patriarch of the Ethiopian Orthodox Church, Abuna Paulos, launched a major prevention campaign utilizing the far-reaching resources of the church. The U.S. Embassy and USAID began supporting a number of awareness programs with Christian churches and the Supreme Islamic Council. The Packard Foundation, which had just entered Ethiopia with a large population-planning program, adapted some of its activity to the HIV/AIDS problem. The issue finally and belatedly reached critical mass in 1999.

During the intervening 20 months, NGOs, the Ethiopian government, international organizations, and Ethiopia's partners have succeeded in breaking the silence. Few Ethiopians today are unaware of the existence of the virus and how, at the most general level, it is contracted. This has been a tremendous achievement since the relative silence of 1996. This is not to suggest, however, that Ethiopians are generally well informed about important aspects of HIV/AIDS. The NGO, Fifty Lemons, did a survey last year of more than 500 high school students in two large towns in Amhara region. The NGO found among the students considerable misunderstanding about contracting the disease. It concluded that a standardized informational program should begin at the middle-school level due to the relatively early age that members of the sample group began their first sexual experience.

The U.S. NGO, Pact, did a partial survey last year of the organizations in Ethiopia involved in HIV/AIDS activities. It identified 30 NGOs, 6 governmental institutions, 5 religious organizations, 1 research institution, 4 voluntary community-based associations, and 1 private-sector organization. The survey did not include several less impacted regions and the number of organizations has surely grown since last year. Pact pointed out that one important part of Ethiopian society, the growing private sector, has so far remained aloof from efforts to alleviate the problem.

The author's delegation encountered a few skeptics who are not convinced that the government is fully committed to taking the pandemic seriously. Truthfully, the bureaucracy has not yet organized itself in a way to take maximum advantage of growing financial resources. The Ministry of Health has traditionally been one of the weakest ministries in Ethiopia. Also, the one-year-old National HIV/AIDS Council has not yet become an effective coordinator of the many disparate efforts to counter the problem. On the other hand, President Negasso remains outspoken in his efforts to bring attention to HIV/AIDS. Prime Minister Zenawi Meles told us that "HIV/AIDS is a threat to the survival of the country," adding that he recognizes the severity of the matter. That Ethiopia requested assistance in October 1999 from the World Bank and recently received a $60-million loan from the International Development Association (IDA) should prove to the skeptics that the government is serious about the issue.

What Are the Obstacles to a Successful HIV/AIDS Program?

Ethiopia is not only populous, but it is geographically large—the size of Texas and California combined. Improvement of the transportation infrastructure has made significant stride, but reaching all parts of the country in a timely way remains difficult, especially so during the rainy season when some areas are completely cut off for short periods of time. Even if it was a wealthy country, the inadequate transportation infrastructure and difficult topography would pose a major challenge to an effective health care system generally and a program to combat HIV/AIDS in particular.

The telecommunications infrastructure is even more backward. Although the Internet has come to Ethiopia, there are only a few thousand hookups and virtually all of them are dependent on the government-controlled telephone system. Service is slow, erratic, and, especially outside of Addis Ababa, frustrating and unreliable. The war on HIV/AIDS would be aided enormously if Ethiopian universities' medical departments and major research institutions and counterpart organizations outside the country had point-to-point satellite connections. Even radio communication is a problem in Ethiopia. Uganda had significant success in the early stages of its HIV/AIDS campaign getting the message to the grassroots by transistor radio because most Ugandans had one. Relatively few Ethiopian peasants can afford a transistor radio.

If the geography and transportation infrastructure of Ethiopia are a challenge, the existing health care delivery system is shockingly ill equipped to carry out a national anti-HIV/AIDS program, particularly outside Addis Ababa. The health care infrastructure is spread thin and poorly equipped. Equipment is often broken and no repair program is established. For doctors to work without examining gloves and other basic tools of the trade is not unusual. Health care facilities, in those relatively few locations where they exist, are usually overcrowded and in need of physical repair. Even if Ethiopians were willing to come forward for HIV/AIDS testing, the testing kits, at $5 each, are too expensive and usually unavailable. One has to admire the commitment of doctors and health care personnel who labor under such difficult conditions.

The human capacity problem in the health sector is perhaps even more serious. There is one doctor for every 40,000 Ethiopians and those doctors tend to be concentrated in Addis Ababa and the major towns. Ethiopia has three schools of medicine, 87 hospitals with less than 12,000 beds, 257 health centers, and 196 private clinics. HIV/AIDS presents significant counseling challenges. Reportedly there are nine psychiatrists for Ethiopia's 64-million people. Probably no practicing doctor in Ethiopia today is properly trained in the administration of the much discussed antiretroviral treatment for AIDS. Although Ethiopia's medical schools are turning out more and more trained personnel, too many of them are leaving after their required in-country service. One doctor who follows this issue closely believes that more than 50 percent of the doctors trained in Ethiopia ultimately leave the country due to low pay, difficult working conditions, lack of opportunity for professional development, and insufficient autonomy. In addition to North America and Europe, many go to other African countries where the opportunities are seen as better.

Inadequate financial resources are always a problem in a poor country, but this does not seem to be the most pressing immediate problem. Ethiopia's partners are responding to the financial need. In addition to the IDA loan, USAID, Germany's German Agency for Technical Cooperation (GTZ), the Netherlands, and the UK are providing grant aid in the battle against HIV/AIDS in Ethiopia. Norway, Denmark, Belgium, and South Korea have also shown interest. The United Nations Development Program (UNDP), the Joint United Nations Programme on HIV/AIDS, World Health Organization, United Nations Children's Fund, United Nations Educational, Scientific, and Cultural Organization, and the Population Fund are engaged. NGOs were among the first organizations and continue to be among the most important ones to devote resources to the effort. The war on HIV/AIDS will require much more money, but for the moment it is a question of building additional human capacity in the health sector, improving coordination, and using existing funds efficiently and effectively.

Does Federalism Help or Hinder Implementation of an HIV/AIDS Program?

Ethiopia's policy of ethnic federalism, adopted soon after the overthrow in 1991 of Mengistu Haile Mariam's regime, is both a blessing and a curse as the country gears up to implement a program to combat HIV/AIDS. Ethiopia is organized administratively on the basis of 9 states or regions, 64 zones, 550 districts, and thousands of kebeles or neighborhood/rural organizations. Although the 85-member National HIV/AIDS Council is charged with coordinating the overall effort, responsibility for implementing the program rests with the regional HIV/AIDS councils. These, in turn, work through the zones, districts, and even kebeles. The regional councils include the state president, all regional ministers, church representatives, labor leaders, the private sector, and

NGO representatives. Zones and districts are also expected to have councils.

Over the long term this layered system of government and local HIV/AIDS councils may help significantly to bring the benefits of the HIV/AIDS program directly to the people. Over the short term, however, the federal system may be more of an obstacle than help. Federalism is expensive and requires large numbers of qualified staff to carry out programs at the different levels of government. It is difficult to coordinate activities even from the regional level. Regional officials complained to the author's delegation about the delays in moving existing funding from the central government to their level. A more serious problem is the shortage of qualified personnel to staff local government generally and the health sector in particular, especially in the traditionally disadvantaged regions of Gambela, Benishangul, Afar and Somali. It will take time for a country as poor and lacking in trained staff as Ethiopia to deal effectively with the HIV/AIDS pandemic. Once it solves the staffing and resource problem, however, the federal system theoretically will help insure the effort reaches the grassroots.

The World Bank and its $60-million IDA loan recognize the need to disburse funds at the local level. Consequently, almost half of the loan is earmarked for community-based activity at the district and kebele level. Once a district government has shown that it has an adequate financial system in place, it is eligible to draw funds from the IDA loan and forward that money for implementation by kebeles in the district. Based on the incidence of HIV and risk factors, the World Bank and Ethiopia have identified 55 (out of 550) districts for funding. The goal is to provide funding to 165 districts during the three-year period of the loan. The money can be used to provide training for district coordinators and to help create a financial system for accountability purposes.

The remainder of the IDA loan is designated for the National HIV/AIDS Council Secretariat and the regional secretariats. NGOs and other organizations can also submit proposals to an emergency fund. A review board evaluates the technical merit of the proposals. As of early May, the review board had approved 28 out of 97 proposals submitted so far. At least one organization had actually received funding. The National Secretariat is just beginning to dispense the funding.

Does the Stigma of Being HIV Positive Set Back Efforts?

The evidence underscoring the problem presented by the stigma of being HIV positive is widespread. Doctors and health professionals everywhere emphasized the unwillingness of Ethiopians to come forward for voluntary testing even when the kits are available. Some referred to the "cover-up of HIV" in the country. The virus is essentially a verboten discussion topic even among relatives and friends. The culture of secrecy, at least among those from the highlands, almost certainly contributes to this situation. Talking openly and frankly about personal subjects is not part of Ethiopian culture. One doctor explained that this practice begins in childhood; children are not told, for example, about menses.

Assuming that HIV-positive students are permitted to attend school, other students often ridicule them if their condition is known. HIV positive orphans have been thrown out of government orphanages, presumably on the grounds that one must make room for someone who has a chance at life. Death certificates, even when AIDS is highly suspected, routinely cite other causes of death such as tuberculosis. When testing proves that AIDS was the cause of death, friends and relatives are usually not told. Ethiopian doctors are unusually reluctant to pass along bad news to patients on any health matter.

Donated blood is tested routinely in Ethiopia for HIV/AIDS. When found to be positive, the blood is destroyed and the donor is not told that he or she is positive. This practice seems to apply throughout the country, including those blood-donation programs administered by hospitals, the Red Cross, and the military. Several doctors said that this poses a serious problem because blood donors, even those who are HIV positive, believe they are free of the virus if they give blood and hear nothing. Others point out that the widespread existence of infection in Ethiopia sharply reduces the willingness of people to donate blood. Donors are afraid that they would learn that they are positive, not realizing that in any event they would not be told. One doctor explained to the author that most Ethiopians believe being HIV positive is the equivalent

of "an immediate death sentence." That being the case, they do not want to know that death is imminent. There is little understanding that one can live for many years and often with a high quality of life after being declared HIV positive.

One vignette poignantly illustrated the HIV stigma problem for the author's delegation. They asked a university doctor what had happened to a former official at the university. The doctor responded, "He died." The delegation remonstrated that he seemed to be so young. The doctor acknowledged, "He was 42." As Americans (but not Ethiopians) are wont to do, the delegation pressed and asked the cause of death. As this conversation became increasingly strained and brief, the doctor replied that he died of "an infectious disease." Our interlocutor politely but firmly made clear that this conversation had ended. We learned subsequently from a non-Ethiopian that the individual in question had died of AIDS.

Does the Ethiopian HIV/AIDS Program Have the Right Focus?

The president, prime minister, and head of the National HIV/AIDS Council all emphasized that Ethiopia is prioritizing prevention and communication. It is difficult to argue with this priority given the lack of resources, limited health care capacity, and large size of the population. But there is room for improvement. The Ministry of Education, for example, has not yet provided clear guidelines for a comprehensive HIV education curriculum. There are several hundred anti-HIV/AIDS clubs in the high schools. But their goals are diffuse and they appear to give more attention to increasing awareness rather than promoting HIV-prevention skills. Beginning the education at an earlier age may also be necessary. Meles recognized that counseling and treatment of those who are HIV positive has a role, but said it needs to be supplemental to prevention until the capacity problem is solved.

HIV/AIDS counseling is a relatively new feature of the program in Ethiopia and has met with mixed results. One male nurse who received two weeks of training in couneling recounted his negative experience at a regional government hospital for the delegation. The nurse's initial attempts at counseling were often met with aggressive behavior and even verbal and physical abuse from his HIV-positive patients. Others denied that they were HIV positive in spite of test results. The counselor refuses to do any more counseling. We heard other reports, however, where counseling was working. Counseling done under the aegis of a church seemed to be more effective, reportedly because infected individuals put greater trust in medical personnel associated with a church than with a governmental organization. Persons who are HIV positive and have publicly acknowledged that fact also seem to be more effective counselors. One woman from Awassa, capital of Southern Peoples' Region, has been positive for years and has reportedly been unusually adept at counseling others.

Skilled counselors in Ethiopia are urgently needed as this will help spread the word that it is possible to have some good years after being tested HIV positive. This may increase the willingness to undergo voluntary testing and even result in greater behavioral change if a person is determined to be positive. The hiding of the infection or suspected infection is now a huge impediment to behavioral change. For the moment, however, there is only a handful of trained counselors in the country. One regional university with a medical school reported that there are no HIV/AIDS counselors on the campus. Much remains to be done in the area of increasing and improving counseling on HIV/AIDS.

During the delegation's visit, limited amounts of antiretroviral drugs were available on the black market or purchased illegally in Ethiopian pharmacies. Within the past month, the government has legalized the importation of these drugs. A small number of wealthy individuals are taking them on an unsupervised or inadequately supervised basis. There is virtually no capacity now to monitor the use of these drugs and few individuals can afford them in any event. The drugs are unavailable in most of Ethiopia. The dean of the medical school in Gondar, a zonal capital, said that there are no antiretroviral drugs in his town. The problem is compounded because medical record keeping is rudimentary at best and most health care facilities do not have computers.

In the case of Ethiopia, dismissing any kind of antiretroviral drug program as not cost effective is tempting. On the other hand, there is one compelling argument in its favor. If one can show that this treatment will extend a reasonable quality of life by a number of years, this may encourage voluntary testing

and the willingness of HIV-positive persons to deal with their problem and perhaps even alter behavior. At a minimum, it offers some hope. Before such a program can be launched, however, training medical and health personnel on how to administer and monitor an antiretroviral regimen, increasing testing facilities and beginning a serious HIV/AIDS research effort is necessary. At the same time, expanding the use of antiretroviral drugs by developing a monitoring program using home care and community participation may be possible.

Have There Been Successful HIV/AIDS Programs in Ethiopia?

The HIV infection rate for military personnel is estimated at about 15 percent in front-line positions along the border with Eritrea, where a war between the two countries recently ended. It declines to 12 percent behind the front lines and 7 percent where soldiers are living with or near their spouses in a fairly normal living environment. Once the soldiers who were stationed along the Eritrean front return home, they will inevitably contribute to a proliferation of the virus.

Ethiopian defense forces are usually cited as being at the forefront of the battle against HIV/AIDS. They have developed an extensive workplan that includes training at all levels of the military, widespread distribution of condoms, information dissemination, surveillance, and research. There is, of course, a security incentive for dealing forcefully with the problem. In addition, military discipline and organization give it an advantage over most other elements of society. Nevertheless, there are other military organizations around the world that take the issue much less seriously than do the Ethiopian defense forces. Testing is far more advanced among defense force personnel than it is for civilians.

On a much smaller scale, Ethiopian Airlines, a governmental parastatal organization has an even more impressive program. Ethiopian Airlines tests all staff every six months. If they test positive, they are told and counseled by in-house medical staff. All HIV-positive cockpit crew are grounded and given other jobs. Some HIV-positive personnel take advantage of free air tickets to visit South Africa or Thailand regularly for treatment. A senior pilot at Ethiopian Airlines explained that, as a result of this enlightened program, the HIV incidence rate for their employees is actually declining.

What Is the Impact of HIV/AIDS on Ethiopian Development?

The short answer is that no one knows for sure. Just as it is difficult to gauge the negative impact of the recently concluded war with Eritrea on development, so it is hard to calculate the effect of HIV/AIDS on development. Reliable economic studies have not been done. That women have been the hardest hit victims of HIV/AIDS in Ethiopia is widely believed. Male behavior patterns and the reluctance to be tested help to insure higher infection rates among women. Persons who follow the issue closely are unanimous that the impact has been horrendous. They just do not know how horrendous. A doctor in Jimma told the author's delegation that HIV/AIDS is setting back development and "making a poor country poorer." The head of a U.S. NGO put it more bluntly: "development is going to pot" because the implementers are dying.

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