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Government's Response to the Challenge of HIV/AIDS in Ethiopia

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Abstract

Ethiopia is facing a huge threat to the survival of its people and the socio-economic development of the country from a generalized HIV/AIDS epidemic. Ethiopia with an estimated 1.3 million HIV/AIDS infected people as of December 2006, is one of the worst-affected countries where HIV infection is concentrating among productive age group, thereby affecting productivity. The objective of this study is to examine the ways in which the government of Ethiopia has been dealing with the spread of HIV/AIDS in Ethiopia and suggests the ways in which it can improve its strategies. More specifically, the study tried to investigate the major cause of the spread of HIV/AIDS in Ethiopia, the government's strategies against the spread of HIV/AIDS in the country and to what extent have they been effective and in what ways they could be improved. The data were collected in eastern part of Ethiopia and also key informants in Addis Ababa were interviewed. The data indicated that HIV related stigma is one of the major causes of the spread of the disease and suggests the need for the further research.

Key words: Ethiopia, Discrimination, HIV/AIDS policy, stigma,

Introduction

HIV/AIDS epidemic is the world's most serious challenge to countries all over the world, both directly as a health issue and indirectly through the challenges they pose for development (SIDA, 1999). In effect, HIV/AIDS tends to exacerbate existing development problems through its catalytic effects and systemic impact, because of the number of people and sectors affected by it. By killing large numbers of productive and reproductive adults, AIDS erodes the human development infrastructure and increases health and welfare demands while adding to the cost of providing services. It also increases the total number of children orphaned by death of one or both parents. Labour costs increase with staff turnover, absenteeism, loss of skills, and increased recruitment and training costs. It reduces formal and informal sector productivity (ibid. p.12). Few concerns in Ethiopia today have received as much attention as the problems of HIV/AIDS. The government officials together with other stake holders are working hard to find effective ways to control the spread of HIV/AIDS. Even though Solutions to control the spread of HIV/AIDS have been difficult to achieve, the government of Ethiopia continued to respond to the challenges of HIV/AIDS. In 1998 the HIV/AIDS department in the ministry of health introduced a new national policy and in 2000 the National HIV/AIDS prevention and control council was established. With its emphasis on multi sectoral response, the policy constituted a decisive and significant break from the past policy (USAID, 2002). When the epidemic first broke out, most interventions were organized with in the health sector, however, later The call for a multicultural response arose with the aim of the strategy to generate political commitment by national governments to mobilize more resources from within and outside countries, and to

replicate on a national scale a more comprehensive program that includes an increased number of interventions targeted to virtually all groups in society (Ainsworth, 2000). My interest in this emanates from the fact that even though the government is formulating policies to fight HIV/AIDS epidemic, the beliefs of the society may be an obstacle to achieve the intended result. Hence, the paper attempts to examine how the government of Ethiopian is handling the challenge of HIV/AIDS and tries to look at what are the obstacles for successful implementation of HIV/AIDS policies.

HIV/AIDS situations in Ethiopia: Statistical Evidence of a National Tragedy.

The HIV/AIDS pandemic has become the leading cause of death in Ethiopia for people between the ages of 15-49. According to Ministry of Health, only in 2005, a total of 134,500 AIDS deaths including 20,900 children occurred. Currently, there are 744,100 orphans who have either lost one of their parents or both parents for AIDS. It is projected that this number continues to increase until 2010 though the rate of increase is expected to lesson due to the impact of the planned ART services (MOH/HAPCO, 2006). It is estimated that 1, 300,000 Ethiopian are living with HIV/AIDS of which Children account for 10 percent of this case. The epidemic is ultimately killing the youngest and most productive members of the labor force in the country. A look at the current statistics for AIDS in Ethiopia indicated that the majority of people with HIV/AIDS are in the economically productive age group (UNAIDS 2006). According to the country situation analysis conducted by UNAIDS, HIV continues to spread in Ethiopia, with the prevalence remaining higher in the urban areas. Young people continue to be the most

affected population particularly young women (ibid). An enormous percentage of sexually active HIV/AIDS sufferers pose a dire risk for those young adults entering the age of sexual maturity. Adult mortality is projected to reduce by 17 years in 2024 compared to what it would have been in the absence of the HIV epidemic (Yared, et; al, 2002).

The Impact of HIV/AIDS on the National Economy

The HIV/AIDS pandemic is having a profound macroeconomic impact in Ethiopia where adult prevalence is much higher. National Intelligence Council underscored that the disease is likely to negatively impact almost all sectors of society by 2010. AIDS will take a heavy economic toll by robbing the countries of many key government and business elites and by discouraging foreign investment. Ethiopia's national economy suffer severely from losing many of its most productive population of 20 to 48 years old citizens, who have been the worst affected by this epidemic. The study suggested that the pervasiveness of HIV/AIDS through Ethiopia could destabilize all professional within the country's workforce (National Intelligence Council, 2002). If the current trend continues, according to country's National AIDS Council" AIDS may be costing Ethiopia significantly in its economic growth every year, further reducing the scope for poverty reduction. It will alter the trajectory of the country's development by retarding growth." (IRIN, 2002).

AIDS appears to be present among all socio-economic groups. The low variant of a macroeconomic simulation model found that there would be a negative effect on saving

and thus capital formation, reducing the capital-labor ratio from about 2.14 in 1995 to 1.64 in 2010 as a result of HIV/AIDS (Lori, et; al, 1999). The HIV/AIDS epidemic is also having a severe microeconomic impact on Ethiopia, affecting rural and urban families' through the country. An estimated 38.7 percent of the populations live below the poverty line (CIA,2007).the study conducted by FAO(2001) Points out that this pandemic can have a devastating impact upon families. HIV/AIDS known to be a disease that tends to impoverish families, particularly when the infected individual is the main income earner in the household, consequently, families end up earning less but spending more on health care, leaving few resources available to purchase other goods. In Ethiopia, a study found that AIDS-afflicted households spent 50-66 percent less time on agriculture than households that were not afflicted (ibid). Hence, realizing such tremendous threat posed by HIV/AIDS to sustainable development of the country, the Ethiopian government, Donors and the Ethiopian civil society have intensified their efforts to find a response to the epidemic. HIV/AIDS is no longer considered only as a health issue, but as a development issue that requires a multi-sectoral response and a strong coordinating mechanism (UNDP, 2000).

Methodology

In total 85 interviews were conducted. The interview mainly semi structured, in some cases unstructured and they were all initially based on a list of questions and topics to be covered. Pamphlets, statistical reports and policy documents collected from organizations and institutions, and internet were additional important source of information. Further,

visiting and observing activities of different kinds which were organized by local NGOs has also been important to contextualize the information given in the interview and document.

What have successive Ethiopian government done?

Ethiopian HIV/AIDS policy has evolved from being non-existent before 1984 to an Ethiopian Strategic plan for intensifying Multi sectoral HIV/AIDS response that is currently implemented in the country. There are many stages and levels involved in the HIV/AIDS policy formulation process in Ethiopia which has been based on the nature of the stake holder's involvements, the spread of HIV/AIDS epidemic and the nature of the political system (HAPCO, 2004). Reviewing Ethiopian government's adequate response and reluctances on HIV/AIDS during the time since the first emergence of HIV in 1984, there are three loosely defined phases of HIV/AIDS policy making periods from 1984 to 2005 can be identified. The period of 1984 to 1987 can be considered as a period of inaction. The second phase of the government response to AIDS was from around 1987 to 1992, and is notable for the government's HIV/AIDS policy evolution to a more human centered approach. However, at this phase, the majority of public stakeholders in the broader policy environment were not involved. The third stage from 1992 to now begun with the formulation of HIV/AIDS policy with the over all objective of providing an enabling environment for the prevention and mitigation of HIV/AIDS epidemic (NACS, 2000).

Phase I

In the first few years after HIV/AIDS appeared in Ethiopia, the government indeed failed to take the challenge of HIV/AIDS epidemic into the public policy agenda. At this phase, 1985-1987, No comprehensive HIV/AIDS combating strategies or public policies were drafted .there are a number of reasons for this, but the most significant of these was that HIV/AIDS did not at first appear to be truly dramatic threat to Ethiopia (MOH, 2002) e government's response at this phase was confined at establishing a national task force which issued the first AIDS control strategy by the end of 1985. Only towards the end of this phase did the Ethiopian government establish an HIV/AIDS department within the Ministry of Health (ibid)

Phase II.

The second phase of the government's response to HIV/AIDS epidemic was from 1987 to 1992. Ministry of health developed a short and medium term plan in 1987 and in 1992. Lisa (2003) referred this phase's interventions as largely ineffective in implementation; inadequate in scale lacking sufficient stakeholder's involvement in planning and implementation especially at the community level. These plans designed to combat the spread of the disease were also poorly or not at all coordinated and integrated across sectors and among service providers and received relatively low priority with in government as well (ibid).It is little wonder then that the ex-regime continuously fell short of the successful drafting of any comprehensive, circumspect and all inclusive policy response to HIV/AIDS. The policy environment made it nearly impossible to

isolate and address the real drivers of the epidemic, the policy problem remained erroneously defined, and ineffectual, impotent policy responses inevitably followed suit.

Phase III

The third phase which begins from 1992 was an important time both in the history of Ethiopia as well as in the evolution of HIV/AIDS policy formulation. The first major National HIV/AIDS policy was created in 1991 with the overall objective of providing an environment for prevention and mitigation of HIV/AIDS, though it was not approved until 1998(MOH, 1998).Following this and recognizing the importance of establishing a clear guidelines and effective organizational structure to meet the challenges of the HIV/AIDS, the National AIDS Prevention and Control Council was established (Amhara HAPCO).Till then, the government's effort had been focused mainly in the Ministry of Health HIV/AIDS department; however, this does not mean that the government made a clear break from the past policies. But it means that the issue of HIV/AIDS receives more attention than it was before. Ex-president of the country, President Negaso G. in 1999 declared the threat of HIV/AIDS epidemic to be treated as a National Emergency and promised to make it a concern of every single government institution, community leaders,

Tackling HIV/AIDS-Related Stigma, a Challenge to Policy

The former head of WHO's global program on AIDS, Jonathan Mann, pointed out that HIV/AIDS related stigma, discrimination against PLWHA, and collective denial potentially remain the most significant challenges of the HIV/AIDS policies. As early as

in 1987, he recommended that not effectively addressing those issues was key challenge to overcoming the spread of the disease (Mann, 1987). The fact that discussing the subject of sexual intercourse in Ethiopia is a taboo subject and the main mode of HIV transmission is sexual intercourse undermines the government's response in tackling the epidemic together with the stigma related to HIV/AIDS. Similarly, Shin (2000) suggests that in the Ethiopian community, HIV-related stigma tends to be firmly linked in people's minds to sexual behavior. This is regarded as promiscuous that places people living with HIV/AIDS into an unnecessary hostile and embarrassing situation, making the government's strategy to fight against the epidemic very difficult. HIV/AIDS workers, as well as those affected, face discrimination and sometimes neglected. Such trends lead to secrecy and denial, which hinders openness about the HIV/AIDS. It prevents people from seeking counseling and testing for HIV. Many people who look healthy, but are infected with the deadly virus can infect uninfected people, through sexual contact. This in turn, jeopardizes the government's response to prevent the spread of HIV. Aggleton et al (UNADIS, 2000) after conducted research on HIV- related stigma affirmed that in Ethiopia HIV/AIDS related stigma is one of the major barrier that prevents people from attending HIV/AIDS testing, seeking treatment, care, and support which undermines the responses of the countries to HIV/AIDS. it is hoped that through the Ethiopian government's system to reduce the HIV/AIDS-related stigma, an increasing number of People living with HIV/AIDS begin to participate in a process like counseling which in turn have the effect of enhancing the acceptance of people living with HIV/AIDS.

Likewise, Lewis et. al,(1998) stressed on that all efforts to decrease the bad image of HIV/AIDS-related stigma would inevitably lead not only to influence public policy, but also contribute to systemic changes that can create a more supportive community by placing HIV/AIDS on the political and social agenda. Abdul (2000) argued that the first and the biggest challenge is political leadership to overcome HIV/AIDS related stigma in the country by mobilizing people in an open, frank, creative and unhesitating way. He further added that every single government institution, every school, every kebele office, every church and mosque should teach about AIDS however, this must start from the top .Lee et al (2002) also reflects the same opinion with that of Abdul stating that effective community mobilization and good community ownership is characterized by the involvement political and traditional political leaders, schools, police, mosques and churches. Brislin (1993) supports the above mentioned ways stating that highly respected community members needs to be involved in introducing and maintaining programs, strategies and attempts to counter HIV/AIDS related stigma, because it is believed that their involvement can enhance attention and acceptance for such programs. With out the cooperation of leaders, and with out a policy that acknowledges the gravity of HIV/AIDS-related stigma, efforts to mitigate and prevent the spread of HIV/AIDS will be seriously hampered. Lack of political will and commitment to openly talk about HIV/AIDS is a significant factor for fueling HIV/AIDS-related stigmas, by maintaining silence, denial and ignorance (Hovedo, 2003).

Uganda has shown an example of how the issue of HIV/AIDS can be addressed openly in all aspects of society and at all levels. Strategies to reduce HIV/AIDS prevalence and the

impacts of HIV/AIDS have been strongly supported by the government, including the personal involvement of the president, Yoweri Museveni. Religious and traditional leaders, community groups and all sectors of the society have also been involved, including PLWHA at all levels (UNAIDS, 2000). Consequently, Uganda is able to contain the wide spread of HIV/AIDS epidemic, while the rate of infection is increasing in the same region, including Ethiopia (Hogle, 2002). Uganda's united approach seems to have created a community that is committed to counter the HIV/AIDS-epidemic. On the contrary, the South Africa's government, and President Thabo Mbeki's expression of uninformed Opinion about HIV/AIDS is an example of how political leaders and policy makers can make the progress in fighting HIV/AIDS nearly impossible. Mbeki questioned the relation between HIV and AIDS, creating confusion among the public which consequently contributed to misconceptions and increased denial about the epidemic (www.aidsalliance.org, 2002). To end up, as they go fully public and function as peer educators, political leaders can become role models in the alleviation and prevention of HIV/AIDS related stigmas.

Various study suggests that Given the prevailing HIV-related stigma, it is extremely difficult for people living with HIV/AIDS to disclose themselves, to seek counseling, care and other supports, consequently, it is important to reach out to the PLWHA and actively offer supports instead of waiting for them to come. Renowned experts from WHO also suggests that counseling can take place in any settings where, there is, or could be, a discussion about HIV/AIDS without high scientific and economic facilities (WHO, 1999). Couple counseling should be recognized and practiced more widely in

countries where the topic of HIV is more stigmatized. Because such trend has shown more effective prevention of HIV/AIDS related stigmas, and enhanced care and support for people living with HIV/AIDS (Painter, 2001). Therefore, in fighting the epidemic, every effort should be put into breaking the long deadly silence on HIV/AIDS in all sectors, particularly by government. Constructive thinking about HIV/AIDS and how to deal with its impacts through laws and policies need to become part of a regular social discourse on HIV/AIDS. Education, care support, provided through campaigns and services need to be reinforced by respected community members who demonstrate in words and in action this thinking. The Ethiopian government has much to do with the culture of taboo and silence surrounding the virus. It is well documented that HIV/AIDS is still not discussed in the majority of Ethiopian households, villages, public gathering and political meetings. Government interventions remain inadequate, and most initiatives are spearheaded by NGOs that have only limited coverage and capacity (Bharat, et, al, 2001)

Discussion

It has also been suggested that stigmatization, as aspect of perceived risk, may be a contributing factor to increased HIV/AIDS infections (Academy for Educational Development, 2003; Burkholder et, al 1999). Although many people possessed accurate knowledge of HIV/AIDS and its mode of transmission, participants continued to believe in the misconceptions of the disease, which increased their level of fear. Although the key informants who are working in HIV prevention program realize how important being open about HIV/AIDS is, some of them were still afraid to discuss the issue openly to people, including their closest family members. They stated that things could have

been better if they were dying from any other disease, and not AIDS. The nature of the AIDS makes it difficult for them to be open to come to HIV/AIDS programs such treatment. This is how one of the participant responded concerning this: "the only one who knows about my HIV status is my sister. Neither The rest of my family members nor community members do know about it. I am taking treatment going very far from home town where no body knows me". However, the participants from program coordinators such as prevention, treatment and caring agree that no matter how difficult being open about exposing HIV status might be, they have been attempting to teach the public not to be afraid to reveal their status once infected. One of them stated that " even though we announced that there would be support and caring program going on in a certain local settings for HIV positive people and for those who lost either their husband or father for AIDS, we could offer such service for only few people regardless of big number of HIV positive people residing in the area. Most of them didn't even show up to take drugs that can make a person live longer and better". This is how a 46 years old man showed his reaction as "I used to choose to hide my status in order to remain part of the community, to keep my job and family, and to avoid stigma and discrimination. Hence, I did not take life prolonging drug for a long time even after I knew my status." Respondents also reported that HIV-related stigma still remains strong in Ethiopia, contributing to denial about the epidemic and deterring access to HIV/AIDS services because it is compounded by the association of HIV/AIDS with socially unacceptable or illegal behaviors. Hence most of the participants working in coordinating HIV programs asserted that additional efforts to fight the HIV/AIDS is needed to tackle the stigma that hinders efforts to fight the epidemic. This saying was supported by the majority of the respondents. A 23 years

old respondent asserted that "I strongly believe that to achieve success in all HIV programs, we have to come together as a community and try to eliminate the stigma attached to HIV/AIDS".

All of my respondents including key informants working in coordinating HIV/AIDS programs agreed with above indicated view. It was not a shared view among some of them but rather, among all of them. They all agreed on that despite the widespread nature of the epidemic in Ethiopia, HIV/AIDS is still heavily stigmatized and all stressed its role hinders the flow information to communities, hampers prevention efforts, and reduces the utilization of services. Respondents also believe that government efforts have not proved sufficient to control the spread of the pandemic or extend the lives of the majority of those infected. They stated that desired level of success has not been achieved for several reasons. Most of the people who would benefit from available prevention and control strategies including treatment could not have access to them because of HIV related stigma.

Conclusion

HIV/AIDS related stigma and discrimination impede Ethiopian Government's efforts to combat HIV/AIDS epidemic. Tackling the spread of HIV among Ethiopians is a difficult and daunting task as it is accompanied by epidemic of fear, ignorance and denial from beginning in any context. Communities at local level should begin to establish an open dialogue about the issue if HIV prevention and control programs to be successful. This is because the epidemic operates as a cycle with in a community and because stigma poses

barriers along with same cycle. Community leaders together with government, NGOs and other stake holders including non- HIV organization may have a significant impact in introducing and maintaining this dialogue so that HIV positive people may be able to feel comfortable accessing prevention, care seeking and treatment services with out fear of HIV-related stigma and discrimination. When the negative feelings are associated with HIV/AIDS it may cause people to become avoidant of the pertinent issues regarding HIV/AIDS prevention, treatment and care seeking activities consequently HIV/AIDS programs may be met with resistance as individual may not consider themselves at risk based on what they associate with the disease.

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