YOUTH CHALLENGE INTERNATIONAL

ETHIOPIA

Federal Democratic Republic of Ethiopia

HISTORY: Ancient Ethiopian monarchy maintained its freedom from colonial rule except during the Italian occupation of 1936-41. In 1974 a military junta, the Derg, deposed Emperor Haile SELASSIE (who had ruled since 1930) and established a socialist state. The regime was toppled by a coalition of rebel forces, the Ethiopian People's Revolutionary Democratic Front (EPRDF), in 1991. A constitution was adopted in 1994 and Ethiopia's first multiparty elections were held in 1995. A two and a half year border war with Eritrea ended with a peace treaty on 12 December 2000. Demarcation of the border has yet to be settled. In 2004 the government began a controversial relocation program, hoping to move up to two million people away from the low-rainfall highlands to improve the country's food security prospects.

GEOGRAPHY

Position: Eastern Africa, west of Somalia, 8 00 N, 38 00E
A landlocked country; bordered by*:* Djibouti, Somalia (east) Eritrea (north), Kenya (south), Sudan (west).
Climate: tropical monsoon with wide topographic-induced variation. Very hot in the east and west but average temperature in Addis Ababa, 20°C (68°F) all year round. Rainy season is from mid-June to the end of September.
Natural hazards: Great Rift Valley susceptible to earthquakes, volcanic eruptions; frequent droughts

PEOPLE - DEMOGRAPHICS

Population: 67,851,281
Refugees and internally displaced persons*:* (2004) refugees (country of origin): 93,032 (Sudan), 23,578 (Somalia)
IDPs*:* 132,000 (border war with Eritrea from 1998-2000 and ethnic clashes in Gambela; most IDPs are in Tigray and Gambela Provinces)
Net migration rate: **(2004 est.)** 0 migrant(s)/1,000 population
note: repatriation of Ethiopians who fled to Sudan for refuge from war and famine in earlier years is expected to continue for several years; some Sudanese and Somali refugees, who fled to Ethiopia from the fighting or famine in their own countries, continue to return to their homes **Notes***:* Estimates for this country explicitly take into account the effects of excess mortality due to AIDS. This can result in lower life expectancy, higher infant mortality and death rates, lower population and growth rates, and changes in the distribution of population by age and sex than would otherwise be expected (July 2004 est.)
Median Age*: total:* 17.4 years,
Population growth (2004 est.): 1.89%
Infant mortality rate (2004 est.) *total:* 102.12 deaths/1,000 live births
female: 91.72 deaths/1,000 live births) *male:* 112.22 deaths/1,000 live births
Life expectancy at birth: (2004 est.) *total population* 40.88 years male: 40.03 years female: 41.75 years

SOCIO-CULTURAL

Nationality: Ethiopian
Ethnic Groups*:* Oromo 40%, Amhara and Tigre 32%, Sidamo 9%, Shankella 6%, Somali 6%, Afar 4%, Gurage 2%, other 1%

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Religions: Muslim 45%-50%, Ethiopian Orthodox 35%-40%, animist 12%, other 3%-8%
Languages: Amharic (official), Tigrinya (north), Oromigna (south), Guaragigna, Somali, Arabic, other local languages, English (major foreign language taught in schools)
Literacy: *definition:* age 15 and over can read and write
total population: 42.7%, *male:*50.3% *female:*35.1% (2003 est.)
Food: *Injera*, the mainstay of the Ethiopian diet, is bread made from the peculiarly Ethiopian *tef* cereal. W*at* is the sauce in which meat and vegetables are cooked.

HEALTH
Major Infectious Diseases*:* typhoid fever, HIV/AIDS, malaria, leishmaniasis (cutaneous), schistosomiasis (bilharzia), rabies; note: overall degree of risk: high (2004)
HIV/AIDS (2003 est.)
HIV/AIDS: *adult prevalence rate*: 4.4%
HIV/AIDS: *people living with it*: 1.5 million
HIV/AIDS: *deaths*: 120,000

ECONOMY
Overview
Ethiopia's poverty-stricken economy is based on agriculture, which accounts for half of GDP, 60% of exports, and 80% of total employment. The GDP is US$50.6 billion and GDP per capita is US$100.
Agriculture –Ethiopia's land tenure system, whereby government owns all land and provides long-term leases to the tenants, hampers growth. Agriculture suffers from frequent drought and poor cultivation practices. Main crops are coffee, grain, sorghum, and castor bean. Coffee exports are critical to the economy but with low prices many farmers switch to qat.
Main Industries: forestry, agricultural processing, textiles
War with Eritrea in 1998-2000 and recurrent drought have buffeted the economy. In November 2001 Ethiopia qualified for debt relief from the Highly Indebted Poor Countries (HIPC) initiative. The government estimates that annual growth of 7% is needed to reduce poverty
Imports- commodities: food and live animals, petroleum and petroleum products, chemicals, machinery, motor vehicles, cereals, textiles
Inflation: 14%
Currency: birr (ETB) note*:* exchange rates are determined on a daily basis

GOVERNMENT
Government type: Federal republic
Head of State: President Girma Wolde-Giorgis
Head of Government: Prime Minister Meles Zenawi
Independence: oldest independent country in Africa and one of the oldest in the world - at least 2,000 years
Capital: Addis Ababa
National holiday: National Day (defeat of MENGISTU regime), 28 May (1991)
Military age and obligation: 18 years of age for compulsory and voluntary military service (2001)

ENVIRONMENT
Natural resources: small reserves of gold, platinum, copper, potash, natural gas, hydropower
Environment – current issues: deforestation; overgrazing; soil erosion; desertification; water shortages in some areas from water-intensive farming and poor management

Source: CIA World fact Book, January 2004
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Lonely Planet World Guide – Ethiopia

ETHIOPIA LITERATURE REVIEW

Focus on GENERAL INTEREST AND CULTURE

Cultural summary: Amhara

Authors: Messing, Simon D. (Simon David); Skoggard, Ian

ORIENTATION

IDENTIFICATION AND LOCATION

The term "Amhara" is derived from AMARI, meaning "one who is pleasing, agreeable, beautiful, and gracious." Amhara culture is often identified with Abyssinian culture, which is regarded as the heir to the cultural blending of ancient Semitic and Cushitic (African) patterns; other heirs are the Tigre [Tigray]-speaking people of Eritrea, and the Tigreñña [Triginya] speakers of northern Ethiopia. The Amhara themselves often employ the term "Amhara" synonymously with "Ethiopian Orthodox (Monophysite) Christian, " although their own, more precise expression for this religion is "Tewahedo" (Orthodox). Ethiopia is located in the northeastern part of Africa, roughly between 5 and 16 degrees north latitude and between 33 and 43 degrees east longitude. It is mountainous, separated from the Red Sea by hot lowland deserts; a steep escarpment in the west borders the hot lowland in the Sudan. The mountain-fortress type of landscape has frequently enabled the plateau people to retain their independence against would-be invaders. The provinces of Begemder [Gonder], Gojam, and Welo [Wallo] are Amharic speaking, as are parts of Shewa [Shoa] since Amhara expansion.

DEMOGRAPHY

According to the 1984 census, the population of Ethiopia was estimated as 42 million. Of these, 28 percent referred to themselves as "Amhara, " and 32 percent stated that they spoke Amharic at home. Hence, about 14 million could be identified as Amhara, subject to qualification, by the effects of Amharization during the rule of Emperor Haile Selassie (1930-1974) and the political strife against Amhara domination since then.

LINGUISTIC AFFILIATION

There are three major linguistic families in Ethiopia: Cushitic, Semitic, and Nilo-Saharan. Amharic is related to the ancient Semitic language, Ge'ez, but contains strong influences from Cushitic. Ge'ez ceased to be spoken by the fourteenth century A.D., but it survives in the Orthodox liturgy to this day. Amharic has been important since the fourteenth century A.D., when the earliest Amharic document, "Songs of the Kings, " was written. Amharic, which is the predominant language on the plateau of northwest-central Ethiopia, is now the official national language of Ethiopia.

HISTORY AND CULTURAL RELATIONS

The Abyssinian tradition of the Solomonid dynasty, as told in the Ge'ez-language book KEBRANAGAST (Honor of the Kings), refers to the rule of Menilek I, about 975-950 BC. It relates that he was the son of Makeda, conceived from King Solomon, during her visit to Jerusalem. Interrupted in AD 927 by sovereigns of a Zagwe line, the Solomonid line was restored in 1260 and claimed continuity until Emperor Haile Selassie was deposed in 1974. Christianity came to Aksum in the fourth century AD, when Greek-speaking Syrians converted the royal family. At the Council of Chalcedon in AD 451, the theological

Monophysites of Alexandria, including the Abyssinians, broke away from the European church; hence the designation "Coptic." Ecclesiastic rule over Abyssinia was administered by the archbishop of Alexandria until 1948. The spread of Islam produced relative isolation in Ethiopia from the seventh to the sixteenth centuries. During this period, the Solomonid dynasty was restored in 1260 in the province of Shewa [Shoa] by King Yekuno Amlak, who extended his realm from Abyssinia to some Cushitic-speaking lands south and east. Amharic developed out of this linguistic blend. Using a vast number of serfs on feudal church territories, ABUNA (archbishop) Tekle Haymanot built churches and monasteries, often on easily defensible hilltops, such as Debra Libanos monastery in Shewa [Shoa], which is still the most important in Ethiopia. With the Muslim conquest of Somali land in 1430, the ring around Abyssinia was complete, and recently Islamicized Oromo (Galla) semi-nomadic tribes from the south invaded through the Rift Valley, burning churches and monasteries. When a second wave of invaders came, equipped with Turkish firearms, the Shewan king Lebna Dengel sent a young Armenian to Portugal to solicit aid. Before it could arrive, the Oromo leader Mohammed Grañ ("the left-handed") attacked and razed Aksum, killing the king in battle in 1540. His children and the clergy took refuge north of Lake Tana. One year later, Som Christofo Da Gama landed at Mesewa with 450 Portuguese musketeers. The tide turned in 1543 when Mohammed Grañ fell in battle. Shewa [Shoa], nevertheless remained settled by Oromo tribesmen, who now took up agriculture. The Portuguese built bridges and castles in and around the town of Gonder [Gondar], and Jesuits began to convert the royal family to Roman Christianity. King Za Dengel was the first royal convert, but the Monophysite clergy organized a rebellion that led to his removal. His successor, King Susneos, had also been converted but was careful not to urge his people to convert; shortly before his death in 1632, he proclaimed religious liberty for all his subjects. The new king, Fasilidas (1632-1667), expelled the Portuguese and restored the privileges of the Monophysite clergy. He--and later his son and grandson--employed workmen trained by the Portuguese to build the castles that stand to this day. But the skills of stone masonry later fell into disuse; warfare required mobility, which necessitated the formation of military tent cities.

The town of Gonder [Gondar] was abandoned by the Solomonid line when a usurping commoner chieftain, Kasssa, chose it as the location to have himself crowned King Theodore in 1855. He defeated the king of Shewa [Shoa] and held the dynastic heir, the boy Menilek II, hostage at his court. Theodore realized the urgency of uniting the many ethnic groups of the country into a nation, to prevent Ethiopia from losing its independence to European colonial powers. He invited foreign technicians and, at first, even welcomed foreign missionaries. But when the missionaries were unable to cast cannons for him and even criticized his often violent behavior, he jailed them. This led to the Lord Napier expedition, which was welcomed and assisted by the population of Tigre [Tigray] Province. When the fort of Magdalla fell, Theodore committed suicide. A conservative Tigre [Tigray] chief, Yohannes, was crowned at Aksum. In 1889 the Muslim mahdi took advantage of the disarray in Ethiopia; he razed the town of Gonder [Gondar] and devastated the subprovince of Dembeya, causing a severe and prolonged famine. Meanwhile, the Shewan dynastic heir Menilek II had grown to manhood and realized that Ethiopia could no longer isolate itself if it were to retain independence. He proceeded, with patient persistence, to unify the country. As an Amhara from Shewa [Shoa], he understood his Oromo neighbors and won their loyalty with land grants and military alliances. He negotiated a settlement with the Tigre [Tigray]. He equipped his forces with firearms from whatever source, some even from the Italians (in exchange for granting them territory in Eritrea). His policies were so successful that he managed to defeat the Italian invasion at Adwa, in 1896, an event that placed Ethiopia on the international map diplomatically. Empress Taitu liked the hot mineral springs of a district in Shewa, even though it was in an Oromo region, and the emperor therefore agreed to build his capital there, naming it "Addis Ababa [Adis Abeba]" (new flower). Menilek II died in 1913, and his daughter Zauditu became nominal head; a second cousin, Ras Tafari Makonnen, became regent and was crowned King of Kings Haile Selassie I in 1930. He had made it possible for Ethiopia to join the League of Nations in 1923, by outlawing the slave trade. One of his first acts as emperor was to grant his subjects a written constitution. He allied himself by marriage to the Oromo king of Welo [Wallo] Province. When Mussolini invaded Ethiopia in 1935, Emperor Haile Selassie appeared in Geneva to plead his case before the League, warning that his country would not be the last victim of aggression. The Italian occupation ended in 1941 with surrender to the British and return of the emperor. During succeeding decades, the emperor promoted an educated elite and sought assistance from the United States, rather

than the British, in various fields. Beginning about 1960, a young, educated generation of Ethiopians grew increasingly impatient with the slowness of development, especially in the political sphere. At the same time, the aging emperor, who was suffering from memory loss, was losing his ability to maintain control. In 1974 he was deposed, and he died a year later. The revolutionary committees, claiming to follow a Marxist ideology, formed military dictatorships that deported villagers under conditions of great suffering and executed students and each other without legal trials. Dictator Mengistu Haile Mariam fled Ethiopia in May 1991 as Eritrean and Tigrean [Tigrayan] rebel armies approached from the north.

SETTLEMENTS

Ethiopia is essentially a rural country. Apart from the capital Addis Ababa [Adis Abeba] (1990 estimated population was 1,912,500), few towns have a permanent population in excess of 10,000: Gonder [Gondar] (95,000, 1989 est.), the old caravan town on the way from the highlands to the Sudan; Harēr, the coffee city; and Dirē Dawa (127,000, 1989 est.), the railroad junction to the coast.

The many small towns are essentially marketplaces, serving the farming hinterland. The typical rural settlement is the hamlet, TIS, called MENDER if several are linked together. The hamlet may consist of two to a dozen huts. Thus, the hamlet is often little more than an isolated or semi-isolated farmstead, and another hamlet may be close by if their plowed fields are near. Four factors appear to determine where a hamlet is likely to be situated: ecological considerations, such as water within a woman's walking distance, or available pasturage for the flock; kinship considerations--persons within a hamlet are nearly always related and form a family economic community; administrative considerations, such as inherited family ownership of land, tenancy of land belonging to a feudal lord of former times, or continuing agreement with the nearby church that had held the land as a fief up to 1975 and continues to receive part of the crop in exchange for its services; and ethnic considerations. A hamlet may be entirely inhabited by Falasha blacksmiths and pottery makers or the Faqi tanners. Most of the Falasha have now left Ethiopia.

To avoid being flooded during the rainy season, settlements are typically built on or near hilltops. There is usually a valley in between, where brooks or irrigation canals form the border for planted fields. The hillsides, if not terrace farmed, serve as pasturage for all hamlets on the hill. Not only sheep and goats, but also cows, climb over fairly steep, bushy hillsides to feed. Some hamlets are fenced in by thorn bushes against night-roving hyenas and to corral cattle. Calves and the family mule may be taken into the living hut at night.

ECONOMY

SUBSISTENCE

Subsistence farming provides the main economy for most rural Amhara. The traditional method required much land to lie fallow because no fertilization was applied. Cattle manure is formed into flat cakes, sun dried, and used as fuel for cooking. New land, if available, is cleared by the slash-and-burn method. A wooden scratch plow with a pointed iron tip, pulled by oxen, is the main farming tool. Insecurity of land tenure has long been a major factor in discouraging Amhara farmers from producing more than the amount required for subsistence. The sharecropping peasant (GABBAR) was little more than a serf who feared the (often absentee) feudal landlord or military quartering that would absorb any surplus. The revolutionary government (1975-1991) added additional fears by its villagization program, moving peasants at command to facilitate state control and deporting peasants to the south of Ethiopia, where many perished owing to poor government planning and support. Among the Amhara, the raising of livestock is traditionally not directly related to available pasture, but to agriculture and the desire for prestige. Oxen are needed to pull the plow, but traditionally there was no breeding to obtain good milkers. Fishing is mostly limited to the three-month rainy season, when rivers are full and the water is muddy from

runoff so that the fish cannot see the fishers. Hunting elephants used to be a sport of young feudal nobles, but hunting for ivory took place largely in non-Amhara regions. Since rifles became available in Amhara farming regions, hunting for Ethiopian duikers and guinea fowl has diminished.

INDUSTRIAL ARTS

Much Amhara ingenuity has long been invested in the direct exploitation of natural resources. An Amhara would rather spend as much time as necessary searching for suitably shaped hard or soft saplings for a walking cane than perform carpentry, which is traditionally largely limited to constructing the master bed (ALGA), wooden saddles, and simple musical instruments. Soap is obtained by crushing the fruit of the ENDOD (PIRCUNIA ABYSSINICA) bush. Tannin for depilation of hides and curing is obtained from the yellow fruit of the EMBWAY bush. Butter is preserved and perfumed by boiling it with the leaves of the ADES (myrtle) bush.

In times of crop failure, edible oil is obtained by gathering and crushing wild-growing sunflower seeds (CARTHAMUS TINCTORUS). If necessary, leaves of the LOLA bush can be split by women to bake the festive bread DABBO. The honey of a small bee (APIS DORSATA) is gathered to produce alcoholic mead, TEJ, whereas the honey of the wild bee TAZEMMA (APIS AFRICANUS MIAIA) is gathered to treat colds and heart ailments.

DIVISION OF LABOR

Although much needed, the caste-like skilled occupations like blacksmithing, pottery making, and tanning are held in low esteem and, in rural regions, are usually associated with a socially excluded ethnic groups. Moreover, ethnic workmanship is suspected of having been acquired by dealings with evil spirits who enabling the artisans to turn themselves into hyenas at night to consume corpses, cause diseases by staring, and turn humans into donkeys to utilize their labor. Such false accusations can be very serious. On the other hand, the magic power accredited to these workers is believed to make their products strong, whereas those manufactured by an outsider who might have learned the trade would soon break. The trade of weaving is not afflicted by such suspicions, although it is sometimes associated with Muslims or migrants from the south.

LAND TENURE

Land tenure among traditional rural Amhara resembled that of medieval Europe more than that found elsewhere in Africa. Feudal institutions required the GABBAR to perform labor (HUDAD) for his lord and allocated land use in exchange for military service, GULT. In a system resembling the European entail, inheritable land, REST, was subject to taxation (which could be passed on to the sharecroppers) and to expropriation in case of rebellion against the king. Over the centuries, endowed land was added to fief-holding church land, AND DEBBER AGER. Royal household lands were classified as MAD-BET, and MELKENYA land was granted to tax collectors. Emperor Haile Selassie attempted to change the feudal system early in his administration. He defeated feudal armies, but was stymied in abrogating feudalistic land tenure, especially in the Amhara region, by feudal lords such as Ras Kassa. The parliament that he had called into existence had no real power. All remaining feudal land tenure was abrogated during the revolutionary dictatorship (1975-1991), but feudalistic attitudes practiced by rural officials, such as SHUM SHIR(frequently moving lower officials to other positions to maintain control), appear to have persisted.

KINSHIP

KIN GROUPS AND DESCENT

The extended patrilocal, patrilineal, patriarchal family is particularly strong among holders of REST land tenure, but found, in principle, even on the hamlet level of sharecroppers. When marriage occurs, usually

early in life, a son may receive use of part of his father's rented (or owned) field and build his hut nearby. If no land is available owing to fragmentation, the son may reluctantly establish himself at the bride's hamlet. When warfare has killed off the adult males in a hamlet, in-laws may also be able to move in. There are several levels of kin, ZEMED, which also include those by affinity, AMACHENET. In view of the emphasis of seeking security in kinship relations, there are also several formal methods of establishing fictive kinship, ZEMED HONE, provided the person to be adopted is ATTENTAM ("of good bones, " i.e., not of Shanqalla slave ancestry.) Full adoption provides a breast father (YETUT ABBAT) or a breast mother (YETET ENNAT). The traditional public ceremony included coating the nipples with honey and simulating breast-feeding, even if the child was already in adolescence.

MARRIAGE AND FAMILY

MARRIAGE

The traditional age of a girl at first marriage may be as young as 14, to protect her virginity, and to enable the groom to tame her more easily. A groom three to five years older is preferred. To protect the bride against excessive violence, two best men are sworn to protect her and wait behind a curtain; they can be called upon in later times also.

There are three predominant types of marriage in Amhara tradition. Only a minority--the priesthood, some older persons, and nobility--engage in Eucharist church marriage (QURBAN). No divorce is possible. Widows and widowers may remarry, except for priests, who are instead expected to become monks. Kin-negotiated civil marriage (SEMANYA; lit., "eighty") is most common. No church ceremony is involved, but a priest may be present at the wedding to bless the couple. Divorce, which involves the division of property and determination of custody of children, can be negotiated. Temporary marriage (DAMOZ) obliges the husband to pay housekeeper's wages for a period stated in advance. This was felt to be an essential arrangement in an economy where restaurant and hotel services were not available. The wife had no right of inheritance, but if children were conceived during the contract period, they could make a claim for part of the father's property, should he die. DAMOZ rights were even recognized in modern law during the rule of Emperor Haile Selassie.

INHERITANCE

When death is approaching, elder kin of the dying person bring the confessor, and the last will concerning inheritance is pronounced. Fields are given to patrilineal descendants, cattle to all offspring. Personal belongings, such as ox hide mats and a SHAMMA (toga), may be given to the confessor, who administers last rites and assigns a burial place in the churchyard.

SOCIALIZATION

Socialization in the domestic unit begins with the naming of the baby, a privilege that usually belongs to the mother. She may base it on her predominant emotion at the time, on a significant event occurring at the time, or on a special wish she may have for the personality or future of her baby. Breast-feeding may last two years, during which the nursling is never out of touch with the body of the mother or another woman. In the post-weaning period children are treated with permissiveness, in contrast to the authoritarian training that is to follow. The state of reason and incipient discipline begins gradually at about age 5 for girls and 7 for boys. The former assist their mothers in watching babies and fetching wood; boys take sheep and cows to pasture and, with slingshots, guard crops against birds and baboons. Both can be questioned in court to express preferences concerning guardianship in case of their parents' divorce. Neglect of duty is punished by immediate scolding and beating.

Formal education in the traditional rural church school rarely began before age 11 for boys. Hazing patterns to test courage are common among boys as they grow up, both physically and verbally. Girls are enculturated to appear shy, but may play house with boys prior to adolescence. Adolescence is the beginning of stricter obedience for both sexes, compensated by pride in being assigned greater responsibilities. Young men do most of the plowing, and by age 18 may be addressed as GOBEZ, signifying (strong, handsome) young warrior.

SOCIOPOLITICAL ORGANIZATION

SOCIAL ORGANIZATION

Social organization is linked to land tenure of kinfolk, feudalistic traditions and the church, ethnic division of labor, gender, and age status. The peasant class is divided between landowning farmers, who, even though they have no formal political power, can thwart distant government power by their rural remoteness, poor roads, and weight of numbers, and the sharecroppers, who have no such power against local landlords. Fear of a person who engages in a skilled occupation, TEBIB (lit., "the knowing one, " to whom supernatural secrets are revealed), enters into class stratification, especially for blacksmiths, pottery makers, and tanners. They are despised as members of a lower caste, but their products are needed, and therefore they are tolerated. Below them on the social scale are the descendants of slaves who used to be imported from the negroid Shanqalla of the Sudanese border, or the Nilotic Barya, so that both terms became synonymous with "slave."

POLITICAL ORGANIZATION

In theory, the emperor was the ultimate head of the entire Ethiopian state, head of the army, the church, and disposer of all lands and offices. In actuality, both the power of hereditary feudal lords and the difficulty of travel restricted his authority until the advent of modern communications and air travel in this century. While it was in the best interests of the emperor to appoint as many loyal provincial governors as he could, certain hereditary nobles held traditional control of areas which the emperor, unless he wanted to go to war, had little likelihood of reclaiming. Below the provincial governors were the village chiefs (CHEQA SUM), who also, in theory, represented and were appointed by the emperor. In most cases, however, they were the hereditary leading men of the village. Governors more often had a say in making a choice between contenders, and the emperor's role in most situations was only to settle a dispute or make an appointment official. A CHEQA SUM acted as a judge, presided over meetings of the village council, attended weddings, and was involved in all land transfers and disputes. He is the lowest representative of the emperor and was responsible for communicating all decrees of the central government to his village.

SOCIAL CONTROL

Social control is traditionally maintained, and conflict situations are resolved, in accordance with the power hierarchy. Judges interpret laws subjectively and make no sharp distinction between civil and criminal procedures. In addition to written Abyssinian and church laws, there are unwritten codes, such as the payment of blood money to the kin of a murder victim. An aggrieved person could appeal to a higher authority by lying prostrate in his path and shouting "ABYET" (hear me). Contracts did not have to be written, provided there were reliable witnesses. To obtain a loan or a job, a personal guarantor (WAS) is necessary, and the WAS can also act as bondsman to keep an accused out of jail. The drama of litigation, to talk well in court, is much appreciated. Even children enact it with the proper body language of pointing a toga at the judge to emphasize the speech.

YOUTH CHALLENGE INTERNATIONAL

RELIGION AND EXPRESSIVE CULTURE

RELIGIOUS BELIEFS

The religious belief of most Amhara is Monophysite--that is, Tewahedo (Orthodox)--Christianity, to such an extent that the term "Amhara" is used synonymously with "Abyssinian Christian." Christian Amhara wear a blue neck cord (METEB), to distinguish themselves from Muslims. In rural regions, the rules of the church have the de facto force of law, and many people are consecrated to church functions: priests, boy deacons and church students, chorister-scribes, monks, and nuns.

CEREMONIES

Ceremonies often mark the annual cycle for the public, despite the sacerdotal emphasis of the religion. The calendar of Abyssinia is Julian, with the year beginning on 11 September, following ancient Egyptian usage, and is called AMETE MEHRAT (year of grace). Thus, the Abyssinian year 1948 a.m. corresponds roughly with the Gregorian (Western) AD 1956. The new year begins with the month of MESKEREM, which follows the rainy season and is named after the first religious holy day of the year, MESQEL-ABEBA, celebrating the Feast of the Cross. On the seventeenth day, huge poles are stacked up for the bonfire in the evening, with much public parading, dancing, and feasting. By contrast, Christmas (LEDET) has little social significance except for the GENNA game of the young men. Far more important is Epiphany (TEMQET), on the eleventh day of TER. Ceremonial parades escort the priests who carry the TABOT, symbolic of the holy ark, on their heads, to a water pool. There are all-night services, public feasting, and prayers for plentiful rains. The rains mark the end of the GENNA season and the beginning of the GUKS tournaments fought on horseback by the young men. The long Lenten season is approaching, and clergy as well as the public look forward to the feasting at Easter (FASSIKA), on the seventeenth day of MIYAZYA. Children receive new clothes and collect gifts, chanting house to house. Even the voluntary fraternal association MEHABBER is said to have originated from the practice of private communion. Members take turns as hosts at monthly meetings, drinking barley beer together with the confessor-priest, who intones prayers. Members are expected to act as a mutual aid society, raising regular contributions, extending loans, even paying for the TAZKAR (formal memorial service) forty days after a member's death, if his family cannot afford it.

RELIGIOUS PRACTITIONERS

Besides the ecclesiastical function of the QES (parish priest), the chorister-scribe, who is not ordained, fulfills many services. He translates the liturgy from Ge'ez to Amharic, chants and sometimes composes devotional poetry (QENE), and writes amulets. The latter may be unofficial and discouraged by the priests, but ailing persons believe strongly in them and may use them to prevent disease. (Also see Medicine below)

ARTS

Verbal arts--such as BEDANYA FIT (speaking well before a judge)-- are highly esteemed in general Amhara culture, but there is a pronounced class distinction between the speech of the rustic peasant, BALAGER (hence BELEGE, unpolished, sometimes even vulgar), and CHOWA LIJ, upper-class speech. A further differentiation within the latter is the speech of those whose traditional education has included SEWASSOW (Ge'ez: grammar; lit., "ladder, " "uplifting"), which is fully mastered mainly by church scholars; the speeches of former emperor Haile Selassie, who had also mastered SEWASSOW, impressed the average lay person as esoteric and hard to understand, and therefore all the more to be

respected. In the arts of politeness, veiled mockery, puns with double meanings, such as SEMMENA-WORQ (wax and gold), even partial knowledge of grammar is an advantage.

The draping of the toga (SHAMMA) is used at court and other occasions to emphasize spoken words, or to communicate even without speech. It is draped differently to express social status in deference to a person of high status, on different occasions, and even to express moods ranging from outgoing and expansive to calm sobriety, to sadness, reserve, pride, social distance, desperate pleading, religious devotion, and so on. Artistic expression in the fine arts had long been linked to the church, as in paintings, and sponsorship by feudal lords who could afford it, especially when giving feasts celebrated with a variety of musical instruments.

MEDICINE

The basic concepts and practices of Amhara medicine can be traced to ancient Egypt and the ancient Near East and can also be attributed to regional ecological links within Ethiopia. Often no sharp distinctions are made between bodily and spiritual ailments, but there are special occupations: the WOGGESHA (surgeon-herbalist) is a pragmatist; the DEBTERA (scribe) invokes the spirit world. The latter is officially or unofficially linked to the church, but the ZAR cult is apart and may even be female dominated. Its spirit healing has a complex cosmology; it involves the social status of the patient and includes group therapy. The chief ZAR doctor is often a matriarch who entered the profession when she herself was possessed by a spirit; she has managed to control some powerful spirits that she can then employ in her battles to overcome the spirits that possess her patients. No cure is expected, only control through negotiation and appeasement of the offended spirit, in the hope of turning it into a WEQABI (protective spirit). By contrast, possession by an evil spirit is considered more serious and less manageable than possession by a ZAR, and there is no cult. An effort is made to prevent it by wearing amulets and avoiding persons, who are skilled in trades like blacksmithing and pottery making. Since these spirits are believed to strike beautiful or successful persons, such individuals--especially if they are children--must not be praised out loud. If a person sickens and wastes away, an exorcism by the church may be attempted, or a TANQWAY (diviner- sorcerer) may be consulted; however, the latter recourse is considered risky and shameful.

DEATH AND AFTERLIFE

The corpse is washed, wrapped in a SHAMMA, carried to church for the mass, and buried, traditionally without a marker except for a circle of rocks. Women express grief with loud keening and wailing. This is repeated when kinfolk arrive to console the relatives of the deceased. A memorial feast (TAZKAR) is held forty days after death, when the soul has the earliest opportunity to be freed from purgatory. Preparations for this feast begin at the time of the funeral: money is provided for the priest to recite the FETET, the prayer for absolution, and materials, food, and drink are accumulated. It is often the greatest single economic expenditure of an individual's lifetime and, hence, a major social event. For the feasting, a large, rectangular shelter (DASS) is erected, and even distant kin are expected to participate and consume as much TALLA and WOT as available.

FILE EVALUATION

Documents referred to in this section are included in this eHRAF collection and are referenced by author, date of publication, and eHRAF document number.

The file includes fifteen documents, all but one based on research conducted in the 1940s, 1950s and 1960s. Overall, a more traditional, and rural Amhara culture is portrayed, except for Levine (1965, no. 11) who also discusses modern changes in Amhara culture. Messing's work (1985, no. 20) systematically covers a broad range of culture, circa 1950s, and is the basic source to be consulted. Included in

Messing's book is an extensive glossary covering such categories as animals, cultigens, herbs, spirits, and charms. The other works compliment Messing by examining more specific aspects of Amhara culture, such as settlement patterns (Buxton 1949, no. 3), political organization (Perham 1949, no. 7), ethnomedicine (Young 1970, no. 12; 1975, no. 17), land tenure (Hoben 1963, no. 14; 1970, no. 19; 1973, no. 13; Crummey 1983, no. 15) and syncretic religious beliefs and practices (Reminick 1974, no. 21; 1975, no. 22). Examples and discussions of Amhara representative arts, oral stories and literature are found in Young (1967, no. 18), Messing (1956, no. 6), and Assefa (1988, no. 16), respectively. It is evident that Amhara culture varies geographically, although no one study covers this variability. The post-Haile Selassie period (1975 to present) is not covered in the file. For more detailed information on the content of the individual works in this file, see the abstracts in the citations preceding each document.

Source: This culture summary was based on the article "Amhara," by Simon D. Messing, in the Encyclopedia of World Cultures, Vol. 9. 1995. John Middleton and Amal Rassam, eds. Boston, Mass.: G. K. Hall & Co. Population figures and territorial names were updated by Ian Skoggard, 1996.

Focus on WOMEN

Gender and daily life in Ethiopia

By Jason Mosley

SCHOOL starts in Wereilu at 7.45 a.m. with the flag ceremony. The students are lined up in somewhat orderly rows by their class leaders while a few of the teachers oversee the process, swishing small switches recently torn from nearby eucalyptus trees. The switches are mostly to keep the assertive African flies on the move, but the overall effect during the ceremony vaguely evokes a shepherding demonstration. Once in order, the students sing the Ethiopian national anthem while one of their number raises the green, gold, and red tri-colour in front of the school's administrative block. A teacher strikes a bell fashioned from some abandoned machinery after the morning announcements and the students head for their classrooms with varying degrees of eagerness to learn.

This was my morning routine five days a week for one and a half years while I served as a Peace Corps volunteer in this rural town in highland Ethiopia. I am still not sure who learned more there, my students or I? Certainly I continue to reflect on my experience five years after departing. Now studying African history, governance, politics and economic development in London, I constantly seek to relate my memories of Ethiopia to the academic literature I read, trying to make the abstract concepts concrete. What lasting effect, if any, have I had on those with whom I lived in Wereilu? As a development worker and a fellow human being, did my presence help?

In the developed world, Ethiopia is usually associated with images from the 1985 famine: starving children, gaunt faces, emaciated cattle, parched land and suffering on a biblical scale. This was not the Ethiopia in which I lived. While food security remained an important development issue during my service, it did not dominate the agenda in Wereilu nor in many other parts of Ethiopia. The librarian was interested in ways to fill his library with free books and the school administration was interested in providing the facility with electricity. I was interested in converting a little-used part of the buildings into a language-laboratory and we were all interested in improving the quality of education available at the secondary school.

Though I was the first Peace Corps volunteer (or foreign development worker of any type, to my knowledge) to be stationed in Wereilu, the school's administration was already well versed in many of the development themes with which I had been indoctrinated during my thirteen weeks of training. Gender, a

touchstone issue in development work worldwide, was particularly important in Ethiopia. The Peace Corps had an active Gender and Development (GAD) committee in the country and other gender-related goals as an organization which influenced my lesson-planning and day-to-day decision making. The Ethiopian Ministry of Education had their own stated goals of increasing female student enrolment and graduation rates. This article will consider some of the implications of gender and development in Wereilu.

Development as Change

In approaching development work, one will inevitably be confronted with the reality that at its core, development is often about changing culture. Even the most practical and altruistic of development projects would be implemented by workers and managers hoping that it would lead to a change in the attitudes of the served populations, opening their minds to the possibility that they can improve their lot in life. When considering gender and development, there can be no doubt that the goal is to achieve fundamental changes in the way that women and men understand their identities and relationship to each other. With respect to gender, development goals include decreasing the gap between male and female access to education, increasing women's choices for work, increasing women's role in government and generally moving towards a participation of women in different aspects of society that approaches their proportion of the population. Another huge set of goals centres on securing women's access to what are considered to be universal human rights including food and personal security, legal rights and entitlements equal to their male counterparts' in society as well as sexual and reproductive safety and freedom. For these goals to be accomplished, local understandings of gender roles and identities must be explored, understood, and changed. One cannot consider the alteration of individual identities and self-perceptions on such a profound level anything less than cultural change. Recognizing this does not invalidate such goals. However, it is worth bearing in mind when considering changes that development is nothing more than cultural imperialism. In some sense, this is true. This does not make the goals of protecting women from culturally sanctioned rape or relegation to a legal minority any less worthy or urgent. But empowering women does change the social dynamic of male-female interaction.

Additionally, it is important to consider both the perspective that one brings to the process of gender and development as well as the nature of one's relationship to the discourse. Understanding one's own prejudices and values, especially as an autonomous, 'grass roots' development worker, is essential when seeking to understand the roles and relations operating in the society with which one hopes to engage in a process of change. In addition, bearing in mind one's inherent location within the dynamic of gender relations should inform the way in which one interacts with others, male and female.

The Gender Landscape in Ethiopia

Although Ethiopians will be the first to claim that Ethiopian culture is different from black Africa, many themes emerge common to the rest of the developing world and sub-Saharan Africa in particular when it comes to gender. While resisting oversimplification, it is possible to describe a few features of the gender dynamic in Ethiopia, particularly the impact on girls' education in the highland areas where I spent nearly all of my time.

Particularly in rural areas, but also in urban settings, women are responsible for performing a higher amount of labour in the home than men. Women and girls do the cooking and cleaning as well as fetching water, which usually entails carrying around twenty litres of water back to the home one or more times per day. If there is a water pipe nearby this could take a few minutes. If not, it could mean up to an hour's walking to a nearby spring or river and back. Women are also responsible for collection of fuel for cooking fires. While men are usually responsible for ploughing, women and children of both genders are involved in most of the other aspects of agriculture including weeding, harvesting and selling produce in the market. Young girls and boys could be responsible for pasturing animals.

Access to education is limited in Ethiopia and girls, particularly in the rural area, get the least access of all. Female students are often prevented from enrolling because of a family's inability to pay for uniforms, fees and materials. Boys are often given priority in these cases, both because of perceptions that they would be most likely to get a job using their education and because there is plenty for the girls to do in the home. According to the Ethiopian Ministry of Education, around 51 per cent of primary school age children were enrolled in the 1999/2000 school year. Broken down by gender, female enrolment was at 41 per cent, compared with 61 per cent for males. Even when enrolled, female students can find themselves at a disadvantage because of work they must do before and after school at home--often cooking and cleaning while their male siblings are studying or playing sport.

Ethiopian girls are also vulnerable to culturally sanctioned violence including abduction, particularly when fetching water or fuel wood. Girls are usually abducted in order to be forced to marry, often by being raped so that her family will be pressured to let her remain with her new husband rather than returning in disgrace. The practice of female circumcision, usually referred to as female genital mutilation (FGM) in the development community, also puts girls at risk in Ethiopia. This practice is perpetuated by women, but justified in gendered terms. It is commonly held that without having been circumcised, a woman will find it difficult to marry or will be difficult for her husband to control. It is also meant to reduce sexual urges, to keep women docile. In a discussion with my students, some expressed the belief that FGM prevents babies from being harmed during childbirth as an uncircumcised woman's external genitalia were thought to become 'stony', impeding the delivery. The ceremony and implementation of FGM involve an operation which is frequently carried out in unsanitary conditions, putting girls at risk of infection. Even years later, women who have undergone the practice are at increased risk for sexually transmitted diseases and complications during childbirth.

Gender and Development in Wereilu

As a male and a foreigner in Wereilu, my legitimacy and ability to perform as an agitator for change was significantly compromised. As a foreigner, direct action on my part could easily be dismissed as not relevant in the local context. More importantly, my perceived and actual stake in the welfare of the community and its social fabric was much lower than that of the rest of the population, although the fact of my living in such a remote and underprivileged area of Ethiopia increased my credibility somewhat. As a male, my opportunities for meaningful interactions with women were constrained by social convention. In addition, if part of the desired process of changing gender identities was meant to empower women, particularly female students, then it was essential that this agenda not be perceived as a male initiative. Many female Peace Corps volunteers started after-school girls' clubs, providing a space where female students could be comfortable expressing themselves. I did not feel this was a legitimate option for me as a male in Wereilu. As such, most of my efforts were woven into English lessons or demonstrated through my relationships and interactions.

The Peace Corps GAD committee initiated a Girls' Mentoring Project in coordination with the transnational organization FAWE (Forum for African Women Educationalists) in the spring of 1998. I was fortunate enough to be able to participate in the three-day conference in Addis Ababa and was responsible for chaperoning two of the female students back and forth from my region. In total 24 female high school students were brought to the capital to stay with prominent Ethiopian female role models and participate with them in the conference. The students shadowed their mentors for two nights and the intervening day. Most of the conference involved only the students, mentors and speakers brought in--providing a space for frank discussion. Many aspects of women's challenges in Ethiopia were addressed, including the sensitive issue of FGM. After the workshop, the students wrote essays about their experience in Addis which were read aloud to the assembled students in a special morning flag ceremony.

From my perspective, the student from Wereilu was visibly transformed by the event. The pride of sharing her experience was clearly empowering for her. In the following term, she joined a new current events

club which I started in order to practice English by discussing the news stories. She was also an active participant in the conversational English curriculum which I also taught. Her confidence was high in a context where female students are often at a disadvantage next to male students. I was no longer in Wereilu when she took the national comprehensive examinations, but I like to think that she scored well enough to secure a place at Addis Ababa University.

We should also consider other experiences, perhaps more typical. For example, my two closest friends in Wereilu, both male teachers, married female students during my service. Aged sixteen and eighteen, the former had a child within a year of the marriage. Both were students in grade 9, though both had dropped out by the time I left Wereilu. The eighteen-year-old student's marriage was arranged. She had repeated the ninth grade twice previously and told me herself she was not interested in studying any longer. This highlights the presence of difficult obstacles facing even those who valued the goal of empowering women in Ethiopia. Both teachers acknowledged the paradox of being progressive educators pushing for gender equality while engaging in practices which clearly violated such goals.

Among my own more active endeavours was an attempt to hire a male serateyna (worker) to help with fetching water and doing laundry, both considered women's work. My strategy back-fired and within a month I had engaged the services of a local woman. I was seeking to challenge gendered stereotypes about the nature of the work. However, my male serateyna had actually been interested in boosting his social capital by becoming associated with the foreigner. I had to shift tactics to focus instead on improving the lot of the female serateyna in what ways I could--providing her with electricity, a generous wage, a safe working environment, and in general treating her as an equal. But she herself brought beliefs about gendered relations that I was unable to affect. For example, I was never able to convince her to share a meal with me, though she cooked most of the food which we both ate in my home.

Reflections

Much development work has been centred on empowering women and especially on increasing their access to education. Women are the primary caregivers in most sub-Saharan African households and Wereilu is no exception. Though there is a large body of literature debating the effectiveness of female-centred development versus more traditional approaches, it is widely accepted that educated and empowered women are more likely to educate and encourage their own female children. In addition, they provide positive role models for male and female children. Empowerment has other positive effects, including increased sexual and reproductive security, without which women are often unable to protect themselves from exposure to sexually transmitted diseases including HIV/AIDS.

Since leaving Wereilu in February of 1999, I have considered many times the impact I may have had as a development worker in my community. In terms of my gender related development activity, my intention was to empower my female students with the belief that their rights as humans were equal to that of their male counterparts in the community, and that they should consider themselves as equally capable of succeeding academically. The reality of life in Wereilu and in Ethiopia is that few students are able to pass the comprehensive examinations with a high enough mark to continue with tertiary education. Most of those who do are male. Additionally, changing ideas about gender can take a long time. The process can foster tension and conflict, even violence, as new ideas clash with tightly held orthodoxies. I was not trying to bring about a revolution in Wereilu. I comfort myself with the notion that some of my students may have considered new ideas about their roles, both male and female. Perhaps in time, it will bear fruit. I look forward to returning to find out.

YOUTH CHALLENGE INTERNATIONAL

Focus on HEALTH – HIV/AIDS

Tragedy and hope: Africa's struggle against HIV/AIDS

Some twenty years ago, the first cases of a mysterious illness that destroyed the body's natural defences against infection were reported in the United States. Since then, the spread of the human immunodeficiency virus (HIV) that leaves victims exposed to an array of diseases known collectively as Acquired Immune Deficiency Syndrome (AIDS), has become a global health emergency. But it is in sub-Saharan Africa, the world's poorest and least developed region, where HIV/AIDS has gone from emergency to tragedy -- endangering not just the lives of its victims but the social, economic and political fabric of society.

The numbers alone are crushing. At the end of 2003 the Joint UN Programme on HIV/AIDS (UNAIDS) estimated that two-thirds of the 40 million people living with the virus were African. Some 3 million of the 5 million new infections in 2003 also occurred in Africa, where infection rates are seven times the world's average. In some countries, as much as 40 per cent of the total population carries HIV. In a region where nearly half of the population lives on less than $1 per day, barely 1 in 100 people in need of lifesaving anti-retroviral drugs can afford them. For the rest there is only the certainty of slow death -- 2.3 million of them in 2003 alone -- and a grimly uncertain future for the millions of orphans they leave behind.

This special reprint edition of ***Africa Recovery*** documents some of the key developments in Africa's struggle against the disease, and highlights the efforts of Africans and their international partners to turn back the tide. The articles include an analysis of the role of men in prevention, a look at efforts to reduce HIV transmission in the military, and the terrible combination of famine and HIV/AIDS in Southern Africa. Other articles examine the development impact of the pandemic, the plight of AIDS orphans and the battle to break through the price barrier to care and treatment for the poor.

Africa's own efforts are detailed in articles on successful prevention campaigns in Senegal and Uganda, and on Botswana's pioneering commitment to provide care and treatment to all of its citizens with HIV. An article on two unprecedented drug treatment initiatives, one by the World Health Organization and another by the US government, bring the issue to the present, and to what many observers say is an historic moment of opportunity.

Resources for HIV/AIDS prevention and treatment programmes, though still woefully inadequate, are increasing. Many more African political leaders have taken personal leadership of anti-AIDS efforts. A vibrant, engaged and independent African civil society, increasingly led by people living with HIV/AIDS, has emerged to energize the struggle, confront stigma and discrimination and give the disease a human face. The long, damaging argument over whether to fund treatment or prevention programmes appears to have been settled in favour of a comprehensive response combining education, prevention, and care and treatment. All of these developments are reasons for hope, even if, for too many, they come too late.

As the enormity of the HIV/AIDS crisis engulfing Africa has slowly emerged from the fog of silence and denial that surrounds it, observers have struggled for words that convey its magnitude. Some draw parallels with modern political horrors, likening the pandemic to a "weapon of mass destruction" or an African "Holocaust." Others look to history for a sense of scale, comparing AIDS to the plague that decimated medieval Europe or the scourges of

ancient times. Sometimes the words are heartbreakingly personal, as when UN Secretary-General Kofi Annan speaks of his experience at the bedside of a dying mother. At other times the words are angry -- denouncing a world that has spent a decade bickering over trade rules and medicine patents while the death toll climbed into the tens of millions.

The words in this HIV/AIDS special issue have a more modest goal: to chronicle the path that has taken Africa to this time of opportunity. The continent's future may well depend on where we all go from here.

Source: From *Africa Recovery, Special compilation of AIDS articles (June 2004), page 3*

AIDS in Sub-Saharan Africa

As of the end of 2001, the Joint United Nations Programme on AIDS (UNAIDS) and the World Health Organization estimate that there are 28.1 million persons living with HIV/AIDS in Sub-Saharan Africa. There were 3.4 million new infections in 2001. Another 19.5 million people in the region have already died from AIDS (2.3 million of them in 2001). AIDS is now the leading cause of death in Sub-Saharan Africa. This region constitutes the global epicentre of the pandemic; it is home to 70% of the people living with HIV in the world.

Profile of the Epidemic

- **Women are disproportionately affected.** They account for 55% of the adults living with HIV/AIDS in Sub-Saharan Africa, a greater percentage than in any other region.

- **The vast majority of people living with HIV/AIDS do not know they are infected.** Voluntary counselling and testing services are in short supply. Stigma and discrimination continue to discourage people from being tested.

- **Without HIV/AIDS, life expectancy in Sub-Saharan Africa would be about 62 years.** In South Africa it is now about 47. In Botswana, Malawi, Mozambique and Swaziland, it is under 40.

- **AIDS has become the biggest threat to development in the region.** The ranks of skilled labourers and professionals are being hit hard. In some countries, health care systems have lost 25% of their personnel to the disease. The ability of countries to ensure law and order is being compromised.

- **The epidemic is making inroads in West Africa.** HIV prevalence rates have now surpassed 5% in Burkina Faso, Cameroon, Côte d'Ivoire, Nigeria and Togo.

- **HIV prevalence rates have risen to alarming levels in parts of southern Africa.** Data for the year 2000 from antenatal clinics reveal prevalence rates among pregnant women of over 30% in Swaziland, Botswana and South Africa's KwaZulu-Natal Province. In urban areas of Botswana, the figure was 43.9%. HIV prevalence rates among people aged 15-49 are 10% or higher in 16 countries in the region. In some of these countries, they are over 20%.

- **In South Africa, 4.7 million people are living with HIV/AIDS (about one person in nine).** Prevalence rates among people aged 20-34 are rising. However, prevalence rates among adolescents have dropped slightly since 1998. Large-scale information campaigns and condom distribution programmes appear to be having some success.

- **There are other success stories.** Two examples: (1) Uganda is the first African country to have subdued a major HIV epidemic. HIV prevalence rates among pregnant women in urban areas have fallen for eight years in a row, from 29.5% in 1992 to 11.25% in 2000. Uganda's response has focussed heavily on information, education, and communication and decentralised programmes that reach right down to the village level. Condom use is up significantly. (2) National AIDS plans have been completed in 31 countries and are in development in another 12 countries.

- **Some progress has been made on the treatment front.** As a result of price reductions for some drugs, at least 10 countries in the region are now providing antiretroviral therapy to people living with HIV/AIDS. Botswana has become the first country in the region to provide antiretroviral drugs through its public health system. However, most people living with HIV/AIDS in Sub-Saharan Africa still cannot access antiretroviral treatments.

Access to HIV/AIDS Treatment in Developing Countries

The vast majority of people in developing countries who are living with HIV/AIDS are unable to access life-saving treatment for HIV infection and related opportunistic infections. This problem is not unique to people living with HIV/AIDS; it affects all people with serious diseases and conditions.

The obstacles to access can be divided into two broad categories:

- the high cost of drugs;
- poor health infrastructures.

This fact sheet explores the problems in each category. First, the context is described. Then, the issues related to the high cost of drugs are discussed. This is followed by an overview of the issues related to health infrastructures. Finally, a list of resources is provided where more information can be obtained. This information sheet is intended to provide readers with a basic understanding of the issues. Before reading the text, please consult the note on terminology below.

Note on Terminology

This information sheet uses the term **developing country** to describe countries that are poor in resources and the term **developed country** to describe wealthier nations. It is important to keep in mind that developing countries are at different stages of development and so cannot always be lumped together as one. For example, some developing countries have more sophisticated health infrastructures and greater resources at their disposal than others.

Although this information sheet focuses on the problems of accessing treatment in developing countries, it is important to acknowledge that there are people in

developed countries who face similar problems accessing treatment and that there are people in developing countries (a tiny minority) who have the money to obtain adeq¾uate treatment. It is also important to not assume that conditions are the same throughout a country or region. In many countries, both developed and developing, health infrastructures in major urban areas are much better than in rural areas.

Antiretroviral therapies are drugs that stop or suppress the activity of a retrovirus, such as HIV. CD-4 counts are a measure of the extent of suppression of the immune system.

Combination therapy refers to the use of a combination of antiretroviral drugs, usually three or more. Combination therapy has become a standard of care in treating HIV infection in developed countries.

Opportunistic infections are infections that do not normally affect healthy people but that can cause disease in people with weakened immune systems (due to HIV/AIDS or other conditions).

Viral load refers to the amount of virus in a person's body, usually measured in the blood stream.

The Context

Epidemiology. At the end of 2000, there were 36.1 million people living with HIV/AIDS in the world. More than 95% of them live in developing countries, where 20 million people have already died from AIDS and over 8,000 more die each day. It is estimated that about 15,000 more people are infected with HIV every day around the world[1].

Per Capita Income. Average annual per capita (i.e., per person) income in high-income countries in 1999 was $25,730[2]. In sub-Saharan Africa and in South Asia, it was $500 and $440 respectively[3].

Per Capita Health Spending. Annual per capita spending on health in North America and Western Europe is more than $1,500. In Latin America, the figures range from $41 in Guatemala to $792 in Argentina. In contrast, in most of Africa and Asia, annual per capita health expenditure is under $20[4].

Other Priorities. All countries face competing demands for limited resources. Under-resourced countries have difficulty meeting even basic needs, such as clean water, adequate housing and nutrition, and decent schools and highways. Many developing countries also face serious epidemics of other diseases, such as tuberculosis and malaria.

The Market for Drugs. Developed countries account for the vast majority of the global market for prescription drugs. North America, Western Europe and Japan alone represent 80% of the market. By contrast, Africa accounts for just 1%.

The High Cost of Drugs

The Issue

Drugs for the treatment of HIV/AIDS are priced out of the reach of all but a tiny number of persons living with HIV/AIDS in developing countries. While the introduction of antiretroviral therapies has benefited persons living with HIV/AIDS in developed countries—mortality rates have dropped by over 70%—these treatments remain largely inaccessible to people in developing countries.

The annual cost of triple combination antiretroviral therapy in the United States ranges from $10,000 to $15,000. Drugs for the treatment of opportunistic infections are also very expensive.

Although the price of drugs is not the only issue affecting access, it is a significant barrier and one that is common to all developing countries, whatever their stage of development.

Pharmaceutical Patents, International Agreements and Drug Prices

Like other inventions, drugs are often protected by patents. When a drug is patented by its manufacturer, other companies are not permitted to make or sell copies of the drug. The manufacturer has a monopoly on sales. The Agreement on Trade Related Aspects of Intellectual Property Rights ("the TRIPS agreement") is the main international agreement governing patent rights. All countries that are part of the World Trade Organization are bound by TRIPS (though the least developed countries have been given until January 1, 2006 to comply). TRIPS requires that countries grant 20-year patent protection to new drugs and that they modify their patent laws accordingly.

The prices of patented drugs are very high. Brand-name pharmaceutical manufacturers argue that high prices are needed to fund research and development. However, treatment activists respond (1) that these manufacturers are among the most profitable in the world; (2) that these manufacturers provide insufficient financial accounting (particularly with respect to their research and development costs) to justify the prices of their products; (3) that the research and development costs of many drugs (including many HIV/AIDS drugs) are partially (often significantly) financed by governments and non-profit agencies; and (4) that research and development costs are more than recovered from sales to people in developed countries, so there is no justification for keeping prices high in developing countries.

Efforts to Improve Access

A number of avenues are being pursued to lower the costs of HIV/AIDS treatments in developing countries. Some of these avenues are described below.

Price Reductions and Drug Donations

As a result of considerable pressure from activists, governments and international agencies, some of the brand-name pharmaceutical companies have lowered the prices of their drugs or given drugs away free in developing countries.

For example, in March 2001, Merck announced discounts of 90% for two of its HIV/AIDS drugs in Sub-Saharan Africa. The offer was later extended to Romania and parts of Central and South America. In June 2001, GlaxoSmithKline announced price reductions of about 80% for three HIV/AIDS drugs in 63 countries. That same month, following several limited price reductions for

its drug fluconazole, Pfizer said it would give the drug away free to AIDS patients in the least developed countries.

As welcome as price reductions are, there are several limitations to this approach:

- It takes a long time to convince pharmaceutical manufacturers to lower prices. Negotiations are very arduous.
- There are usually conditions attached to the price reductions. Sometimes the reductions apply only to drugs sold in the public sector; or they apply only to some developing countries; or they are only for some indications. Sometimes they are for a limited period of time.
- The reduced prices are usually still too expensive for most people in developing countries.

There are usually conditions attached to drug donations as well. Furthermore, there are questions about whether price reductions and drug donations are a sustainable solution, and whether this is the best approach to take. Discounts can be eliminated or reduced after they are put into effect, and drug donations can be discontinued. Developing country health systems need a reliable source of inexpensive essential medicines and should not have to rely on the whims of company goodwill. Developing the capacity to manufacture generic copies of patented drugs and to import cheaper drugs (see below) may be a better solution.

Getting Governments and the Private Sector to Pay

Some developing country governments have the resources to pay for HIV/AIDS treatments. Brazil, in addition to bringing about substantial price reductions through generic manufacturing (see below), fully subsidizes the costs of many antiretroviral therapies and treatments for opportunistic infections for 90,000 persons living with HIV/AIDS in that country. This has resulted in a drop of over 50% in AIDS-related deaths in Brazil.

In some countries, governments have been sued in the courts over their failure to meet their legal obligations to provide HIV/AIDS treatments to people who need them. This approach has met with some success in countries where the right to health is enshrined in the constitution. In the Latin American countries of Argentina, Costa Rica, El Salvador and Venezuela, the courts have ruled that governments must provide the treatments. However, the court orders are not always fully implemented for a number of reasons, not the least of which is that the governments indicate that they have difficulty subsidizing the high costs of HIV/AIDS treatments.

In May and June of 2001, two large companies in South Africa—Anglo-American and Daimler/Chrysler South Africa—announced that they would pay for HIV/AIDS medications for infected workers and spouses. These companies recognized that their work forces were being decimated by HIV/AIDS and that it was in the companies' best interests to provide free medications.

Also, over the years, there have been several attempts to establish funds to help purchase HIV/AIDS treatments for people in developing countries. When used in combination with other approaches outlined in this section, like price reductions and compulsory licensing, such funds could be extremely helpful in making HIV/AIDS drugs affordable. Currently, through the

auspices of the United Nations, there is an effort underway to establish a Global AIDS and Health Trust Fund. Many details still need to be worked out, such as how large the fund will be; whether it will cover both HIV/AIDS prevention and treatment; whether it will address infrastructure issues (see below); and which diseases other than HIV/AIDS will be included.

Compulsory Licences

Governments can issue licences to companies to manufacture generic copies of patented drugs (without the approval of the patent holder). These are called “compulsory licences” and they are allowed under TRIPS. Governments have to enact legislation authorizing compulsory licensing. The generic manufacturer has to provide adequate compensation to the patent holder—such as through a royalty on the sale of the drug. This is a legal way of breaking the patent holder's monopoly.

No country has yet used compulsory licensing for drugs used in the treatment of HIV/AIDS, largely because of intense pressure from industrialized countries and the multinational pharmaceutical manufacturers. In some cases, these countries and manufacturers have tried to coerce developing countries into adopting patent legislation that is more restrictive than what TRIPS requires and that outlaws compulsory licensing (and parallel importing as well). The United States government has even threatened trade sanctions. In response to pressure from treatment activists in the United States, the U.S. Government has pledged to refrain from bullying countries in this manner.

What would happen if compulsory licensing were used? Brazil, Thailand and India are three countries that have authorized generic manufacturing of HIV/AIDS drugs. They have succeeded in reducing prices substantially. A daily dose of the antiretroviral drug AZT costs $10.00 in the United States, but only $1.08 in Brazil. A daily dose of fluconazole, a drug used to treat certain opportunistic infections, costs $12.20 in the United States, but sells for as little as $0.29 in Thailand and $0.64 in India.

Technically, these countries did not use compulsory licensing. Instead, they authorized generic manufacturing while they were still excluded from the provisions of TRIPS. But the effect is the same: generic manufacturing sharply lowered prices.

Unfortunately, TRIPS appears to allow compulsory licensing only when the generic drugs are manufactured primarily for local (i.e., in-country) use. This might prevent a company that had received a compulsory licence from exporting its products to another country that may not have the capacity to manufacture generic drugs.

Voluntary Licences

A pharmaceutical manufacturer could issue voluntary licences to a local manufacturer to produce a generic version of its drug. In exchange, the local manufacturer would pay compensation to the patent holder. This would be very similar to compulsory licensing, except that the patent holder would willingly issue the licence. Treatment activists in South Africa attempted (without success) to convince Pfizer to issue a voluntary licence for fluconazole.

Parallel Importing

When a country imports a drug sold (or authorized for sale) by the patent holder in other countries, for resale at home, without the consent of the patent holder, this is called parallel importing. TRIPS permits parallel importing.

Parallel importing can result in lower prices because the patent holder often sells its drugs at different prices in different countries. For example, in September 1999, Pfizer was selling a daily dose of fluconazole at prices that ranged from $9.35 in South Africa to $13.37 in France and to $27.60 in Guatemala. Obviously, the price reductions achieved through importation would not be as significant as those that can be obtained from compulsory licensing.

TRIPS does not permit the importation of generic copies of drugs into countries where the drugs are protected by a patent. Attempts to import generic HIV/AIDS drugs into South Africa and Ghana have been staunchly resisted by the brand-name pharmaceutical manufacturers.

Other Avenues

The following are brief descriptions of some of the other measures that are being utilized or explored to bring prices down.

Distribution Pipelines. This involves taking surplus medications from developed countries and distributing them to people in developing countries. One of the most successful initiatives of this type has been the United States-Venezuela Air Bridge.

Bulk Buying. This involves several countries getting together to make joint purchases of HIV/AIDS treatments. This has helped to reduce prices in the countries of the Caribbean.

Technology Transfer. This involves selling the rights to drugs developed with public funds to countries directly, or to a body like the World Health Organization (WHO), rather than to pharmaceutical manufacturers. This already happens with vaccines for some major illnesses. Because the patents for these vaccines are held by WHO, the vaccines have been distributed at cost to developing countries. With respect to HIV/AIDS treatments, however, at this stage this is just an idea that is being discussed.

Debt Cancellation. Eliminating the debt of resource-poor countries would enable these countries to invest more resources in improving access to treatments, both by buying medicines and by improving health infrastructures.

Poor Health Infrastructure

In addition to the problem of unaffordable drugs, and the lack of clean water and adequate nutrition, some developing countries have inadequate health infrastructures for providing care and treatment. For example:

- There are too few clinics, hospital beds and laboratories. For example, the number of hospital beds per 1,000 population is 0.3 in Bangladesh and 1.6 in Botswana (compared to 4.0 in the United States and 8.7 in France)[5].
-
- There is a shortage of competent health care professionals. Medical facilities are often understaffed. For example, the number of doctors per 100,000 population is 16 in sub-

Saharan Africa and between 33 and 48 in South Asia (compared to between 200 and 300 in developed countries)[5]. For nurses, the disparities are similar.

- In the rural areas of Africa and Asia, where most people live, the proportion of doctors, nurses and hospital beds is even lower[5].
- There is often a lack of medical and laboratory equipment for doing diagnostic testing.
- Health care professionals and laboratory technicians are often not adequately trained.
- Drug distribution systems are often non-existent or incomplete.

For persons living with HIV/AIDS, these infrastructure problems have several repercussions:

- HIV cannot be properly diagnosed.
- Correct treatment cannot be properly prescribed.
- The best care cannot be provided.
- It can be difficult or impossible to access CD-4 and viral load diagnostic testing to measure how well the antiretroviral therapies are working and to monitor the emergence of drug resistance. Because HIV mutates rapidly, the virus can become resistant to the drugs. When that happens, patients need to change their mix of antiretroviral drugs. But these tests are very expensive and many laboratory technicians in the developing world lack the equipment and training to perform the tests.

As well, the lack of adequate food, clean water, and electricity for refrigerating drugs, can make it difficult for persons living with HIV/AIDS in developing countries to comply with their treatment regimens.

HIV/AIDS and Education

"That HIV/AIDS has not been adequately considered in… development thinking is perhaps not surprising… However, its grim reality is now becoming apparent. Not only does it mean that development goals will be unattainable, but in fact there may be a real reversal in the development status of many nations, and 'development' cannot be business as usual. Nowhere is this more the case than in the education sector…" (Peter Badcock-Walters and Alan Whiteside, HIV/AIDS and Development in the Education Sector, 1999)

Background

Education, from early childhood to adult education, is at the heart of development. It is critical for economic growth, is a primary means for societies to nurture and renew their cultural life, and has a major positive impact on public health and nutrition, especially for women and children. It concerns the development of that most valuable of resources: human capital. But it is also intrinsically valued as an end in itself, as a realization and expression of the human spirit.

The Development Assistance Committee of the OECD has set ambitious targets for progress in education and poverty reduction, to be achieved by 2015. Chief among these are:

- reducing the number of people living in extreme poverty by half
- provision of universal primary education in all countries

- promoting gender equality by eliminating gender disparities in primary and secondary education
- reducing mortality rates for infants and children under the age of five years by two thirds

These laudable objectives are unlikely to be met for one stark, insufficiently considered reason: HIV/AIDS. The epicentre of this human tragedy is Sub-Saharan Africa, but HIV/AIDS is fast making inroads in Asia and parts of Central Europe and Latin America.

Youth, Educators and Vulnerability

There is clear evidence that both young people and educators face special risks from HIV/AIDS. About a third of the world's HIV+ people are between the ages of 15 and 24-and every minute six young people under 25 become infected. Youth commonly lack basic information about how to protect themselves from infection. Young women and girls are particularly vulnerable and are less likely than boys to be informed about effective means of AIDS prevention. Recent surveys conducted in fifteen countries around the world found that 50% or more of girls aged 15 to 19 do not know that someone who looks healthy can be HIV+ and transmit the virus to others.

Various circumstances increase the risk for both students and educators. In many developing countries, there is much age mixing in schools, which tends to raise levels of sexual interaction among pupils. In addition, the age of sexual initiation seems to be falling in some countries. In Malawi, research suggests that half of primary school children are sexually active. At the same time, young people lack opportunities to learn about sexuality and reproductive health.

Students-especially girls-are vulnerable to sexual harassment and abuse. A Human Rights Watch report (March 2001) on sexual violence in South African schools documents an alarming incidence of rape and abuse experienced by girls at the hands of both teachers and fellow pupils. There is reason to believe that young girls are targeted for sexual aggression because they are perceived to be 'safe' or free from HIV infection.

Experience shows that occasional and regular patterns of migration or mobility can promote risk of HIV infection. In education, such patterns include:

- full-time boarding at schools and colleges
- temporary accommodation arrangements for trainee teachers when they are posted to schools without accommodation
- teachers who cannot be joined by their families because of a lack of teacher accommodation
- the necessity for rural teachers to travel long distances, and be away for long periods, to collect pay cheques
- the necessity for educators to attend training courses away from their families for weeks or months at a time

HIV/AIDS has the potential to affect:

- demand for education
- supply of education
- availability of resources for education

- potential clientele for education
- process of education
- content of education
- role of education
- organization of schools
- planning and management of the education system
- donor support for education

[drawn from M.J. Kelly: '*What HIV/AIDS Can Do to Education, and What Education Can Do to HIV/AIDS*', presented to the Sub-Saharan Africa Conference of Education for All, 2000: Johannesburg, 6-10 Dec 1999]

Demand for Education

HIV/AIDS is already having an impact on the numbers of school-age youth. In Zambia, Swaziland and Zimbabwe, the number of primary school-age children is expected to be more than 20% lower than pre-HIV/AIDS projections by 2010. In Kenya and Uganda, the figures are 12% to 13% lower. In families where parents are sick, children - especially girls - are being taken out of school to provide care or to make an economic contribution to declining household incomes.

The dramatic growth in the number of AIDS orphans (to almost 24 million in East and Southern Africa by 2010) will also affect demand for education. Orphans are particularly vulnerable to a vicious poverty cycle that is their inheritance from HIV/AIDS. Only 24% of Mozambican children who have lost parents to AIDS are attending school. Orphans and family members who take over the care of orphans often find the costs of schooling prohibitive. In the absence of breadwinners, many orphans may be forced into child labour to sustain themselves and their beleaguered households. Some may be forced into desperate survival strategies, such as engaging in sex work, that put them further at risk.

Young people, especially young women, are particularly at risk from HIV/AIDS. In Eastern and Southern Africa, about half of those who become HIV+ are between the ages of 15 and 24. At secondary and tertiary levels of education, illness among students will increasingly take its toll, adversely affecting attendance and enrolments.

Other factors that contribute to irregular attendance or decreased enrolments are:

- loss of family income from AIDS-related illness and death, as well as costs of care and funerals
- increased drop-out rates as young people are required to care for sick family members and to generate income
- damage to extended family and community structures and consequent loss of the traditional economic 'safety net'
- trauma arising from illness and death
- stigma and discrimination suffered by students as a result of their HIV status or HIV/AIDS in the family

- the perception that investment in education is not worthwhile, given the growing prospect of premature mortality

Supply and Quality of Education

The education sector is typically the largest employer of public service staff in developing countries. Among the most dramatic impacts of HIV/AIDS on the supply of education is the loss of trained teachers. UNICEF estimates that 860,000 children in Sub-Saharan Africa lost their teachers to AIDS in 1999. A recent sample survey in South Africa found that more than half of the deaths among members of the largest teachers union between August 1999 and May 2000 were AIDS-related.

In the worst affected countries, the AIDS-related decline in teacher supply is expected to outstrip the ability of training colleges to provide new qualified teachers. Student-to-teacher ratios and other quality indicators are likely to worsen significantly over time.

Patterns of HIV/AIDS impact among teachers are similar to those among other educational staff teacher trainers, college and university lecturers, education officers, inspectors, planners and managers, inevitably reducing the education system's overall capacity to match supply with demand.

The productivity of teachers is severely compromised by mounting AIDS-related illness. According to the World Bank, an average of six months of professional time is lost before a person develops full-blown AIDS. Other factors affecting education supply and quality include closure of classes and schools in areas affected by declining population and enrolments (in the Congo, schools have already closed after losing all of their teachers to AIDS). Dependence of remote schools on untrained teachers is increasing as qualified educators succumb to AIDS and move to be closer to mainly urban-based health facilities. Teacher attrition is being caused by the movement of educators to industry and other branches of government to replace skilled people lost to AIDS. The loss of experienced educators, as well as specialists in maths, science and technology, results in an ever-decreasing number of qualified staff. Another loss is that of institutional memory - as the teachers move away, so, too, does the history of the institution.

The Availability of Resources for Education

HIV/AIDS is likely to reduce financial resources available for education, in many cases reversing the hard-won gains in educational provision achieved over the past twenty years. Public funds re-allocated to health and welfare services will result in reduced public funding for education, and declines in growth and national income. Costs related to absenteeism, staff illness, and death and bereavement benefits will further reduce availability of funds. Families and communities will be unable to contribute - financially and otherwise - to education as they have done in the past, due to loss of income, diversion of resources and effort to AIDS care, incapacity of the ill and loss of family/community leaders. Costs for education are out of reach for a growing numbers of orphans - in Zambia alone, it is estimated that there are almost 1.7 million AIDS orphans, with 7% of the country's households already headed by children aged 14 or under. In addition, the return on investment for bursaries and student loans will slide as numbers of graduates drop and working lives are curtailed by sickness and mortality.

Potential Clientele

The potential clientele and beneficiaries of education will change as HIV/AIDS reshapes demographics. Rapid growth in numbers of orphans and the huge pressure that this will exert on extended families, communities and all public services will affect education at every level. Survival strategies of AIDS-devastated families will take many children out of school, due to inability to meet educational costs while the need for children to become full-time care givers or income earners will increase.

The Education Process

HIV/AIDS will fundamentally alter the education process in developing countries. Patterns of participation by learners and educators will be disrupted, characterized by sporadic 'dropping-in' and 'dropping-out', causing general destabilization of the system as it attempts to adjust to continuous upheaval. Fragile educational management structures may be pressed to the breaking point due to constant trauma from episodes of illness, death and grieving. Increased dependence on less qualified and younger staff will jeopardize any gains made, and low morale and anxiety among all education stakeholders, accompanied by lack of focus because of concerns about loved ones who are sick at home, will contribute to system fallout. Distrust between learners and teachers, as well as community hostility towards teachers, who may be blamed for the introduction and spread of HIV, will develop. A generalized climate of fear - with respect to people's HIV status, illness and death; to HIV-related discrimination and stigma; to sexual abuse and exploitation - will ensue, resulting in fear of the future.

Content of Education

Effective HIV/AIDS education will need to form part of the basics of education, as will education about overall sexual and reproductive health, including other sexually transmitted disease - the risk of HIV infection is increased by up to 40 times by the presence of another STD. Human rights education which addresses HIV/AIDS in the context of larger questions of social exclusion and inclusion - especially gender equity and empowerment - should also be a fundamental part of any program. Work-related training and skills that can better prepare those compelled to leave school early (AIDS orphans and others) to fend for themselves and their loved ones should be introduced into the curriculum at an earlier stage.

Role of Education

Counselling services and trauma support for students, educators and families will mean a change in the role of education. Educational institutions will need to become multi-purpose community centres for the provision of information and awareness about HIV/AIDS, and educators need to provide visible and vocal role models to highlight positive lifestyles and open up a transparent community dialogue on HIV/AIDS.

Organization of Schools

To deal with the HIV/AIDS challenge, the organization of education must take into account a number of emerging needs, including flexible timetables that accommodate the income-generating burdens that students will bear. Provisions should be made to ensure that schools are located closer to the homes of both students and teachers, and special provisions should be made for orphans and children from infected families, for whom normal school attendance is not an option. A learning continuum between classroom and home environments should be

established, so that families and communities (especially women who are on the frontline of the epidemic) can be empowered in the HIV/AIDS struggle. And new partnerships between the formal education sector and other sectors, including NGOs, should be established in order to achieve community impact.

Planning and Management

HIV/AIDS is a vital crosscutting issue to be figured into all aspects of planning and management. The whole education system must be marshalled into a coordinated strategy for HIV/AIDS prevention and management, backed up by strong political will. Losses of teaching staff, planners and managers to HIV/AIDS will necessitate capacity-building and human resource planning to maintain the system, which will need to plan for the additional provision of qualified graduates in priority HIV/AIDS fields such as health care. More flexibly qualified education graduates can fill the gaps left by colleagues lost to HIV/AIDS. Effective research, information and monitoring systems will be needed to understand the impact of HIV/AIDS on the system, and crisis management, responsive decision-making, and streamlined funding mechanisms will all be required. Educators, planners and managers need retraining - to reduce high-risk behaviour (including sexual exploitation in the educational environment), to overcome cultural resistance ('breaking the silence' on HIV/AIDS), and to achieve a culture shift that openly addresses the epidemic, sexuality and positive lifestyles.

Donor Support for Education

Donor contributions to effective and sustainable education systems in the developing world are threatened by HIV/AIDS. The epidemic may raise doubts and uncertainty about how and where to invest in education. Until recently, donors themselves have been slow to apprehend the gravity of the situation. The UN has estimated that between US$7 and US$10 billion is required globally for an effective response to HIV/AIDS. However, total aid flows for HIV/AIDS in 1998 were just over US$300 million.

Few donors have comprehensively reviewed their education sector cooperation in the light of HIV/AIDS. Until this happens, education sector goals for development assistance are will remain uninformed and unrealistic.

What Education Can Do to HIV/AIDS

In the short and medium term, education has the potential to:

- provide knowledge that will inform self-protection
- foster the development of a personally held, constructive value system
- inculcate skills that will facilitate self-protection
- promote behaviour that will lower infection risks
- enhance capacity to help others to protect themselves against risk

When infection has occurred, education has the potential to:

- strengthen the ability to cope with personal infection
- strengthen capacity to cope with family infection
- promote caring for those who are infected

- help young people affected by HIV to stand up for their human rights
- reduce stigma, silence, shame, discrimination

When AIDS has brought death, education has the potential to:

- assist in coping with grief and loss
- help in the reorganization of life after the death of family members
- support the assertion of personal rights

In the long term, education has the potential to:

- alleviate conditions such as poverty, inequality, ignorance, gender discrimination and social exclusion that facilitate the spread of HIV/AIDS
- reduce vulnerability to risky situations such as prostitution and over-dependence of women on men.

[drawn from M. J. Kelly: *'What HIV/AIDS Can Do to Education, and What Education Can Do to HIV/AIDS'*, presented to the Sub-Saharan Africa Conference of Education for All, 2000: Johannesburg, 6-10 Dec 1999]

An 'Education Vaccine' Against AIDS?

In the early stages of the HIV/AIDS epidemic, there appeared to be a high correlation between levels of education and prevalence of HIV - the better educated were more likely to become infected. Recent evidence suggests that this pattern may be changing. The virus is increasingly prevalent among the less educated, the illiterate and the poor, and may be declining among those with primary and post-primary education. This trend may in some measure be linked to initial AIDS awareness and prevention measures introduced in the education sector. Some observers are speaking with hope about an 'education vaccine' against AIDS.

This lends urgency to the goal of universal primary education - to equip the poor to protect themselves against HIV/AIDS. Although there is no question that HIV causes AIDS, there is also no question that poverty and unequal power relations (especially gender inequality) provide the fertile ground in which the virus grows. As education attacks these social conditions, it can have a powerful impact on HIV/AIDS.

Teaching Activities and Programmes

Effective HIV/AIDS, sexual health and sex education needs to be built into the curriculum at all levels of the system. This amounts to a revolutionary change in many countries where moral conservatism and cultural taboos are deeply entrenched. Such education needs to go beyond the basic biological facts to an open discussion about sexuality, relationships, values and choices.

To date, many HIV/AIDS and sex education efforts have been held back by the reluctance of educators to deal with sexual issues - a problem compounded by cultural resistance and a lack of adequate training in sex and HIV/AIDS education. Providing better training, information materials and preparation for educators is a major priority.

HIV/AIDS education programmes have, to date, been lacking in recognizing traditional and cultural beliefs that may identify witchcraft, evil spirits or offence to ancestors as causes of

AIDS. To succeed, education programs must incorporate sensitivity with respect to traditional belief systems in order to enlist the involvement of traditional leaders and healers.

Another barrier to effective HIV/AIDS education is the relatively early departure of many young people from the education system - in many countries the majority of students have left formal schooling by the age of 15. This suggests two things: the importance of starting sex and HIV/AIDS education at an early age; and the importance of programs targeting out-of-school youth and adults. In South Africa, an innovative national initiative, LoveLife, makes use of the arts, mass media, music and popular culture to reach large numbers of young people with positive messages about sexuality and HIV/AIDS prevention.

Some parents in developing countries are concerned that the introduction of sex education will lead to greater sexual activity among youth. UNAIDS studies around the world have found little evidence to support this concern. In fact, there is evidence that young people exposed to such education are more likely to be cautious.

Access to sex and HIV/AIDS education is ultimately a human right, vitally connected to universal rights to education and basic health. A human rights approach to development can be defined as ‘empowering people to take their own decisions about their own lives, rather than being the passive objects of choices made on their behalf’ (DFID, Human Rights for Poor People, 2000). It follows that young people and adult learners have a clear entitlement to education about HIV/AIDS, not only as a health issue but also as a development issue with huge human rights implications.

Because of the stigma and discrimination associated with HIV/AIDS - as well as associations with equality, rights to privacy, and the right to work - human rights education at all levels is required. Equally important are life skills programs that develop capacities for problem-solving, decision-making, critical thinking, self-esteem, relationship building, communications, confidence and responsibility. Because many youth and orphans need to generate income to support themselves and their AIDS-affected households, vocational training opportunities need to expand.

Life skills programmes have often had limited impact where they have been introduced in a ‘top down’ fashion, with inadequate consultation and poor teacher preparation. Emerging thinking stresses certain elements to strengthen life skills programs: the involvement of young people, families and communities in program design; participatory and experiential learning techniques, especially peer learning models; expanding collaboration with partners outside the system, including AIDS service organizations, NGOs, community-based organizations, and business. Life skills also need to draw on both modern youth culture and traditional cultures.

New approaches and financial resources are urgently needed by the growing AIDS orphan population, as is a rethinking of conventional, ‘formal’ educational methods in order to move towards more flexible, community based responses within a framework of life-long learning.

Teaching is being transformed by HIV/AIDS, with new tasks constantly emerging for educators in the fields of care, counselling and trauma support. The array of deprivations and special needs arising from HIV/AIDS ‘will challenge the education system to go beyond its traditional teaching role and develop capacity and systems to support the large numbers of children in crisis, and provide them with life and survival skills from relatively early ages’ (LoveLife, *The*

Impending Catastrophe: A Resource Book on the Emerging HIV/AIDS Epidemic in South, 2000).

Institutional, Planning and Management Interventions

Carol Coombe of the Centre for the Study of AIDS in Pretoria has proposed the following framework for protecting education in the face of the HIV/AIDS threat:

- stabilizing the education system (system self-preservation) to ensure that even under attack by the pandemic the system works so that teachers are teaching, children are enrolling and staying in school, managers are managing, and personnel, financial and professional development systems are performing adequately;
- mitigating the pandemic's potential and actual impact on the sector (counteracting the pandemic) to ensure that those affected and infected by the pandemic can work and learn in a caring environment which respects the human rights of all;
- responding creatively and flexibly to HIV/AIDS (outwitting the disease) to ensure that the system continues to provide meaningful, relevant educational services to learners in and out of school in complex and demanding circumstances.

Stabilizing the system requires that the potential consequences of HIV/AIDS are factored into education plans by ministries and their partners in the NGO and international sectors and that there are enough teachers to replace those who leave-especially those with expertise in teacher education, maths, science and technology. Supply teachers are required to cover for those who are regularly absent, and new teachers need to be trained in order to keep expansion and quality up. Support for those coping with trauma in the classroom is required, as are methods to replace management skills.

To mitigate the impact of HIV/AIDS, schools need to be safe, founded in a culture of care, meaning a zero tolerance policy for violence and rape to ensure that human rights are protected and nurtured.

A Foundation for Action

Advances in the educational struggle against HIV/AIDS must be supported by placing HIV/AIDS at the centre of educational agendas, policies, planning and management. Coherent strategies that can be shared must be developed-politicians, education officials and international agency staff must commit to this development. Research into HIV/AIDS with respect to education is also required, followed by critical analysis of information and performance. Partnerships between government departments, civil society organizations, religious groups, and businesses can serve to support advances in education, as can streamlined funding mechanisms so that resources are distributed effectively.

The Mobile Task Team on HIV and Education in South Africa has developed a ‘Rapid Appraisal Form’ to assist educators in assembling a baseline analysis of their own national or local situations as well as to identify indicators of progress on HIV/AIDS and education. UNAIDS is currently finalizing a global strategy framework on ‘HIV/AIDS, Schools and Education’ to inform and guide education planners, policy makers and task force teams.

YOUTH CHALLENGE INTERNATIONAL

The Role of International Agencies

International development agencies can play a critical role in the education arena by integrating HIV/AIDS into all planning and implementation of educational assistance and by entering into partnerships to support the educational response to HIV/AIDS. HIV/AIDS can be incorporated into agency-sponsored workshops and negotiations, and agencies can disseminate knowledge. Improving co-ordination among aid agencies, shoring up depleted human resources in the most affected countries and providing support to the HIV/AIDS network will assist in promoting a new international focus with respect to education.

Conclusion

One commentator on HIV/AIDS and Education has written movingly of 'the awe-inspiring silence' which surrounds the epidemic at the institutional, academic and personal levels. Many educators and institutions continue to carry on 'as if HIV/AIDS did not exist' (M J Kelly, *African Universities and HIV/AIDS*, 2000).

In a world transformed by HIV/AIDS, nothing can be business as usual. It is time to break the silence. In the words of Nelson Mandela at the Durban 2000 International AIDS Conference, 'The time for action is now, and right now.'

NOTE: The above few articles were taken from

http://www.icad-cisd.com/content/youth_connection.cfm?lang=e