

Invited Symposium: African Refugees: A case study of Kaliti, Ethiopia. Child and family study group, Cambridge University, March 29, 2000.

This paper presents information about a group of war-traumatized displaced Ethiopian adolescents living in a shelter in Addis Ababa, Ethiopia. The data is based on 18 months of ethnographic fieldwork with a group of Ethiopian students, and from administering standardized and non-standardized psychological tests.

Before being displaced, the adult male parents of the adolescents lived and worked for decades in Aseb the major port on the Red Sea, or Asmera the capital of what is now Eritrea. Their wives were native to these cities or to the villages near them. As families they owned homes, they produced children, sent them to schools, and took care of their health needs. They gave their children time and attention. They were able to do this because their incomes were relatively comfortable. In Ethiopian terms, they lived a middle class life.

In 1991, Aseb and Asmera fell which forced Ethiopian men and their children to leave. The women, considered Eritreans, were placed into a horrendous dilemma, and forced to make a nearly instantaneous decision. They could stay in Eritrea with their extended families, which meant saying good-bye to their husbands and children who were considered enemies in Eritrea, or they could join their husbands and children on the long uncharted march back to Ethiopia through the Danakil Depression. In the Danakil Depression there is no vegetation or water, and temperatures reach 140 degrees Fahrenheit in the shade. Natural hot springs produce steam that obliterates the view. Volcanic rocks spew hot fumes, producing a real life image of Dante's inferno.

The suddenness of having to leave was portrayed to us by Yosuf, who was then a child of eleven living with his family in an army barracks, now a typical adolescent in Kaliti. He recalled arriving home from school with a friend to see the barracks cordoned off by barbed wire. In spite of being able to see his parents, he and his friend were forced to board a lorry and leave without their families. The second night his friend collapsed. Yosuf held him in his lap, and listened to him calling out over and over again, "water, water, water." It was his first witness to death. The next morning he was forced to leave without knowing if his friend would be buried. Of the 100 people in his lorry, only 40 arrived alive. As he stepped off the lorry he recalls climbing between dead bodies of relatives and friends.

The journey was even worse than everyone feared. For those who walked, the important thing was to make progress. However slowly they moved, it was always necessary to move forward. After the early morning hours, the heat beat down, and the wind began to blow. Before the middle of the day the marchers shuffled, and suffered in silence. For many, their feet gave out and they tied cardboard on them so they could carry on. The sun would not relent. As they scanned the sky for relief planes, they kept walking. They tried not to look at the old, the infirm, or the small children whose parents could no longer carry them, because they knew they could not help them, nor watch their agony, nor

participate in their death. There was only energy for self-preservation. When they stopped at the end of the day, the bereaved tried to enlist the strongest to bury the dead. Most of the dead were not buried. Water finally was dropped from a helicopter. The parents sent their children to fetch it. Many of these survivors who are now in the later teens and early twenties know they survived when their younger siblings and grandparents did not, simply because they were stronger.

After the adolescents arrived in Addis Ababa in 1991 and 1992, they spent some months being “processed.” Then they were sent to Kaliti where they have remained ever since. One resident told us his assessment of the camp, “Look at this shelter. This is not a living place, but a graveyard. We are put in a graveyard while we are still alive (Feleke).” Our ethnographic record indicated that there were deaths not only among children and the elderly, but also among adolescent men and women. Many people, of all ages, died after long and chronic illnesses. There was little doubt that these illnesses were the result of opportunistic infections brought about by the HIV virus.

I will talk to today about these adolescents and their life in Kaliti, expressing both their sorrows and their resilient abilities to cope. The approximate size of Kaliti camp (including living areas, public play areas, the school room, the committee room, the two latrines, the stores, and all other communal areas) was about 4,125 square meters, or slightly less than an acre (4,840 square yards). Given the current population of 2,076, if the camp were one square mile there would be nearly a million people living in it. The density of living space (about one person per 3.18 meters) meant that if you took a step in any direction you would either meet another person or be forced to take a side step. (In fact, this was in excess of the population density of the Warsaw ghetto at its most crowded time [Goldhagen, 1996]).

THE ADOLESCENT STUDY

From the census we took we made a list of all the boys and girls ages twelve through twenty-five because these ages would include adolescents and youth. We were aware that this age span represented considerable differences in psychosocial maturity and in physical and cognitive development. We also knew that at the time of the march there were considerably developmental differences between the two groups.

There were 835 people in this age span, which constituted 40% of the total population of Kaliti. We randomly chose 108 participants (86 male, 40 female). The mean age was 17.7 years ($SD=8.41$). Examination of the percentages of the adolescents who experienced each type of trauma revealed that nine of ten lost property, seven of ten suffered from lack of water, and six of ten from lack of food. Nearly half were sick. Perhaps the most shocking result was that more than a third witnessed the death of a family member, and nearly a third felt that they were near death. A quarter of the sample was tortured.

GENDER DIFFERENCES

There were significant gender differences. The males showed a higher number of traumas as well as more intensity of trauma than the females. During the march, the enemy perceived the older boys as potential soldiers. Their peer groups were dispersed, and bonding between young men was discouraged, sometimes with violence. More than one in ten of our sample was imprisoned, but in every instance they were older males. Developmentally, at the very time the older boys needed their peer community, they were deprived of it.

Even after arriving in Kaliti the older males had more difficulties. At the end of the war 160 males were sent to Kaliti under a special program for unaccompanied children. When we first heard about them we were surprised that they were all male, particularly since we knew many females who were also without parents. While the benefits seemed in the boys' favor, being considered "orphans" actually worked adversely. The assistance (which they needed to survive) encouraged the boys to stay apart from the community and retain their special orphan status. This in fact was quite a low status because being without family was almost the same thing as being without an identity. The benefits also kept them from starting their own families, because if they did become adults they would have had to give up their financial resources they received as unaccompanied children. Yet, by prolonging their economic links to assistance, they had also to endure the personal cost of community isolation.

With no work to be had, and no secure future to contemplate, they could not but be influenced by their elders whose lack of hope (either because of their own trauma, or because there was no work to be had) spread a listless disappointment over every moment. In the tearoom these boys did not come to grips with the grim reality of having little opportunity outside of government whim, nor did they move to find a way past their impasse. They did not talk about their dead parents, or the sights and smells of their shared traumatic memories. Nor did they acknowledge what lay outside the tearoom where the latrines remain clogged, too many of the smaller children unschooled, and the elderly hungry and lonely.

The behavior of these young men was most conspicuous in what they did not do. They did not leave the tearooms to commence working on these problems. They did not begin an association for a common buying power in basic foods or medicines. They did nothing about the loan sharks that charged usurious rates to widows with children. In contrast, the behavior of the older girls was conspicuous in what they were doing. The girls found some work in the Food for Work program, either for themselves if they had children, or by substituting in the program for their mothers. They also eased the family burden by doing household chores and caring for relatives.

The girls were less troubled in part because they were less traumatized. This was not to say that the girls were without burdens, far from it. The burden was particularly heavy for the girls who had only their mothers at home and who had to take on a larger amount of family work. The difficulty was increased for those girls who had aspirations beyond those of the traditional female. For example, female adolescents who wanted to attend school were a financial burden to their families, who had to pay school fees, supply extra

clothes, and incur the indirect cost associated with the lack of possible income. Not unlike young females in other cultures, their hopes of bettering themselves increased their immediate problems, often in quite a painful way.

KALITI ADOLESCENTS

Ethiopian adolescents were no longer living as traditional Amhara and Tigrey. By 1990, a study conducted by the Ethiopian Ministry of Labor and Social Affairs (1991) found that in the urban areas of Ethiopia half the males and a fifth of the females experienced premarital sex. Abortion, which accounted for a third of maternal deaths in the country, was the highest cause of adolescent deaths (Hailemariam & Asrat, 1996). Suicide, often associated with parental-adolescent conflict, became common among urban adolescents (Wakbulcho, 1996). These facts were unheard of among traditional adolescents.

Many of today's adolescents and certainly the adolescents in Kaliti, as they eagerly told us, would not only choose their own marriage partners, but physical puberty would have little bearing on the age of marriage. Their choice was more likely to be determined by their ability to supply financial support to their children, and on love. The expectation - or at least the hope of those we talked with in Kaliti - was to avoid divorce, a distinct change from tradition.

Virginity in Kaliti was still considered important, but most of them said it was not nearly as important as in the traditional upbringing. And even having children out of wedlock did not prevent a young Kaliti woman from marrying, although it was problematic for her. While the women in the study were circumcised, only one planned to have her daughter circumcised. The Kaliti adolescents believed in Western science and medicine yet they also maintained their traditional beliefs. Kaliti adolescents wanted their children to be religious.

All of this was not to say that Kaliti adolescents (and modern Ethiopian adolescents) were not proud of their culture. They repeatedly expressed how proud they were of being Ethiopian, and showed this by many of their behaviors. They dressed traditionally for special occasions and they observed many religious ceremonies. They knew the traditional dances and songs (along with the modern Ethiopian ones). They maintained their devotion to the Ethiopian Orthodox Church, although there was a Protestant Christian movement that was capturing many adolescents in Ethiopia.

While the traditional religious belief among the parents placed all illness, particularly mental illness and more importantly AIDS in the religious context the adolescents had considerably different views. They knew that illness was more accurately explained by the principles of natural science, including the fact that one got infected by the HIV virus which came from sexual contact, and not by touching hands. Again, they straddled the fence, while knowing caused and incurable nature of being infected, they still had sufficient room in their beliefs to go to natural healers for traditional healing. (Although there were many types of traditional healers with different kinds of cures, beginning on the one hand in wearing religious amulets to engaging in trance ceremonies to purging

spirits and finally to consultation with medical doctors. As I will show they had both the knowledge, the desire, the opportunity due to their new found freedoms to intermingle and which were far beyond what their parents might even have been able to imagine, that they finally managed to live healthy and to enjoy themselves.

These adolescents were at the same time proud of their culture also had a stake in the international youth culture. Western sports heroes, Hollywood movie stars, and other media moguls were as apparent on the walls of the tents of Kaliti adolescents as they were in the bedrooms of adolescents living in the West. No matter how poor the Kaliti adolescents may have been, the T-shirts, hats, and shoes they wore shared the same logos as those of adolescents around the world. These international brands were as likely to be admired by the Kaliti adolescents as the adolescents in the Bronx or in Rome. Their hairstyles were more likely to be seen on Western television than among rural Ethiopians. Many Kaliti adolescents went to the local hotels to watch movies piped in with satellite dishes. The few words they might know in English could easily be found among the international culture.

In short, although the parents of this group were brought up in Amhara culture where they learned to respect their parents and to be obedient to all authority, they were still allowing their adolescent boys and girls to become part of the modern international adolescent culture. This helped the adolescents immensely. They maintained their Amharic tradition of respect for authority, particularly their parents.

When this was coupled by the willingness of the parents to let them go into the modern world, which consisted of encouraging their secular education, allowing them an easy entry into adult status, such as letting them be with one another the adolescents were able without much of the Western association of strum and drass live through a emotionally gratifying youth.

Importantly, the changes from tradition were also found among their parents. Kaliti parents encouraged education for both sexes. Instead of being encouraged to stay in same gender groups highly controlled by their parents, adolescents were allowed to interact with one another across gender lines. They also gave more freedom to adolescent women. Parents gave them the authority to actively respond to their changed circumstances.

To the extent that families allowed adolescents new freedoms they encouraged the development of an adolescent community. They did this by allowing young people the authority to actively respond to their circumstances. Adolescents were allowed to interact with one another across gender lines. This allowed the young people to open up to each other and made living in such a high density less of a burden than an opportunity. The adolescents brought to this a particular gratitude and understanding. They were able, as many of them said, to take some solace in comparing themselves to other Ethiopians so many of whom were as impoverished as they. They repeatedly said that in comparison to their parent's adolescence they had much to be thankful for.

NOTE MUST SHOW THE SHIFT IN RELIGION AND TRADITIONAL AND MODERN MEDICINE

So far I have illustrated life among the adolescents in Kaliti, in particular showing how they were considerably more modern than the adults. I also showed how community attitudes had shifted toward accepting the new behaviors of the adolescents. Now I turn to three cases which illustrate how these factors and of course the poverty and low social status of their lives changed the burden of being HIV infected. I will then draw my suggestion for mental health programs and policies.

CASE STUDIES

The following **three case studies** illustrate the important psychosocial context of HIV in the camp. They are presented from a diary taken over the time I was in the camp. Tshenish, an Amhara woman from Wello in her late thirties had been sick in bed for seven months before we met her. In stature she was a diminutive woman, but she had a liveliness of spirit, a gentleness of nature, and a directness of purpose that endured throughout our work with her. Each time I saw she insisted on my sitting on her mud bed. She would raise up to give me her hand, covering herself with a blanket that seemed older than the relics I had seen in the museums. Although I felt embarrassed to see her sunken breasts slide out from under her soiled robe, I thought about how attractive she must have been as her stick like arm pulled her robe back in modesty.

She told me that when she and her husband were forced to leave Asab, they had their own house, and even, she said proudly their own refrigerator. I knew she had worked as what they called in the camp, a “bar girl”, which meant that she served drinks and was friendly to foreigners coming into the port. Tshenish’s husband died of thirst as they made their way across the Danakil Depression. At first she said they had two adolescent children, but later she shared with me the more honest fact that she had only one. She exaggerated the number, because by having two instead of one she received more rations. This was her rent. Her adolescent girl was staying with relatives in Addis.

When I asked about her health she was clear and focused. Her medical problem began with hemorrhoids. Then according to her, her illness progressed to gynecological bleeding. She told me that medical care was a common concern for everyone in the camp. Displaced people got access to the public health system by first going to the Kabele and getting a letter certifying their inability to pay for medical care. Then they had to take the letter to the public clinic and wait in line to be served. The public health clinic was about 3 miles away. This was too far for her to walk, so she went to the clinic in a rented horse drawn cart (*Gari*) for a half a burr, which considering her income meant skipping a meal. Since she usually could afford to eat only one meal per day this was quite a sacrifice.

The health clinic would see only 10 people from Kaliti each day. When I asked what would happen if she went and they had already reached their quota she began to cry, saying that she would have to try again another day. Later I learned that children under the age of five, as well as pregnant mothers who wanted neonatal care, and all

emergencies were not included in the quota. This sounded considerably better, but in fact because Tshenish and the other chronically ill were not considered emergencies.

Recently a doctor at the clinic had written Tshenish a referral letter to see a specialist. Her only cost would be to pay for transport. Because she was so weak she would have to go with another person, which doubled the cost of transportation. But even if she had the money to get there seeing the doctor also meant catching the bus, which was a 15-minute walk. She would then have to ride for a half-hour on the bus, and quite possibly have to transfer to another bus. Between the cost and the difficulty she chose to remain in bed.

For her to see the specialist she would have to sell her monthly grain ration in advance. The "businessman" who would loan her the money against the collateral of her grain would ask for a 15% fee.

The lab report on Tshenish had come back, indicating she had cancer. I was not sure what kind of cancer it was, because the doctor did not tell her she had cancer or for that matter any details about her illness. We had faced this before, it was part of the way that physicians, and indeed friends and relatives dealt with bad information. We were told that only a Priest gave bad news, because bad health and other difficult circumstances were part of God's will.

When I asked others in the camp about informing Tshenish about her condition they said that telling her the truth would kill her. When Tshenish was at the doctor's she asked several times if she had AIDS and the doctor told her that she did not have. She asked me why after having lab tests and getting results she was not given medicine or surgery? The doctor told our colleague who accompanied her that it was too late for any care, but she didn't know it. As I was leaving her tent she said, "I can't return to my mother's stomach", meaning that she should be told the truth, she was too old to be protected from it.

Today I went to Kaliti and found that Tshenish was bleeding and it was impossible to stop the flow. Her hands and feet were beginning to swell. We went to find the local Priest to give Tshenish her last rites. She said she was too tired to talk. I asked one of the young men in the camp who was working with us to stop in and see her each day. He asked me what he should say to her. I said that he should just talk to her and be with her while she was in need. He did not have to choose or avoid any topic, these were my suggestions for counseling.

When I saw her today she was sleeping with her blanket over her head and the flies swarming around her. She woke up one more time, around 5PM, asking for water and a bit of food. Then she passed in her sleep. The Priest came to get her ready for the funeral and they buried her without a coffin near the local church. Her adolescent daughter, her only living relative, was not informed about her death, and had not been to the funeral.

Yodit was a dark skinned diminutive woman barely 21 years of age. She weighed no more than 80 pounds. She was married as a child, left by her husband, married again and gave birth. Then the second husband left, and she was alone with her baby who was quite ill.

The first time I saw her she was holding her infant baby who was completely covered with blankets held together by a soiled towel serving as a cradle. After we sat down she took off the piece of cloth that served as the baby's veil. I looked into the child's face, its eyes were bulging out from a nearly hairless head, its mouth grasping for milk that had not been forthcoming. Yodit took it to her breast. In its exasperation the child stiffened and wailed silently. Then she told us the doctor said her baby was fine except for being malnourished. This soothed Yodit into thinking that there was salvation for her child.

She accepted my offer to hold her baby, and I took it in my arms trying to comfort it. I could not hold this child for long without realizing how unlikely it was for it to survive.

The next day when I arrived in Kaliti I learned that Yodit's child had died. The bed where the baby had lain was now filled with mourners Yodit's sat on her bed without making much contact with those who sat across from her. At first, the tent was quiet and the lack of noise was peaceful. After a while the social atmosphere in Yodit's tent alternated changed from dead silence to forced hilarity. The came from slightly off color comments about the *ferenji* from the 20 or so women who were mourning or from the occasional young man or two who came in. One of the men was wearing a blue, gold and white sweat-shirt with the logo, "worlds greatest father". The dead child's father was not there, nor was he mentioned.

When I left the tent I noticed a group of red backed finches eating the coffee grounds that were thrown during the ceremony. Yodit against all protocol followed me out of the tent. She said she had been to the doctor who had reported to her that her chest x ray was inconclusive. She needed another one. X-rays for TB were free, but she didn't have the money to pay the transport. I gave her some.

Yodit told me that since her baby died her friends didn't like her anymore. She had supported herself and her baby, before it died on the 50 kilos of grain per month the Relief and Rehabilitation Committee gave her as a person too sick to participate in Food for Work. She thought she blamed her for the child's death. As time wore on I observed her talking and laughing with her friends, but at other times she only slept. She complained of not being able to stay asleep.

She had finished her TB injections and had started on the 6 months of pills. She was eating better and had lost her fever and cough. She was able to cook and was visiting and taking *chat* with her friends. She was ready to take her next TB check up. If the results were negative she planed to move in with her aunt in Addis at least for a couple of weeks, but the results were positive.

At the time she had plans to go back to Asmara where her mother lived if she could only be assured of getting her TB medicine and transport. She had food for work, but was too sick to do it, so she subleased it to an orphan, but between the two of them, it amounted to next to nothing. She was relying on her friends for food. How long could this go on for? Anyone without a family was at a terrific disadvantage, helping friends had its limits, they were on a much shorter tether than family members.

Later Yodit came into Mulu's tent and asked me if I remembered when I came into the camp with foreigners who took photos. One of them she said had taken a photo of her now dead, daughter. Could she get a copy? I told her I would most definitely try. Some days later I started taking photos of her but first she insisted on having one with me and her in it. We had our arms around each other so I could feel how small she was, certainly less than 85 pounds. The next photo I took, it was of her and her best friend, who had just had a baby. The third was of her with her group of friends. One was 22 years old and had a small child, another was 22 with a 7 year old child, who did not live with her, (she was being fostered in Addis). Then there was Yodit who was 20 and had one dead child. None of them had men in their lives.

A few months later I found Yodit in bed looking very bad. Her arms from the elbow down were flat, as if they were pieces of cardboard not flesh. The skin on her face was scaly and blotched, and her feet curled up under the covers so that from head to toe she was no more than a small replica of her former self. She complained of being hot.

I finally received the photos of Yodit and her deceased baby. I went by to give it to her. I had thought she would cry, but instead she kissed the photos and held them to her chest, as if they were the baby itself. In different circumstances she could well have been a Parisian model or a happily married young Tigrenya woman. I always reminded her that she was named after Yodit, the Jewish queen. We shared some tradition.

Ato Soloman a 21-year-old orphan lived alone in the back corner of a run down tent. I first saw him at the clinic where he was getting treatment for what he described as continual diarrhea. More than a month after that our teacher took me aside to let me know that he was talking of committing suicide, because he could not get better without the medicine and he could not get the medicine, because he had no money to buy it. When he was sick he was not able to get out of bed, could not eat food without throwing it up or even keep water down. He had diarrhea continually.

Soloman was tall and slender, and had what Ethiopians referred to as smooth hair. His eyes had a touch of green. He liked to talk, particularly about ideas, in fact about psychology and philosophy. He saw himself as an actor and art he said was the most important thing in his life. He was displaced without his family, all of whom save one sibling were dead.

He said he has been sick for three years, but that each time he took Bactrim he would get better, and then when he finished the course of the medicine he would get sick again.

(Later I learned that this was what many doctors in Addis gave to people who they thought were HIV positive). A couple of months ago, when I saw him at the clinic, he had just finished a course of medicine and indeed it did eliminate his vomiting and diarrhea. For a while he was doing better.

Each time he got sick he worried about what would happen to him, because he had no one to help him - no one to help him get food (literally bring it into his reach), or to prepare it for him, or to help him get up and to the latrine. There was not even anyone to hold his head, when he was too sick to lift it. He could not get the medicine that was prescribed because he had no money. He had already been to see a traditional healer but he was told to that if he wanted to be helped he would have to pay 100 birr, which of course was out of the question.

The next time I saw him he was in another bout of sickness. He had thrown up so much that he was having dry heaves. As I entered I saw him wrenching in pain. He said he was losing weight. Two days later Soloman was still in his bed, gagging and having dry heaves for the third consecutive day. The next day as I approached Soloman's tent, I could hear him heaving. Zewde the mother of his best friend Berekat came in with me. She went over to him and lifted his head up so he would be able to find the tin can, which lay by his side. To do she had to step over the garbage on the ground that surrounded his bed.

We had pleaded with him to get his free paper so he could go for emergency treatment, but he was not able to go because he had no family and no one offered to help him go the Kabele to get it. Finally we were able to arrange for him to get in to the hospital. The next time we saw him he was back from the hospital. He was in bed, but was much more animated. He even smiled at me. He showed me his chest x-ray, which he said was clean, and he also told me that the doctors kept telling him he did not have a physical problem. He looked at me straight in the eyes, asking me, what he could he do? I said it must be very frustrating for him to be sick and be told there was nothing wrong with him.

He said he had lost about what was equivalent to 20-25% of his weight and was getting weaker all the time. Two weeks later Soloman looked awful, once again he was sick in bed and not be able to get out. I found myself not even wanting to go into his tent, even though I felt bad about my feelings. He used the 50 birr I gave him, not to go to the hospital, but to buy food. We agreed to help him get to the doctor for a saliva test for TB. We both knew that he most likely had complications, probably AIDS, but no one talked about it. I didn't know what to do for him. He would have an episode and bounce back, but less after each episode, eventually he would fade into death.

Soloman teeth were now protruding from his sunken face. He lay on his bed, his rags over himself for covers, and the same gray jacket pulled up tight for warmth. I found myself not really wanting to be inside the tent, but not wanting not to go inside either. I compromised by leaning against the opening. Later I came by to tell him that I was going to bring a *ferenji* nurse who might be able to get him into the Alert hospital. I did not yet

bring up HIV testing. He indicated that he was glad, but he was too weak to talk. I told him to hold on, that God loved him, what I really wanted to say was that I loved him, but I was too embarrassed.

As we came up to Soloman's tent one of our colleagues warned us that no one was taking out his waste (meaning urine and feces). If Soloman couldn't do it, then it was family responsibility. I would have hoped that there was more civil responsibility and through the health committee this would have been taken care of. In fact they should also be turning him in his bed so he wouldn't get sore, seeing to it that he was warm, making sure he got enough water and had ORS.

Yesterday I went with an American nurse to talk to Soloman about taking him to the private clinic for an AIDS test. I had already talked to several of my colleagues in the about the fact that Soloman might have AIDS. The general sentiment among them was that it was OK for him to get a test, but that we should keep it at a very low profile, namely don't mention the word to him or pass it on to anyone else. Later when I went to talk to Soloman he said he wanted to go for the medical exam. He considered himself lucky to have the chance. While we talked the cockroaches roamed across him unaccosted

I went to Kaliti essentially to pick up Soloman and take him to the private clinic. He was dressed well, with a clean sweatshirt and a broad smile. It was nice to see him this way, like he had come back from the dead. When we got to the clinic he told the doctor that he had sex eight years ago, and not since. The doctor examined him on the table, and said, right off that maybe his problem was that he was starving.

Then he also ordered a chest x-ray, a sputum test, and other lab work, we were to return on Monday for the results. I kept on wishing that the other doctors were right that there was nothing wrong with him, and he only needed more to eat, time would tell. It was nice riding back to camp with him, because being filled with the energy he had between bouts of his illness he was able to talk about what he loved, Ethiopian theatre.

Yesterday we took Soloman back to the doctor. His lab test showed he had a bacterial infection in his lungs (pneumonia), anemia, and the doctor suspected TB, and finally HIV. He was treated for the bacteria infection with antibiotics, and given iron pills for his anemia, and we were told that in ten days time he would redo the blood and chest x-ray, and then we could decide what to do.

Soloman said he did not want to take the medicine anymore because he it was making him sick to his stomach. I told him and the camp students that he had to take the medicine and also eat because if he didn't everything we had done so far would go to waste. I was really trying my best to make his vital signs look better. It was the only way I knew that might forestall the inevitable.

Furthermore I told the camp students that since we (the program, me, even the American nurse) have given Soloman so much, that the rest of what he needed should come from the camp. I was continuing in my philosophy of mutuality, we give and then they give, etc., but I realized finally that this was not a blanket way to work. There were subtleties that the people knew more about than I. At some point they would have to adopt the wiser and to me very foreign strategy of letting him die so they could spend what resources they had on the healthy.

Soloman told me he had been getting food because Zewde had been loaning it to him. When he presented it that way I assumed that the loan meant that she was getting some interest, and that made me sick to my stomach. Zewde was the person I had worked most closely with, and had given so much to. When I talked to Zewde about it she said it was a loan without interest, in short a good deed. However since the grain was late they could not afford to loan him anything any longer. They had no reserve. I asked her to please give him food for 10 more days. Zewde said they could not do that. I was faced with the grim reality that having worked so long with Zewde I still could not get them to help Soloman. When the strings were drawn tight, they could only take care of their family and they would let the weak die.

Maybe I was asking too much. I wanted Soloman to have some protein, at least lentils or beans, yet this was beyond what most healthy people in the camp received. I was ready to settle for at least enough food for him to be able to keep his medicine down. I was even willing to come up with 90% of what he needed, but I kept for some at the time unknown reason that someone else would have to give 10%. I was ready to accept even 5%, and not being able to crack this problem, I was convinced that I had made no progress at all with the counseling, and that the very family I had given so much to was not willing to help him.

A few days later Zewde's father died, and there was a big funeral tent where many people were seated. Soloman was there leaning against a post. He said he had eaten. I didn't ask who fed him, but I looked into his face, and saw that his eyes were sharper and his face fuller than before. The taut tension of death was at least for the moment gone. I could not help but think that life imitated art.

We took Soloman to the clinic. The doctor said that his blood work was slightly improved, but still not good enough. The doctor recommended an AIDS test, and Soloman agreed.

The lab results from the Swedish clinic confirmed that Soloman was HIV positive. The next problem we had was to decide what to do with the results. Should we tell Soloman, should we advise him to keep the information under cover, or to share it with the friends, the community?

I talked briefly to my colleagues in the camp about Soloman. Some said that I should not tell him the results of the test, because it would be bad for him, and also because people

in the camp would avoid him if they knew he was HIV positive. They said they were aware about how the disease was transmitted and they were not afraid of touching him, but they were sure that the people in the camp would not touch him, not even talk to him if they knew he had AIDS. I was not sure if they were right, maybe Solomon could be better served by telling others about his condition. He could help the camp by telling people of his status.

However, since I was on the verge of leaving I was in a bind. I did not want to tell Solomon about the results and then leave, nor did I want to not tell him, or give the results to someone else to tell him before I left.

On the day of my departure ceremony the dancers performed and thanked me for my help. I visited Solomon several times throughout the day. He reported to me that the doctor had taken him alone into his room, and told him he was HIV positive. He had told Berakat that he was HIV positive. He was very weak and yet because I asked him to come to the dance ceremony he came, and was able to stay long enough to have his photo taken with me. He left for his tent. A few minutes later I saw him vomiting by the large empty oil container near the school. He said he only suffered from the fear of being alone, he could endure the pain. I felt awful that at the moment he knew about his HIV status, I was so close to leaving. He tried to cry repeatedly but never really broke down into tears. We held hands, and he said that he had not had sex in six years, and what bad luck this was, and I agreed, and this was the end of my last day's work in Kaliti.

THE RETURN VISITS

I went back to Kaliti twice after I left from my initial assignment. The first time was for a short visit after about six months. As soon as I entered Kaliti for the first time after I had left, I passed a tent where a post funeral ceremony was in full swing. It was a celebration of the 40th day after death and thus the end (or the end of the first phase) of mourning. As I entered the tent everyone greeted me with great friendship and warmth. One man told me that everything in Kaliti was OK. "we are like any community, some die, some are born". As I continued throughout the camp I was sadly impressed with the numbers of sick, many had the typical signs of wasting.

I was told that Yodit died just a week or so ago. I was struck by sadness for not able to see her before she passed. Within a few minutes I was told that that Solomon died. I learned that Solomon had pleaded with Berhane (one of my co-workers) to kill him, all he needed he said was a single injection. He had no family what did it matter? He ended up dying alone, not only without anyone's help, but shunned because people knew that he had AIDS.

I was reminded of Plato. In his book the Republic he wrote that the family was an obstacle to the well being of the community and the citizenry of a nation. Plato contended that the major reason why the Roman Empire fell was that families worked toward providing for their own at the expense of the being equally concern for those outside of the family network. Citizenship was squelched by family loyalty, which drew off the

energy to create the larger good, the common concern of being a member of the greater community. Plato contended, as was the case in Kaliti, that caring for one's family came first, even it was at the expense of the broader welfare of the community. This worked not only against Solomon's well being, but also adversely for the orphans, and whoever did not have family support.

Plato was not alone in this belief, Kant agreed. He felt that moral training would have to follow universal concerns (such as doing onto others what you wanted others to do to you), and family values were much more parochial. Under family morality children learned that family would only provide them safety, thus reducing the wider value of citizenship.

CONCLUSION:

In Kaliti I found a group of adolescents who, in spite of being highly traumatized, did their best to be successful in school. They worked to bring in income for themselves and their family. They suffered without becoming self-destructive or violent toward others. Their mental health was consistent with how we defined the camp - that it was very poor, but not so poor relative to other impoverished Ethiopians. Therefore the poverty was not as psychologically traumatic to them as it might have first appeared.

What separated the resilient from the psychopathological among the adolescents was that the resilient ones were able to take advantage of the perspective of their unique circumstances. They actively helped out with the chronically ill, a term I have used that was no more than an aphorism for people with AIDS and its related opportunistic infections. They found in their assistance to these people a degree of self-respect that was not otherwise available to them.

Other studies have found that providing care to terminally ill patients was not only a depressing and difficult psychological process, it also brought with it positive mental health (Folkman, 1997). The caregivers in caring for and coming to terms with the grim reality of their loved ones, actually found they were also maturing and finding their own meaning in life. As Frankl (1963) pointed out among holocaust survivors adequate mental health (even in relative terms) came to those who were able to create some redeeming value from the loss that was so omnipresent.

As studies of the Rwandan genocide survivors (Geltman & Stover, 1997) showed how adolescents ultimately come to terms with their experience depends less on traditional mental health services based on trying to help individuals talk through their trauma but on the community's ability to offer assistance. Among orphans traumatized by war and famine it was found that what accounted for the well being of the survivors was not individual counseling, but the care they received from the group (Wolff, et al., 1995). In the case of Kaliti it was the community's openness in allowing a nontraditional life style among the adolescents that allowed them to do as well as they did.

What we have seen in Kaliti has led me to believe that we in the West might over-rate the importance of family while at the same time ignore many moderating variables such as the importance of community in dealing with helping poor people survive chronic illnesses. Coming into a new understanding of this would we hope shift resources from family (including families of women and children) to community structures. We would place more concern on places like the tea-rooms where men flounder and to the problems of health care, not so much toward the lack of sufficient care but to the demise of humanistic care.

ADDONS

Nesibu and SIM

Nesibu's client, Getachew, smooth hair, skin problem, wife left him with 2 year old toddler, now six years old (NOTE LATER TO GET SCABIES, WHILE HE WAS DYING IN FILTH)