

Federal Democratic Republic of Ethiopia

**Report on Progress Towards Implementation of the  
Declaration of Commitment on HIV/AIDS**

Reporting Period: January 2003-December 2005

**HAPCO  
February 2006  
Addis Ababa  
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## Acronyms

<b>AAC</b>	- Anti-AIDS Clubs
<b>AIDS</b>	- Acquired Immune Deficiency Syndrome
<b>ANC</b>	- Antenatal Clinic
<b>ART</b>	- Antiretroviral Treatment
<b>ARD</b>	- Antiretroviral Drugs
<b>BCC</b>	- Behavioral Change Communication
<b>BSS</b>	- Behavioral Surveillance Survey
<b>CBOs</b>	- Community Based Organizations
<b>CSO</b>	- Civil Society Organizations
<b>CDC</b>	- Center for Disease Control
<b>CRIS</b>	- Country Response Information System
<b>CSWs</b>	- Commercial Sex Workers
<b>DHS</b>	- Demographic and Health Survey
<b>DoC</b>	- Declaration of Commitment
<b>DPCD</b>	- Disease Prevention and Control Department
<b>EC</b>	- Ethiopian Calendar
<b>EFY</b>	- Ethiopian Fiscal Year
<b>EMSAP</b>	- Ethiopian Multi-Sectoral HIV/AIDS Prevention and Control Project
<b>ERCS</b>	- Ethiopian Red Cross Society
<b>FBOs</b>	- Faith Based Organizations
<b>FDRE</b>	- Federal Democratic Republic of Ethiopia
<b>FP/RH</b>	- Family Planning/Reproductive Health
<b>GoE</b>	- Government of Ethiopia
<b>HAPCO</b>	- HIV/AIDS Prevention and Control Office
<b>HBC</b>	- Home Based Care
<b>HCs</b>	- Health Centers
<b>HEWs</b>	- Health Extension Workers
<b>HIV</b>	- Human Immuno Deficiency Virus
<b>HSDP</b>	- Health Sector Development Program
<b>IDA</b>	- International Development Association
<b>Idir</b>	- Community Based Traditional Self-help group
<b>IEC</b>	- Information, Education and Communication
<b>MOA</b>	- Ministry of Agriculture
<b>MDGs</b>	- Millennium Development Goals
<b>MOD</b>	- Ministry of Defense
<b>M&amp;E</b>	- Monitoring and Evaluation

<b>MOE</b>	- Ministry of Education
<b>MOFED</b>	- Ministry of Finance and Economic Development
<b>MOJ</b>	- Ministry of Justice
<b>MOH</b>	- Ministry of Health
<b>MOLSA</b>	- Ministry of Labor and Social Affairs
<b>MOYCS</b>	- Ministry of Youth, Culture and Sport
<b>MTCT</b>	- Mother to Child Transmission
<b>NAC</b>	- National AIDS Council
<b>NGOs</b>	- Non Governmental Organizations
<b>NSF</b>	- National Strategic Framework
<b>OIs</b>	- Opportunistic Infections
<b>OVC</b>	- Orphan and Vulnerable Children
<b>PLWHA</b>	- Persons Living with HIV/AIDS
<b>PMTCT</b>	- Prevention of Mother to Child Transmission
<b>RACs</b>	- Regional AIDS Councils
<b>REBs</b>	- Regional Education Bureaus
<b>RHAPCOs</b>	- Regional HIV/AIDS Prevention and Control Office
<b>RHBs</b>	- Regional Health Bureaus
<b>SPM</b>	- Strategic Plan for Management
<b>STIs</b>	- Sexually Transmitted Infections
<b>TB</b>	- Tuberculosis
<b>UN</b>	- United Nation
<b>UNAIDS</b>	- United Nation Joint Program on HIV/AIDS
<b>UNICEF</b>	- United Nations Children's Emergency Fund
<b>UP</b>	- Universal Precaution
<b>USAID</b>	- United States Agency for International Development
<b>VCT</b>	- Voluntary Counseling and Testing
<b>WHO</b>	- World Health Organization

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We would, therefore, like to express our gratitude to these organizations, in particular to UNAIDS/E, the concerned staff of HAPCO especially the members of the M&E Task Force for their active participation and contribution to the preparation of the report.

## 1. STATUS AT A GLANCE

### ETHIOPIA'S UNGASS REPORT, 2006

#### 1.1 UNGASS CORE INDICATORS

GE	INDICATORS	PERCENTAGE		
		Public and Private Schools		All Schools (N=30)
GE:3	Percentage of schools with teacher/s trained in life-skills based HIV/AIDS education	Secondary (N=22)	Primary (N=8)	80
		60	20	
GE:4	Percentage of large enterprises or companies which have HIV/AIDS work policies and programmers	<b>Public</b> 33		<b>Private</b> 33
GE:5	Percent of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counseled	Indicator data not available. No. of STIs treated in 2005 is 40,718		
GE:6	Percent of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT	3.03		
GE:7	Percent of women and men with advanced HIV infection receiving antiretroviral combination therapy	7.2		
GE:8	Percent of orphans and vulnerable children whose households received free basic external support in caring for the child	<b>Male</b> 4		<b>Female</b> 3
GE:9	Percent of transfused blood units screened for HIV	100		
GE:10	Percent of young men and women aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	<b>Male</b> 30		<b>Female</b> 19
GE:11	Female and Male Median age at first sex-age group 15-24	<b>Male</b> 22.9		<b>Female</b> 19.2
GE:12	Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partners in the last 12 months	<b>Male</b> 37.44		<b>Female</b> 5.86
GE:13	Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	<b>Male</b> 46.71		<b>Female</b> 29.58
GE:14	Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	1.05		
GE:15	Percent of young women and men aged 15-24 who are HIV infected* (Unadjusted Prevalence)	<b>Capital</b>	<b>Other Urban</b>	<b>Rural</b>
		13.35	8.64	2.85
GE:16	Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	89.54		
GE:17	Percentage of infants born to HIV infected mothers who are infected	25.7		

## **1.2 Status of the HIV/AIDS Epidemic in Ethiopia**

Ethiopia is among the first countries hard hit by the HIV/AIDS pandemic. Since the first two reported AIDS cases in 1986, the disease has spread at an alarming rate throughout the country.

The establishment and gradual expansion of HIV sentinel surveillance sites towards the rural areas made it possible to keep track of trends in the spread of the disease. The recent “AIDS in Ethiopia – Fifth Report” issued by the Federal Ministry of Health in June 2004; is based on Antenatal Clinic Surveillance data from 1989-2003, and data reported by health institutions on suspected AIDS cases, voluntary blood donors, VCT clients, immigration visa applicants and TB patients.

According to the Fifth Report of “AIDS in Ethiopia”, the number of people living with HIV/AIDS in 2003 constituted 1.5 million and of these 817,000 were women, and 96,000 children under 15. The national adult HIV prevalence in 2003 was estimated to be 4.4% of which 12.6 is urban and 2.6% rural.

According to the 2005 projection in the Fifth Report of FMOH, the HIV national adult prevalence rate is estimated to be 4.7% of which 12.5% are urban and 3.0% rural. The cumulative number of people living with HIV/AIDS is about 1.7 million out of which about 286,200 are AIDS cases that will be in need of ART.

The 2003 HIV prevalence is higher among women (5%) than men (3.8%), and is higher in urban than in the rural population. In the 15-24 age group the HIV prevalence is 8.6% (unadjusted for urban/rural population sizes). Thus the highest HIV prevalence still occurs in this age group.

As per the Fifth Report (June 2004), by mid-2003 the cumulative number of AIDS cases in the country was estimated at 147,000. The estimated number of new AIDS cases in the adult population constituted 98,000 (46% male and 54% female) and in children 25,000. Some 90,000 adults and 25,000 children had died of AIDS in 2003. It is estimated that during the same year AIDS had orphaned around 539,000 children.

The estimated number of people living with HIV/AIDS (PLHA) in need of combined ARV treatment has increased from about 245,000 in 2003 to 265,000 in 2004 and 286,200 in 2005.

It is estimated that in 2003 there were 197,000 new infections in the adult population and 35,000 in children under 15. In the same year, a total of 128,000 pregnant women and an estimated 35,000 new born were living with HIV/AIDS.

The prevailing mode of HIV transmission remains heterosexual, accounting for about 87% of all infections in the country. About 10% new infections occur as a result of mother-to-child transmission.

In 2003, the adult HIV incidence was 1.82% in urban areas, 0.46% in rural areas and 0.68% for the nation. In general there seems to be a genuine and significant decline in the rate of new infections between the years 1991-97 in the last 5-7 years in urban and 3-5 years in rural areas respectively. This is also corroborated by the consistency of some of the service based prevalence data and their trend analysis over the years. ("AIDS in Ethiopia, Fifth Report, June 2004).

*In conclusion it can be stated that the national HIV incidence rate in Ethiopia is leveling off and the rate at which it is progressing is declining over the last few years, and the epidemic appears to be stabilizing particularly in urban areas, indicating some behavioral change in the population*

Demonstrated increase in the awareness of the disease, substantial increase in distribution of condoms from less than one million in 1996 to about 66 million in 2002 and 71 million in 2004/05, and significant increase in voluntary and premarital HIV testing support the observation that some degree of behavioral change has occurred in the community resulting in the observed decrease of HIV incidence.

However, despite the modest progress made so far, there are still a number of underlying factors that contribute to the spread of HIV/AIDS in Ethiopia. These include poverty, illiteracy, stigma and discrimination of those infected and affected by HIV/AIDS, high rate of unemployment, widespread commercial sex work, gender disparity, population movements including rural to urban migration and harmful cultural and traditional practices.

### **1.3 Response to the HIV/AIDS Epidemic in Ethiopia**

The response to the AIDS epidemic in Ethiopia is a collective effort of the government, multilateral and bilateral donors, national and international non-governmental organizations, community-based organizations, faith-based organizations, the private sector, associations of PLHA and individuals.

In 2000-2004, the National Policy on HIV/AIDS (1998) and the Strategic Framework for the National Response to HIV/AIDS (2001-2005) guided the national response to the epidemic. The overall objective of the Policy and Strategic Framework was to guide the implementation of successful programs to prevent the spread of the disease, decrease vulnerability of individuals and communities to HIV/AIDS, to care for those living with HIV/AIDS and to reduce the adverse socio-economic consequences of the epidemic.

The response to the epidemic was designed to address both the direct causes as well as the underlying factors influencing the course of the epidemic.

In 2002/03 it can be stated that a multi-sectoral implementing mechanism has been firmly put in place from the national to the grassroots level.

An important development that took place in 2005 concerns the launching of the Strategic Plan. On the 24<sup>th</sup> of January 2005, the Federal Democratic Republic of Ethiopia (FDRE) launched the Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response (2004-2008), along with the Free Anti-Retroviral Treatment Program and a number of documents strategically important for the Strategic Plan implementation, namely: Social Mobilization Strategic Document; Anti-Retroviral Therapy Implementation Guidelines; and the report “AIDS in Ethiopia – Fifth Edition”. The new SPM builds upon achievements made so far, and takes into consideration lessons learned through the implementation to date of the response to HIV/AIDS in Ethiopia.

The Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response (2004-2008), is based on guiding principles such as: multi-sectoralism, empowerment, shared sense of urgency, gender sensitivity, involvement of PLHA, result oriented interventions and best use of resources in terms of allocation, harmonization, efficiency and accountability.

Capacity building, community mobilization and empowerment, integration with health programs, leadership and mainstreaming, coordination and networking and targeted response constitute the *Six Strategic Issues* that make the core of the Strategic Plan and Management (SPM).

The new SPM assigns a new and bigger role for the health sector. New arrangements for coordination of the response to HIV/AIDS have been introduced. Under the new arrangements, Federal Ministry of Health will spearhead the leadership of the National Response to HIV/AIDS. Federal level HAPCO and Regional HAPCO will be directly accountable to Federal Ministry of Health and Regional Health Bureaus respectively.

HAPCO will be limited to national and regional level, to focusing on coordination, resource mobilization and multi-sectoral monitoring and evaluation (M&E). Regional HAPCOs will coordinate interventions at zonal, woreda and kebele levels through the health infrastructure at these levels without opening separate offices. Zonal and woreda health offices and health extension agents at kebele level will directly coordinate and implement the multi-sectoral HIV/AIDS response at their respective levels.

Strategic priorities of the response include prevention, PMTCT, treatment and care. As part of the HIV prevention efforts a number of innovative approaches have been adopted. These include:

- Establishment of AIDS resource centers;
- Implementation of a Health Extension Program;
- Expansion of PMTCT; and
- Establishing resource centers for youth and youth clubs

Among these, the Health Extension Program launched by the MOH in 2003 deserves particular attention. The program represents an innovative community-based approach directed at creating healthy environment as well as healthful living by introducing a health extension service delivery and quality of care sub-system. Two female health extension workers will be trained and assigned to a health post providing outreach services to households in their respective rural kebeles. Addressing HIV/AIDS issues makes a significant component of the health extension workers' responsibilities. It is planned to train about 25,000 health extension workers over the five-year program period and place them in about 12,500 rural kebeles. The first batch of 2800 Health Extension Workers (HEWs) has been trained in the four large regions (Amhara, Oromia, SNNPR and Tigray) and has started work in the respective kebeles. 7190 HEWs will be placed at kebeles by December 2005, bringing the total number deployed in January 2006, to 9990.

Several independent performance reviews of various interventions have been carried out in Ethiopia during the reporting period. According to the reviews and consultations, the major achievements as related to the response to HIV/AIDS include:

- An increased level of awareness and positive trends in behavioral change;
- An increased demand for voluntary counseling and testing (VCT);
- An increased trend in condom distribution and utilization;
- Integration and expansion of VCT;
- Initiation of prevention of mother-to-child transmission (PMTCT) and anti-retroviral (ARV) services;
- Positive trends in openness, and reduction of stigma and discrimination; and
- Encouraging trends in involvement of PLHA in the response.

Compared to the magnitude of the epidemic the achievements gained so far are very modest and the national response still faces serious challenges. As identified in the Ethiopian Strategic Plan (2004-2008), the challenges affecting the full implementation of the SPM include the following: -

- Consensus around the new implementation arrangement i.e. the spearheading role of the MOH and the coordinating functions of HAPCO;
- Resource availability and absorption/utilization capacity;
- Addressing the growing service demand and sustainability;
- Rapid expansion of the epidemic to the rural areas; and
- Adequate number of qualified and committed manpower at all levels but mainly at regional and woreda level.

The successful implementation of the Strategic Plan (2004-2008) will depend to a large extent on the continued commitment of the government, active participation of stakeholders at all levels and direct involvement and ownership of the community.

## 2. Overview of the HIV/AIDS Epidemic in Ethiopia

### 2.1 Introduction

The Declaration of Commitment on HIV/AIDS adopted by 189 member states in 2001 provides for careful monitoring of progress in implementing the agreed-on commitments, and requires member states to report on progress achieved using a list of core national-level indicators.

This report has been prepared in the spirit of the declaration to assess the current state of the national response to HIV/AIDS in Ethiopia and monitor progress in the implementation of the Declaration of Commitment.

The main sources of data for this section are the “AIDS in Ethiopia – Fifth Report”, issued by the FMOH in June 2004, the DHS preliminary results, the Welfare Monitoring Survey-2004 and programmatic routing report. The report is based on ANC surveillance data from 1989-2003 and data reported by institutions on suspected AIDS cases, voluntary blood donors, VCT clients, immigration visa applicants, and TB patients. This time a few impact studies have also been reported in the Fifth Edition. The estimates mentioned hereafter have been derived from the 2003 ANC-based National Sentinel Surveillance (NSS) findings. Furthermore, these estimates are derived from a larger database i.e. 29 rural and 37 urban sites compared to the 6 rural and 28 urban sites in 2001. Estimates of the number of patients requiring anti-retroviral treatment, as well as HIV positive mothers and new born have been included for the first time.

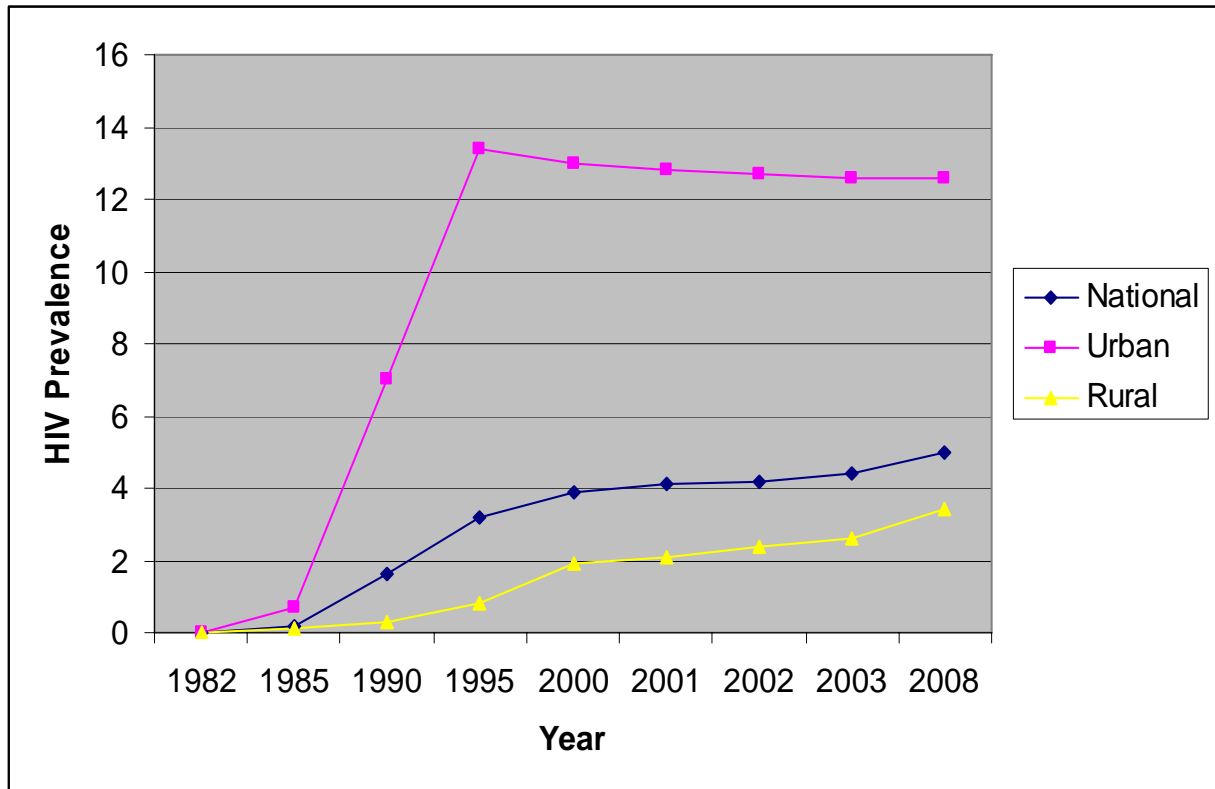
### 2.2 ANC-Based HIV Prevalence

Ethiopia is among the first countries hard hit by the HIV/AIDS pandemic. According to the Fifth Edition of “AIDS in Ethiopia” series issued by the FMOH in June 2004, the national adult HIV prevalence in 2003 is estimated to be 4.4% of which 12.6% is urban and 2.6% rural<sup>1</sup>. According to the 2005 projection, the HIV national adult prevalence rate is estimated to be 4.7% of which 12.5% are urban and 3.0% rural. The cumulative number of PLHA is 1.7 million out of which more than 286,200 are AIDS cases in need of ART.

The trend of the HIV epidemic from 1982-2003 suggests three key points: a continuing gradual rise in national prevalence (3.2% for 1995, 4.1% for 2001, 4.2% for 2002 and 4.4% for 2003); an urban epidemic that has peaked and plateaued at high prevalence levels; and a very gradual but steady rise in HIV prevalence in rural Ethiopia<sup>2</sup> as shown in the following graph.

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1. FMOH, DPCD – “AIDS in Ethiopia – Fifth Report”, June 2004, Page 7.
  2. Ibid, page 7.

**Fig. 1 Estimated and Projected HIV Prevalence, 1982-2008, among Adults 15 Years and Above) Population, Urban, Rural and National**



**Source:** - “AIDS in Ethiopia, Fifth Report”, June 2004, Page 8

The 2003 HIV prevalence is higher among women (5%) than men (3.8%), and is higher in the urban (12.6%) than in the rural population (2.6%).

The 2003 estimate of PLHA is 1.5 million and out of these 96,000 are children under 15 years. Younger females who are living with HIV/AIDS outnumber males, while more males are observed in older age groups (i.e. 30 years and above).

HIV prevalence in the 15-24 age group is 8.6% (unadjusted for urban/rural population sizes). HIV prevalence in the rural areas increases steadily, with consistent decrease in the rate of progression.

The establishment of HIV sentinel surveillance sites made it possible to keep track of the trends in the spread of HIV/AIDS. According to the ANC based surveillance findings a total of 23,861 samples were collected from 66 sites (37 urban and 29 rural) in 2003. HIV prevalence varied across sites from 0.5% to 30.2%. 12,206 specimens were collected from urban ANC sites and HIV prevalence ranged from 2.2% to 30.2%, whereas a total of 11,926 specimens were collected from 29 rural ANC sites and the

observed HIV prevalence ranged from 0.5% to 11.9%. In rural Ethiopia as well as in the rest of the country, HIV prevalence was more pronounced in the younger age groups (15-30 years). Among 23,861 samples collected from 66 ANC sites in 2003, the crude prevalence level was observed to be 8.2%.

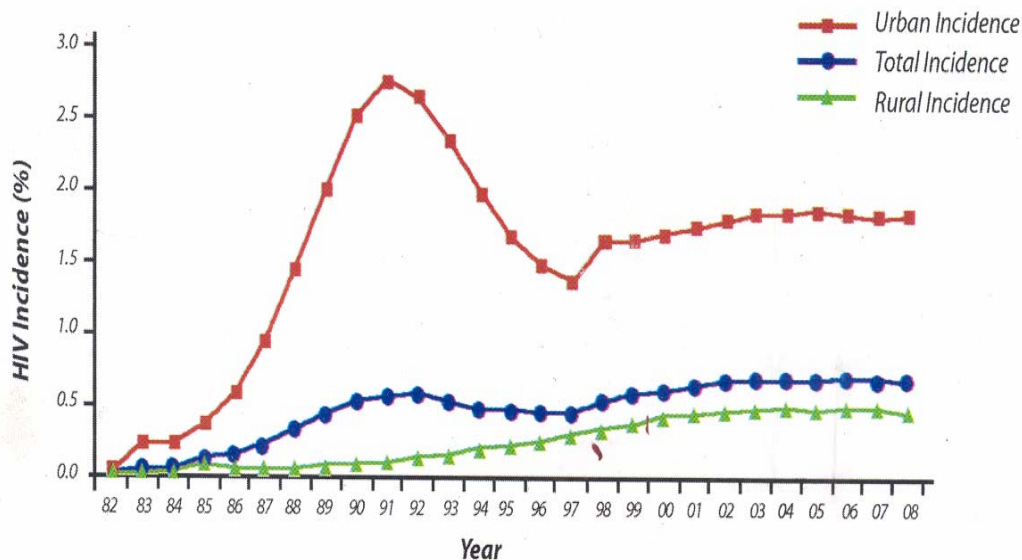
As per the “AIDS in Ethiopia, Fifth Edition” (June 2004) the cumulative number of AIDS cases in the country by mid 2003 was estimated at 147,000. It is estimated that there were 197,000 new infections, 98,000 new AIDS cases (46% male and 54% female) and 90,000 AIDS deaths in the adult population in 2003. AIDS accounts for an estimated 30% of all young adult deaths and is expected to bring about a significant reduction in life expectancy. In the same year, a total of 128,000 pregnant women and an estimated 35,000 new born were living with the virus. Among children aged 0-14 years, there were 35,000 new HIV infections, 25,000 new AIDS cases and 25,000 AIDS deaths. A total of 4.6 million children under 17 are estimated to be orphans for various reasons, of which 539,000 were orphaned due to AIDS.

The prevailing mode of HIV transmission remains heterosexual, accounting for about 87% of all infections in the country. About 10% new infections occur as a result of mother-to-child transmission.

### 2.3 Estimated Adult HIV Incidence

The rate of new infections in percent (i.e. new infections per 100 uninfected adults per year) is shown in the following incidence graph.

Figure 4.2. Estimated HIV Incidence by Year, 1982-2008



**Source:** FMOH, DPCD – “AIDS in Ethiopia – Fifth Report”, June 2004.

The adult HIV incidence for 2003 was 1.82% for the urban areas, 0.46% for the rural areas and 0.68 for the nation. The level of the projected adult HIV incidence for 2005 is by and large the same as in 2003.

Urban incidence rose sharply until 1990/91, declined over the next five years and has since reached a plateau. Rural incidence rose slowly until 2002 and seems to have leveled off at lower rates than the urban incidence. National incidence parallels the rural rate except for a pronounced rise in the late 1980s and early 1990s due to the sharp rise in incidence in urban Ethiopia.

The current adjusted national estimate as well as the estimated number of PLHA is lower compared to previous estimates for the country. These differences may be attributable to various factors: first, a significant increase in the number of surveillance sites in rural Ethiopia; second, a change in the software used to analyze surveillance data (EP: Model to EPP); third, all regional and national estimates are self-weighted by their relative urban/rural population sizes (i.e. big regions are given more weight than smaller ones); and fourth, the impact of the various intervention programs. The current estimations using EPP may also have been affected by the urban bias of the previous raw data, which may tend to increase the error margin.

Trend analysis on HIV prevalence showed that the urban epidemic has leveled off at high prevalence in the past few years, whereas the rural epidemic shows a gradual increase with reduced rate of progression.

In general there seems to be a genuine and significant decline in the rate of new infection between years 1991-97 in urban areas and the rate of progression of the epidemic in the urban and rural areas in the last 5-7 and 3-5 years, respectively. This is also corroborated by the consistency of some of the service based prevalence data and their trend analysis over the years.

In conclusion, the national HIV incidence rate in Ethiopia is leveling off and the rate at which it is progressing is declining over the last few years and the epidemic appears to stabilize, particularly in urban areas, indicating some behavioral change in the population.

#### **2.4 HIV/AIDS Impacts as seen in Surveys and Reports**

Rural Ethiopians and women are bearing the brunt of the disease and its impact. There are no recent studies on the impact of HIV/AIDS. However, a few surveys and reports are referred to in the Fifth Edition of "AIDS in Ethiopia". The study conducted by the FDRE Ministry of Education in 2003 indicated that between 1998/99 and 2000/01, there was a 5% increase in death among teachers – some of which might be attributed to AIDS. Absenteeism of one week out of a semester was reported among a third of the teachers due to sickness of the teacher or members of his/her family. Overall, school drop out rates increased from 1996/97 to 2000/01 – possibly due to sickness and death of parents. The same study found that orphan students who lost their parents presumably due to

AIDS and associated disease were more likely to drop out of school and repeat classes than their non-orphan counterparts.

Education costs are increasing due to the replacement of non-productive teachers and premature payment for terminal benefits. These factors are expected to contribute adversely to the overall cost and quality of educational services, but cannot be directly and solely attributed to the impact of HIV/AIDS.

According to a 2003 study conducted by the Ministry of Labor and Social Affairs, AIDS orphans unable to sustain their own livelihood are expelled from their parental residences following the deaths of their parents. Most AIDS orphans live with poor relatives with low educational backgrounds, who are often unable to provide for the physical, educational and health needs of the child.

A report issued in 2003 by the TB & Leprosy Prevention and Control Team of the MOH listed the following major problems attributable to co-infection:

- Increase in the number of TB patients,
- Low cure rate of TB patients,
- High mortality during treatment,
- High rate of adverse drug reactions leading to a high number of defaulters,
- High rate of TB recurrence, and
- Increase of TB drug resistance.

A study conducted by the Employers Federation of Ethiopia in 2002 showed that the impact of HIV/AIDS is most severe in the wholesale and retail trade followed by the manufacturing, agriculture and public service sectors. Reduced productivity, shortages of skilled manpower, increased mortality in the work force, increased absenteeism and rising medical costs were found to be the major effects in the industrial sector.

In view of the large number of people requiring treatment, care and support both for the infected as well as the affected, the epidemic poses a great threat to the overall development efforts of the country. Moreover the degree of impact could be much higher in Ethiopia than other Sub-Saharan African countries due to the large population size and the level of poverty of the population.

### **3. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC IN ETHIOPIA**

The response to the AIDS epidemic in Ethiopia represents the collective efforts of the government, multilateral and bilateral donors, international and local NGOs, association of PLHA, FBOs, CBOs, the private sector, civil society organizations as well as individuals. Effective national response began in the year 2000 after the Government recognized the serious threat posed by the epidemic and the need for a multi-sectoral response to control the spread of HIV/AIDS and mitigate its impact. As a follow-up to this, the response of the government was as follows.

#### **3.1 Government Response**

##### **Amount of National Funds Spent by the Government of Ethiopia on HIV/AIDS**

Federal and Regional Governments (State Governments) have allocated budgets for their activities against HIV/AIDS. By the year 2002/03 all of the eleven regional offices had been equipped and supported with operational fund, and 190 woredas and 4602 kebeles with an estimated population of 21.3 million were covered with EMSAP funds. By 2004/05 GF has covered the remaining woredas in all regions.

Available data in the Annual Reports of HAPCO show that the amount of fund disbursed by HAPCO to implementing bodies has steadily increased during the reporting period. For example, it was Birr 68.9 million (USD 8.1) in 2002/03, Birr 198.4 million (USD 23.3) in 2003/04 and Birr 471.6 (USD 55.5) in 2004/05. The increase in 2004/05 is mainly due to the availability of Global Fund Resources. Out of the total disbursement, the proportion of funds used for procurement of drugs and medical supplies was 74.3% in 2002/03, 41.6% in 2003/04 and 28% in 2004/05. The GoE has put a policy of exempting from tax all items related to HIV/AIDS and in 2003-2004/05 the Government has provided for the HIV/AIDS response a sum of two million USD from its capital budget as a matching fund to IDA credit (MAP-I).

In addition to the allocation from the capital budget, it also supports all costs for education sector (on life skill education) and the health sector (e.g. free hospital beds).

For the period 2004/2005, the total expenditure on HIV/AIDS was US \$ 18.9 million from public sources, 73.2 million from bilateral sources and 16.2 million from the Global Fund (for details see Annexes).

## Strategic Plan

In 1985, the GoE established a National Task Force on HIV within the Ministry of Health. Two Medium Term Prevention and Control plans were designed and implemented between 1987 and 1996. However, the impact of the interventions was low as compared to the extent of the epidemic.

With the HIV/AIDS situation worsening, the government responded by issuing a National HIV/AIDS Policy in August 1998. The Policy has the overall objective of providing an enabling environment for a multi-sectoral approach for the prevention and control of the epidemic. At the same time, the Ministry of Health coordinated a process of strategic planning and program development in nine regions and two city administrations. The result was a five-year Federal Level Multi-Sectoral HIV/AIDS Strategic Plan 2000-2004 (costed at US\$ 11 million) and accompanying Regional Multi-Sectoral HIV/AIDS Strategic Plans 2000-2004 (Costed at USD 45 million). Together, these plans were synthesized (1999) into the strategic framework for the National Response to HIV/AIDS in Ethiopia for 2001-2005.

The National AIDS Prevention and Control Council was then established in April 2000. The Council appointed a National HIV/AIDS Board of Advisors to oversee the plan. A National AIDS Council (NAC) Secretariat was established in 2000 and this evolved to the current HIV/AIDS Prevention and Control Office (HAPCO), which were established

in June 2002 to coordinate and facilitate implementation activities. The National Strategic Framework and Plan was updated and developed for 2001-2005.

One of the other major Government responses was the launching of the World Bank supported Ethiopian Multi-Sectoral HIV/AIDS Project (EMSAP, August 2000), which is a multi-sectoral and multi-dimensional HIV and AIDS prevention and control program focusing on mobilizing the overall society against the epidemic.

In addition to the Government's responses to the HIV and AIDS epidemic, multilateral and bilateral agencies, NGOs, FBOs, the business communities, the CSOs, the CBOs and the international community have been responding in different ways. Currently there are about 183 identified actors that are engaged in HIV/AIDS interventions. This includes HAPCO, 11 regional secretariats, 14 line ministries, 36 government agencies, 9 UN agencies, 7 bilateral donors, 49 international and 55 indigenous NGOs.<sup>3</sup>

After thorough analysis of the limitations, the Ethiopian strategic plan for intensifying multi-sectoral HIV/AIDS response, (2004-2008), December 2004 identified the following six strategic issues:

- Capacity building,
- Community mobilization and empowerment,
- Integration with health programs,
- Leadership and mainstreaming,
- Coordination and networking, and
- Targeted response.

Budgetary need for the implementation of the SPM is estimated to be around 6 billion Ethiopian Birr which is equivalent to US\$ 7705.9 million

Under the new implementation arrangement of the national response, at the federal level HAPCO will be directly accountable to MOH and the RHAPCOs will be accountable to their respective RHBs.

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3.Hailu Meche – Updated Strategic Framework for the National Response to HIV/AIDS, 2004-2005, Addis Ababa, September 2003.

Zonal and woreda health offices and the health extension agents at kebele level will directly coordinate and implement the multi-sectoral HIV/AIDS response at their respective level.

The guiding principles of the SPM are: -

- Multi-sectoralism,
- Empowerment,
- Shared sense of urgency,

- Gender sensitivity,
- Involvement of PLHA,
- Result oriented interventions, and
- Best use of resources.

The health policy coupled with the recent major development of the decentralization of health governance to the woredas and kebeles, and the focus on the health extension program as a major mode of implementation of preventive and promotive health policy at household level, provides an outstanding chance to combat new infections and mitigate the impact of the disease. This approach will create an excellent opportunity and capacity for integration of HIV/AIDS response in health programs at the grass roots level and ensure sustainability.

Universal coverage by the health extension program, coupled with capacity building from primary to tertiary levels, can ensure effectiveness and sustainability of the programs in the fight against HIV/AIDS (HAPCO/FMOH – Ethiopia Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response, December 2004).

### **Coordination Mechanisms**

During 2002/03 the following Fora have been established:

- NGOs Forum.
- GO Forum.
- Donors' Forum.

The National Partnership Forum against HIV/AIDS, which is intended to serve as a Platform for all of the stakeholder's fora has been formed and is playing an effective role.

In 2004/05 Network of PLHA Associations, representative of Institutions of Higher Education, Coalition of Women Against HIV/AIDS, Youth Network and Media sub-forum have been registered as members of the National Partnership Forum against HIV/AIDS.

Thus overall coordination of the multi-sectoral response has been strengthened using the National Partnership Forum and the various sub-fora against HIV/AIDS.

In 2004/05 in order to provide free ARV treatment in an integrated manner and thereby avoid wastage and duplication of effort, a coordinating Task force has been formed; chaired jointly by FMOH and HAPCO and comprising of staff representing WHO, UNAIDS, CDC, USAID, DACA, Oromia Health Bureau, Addis Ababa Health Bureau and Network of Associations of PLHA.

The Task Force has set-up sub-committees coordinating ART, VCT, PTMCT, M&E and laboratory services and is effectively coordinating the tasks in an integrated manner.

Several guidelines and manuals on different intervention areas and policy-related issues have been developed and made operational. These include the following: -

- Guidelines on VCT
- Guidelines on PMTCT
- Guidelines on home based care and support
- Policy on ARD
- Framework for M&E
- Revised project appraisal guideline
- Mainstreaming HIV/AIDS in Government institutions
- National strategy on blood supply and
- The national framework for communication

In order to effectively institutionalize the multi-sectoral AIDS control strategy, AIDS control focal units have been established in all major government sectors, CSOs, associations of PLHA, FBOs, the ERCS, the private sector, international partners and professional associations. HIV/AIDS task forces/focal persons are already set in the 28 federal government agencies and 125 regional government bureaus. They are enabled to promote workplace interventions and advocate for mainstreaming HIV/AIDS in their respective institution.

To sum up, significant progress has been made since 2003 towards reaching many of the 2003 targets regarding policy development as outlined in the Declaration of Commitment. Such developments include:

- Ethiopia has developed and implemented a national multi-sectoral AIDS strategy and the strategy has been revised and updated.
- National multi-sectoral Strategic Plans have been developed and revised to incorporate current developments.
- HIV/AIDS has been integrated into the country's general development plan (the HIV/AIDS component of the second phase of the SDPRP has been prepared).
- A functional national multi-sectoral HIV/AIDS coordination body exists in the form of HAPCO. Multiple coordination roles are assumed by other bodies such as the National Partnership Forum and various Sub-Fora, the Coordination Task Force, (coordinating ART, VCT, PMTCT, M&E and laboratory services), and the Country Coordinating Mechanism (CCM for Global Fund). Coordination at Regional and Woreda (district) levels is undertaken by the Regional HAPCOs and Woreda Health Offices.
- The impact of HIV/AIDS on the socio-economic status of the country had been evaluated.
- Ethiopia has a strategy that addresses HIV/AIDS issues among its uniformed services (including armed forces and police).

The above description of the government response is based on data extracted from the annual reports of HAPCO for the period EFY 2002/03 to 2004/05; available UNGASS core indicators for generalized epidemics and the national composite policy index questionnaire completed by the relevant organizations as per the guidelines on construction of core indicators for 2006 reporting.

## Community Response

NGOs, FBOs, CBOs, professional associations and the private sector are actively involved in the multi-sectoral activities.

CBOs like Idirs, Women's and Youth Associations, Anti-AIDS Clubs are intensively engaged in prevention and care and support activities. Associations of PLHA are actively engaged in care and support, IEC and advocacy tasks. Professional associations like the Ethiopian Public Health Association, Ethiopian Medical Association, Teachers and Journalists Association and others are playing significant roles. The Ethiopian Public Health Association has undertaken an assessment on the scope of the training interventions undertaken by different actors working on HIV/AIDS.

## Donors Response

A number of multilateral, bilateral and private external support agencies have responded by supporting AIDS-related activities in the country. They have provided financial and technical assistance to governmental and non-governmental organizations, religious groups and community-based organizations.

### **3.2 Prevention**

Major priority areas for intervention identified by the NSF include IEC/BCC, condom promotion and distribution, VCT, PMTCT, control of STIs, blood safety, universal precaution, legal and human rights related to PLHA, research and surveillance and care and support. Some of the main activities performed during the reporting period include the following:

#### **3.2.1 IEC/BCC**

Throughout the reporting period different agencies have sponsored drama, short messages and panel discussions and shared best experiences which were transmitted to the public in different languages using electronic and print media at both national and local levels. In 2002/03 there were 8360 Anti-AIDS Clubs (7600 in primary and junior high school, 360 in high schools and 400 out-of-school).

These clubs have been engaged in mass media campaigns, school-based AIDS education and peer education programs, which aim to bring about changes in knowledge and behavior that reduce the risk of HIV exposure and infection. They have also provided home-based care and other edutainment services.

Based on the encouraging results registered in three pilot woredas, community conversations involving different sectors of the community were undertaken in 121 rural and urban woredas in nine regions. Changes in behavior have been observed after these conversations. Topics discussed include: necessity of testing for HIV before marriage,

abolition of early marriage, necessity of care and support for orphans and PLHA and elimination of harmful cultural and traditional practices like rape, female genital mutilation and abduction etc.

AIDS Resource Centers are being built in all regions. The Oromia AIDS Resource Center is completed and has started to provide service. An AIDS Resource Center has been established in Addis Ababa with technical and financial support of John Hopkins University. The center offers services such as reading, Internet, printing and distribution of posters, brochures etc. Over 100 users (mostly young people) browse the Internet daily.

Youth centers are being built in each region in collaboration with the Ministry of Culture and Sports.

A comprehensive strategy for IEC is an essential element in HIV prevention. Ethiopia has a general policy and strategy to promote IEC on HIV/AIDS and a national communication framework has been endorsed in 2002.

Reproductive and sexual health education for young people is addressed in the NSF. There is an on-going attempt to develop a policy to promote reproductive and sexual health education for young people.

The NSF and the National HIV/AIDS Communication Framework have identified groups with high or increasing rates of HIV infection such as youth, mobile populations, sex workers, and refugees.

Ethiopia does not have a policy or strategy that promotes IEC and other health interventions for cross-border migrants.

### **3.2.2 Condom Promotion and Distribution**

Ethiopia has adopted a strategy to expand access including among vulnerable groups, to essential preventive commodities, which include, but are not limited to, condoms, sterile needles and HIV tests.

Significant improvements have been observed in the supply and distribution of condoms. DKT is the leading NGO engaged in social marketing of condoms. DKT distributed 41.8 million condoms in 1999, 49.9 million in 2000, and 57.7 million in 2001/02. Recent data indicate the distribution of 67.6 million in 2002/03, 49 million in 2003/04 and 71 million in 2004/05 (source: DKT, Equatorial Business Group and MOD). The lower figure for 2003/04 is due to absence of data on condom distribution in the uniformed services during 2003/04.

Government owned health facilities have played a significant role in condom promotion and served as important outlets for distribution. Encouraging results have been registered among government agencies in making condoms available at work places.

Training on condom use was given to 894 persons in 2003/04; while in 2004/05 218 various condom promotion messages were transmitted on TV, radio and other media (source: HAPCO Annual Reports).

### **3.2.3 Voluntary Counseling and Testing (VCT)**

The total number of VCT centers reached 170 in 2002/03. In 2003/04 107 new centers were established and the total reached 277, whereas in 2004/05 248 new VCT centers started functioning and the total number of VCT centers in the country reached 525. The number of VCT centers in 2005 is 658. During 2004/05, 41,387 clients got VCT services, while in 2005 the number of clients who received VCT services rose to 367,006.

200 laboratory technicians and counselors were trained by HAPCO in 2002/03, while 384 counselors were trained in 2003/04, and 75 Lab. Technicians and 130 counselors were trained in 2005.

VCT services are not yet properly linked with care and support programs and much still remains to improve the quality of the service. As the epidemic is spreading to the rural areas, it is essential to introduce and expand VCT services to the rural population including the pastoralists.

### **3.2.4 Prevention of Mother-to-Child Transmission (PMTCT)**

In collaboration with HAPCO and other stakeholders, the FMOH has developed PMTCT Policy and Guidelines (2002).

The following have been performed during the reporting period:

- The National Plan for the expansion of PMTCT has been developed and officially launched.
- The PMTCT Manual and Guideline have been finalized, included in the policy and use of ARDs, and made operational.
- Relevant training has been provided to core professional staff.
- Essential kits and medical supplies have been procured and distributed. The PMTCT program, which was jointly sponsored by HAPCO, UNICEF and the FMOH, has been launched in the first four selected sites, namely: Gondar, Jimma, Dilla and Dire Dawa.
- The PMTCT Guideline has been revised in 2005 and is ready for printing.

The 12 PMTCT centers in 2002/03 grew to 37 in 2003/04 and to 72 by 2004/05. 12 centers were strengthened in 2003/04. 134 health workers were trained by NIGAT and CRDA in 2003/04.

In 2004/05, the total number of mothers who got the service amounted to 47,890, whereas in 2005 the total number of PMTCT clients amounted to 130,230.

PMTCT activities have been constrained by factors, such as the limited availability of antenatal care and maternal health services, limited access to VCT services which by and large are not yet integrated with ANC and PMTCT services, in adequate care and support services for the mother and families living with the virus and difficulty of maintaining alternative infant feeding options.

### **3.2.5 Control of Sexually Transmitted Infections (STI)**

The national coverage of services to control STIs is very low (only 14%). The service is provided by the existing health delivery facilities of both government and non-government organizations.

During 2002/03, the Guideline for Syndromic Management of STIs was finalized. In 2005, the Guideline for Syndromic management has been revised and is ready for printing. Training was provided to concerned health workers and drugs procured and distributed to health facilities. In 2003/04, the report from six regions showed that training was given to 597 health workers. However, drugs were procured and distributed to health facilities both in 2003/04 and 2004/05.

A total of 75,386 cases of STIs got treated in 2004/05 including in private health facilities. In comparison the number of STI patients who were diagnosed, treated and counseled in 2005 amounted to 40,718. The lower number of STI cases could be due to underreporting.

### **3.2.6 Blood Safety**

The Ethiopian Red Cross Society (ERCS) is the only source of safe blood supply in the country. The Red Cross has set in place a system of screening blood in all of its outlets and hospitals that are engaged in providing the service. During 2002/03, eleven blood banks have been established and strengthened as planned. The National Blood Service Strategy has been finalized and made operational.

In 2003/04 five blood banks have been strengthened and one has been established. Four health workers have been trained during the year.

In 2004/05, two blood banks are being established through the support of the World Bank, while through the support of the US Government blood banks are being built in four hospitals, and strengthened in four other hospitals. Training on blood safety is being given to health workers.

The ERCS has not yet incorporated VCT in its services. The number of blood units screened for HIV in the last 12 months of 2005 was 27,117.

### **3.2.7 Universal Precaution (UP) / Infection Prevention (IP)**

Training on UP has been given for front line health workers and home care givers. According to the Report from four Regions, out of the planned 3035 persons, only 86 frontline health workers and home care providers were trained in 2003/04. 116 different categories of health personnel were trained in IP in 2005.

Home care providers have been assisted with protective materials and sanitary equipment, by NGOs and other implementing agencies. Many NGOs, Youth and Anti-AIDS Clubs have played important roles in disseminating information on the importance of UP. However, the level of public awareness on UP is still low.

### **3.2.8 Legal and Human Rights Related to PLHA**

There are no separate laws and regulations that protect PLHA against discrimination. Since 2002/03 the task force coordinated by the Ministry of Justice has been reviewing existing laws with a view to preparing legislation against stigma and discrimination related to PLHA. The task force has continued to review existing laws and regulations in 2003/04.

Ethiopia does not have laws and regulations that protect against discrimination of groups of people identified as being especially vulnerable to HIV/AIDS discrimination such as sex workers, youth, prison inmates, and mobile populations. Similarly, the country has a mechanism in place to ensure equal access, for men and women, to prevention and care with emphasis on vulnerable populations.

In 2002/03 intensive advocacies, against stigma and discrimination, have been carried out at all levels. Panel discussions and awareness raising workshops on stigma and discrimination have been conducted at schools, workplaces and for CBOs. The media have played a significant role in the fight waged against stigma and discrimination. Religious leaders, community leaders and PLHA have come out strongly against stigma and discrimination. In 2003/04 198 persons have been trained on legal and human rights related to PLHA and 2050 have participated in awareness raising workshops.

### **3.2.9 Research and Surveillance**

In 2002/03 a number of surveys and periodic sentinel surveillance have been conducted and useful data and information have been generated. The First Round of BSS had been completed and disseminated and data collection for the second round BSS has been completed. The MOH increased the number of urban and rural sentinel sites from 15 to 34 and produced the 4<sup>th</sup> sentinel National Report in October 2002. The findings of the MOH surveillance are still the basis for measuring the status and the trends of the HIV epidemiological situation in the country.

The 5<sup>th</sup> Report of the MOH on the 2003 sentinel surveillance findings came out in June 2004. Other surveillance activities supported by USAID, CDC and other agencies have been undertaken in 2003. NGOs and other actors have also carried out KAP studies. The 6<sup>th</sup> Report of the FMOH will be available for users very soon.

The EHNRI with the support from EMSAP has undertaken basic research on the development of vaccine and related issues. The Medical Faculty of Addis Ababa University undertook the NIGAT project on PMTCT. Research protocols in general are reviewed and approved by the Science and Technology Commission.

However, research still remains as one of the intervention areas that have not been addressed sufficiently.

### **3.3 Care/Treatment and Support**

Comprehensive care includes, psychosocial care, access to medicines and home and community-based care.

#### **3.3.1 Home-Based Care (HBC)**

Community-based home care services have expanded in 2002/03. HBC Guideline has been developed and home care providers have been trained. An estimated 50,000 PLHA in EMSAP covered woredas have been provided with welfare support (food, medication, clothing, shelter and psychosocial counseling). Local and international NGOs, PLHA associations, AACs, community organizations (e.g. Idir) have participated actively in providing HBC and support services.

#### **3.3.2 Antiretroviral Treatment (ART)**

Following intensive advocacy campaign from associations of PLHA and other organizations, and in appreciation of the gravity of the problem, the government adopted the policy of ARV drug supply and use in July 2003, paving the way for more initiatives towards facilitating access to free and low cost ARV drugs.

Other significant related actions of the government include the development of key technical tools such as the national guidelines on the use of ARV drugs, PMTCT, ARV procurement and distribution, VCT, management of OIs, Isoniazid Prophylactic Therapy (IPT) and Cotrimoxazole Prophylactic Therapy (CPT) and the adoption of Integrated Management of Adult and Adolescent Illnesses (IMAI) Guidelines for Ethiopia (FMOH – Road Map for 2004-2006, Page 8.).

In 2003 the National Guidelines on ARV was developed, and training of health care providers started. A total of 690 physicians, nurses, pharmacists and laboratory technicians from 58 centers were trained in ART. In 2003/04 22,681 mothers were counseled and 955 mothers and 665 babies received NVP.

During the last two years, there have been notable efforts to build the capacity of the health system and health professionals to support scale-up of HIV service.

ART was started in 2002/03. In 2002/03 the number of PLHA on ART was 3000 while in 2003/04 there were 9000 PLHA on ART. There were 9400 patients on ART up to the end of EFY 1996 (2003/04). In 2004/05 there were 11,820 new patients on ART making a total of 21,220 on ART (Annual Report of HAPCO for 2004/05). This is way behind the annual target of 41,000 new patients on ART by the end of 2005. The strategic objective is to achieve the annual targets of 41,000 and 50,000 new patients on ART by the end of 2005 and 2006 respectively (see Road Map – Page 6).

Since 2004/05 forty-two hospitals around the country are currently providing fee based ART services to approximately 13,500 patients at a monthly cost ranging between 300 and 700 Birr (about USD 35-82), depending on the regimen used, and free ARV drugs to about 2000 patients (FMOH/DPCD Accelerating Access to HIV/AIDS Treatment in Ethiopia – Road Map for 2004-2006).

In a move to make ARV treatment more accessible, the Ethiopian Government launched the free ARV treatment initiative on 24 January 2005, thus materializing its commitment towards the Global 3 by 5 initiatives that aims at having 3 million people in developing and middle income countries on treatment by end of 2005. At the same time, other essential documents were developed to further clarify how the implementation of the ART program will be achieved. Following the publication of the “Guideline for Implementation of Anti-Retroviral Therapy in Ethiopia” in January 2005, the “Accelerated Access to HIV/AIDS Treatment in Ethiopia; Road Map 2004-2006” was the next important document published by the FMOH.

This document reflects the national target and therefore includes all sources of ART in the country; fee-based ART through private hospitals and government pharmacies, free ART through Global Fund, and PEPFAR, AIDS funds initiatives in the public and private sector and lastly through private initiatives from partners like NGOs and FBOs.

It has been observed that the care and support services whether institutional or home based are far below the actual demand.

Ethiopia has a strategy that promotes comprehensive HIV/AIDS care and support with emphasis on vulnerable groups. The country also has a strategy that ensures access to HIV/AIDS-related medicines. For example PMTCT and drugs for TB are provided free of charge. On the other hand, there is no policy that addresses the needs of orphans and other vulnerable children.

### **3.4 Knowledge and Behavior Change**

Increasing number of PLHA are coming out public and sharing their experiences through the media and public gatherings. During 2002/03 there were three PLHA associations

with nine regional branches and over 5000 members. There was also an association of children orphaned by AIDS. As a result of the activities of PLHA associations, Idirs, AACs and Community-based associations; lively discussions have been held at household and community levels.

According to the EFY 1996 (2003/04) Report of HAPCO, behavioral changes are being observed. Open discussion is now common at rural and urban sites. Community conversations have shown marked change in communities in SNNPR and Yabello in Oromia.

According to the second generation BSS, awareness on HIV/AIDS has been found to be nearly 97% at national level. However, its impact on behavior change has lagged behind as evidenced by the high level of misconceptions and stigma as well as the low risk and self-efficacy perception that has been demonstrated in the findings of the BSS.

IEC/BCC efforts were not coordinated properly at all levels. The emphasis was mainly on individuals but not on social values and norms. More attention has been paid to urban centers but not on the rural and pastoral areas. It is hoped that IEC efforts will be effectively guided and more coordinated through the implementation of the National Framework for Communication which was developed and put in use during the reporting period.

3287 peer educators were trained in 2003/04. 5470 persons participated in seminars and although quantitative data are lacking, it was reported that IEC materials have been produced extensively in 2003/04.

There is an on-going BSS. The findings of this BSS 2005 will give us insight into the level and characteristics of behavioral changes that may have occurred as a result of the multi-sectoral response. The findings of BSS 2005 will be reported at a later date possibly in April-May 2006.

### **3.5 Impact Alleviation**

According to AIDS in Ethiopia 5<sup>th</sup> Report, HIV/AIDS has a visible effect and detrimental impact on the society and economy of the country. Some of the important impact analyses on the present results and extrapolations for future years indicate that: -

- HIV/AIDS accounted for an estimated 38% of all TB case incidences in 2003.
- The population lost to AIDS was about 900,000 by 2003 and is projected to reach 1.8 million by 2008 if present trends continue.
- Adult (15-49 years) deaths due to AIDS are expected to rise tremendously, in the coming years and already account for about a third of all young adult deaths in the country.
- HIV/AIDS on average is expected to reduce Life Expectancy in Ethiopia by 4.6 years in 2003.
- In 2003 alone, it was estimated that 539,000 children lost one or both of their parents due to AIDS.

According to the incomplete annual reports of HAPCO:

- In 2003/04 and 2004/05 15,860 and 33,440 PLHA were given care and support respectively.
- 80,000 orphans were given support in 2002/03. In 2004/05 69,035 orphans and 34,231 PLHA in total 103,266 were given support for school fees, food, rehabilitation and other similar support by the Global Fund, the World Bank and other partners. The number of people getting support has increased steadily (62,000 in 2002/03, 106,871 in 2003/04 and 103,266 in 2004/05). Recent data acquired through the Welfare Monitoring Survey-2004 show that the number of orphans and vulnerable children who received support during the last 12 months amounted to 146,272 out of 4.2 million orphaned and vulnerable children covered by the survey.
- 1814 home care providers were trained in 2003/04 and 5092 in 2004/05.
- 1343 selected PLHA and their families and orphans were given life-skill training and started income generating activities.

In terms of the absolute numbers of people requiring treatment, care and support both for the infected as well as the affected, the epidemic poses a great threat to the overall development efforts of the country and the impact should not be underestimated.

The current state of the epidemic calls for timely and scaled up intervention to curb the gradual rise in the number of people infected and affected by HIV/AIDS (Fifth Report, June 2004).

## **4. Core Indicators for DoC Implementation - 2006 reporting**

### **4.1 Method of Data Collection for UNGASS Indicators**

Desk review and Key Informant Interviews with focal persons were used to get information on the indicators and NCPI questionnaire. The Information on the National Commitment and Action Indicator, related to national expenditure on HIV/AIDS, is an estimate provided by the Plan and Program Department of HAPCO.

Some of the information on Knowledge and Behavior Indicators was obtained from the recent DHS conducted by the CSA. BSS 2005 is underway and will take some time for completion. The result will be communicated as soon as it is available.

## GE: Indicator 1 Amount of National Funds Disbursed by Government

The sources of data for this indicator are not National AIDS Accounts, HIV/AIDS budget analysis or special surveys on financial resource flows. Information on this indicator was gathered from the executed public budgets consolidated by HAPCO and does not include private sources of funding.

According to the available data for 2004/2005 (EFY Hamle 1/1996 - Sene 30/1997); expenditure on HIV and AIDS amounted to US\$ 18.9 million from public sources; US\$ 73.2 million from bilateral sources, and US\$ 16.2 million from the Global Fund (For details see annexes). Due to lack of data, comparison could not be made with similar expenditure in 2003.

## GE: Indicator 2 Government HIV/AIDS Policies

To assess the progress in the development and implementation of national-level HIV/AIDS policies and strategies; the National Composite Policy Index Questionnaire has been used. The questionnaire was sent to 34 selected key informants representing HAPCO, Government institutions, major Civil Society Organizations working in the area of HIV/AIDS, non-governmental organizations, bilateral agencies and UN system organizations. A total of 17 organizations responded to the relevant sections of the questionnaire on Strategic plan, M&E, Human rights, Civil Society Participation and on Prevention, Care and Support.

Separate indexes have been calculated for each policy area by adding up the scores for the respective specific policy indicator and calculating the average of the scores given by the respondents. The scores and responses of the key informants have been reviewed and checked for any inconsistencies and/or contradictory answers. The results of the Key Informant Survey on the NCPI are given in the annex.

## GE Indicator 3 Life - Skills-based HIV/AIDS Education in Schools

A cross-sectional survey was conducted in Addis Ababa in order to collect data on this indicator. In consultation with the Ministry of Education and the Addis Ababa Bureau of Education, 30 schools, including both private and public schools, were selected for the assessment of life-skills based HIV education in schools. Out of 30 sampled schools, 20 were public schools (15 secondary and 5 primary schools) and 10 were private schools (7 secondary and 3 primary schools). In-depth interviews were conducted with school principals in order to gather the required data.

Life-skills based HIV education in Ethiopia has been undertaken so far on a non-regular basis by integrating it with subjects like Biology, Environmental Science, English and local languages. The common school based HIV/AIDS prevention activities include:

organizing seminars and workshops to teachers and Anti-AIDS clubs; conducting drama, literature and songs; celebration of the World AIDS Day; educating school community by inviting PLHA as guest speakers, IEC activities via Anti-AIDS clubs; school mini-media; obtaining IEC materials such as newspapers, magazines and brochures containing information on HIV/AIDS and reproductive health from government institutions and NGOs involved in HIV/AIDS prevention and control activities; and organizing inter-school experience sharing programs.

A recent progress in Ethiopia in terms of life-skills-based HIV education is related to the development of manuals. The Addis Ababa Bureau of Education has produced manuals for life-skills-based education for each of the schools with grades 1 to 4 (primary); 5 to 8 (junior secondary); secondary (9 to 10); as well as technical and vocational schools. However, the distribution of the materials to the respective schools has not yet materialized.

The survey results showed that 80% of the schools had at least one teacher trained in life-skills based HIV education in the last five years. Of the schools that had at least one teacher trained in life-skills-based HIV education in the last five years, secondary and primary schools accounted for 60% and 20% respectively. The disaggregated result by ownership also showed that 56.7% and 23.3% of public and private schools respectively were trained in life-skills-based HIV education in the last five years (For details see Annex 3 National Return Form GE: Indicator 3).

It was however learnt that although none of the schools had taught life-skills-based HIV education on a regular basis to the students in the last academic year, all schools, irrespective of their level and ownership, which received training in life-skills-based HIV education had given such education to their students on a non-regular basis by integrating it with conventional subjects. The exercises made by schools to equip students with life-skills-based HIV education also included the motivation of students to learn about HIV/AIDS through self-learning and peer education schemes; art; poems; drama; watching video shows; and reading different magazines and brochures on the subject.

#### GE: Indicator 4 Workplace HIV/AIDS Control

A survey has been conducted on a sample of major enterprises/companies in both the public and private sectors in order to assess progress in implementing workplace policies and programs to combat HIV/AIDS. In collaboration with the Ethiopian Employers Federation (EEF), a total of 30 employers (18 from public sector & 12 from the private sector) were selected on the basis of the size of their labor force. The selected enterprises/companies are assumed to be representative of the major employers in the country. The ministries of Transport and Communication, Labour and Social Affairs, Culture and Tourism, Education and Health are among the selected public sector employers.

Public and private sector employers in Ethiopia have recognized the seriousness of the HIV/AIDS epidemic and its impact on the workplace. To support the national response to

HIV/AIDS, a number of employers have submitted to HAPCO at all levels, their action plans focusing on the prevention of HIV/AIDS and care and support of employees living with HIV/AIDS as well as AIDS orphans.

The survey results showed that 33.3% of the enterprises/companies captured by the survey have anti-discrimination-at-work-policies and all preventive and control programs recommended by the UNGASS Declaration of Commitment on HIV/AIDS.

This workplace-based survey showed that due emphasis was not given by the majority of the surveyed enterprises/companies to the development or adoption of workplace policies although, many of these enterprises have workplace-based HIV/AIDS prevention and control programs. According to the results of the survey (see Annex 3, GE: Indicator 4), 86.7% of the enterprises/companies workplace-based HIV/AIDS prevention and control programs cover education on basic facts about HIV/AIDS followed by condom promotion (83.3%), STI diagnosis and treatment (76.7%), specific work related HIV transmission hazards and safeguards (73.3%), VCT services (70%) and provision of HIV/AIDS-related drugs (63.3%).

### **GE. Indicator 5- Sexually Transmitted Infections: Comprehensive Case Management**

STI services are integral parts of the general health services and in 2004/05 a total of 75,386 cases were treated nation wide. The number of STI cases who were diagnosed, treated and counseled in 2005 was 40,718; however it seems that there is gross underreporting. The highest number of cases-28.7% falls in the age group 20-29. (For details see annexes)

### **GE Indicator 6 - MTCT: Antiretroviral Prophylaxis**

In 2005, the number of HIV-infected pregnant women provided with NVP was 4438. The estimated number of HIV-infected pregnant women in 2005 was 146,570 (AIDS in Ethiopia, 5<sup>th</sup> Report). Hence the percent of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce vertical transmission (PMTCT) amounted to 3% (For details see annexes).

### **GE Indicator 7 – HIV Treatment: Antiretroviral Combination Therapy**

In 2005, the estimated number of people with advanced HIV infection is 286, 250 out of which 20,477 (7.2%) received antiretroviral combination therapy in accordance with the nationally approved treatment protocol.

## GE Indicator 8 – Support for Children Affected by HIV/AIDS

HIV/AIDS has orphaned a large number of children in Ethiopia. In 2003 alone, it was estimated that 539,000 children lost one or both of their parents due to AIDS (AIDS in Ethiopia: Fifth Edition). According to a 2003 study conducted by the Ministry of Labour and Social Affairs, AIDS orphans live with poor relatives with low educational backgrounds, who are often unable to provide for the physical, educational and health needs of the child. This implies the tremendous need for all round support for AIDS orphans.

Under the Declaration of Commitment countries are expected to develop and implement national policies and strategies to provide a supportive environment for orphans and other vulnerable children by 2005. However, even though there is no national policy in place to provide essential support to children orphaned or made vulnerable by HIV/AIDS, various initiatives are targeting economic support and vocational skills for orphans to sustain their lives economically.

Such initiatives do not originate from a common policy and strategy but are instead driven by community needs. The amount of such support is, however, limited compared to the large number of needy orphans. For example, out of 4,166,465 orphaned and vulnerable children covered by the Welfare Monitoring Survey-2004 undertaken by the Central Statistical Agency, it is only 3.5% who have received some support in the form of medical treatment, counseling service, education, other social services-clothing, food, financial support etc. (For details see Annex 6). In view of the huge gap between the demand for support and the actual support provided to orphans and OVC, there is an urgent need to develop and implement strategies to promote education for vulnerable children, provide critical psychosocial support, and protect them from violence, discrimination and abuse.

## GE Indicator 9 – Blood Safety

The number of blood units screened for HIV in the last 12 months (2005), was 28,539. The total number of blood units transfused in 2005 was 24,258. The transfused blood in the Ethiopian case is 100% HIV screened.

## GE Indicator 10 – Young People’s Knowledge about HIV prevention

The provisional result of the DHS survey showed that the percentage of total respondents who gave the correct answer to all the five questions is 22.4% (47.5% urban & 17.1 rural). When disaggregated by gender 19.4% female (44.4 % urban & 14% rural), and 30% male (56.7% urban & 25.1 % rural)

If we consider men and women aged 15-49, those who said HIV transmission can be reduced by using condoms was 62.5% for women and 79% for men. A similar result of the DHS 2000 was very low i.e. 17 percent of women and 36 percent of men mentioned

the use of condoms as a way to avoid HIV/AIDS. In general the DHS results show that the proportion of urban residents who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV are more than their rural counterparts. There is wide variation among regions in the level of knowledge about HIV. Addis Ababa and Harari residents are more aware about ways of preventing the sexual transmission of HIV (for details see annexes).

### GE Indicator 11 – Median age at first sex

For the age group 15-24 the national average of respondents who responded to have started sex before age of 15 is 20% (47% for male urban & 38% for rural; urban female 50% & rural 40%). The median age for women was higher in urban compared to rural areas (21.6 urban and 18.9 rural), while the median age was more or less the same for both urban (22.4) and rural areas (23.0) (for details see annexes).

### GE Indicator 12 – Higher-risk Sex among Young Women and Men

Among sexually active young women and men aged 15-24, the percentage who have had sexual relations with non-marital, non-cohabiting partner in the last 12 months was 5.8 for women and 37.4 for men, the national average is 14.6 %. It is obvious that men were engaged more in higher risk sex than women (for details see annexes)

### GE Indicator 13 – Young People’s Condom use with Non-Regular Partners

Among women and men aged 15-24 who have had higher risk sex in the last 12 months, the percentage who say they used a condom the last time they had sex with a non-marital, non-cohabiting partner was 30 for women and 47 for men. The percentage-using condom at last higher risk sex was more for men in the 18 to 19 and for women in the 20 to 22-age bracket. The proportion using condom was also higher in urban than in rural areas (Men: 84.4 for urban and 23.3 for rural; Women: 46.4 for urban and 4.8 for rural), and the national average is 42% (See annex for details).

### GE Indicator 14 – Orphans’ School Attendance

Information on orphans is given under Indicator No.8. With respect to orphan school attendance, available data (WMS-2004) show that a lot of effort has been made to assist vulnerable children. However, a lot remains to be done. This is clearly shown by the results of the Welfare Monitoring Survey-2004. The rate of double orphan school attendance to the rate of non-orphan school attendance for age 10-14 is 105. This is because very high number of non-orphan children ages 10-14 are out school due various factors.

## GE Indicator 15 – Reduction in HIV Prevalence

All information presented for this indicator is derived directly from the 2005 ANC surveillance round with the use of computer model. Observed HIV prevalence is subject to sampling error, and the true prevalence is likely to be found within the 95% confidence limit. Accordingly the unadjusted prevalence for the capital city (Addis Ababa) is 13.35%, and 8.64% for other urban areas and 2.85 for the rural areas. All in all 30,700 samples have been collected from all sites and are ready for testing. Hence the new prevalence rate will be available soon.

## GE Indicator 16 – HIV Treatment: Survival after 12 Months on ART

In 2005, cohort data has been collected from all 73 ART providing hospitals out of which only 5 provided the service for 12 months. As per the cohort analysis done on the data from the 5 hospitals, the survival rate is 90%.

## GE Indicator 17 – Reduction in MTCT

The proportion of HIV positive pregnant women provided with antiretroviral treatment is 3%. Therefore, the reduction in mother to child transmission is estimated 25% using the defaults formula of calculation. This is because there has not been efficacy survey on antiretroviral treatment.

## 5. MAJOR CHALLENGES FACED AND ACTIONS NEEDED TO ACHIEVE THE UNGASS GOALS/TARGETS

The multi-sectoral response has registered several achievements during the reporting period. However, it has also faced major challenges. The following are some of the major challenges that could affect the implementation of the strategic plan (2004-2008) that have been identified in the strategic plan.

### 5.1 Major Challenges

#### i) Capacity Limitation

Shortage of qualified manpower, inadequate facilities, lack of institutions producing relevant technical personnel have constrained the implementation of the multi-sectoral response at all levels. Its impact is reflected on the performance and outcome of all activities. Thus capacity limitation is a major obstacle in the fight against HIV/AIDS. Hence adequate number of qualified and committed manpower will be required at all levels especially at regional and woreda level. As in the past, getting the right type of manpower, training and retaining them will pose a serious challenge.

## **ii) Resource Availability and Absorption/Utilization Capacity**

There have been problems regarding availability of adequate funds, fund disbursement, and SoE settlement. Implementing agencies both in the public and NGO sectors have manifested capacity limitation in fund management, utilization and settlement of expenditure.

The estimate of resource requirement for the implementation of the SPM, which is need based is quite enormous. The major source of fund for the hitherto activities are multilateral and/or bilateral external sources either through grant or soft loan. Though it appears that there may not be shortage of influx of assistance, sustainability is questionable. Availability of adequate and timely financial resources has always been and will continue to be a challenge. Poor absorption and utilization of funds within a given period will also remain to be a challenge.

## **iii) Addressing the Growing Service Demand and Sustainability**

The public is now sensitized and encouraged to seek for preventive, care and support services at all levels. However, the sustained availability and the expansion rate of services like VCT and ART may not be commensurate with the growing demand. For instance out of the 265,000 PLHA who need ARV treatment, it is only 21,220 who actually get the service at present. The gap between number of orphans and PLHA who need and those who get care and support services is quite wide. This could pose a serious challenge on the capacity of the government in making such services available adequately and in time.

## **iv) Perception of and Consensus Around the New Implementation Arrangements**

There are problems of coordination between donors, implementers and coordinating bodies like HAPCO. There are also problems related to lack of joint planning, sharing of data and mutual support.

As defined in the strategic plan, the main thrust of the new implementation arrangement for the SPM is on the two prongs of enhanced government commitment on the one hand and community mobilization and empowerment on the other. The government recognizes its critical role in accelerating the ongoing national multi-sectoral response and opts to organize its implementation mechanism for discharging its responsibilities in the combat against HIV/AIDS through the spearheading role of the MOH and the coordinating function of HAPCO. The departure in the strategic plan of 2004-2008 is social mobilization – empowering the community for a meaningful impact on our fight against HIV/AIDS. All stakeholders need to have a clear understanding of the benefits of social mobilization and commitment to use this untapped resource effectively and efficiently.

The prevailing state of the community that is mainly characterized by passive involvement and dependency on external factors (government and others) may also pose

a challenge in community mobilization and in assuming its responsibility and ownership roles.

#### **v) Mainstreaming**

The national response to HIV/AIDS is a multi-sectoral agenda that requires the active participation of the government and all other stakeholders. It is essential for all sectors to mainstream HIV/AIDS in their policy and work plans. Making all sectors to mainstream HIV/AIDS into their regular activities poses a challenge for the government.

#### **vi) Rapid Expansion of the Epidemic to the Rural Areas**

As shown in the 5<sup>th</sup> edition of “AIDS in Ethiopia” the epidemic is gradually spreading in the rural parts of the country. The spread of HIV to the rural areas appears to be associated with urban-rural mobility and food insecurity both of which are linked to poverty and developmental issues. Hence, the issues become part of the overall development challenge in both urban and rural areas.

### **Remedial Actions Envisaged to Ensure Achievements of Agreed UNGASS Targets**

As HIV/AIDS is not merely a health problem but a broad socio-economic crisis, it requires the active and continued involvement of all sectors at all levels. The involvement of a wide range of actors in the ongoing fight against the epidemic requires an effective and efficient coordination mechanism and modalities, problem identification, information sharing, planning, implementation, monitoring and evaluation.

Coordination and networking between stakeholders and programs avoids resource wastage and duplication of efforts, enhances success through documenting and disseminating best practices and research findings, avails technical support and ensures a smooth flow of funds and information dissemination. Institutional arrangements have been reviewed to bring effective coordination and synergy.

Governance has been given due attention in the SPM. It is identified as the key factor for intensifying the national multi-sectoral response, since it embraces management, coordination and accountability.

HIV/AIDS councils will be strengthened at all levels of administration, from national to kebele levels. The Ministry of Health will spearhead the leadership in the national response to HIV/AIDS. HAPCO shall be limited to national and regional levels focusing only on coordination, resource mobilization and multi-sectoral monitoring and evaluation. HAPCO will coordinate interventions at zonal, woreda and kebele levels through the health structures at these levels, without opening separate zonal, woreda and kebele level offices.

This arrangement will allow for effective, integrated and sustainable coordination and service provision, particularly at lower levels.

The strategic plan provides a broad multi-sectoral plan for response to the epidemic. Each sector is expected to develop specific plans based on its role/mandate in the society and its capacity. The plans should focus on the sector's comparative advantages in implementing the strategic plan. Each sector is expected to effectively mainstream HIV/AIDS in its sectoral policy and plan, to establish a focal task force/person responsible for advocating, managing and coordinating the implementation of HIV/AIDS activities within the sector and also to network with other sectors.

Enhanced capacity building measures shall be taken at all levels. A minimum package of services for targeted prevention, care and support will be defined at the level of health post, health center and hospital and capacity building should occur at all levels. Universal coverage by the health extension program, coupled with capacity building from primary to tertiary levels, can ensure effectiveness and sustainability of the programs in the fight against HIV/AIDS.

Provision of continuous and intensive training particularly on financial management and assignment of accountants will minimize problems related to absorption/utilization of allocated funds. The partnership forum established at sectoral and national levels will continue to help the integration and coordination of the multi-sectoral response.

#### **SUPPORT REQUIRED FROM DEVELOPMENT PARTNERS**

The total budget required for four years for the implementation of the Strategic Plan is around 6 billion Birr.

The budget is meant for capacity building for the health and education sectors as well as the community at large (17%), for expansion of health services and human resources development to increase health coverage of the country (3.7 billion or 61.7%, of which 60% goes to procurement of drugs), and 1.1 billion Birr or 18.3% goes for services to be rendered to PLHA and orphaned children.

Adequate resources are required from local and external sources to sustain the multi-sectoral response.

## **6. Monitoring and Evaluation Environment**

### **6.1 Overview of the Current M&E System**

The Government has given priority attention to strengthening the M&E of HIV/AIDS. HAPCO have strengthened M&E by institutionalizing M&E and opening a Plan and Program Department. There is an M&E unit within HAPCO staffed by full-time M&E Officers. A number of regions have hired M&E officers and they are also planning to hire data managers and computer specialists. There is also a plan to strengthen the M&E capacity at RHB level. Budget has been secured to hire medical record specialists/data clerks for all health facilities starting ART.

A National Advisory Committee on HMIS and M&E has been established with representation from government, research institutions and donors. The Committee is tasked to strengthen M&E and HMIS in the country.

A Donors' M&E Committee has been established under the HIV/AIDS Donors' Forum of the National Partnership Forum on HIV/AIDS. The Committee is actively supporting the role of the National M&E Framework

A Multi-Sectoral M & E Network has been established. A Multi-Sectoral M & E Task Force, which is a technical of the Network, has also been established. The Task Force has succeeded in creating a National Best Practice Mechanism; which has already started to collect best practices from all parts of the country.

### **6.2 The National Multi-Sectoral M&E Framework for HIV/AIDS**

The framework was developed and launched nationally in December 2003. The framework promotes the three ones i.e. one agreed HIV/AIDS Action Framework, one National AIDS Coordinating Authority, and one agreed M&E Framework

The M&E Framework clearly defines indicators for the specific HIV/AIDS intervention areas, sources of data to generate the indicators, measurement tool, frequency of data collection, responsible body for data collection, and the method of measurement. The selection of indicators has been made through a series of consultations with different stakeholders, and M&E team from HAPCO, MOH and WHO worked on the final document.

The goal of the National M&E Framework is to provide information that will enable tracking of progress and to enhance informed decision-making at all levels in the implementation of interventions under the multi-sectoral response to HIV/AIDS in Ethiopia.

### **6.3 National M&E Operational Manual Series**

The operational manual has been developed with specific reference to program indicators in the National HIV/AIDS M&E Framework. In addition to program indicators, previously existing reporting systems and additional information requirements by HAPCO have been reviewed and included in the operational manual. The operational manual is prepared in such a way that partners complete only those reporting formats that are relevant to the type of HIV/AIDS activities they are implementing or supporting. For this purpose, partners are classified into 10 categories based on the type of activity they are implementing and type of reports expected of them. For each category, one operational manual module is prepared, which avoids any confusion on reporting and minimizes resources required to distribute one bulky manual with all reporting formats to all partners. Detail formats and registers for Health Indicators (patient monitoring systems for ART, PMTCT, Lab and STI) were also included.

In addition to the formats themselves, this operational manual includes information flow, frequency and data of reporting and guides/descriptions on completing the format.

### **6.4 Surveys**

A number of surveys that are needed to get information on survey based National indicators have been launched, namely: BSS, National Health Facility Survey, DHS, National Welfare Monitoring Survey and Coverage Survey (completed). Data from these surveys (BSS, Health Facility Survey and DHS) will be reported in due course.

### **6.5 Reviews and Evaluation**

Different reviews and evaluations have been undertaken by HAPCO in 2002/03. A Joint Mid-Term Review of the overall government response was undertaken with the participation of stakeholders including the World Bank. The NSF (2001-2005) has been reviewed and updated based on past experiences.

Reporting formats have been updated and distributed to regions and other implementing agencies.

National M&E TOT was conducted in 2005 for all regional M&E officers of both HAPCO and MOH.

### **6.6 M&E Capacity**

HAPCO will work with all partners to build M&E capacity and strengthen the HIV/AIDS M&E system. However, implementation of the M&E Framework will require a lot of resources including M&E capacity building; finance for data collection, analysis and dissemination; and technical support for population-based and health facility surveys.

This requires due emphasis at all levels for strong management support and allocation of adequate budget for M&E.

## 7. Conclusion

During the reporting period, the generalized HIV/AIDS epidemic in Ethiopia has been tackled by addressing priority intervention areas such as intensive IEC/BCC, Condom promotion and distribution, VCT, STI treatment and control, PMTCT etc. Programs providing supportive care have been initiated in many areas. Persons living with HIV/AIDS have formed associations to provide mutual support and educate individuals, families and communities on the socio-economic impact of the epidemic (HAPCO Annual Reports for EFY 1995, 1996 and 1997).

Still major weaknesses have been identified. These weaknesses include the following:

- Health sector has been overwhelmed by the demand for services;
- There has been low implementation capacity in communities and as a result lack of community ownership of the programs;
- There has been lack of focus on priority intervention areas and target groups; and
- There has been limited coverage of basic prevention and care services including VCT, ART and PMTCT.

Efforts to control and respond to the AIDS epidemic have been greatly enhanced since 2003; through application of guiding principles such as multi-sectoralism, empowerment, shared sense of urgency, gender sensitivity, involvement of PLHA, result oriented interventions and best use of resources and by the strong political commitment and leadership at every level.

These efforts have resulted in high level of awareness on HIV/AIDS and some positive trends in behavioral change manifested by increased trend in condom distribution and utilization, increased demand for VCT and decline in the national HIV incidence rate (AIDS in Ethiopia, Fifth Report, June 2004). However, compared with the magnitude of the problem the results achieved so far are extremely modest and the national response and intervention are still far from adequate.

Consequently, capacity building, integration of HIV/AIDS interventions with the health sector; community mobilization and empowerment; leadership and mainstreaming; coordination and networking have to be critically addressed.

In the final analysis, the successful implementation of the Strategic Plan (2004-2008) will depend to a large extent on the continued and sustained commitment of the government, active participation of stakeholders at all levels and direct involvement and ownership of the community.

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