# Report on progress towards implementation of the UN Declaration of Commitment on HIV/AIDS

# 2010

Federal Democratic Republic of Ethiopia

Federal HIV/AIDS Prevention and Control Office

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# Acronyms

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Clinic |
| ART | Antiretroviral Treatment |
| BCC | Behavior Change Communication |
| BSS | Behavioral Surveillance Survey |
| CBO | Community Based Organization |
| CSO | Civil Society Organizations |
| CDC | US Centers for Disease Control and Prevention |
| CRIS | Country Response Information System |
| DAC | Development Assistance Committee |
| DCA | District Comprehensive Assessment |
| DHS | Demographic and Health Survey |
| EIFDDA | Ethiopian Inter-faith Forum for Development, Dialogue and Action |
| EMSAP | Ethiopian Multi-Sectoral HIV/AIDS Prevention and Control Project |
| ESDP | Education Sector Development Program |
| ERCS | Ethiopian Red Cross Society |
| FBO | Faith-Based Organization |
| FDRE | Federal Democratic Republic of Ethiopia |
| GIPA | Greater Involvement of People Living with HIV/AIDS |
| HAPCO | HIV/AIDS Prevention and Control Office |
| HBC | Home-Based Care |
| HCT | HIV Counseling and Testing |
| HEW | Health Extension Worker |
| HIV | Human Immunodeficiency Virus |
| HSDP | Health Sector Development Program |
| IEC | Information, Education and Communication |
| ILO | International Labor Organization |
| MDG | Millennium Development Goal |
| M&E | Monitoring and Evaluation |
| MOE | Ministry of Education |
| MOFED | Ministry of Finance and Economic Development |
| MOH | Ministry of Health |
| MOLSA | Ministry of Labor and Social Affairs |
| NAC | National AIDS Council |
| NGO | Non Governmental Organizations |
| OECD | Organization for Economic Co-operation and Development |
| ODA | Official Development Assistance |
| OI | Opportunistic Infection |
| OVC | Orphan and Vulnerable Children |
| PASDEP | Plan for Accelerated and Sustained Development to End Poverty |
| PLHIV | People Living with HIV |
| PMTCT | Prevention of Mother-to-Child Transmission of HIV |
| PwDs | People with Disability |
| RHB | Regional Health Bureau |
| SPE | Single Point Estimate |
| SPM | Strategic Plan for Multi-sectoral HIV/AIDS Response |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| UN | United Nations |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| UNDAF | United Nations Development Assistance Framework |
| UNICEF | United Nations Children's Fund |
| UP | Universal Precaution |
| USAID | United States Agency for International Development |
| USDOL | United States Department Of Labor |
| VCT | Voluntary Counseling and Testing |
| WHO | World Health Organization |

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# 1. Status at a glance

## 1.1. Participation of stakeholders in the UNGASS report writing process

This report was prepared by the Government of the Federal Democratic Republic of Ethiopia through the Federal HIV/AIDS Prevention and Control Office (FHAPCO) – the national authority to coordinate the multisectoral response in the country – and involving a wider consultation with sector ministries, Regional HAPCOs, Regional Health Bureaus, civil society organizations, associations and networks of PLHIV, the private sector, as well as multilaterals and bilateral development partners. The report provides evidence-based information on the HIV/AIDS epidemic and response in Ethiopia for the years 2008 and 2009 in order to track the country's progress towards achievement of the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS.

The report preparation process was led by the National Plan M&E Directorate of the FHAPCO in consultation of the National M&E Advisory Group. The report presents progress made in terms of the policy environment as well as programmatic intervention areas. Information on the policy and legal environment was gathered through a desk review and key informant survey using the National Policy Composite Index (NCPI) included in the UNAIDS guidelines for UNGASS reporting[1]. The different sections of the NCPI was completed by a variety of stakeholders and federal and regional level, including government ministries, nongovernmental organizations (NGOs), people living with HIV, United Nations agencies and private sector representatives. Information on the epidemic and the response was assembled from the annual reports of FHAPCO, government sectors and partners' program performance reports, reports of national and small-scale and community-wide surveys, surveillance data, published scientific studies and other data published in 2008 and 2009. However, national level data and information on some UNGASS indicators were generated from relatively older sources, such as the 2005 Demographic and Health Survey (DHS 2005), the 2005 Behavioural Surveillance Survey (BSS 2005), the 2004 Welfare Monitoring Survey (WMS 2004) and the Single Point Estimate based on calibrated 2005 ANC sentinel surveillance and DHS+ 2005.

The draft report was reviewed at a consultation meeting involving experts and officials from government sectors, national and international development partners, civil society organizations, networks and associations of PLHIV, the private sector and other stakeholders.

## 1.2. Status of the HIV/AIDS epidemic

With an estimated 1.1 million people living with HIV, Ethiopia has one of the largest populations of HIV-infected people in the world. However, HIV prevalence among the adult population is lower than many sub-Saharan African countries[2]. Adult HIV prevalence in 2009 is currently estimated to be between 1.4% and 2.8%[3]. A new single point estimate of HIV prevalence will be generated following the completion of a population-based sero-survey in late 2010.

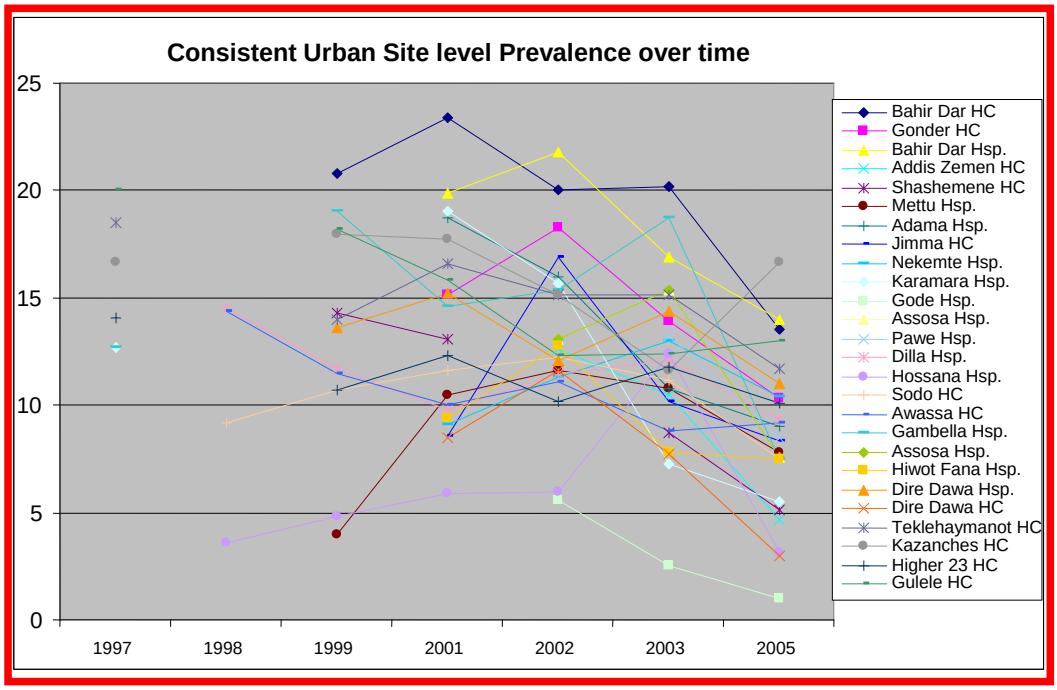
[1] UNAIDS, Guidelines on Construction of Core Indicators: 2010 Reporting (UNAIDS/09.10E / JC1676E), March 2009.

[2] Federal Ministry of Health-Federal HAPCO: Single Point HIV Prevalence Estimate, June 2007

[3] Ethiopian Health and Nutrition Research Institute, Preliminary data from *AIDS in Ethiopia, 7th Edition*, March 2010.

Ethiopia's HIV/AIDS epidemic pattern continues to be generalized and heterogeneous with marked regional variations. At the national level, the epidemiologic trend over the past eight years has been stable. However, HIV prevalence appears to be declining in urban areas, according to analysis of data from ANC sites that collected data consistently for more than ten years. For example HIV prevalence among pregnant women attending ANC in Addis Ababa has declined from 23% in 1996 to 10% in 2007. Peri-urban and small market town residents, young females are the most at risk individuals and affected segments of the population by the epidemic.

*Figure 1. HIV Prevalence among pregnant women attending ANC clinic in urban sites (1997-2005)*




Available data from a variety of studies suggests that the following populations are at higher risk of HIV infection: sex workers, uniformed services, long-distance-trucker-drivers; refugees and displaced people, daily laborers, mobile/migrant laborers, including cross-border population, street children, high school and university students, out-of-school youth and indigenous populations in remote foreign tourist destinations involved transactional sex. A national survey focused on most-at-risk populations planned for 2010 is expected to provide additional information on which population groups should be targeted by HIV prevention efforts.

## 1.3. Policy and programmatic response to the HIV/AIDS epidemic

The Government of Ethiopia is making tremendous efforts towards containing the epidemic. As part of this endeavor, the Government put in place a national HIV/AIDS policy in 1998 to create an enabling environment to fight the pandemic. Overall, support and commitment in relation to HIV and AIDS has increased over the years, and progress has been made in the development of specific HIV/AIDS related legislation and revising the HIV policy to promote and protect human rights. Moreover, there have been some encouraging efforts to enforce the existing policies, laws and regulations. Civil society involvement in the process of planning, monitoring and evaluation of HIV/AIDS responses at various levels are improving.

Ethiopia, as a UN Member State, joined the international community in the Political Declaration on HIV/AIDS of the UN General Assembly issued on June 2006, which committed all countries to move towards universal access to HIV prevention, treatment, care and support by 2010. Since then Ethiopia has made notable achievements in the response against HIV and AIDS. These include joint planning to harmonize the efforts of stakeholders around a comprehensive multi-sectoral national HIV/AIDS strategic plan. In line with the Three Ones principles of harmonization and alignment, the strategic plan was developed with the participation of regional states, sector ministries, employee associations, the private sector, development partners, the Network of Networks of HIV positives in Ethiopia (NEP+), Ethiopian Inter-faith Forum for Development, Dialogue and Action (EIFDDA) and others for intensifying a comprehensive response at various levels and moving towards the goal of universal access to HIV prevention, treatment, care and support by 2010. This multi-sectoral strategic plan is framed by the national HIV/AIDS policy and the country's overall development plan, known as the Plan for Accelerated and Sustained Development to End Poverty, or PASDEP.

In order to ensure that quality HIV/AIDS services are delivered at the community level, various guidelines and standards were developed, distributed and being implemented in 2008 and 2009. The Government of Ethiopia has started integrating services such as PMTCT and HIV counseling and testing (HCT) with family planning and maternal, newborn and child health services. This direction is reflected in the various program documents[4],[5].

The HCT program has shown considerable improvement both in terms of service expansion as well as utilization. A total of 5.8 million people (53% male) received HIV counseling and testing in 2008/09, this is a 22% increase from the previous year. As of end of 2009 there were a total of 241,236 people ever started ART and 176,644 currently on ART. Females accounted for 57.9% of ART clients. ART coverage increased from 46% in 2008 to 53% 2009. However, lost to follow up to ART service was 28% by the end of 2008. A total of 11,000 children were ever started ART, including 8,761 currently on ART as of December 2009. ART coverage for children was 43%. However, despite the remarkable achievement in treatment, there is a widely held concern that PMTCT activities have been lagging behind. From an estimated 84,189 HIV positive pregnant women in 2009, only 6,466 (8%) received antiretroviral prophylaxis. It is worth to note that this figure does not include mothers who are enrolled in the ART program.

Comprehensive knowledge about HIV prevention and transmission is still shallow. Condom use has shown an increasing trend over the past years, though condoms were not widely available for the purpose of HIV prevention except through social marketing schemes.

Available evidence has demonstrated that the national response has shown improvement in the health sector interventions, while there are still potential areas for improvement in non-health areas such as the education sector, workplace programs, and care and support to orphans and vulnerable children (OVC). The national strategic direction is to scale up prevention interventions particularly for most-at-risk populations (MARPs), OVC and PMTCT, strengthen non-health sector responses, and improve strategic information generation and utilization on MARPs.

[4] Guidelines for HIV counseling and testing in Ethiopia, Addis Ababa, Ethiopia; 2007.

[5] FHAPCO and Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia: Road Map 2007-2008/10, Addis Ababa, Ethiopia

## 1.4. UNGASS core indicators

*Table 1: UNGASS indicators*

| No | Indicator | Value (in %) | Source of information |
|---|---|---|---|
| National Commitment and Action | | | |
| 1 | Domestic and International AIDS spending by categories and financing source | - | - |
| 2 | National Composite Policy Index | See annex 2 | Desk review and key informant interviews |
| National Program Indicators | | | |
| 3 | Percentage of donated blood units screened for HIV in a quality-assured manner | 100% | HAPCO-M&E, ERCS, 2009 |
| 4 | Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy | 53% | HAPCO-M&E, 2009 |
| 5 | Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission | 8%[6] | HAPCO-M&E, 2009 |
| 6 | Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV | 40.6% | FMOH 2009 |
| 7 | Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results | 2005 survey data: 2.1% (m); 1.8% (f)<br>2009 program data: 18.4%[7] | DHS 2005<br>HAPCO-M&E 2009 |
| 8 | Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results | 97.3% | BSS II 2005 |
| 9 | Percentage of most-at-risk populations reached with HIV prevention program | - | - |
| 10 | Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child | 2004 survey data: 3.5%<br>2009 program data: 34.6%[8] | WMS 2004<br>FHAPCO 2009 |
| 11 | Percentage of schools that provided life skills-based HIV education within the last academic year | 38.4% | HAPCO-M&E, 2009 |
| Knowledge and Behavior Indicators | | | |
| 12 | Current school attendance among orphans and among non-orphans aged 10–14 | Orphans: 53.3%<br>Non-orphans: 58.9% | DHS 2005 |
| 13 | Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | 24.8% | DHS 2005 |
| 14 | Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | 35.7% | BSS II 2005 |
| 15 | Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 | Male: 1.7%<br>Female: 15.8% | DHS 2005 |
| 16 | Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months | Male: 2.4%<br>Female: 0.1% | DHS 2005 |
| 17 | Percentage of adults aged 15–49 who had more than one | Male: 8.5% | DHS 2005 |

| | | | |
|---|---|---|---|
| | sexual partner in the past 12 months who report the use of a condom during their last intercourse | | |
| 18 | Percentage of female and male sex workers reporting the use of a condom with their most recent client | 83.6% | BSS II 2005 |
| 19 | Percentage of men reporting the use of a condom the last time they had anal sex with a male partner | - | - |
| 20 | Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected | - | - |
| 21 | Percentage of injecting drug users who report the use of a condom at last sexual intercourse | - | - |
| Impact Indicators | | | |
| 22 | Percentage of young women and men aged 15–24 who are HIV infected | 3.5% | ANC sentinel surveillance, 2007 |
| 23 | Percentage of most-at-risk populations who are HIV infected | - | - |
| 24 | Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART | 72.5% | FHAPCO-M&E, 2009 |
| 25 | Percentage of infants born to HIV-infected mothers who are infected | 20%[9] | Single Point Estimate |

# 2. Overview of the AIDS epidemic in Ethiopia

## 2.1. Introduction

The 2001 UN Declaration of Commitment on HIV/AIDS requires member states to report every two years on progress achieved using a core set of national level indicators. Ethiopia has prepared and submitted three rounds of UNGASS report since 2003. This report is the fourth round and covers the years 2008 and 2009. The report was prepared in a participatory and highly consultative manner to assess the current status of the epidemic, the national response and progress towards implementation of internationally agreed and nationally adapted targets.

With a total population of 73.9 million (50.5% male)[10], Ethiopia is a low-income country with an economy largely dependent on the agriculture sector. According to the UNDP Human Development Index (HDI 2007) Ethiopia ranks 169th out of 177 countries. Similarly the Human Poverty Index value rank of 54.9 puts Ethiopia 105th among the 108 developing countries.

In line with the national development plan – the Plan for Accelerated and Sustained Development to End Poverty (PASDEP) – the country is implementing a 20-year rolling Health Sector Development Plan (HSDP). The current five-year plan, HSDPIII (2005/06 to 2009/10), has clear strategies for making targeted interventions against poverty-related diseases, with significant emphasis on three priority diseases - HIV/AIDS, malaria and tuberculosis (TB). To achieve the national target of universal primary health care coverage, both the Federal Ministry of Health and Regional Health Bureaus have prioritized health center construction.The national baseline at the start of the 2008/09 fiscal year was 1,620 health centers; and 965 new health centers were constructed or under construction at the end of the year, therefore reaching the cumulative total of 2,585 health centers available or under construction. The cumulative number of health posts constructed up to end of the 2008/09 fiscal year was 12,488 – 83.1% of the national target. An additional 29 hospitals were also under construction in eight regions[11].

*Table 2: Key health and health-related indicators, MOH 2008/9*

| Health Indicator at a glance | % | Year |
|---|---|---|
| Antenatal coverage | 66.3 | 2008/09 |
| Health service utilization | 0.24 | " |
| Antenatal coverage | 59.4 | " |
| Postnatal coverage | 34.3 | " |
| Skilled birth at health institutions | 24.9 | " |
| EPI coverage | 81.0 | " |
| Fully Immunized children | 65.5 | " |
| HIV Prevalence | 2.2/2.3 | " |
| HIV Health Service Expansion | # | |
| HCT | 1823 | 2009 |
| PMTCT | 1023 | " |
| ART | 517 | " |
| TB/HIV | 677 | " |
| Health Human Resource | | |
| Doctor to Population ratio | 1:37,996 | 2008 |
| Health Officers to Population ratio | 1:63,785 | " |
| Nurses to Population ratio | 1:4,725 | " |
| HWE to Population ratio | 1:3,224 | " |
| OPD Visit per capita | 0.24 | " |

*Source: Multi-sectoral HIV/AIDS Response Annual Monitoring and Evaluation Report, July 2008-June 2009, Federal HAPCO and Health and Health Related Indicators, 2009/10.*

Management of the health system has been reformed based on the Business Process Reengineering (BPR) model. The reform process reinforced the national multi-sectoral HIV/AIDS response, improved utilization of the available limited resources, harmonized plans and stimulated organizational transformation to increase customer' satisfaction through fundamental changes of the organizational system and structure.

The Health Extension Program (HEP) is one of the major pillars of the health service delivery system in Ethiopia. The program aims to improve access and equity in the delivery of essential health services at village level across the country, including HIV/AIDS, STI and TB prevention and control, maternal and child health and sanitation. A cumulative number of 31,831 HEWs were trained and deployed up to the end of Ethiopian Fiscal Year (EFY) 2001, which is above the target of 30,786. HEWs are actively involved in community mobilization and education activities of the HIV/AIDS programs through Community Conversations.

The Ethiopian Calendar

The Ethiopian Calendar consists of 12 months of 30 days each and a 13th month of five days (six days in a leap year). It is based on the Julian calendar, which is about seven years behind the Gregorian calendar used by most of the rest of the world. Ethiopia's New Years Day occurs in early September. Therefore, on 11 September 2007, Ethiopia began its third millennium (2000 EC). The Ethiopian government's fiscal year runs from 8 July to 7 July of any given year.

Examples: 2001 Ethiopian Calendar (EC): 11 Sept 2008 – 10 Sept 2009; 2001 Ethiopian Fiscal Year (EFY): 8 July 2008 – 7 July 2009.

This document presents all dates in the Gregorian calendar, but because the majority of government reporting is done by the Ethiopian Fiscal Year, annual reporting falls across two Gregorian years. Therefore, "2008/09" most often means the 12 months between 8 July 2008 and 7 July 2009. For ART and PMTCT data reported from facilities on a monthly or quarterly basis, the federal HIV/AIDS Prevention and Control Office (HAPCO) has provided data for January to December.

## 2.2. Current status of the epidemic

*Table 3: UNGASS indicators on HIV prevalence*

| UNGASS indicator | | | |
|---|---|---|---|
| Indicator #22: Reduction in HIV prevalence | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of young women and men aged 15–24 who are HIV infected | 15-24-year-old pregnant women | 3.5% | HIV Sentinel surveillance, 2007 |
| Numerator: Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive | | 575 | |
| Denominator: Number of antenatal clinic attendees (aged 15–24) tested for their HIV infection status | | 16,543 | |

### 2.2.1. General p

### opulation

The HIV/AIDS epidemic in the country is classified as “generalized” among the adult population with significant heterogeneity among regions and population groups. The rural epidemic appears to be relatively widespread but heterogeneous, with most rural areas having relatively low prevalence of HIV. The epidemic continues to impact every sector of society with huge regional, urban-rural and sex differentials[12].

Adult HIV prevalence in 2009 is currently estimated to be between 1.4% and 2.8%[13]. A new single point estimate of HIV prevalence will be generated following the completion of a population-based sero-survey in late 2010. The last single point estimate exercise, done in 2007, estimated urban and rural prevalence of 7.7% and 0.9% respectively for 2009. Prevalence was 1.8% for males and 2.8% for females, and women accounted for 59% of the HIV-positive population. According to the 2007 Single Point Estimate, there were an estimated 1,116,216 people living with HIV in 2009, of which 336,160 were eligible for ART. There were an estimated 131,145 new HIV infection (57% Female) and 44,751 AIDS-related deaths (57% Female). The total estimated number of HIV-positive pregnant women and annual HIV positive births in the same year were 84,189 and 14,140 respectively.

There were an estimated 72,945 children less than 15 years old living with HIV, out of which 20,522 needed ART. Due to the combined effect of poverty and AIDS, more than 5.4 million children under the age of 18 years were orphaned out of which 855,720 (16%) lost at least one parent due to AIDS.

Available data suggested that HIV prevalence may be increasing in small market towns compared to big towns, which is worrisome as the former can serve as bridging sites for urban to rural spread of HIV. While gender-based violence and substance abuse (alcohol and khat) were considered as factors that exacerbate the spread of HIV among certain groups[14], widow inheritance, polygamy, high divorce rate and skin tattooing intensified the magnitude in some areas of the country[15]. A national study[16] demonstrated that alcohol and khat use substantially and significantly increase the likelihood of having multiple sexual partnerships (MSPs); those who use alcohol and khat are about twice more likely to have MSPs than those who are not using these substances. Condom use is less by at least 50% among alcohol and khat users than those who do not use these substances.

## 2.2.2. Pastoralist community

HIV prevalence in the regional states where pastoralists mainly reside was 1.9% (in Afar region) and 0.8% (in Somali region) according to the 2007 Single Point Estimate. According to a study conducted among pastoralist communities in Somali Region, cultural and traditional practices, and low awareness and knowledge about HIV/AIDS due to limited HIV/AIDS interventions were the main factors that put pastoralist communities at risk of HIV infection[17]. The study revealed an awareness level of 85%. which is lower than the national figure documented in DHS 2005 (90% women and 97% men). Correct use of condom was reported to be 19%. About two-third (38%) were found to know that HIV is transmitted from infected mother to child – higher than the regional average of 6% and national average of 20% documented in 2005 DHS. Furthermore, only 33.3% and 52.4% mentioned that abstinence from sex and a faithful relationship with an uninfected partner can protect a person from contracting HIV infection. Misconception about HIV transmission was high: 38% said HIV can be transmitted by mosquito bite. The same proportion (38%) also said that a healthy looking person can have HIV.

### 2.2.3. Young people and gender

Recent data regarding young people and gender in relation to HIV prevalence are scanty, and trends will be difficult to confirm until the next DHS is conducted in late 2010. The 2005 DHS suggested that young women are particularly vulnerable to HIV infection compared with young men. The risk of HIV infection among rural women and men is almost identical, while urban women are more than three times as likely as urban men to be infected (DHS 2005). A high rate of condom use was also reported by never married, educated young women in the highest wealth quintile[18].

### 2.2.4. Vulnerable and most-at-risk populations

The 2007 "epidemiological synthesis" exercise that reviewed and analyzed available data over a period of 15 years suggested that uniformed services, truckers, refugees and displaced people, street children, daily laborers, students and other mobile populations are vulnerable groups for HIV infections in the country[19]. A 2009 evaluation exercise of the Ethiopian Strategic Plan for Intensifying Multi-Sectoral Response 2004-2008 (SPM) further identified students (from high school through university), migrant laborers, out-of-school youth, and indigenous populations in remote foreign tourist destinations that are involved in high risk commercial sex transactions as populations potentially at greater risk of HIV infection[20]. Mobile populations including cross-border populations may also be considered among the most-at-risk groups in the country[21]. A national survey focused on most-at-risk populations planned for 2010 is expected to provide additional information on which population groups should be targeted by HIV prevention efforts.

A sub-national study was conducted in HIV hotspots of Amhara Regional State to determine most locally relevant MARPs and their magnitude, determine prevalence of HIV and syphilis, and identify risk factors for HIV infection. The ten hot spot districts were identified based on the ANC-based HIV prevalence and facility based HIV data from the region. The study focused on five groups: sex workers (n=389), long-distance truck drivers (n=51), mobile merchants (n=179), daily laborers (n=349), and students (n=389). HIV prevalence among these groups, ranging from 11.6% to 37%, was considerably higher (1.5 to 5 fold) than the national urban adult population (7.7%)[22]. Higher prevalence was linked with high sexual partner change, concurrent sexual partnership, high exposure to STIs, and low and inconsistent condom use. However, generalizing these findings is difficult because of the small sample size of the study group as well as the nature of the sites which were identified as hot spots.

A recent study on mobile counseling and testing data identified petty traders as a potential high risk population[23]. Moreover, anecdotal evidence suggest the emergence of new risk groups in Ethiopia, for instance, men having sex with men (MSM) and injecting drug users.

Prisoners may also be at higher risk of infection. The Government of Ethiopia has extended comprehensive HIV/AIDS-related services in prisons, including AIDS-related treatment in prison health clinics[24].

## 2.2.5. Female sex workers and clients

The size of the sex worker population in Ethiopia is not known. However, evidence suggest that sex work in Ethiopia is undergoing demographic and behavioral change. The number of sex workers is growing; much younger girls are joining the trade, and the average number of client they are seeing is increasing[25].

A recent analysis of data from mobile counseling and testing clinics in 40 towns located on the major transportation corridors that link Addis Ababa to Ethiopia's borders found that 25.3% of the sex workers who received the service were HIV positive[26]. The study also documented that despite high levels of risk perception, high levels of trust on condoms and preference to use condoms, sex workers sometimes fail to negotiate safer sex. The reported reasons for the lack of consistent condom use among sex workers were violence, financial incentives and preference for unprotected sex with trusted partners.

The few available studies of sex workers suggest that higher rates of HIV infection are associated with increasing age, (probably associated with longer duration in sex work), marital status (high among divorced/widowed), place of work (in those working in bars/hotels), the presence of active syphilis and other STIs, higher numbers of sexual partners, and inconsistent condom use[27]. However reported condom use among sex workers has significantly risen in the past years from only 5.3% in 1989 to 91.6% in 2005[28], to almost universal condom use during paid sex (99.4%) in 2009[29].

A recent behavioral study focusing on venue based sex workers conducted in ten small and major towns of the country documented that sex workers are young, with a mean age of 22 years a range of 14-54 years with a third of them under the age of 20 years. This mean age and percentage of sex workers under the age of 20 have remained relatively constant since 2002. However, the mean age is much lower than that recorded (31.5 years) in Addis Ababa ten years ago[30]. There are concerns that younger women engaging in sex work may be less likely to negotiate safer sex such as condom use with their partner.

The same study demonstrated a significant increase in sex workers' mean number of clients per week from three in 2000 (BSS 2000) to five. This trend suggests an increased demand for paid sex and may also mean an increase in the number of unprotected sexual acts if condom use is assumed to be equal or decreases. About 88% of sex workers reported having sex with at least one paying partner in the seven days preceding the study. The study also showed that about one-third of sex workers reported having one or more non-paying partners in the 30 days preceding the study, with a mean of 2.5 non-paying partners in a month. When paying and non-paying partners are combined, sex workers have a mean of 20-23 sexual partners per month. Condom use with paying clients was almost universal (99.4%) during their most recent client (last seven days) and 86.2% over a 30 days period. However, consistent use of condom with non-paying partners was only 66%. Compared to the 2005 BSS, there is an increasing trend in condom use with paying partners and a declining trend of consistent condom use with non-paying partners.

Table 4: C*ondom use pattern among sex workers in ten towns, 2008*

| | 2002 BSS | 2005 BSS | 2008 DKT/HAPCO |
|---|---|---|---|
| Condom use with the most recent sex with paying client (last 7 days) | 91.6% | 98.3% | 99.4% |
| Consistent condom use with paying client (last 30 days) | 91.6% | 98.3% | 86.2% |

| | | | |
|---|---|---|---|
| Condom use with the most recent sex a non-paying partner (last 30 days) | | 78.3% | 65.7% |
| Consistent condom use with non-paying partner (last one year) | 70.5% | 70.2% | 56.3% |

In terms of other socio-demographic parameters, the study documented that 70% of sex workers attended at least elementary school. While two-third of them reported having never been married, a considerable portion (31%) were divorced or widowed; and 83% were not born in the towns they inhabited. Poverty and marriage dissolution are considered to be major "push" factors for joining sex work.

Another study on sex workers in five big cities of the country showed that 76% maintained only commercial/non-regular sexual partners, while one-quarter had regular cohabitating or non-cohabitating partners. Respondents had an average of 4.2 paying clients in the past week, with those working in red light districts having considerably more partners (a mean of 5.8) compared to those working in hotels or bars (a mean of 2.9 partners). Condom use was very high, with 99% reporting condom use during last sex, and 98% reporting consistent condom use with their five most recent non-regular partners. Consistent condom use was lower with regular partners (61%). At the same time, 9% of respondents reported a suspected or confirmed sexually transmitted infection (STI) in the previous 12 months[31].

*Clients of sex workers*: Studies find that clients of sex workers come from all walks of life, including truckers and intercity bus drivers (22%), merchants and traders (15%), uniformed workers (14%), civil servants, daily laborers and unemployed (12% each). Most clients of sex workers were middle aged, with nearly half between the ages of 30-39 and 14% between 17-24 years. The vast majority (96%) had some education and nearly 70% completed 9$^{th}$ grade[32].

## 2.2.6. People with disabilities

There are an estimated 7 million people living with some kind of disability in Ethiopia, 10% of the total population. Visual impairment accounted about 42.2% of all disabilities while hearing impairment and disability from leprosy contributes 7.8% and 6.5% respectively. People with disabilities (PwDs) are among the most socially and economically disadvantaged segment of the population. Besides their physical suffering from pain and immobility, these individuals are socially distressed from various forms of stigma and discrimination, mental anxiety, dependency and rejection. Generally there is lack of epidemiological data on the prevalence of HIV among people with disabilities. However, a study conducted to assess the HIV/AIDS and disability situation in Ethiopia suggested that people with disabilities could be among vulnerable groups. The report documented that in one town (Ambalage woreda of Grayne station) 132 blind persons were tested for HIV and six were found to be positive[33].

The study also found that people with disabilities are among the poorest, less educated and most stigmatized people. The stigma experienced by PwDs creates a feeling of insecurity that drives them to risky sexual behavior such as having multiple sexual partners. Furthermore, PwDs are vulnerable to violence and sexual abuse, including rape – situations where they are less likely to negotiate safer sex, such as condom use. The prevailing social discrimination places women, children and the elderly with disabilities at even higher risk due to greater possibility of physical and sexual abuses. Almost all services are prepared for able bodied persons. PwDs therefore have little access to HIV/AIDS information and services. HIV prevention messages and communications are often inaccessible to people who have visual or hearing impairments, and health services have limited access to people with physical disabilities. The study specifically pointed out that restrictions of PwDs to the home environment, low income, and low levels of education are the most important factors for poor access to HIV/AIDS interventions and services.

There is a national HIV and Disability Taskforce with members from government, UN agencies and associations working on issues of disabilities in Ethiopia. Currently there are 17 organizations working on issues of disabilities that at the same time have HIV/AIDS awareness raising programs. However there is lack of information on the magnitude of HIV among PwD, capacity to provide HIV/AIDS services as well as poor capacity to mobilize PwDs. Furthermore, there is insufficient coordination among the different associations working on disabilities to deal with HIV/AIDS[34].

## 2.3. Knowledge and behavior

*Table 5: UNGASS indicators on knowledge*

| UNGASS indicators | | | |
|---|---|---|---|
| Indicator #13: Knowledge about HIV prevention ( young people) | Disaggregation | Value | Source/ Year |
| Indicator Value: Correct answer to all five questions | Male<br>Female | 33.3%<br>20.5% | DHS 2005 |
| Questions:<br>1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?<br>2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?<br>3. Can a healthy-looking person have HIV?<br>4. Can a person get HIV from mosquito bites?<br>5. Can a person get HIV by sharing food with someone who is infected? | | | |
| Percentage of young people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | | | |
| Numerator: Number of respondents aged 15–24 years who gave the correct answer to all five questions | Male<br>Female | n/a<br>n/a | |
| Denominator: Number of all respondents aged 15–24 (unweighted) | Male<br>Female | 2,317<br>5,869 | |
| Indicator #14: Knowledge about HIV prevention ( most-at-risk populations) | Disaggregation | Value | Source/ Year |

| | | | |
|---|---|---|---|
| Indicator Value: Correct answer to all five questions | Female sex workers | 35.7 | BSS 2005 |
| Questions:<br>1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?<br>2. Can using condoms reduce the risk of HIV transmission?<br>3. Can a healthy-looking person have HIV?<br>4. Can a person get HIV from mosquito bites?<br>5. Can a person get HIV by sharing a meal with someone who is infected? | | | |
| Numerator: Number of most-at-risk population respondents who gave the correct answers to all five questions | Female sex workers | 470 | |
| Denominator: Number of most-at-risk population respondents who gave answers, including "don't know", to all five questions, | Female sex workers | 1,314 | |

### 2.3.1. Knowledge and behavior among the general population

According to an evaluation of progress against the 2004-2008 strategic plan, comprehensive knowledge about HIV prevention and transmission is still low[35]. The 2005 DHS report showed that young women age 15-24, especially never-married, are generally somewhat more knowledgeable of the various modes of prevention than older women, while the opposite pattern is observed among men. A national survey conducted in 2008 for the Health Impact Evaluation found that comprehensive knowledge of HIV prevention and transmission was 12.5% among women – lower than the 16% reported by DHS 2005. According to this survey, knowledge levels were lowest among women above the age of 30, married, lowest wealth index, rural, uneducated and from emerging regions (Afar, Somali, Benshangul-Gumuz, and Gambella). Although direct comparison of the two surveys (DHS 2005 and the 2008 Health Impact Evaluation) has to be done cautiously, the apparent lack of progress is reason for concern[36].

The 2008 Health Impact Evaluation found that only 53.2% of women know that a healthy-looking person can have the virus, compared to 37% in the DHS 2000 and 51% in the DHS 2005. Half of the respondents in 2008 were aware that HIV cannot be transmitted through a mosquito bite. A large proportion of women knew that HIV cannot be transmitted by supernatural means (67.5%) or though sharing food with an infected person (74.3%). Only 54.4%, 46.5% and 41.3% of the women indicated that abstaining from sexual intercourse, limiting sex to one uninfected partner and using condom every time they have sexual intercourse reduce the risk of getting the AIDS virus, respectively[37].

Knowledge of using condoms as a means of avoiding HIV was 40%, similar to the DHS 2005 result of 41%. The proportion of women having had two or more partners was 0.2% in 2005 and 1.3% in 2008, and those who reported having had higher risk sexual intercourse was 2.7% in 2005 and 5.3% in 2008.

*Table 6: Knowledge and behavior related to HIV/AIDS and condom use from various surveys*

| Indicator | DHS 2000 [Both sex] | DHS 2005 women | Health Impact study DCA 2007 (women) |
|---|---|---|---|
| Proportion of women who are aware of HIV/AIDS | 85% | 96% | 93% |
| Comprehensive knowledge of HIV/AIDS transmission[38] among women age 15-49 years<br>Comprehensive knowledge of HIV/AIDS transmission among young women (15-24 years) | | 16%<br>20% | 12.5%<br>15.2% |
| Percentage of women who say that HIV can be transmitted by breastfeeding (from mother to child) | 58.2% | 69.3% | |
| % of women know that healthy-looking person can have AIDS virus | 37% | 51% | 53.2% |
| % of women who said HIV cannot be transmitted through a mosquito bite | 0.1% | 47% | 50% |
| % of women who said HIV cannot be transmitted by supernatural means | | 70% | 67.5% |
| % of women who said that a person cannot become infected by sharing food with a person who has AIDS | | 63.4% | 74.3% |
| % of women with Knowledge that the chances of getting the AIDS virus can be reduced by abstaining from sexual intercourse | 10.8 | 62% | 54.4% |
| % of women knowledge that the chances of getting the AIDS virus can be reduced by limiting sex to one uninfected partner who has no other partners | 52.6% | 63% | 46.5% |
| % of women who know that using condom every time they have sexual intercourse reduce the risk of getting the AIDS virus | 17.1% | 40% | 41.3% |
| % of unmarried women who had two or more sexual partners in past 12 months | 1.1% | 0.2% | 1.3% |
| % of young women (15-24) engaged in higher-risk sex activity among those who had sexual intercourse in the past 12 months | | 6% | 8.6% |
| % of women who had higher risk sexual intercourse (sex with a non-marital, non-cohabitating partner) in past 12 months | | 2.7% | 5.3% |
| % of women who had higher risk sexual intercourse in the past 12 months who reported using a condom at the last time they had sex | 13.4% | 24% | 46.7% |
| % of never-married young women reported that they had had recent sex with in the 12 months period before the survey | 11% | 2% | 3.6% |
| % of young women (15-24) who reported who had sex in the past 12 months reported using condom the last sexual intercourse | | 5.8% | 45.3% |
| % of young women (15-24) reported know a condom source | | 34% | 64.4% |
| % of young women (15-24) who had sex by the age of 15 | | 16% | 6% |

A study aimed at understanding HIV and AIDS in the context of the Productive Safety Net Program (PSNP) -- one of the largest development programs in Ethiopia -- showed that women's knowledge of HIV and AIDS was assessed generally to be lower than men's [39].

A study conducted by EIFDDA in 33 districts all over the country (n=13,385) documented an HIV/AIDS awareness level of 93%. Sixty-nine percent said a healthy looking person can have HIV, 59% rejected two common misconceptions (HIV can be transmitted by mosquito bite and sharing food with PLHIV), about half of respondents mentioned that condom and faithfulness can prevent HIV infection, and 33.3% were found to have comprehensive knowledge on HIV/AIDS. A majority of respondents stated that substance use, such as alcohol and khat, multiple sexual partnerships, mobility and harmful traditional practices as risky to HIV transmission in the community[40].

An impact assessment study of ILO/USDOL workplace interventions in seven enterprises found that 70.2% of workers had knowledge of the three means of protection against sexual transmission of HIV infection[41]. Some improvement was observed on the attitude of the study population towards people living with HIV/AIDS (PLWHA) compared to the baseline. About 10% more respondents expressed their willingness to use the same toilet and share utensils with HIV positive coworkers. The study also documented that half of respondents agreed with the practice of using condoms by married men and women. Only 8.5% felt that they are at risk of HIV infection. Surprisingly, 37.6% of the respondents reported that they did not know how to use condoms correctly, and 44.8% of respondents had ever been tested for HIV.

### 2.3.2. Knowledge and behavior among youth

Evidence suggests that a substantial proportion of young people continues to engage in risky sexual behaviors. For example, never-married, sexually active females have the highest risk of infection in the country, with HIV prevalence higher than the average for all women of reproductive age[42].
In the 2008 Health Impact Evaluation, only 15.2% of young women aged 15-24 had comprehensive knowledge about HIV/AIDS, compared to 20% in the 2005 DHS. Forty-eight percent, 50% and 58% of women age 15-24 reported consistent condom use, limiting sexual intercourse with one uninfected partner and abstaining from sex as means of contracting HIV infection[43]. The level of comprehensive knowledge increased with education and wealth status. Interestingly, quite a larger proportion of young women (64.4%) knew where to obtain a condom, almost twice as high as the 2005 DHS (34%).

The 2008 Health Impact Evaluation found higher rates of high risk sexual behavior[44],[45] compared to the 2005 DHS. In particular, the 2008 study reported higher risky sexual behavior among the youth, rural people, the uneducated and those from the lowest wealth quintile. In addition, the proportion of women having had two or more partners increased over six fold (from 0.2% to 1.3%) while having had higher risk sexual intercourse doubled (from 2.7% to 5.3%).

Encouragingly, the proportion of young women aged 15-24 having sex by the age of 15 was 16% in the 2005 DHS and 6% in the 2008 Health Impact Evaluation. In the more recent survey, quite a small proportion (3.6%) of never married young women reported having sex in the past 12 months, of which 8.6% engaged in higher-risk sex activities, compared to 6% in 2005 DHS. Higher-risk sexual activity was observed among young women with secondary and above education (21% among those with education to 1.8% with no education), among those in the highest wealth quintile than those in lowest (24% with the highest to 2% with the lowest). Among never-married young women who had sex in the past 12 month, a significant proportion (45.3%) reported using condoms during the last sexual intercourse.

Another study documented that sexually active youth understand and report the value of wearing condom during sex; however they sometimes fail to negotiate safe sex for reasons of curiosity, to increase sexual satisfaction, questioning condom's effectiveness and influences of substance such as alcohol, khat and shisha[46].

A study conducted in Addis Ababa to look into male norms that lead to increased HIV risk among youth (mean age of 19 years) documented that 37% have had sex with an average age of first sex of 18 years. While a negligible proportion mentioned multiple partners in the last six months, 9.3% and 5.4% reported having had sex with a casual partner and with commercial sex workers respectively[47].

The magnitude of alcohol use is high among youth, where about 10.9% of in-school-youth (ISY) had consumed alcohol drinks the month preceding the interview, and of all ISY, 3.3% were regular alcohol consumers. Males were 1.4 times more likely than females to have reported condom use during their first sex[48].

One-fifth (n=364) of high school adolescents in one Ethiopian town reported that they had premarital sexual intercourse at the time of survey conducted; of which about three-forth were male[49].

A small scale study (n=729) among Addis Ababa youth indicated that HIV/AIDS knowledge, particularly of HIV transmission, among the members of the youth groups was high. Most respondents (86%) believed that sexually transmitted infections increase the chance of getting HIV infection. About two-thirds (70%) mentioned that HIV infected women can transmit HIV to her baby. Furthermore, 87% said that a healthy looking person can have the AIDS virus. While 99% said HIV cannot be transmitted by sharing meal with HIV infected person and 98% mentioned that condoms protect a person from getting HIV, surprisingly about one-third (32%) of respondents erroneously believed that HIV could be transmitted through a mosquito bite[50].

Although the results may not be nationally representative, a small-scale 'proof-of-concept' study (n=7,885; in eight facilities in Oromiya region) found that many voluntary counseling and testing (VCT) clients (29% of male and 35% of female) had never had sex, and that their reason for having an HIV test was due to "a parallel belief system" about the mode of HIV transmission. Although these clients knew that HIV is transmitted sexually, they felt it equally probable that HIV could be transmitted via other unlikely or even impossible means. Among these VCT clients who had never had sex, 95% (2,567) believed that sometimes people are infected with HIV "for no apparent reason", while 20% believe people who abstain from sex are protected from HIV[51].

*Table 7: UNGASS indicator for sexual behavior*

| UNGASS indicators | | | |
|---|---|---|---|
| Indicator #15: Sex before the age of 15 | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of young women and men who have had sexual intercourse before the age of 15 | Male<br>Female | 1.7%<br>15.8% | DHS 2005 |
| Numerator: Number of respondents (aged 15–24 years) who report the age at which they first had sexual intercourse as under 15 years | Male<br>Female | n/a<br>n/a | |
| Denominator: Number of all respondents aged 15–24 years (unweighted) | Male<br>Female | 2,317<br>5,869 | |
| Indicator #16: High risk sex | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of adults aged 15–49 who have | Male | 2.4% | DHS 2005 |

| | | | |
|---|---|---|---|
| had sexual intercourse with more than one partner in the last 12 months | Female | 0.1% | |
| Numerator: Number of respondents aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months | Male<br>Female | n/a<br>n/a | |
| Denominator: Number of all respondents aged 15–49 years (unweighted) | Male<br>Female | 5,472<br>14,070 | |
| Indicator #17: Condom use during higher-risk sex | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse | Male<br>Female | 8.5%<br>n/a | DHS 2005 |
| Numerator: Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex | Male<br>Female | n/a<br>n/a | |
| Denominator: Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months (unweighted) | Male<br>Female | 176<br>17 | |
| Indicator #18: Sex-workers -condom use | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of female and male sex workers reporting the use of a condom with their most recent client | Female<br>Female <25<br>Female25+ | 83.6%<br>84.3%<br>81.5% | BSS 2005 |
| Numerator: Number of respondents who reported that a condom was used with their last client | Female<br>Female <25<br>Female25+ | 1,114<br>872<br>242 | |
| Denominator: Number of respondents who reported having commercial sex in the last 12 months | Female<br>Female <25<br>Female25+ | 1,332<br>1,035<br>297 | |

Young men are more likely than young women to know where to obtain a condom (56 and 34 percent, respectively)[52]. The proportion of young women who knew where to obtain a condom in the 2008 Health Impact Evaluation was double compared to the percentage recorded in DHS 2005 which was just 34%. Knowledge of a condom source increased with level of education and wealth status, which is consistent with the pattern observed in comprehensive knowledge among youth. Never married young women are more likely to know where to obtain a condom than those who were ever married. Use of condoms among women who had high-risk sex (sexual intercourse with a partner who is neither a spouse nor cohabiting partner) in the past 12 months was46.4% in the 2008 Health Impact Evaluation[53], compared to 24% reported in the 2005 DHS.

Among Addis Ababa youth, 55% who have had sex used a condom the first time they had sex and 76% used a condom the last time they had sex. Their main reason for using a condom was for the prevention of STIs and HIV infection (55%), and reason for not using condom was 'trust on partner' (25%). A majority of the youth group members said they are capable of using condom correctly (60%), are confident they can negotiate condom use every time they have sex with partners (70%), and are likely to use condom next time they have sex with their partners (70%). Use of any other types of family planning, however, is very low[54].

A multi-woreda KAP study conducted by EIFDDA revealed that 20% of respondents had multiple sexual partners during their life time while 5% had extramarital/partner sex in the last 12 months[55]. About 30% had ever used a condom. Moreover, only 21% had used a condom during their most recent sexual encounter. Among those who had extramarital/partner sex in the last 12 months 59% used a condom.

### 2.3.3. Stigma and discrimination

The government has been working closely with civil society to better monitor the situation around stigma and discrimination of people infected and affected by the virus and design programs to raise awareness and understanding. For example, a multi-site study on knowledge, attitude and behavior study conducted by the faith-based network EIFDDA in 33 woredas among the general population found that 30% of the respondents had acceptable attitudes regarding PLHIV on all four indicators (willingness to care for PLHIV, to buy from PLHIV, allow PLHIV to teach their children and keep family member's HIV result secret). This may highlight an improvement as compared to the figure documented in DHS 2005 which was only 10.7% among females and 16% among males in the general population. Accepting attitudes were higher among younger and educated groups of respondents[56].

A recent study found that 8% of PLHIV respondents had experienced human rights violations such as denial of employment (3%), eviction from home (3%), and loss of job (2%) as a result of their HIV status. In addition, 18% had verbal insults directed at them because of their HIV status. Those directing verbal insults included neighbors (48%), family or relatives (14%), co-workers (11%), friends (11%), strangers and social acquaintance (8%)[57].

A study conducted among youth in Addis Ababa found that discussion about HIV and AIDS, condoms and sex life with male friends wasn't a problem, but talking to family members and doctors was. It was reportedly easier to talk about HIV and AIDS (41% to family members, and 23% to doctors) than sex life (7% each to family members and doctors) and condoms (11% to family members, and 18% to doctors) [58].

The national PLHIV network, NEP+, and Federal HAPCO, in collaboration with other partners, have launched a national study to measure the level of stigma associated with HIV and AIDS – "*The People Living with HIV Stigma Index"* – based on an internationally developed tool using resources obtained from International Planned Parenthood Federation (IPPF) and other donors. A national Technical Working Group was established to oversee and provide close technical support as well as strategic guidance throughout the process[59].

## 2.4. Impact of AIDS

*Impacts of HIV/AIDS on Livelihoods and Food Security:* A study in three woredas (n=1,245 households, of which 620 were HIV/AIDS affected and 625 not affected) revealed that, of the total 223 deaths in 2006-07 – when ART coverage was very low – 90% took place in affected households. HIV/AIDS-affected households had a higher percentage of widow-headed households, a higher dependency ratio and a much higher number of orphans. In terms of labor availability, male-headed, unaffected households had two times higher number of adult labor than those affected households. Similarly female-headed, HIV/AIDS-affected households had the lowest number of working adults, reduced on average by half compared to male-headed, HIV/AIDS-affected households.

In terms land utilization, unaffected households in the study had utilized more land and had more labor force to cultivate it compared to affected households. Male-headed households also had more land utilized and labor force than female-headed households. When looking at income and assets, on average, affected households earned less income from various sources such as sale of crops and livestock and self employment. The difference in average annual income between the two groups amounted to 1,000 birr per household. A higher number of unaffected households owned various types of assets than affected households. Six percent of affected households reported to have plough oxen, compared to 52% of unaffected households. More unaffected households also reported owning radios, farm implements and jewelry. By contrast, a higher number of affected households reported selling assets, including productive ones[60].

Regarding food security status, the Food Consumption Score (FCS) results show a higher percentage of affected households had poor consumption compared to unaffected households. The affected households used more severe coping strategies as compared to unaffected households. The study found a statistically significant association of being HIV/AIDS-affected with consumption-related strategies like reducing the quantity or number of meals eaten, and going the entire day without eating.

Since the study, there has been a significant increase in nutritional support to people infected and affected by HIV. In addition, HIV/AIDS services have been mainstreamed into the national Productive Safety Net Program, which distributes cash and food to chronically food-insecure beneficiaries in rural areas, and mobilizes communities to participate in public works programmes.

*Impact of ART on AIDS mortality:* As in many developing countries, Ethiopia does not have a well functioning vital registration system that provides accurate cause-specific adult mortality estimates. As a result, little is known about the effect of HIV/AIDS at the population level, or about the effectiveness of efforts to mitigate its impact. However, findings of a mortality surveillance study that collected burial data in Addis Ababa (based on verbal autopsy interview with close relatives or caretakers and physician review of cause of death) documented a reduction in AIDS mortality following the introduction of ART[61]. This reversal was indicated by a declining ratio of observed over projected deaths (for all-cause mortality), and by estimates of the trend in AIDS-specific mortality. The decline in the number of adult AIDS deaths since the rapid scale up ART is significant.

# 3. National response to the HIV/AIDS epidemic in Ethiopia

Despite the overwhelming challenges, the Government of Ethiopia is making efforts towards containing the epidemic and mitigating the impact of HIV/AIDS through an intensified national response in a comprehensive and accelerated manner.

Ethiopia has developed and implemented a Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support (2007–2010). This process has been guided by the HIV/AIDS Strategic Plan for Multisectoral Response (SPM), Ethiopia's universal access commitment, and the "Three Ones" principles. This harmonized SPM was prepared with participation of regions, sector organizations, employee associations, the private sector, development partners, the Network of Network of HIV Positives in Ethiopia (NEP+), the Ethiopian Inter-Faith Forum for Development, Dialogue and Action (EIFDDA) and others.

The SPM aimed to enhance implementation capacity, coordination and networking, leadership and mainstreaming, social mobilization and community empowerment, integration of services and targeting responses in order to alleviate the health, social and economic impact of HIV/AIDS. It has been the lead document in coordinating the national response to the epidemic in Ethiopia.

Commendable progress has been seen in creating an enabling environment and institutional strengthening in terms of governance and mainstreaming, partnership and networking, resource mobilization, multisectoral approach, and addressing gender issues in the context of HIV/AIDS[62].

Huge efforts had been made to build the implementation capacity, especially in the health sector, in areas of human resource development, site expansion and construction of health facilities; strengthening the capacity of sectors and community based organizations (CBOs), faith based organization (FBOs), PLHIV associations and others; establishing HIV/AIDS coordinating units; and establishing youth centers in various parts of the country. Intensive trainings have been given on various components of the HIV/AIDS program, including on HIV counseling and testing, prevention of mother to child transmission (PMTCT), and chronic HIV care including ART.

Ethiopia is also taking a leadership role at global and regional levels. First Lady Azeb Mesfin is currently the Chair of the National Coalition of Women Against HIV/AIDS and the President of Organization of African First Ladies Against HIV and AIDS. In these roles, the First Lady Mrs. Mesfin has shown extraordinary dedication to the cause of African women, both against HIV and against social norms that drive the vulnerability of women and girls. In addition, the Minister of Health, Dr. Tedros Adhanom, has recently served as the Chair of the executive boards of both UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria.

This leadership role was recently recognized when Ethiopia was selected to host the 2011 International Conference on AIDS and STIs in Africa (ICASA). As it announced the host country, the Society for AIDS in Africa praised the Ethiopia's "stability, communication, security, accommodation, dynamic NGO presence, strong scientific population and most importantly, the Government's strong commitment in the fight against HIV, AIDS, TB and Malaria"[63].

## 3.1. Policy environment

The Government of Ethiopia endorsed a comprehensive HIV/AIDS policy in 1998, which is under revision currently to accommodate provisions for treatment and care aspects of the HIV/AIDS response. A number of other supporting policies, strategies and guidelines were also developed, distributed and utilized to guide comprehensive HIV prevention, treatment, care and support services at affordable cost for all needy individual and family, whereas HCT and ART programs are provided free of charge and addresses the barriers for women, children and other most-at-risk populations.

After a thorough review and analysis of the epidemic, the current response's major achievements, gaps, and challenges of the National HIV/AIDS program which was guided by the SPM in the past five years, a second multisectoral strategic plan (SPMII) was developed with the involvement of appropriate stakeholders using regular consultation and brainstorming sessions. The plan covers five years (2009-2014) and focuses on the enabling environment for the response and priority programmatic thematic areas. Strategic issues included in the enabling thematic area are capacity building, community mobilization and empowerment, leadership and governance, mainstreaming, coordination, and partnership and networking. Whereas strategic issues in the programmatic thematic areas include: intensifying HIV prevention, increasing access and quality of chronic care and treatment, strengthen care and support, and enhance generation and use of strategic information.

The main national strategies developed and implemented by different stakeholders at national level to curb the epidemic and address the burden of the pandemic are; (a) Promote VCT and other behavioral change interventions, (b) Promote the use of male and female condoms, (c) Provide user-friendly reproductive health and STI services, (d) Enhance bargaining and negotiations skills for safe sex where applicable, (e) Provide safe and alternative income generating and employment opportunities where applicable, (f) Strengthen and expand school anti AIDS clubs and mini medias, (g) Integrate HIV/AIDS in life skill education and basic curriculum, (g) Develop youth centers and entertainment resorts, and (h) Organize the youth on voluntary basis and provide peer education.

*HIV and Human rights:* For the protection of most-at-risk populations or other vulnerable subpopulations, the country has developed non-discrimination laws or regulations. CSOs such as Ethiopian lawyers' association, women's association, and professional associations like teachers' association are enforcing laws and regulations to be implemented. In addition to this, work place policies are implemented and followed by the civil service agency, and the Ministry of Labor and Social Affairs. Moreover, in Ethiopia, the criminal law and HIV/AIDS policy which was issued in 1998 are under review to remove inconsistencies with the national HIV strategy that may present obstacles to effective HIV prevention, treatment, care and support for these subpopulations.

Ethiopia has laws and regulations that protect people living with HIV against discrimination. These include both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.). Mandatory HIV testing for employment is strictly prohibited in the country's Labor law (Labor Proclamation No. 262/2001 and 377/2003 Article 14.1 d). Additionally, the Civil Service Workplace HIV/AIDS Guideline of the country also protects people living with HIV from discrimination by employers. Governmental sectors and non-governmental organizations have been strongly working for the implementation of these laws and regulations (e.g. Ethiopian Human Rights Commission, Federal Ministry of Labor and Social Affairs, Federal Ministry of Women's Affairs, Ethiopian Women Lawyers Association, Women's Coalition, women's PLHIV network and others).

As part of the human rights issues, the country has a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination), and to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national or local ethical review committee. The ethical review committee includes representatives of civil society and people living with HIV. For monitoring and enforcement of the human right issues, the country has independent national institutions with focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment. There are organizations like the Ethiopian Women Lawyers Association providing free legal services to people living with HIV, and there are programs to educate, reduce HIV-related stigma and discrimination, raise awareness among people living with HIV concerning their rights.

*HIV and youth:* There is a national youth policy that calls on youth to be active participants in and beneficiaries of democratization and economic development activities. The policy addresses a wide range of youth issues, ranging from HIV/AIDS to environmental protection and social services. In addition, the Ethiopian Government has also formulated the youth development package with the view to alleviate the economic, social and political problems of youth[64].

*Program guidelines and standards:* Furthermore, in order to ensure that standardized and quality HIV/AIDS services are being rendered at the community level, various guidelines and standards were developed and distributed. A partnership implementation guideline, social mobilization manuals, a life skills training manual, school Community Conversation guidelines and manual, behavioral change communication message development materials, peer education, life skills education and ART adherence implementation and training manuals were prepared and distributed at various levels.

In addition, a Master Plan for the Public Health Laboratory System in Ethiopia has been developed by EHNRI to serve as the blueprint for the development of Ethiopia's public health laboratory system[65]. Furthermore, a National Logistic Master Plan was developed by PFSA to strengthen procurement, distribution and utilization of HIV/AIDS and other heath commodities in the country.

To facilitate coordination, assist in standardization and better guide the PMTCT program in the country, the following program documents were produced during the reporting period: a PMTCT training manual, a revised manual for the implementation of PMTCT, guidelines and a task-shifting training manual for pediatric HIV/AIDS care and treatment, and a national training manual for Mothers support Group (MSG)

The Joint Coordination Committee (JCC) which comprises of the FMOH and development partners has met on a weekly basis and continued to play a decisive role in addressing coordination, harmonization, financing and monitoring issues at FMOH and Regional levels. Joint Review Missions (JRMs) have also vigorously addressed planning and implementation issues during their field visits.

## 3.2. Resource mobilization and national AIDS spending

### 3.2.1. Support from the country's development partners

The Government has mobilized resources from external and internal sources to allocate the intended national budgets to support the national HIV programs. Ethiopia has been a major recipient of international aid in recent times. There are many development partners assisting the Government of Ethiopia in its goal of providing universal access to quality prevention, care and treatment for those who need the services and improving the health system.

There is a framework of the International Health Partnership (IHP) developed jointly by the Federal Ministry of Health, development partners and civil society on scaling up health services by increased and more effective aid, for reaching the health MDGs through the Heath Sector Development Program (HSDP) and support the long-term vision for development and the medium term strategies and priorities articulated in the Plan for Accelerated and Sustainable Development to End Poverty. The IHP Country Compact establishes guiding principles and management arrangements that will be observed by Government and development partners, including a code of conduct on the harmonization of official development assistance (ODA) to achieving the health MDGs.

The essential components of the Code of Conduct and the Harmonization Manual are:

- A three tier collaborative governance system led by the ministry and including development partner participation at both policy and technical levels. There is an Annual Review Meeting (ARM) that endorses plans and reviews performance reports.
- The vision of one plan, one budget and one report, based on ministry-led processes.
- Agreed funding mechanisms that allow for three channels of financial resource management:
    - Channel I: pooled and managed by government or earmarked by agencies with direct disbursement;
    - Channel II: donor held financing provided directly to sector units or decentralized regional offices to be directly used and accounted for by them;
    - Channel III: direct donor programmed funds disbursed by Development Partners to finance specific contributions to HSDP usually through NGOs.
- Monitoring and evaluation - this includes agreeing a set of indicators to be used for monitoring and evaluation of progress and the issuance of one report[66].

According to OECD-DCA statistics, net ODA to Ethiopia amounted to US$1.94 billion in 2006, making it the 7th largest aid recipient among developing countries[67]. The health sector has enjoyed a large share of ODA, especially following the development of the HSDP by MOH. When looking at program distribution, more than 72% of donor resources financed three diseases: HIV/AIDS, malaria and tuberculosis. The Global Fund and GAVI account for about 55% of all donor resources.

*Global Fund*: The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is the major source of funds for the multi-secotral HIV/AIDS response in Ethiopia. The Global Fund annual spending on HIV/AIDS program increases from 91,209,956.4 Birr in 2003/04 to 1,126,644,612 Birr in 2007/08 - a more than 12 fold increase over 2003/04 spending. A total of USD 896.4 million in GFATM grants has been approved (Rounds 2, 4, 7 and RCC) and out of which 395.9 million USD (44.1%) has been transferred to the Principal Recipients. Out of a total of 3.7 billion birr distributed to implementing organizations at federal and regional level (including government and civil society organizations), 2.4 billion (65%) has been settled[68].

*The World Bank:* In its EMSAP II project, the World Bank has provided 25 million USD to the AIDS response over the last three years. Since the project started, 18.3 million USD (73%) has been obtained and distributed, including 6.98 million USD received in this year alone[69].

*United Nations:* The United Nations and the Government of Ethiopia jointly formulated a Un Development Assistance Framework (UNDAF) for the period 2007-2011 to address the national priorities expressed in the country's development plan, PASDEP. The framework brings 42 UN agencies under one umbrella and serves as a common platform to discuss development issues, pool resources, jointly work towards a common agenda and improve the effectiveness and efficiency of UN responses to identified development challenges. UNDAF has five priority thematic areas for development cooperation: Humanitarian Response, Recovery and Food Security; Basic Social Services and Human Resources; HIV/AIDS; Good Governance; and Enhanced Economic Growth. The goal of the UNDAF HIV/AIDS thematic area is to substantially reduce the vulnerability to HIV infection, especially of women and girls, and alleviate the impact of the epidemic, with emphasis on underserved and affected populations. According to a midterm evaluation of the UNDAF conducted in 2009, technical expertise provided by UN agencies through research, data generation, and coordination, contributions to policy and strategy development and active follow-up of government-led activities has been an added value. Financially out of US$81,850,000 committed, US$64,400,000 (78%) was spent between 2007 and 2009[70].

*HIV Governance Pooled Fund*: HIV Governance Pooled Fund was established in July 2008. The major focus of the project is to improve governance of the HIV/AIDS response through ensuring accountability, improving capacity and promoting responsiveness of coordinating and implementing institutions at all levels and thereby accelerate effective delivery of the programs ongoing by other major projects. It has key activities such as improving capacity of HAPCO to manage the overall national response to HIV/AIDS, mainstreaming of HIV/AIDS and related issues in federal and regional parliaments and supporting policy dialogue, strengthening national partnership forums, improving the availability of relevant social science research and building the capacity of national and regional parliaments to provide oversight on multi-sectoral HIV/AIDS response. The HIV Governance Pool Fund donors are DFID, Irish Aid, Italian Cooperation and UNFPA who will be contributing US$7,481,000.00 within three years for its implementation.

### 3.2.2. National AIDS spending

According to the national multi-sectoral plan of action a total of 2,332,449,291 birr (1.3% domestic and 98.7% external) and 1,388,010,350 birr (2% domestic and 98% external) were planned to be mobilized for the comprehensive HIV/AIDS programs in 2007/08 and 2008/09 respectively[71]. A National Health Accounts exercise – including a multisectoral HIV/AIDS sub-account – was in the process of finalization in early 2010.

## 3.3. Health system strengthening

Investment in the HIV/AIDS program has positively impacted the health system. The large increases in funding for HIV treatment resulted in substantial investments to support rapid scale-up in clinic capacity and infrastructure, characterized by the expansion and renovation of clinic space, improvement of laboratory facilities, HIV-specific clinical training, and the establishment of dedicated administrative and reporting systems[72].

The Government of Ethiopia, in collaboration with partners, continues working to improve the quality and volume of hospital care delivery to reduce morbidity and mortality in the country through a systems-based-approach that focused on improving management capacity of hospitals under the '*Blueprint for Hospital Management in Ethiopia'* and '*Standards for Hospital Management in Ethiopia'* initiatives. The Clinton Foundation HIV/AIDS Initiative (CHAI) and Yale University have supported a Masters of Hospital and Healthcare Administration (MHA) program at Jimma University. Furthermore, regional health bureaus were supported to establish 67 governing boards and assign Chief Executive Officers (CEOs) in 77 health facilities. 'Quality Management Teams' (QMT) were established in each hospital. These QMTs report to the CEO of each hospitals[73]. These new initiatives are believed to significantly improve performance and service delivery standards in public health facilities in the country.

The Laboratory Services Initiative (LSI) supports national reference laboratory at the Ethiopian Health and Nutrition Research Institute (EHNRI) to meet its goals to strengthen the national laboratory system. LSI provides EHNRI with strategic, managerial, institutional and technical support as well as human resources for activities related to improving the quality of integrated laboratory services.

The Ethiopian Millennium Rural Initiative (EMRI) is a community-based comprehensive rural primary health care unit (PHCU) delivery model with the goal of improving the health status of rural and semi-urban communities focusing on maternal and child health. Working in 30 PHCUs in four regions, EMRI is developing a model that will be replicated and scaled up to 3,200 similar primary health care facilities all over the country. Moreover, 100 rural health centers in 10 regions received various types of medical equipment. Two hundred eighty-six health centre staff at 23 health centers were also provided simple equipment maintenance and handling training. The system of HIV/AIDS commodities quantification, forecasting and advising on new products has also greatly improved. This resulted in improved quality and availability of a range of commodities for health and HIV/AIDS services.

## 3.4. Leadership and mainstreaming

As part of the national multi-sectoral strategy, HIV/AIDS is integrated into country's general development plans such as the PASDEP), the UNDAF and various sector plans. A 2007 study on HIV/AIDS mainstreaming showed that almost half of respondents from visited institutions had knowledge and understanding on HIV/AIDS mainstreaming, and a majority recognized its importance. Totally 65% of organizations visited indicated that they considered HIV/AIDS as one of their activities and more than half (52.3%) of the institutions reported to have mainstreamed HIV/AIDS. The assessment further showed a need for stronger sensitization/training/orientation of top management; utilization of already developed guidelines and protocols and action plans; technical and financial support, and regular reviews of progress.

In terms of service provision, IEC/BCC activities were implemented by more than half (57.3%) of public sector institutions, two-thirds (66.7%) of NGOs, four-fifths (80%) of private business institutions and more than four-fifths (83.3%) of FBOs. Moreover, about 37% of public sector institutions, 33.3% of NGOs, 20% of private business institutions and about 17% (16.7%) of FBOs reported that they had either provided or were currently providing condom promotion services. About 31% of public sector institutions, 33.3% of NGOs, 20% of private business institutions, and about 17% of FBOs reported that they provided care and support services for HIV/AIDS infected and affected people[74].

In 2008/09, 41% of government sectors had policies and guidelines for HIV in place, while 48% had established "AIDS funds", which are mobilized from employees of the organization to provide care and support to HIV-affected workers[75]. Eighty-four percent of government organizations had developed action plans to address HIV/AIDS in their workplaces. The proportion of government organizations that allocated 2% of their core budget to HIV activities increased to 64% in 2008/09 from only 18% in 2007/08. Furthermore, about 88% of organizations assigned focal person for HIV/AIDS activities – a marked increase from the 2007/08 proportion of only 50%[76].

Several sector ministries – including the Ministry of Finance and Economic Development, Ministry of Women's Affairs, Ministry of Agriculture, and the Telecommunication Commission – had provided training of trainers (TOT) and training of peer educators. Furthermore, the Ministry of Women's Affairs has drafted standard service delivery guidelines for OVC care and support activities. Various kinds of IEC/BCC activities, including printing and distribution of materials, are being implemented by many public and private sectors, universities, CSOs, NGOs, FBOs, etc.

The education sector plays an important role in shaping the attitudes and behavior of young people regarding the provision of care and support for infected and affected orphans and vulnerable children, as well as laying the foundation for and contributing to improved social and economic development. In this connection as well as in view of the fact that the sector is the largest employer of civil servants and its potential to reach out to a large number of young people, teachers and parents, the national HIV/AIDS Strategic Plan positions the sector as one of the primary actors of the national response. The Ministry of Education (MOE) has finalized a sector policy and strategy on HIV and AIDS that aims to create an HIV-free environment in the education sector in Ethiopia. The policy's objective are:

- Prevention of the spread of HIV in public, private, formal and informal education settings by targeting learners/trainees, families, children, teachers, facilitators and other education sector staff in the country;

- Mitigation of the impact of HIV and AIDS on the sector by creating a supportive learning and teaching environment that is free from stigma and discrimination;

- Mainstreaming of HIV and AIDS interventions into the education sector's structures and processes; and integrating HIV and AIDS issues as pertinent research topics of tertiary-level institutions[77].

Within the education sector, there has been an encouraging start to mainstreaming HIV/AIDS into the curricula of grades 5-8, and developing the capacity of anti-AIDS clubs in schools. The Ministry of Education has reported that all teacher-training institutions, colleges and universities (except Addis Ababa University) have incorporated life skills-based HIV education into their curricula. However, an appraisal of the Ministry's institutional structures, programs, annual plans and periodic reports revealed that the potential role of the education sector in fighting HIV/AIDS and mitigating its impact in Ethiopia remains under-exploited[78].

The Productive Safety Net Program (PSNP) is one of the largest development programs in Ethiopia. PSNP distributes cash and food to chronically food-insecure beneficiaries in rural areas, and mobilizes communities to participate in public works programmes. Efforts to mainstream HIV/AIDS in PSNP have had varied results across regions, with SNNP found to be the most advanced. Through the implementation of the PSNP, a considerable number of public or community assets have been developed; these include schools, clinics, health posts, water collection points, roads, forests replanted, etc. Those which improve health and education facilities indirectly affect knowledge and prevention of HIV and AIDS, while those improving communications and marketable economic surpluses have had a more mixed effect, with opportunities for risky sexual activities having been increased to some degree. The reduction of the need for migration of rural inhabitants to small towns for work has reduced their vulnerability to HIV infection. The prioritization of female-headed households in PSNP has further contributed to vulnerability reduction, since women beneficiaries were economically empowered and appeared better informed about HIV and AIDS[79].

## 3.5. Social mobilization and community response

The World AIDS Campaign theme of "Stop AIDS with Committed Leadership – Keep the Promise" was led by a message from the Prime Minister that focused on Universal Access and Human Rights was transmitted through various national media outlets, both electronic and print. The Prime Minister's leadership on HIV/AIDS has mobilized formal and informal leaders from public and private sectors, as well as communities, to meaningfully contribute to the fight against the epidemic through renewed commitment.

Social mobilization efforts in Ethiopia are mainly measured by the number of Community Conversations (CC) conducted at *kebele* (commune) level and the development of community action plans. During 2008/09 92% of kebeles conducted CC, and 74% of them developed action plans to address the identified priority needs within their communities. Seven regions were successful in covering all their kebeles with CC and developing implementation plans for action. Furthermore, 35,097 Community Conversation Facilitators (CCFs) have been trained—the equivalent of two CCFs per kebele nationwide (135% of the target) [80]. There are also 35,097 Agriculture Development Agents (ADA) trained to facilitate Community Conversations. Moreover, the government's Health Extension Program (HEP), through house-to-house education, created community health (Anti-AIDS) promoters from model households. These promoters transmit key HIV/AIDS and other health messages and simple doable action in their families and neighborhood households, which leads to social transformation, enacting of community bylaws and enhancing demand for HIV services. To help standardize and support activities of various actors, social mobilization manuals were developed and widely disseminated to users.

Efforts to enhance the involvement of *Idirs* (village-based social safety nets where people share the cost of major social events, such as funerals) in HIV activities were intensified by creating networks so that they play proactive roles in mobilizing additional community resources to support PLHIV and orphans.

*Civil society organizations:* Umbrella networks, PLHIV associations, FBOs, CBOs, human rights organizations, children and young people organizations are involved at national and regional levels in the joint planning, monitoring and evaluation activities (e.g. the development of the national strategic plan and joint annual review meetings) and are active members of various multi-stakeholder forums, such as the National Partnership Forum (NPF), National AIDS Council (NAC) Global Fund Country Coordinating Mechanism (CCM) and various HAPCO and MoH technical working groups (TWGs). Civil society organizations reported in the NCPI that they have adequate access to information on sources and modalities of financial support. CBOs and FBOs are playing key roles in social mobilization, prevention interventions for youth, most-at-risk-populations prevention, reduction of stigma and discrimination, Home-based care services and the OVC support, etc. Some NGOs have also become well known and more active in the fight against HIV/AIDS program. NEP+, EIFDDA and OSSA are good examples among the indigenous civil societies currently working on HIV/AIDS in all regions of the country.

Given that religion plays a central role in the Ethiopian society, mainstreaming HIV and AIDS within faith-based organizations (FBOs) was a key strategic move in the fight against the epidemic. EIFDDA – a network of the major denominations in the country – has been active in the battle against HIV/AIDS, with a special focus in the areas of reducing stigma, denial and discrimination, and care and support to OVCs through support from various donors, including the Global Fund. EIFDDA mobilizes the community and religious leaders through training on human rights and stigma and discrimination, training of CCFs to mobilize the community for HIV-related interventions, and implements interventions in support of OVCs.

The Ethiopian Business Coalition against HIV/AIDS (EBCA), in collaboration with UNAIDS, implemented a Rapid Results Approach (RRA) to achieve rapid HIV/AIDS results within 11 horticultural companies. The RRA is a way for companies to achieve HIV/AIDS and social program results within 100 days or less. It helps companies to take their most challenging long-term HIV/AIDS and social responsibility projects and restructure them into a series of short-term initiatives that produce real results quickly. RRA can help companies or organizations to accelerate the achievement of results while also building the capacity of their people. Through this initiative 95 people were trained in RRA, companies established HIV/AIDS committees, launched HIV/AIDS awareness activities and VCT. In addition, a few started care and support programs and five of them drafted HIV/AIDS policies[81].

## 3.6. Life skills-based-HIV/AIDS education

*Table 10: UNGASS Indicator on Life-Skill Education*

| UNGASS indicator | | | |
|---|---|---|---|
| Indicator #11: Life skills-based HIV education in schools | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of schools that provided life skills-based HIV education within the last academic year | Total<br>Primary<br>Secondary | 38.4% | FHAPCO M&E report, 2008/9 |
| Numerator: Number of schools that provided life-skills based HIV education in the last academic year | Total<br>Primary<br>Secondary | 7,782 | |
| Denominator: Number of schools surveyed | Total<br>Primary<br>Secondary | 20,263 | |

Life skills-based HIV/AIDS education is one of the key strategies to increase HIV/AIDS-related knowledge, reduce stigma and discrimination and reduce risky behavior among students and teachers. A Ministry of Education report indicates that all training institutions, colleges and universities have incorporated life-skills based HIV/AIDS education into their curricula. Preliminary work has begun to make HIV/AIDS life skills-based education a stand-alone course[82].

There are more than 20,000 schools in the country, of which 95% are primary schools (1-8$^{th}$ grade). In 2009 alone 118,575 students and teachers (25% of the annual plan) had been trained in life skills education and 38% of the schools conducted School Community Conversations. With the Ministry's leadership, over 400 in-school anti-AIDS clubs and more than 200 out-of-school anti-AIDS clubs were established. In addition vocational trainings were given to more than 40,000 vulnerable groups[83] in support of their livelihoods.

## 3.7. Greater involvement of people living with HIV/AIDS

The Government of Ethiopia, development partners and other stakeholders are committed to ensuring the Greater Involvement of People Living with HIV/AIDS (GIPA) as a critical measure to achieving the national HIV/AIDS control and prevention targets and in turn the MDGs. In this connection, HAPCO and its partners support the active involvement of PLHIV in designing, implementation, monitoring and evaluation of national policies, strategies and programs so as to ensure the quality as well as effectiveness of the national response against the AIDS epidemic at various levels. The national program recognizes that the enhanced involvement of people living with HIV at all levels helps to reduce stigma, improve acceptance, recognition and effectiveness of prevention, care and treatment services. GIPA is grounded with the ideology of realization of the rights of PLHIV to self determination and proactive participation in the decision making processes that affect their own and their family's lives without fear of stigma and discrimination.

Currently there are more than 400 PLHIV associations in Ethiopia organized in regional networks and the National Networks of Networks of HIV Positives in Ethiopia (NEP+). These associations and networks are working in close collaboration with government sectors, NGOs, CBOs and donor organizations in various areas of the HIV/AIDS response and actively implement the GIPA guideline. The guideline is used to integrate PLHIV into all aspects of the national response in order to contribute to the HIV/AIDS program's success[84]. Furthermore, NEP+ represents its constituencies in the NAC, National HAPCO Board, National Implementations Review Board, National Project Review Board, and the CCM. This is a result of better organization, better capacity and systematic engagement of the associations in the multisectoral response to HIV/AIDS in the country.

NEP+, regional networks and associations of PLHIV, in collaboration with the Federal HAPCO and other partners, have also developed a *National Advocacy Strategy* that covers with eight key advocacy issues to support the implementation of its programs in the country[85], and a national study to measure the level of stigma associated with HIV and AIDS – "*The People Living with HIV Stigma Index"* – will be conducted in the near future.

The NEP+ is one of the two CSO principal recipients of a GFATM Round 7 grant. The five-year grant primarily supports strengthening, expansion and scaling up of care and support services. The grant also supports the capacity development of the network including its constituent regional networks, as well as pushing forward its advocacy issues at the national level, and hence contributing to the national GIPA agenda[86].

With the aim to understand the nature of existing capacities of PLHIV Income Generation Activity (IGAs) interventions in the country and other factors that influence the effective engagement of PLHIV[87], NEP+ has commissioned a national study which is currently in its final stage. The study is expected to come up with practical recommendations and outline strategies to address implementation challenges, capacity gaps and other constraints that surround current IGA interventions for PLHIV.

A joint effort to promote the human rights of PLHIV within the context of the existing laws and legislation has been initiated between the NEP+, UNAIDS and the Ethiopian Human Rights Commission. So far successful consultative meetings and the national workshop were conducted to reach a common understanding on the way forward.

## 3.8. HIV prevention

Given that the only sure way to stop the HIV epidemic is by preventing new infections, the Government of Ethiopia attaches serious weight to HIV prevention. This is in line with the national health policy, where disease prevention is the main pillar. In keeping with this and with the aim of (i) getting a renewed commitment of all stakeholders for HIV prevention; (ii) identifying HIV prevention priorities to feed into the new national Strategic Plan for Multi-sectoral Response (SPM2); and (iii) creating a forum for sharing knowledge and experiences on more effective HIV prevention interventions; and (iv) reviewing the current prevention response in the country and re-strategize as necessary, a three-day national summit was organized in April 2008 with the theme of "Putting Prevention First". Close to 300 individuals representing various institutions working on HIV/AIDS prevention participated in the summit. The consensus reached was to scale up prevention among MARPs, to develop a national prevention road map, and to generate strategic information to guide the response. A similar regional summit was organized in Amhara region.

According to the NCPI report, 72% of the key informants agreed that the majority of people in need have access to HIV prevention services that are given by the implementing partners, such as blood safety, universal precautions in health care settings, risk reduction IECs, condom, HCT, reproductive health services including sexually transmitted infections prevention and treatment, in-school and out-of-school-based HIV education designed for young people, and HIV prevention activities in the workplace. According to these informants, there are some programs which were not implemented to the planned level and standard. These include: prevention of mother-to-child transmission of HIV, risk reduction for commercial sex workers and HIV prevention in the workplace.

### 3.8.1. Behavior change communication

Behavior Change Communication remains one of the key national strategies for HIV prevention and is implemented through a wide range or interventions including interpersonal communication, communications through electronic and print media and others. The key prevention messages that are explicitly promoted include being sexually abstinent, delaying sexual debut, being faithful, using condoms consistently, engaging in safer sex and involving people with HIV to a greater extent.

*Interpersonal communication:* peer education programs focusing on various target groups; Community Conversation and Anti-AIDS community health promoters among general community and in schools; youth dialogues; discussions through anti-AIDS Clubs (AACs), idirs and faith-based institutions/leaders; discussions in work places; one-on-one education /counseling and the likes continued to be widely implemented during this reporting period.

*Radio and Television:* Ethiopian Television, Ethiopian Radio, the Walta Information Center, Radio Fana and other FM radio stations have played a big role in the dissemination of prevention messages to the general public, both at national and regional levels using national and local mass media. *DAGU, a* youth media program, aims to reach in-school and out-of-school youth in Addis Ababa. *BETENGNA,* a radio diaries program, aims to address issues of stigmatization and marginalization, as well as increase public awareness and use of VCT, PMTCT and ART services. *Yibekal* is another radio program that focuses on HIV testing and sharing individuals' experiences for learning. In addition to these, a number of radio and TV spots on core HIV prevention issues continued to be transmitted throughout the reporting period to serve as reminders and support interpersonal communication activities.

*National and Regional AIDS Resource Centers (ARCs)* continued to provide up-to-date web and print;-related information for a wide range of national and international audiences, including students, researchers, media professionals, advocacy groups, civil society organizations, development partners and others, This year alone over 200,000 individuals used the open library services of the AIDS Resource Centers.

*Wegen AIDS Talk line*: Housed in the national ARC, Wegen AIDS Talk line is a toll free telephone service that provides HIV and AIDS information for the general public. This year alone 2.4 million (81% male) calls have been received by the Talk line. A majority of the calls (84%) were focused on general information on HIV/AIDS, STIs and TB; while 14% were for counseling and 2% were for referral services.

*Fitun Warm-line*: Housed in the national ARC, Fitun Warm-line is another toll free telephone service specifically designed to provide technical support for health care providers on ART. This year alone, more than 500 health care workers have received technical support through the Warm-line.

*Lambadina* is a monthly bilingual, Amharic and English, newspaper published and widely distributed by the Ethiopian Volunteer Media Professionals Association (EVMPA) with financial and technical support of UNICEF Ethiopia and FHAPCO. The newspaper mainly addresses issues related to young people and reproductive health in general and sexuality as well as HIV/AIDS/STIs in particular. The newspaper has contributed to national efforts to increase the knowledge and skill of youth, and encouraging open dialogue about sex and sexuality, as well as clarifying common misconceptions[88].

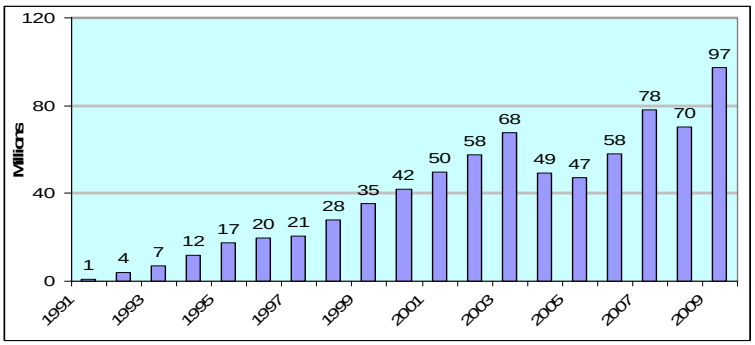
*HIV/AIDS printed materials*: A guideline for the production of BCC materials has been developed, and a number of leaflets, fliers and posters addressing various HIV prevention themes/topics for different audience groups were produced and distributed.

Despite the above achievements, there is a continuing concern regarding the standards for communication materials and indicators for tracking progress on behavior change; as well as on how to monitor the impact of community education programs, including their educational and instructional materials[89]. An evaluation of progress against the 2004-2008 strategic plan for the HIV/AIDS response found that awareness creation successes were not accompanied by behavior change, and it called on the government and other stakeholder to strengthen BCC to promote and enforce responsible sexual behaviors[90]. Research on the impact of BCC interventions on behavior change is limited. Determining the efficiency, cost effectiveness and overall impact of the various BCC interventions and related trainings will be crucial given that prevention is a key national priority and that recent surveys suggest limited progress on HIV-related knowledge and behavioral change.

### 3.8.2. Condom promotion and distribution

Demand and supply of condoms has dramatically increased in the country in recent years. A total of 97 million condoms were distributed in the last fiscal year, which is 2.2 per person among the sexually active population. Condom distribution increased by 28% compared to the previous year. However, the achievement is just 48% from what had been planned for the period[91].

*Figure 2: Trend on Condom Distribution from 1991 – 2009*


120
80
40
0
Millions
1
4
7
12
17
20
21
28
35
42
50
58
68
49
47
58
78
70
97
1991
1993
1995
1997
1999
2001
2003
2005
2007
2009

### 3.8.3. HIV counseling and testing

*Table 12: UNGASS indicator for HIV counseling and testing*

| UNGASS indicators | | | |
|---|---|---|---|
| Indicator #7: HIV testing in the general population | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results | Male<br>Female | 2.3%<br>1.9% | DHS 2005 |
| Numerator: Number respondents age 15–49 who have been tested for HIV during the last 12 months and who know their results | Male<br>Female | n/a<br>n/a | DHS 2005 |
| Denominator: Number of all respondents aged 15–49 | Male<br>Female | 6,033<br>6,812 | DHS 2005 |
| Indicator #8: HIV testing in the Most-At-Risk Population | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results | Female sex workers | 97.3% | BSS 2005 |
| Numerator: Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results | Female sex workers | 363 | BSS 2005 |
| Denominator: Number of most-at-risk population included in the sample | Female sex workers | 373 | BSS 2005 |
| Related indicator | | | |
| HIV testing in the general population (program data) | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results | All 15 -49<br>Male<br>Female | 18.4%[92]<br>20%<br>16.3% | FHAPCO, M&E, 2009 |
| Numerator: Number respondents age 15–49 who have been tested for HIV during the last 12 months and who know their results | All 15 -49<br>Male<br>Female | 6,630,647<br>3,533,924<br>3,960,723 | January-December 2009 |
| Denominator: Number of women and men aged 15–49. | All 15 -49<br>Male<br>Female | 36,000,000<br>17,640,000<br>18,360,000 | CSA[93]<br>Total Adult (15-49) population |

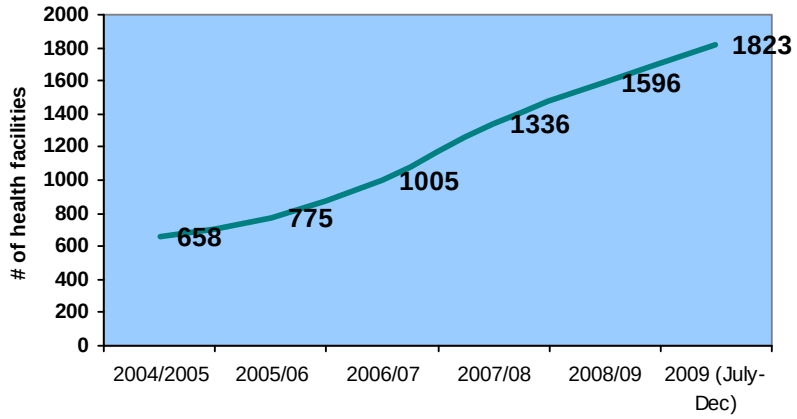
HIV counseling and testing (HCT) is an important entry point for HIV prevention and for early access to treatment, care and support; and is one of the essential components of the national multi-sectoral response against HIV/AIDS and promoted and broadly available, reasonably priced and easy to get to all individuals and communities. The high value attached to the national HCT program is reflected by the consistent increase in the number of counseling and testing facilities as well as the parallel increase in the number of people being tested for HIV.

September 10 was designated as National VCT Day in 2005, and it has continued to be observed in subsequent years with various activities to educate the public on the benefits of testing and to improve uptake of quality VCT services. A number of key activities were carried out during the preparation of this national event, including development of a national communication strategy, various promotional materials, mobile counseling and testing, and a mass rally/walk where over 2,000 people participated. Similar events were organized and implemented in all regional states.

The HIV counseling and testing program has shown a considerable improvement both in terms of service expansion as well as service utilization. A total of 1,823 public and private health facilities were providing HCT service in December 2009. The role of private health facilities in the expansion of the HCT service in major urban settings is profound. Recent report indicates that about 209 private health facilities are engaged in the provision of HCT service. The 2008 Health Impact Evaluation suggested that knowledge of people about where to get HIV an test is continuing to grow (71% of studied population), and that this knowledge is considerably higher among urban women (83.0%) when compared with rural women (58.3%)[94]. Bearing in mind the sample difference between the 2008 survey and the 2005 DHS, the proportion of women ever tested for HIV had increased from 4% (DHS 2005) to 28% (2008 DCA). In the later study, the highest testing rate was observed among women age 20-29 and 30.2% (n=2,971) of young women age 15-24 received HIV test. Likewise, urban areas had three fold coverage of HIV testing (38.8%) compared with rural areas (12.6%) with very wide variations across regions, ranging from 3.5% in Somali Region to 48.5% in Addis Ababa.

The figure below shows HCT service expansion, including voluntary counseling and testing (VCT) as well as provider initiated counseling and testing for HIV (PICT).

*Figure 3: Health facilities providing HIV counseling and testing, December 2009*

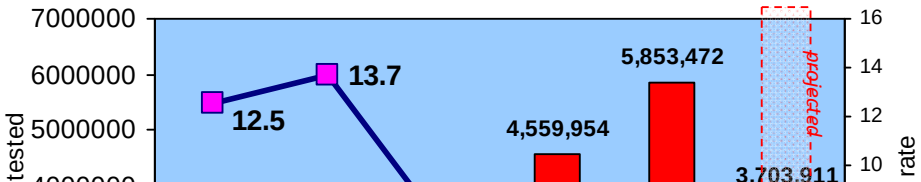



The number of clients using HCT services has significantly increased. A total of 5.85 million people (53% male) received HIV counseling and testing in 2008/09 – a 22% increase from the previous year. However, the achievement is 88.8% of the 2009 target[95]. Out of the total tested, 3% were found to be HIV positive[96]. Interestingly, within the last six months (July to December 2009) alone, over 3.7 million people were tested for HIV. This shows an ever increasing trend in the number of people tested for HIV to know their status.

The HIV positivity among tested individuals has declining throughout recent years where in 2005/06 the HIV positivity was the highest (13.7%) and it has come down to 1.9% at the end of 2009.

*Figure 4: Trend on the number of clients counseled and tested for HIV, December 2009*





Mobile VCT services have been effective in reaching out to at-risk populations who might otherwise not seek testing. According to a multisite survey, clients of mobile VCT services were found to be more male than female (67.7% male), young people in the age group 15-24 years (54.8% of all clients), never married (57.3%), with primary or secondary education (72.4%), daily laborers (26.7%) and students (25.3%)[97]. Only 1% of respondents stated that they were clients of female sex workers. A majority of the clients (66%) reported that the mobile HCT program was the first time they had been tested for HIV. The predominant reasons for HIV testing were to plan for the future (61%) and perception of HIV risk (31%). HIV positivity rate was 5.3% (3.6% males and 8.6% females), while 25.3% of clients who identified themselves as sex workers were HIV positive. A majority (72%) of the HIV-positive clients were referred to pre-ART and ART services.

According to a study conducted to assess the potential for integration of VCT into family planning services in Ethiopia, more than 25% of clients were having repeated testing one and half years later[98].

A study among Addis Ababa youth[99] documented that, although a vast majority (91%) indicated that they would like to get tested for HIV, a little lower than half (42%) have never tested and 44% believed that there was no chance that they would be infected. A multi-center knowledge, attitude and practice (KAP) survey documented the encouraging result of 39% reported HIV testing among young adults[100].

### 3.8.4. Prevention of mother-to-child transmission of HIV

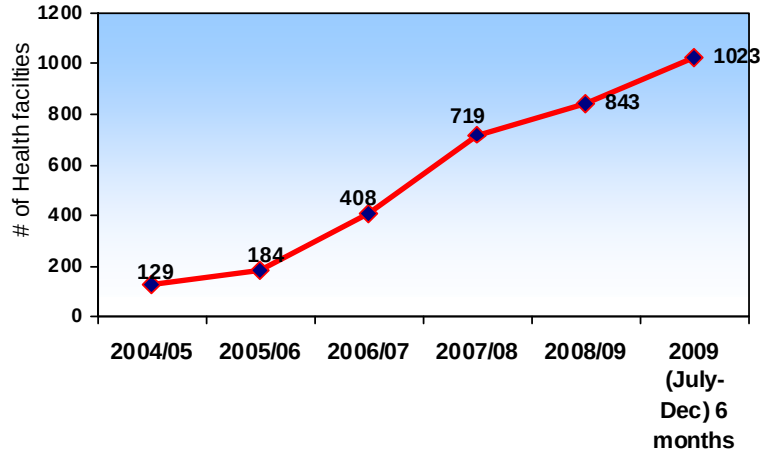
*Table 15: UNGASS indicator on PMTCT*

| UNGASS indicator | | | |
|---|---|---|---|
| Indicator #5: Prevention of mother-to-child transmission | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission | All<br>First line<br>Second line | 8% | |
| Numerator: Number of HIV-infected pregnant women who received ART medicines to reduce the | All<br>First line | 6,721 | HAPCO M&E reports |

| | | | |
|---|---|---|---|
| risk of mother-to-child transmission in the last 12 months | Second line | | |
| Denominator: Estimated number of HIV-infected pregnant women in the last 12 months | All<br>First line<br>Second line | 84,189 | Single Point Estimate, 2007 |

The country has made progress in the provision of services to reduce HIV transmission from infected mother to newborns by increasing the proportion of women who get tested and know their results through expanding rapid testing to many PMTCT sites. However, the national ANC coverage is 66.3%, whereas coverage of skilled birth at a health institution is at 24.9%, which both influence the utilization of PMTCT.

*Figure 5: Number of facilities providing PMTCT services*

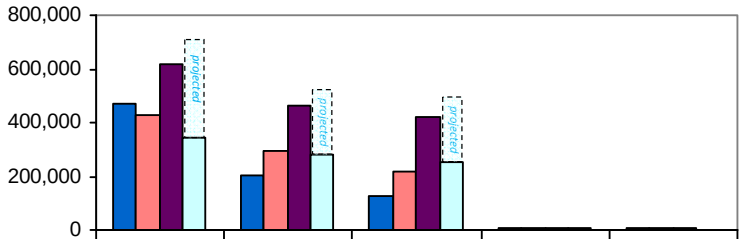



A total of 1,023 health facilities were providing PMTCT services at the end of 2009. More than 616,763 pregnant women made at least one antenatal clinic visits during the last fiscal year, and 417,841 underwent HIV testing, of which 10,267 (2.4%) of the pregnant women tested positive. Of the total pregnant women diagnosed with HIV, only 6,466 (63%) received antiretroviral prophylaxis (ARV/NVP) and only 5,025 infants received PMTCT prophylaxis in the same year. The proportion of diagnosed HIV positive pregnant mothers receiving antiretroviral prophylaxis was significantly greater than the 52% in 2007/08.

From July to December 2009 alone, 343,476 pregnant women visited antenatal clinic of which 253,459 (73.7%) underwent HIV testing with the same (2.4%) positivity rate as the previous year. Unfortunately out of those tested positive only 57.7% received ARV/NVP [101].

A comparison of the number of pregnant women receiving ARV/NVP during childbirth from January and December 2009 (6,721) to the estimated 84,189 HIV-positive pregnant women in 2009[102] puts national PMTCT coverage at 8%. PMTCT coverage has thus showed incremental improvement over the past few years where it was 5% in 2006/07 and 6% in 2007/08.

*Figure 6: PMTCT program implementation trend, December 2009*




| | ANC | Pre-counseling | Tested | +ve | Received ARV/NVP |
|---|---|---|---|---|---|
| 2005/06 | 468,532 | 204,266 | 123,380 | 6,655 | 3,967 |
| 2007/08 | 429,310 | 292,150 | 215,851 | 8,564 | 4,478 |
| 2008/09 | 616,763 | 465,349 | 417,841 | 10,267 | 6,466 |
| 2009/10 (6 months) | 343,476 | 279,634 | 253,459 | 6,298 | 3,324 |

Generally the progress around PMTCT services remained very slow and the coverage has been extremely low. The major gaps and challenges identified in the implementation of PMTCT in the country include: limited expansion of the service; inadequate use of PMTCT service even where it is available; poor early infant diagnosis, poor integration of PMTCT with ANC services; low ANC coverage, low percentage of deliveries attended by skilled health personnel; limited number of skilled and motivated human resources, poor community component of PMTCT; weak community-health facility referral linkages; poor male partner involvement; and a weak M&E system[103].

According to the 2008 Health Impact Evaluation report, among all women aged 15-49 that gave birth within the two years preceding the survey, 28.3% received HIV counseling during antenatal care and only 9.2% received test results. Women from rural areas, uneducated, and from the lowest wealth index category were less likely to be counseled and receive test result[104]. The findings of this evaluation suggest that, while coverage is still low, there has been significant improvement in PMTCT program uptake since the 2005 DHS, where the proportion of ANC clients who received HIV counseling was only 3%.

A national assessment conducted to understand the situation of the PMTCT response within the broader reproductive health context found that inadequate human and technical capacity at the national and sub-national levels are creating a barrier to lead the programs in a comprehensive and integrated manner. Moreover, a vertical provision of service and less coordinated monitoring and evaluation system have prevented smooth collaboration and integration between the ANC and PMTCT programs. The slow roll out of the HMIS reform has also been a challenge[105].

A USAID funded 'Capacity Project' supporting the national effort to advance a comprehensive maternal and child health (MCH)/PMTCT program in rural and semi-urban areas worked to increase demand for and access to comprehensive MCH/PMTCT services through the establishment of Mother Support Groups (MSGs), involvement of Health Extension Workers (HEWs), Community Action Facilitators (CAFs), expansion of PMTCT services in public and private sector health facilities, improvement of pediatric HIV case detection and referral services and enhanced health workers competency through trainings[106]. In areas supported by the project (rural and semi-rural areas of Amhara, Tigray, Oromia and SNNP), 234,618 women accessed ANC services, of which 78% got tested and received their results with a 2.2% HIV positivity rate. Forty-one percent of the mothers and 25% of the children received ARV prophylaxis. Moreover, 97%, 61% and 3% of pregnant women received counseling on infant feeding, post-partum family planning methods and referred for ART respectively. Additionally 31,190 male partners of ANC clients were counseled and tested for HIV. A new 'HIV-suspected' registration format was developed and piloted in health facilities of the four project regions to help facilitate tracking and follow up of pediatric HIV clients.

With the aim of better leading the PMTCT program in the country, build the country's capacity and learning from experiences of countries with advanced PMTCT programs, a team from Ethiopia participated in a regional consultation on Accelerated PMTCT and Pediatric HIV Care and Treatment in Eastern and Southern African countries in September 2009. The team subsequently organized a national micro-planning workshop on PMTCT in collaboration with partners as an additional step towards an improved program response.

### 3.8.5. Blood safety

*Table 18: UNGASS indicator on blood safety*

| UNGASS indicator | | | |
|---|---|---|---|
| Indicator #3: Blood safety | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of donated blood units screened for HIV in a quality-assured manner | All | 100% | Ethiopian Red Cross Society 2009 |
| Numerator: Number of donated blood units screened for HIV in a quality assured manner | All | 38,245 | |
| Denominator: Total number of blood units donated | All | 38,245 | |

The Ethiopian Red Cross Society (ERCS), under the leadership of Ministry of Health, is responsible for the national blood bank services in the country. ERCS has reported that the total number of blood units donated and screened for HIV in a quality-assured manner nationwide in 2009 was 38,245 units. In order to ensure 100% safe blood transfusion, all blood collected was subjected for mandatory HIV screening and 799 (2.1%) of blood units were discarded due to HIV. More than half (62%) of the blood units were collected in Addis Ababa's blood transfusion center. The number of blood units collected and screened increased from 33,507 in 2007/08 to 38,245 by 2008/09[107].

## 3.9. Care and support

### 3.9.1. Orphans and vulnerable children

*Table 19: UNGASS indicators on orphans and vulnerable children*

| UNGASS indicators | | | |
|---|---|---|---|
| Indicator #10 : Support for children affected by HIV/AIDS | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of OVC (0-17) children whose households received free basic external support in caring for the child | All | 34.6% | WMS 2004 |
| Numerator: Number of OVC who live in households that received at least one of the four types of support for each child | All | 795,991[108] | |
| Denominator: Total number of OVC (0–17) | All | 2,300,000[109] | |
| Indicator #12 : Orphans – School Attendance | Disaggregation | Value | Source/Year |
| Indicator Value: Current school attendance rate of orphans (10–14) | All<br>Male<br>Female | 53.3%<br>56.9%<br>49.9% | DHS 2005 |
| Numerator: Number of children who have lost both parents and who attend school | All<br>Male<br>Female | n/a<br>n/a<br>n/a | |
| Denominator: Number of children who have lost both parents (unweighted) | All<br>Male<br>Female | 230<br>110<br>120 | |
| Indicator Value: Current school attendance rate of children aged 10–14 both of whose parents are alive and who live with at least one parent | All<br>Male<br>Female | 58.9%<br>60.3%<br>57.4% | |
| Numerator: Number of children both of whose parents are alive, who are living with at least one parent and who attend school | All<br>Male<br>Female | n/a<br>n/a<br>n/a | |
| Denominator: Number of children both of whose parents are alive who are living with at least one parent | All<br>Male<br>Female | 7,098<br>3,728<br>3,370 | |
| Related indicators | | | |
| Support for children affected by HIV/AIDS (program data) | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of OVC (0-17) children whose households received free basic external support in caring for the child | All | 34.6% | FHAPCO, M&E 2009 |
| Numerator: Number of OVC who live in households that received at least one of the four types of support for each child | All | 795,991[110] | |
| Denominator: Total number of OVC (0–17) | All | 2,300,000[111] | |

Coordination of the national OVC care and support program is mandated to the Ministry of Women Affairs (MOWA), and the ministry is developing national standards, service packages and service delivery guidelines. Moreover, the Ministry of Labor and Social Affairs, the Ministry of Education, and the Ministry of Health, with involvement of NGOs, CBOs, FBOs and the private sector, has made a number of steps to provide a range of support to OVC, usually through their guardians wiithin the community. There are many small-scale OVC care and support activities going on in the country including provision of training in business skills and management to support OVC, cash transfers through micro-finance schemes to households, and food and nutrition support.

In the fiscal year 2008/09, 235,558 orphans and vulnerable children (OVC) received education support (53% of the target), 167,313 received nutritional and shelter support (45% of the target), 23,741 received financial support, and 20,348 received support through income-generating activity (IGA) programs (127% of the target), according to data collected by FHAPCO. Furthermore, over 560,433 OVCs were reached by PEPFAR-supported programs. The number of supported OVCs being counted by both FHAPCO and PEPFAR is unknown. Nonetheless, the number in need of support is more than 2 million[112].

Through EIFDDA's OVC program, over 30,000 OVC received educational support, 13,000 OVC received food, shelter, and clothing support, 1,000 older OVCs and 2,150 guardians received training on business skills, and over 200 PLHIV received home based care[113].

### 3.9.2. Food security and nutrition among people infected and affected by HIV and AIDS

Ethiopia has experienced complex humanitarian crises in the form of both man-made and natural disasters, such as conflict/post conflict situations and recurrent drought and floods. When these populations are also affected by AIDS, their resilience is heavily compromised because household and community assets are further depleted. This results in negative coping strategies, including migrations to urban centers for survival sex (leading to an increase in commercial sex workers) and sale of food and assets to cover costs for treatment[114].

PLHIV require more nutrients to compensate for poor absorption, adverse drug effects, frequent diarrhea, nausea and recurrent opportunistic infections. The Government of Ethiopia, in collaboration with the World Food Programme (WFP), is providing food and nutrition assistance to an estimated 110,000 PLHIV (including women enrolled in PMTCT) and OVCs. A survey to review the outcomes of this intervention comparing values between 2006 and 2008 revealed that an increased proportion of PLHIV reported improving health status from 64% to 81.6%[115]. Furthermore, the percentage of PLHIV receiving home-based care (HBC) or ART with improved functional status in the last one month before the survey increased from 73% to 92.4%. The initiative also improved the proportion of treatment adherence among PLHIV on ART from 77% to 96%, and school enrolment among OVC aged 5 and above from 80% to 99%.

## 3.10. Treatment

### 3.10.1. Antiretroviral treatment

*Table 20: UNGASS indicator on ART*

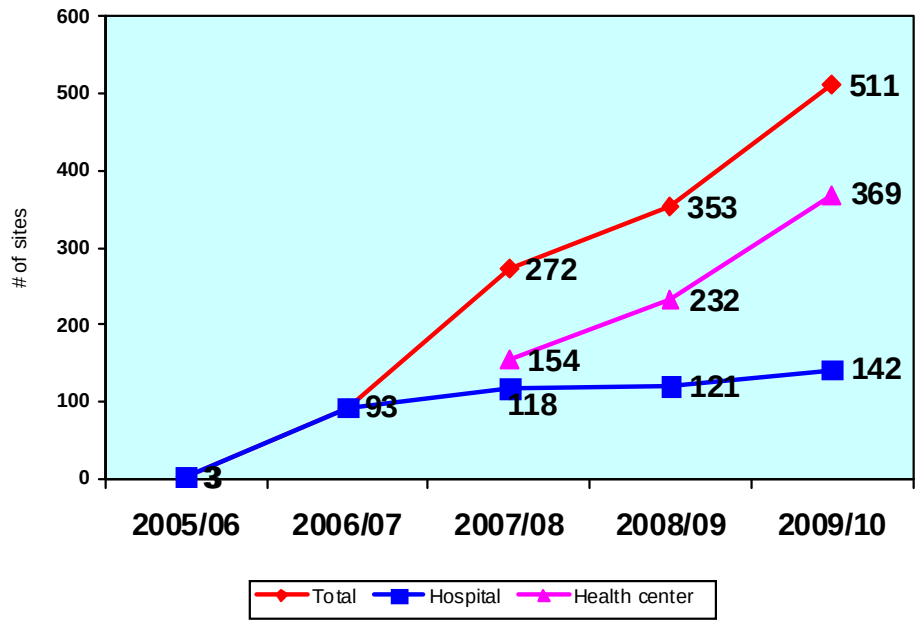
| Related UNGASS indicator | | | |
|---|---|---|---|
| Indicator #4 : HIV Treatment: Antiretroviral Therapy | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy | All<br>Adult<br>Children | 52.5%<br>52.8%48.7% | HAPCO program data, 2009 |
| Numerator: Number of adults and children with advanced HIV infection who are currently receiving antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period | All<br>Adult<br>Children | 176,632<br>166,640<br>9,992 | |
| Denominator: Estimated number of adults and children with advanced HIV infection | All<br>Adult<br>Children | 336,160<br>315,638<br>20,522 | Single Point Estimate, 2007 |
| Indicator #24 : HIV Treatment: survival after 12 months on Antiretroviral Therapy | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART | Adult<br>Children | 72.5%,<br>-- | FHAPCO-ART scale up study, 2008 |
| Numerator: Number of adults and children who | Adult | 45,427 | |

| | | | |
|---|---|---|---|
| are still alive and on ART at 12 months after initiating treatment | Children | -- | |
| Denominator: Total number of adults and children who initiated ART who were expected to achieve 12-month outcomes within the reporting period, including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow-up at month 12. | Adult<br>Children | 62,689<br>-- | |

Rapid expansion of ART services at both hospital and health centers in most parts of the country over the last five years has greatly contributed to improved coverage of treatment, especially through the reduction of the cost of transportation which is a barrier to many PLHIV in small towns and rural areas.

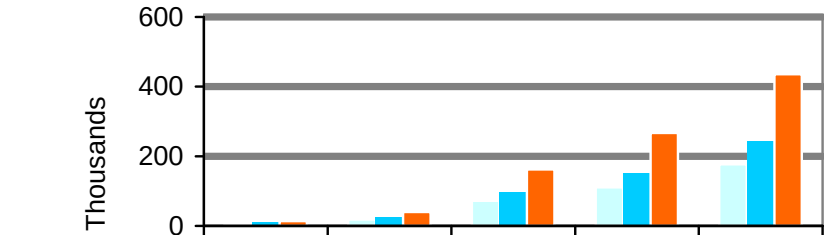
Currently 511 health facilities (142 hospitals and 369 health centers) provide ART service throughout the country; which translates to 91% of the hospitals and 52% of the health centers[116,117]. Chronic HIV care including ART services are being provided in public, private, armed force, police and prison health facilities. The figure below shows the increasing trend in number of facilities providing ART service through time.

*Figure 7: Trends of ART Service Providing Facilities Expansion, December 2009*



According to the 2007 Single Point Estimate, 336,160 PLHIV were in need of ART in 2009, out of which 20,522 were children below the age of 15 years. The number of AIDS cases ever started on ART has grown to 241,759 as of December 2009, among which 176,632 were currently on treatment – coverage of 53% of those in need. In 2009 alone, 43,130 new HIV patients were started on ART. Likewise the total number of people ever enrolled to chronic HIV care reached to 435,150 by the end of 2009.

*Figure 8: Adults and children receiving chronic HIV care and ART, December 2009*




| | 2005/06 | 2006/07 | 2007/08 | 2008/09 | 2009/10 |
|---|---|---|---|---|---|
| Currenlty on ART | 3880 | 18594 | 72,100 | 110,611 | 176,632 |
| Ever Started ART | 8276 | 24236 | 95,908 | 150,136 | 241,759 |
| Ever Enrolled | 13773 | 39489 | 161,529 | 266,507 | 435,150 |

Out of all ART clients 58% (102,379) were female, a reflection of the higher number of women living with HIV. In terms of drug combination, the majority of patients are on the 1st line regimen (d4T-3TC-NVP), while only 1% (1,079) of the patients have switched to a 2nd line regimen.

A significant number of patients (28%) had been lost to follow up as of December 2008. Patients alive and on treatment has significantly declined as the duration of treatment increased. The minimum survival rate of people receiving ART was found to be 78.6% (89,451) at six months, 72.5% (62,659) at 12 months, and 64.6% (18,999) at 24 months[118].

The vast majority of the patients (80.1%) initiated ART below 200 CD4 count at entry. ART has also improved the functional status of patients with the rate of change of working patients increased positively by 42% within six months duration of treatment while the rate of change of ambulatory and bedridden patients declined considerably. Adherence rate declines as the duration of treatment increases, 88% at the first six months and 84% at 12 months. The highest levels of death and lost to follow up are observed in the first six months of ART treatment, where about 14.5% dropped out from the program. The most cited reasons for drop out are economic problems, seeking religious treatment, fear of drug side effects and poor patient handling. Furthermore, the overall death rate was 6.5% at six months. Both death and lost to follow up rates have declined at 12 and 24 months of treatment.

Efforts to reduce the percentage of patients lost to follow up are being strengthened by an Advanced Clinical Monitoring project that includes FHAPCO, the Ministry of Health, the Ethiopian Health and Nutrition Research Institute, the Ethiopian Science and Technology Agency, seven Ethiopian medical universities, the US Centers for Disease Control and Prevention and Johns Hopkins University's TSEHAI program[119].

*Pediatric treatment program:* A total of 13,305 children were ever started on ART at the end of 2009, while 9,992 were currently on ART. ART coverage for children was 48.7%. To improve the national early infant HIV diagnosis program, the Ethiopia National Health and Nutrition Research Institute acquired BD FACS Count CD3/CD4 single tube reagents for 17,500 tests, which was implemented in the 12 hospital laboratories. This test, which is used to monitor the patient's immunological response to HIV infection, is less expensive and has greater features than the existing ones, thus enable laboratories to meet the growing demands of expanding HIV/AIDS services.

Ethiopia introduced pediatric fixed-dose combination drugs (FDCs) and dried blood sample (DBS) bundles to collect dried blood samples from infants at the point of care in more than 170 health facilities. So far 4,087 early infant diagnostic tests were performed, a 122% increase from 2007. In Addis Ababa alone, 22 health workers in 24 health centers received training on pediatric ART, and 1,892 children were tested through DNA PCR with 705 children placed on treatment. To respond to the problem of pediatrics patients' lost-to-follow up, a pediatric retention activity was piloted throughout the country and tracked 767 pediatric patients of which 290 were found[120].

A costing study at nine PEPFAR-supported ART sites[121] found that the median economic cost per patient year was $610 (in 2006 U.S. dollars) for established adult ART patients. The median cost per patient year was $134 for pre-ART patients. ARVs cost a median of $405 for ART patients. Beyond ARVs, laboratory supplies were the most substantial cost category for both ART and pre-ART patients, accounting for a median of $76 and $49 per patient year, respectively.

### 3.10.2. TB/HIV services

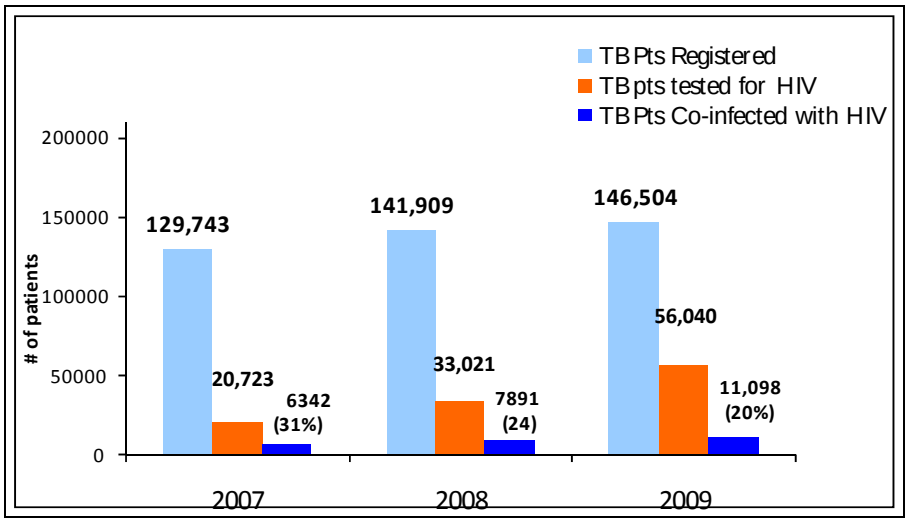
*Table 23: UNGASS indicator on TB/HIV management*

| Related UNGASS indicator | | | |
|---|---|---|---|
| Indicator #6 : Co-management of TB and HIV Treatment | Disaggregation | Value | Source/Year |
| Indicator Value: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV | Adult<br>Children | 1.7%<br>-- | WHO/FMOH 2009 *Denominator = Estimated number of PLHIV in 2009 (1,116,216) multiplied by the estimated prevalence of TB (24%) among PLHIV* |
| Numerator: Number of adults with advanced HIV infection who received ART combination therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment within the reporting year | Adult<br>Children | 4,515<br>-- | |
| Denominator: Estimated number of incident TB cases in people living with HIV. | Adult<br>Children | 267,892<br>-- | |

The introduction of provider initiated counseling and testing in most public health facilities has improved HIV screening among TB patients from 16% in 2007 to 38% in 2009. A total of 56,040 TB patients were tested for HIV, of which 11,118 (20%) were found to be HIV positive. The co-infection of TB patients has declined from 31% in 2007.

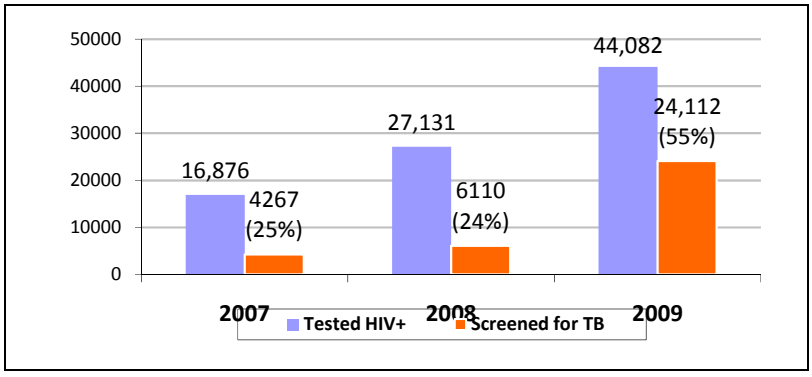
In addition, a total of 24,112 HIV-positive people were referred from HCT, chronic HIV and ART clinics for TB screening out of which 4,154 (17.2%) were found to have active TB and 2,403 (10%) with latent TB, and hence put on IPT. The proportion of HIV-positive patients who were screened for TB increased from 25% in 2007 to 55% in 2009.

*Figure 9: TB patients registered and screened for HIV and co-infection (2007-2009)*




Furthermore, in the fiscal year from July 2008 through June 2009, 68% of HIV-positive TB patients were put on Cotrimexazole Prophylaxis Therapy (CPT) and 41% of HIV-positive TB patients have started ART[122].

*Figure 10: Proportion of HIV + clients screened for TB*



TB indicators remained stable between 2008 and 2009, with TB case detection rate being at 34% (below the national target of 67.8%). TB treatment success rate was at 84% and a TB cure rate at 67% over the last fiscal year. Both of these indicators have showed a gradual increasing trend over the past ten years[123].

In 2009, 33,069 new sputum smear positive TB cases were detected. The number of ases detected is still way below the planned target, which is due to a combination of factors that includes lack of integration of TB case detection in all out patient departments (OPDs) as part of PICT; the need for stronger involvement of Health Extension Workers (HEWs) to refer those with signs of the disease to health facilities; lack of provision of services by some health facilities; focus of training and supervision on improvement of TB success rate with less emphasis on detection rate, lack of functional laboratories in many health facilities; and inadequate skill of some laboratory technicians on how to do proper microscopic examination using the Acid Fast Bacilli (AFB) staining.

# 4. Monitoring and evaluation

## 4.1. Overview of the current M&E system

As part of the "Three Ones" principles, the country has one national Monitoring and Evaluation (M&E) plan that covers five years, from 2009-2013. This M&E plan was developed in consultation with civil society, including people living with HIV, and endorsed by key partners in M&E. Moreover, recently, most key partners have been aligning their M&E requirements (including indicators) with the national M&E plan. The national M&E plan has a well-defined standardized set of indicators that includes; a data collection strategy, bio-behavioral surveillance, routine program monitoring and evaluation, supportive supervision and research studies. There are separate databases at various offices for the HIV M&E related activities (i.e. FHAPCO for routine programmatic data, EHNRI for surveillance data, FMOH/PPD for HMIS data and CSA for DHS and demographic data). Moreover, there is an effort to develop a central national database and warehouse that captures both the health facility and community level HIV-related data at all levels with a functional mechanism that allows for easy sharing among these databases. The M&E directorate of FHAPCO has endorsed and adopted the CRIS version 3 software developed by UNAIDS to establish this national and warehouse for the multi-sectoral HIV/AIDS response.

The majority of HIV/AIDS data collection is divided into two sources: routine program monitoring data and survey or studies conducted to evaluate the program effectiveness. Routine program data are coming from HARS (HIV/AIDS Program Response) from HAPCO; EMIS (Education Management Information System) from MOE; LMIS (Logistics Management Information System) from PFSA (Pharmaceutical Fund and Supply Agency); and LABMIS (Laboratory Management Information System) from EHNRI. The routine program monitoring is divided into two categories: clinical-based activities and non-clinical based activities. The clinical activities includes HCT, PICT, PMTCT and ART, while the non-clinical are community mobilization and empowerment, school HIV/AIDS interventions, mainstreaming, condom promotion and distribution and care and support.

Recognizing the gap in generation and reporting of non-clinical as well as non-health sector program activities, FHAPCO in collaboration with stakeholders, has started the process of establishing a 'Community Management Information System' that will capture non-clinical data from all implementing partners at various levels. As part of the process, a draft guidelines has been developed and shared with partners for contribution. Furthermore, a national consultative workshop has been organized to finalize the draft guideline that included data recording, compilation and reporting formats for various activities by levels.

There are quarterly Joint Review Meetings (JRM) that aim to assess achievements, shortfalls, challenges and emerging issues in the national response. These JRMs embody the Three Ones principle. It is an outstanding opportunity for reviewing progress on HIV/AIDS activities, joint planning, sharing surveillance and researches results, disseminating program guidelines and manuals, as well as reviewing the extent to which the national strategic plan has been implemented as measured against the benchmark of the results framework.

A number of operational researches are underway, including a research protocol to undertake study on early warning indicators of drug resistance to HIV; a nation-wide Threshold Survey to assess the drug resistance of HIV/AIDS; a study on immune response towards different antigens of TB/HIV patients, and an assessment on resistance to TB drugs.

All necessary preparatory process including finalization of protocols has been completed to carry out nationwide biological and behavioral surveys including ANC-based HIV sentinel surveillance, a population-based sero-survey, a Behavioral Surveillance Survey, a Demographic and Health Survey, and survey on most-at-risk populations.

In order to build the capacity of M&E staff, the Government of Ethiopia, in collaboration with PEPFAR Ethiopia and local universities, has been implementing a masters level graduate program in the area of health monitoring and evaluation, FELTP[124] and Biostatistics. Moreover, regional level M&E trainings were held in most parts of the country by the federal government concerned bodies (FHAPCO[125], FMOH/PPFD[126], EHNRI[127] and regional HAPCOs) on M&E need assessment, planning, monitoring and evaluation strategies, HMIS[128] and HIV surveillance.

Among many achievements in the past two years in the area of monitoring and evaluation activities: the development of the Annual national performance report of 2008/09, which was distributed and presented at the 12th National AIDS Council (NAC) meeting, the preparation and dissemination of the multi-sectoral HIV/AIDS M&E Annual report (2008/09), the evaluation of SPMI (2004 – 2008), the development of the national M&E framework and costed five year plans, he ongoing rollout of the HMIS in all regional health facilities. Moreover, the government has also initiated non-ANC based surveillance (TB/HIV, STI, MARPs and so on), as part of the second generation surveillance system, the implementation of the regular strategic information TWG meetings (i.e., national M&E advisory committee, national surveillance and survey TWG, national HMIS advisory group and national DHS TWG) with the involvement of the major relevant stakeholders, and the major partners have been sharing their data/report with key stakeholders (FMOH/HAPCO, EHNRI, UNAIDS, WHO, PEPFAR) to reconcile and reach consensus on a single national value for each indicators as part of the Three One principles.

## 4.2. Challenges faced in the implementation of a comprehensive M&E system

The existing HIV/AIDS monitoring and evaluation system is not able to fully collect all relevant information such as care and support activities planned and implemented by partners. Monitoring indicators, data collection and reporting tools, as well as the process to verify data are not harmonized and standardized[129].

Some indicators were incompatible or non-measurable with available information from the routine data collected through the system. Some indicators also lack hierarchical presentation. The system suffers from absence of baselines for many of the indicators. Data sources and empirical evidence for the program monitoring and evaluation were scattered and not easily accessible; more so in the non-health sector.

The monitoring system designed for treatment, care and support for PLHIV does not link with related food and nutrition and/or food security indicators, and therefore it is difficult to determine nutritional progress of beneficiaries. Shortage of surveillance information related to MARPs, risky conditions for HIV infection such as gender-based violence (GBV), harmful traditional practices (HTP) and drug use, HIV incidence/prevalence data in HIV hot spots, etc. Furthermore studies that aim at determining the effectiveness of interventions, particularly community-based prevention programs, such as social mobilization and IEC/BCC activities are needed.

The monitoring and evaluation system also suffers from shortage of skilled personnel in information management and poor communication infrastructure below the national levels that usually has led to delays in reporting of monitoring information.

## 4.3. Remedial actions planned to overcome the challenges

Federal and regional HAPCOs and other key agencies should indentify and establish an effective mechanism to regularly update the list of priorities for research and surveillance needs, and coordinate the efficient dissemination of result so that the fight against HIV will become evidence based and more effective.

There is an urgent need for evidence generation and utilization about the known and emerging high risk groups, as well as on HIV infection exacerbating conditions, such as GBV, drug use (alcohol and khat), harmful traditional practices (early marriage, FGM, polygamy, widow inheritance, etc) and others. Guidelines and manuals will be prepared, distributed and utilized to improve quality standards for HIV and AIDS intervention services.

# 5. Best practice: Working with the Ethiopian Orthodox Church to improve ART adherence[130]

Faith is a central part of life for the vast majority of Ethiopians, and the centuries-old Ethiopian Orthodox Christian Church is the country's largest religious denomination, with more than 32 million followers, or 43.5% of the population[131]. For Orthodox Ethiopians, holy water is a traditional cure for disease and ailments. Followers regularly gather at more than 160 sacred sites across the country where they can drink holy water and be baptized as treatment for all types of afflictions.

Since the start of the HIV/AIDS pandemic, infected and affected Ethiopians have sought the healing power of holy water and flocked to these holy sites by the thousands – if not hundreds of thousands – in search of a cure, often while abandoning their antiretroviral treatment (ART). This defaulting phenomenon caught the attention of Johns Hopkins University-Technical Support for Ethiopian HIV/AIDS Initiative (JHU-TSEHAI) in the Southern Nations and Nationalities Peoples regional state (SNNPR) in December 2007. Following a joint assessment with the Development and Inter-Church Aid Commission (DICAC), His Holiness Abune Paulos, Patriarch of the Ethiopian Orthodox Church, sent a letter to the US Ambassador, H.E. Donald Yamamoto, requesting the assistance of JHU-TSEHAI in the church's fight against HIV/AIDS. As a result, a faith-based behavior change initiative was launched in collaboration with the Ethiopian Orthodox Church's Hawassa Diocese.

The assessment was conducted in four Dioceses in SNNPR. It looked into the primary reasons why parishioners default from their ART medication and seek holy-water treatment instead, despite the fact that the church had been openly advocating the compatibility of holy water and ART for more than three years. The study also looked into why there were long-term PLHIV settlements within church compounds resembling internally displaced population (IDP) camps.

The most consistent reason for treatment default was identified as a serious knowledge gap by clergy members regarding their overall understanding of HIV/AIDS, and the lack of concise and factual information on both the science of the disease and the existing, progressive teaching and guidance of the church on this issue. This knowledge vacuum facilitated both individual and institutional misinterpretations of church doctrines on HIV/AIDS.

To tackle this knowledge gap, JHU-TSEHAI, in collaboration with the SNNPR Health Bureau/HAPCO (SNNPR-RHB/HAPCO), the Hawassa Diocese and FHI-Ethiopia, conducted two three-day trainings for a total of 180 trainers or clergies members from three selected zones (Burgy, Gedio and Sidama) in May and June 2009. The objective of the training was to create awareness via the Orthodox Church on HIV prevention, adherence and quality of care throughout the region and further more nationally.

The training focused on the basic science and psychosocial aspects of HIV/AIDS, the basic benefits of ART and PMTCT, and the complementary teaching of the church doctrine on the use of ART for comprehensive treatment of the individual. JHU-TSEHAI, FHI-Ethiopia and SNNPR-RHB/HAPCO provided the training physicians, and the Ethiopian Orthodox Church supplied their highest church scholars, who took the opportunity to refute other falsely promoted church activities or the misuse traditional church practices.

In addition, JHU-TSEHAI and SNNPR-RHB/HAPCO supported the establishment of a task force comprised of the Hawassa City Government, community based organizations and PLHIV associations to address the issues of resettlement of PLHIV living on church grounds. The situation had created an unsafe and environment that had overwhelmed the church's ability to manage. This settlements were also a direct violation of the church teaching and practice, and were disturbing daily churchgoers. The threat of an outbreak of communicable disease due to unsanitary conditions – including no running water, toilet facilities and shelter – was recognized by the RHB and city administration, and assistance was provided to the church to alleviate the situation. By January 2010, this intervention encouraged the departure of more than 3,000 PLHIV from the grounds of various churches. Health officials ensured that linkages were made for resettled PLHIV with their local health facilities, and community-based organizations provided financial assistance and transport to stranded settlers who were willing to return to their place of origin.

The church and SNNPR-RHB/HAPCO are currently linked in a solid working partnership in HIV prevention and AIDS treatment. Clergy members are intellectually empowered and better equipped to educate their followers in both proper church doctrine and the science of HIV transmission and AIDS treatment. In addition, specific clergy training materials were developed by the JHU-AIDS Resource Center (JHU-ARC) in collaboration with the church's highest scholars and endorsed by the His Holiness, the Patriarch, for use nationwide. On February 2010, this project was presented at a national Joint Review Meeting as a best practice by the Ethiopian Orthodox Church and SNNPR RHB/HAPCO. It is expected that this initiative will be replicated throughout the country and forge a lasting collaborative relationship among faith based organizations and regional governments and partner organizations in the fight against HIV/AIDS nationwide.

# 6. Major achievements and challenges

## 6.1. Major achievements

In general, encouraging results were achieved in HIV/AIDS prevention and control in Ethiopia during the reporting period. Prevention efforts initiated in the millennium AIDS campaign on HIV counseling and testing and enrollment in ART as one approach for prevention has been sustained and there has been a remarkable increase in both facility-based and community-based services. Multi-sectoral coordination mechanisms have been functional at all levels and remain vital in the HIV prevention and control programs. Social mobilization and Community Conversations activities are intensified. The National Prevention Summit gave more emphasis to most-at-risk populations through the development of focused interventions.

Several important guidelines, implementation manuals, standard operating procedures and training manuals have been prepared, distributed and utilized to improve quality standards for HIV and AIDS services. Various in-service and pre-service training mechanisms have been employed and health workers have been trained on service deliveries in accordance with the national and international standards

There has been an extraordinary performance and substantial expansion of access to HIV counseling and testing and ART services in Ethiopia.

- HCT uptake increased and in 2008/9 year alone 5.8 million clients were tested for HIV. Rapid HIV counseling and testing service was expanded significantly. The number of facilities providing HCT were 1,005 in 2007/08 and increased to 1,823 by 2008/09. Provider-initiated counseling and testing (PICT) has been well integrated with routine health services.
- Health facilities providing ART reached 517 in December 2009. The number of AIDS patients ever started on ART has grown to 241,759 in December 2009, among which 176,632 were currently on treatment. This year alone 91,100 new AIDS patients started ART.
- HIV prevention services including HCT, PMTCT, IP/PEP, condom, STI prevention and control are better integrated in to the overall health system.
- A little less than half of key public sectors had sectoral policies and guidelines for HIV, and many organizations have developed action plans to address HIV/AIDS in their workplaces. About half had established AIDS funds (fund mobilized from employees of the organization to provide care and support to HIV affected workers). The proportion of organizations that allocated 2% of their core budget to HIV activities increased to 64% in 2009 from only 18 in 2007. Furthermore about 88% of organizations assigned focal person for HIV/AIDS activities, this is markedly increased from the 2007/8 proportion of only 50%.
- There was better involvement of communities, community-based organizations and faith-based organizations in supporting orphans and PLHIV and mitigating the impact of HIV..
- Social mobilization efforts, especially Community Conversations (CCs), were successful in reaching millions of people through grassroots level organizations and creating awareness about HIV and available services, creating demand and increasing service uptake. Social mobilization activities were further intensified using health extension workers. Stigma and discrimination were substantially reduced paving the road for better access to services
- Significant success was recorded towards the Greater Involvement of PLHIV (GIPA) in the national as well as local response against the epidemic.

- Effective coordination and networking of activities were achieved through joint review meetings and joint integrated supportive supervisions. Better coordination of resources was achieved by aligning and harmonizing donors and their programs
- An end-term evaluation of the Ethiopian Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response (SPM) and the Global Fund Health Impact Evaluation were conducted.
- A national assessment of the M&E system was conducted, the result of which has helped ongoing efforts to revise the 2003 M&E framework and develop a costed M&E plan.

## 6.2. Progress made on key challenges reported in the last UNGASS report

*Insufficient human resources*: Strategically intensive decentralization, task shifting to the health officers, nurses, and health extension workers and utilization of chronic care model that links health care delivery with community- and home-based interventions helped maintain the performance of other health programs such as tuberculosis and maternal and child health services while achieving successes in the medical interventions of HIV/AIDS programs. The massive involvement of HEWs in both facility-based and community-based HIV/AIDS interventions by creating awareness about available services and creating demand for the service is very encouraging. Recently introduced supportive supervision and a mentorship program is one of the good lessons in addressing the quality of services being provided while implementing a task shifting strategy. The health network model has been a key instrument for the smooth transition of patients from hospitals to the health centers and sample transfer from health centers to hospitals and regional laboratories.

*Quality*: There are initiatives against the high number of patients lost to follow up to the ART services in collaboration with partners, but these efforts require additional strengthening.

*Harmonization and alignment*: Marked attempts have been made towards better coordination and integration efforts of all partners at national level through various forums of joint planning and reviewing processes through the principles of the "Three Ones". Establishment of the HIV Governance Pooled Fund through a donor consortium and in support of better coordination and alignment is a good example.

*PMTCT*: There have been efforts to improve service uptake through closer integration with maternal and child health services, but PMTCT coverage is still low. This is a weak link in the HIV/AIDS response that requires serious attention.

*Mainstreaming and leadership*: The scope and intensity of HIV mainstreaming has improved significantly but the achievement is still not satisfactory. There is still limited capacity in key strategic sectors such as education, youth and sport, and women.

*Surveillance and research*: Three important evaluations were conducted that improve our understanding of the impact of the national response against the epidemic. However, up-to-date sero-surveillance data are needed for both general and most-at-risk populations, and data are still lacking in the non-health sector response and community (non-facility based) based interventions. Moreover, there is inadequate strategic information on various interventions' outcomes and estimates of the size of populations who are most at risk to HIV infection.

## 6.3. Challenges faced through the reporting period

- *HIV prevention interventions:* HIV prevention interventions targeting the general population are done at scale but there is limited scale of HIV prevention programs targeting the vulnerable and most at risk population groups.
- *Prevention of mother-to-child transmission of HIV*: The progress in the provision of PMTCT has been extremely slow.
- *Prevention of sexually transmitted infections:* The STI program does not seem to have received the attention it deserves, although the service was integrated with the routine health services. STIs are not systematically monitored and program monitoring data is inadequate.
- *Orphans and vulnerable children*: Coordination and harmonization of OVC activities are not strong, especially at grassroots level.
- *Most-at-risk population groups:* There is inadequate strategic information about the sizes, behavioral risk factors and HIV prevalence of MARPs.
- *Social mobilization:* Awareness creation efforts were largely targeting the general public and the effort to reach vulnerable and most at risk population groups through BCC is inadequate.
- *School-based interventions:* the national response recognized education as a 'social vaccine' to HIV/AIDS, and schools as the entry points to reach a significant proportion of youth. However, the coverage of in-school HIV/AIDS interventions, such as life skills-based training and school Community Conversations, remains low.
- *Human resources:* The efforts to build human resource capacity to respond to the epidemic have been focused mainly in the health sector, whereas the potentials in the non-health sector and in non-public sector remained underdeveloped and underutilized.
- *Leadership commitment:* Although better leadership commitments were achieved at national, regional and operational levels in general, the scope and effectiveness of commitments significantly vary. Sub-regional level and non-health sector leadership commitments remain much less than desired, and this has limited the quality and volume of success in the multi-sectoral response. Progress was made to mainstream HIV and AIDS activities in sectoral public agencies, but efforts and achievements in mainstreaming remain much less than desired in many non-public sectors.
- *Monitoring and evaluation:* There is a shortage of information on the progression of the epidemic due to delays in a planned sero-survey, behavioral and other biological surveys among the general population, vulnerable as well as most at risk groups. There is weak system in documentation of best practices. There is inadequate up-to-date information about the effectiveness of interventions. There is no agreed standard definition of MARPs, and no national level mapping and size estimation on MARPs for targeted interventions.
- *HIV and human rights:* Enhancement of HIV and human rights laws need to be addressed urgently to mitigate stigma and discrimination and enhance the involvement of PLHIV in the prevention and control of the HIV/AIDS epidemic

## 6.4. Remedial actions planned

Consolidated operational annual plans will be prepared to translate the SPMII into action. The implementation process and achievements will be closely monitored and evaluated. Multisectoral actors at all levels are expected to develop and implement their HIV/AIDS response plans based on this SPM in harmony with the principles of the "Three Ones".

*HIV prevention programs:* Based on a comprehensive national multi-sectoral HIV prevention road map, multi-sectoral prevention annual work plans will be developed at all levels to intensify HIV prevention efforts. The program shall define, develop and implement a package of HIV prevention services to address MARPs based on existing experiences and strengthen the existing interventions for the general population. Prevention efforts shall also focus on interrupting urban-to-rural transmission and containing the rural epidemic at its current low levels through social mobilization. The national coordination and synchronization mechanism of HIV prevention efforts from all sectors including private and non-governmental actors will also be strengthened.

The community mobilization and peer education programs will be strengthened to better reach vulnerable and high-risk populations, such as youth and women. Community Conversations and community dialog will be tailored to bring social transformation and ensure community ownership. Attention shall be given to awareness creation and behaviour change communication on HIV prevention and transmission along with expansion of prevention services such as condom promotion, HCT, PMTCT and interventions for MARPs.

*HIV mainstreaming:* emphasis will be given to strengthen mainstreaming activities with special focus on key strategic sectors including education, youth, women and the workplaces.

# Annex I: National composite policy index

NCPI DATA GATHERING AND VALIDATION PROCESS

- Describe the process used for NCPI data gathering and validation:

The survey that was designed to get together the National Composite Policy Index (NCPI) was carried out in the months of December, 2009 and January, 2010 using the NCPI Instruments given in the Guidelines on Construction of Core Indicators: 2010 Reporting (UNGASS 2010).

The different sections of the NCPI were completed by a variety of stakeholders, including non-governmental organizations (NGOs), people living with HIV, national human rights commissions, United Nations agencies and private sector representatives. Thus, the methodology deployed in order to measure the progress include; make desk review, interviewing the appropriate governmental & nongovernmental respondents, collating data and presenting this information for discussion at a validation and/or consultation meeting where the involvement of government officials, civil society and other stakeholders presence and inputs are vital.. The NCPI comprised a lot of questions that summarize the core components of a rights-based move toward on the legal and policy environment, the availability of HIV-related services and vulnerable subpopulations.

Identification of key stakeholders was done by the NCPI consultant, Hailegiorgis Tilahun, in collaboration with FHAPCO, CSOs and UNAIDS. Two NCPI assistants, namely; Habtamu Girma and Desta Kassa, with prior experience in key informant interviewing underwent two days of training. Pre-testing was carried out among these assistants, only for familiarization, as no modification of the tools was anticipated. Progress report was presented to the National M&E Advisory committee through the FHAPCO M&E Directorate and amendment to the process were suggested to involve the Regional concerned bodies (RHBs, RHAPCO and other stakeholders working in the regions). All these respondents were successfully interviewed. These include; 36 part A respondents (i.e. government ministries and agencies) and 42 part B respondents (i.e. civil society organizations, bilateral agencies, UN & USG organizations. Moreover, the data was entered to SPSS software to tabulate and examine the narrative reports for text relating to the different sections of the NCPIs. For this round of NCPI analysis, an attempt was made to conduct a trend analysis and include description of progress made in (a) policy, strategy and law development and (b) implementation of these in support of the country's HIV response.

TABLE 1: LIST OF PART A RESPONDENTS

| ORGANIZATION | NAME AND POSITION | RESPONDENTS TO PART A | | | | |
|---|---|---|---|---|---|---|
| | | A I | A II | A III | A IV | AIIV |
| FHAPCO | Afework Kassa, Plan, M&E Directorate, Director | ✓ | ✓ | ✓ | ✓ | ✓ |
| FHAPCO | Mifta Awel, Planning expert | ✓ | ✓ | | | |
| FHAPCO | Eleni Seyoum, Monitoring and Evaluation Officer | | | | ✓ | ✓ |
| CENTRAL STATISTICS AUTHORITY | Gebeyehu Abelit, Deputy Director General Of Population & Social Statistics | | | | | ✓ |
| MINISTRY OF EDUCATION | Hadish G/Tensai, Resource Mobilization Expert | | ✓ | ✓ | ✓ | ✓ |
| ETHIOPIAN HEALTH NUITRITION RESEARCH INSTITUTE | Hussein Faris Director Of Plan, Finance Monitoring & Evaluation Directorate | | | | | ✓ |
| MINISTRY OF YOUTH & SPORTS | Mekkonen Yidersal, HIV/AIDS Program Focal Person | | | ✓ | | |
| MINISTRY OF LABOR & SOCIAL AFFAIR | Mesfin, Director Of Directorate Of Harmonious Industrial Relations | ✓ | | ✓ | ✓ | |
| MINISTRY OF LABOR & SOCIAL AFFAIR | Solomon Demisse | ✓ | | ✓ | ✓ | |
| ADDIS ABABA UNIVERSITY | Biniam Eskinder , March Project Focal Person | | | ✓ | | |
| AAHAPCO | Achamyeleh Alebachew, RHAPCO Head | ✓ | ✓ | ✓ | ✓ | ✓ |
| NATIONAL DEFENSE FORCE | Yiheis Aytenfsu, Head Of HIV/AIDS/STIS Department | ✓ | | ✓ | ✓ | |
| OROMIA HAPCO | Zenebech ,RHAPCO Head | ✓ | ✓ | ✓ | ✓ | ✓ |
| FEDERAL POLICE | Tsegaye Kaleab, MARCH Project Director | ✓ | | ✓ | ✓ | |
| MINISTRY OF HEALTH | Kiros Kidanu, Associate Director of Policy And Planning Directorate | | | | | ✓ |

| | | | | | | |
|---|---|---|---|---|---|---|
| MINISTRY OF HEALTH | Aschalew Endale, NOP-HIV/AIDS | | | ✓ | ✓ | |
| SOMALIA HAPCO | Mohammed Ahmed, Planning & Program Head | ✓ | ✓ | ✓ | ✓ | ✓ |
| SOMALIA HAPCO | Mohammed Ahmed, Senior Training Expert | ✓ | ✓ | ✓ | ✓ | ✓ |
| SOMALIA HAPCO | Afewerk Aberkersa- Senior Planning Expert | ✓ | ✓ | ✓ | ✓ | ✓ |
| SOMALIA HAPCO | Ahmed Deik, Planning Team Leader | ✓ | ✓ | ✓ | ✓ | ✓ |
| SOMALIA HAPCO | Kalil Tlaji, M&E Officer | ✓ | ✓ | ✓ | ✓ | ✓ |
| SOMALIA HAPCO | Nasir Aden, App Officer | ✓ | ✓ | ✓ | ✓ | ✓ |
| GAMBELLA HAPCO | Othow Akwa, Rhapco Head | ✓ | ✓ | ✓ | ✓ | ✓ |
| GAMBELLA HAPCO | Alemu Tilahun, Head Of Disease Prevention & Control | ✓ | ✓ | ✓ | ✓ | ✓ |
| GAMBELLA HAPCO | Ojulu Omot , Advocacy & Training Expert | ✓ | ✓ | ✓ | ✓ | ✓ |
| GAMBELLA HAPCO | Ojulu Odola Advocacy & Training Team Leader | ✓ | ✓ | ✓ | ✓ | ✓ |
| SNNPR HAPCO | Bekele Yilma, M&E Officer | ✓ | ✓ | ✓ | ✓ | ✓ |
| SNNPR HAPCO | Fikrte Abera, Clinical Service Officer | ✓ | ✓ | ✓ | ✓ | ✓ |
| SNNPR HAPCO | Feleke Gebre, Program Officer, | ✓ | ✓ | ✓ | ✓ | ✓ |
| SNNPR HAPCO | Tamirayehu, Officer, | ✓ | ✓ | ✓ | ✓ | ✓ |
| Amhara RHAPCO | Getaneh Derseh, RHAPCO Head | ✓ | ✓ | ✓ | ✓ | |
| Amhara RHAPCO | Ayalew Jemberie, M&E Officer | ✓ | ✓ | ✓ | ✓ | ✓ |
| DIREDAWA HAPCO | Africa Mulugeta , Global Fund Program Officer | ✓ | ✓ | ✓ | ✓ | ✓ |
| DIREDAWA HAPCO | Yehwalashet, M&E Officer | ✓ | ✓ | ✓ | ✓ | ✓ |

TABLE 2: LIST OF PART B RESPONDENTS

| ORGANIZATION | NAME AND POSITION | RESPONDENTS TO PART B | | | |
|---|---|---|---|---|---|
| | | B I | BII | BIII | BIV |
| MINISTRY OF JUSTICE | Hibret Abahoy, Womens & Children Affairs | ✓ | ✓ | | |
| MINISTRY OF WOMEN AFFAIRS | Mulatwa Wolde, HIV/AIDS Focal Person & Gender Expert | ✓ | ✓ | | |
| AMHARA REGION | CARE | ✓ | ✓ | ✓ | ✓ |
| AMHARA REGION | CSO Forum | ✓ | ✓ | ✓ | ✓ |
| AMHARA REGION | NGO Forum | ✓ | ✓ | ✓ | ✓ |
| AMHARA REGION | NAP+ | ✓ | ✓ | ✓ | ✓ |
| SNNP REGION | NAP+ - Abebaw Derbe, Program coordinator | ✓ | ✓ | ✓ | ✓ |
| SNNP REGION | OSSA | ✓ | ✓ | ✓ | ✓ |
| SNNP REGION | NGO Forum | ✓ | ✓ | ✓ | ✓ |
| UNFPA | HIV/AIDS - Ayehu Tameru, NPO | | ✓ | ✓ | |
| NEP+IN ETHIOPIA | Dereje Alemayehu, Research & Advocacy Manager | ✓ | ✓ | ✓ | ✓ |
| DKT | Genna Aman,senior project advisor | | | ✓ | |
| CETU | Hailekiros Weldemichael,Social Affairs Division Head | ✓ | ✓ | ✓ | |
| FENAPD | Kassahun Yibeltal, President | | | | ✓ |
| CRDA | Semu Ketema Tefera, National Coordinator | ✓ | ✓ | ✓ | ✓ |
| EVMPA-MEDIA SUB FORUM | Sisay Abebe | ✓ | ✓ | | |
| GAMBELLA | PACT - David Olok, Project officer | ✓ | ✓ | ✓ | ✓ |
| GAMBELLA | NEP+ - Chang Kooth , Program Coordinator | ✓ | ✓ | ✓ | ✓ |
| PEPFAR | Abeje Zegeye - TWG Chair, Care and Support | | | | ✓ |
| PEPFAR | Kassa Mohammed- TWG Chair, Prevention | | | ✓ | |
| WFP | Meherete Selassie Menbere, HIV/AIDS Team Leader | | | | ✓ |
| WHO | Seblewengel Abate, NPO | | | | ✓ |
| UNICEF | Fikir Melesse NPO | | | ✓ | ✓ |
| ETHIOPIAN INTERFAITH FORUM DEVELOPMENT DIALOGUE ASSOCIATION | Habtamu WoldeYes, HIV unit Head | | ✓ | ✓ | ✓ |
| OSSA | Ibrahim Yosuf, Program manager | ✓ | ✓ | ✓ | ✓ |

| | | | | | |
|---|---|---|---|---|---|
| NNPWE | Eyelachew Etsub, Project Coordinator | ✓ | ✓ | ✓ | ✓ |
| CENTER FOR COMMUNICATION PROGRAMS/ARC | Gashaw Mengistu, ARC Coordinator | | | ✓ | |
| DIREDAWA REGION | Henock kebede, Head of NEP+, | ✓ | ✓ | ✓ | ✓ |
| DIREDAWA REGION | Tadelu Hailu- OSSA M&E officer, | ✓ | ✓ | ✓ | ✓ |
| DIREDAWA REGION | Birhanu Gobena- CRDA Liaison officer | ✓ | ✓ | ✓ | ✓ |
| SOMALI REGION | Mubarek Ahmed-officer, | ✓ | ✓ | ✓ | ✓ |
| SOMALI REGION | Yohannes Adere- NEP+ Advocacy and PR | ✓ | ✓ | ✓ | ✓ |
| SOMALI REGION | Wendmagegnehu Birhanu - Selam association M&E officer, | ✓ | ✓ | ✓ | ✓ |
| SOMALI REGION | Abdulahi Abder- ENAMLET vice chair, | ✓ | ✓ | ✓ | ✓ |
| SOMALI REGION | Abun Dibbe- HAVOYOCO chair person, | ✓ | ✓ | ✓ | ✓ |
| SOMALI REGION | Dawit Bhunell- Rejow women Association Head | ✓ | ✓ | ✓ | ✓ |
| SOMALI REGION | Aredo Aden-chair person | ✓ | ✓ | ✓ | ✓ |
| UNAIDS | Mulumebet Merhatsedik, Prevention Focal Person | ✓ | ✓ | ✓ | |
| NEWA | Tsehai Abate, Program Officer | ✓ | ✓ | ✓ | ✓ |
| ETHIOPIAN BUSINESS COALITION AGAINST HIV/AIDS | Tigist Urgessa, Training Coordinator | ✓ | ✓ | ✓ | ✓ |

## I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV? YES

✓ Period covered: Since 2001 the country has developed a national strategy. Please also note that the recent SPMII covers the period from 2010-2014

1.1. How long has the country had a multisectoral strategy? Number of Years: SINCE 2001 FOR ABOUT 8 YEARS

✓ The first multi-sectoral response to the HIV/AIDS epidemic is framed around the National policy and the Five-year Strategic Framework that were issued out in 1998 and 1999 respectively. Several independent attempts have been undertaken to review and evaluate the performance and achievements of the ongoing interventions. The two Strategic Plan and Management documents (SPMI & SPMII) have been prepared mainly through critical review, analysis and synthesis of the relevant documents with the involvement of relevant stakeholders using regular consultation and brainstorming sessions. The Strategic Plan and Management document has nine major sections which cover; (Part one) a synoptic overview of the situation of HIV/AIDS in Ethiopia and the national response to date. (Part II) consists the mission, vision, goal and guiding principles of the national response, while (Part three) elaborates on the major strategic issues that the Government of Ethiopia has identified. (Part four) focuses on the main thematic areas along with their corresponding objectives and strategies. (Part five) of the SPM covers the strategic plan matrix, which outlines selected strategy, major activities, indicators, means of verification and responsible body for the activities of the given thematic areas. (Part six) covers the budgetary requirements and justification. (Part seven and eight) cover governance and institutional arrangement, and monitoring and evaluation respectively. (Part nine) elaborates on the major challenges and the ways forward. The SPM is subsequently concluded with the annexes which include the minimum service delivery package by institutional level, role of key implementing agencies, list of policy document and acronyms. This SPMI covers four years (2004-2008) and the current plan runs from 2010 – 2014132.

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

| SECTORS | INCLUDED IN STRATEGY (YES/NO) | EARMARKED BUDGET (YES/NO) |
|---|---|---|
| Health | YES | YES |
| Education | YES | YES |
| Labour | YES | NO |
| Transportation | YES | NO |
| Military/Police | YES | NO |
| Women | YES | NO |
| Young people | YES | NO |
| Agriculture | YES | NO |
| Finance and Economy | YES | NO |
| Justice | YES | NO |
| Trade and Industry | YES | NO |
| Culture and Tourism | YES | NO |
| Minerals and Energy | YES | NO |

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

✓ The funds required for the implementation of their sector HIV/AIDS activities come from the Government annual budget plan and from other local NGOs working in the fight against HIV. Moreover, since, many sectors are cross-cutting, the workers and their families reached through the services accessible to the general population.

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

| TARGET POPULATIONS | |
|---|---|
| Women and girls | YES |
| Young women/young men | YES |
| Injecting drug users | NO |
| Men who have sex with men | NO |
| sex workers | YES |
| Orphan and vulnerable children | YES |
| Other specific vulnerable subpopulations | YES |
| SETTINGS | |
| Workplace | YES |
| Schools | YES |
| Prisons | YES |
| CROSS-CUTTING ISSUES | |
| HIV and poverty | YES |
| Human rights protection | YES |
| Involvement of people living with HIV | YES |
| Addressing stigma and discrimination | YES |
| Gender empowerment and/or gender equality | YES |

1.4 Were target populations identified through a needs assessment? YES

✓ The needs assessment is an ongoing process. The latest need assessment was completed before the finalization of the SPMII planning. The regions as well as the national program planning were done based on evidence based processes using different programmatic as well as surveillance and survey results. Thus, some target populations identified through review of documents like BSS, ANC based surveillance report, PRSP, DHS, formative assessments.

IF YES, when was this needs assessment conducted?

✓ Year 2008

1.5 What are the identified target populations for HIV programmes in the country?

➢ Although Ethiopia is in the stage of a generalized epidemic, it was crucial to center on special target groups to rapidly control the epidemic and alleviate its impact through an effective use of resources. Based on the epidemiological facts and other assessment tools, the identification of the target population who are infected and affected most and who are highly vulnerable to infection was done in the country. And, thus[133];

✓ The youth population aged 15-29 years is highly affected by the epidemic and the large number of

this age group are in schools, therefore, targeted behavioral change communication and integration of HIV/AIDS prevention issues in the curriculum and in civic education was believed to be a strategy to effectively control the spread of HIV among the youth and the school community. In addition, youth out of school need to be targeted appropriately.

- ✓ Due to deep-rooted poverty, the number of commercial sex workers, especially in urban settings are rapidly increasing and resulting in the rapid transmission of the virus. Thus, comprehensive and tailored packages of interventions should be designed to address their special need.
- ✓ The mobile population groups, such as; long distance truck drivers, migrant laborers, and uniformed people, should be addressed with targeted interventions focusing on their mobile nature.
- ✓ Orphans and other vulnerable children must and deserve to be targeted both from care and support point of view as well as prevention and reduction of vulnerability.
- ✓ Special small scale studies, like the Amhara MARPs Survey, revealed that other specific vulnerable sub-populations in various regions of the country, such as Refugees, Construction work daily laborers, Students, Mobile merchants are also identified as most at risk population targeted both for preventive, care and treatment interventions.

1.6 Does the multisectoral strategy include an operational plan? YES

1.7 Does the multisectoral strategy or operational plan include?

| | |
|---|---|
| a. Formal programme goals? | YES |
| b. Clear targets or milestones? | YES |
| c. Detailed costs for each programmatic area? | YES |
| d. An indication of funding sources to support programme implementation | YES |
| e. A monitoring and evaluation framework? | YES |

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

- ✓ Active Involvement: Currently, the country has ensured that civil society was fully involved and fully participated in developing the Strategic plan and management documents and actively involved in all supportive supervisions and review meetings at all levels. Active involvement was ensured through open and decentralized discussions with various stakeholders. Accessibility of funding for civil society organizations also enhanced their involvement.

IF active involvement, briefly explain how this was done:

- ✓ CSOs participated actively in the development and revisiting of the different HIV/AIDS related implementation Guidelines, the setting of the Universal Access targets and costing as well as in the development of the multisectoral strategy/action framework (SPMIII) document. Currently, most of the civil society organizations, bilateral and other multilateral organizations are found to be an active participant in the different Technical Working Groups (TWGs) at national as well as regional levels, particularly those on prevention, treatment, care and support as well as M&E. They all the time participate in annual and bi-annual reviews meetings and share their best practices and provide other inputs to these important events.

- ✓ At present, the civil societies in Ethiopia have established a very strategic role for themselves in delivering key programmes through government partnership. They also contribute to overall monitoring and evaluation of progress made at national level and thus recognizes themselves as stakeholders and partners. According to some of the regional informants, CSOs are involved in such a way that they are organized through the partnership forums, and most of them are fully participating in the national as well as regional council meetings while the strategic planning documents and annual performance reports are approved.

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals,

multi-laterals)? YES

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy? YES, MOST PARTNERS

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment /UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach? YES

2.1 IF YES, in which specific development plan(s) is support for HIV integrated?

| | |
|---|---|
| a. National Development Plan | YES |
| b. Common Country Assessment / UN Development Assistance Framework | YES |
| c. Poverty Reduction Strategy | YES |
| d. Sector-wide approach | YES |

2.2 IF YES, which specific HIV-related areas are included in one or more of the development plans?

| HIV-related area included in development plan(s) | |
|---|---|
| HIV prevention | YES |
| Treatment for opportunistic infections | YES |
| Antiretroviral treatment | YES |
| Care and support (including social security or other schemes) | YES |
| HIV impact alleviation | YES |
| Reduction of gender inequalities as they relate to HIV prevention/ treatment, care and/or support | YES |
| Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support | YES |
| Reduction of stigma and discrimination | YES |
| Women's economic empowerment (e.g. access to credit, access to land, training) | YES |

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes? YES

3.1 IF YES, to what extent has it informed resource allocation decisions?

Low High

0 1 **2** 3 4 5

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)? YES

4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

| | |
|---|---|
| Behavioral change communication | YES |
| Condom provision | YES |
| HIV testing and counseling | YES |
| Sexually transmitted infection services | YES |
| Antiretroviral treatment | YES |
| Care and support | YES |

If HIV testing and counseling is provided to uniformed services briefly describe the approach taken to HIV testing and counseling (e.g., indicate if HIV testing is voluntary or mandatory etc):

- Three types of HIV testing are available in the country: (1) Client-initiated, or voluntary counseling and testing, (2) Provider-initiated testing and counseling and (3) Mandatory HIV screening.[134]

- Ethiopia responded to the HIV/AIDS epidemic as early as 1985. The Federal Ministry of Health and the HIV/AIDS Prevention and Control Office (MOH/HAPCO) developed an HIV/AIDS policy, different guidelines (PMTCT, ART, IP, VCT etc) and strategic documents to create an environment conducive for the implementation of HIV prevention, care, and treatment and support programs. As part of this effort, the first counseling and testing guidelines were published by the federal Ministry of Health (FMOH) in 1996 and the second edition, currently in use, in 2002.Counseling and Testing, as a crucial intervention component of the HIV/AIDS prevention, care and support program are promoted and widely available, affordable and accessible to all individuals and communities.
- Some of the Policy Statements clearly stated in the national guideline are;
  - ✓ HCT services shall be standardized nationwide and shall be authorized, supervised, supported and regulated by appropriate government health authorities
  - ✓ Informed consent for testing shall be obtained in all cases, except in mandatory testing
- According to the national HIV Counseling and testing guideline,
  - ✓ Compulsory HIV testing can only be performed for specific reasons with individuals or groups when requested by the court. In all cases of compulsory HIV testing, individuals shall be informed of test results.
  - ✓ HIV is a blood-borne pathogen spread by blood transfusion or tissue/organ transplantation; therefore it is mandatory to test blood or tissue for HIV before transfusion/transplantation/grafting.
  - ✓ Mandatory screening of donated blood/organ/tissue is required prior to all procedures involving transfer of body fluids or body parts, such as artificial insemination, corneal grafts and organ transplant. Donors should be specifically informed about HIV testing of donated blood/organ/tissue.
- In the national HIV Counseling and testing, military or uniformed personnel in Ethiopia, (military or police), represent mobile high risk populations. Thus, Counseling and testing services for these groups should be developed with support from the military or police command and should include: Establishment of counseling and testing services in all military and police health facilities and in outreach programs to camps, VCT promotion among uniformed personnel and stigma reduction and Partner/spouse referral
- But, recently in the country, although VCT has been recognized as a rights-based approach to HIV testing, there had been increasingly a call to move away from a sole reliance on the VCT model in the past few years. The move towards a more aggressive type of testing is justified, among other things, by the wide availability of ART. [135]

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations? YES

5.1 IF YES, for which subpopulations?

| | | |
|---|---|---|
| a. | Women | YES |
| b. | Young people | YES |

| | |
|---|---|
| c. Injecting drug users | NO |
| d. Men who have sex with men | NO |
| e. Sex Workers | YES |
| f. Prison inmates | YES |
| g. Migrants/mobile populations | YES |

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

✓ CSOs such as Ethiopian lawyers association, women's association, and professional association like teachers association are enforcing laws and regulations to be implemented. In addition to this, work place policies are under implementation and followed by civil service agency and ministry of labour and social affairs.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations? NO

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006? YES

7.1 Have the national strategy and national HIV budget been revised accordingly? YES

7.2 Have the estimates of the size of the main target populations been updated? YES

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy? YES

7.4 Is HIV programme coverage being monitored? YES

(a) IF YES, is coverage monitored by sex (male, female)? YES

(b) IF YES, is coverage monitored by population groups? NO

(c) Is coverage monitored by geographical area? YES

IF YES, at which geographical levels (provincial, district, other)?

- Coverage is monitored by geographical areas at Regional, Zonal, district and Health facility/site level

Briefly explain how this information is used:

- The M&E data are used by all the stakeholders for evidence based planning and decision making activities (i.e., for the revising of the national strategy, for budget allocation and for programme improvement). For instance, recently the SPMII is revised based on the evidences obtained from the M&E reports and routine program monitoring data are highly being used for making corrective measures.

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs? YES

| Overall, how would you rate strategy planning efforts in the HIV programmes in 2009? | |
|---|---|
| Very poor | Excellent |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2009 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | **9** | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| 2005 | 0 | 1 | 2 | **3** | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- The second round Strategic plan and management (SPMII) document was developed at national level with full involvement of all the relevant stakeholders. And, thus, the principles of Three Ones' were applied strongly, and there was a wide participation from development partner as well as civil society both at the national as well as regional levels to commonly understand on how strategically plan, implement and monitor the programs of different levels.

What are remaining challenges in this area:

- Some partners' plans and their M&E Indicators are not harmonized and aligned. The community based HIV/AIDS information are not well-captured and readily available for evidence based planning and decision making process at all levels. However, there is still room for improvement, particularly for community level PMTCT and OVC indicators.
- Lack of enough information on the magnitude of HIV among most at risk populations and the size of MARPs for intervention.

Over all, there is a progress with respect to the efforts made on the strategic plan development and implementation processes in relation to HIV and AIDS in 2009 compared to that of 2007 and 2005.

## POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favorably about HIV efforts in major domestic forums at least twice a year?

| | |
|---|---|
| President/Head of government | YES |
| Other high officials | YES |
| Other officials in regions and/or districts | YES |

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)? YES

- In September 1987, the AIDS Control Program was established at a department level in the MOH, with the responsibility of coordinating the national prevention and control program. Subsequently Short and Midterm Plans for control were developed (1987-1989). In 1998 The National HIV/AIDS Policy was issued, followed by the development in 1999 of the Strategic Framework for the National Response. Both documents served as the basis for the expanded and scaled up multi- sectoral response136.

2.1 IF YES, when was it created? Year: 2000

2.2 IF YES, who is the Chair?

Name: Girma Woldegeorgis Position/Title: President of the Federal Democratic Republic of Ethiopia

- In April 2000 the National AIDS Council (NAC) was established under the chairmanship of the country's president. The Council was composed of representatives from relevant government, Private, Faith Based, Non Government Organizations and prominent figures. A Secretariat accountable to the Prime Minister's Office was also established to coordinate the national multi-sectoral response. Similar structures with similar constituencies were also established in the regions and at lower administrative levels. The legal establishment of HIV/AIDS Control and Prevention Office in 2002 and the launching of multi-sectoral HIV/AIDS control and prevention programs were some of the major steps forward in the battle against HIV/AIDS.

2.3 IF YES, does the national multisectoral AIDS coordination body:

| | |
|---|---|
| - Have Terms Of Reference? | YES |
| - Have Active Government Leadership And Participation? | YES |
| - Have A Defined Membership?<br>If Yes, How Many Members? [61]<br>- Include Civil Society Representatives?<br>If Yes, How Many? [5]<br>- Include People Living With HIV?<br>If Yes, How Many? [NEP+ - representing 138 Associations]<br>- Include The Private Sector? | YES<br><br>YES<br><br>YES<br><br>YES |
| - Have An Action Plan? | YES |
| - Have A Functional Secretariat? | YES |
| - Meet At Least Quarterly?<br>- Review Actions on Policy Decisions Regularly?<br>- Actively Promote Policy Decisions?<br>- Provide Opportunity For Civil Society To Influence Decision-Making?<br>- Strengthen Donor Coordination To Avoid Parallel Funding And Duplication Of Effort In Programming And Reporting? | YES<br>YES<br>YES<br>YES<br>YES |

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes? YES

IF YES, briefly describe the main achievements:

- Council meetings, Joint review meetings, joint planning, Partnership forums and other conferences are mechanisms to bring government, funding agencies, civil society and private sectors together. Through these mechanisms, the achievements so far are leadership commitment at all levels is improved, coordination is improved, duplication of efforts are to some extent reduced, HIV/AIDS is mainstreamed in all governmental and non-governmental sectors, resources are mobilized and generally the response is strengthened.

Briefly describe the main challenges:

- Harmonization and coordination still fragile, There is a high Government skilled staff turnover at all level to strengthen the health system development, Lack of recent epidemiological data for evidence based strategic planning development and decision making process, and there is a gap between the unmet need to UA and available secured fund

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year? Percentage:

- According to the informants, an estimated 75% of the national HIV budget was spent on activities implemented by civil society in the past two years - because most of the activities specially the non-health programs at the community level are implemented by civil society organizations.

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

| | |
|---|---|
| Information on priority needs | YES |
| Technical guidance | YES |
| Procurement and distribution of drugs or other supplies | NO |
| Coordination with other implementing partners | YES |
| Capacity-building | YES |

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies? YES

6.1. IF YES, were policies and laws amended to be consistent with the National AIDS Control policies? NO

| Overall, how would you rate the political support for the HIV programme in 2009? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2009 | Very poor | | | | | | | | | | Excellent |
| 2009 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| 2005 | 0 | 1 | 2 | **3** | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- ✓ According to the national and regional informants, since 2007, some of the key achievements in this area are; the political leaders' commitments were increased at national and regional level. For example, in some regions like Amhara, the regional government committed to cover the salary of the coordinating office staffs from the regional government budget to the district level. The political support was also reflected through council meetings (the council members have a regular meeting to review, monitor and evaluate the implementation of the HIV/AIDS programs at different level, and political leaders speak out the issue of HIV/AIDS at every public meeting).

What are remaining challenges in this area:

- ✓ The informants have also indicated that at lower level, there is a need to strengthen the political leaders' commitment to work closely with the stakeholders to mobilize the community to sustain the ongoing HIV/AIDS programs and to strengthen the community level programs (e.g. community conversation, community PMTCT programs, OVC and others)

Overall, there is almost similar progress trends with respect to the efforts made on the political supports in relation to HIV and AIDS in 2009 compared to that of 2007.

## PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population? YES

1.1. IF YES, what key messages are explicitly promoted? Check for key message explicitly promoted

| | |
|---|---|
| a. Be sexually abstinent | ✓ |
| b. Delay sexual debut | ✓ |
| c. Be faithful | ✓ |
| d. Reduce the number of sexual partners | ✓ |
| e. Use condoms consistently | ✓ |
| f. Engage in safe(r) sex | ✓ |
| g. Avoid commercial sex | ✓ |
| h. Abstain from injecting drugs | ✓ |
| i. Use clean needles and syringes | ✓ |
| j. Fight against violence against women | ✓ |
| k. Greater acceptance and involvement of people living with HIV | ✓ |
| l. Greater involvement of men in reproductive health programmes | ✓ |
| m. Males to get circumcised under medical supervision | ✓ |
| n. Know your HIV status | ✓ |
| o. Prevent mother-to-child transmission of HIV | ✓ |

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media? YES

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people? YES

2.1. Is HIV education part of the curriculum in:

| | |
|---|---|
| Primary Schools? | YES |
| Secondary Schools? | YES |
| Teacher Training? | YES |

2.2. Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women? YES

2.3. Does the country have an HIV education strategy for out-of-school young people? YES

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk or other vulnerable sub-populations? YES

3.1. IF YES, which populations and what elements of HIV prevention do the policy/strategy address? Check which specific populations and elements are included in the policy/strategy

| | IDU* | MSM** | CSW | CLIENTS OF SEX WORKERS | PRISON INMATES | STUDENTS | DAILY LABORERS | UNIFORMED PEOPLE | TRUCK DRIVERS |
|---|---|---|---|---|---|---|---|---|---|
| Targeted information on risk reduction and HIV education | | | ✓ | | | ✓ | ✓ | ✓ | ✓ |
| Stigma and discrimination reduction | | | ✓ | | | | | | |
| Condom promotion | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| HIV testing and counseling | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Reproductive health, including sexually transmitted infections prevention and treatment | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Vulnerability reduction (e.g. income generation) | N/A | N/A | ✓ | N/A | N/A | | ✓ | | |
| Drug substitution therapy | | N/A | N/A | N/A | N/A | | | | |
| Needle & syringe exchange | | N/A | N/A | N/A | N/A | | | | |

| Overall, how would you rate policy efforts in support of HIV prevention in 2009? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Very poor | | | | | | | | | | Excellent |
| 2009 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | **6** | 7 | 8 | 9 | 10 |
| 2005 | 0 | 1 | 2 | **3** | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- ✓ Some of the key achievements gained due to the national level efforts in the implementation of HIV prevention programs are (1) the continuation of the millennium AIDS campaign on HIV counseling and testing and enrollment in ART as one approach for prevention, (2) the occurrence of the national prevention summit that gives more emphasis to the most at risk population through focused interventions, (3) the Health facilities (HCT, ART, and Care) coverage expansions, and (4) community conversations at various level. For example, we can take the Amhara region experience in to account, there was prioritization of prevention intervention for the identified most at risk populations, based on the Amhara MARPs Survey finding).

What are remaining challenges in this area:

- ✓ There are some remaining challenges in the area of the HIV prevention program that need to be addressed by different strategies. Some of these are lack of standard definitions of MARPs, and lack of national level mapping and size estimation on MARPs for targeted interventions. Moreover, most civil society organizations have also pointed out that currently less attention is given for prevention activities both from government and development partners' side than before.

Overall, there is an encouraging progress in the efforts in the implementation of HIV prevention services in 2009 compared to that of the 2007 and 2005.

4. Has the country identified specific needs for HIV prevention programmes? YES

IF YES, how were these specific needs determined?

- ✓ The country has identified and determined the specific needs for HIV prevention programmes for both the general as well as most at risk populations at all levels through the national prevention summit, Joint review meetings, planning and partnership forums. The Surveillance, Surveys, public health evaluations and other small scale studies were also executed to identify the specific prevention needs of different population groups.

## 4.1. To what extent has HIV prevention been implemented?

| HIV PREVENTION COMPONENT | THE MAJORITY OF PEOPLE IN NEED HAVE ACCESS |
|---|---|
| Blood safety | Agree |
| Universal precautions in health care settings | Agree |
| Prevention of mother-to-child transmission of HIV | Don't Agree |
| IEC* on risk reduction | Agree |
| IEC* on stigma and discrimination reduction | Agree |
| Condom promotion | Agree |
| HIV testing and counseling | Agree |
| Harm reduction for injecting drug users | Don't Agree |
| Risk reduction for men who have sex with men | Don't Agree |
| Risk reduction for sex workers | Agree |
| Reproductive health services including sexually transmitted infections prevention and treatment | Agree |
| School-based HIV education for young people | Agree |
| HIV prevention for out-of-school young people | Agree |
| HIV prevention in the workplace | Agree |

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

| | Very poor | | | | | | | | | | Excellent |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2009 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | **6** | 7 | 8 | 9 | 10 |
| 2005 | 0 | 1 | 2 | **3** | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- ✓ The community is mobilized through community conversation, forums, mass media and other mechanisms like school intervention program and others. And, thus, the utilization of the health services is improved such as HCT, PMTCT and ART.
- ✓ Condom distribution is by far increased from the past years in the last two years. Leadership commitment is also enhanced in. And, thus, significant amount of resources mobilized from donors and local governments.
- ✓ Special focused intervention strategies have been put into place for most at risk population and other high risk groups (e.g.; Amhara region etc.).

What are remaining challenges in this area:

- ✓ Access and quality gaps.

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community-based care). YES
   1.1 IF YES, does it address barriers for women? YES
   1.2 IF YES, does it address barriers for most-at-risk populations? YES
2. Has the country identified the specific needs for HIV treatment, care and support services? YES

IF YES, how were these determined?

- ✓ Globally, the beginning of ART provides a massive chance in terms of reducing morbidity and mortality due to AIDS. Since 2005 a rapid ART scale up is going on in Ethiopia with high emphasis given to service linkage between treatment, care and support. The free Art program was launched in July 2005. Despite the many challenges, ART Scale up has been expanded from only three health facilities in 2005 to 400 in 2008. The number of people ever started on ART has also shown an unprecedented increase during the same period from 900 in 2005 to 180447 by the end of December 2008[137].

2.1. To what extent have the following HIV treatment, care and support services been implemented?

| HIV TREATMENT, CARE AND SUPPORT SERVICE | THE MAJORITY OF PEOPLE IN NEED HAVE ACCESS |
|---|---|
| Antiretroviral therapy | Agree |
| Nutritional care | Don't Agree |
| Pediatric AIDS treatment | Don't Agree |
| Sexually transmitted infection management | Agree |
| Psychosocial support for people living with HIV and their families | Agree |
| Home-based care | Agree |
| Palliative care and treatment of common HIV-related infections | Agree |
| HIV testing and counseling for TB patients | Agree |
| TB screening for HIV-infected people | Agree |
| TB preventive therapy for HIV-infected people | Agree |
| TB infection control in HIV treatment and care facilities | Agree |
| Cotrimoxazole prophylaxis in HIV-infected people | Agree |
| Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape) | Agree |
| HIV treatment services in the workplace or treatment referral systems through the workplace | Agree |
| HIV care and support in the workplace (including alternative working arrangements) | Agree |

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV? YES

4. Does the country have access to regional procurement and supply management mechanisms

for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs? YES

IF YES, for which commodities? The country has a policy for importing and using generic drugs for HIV access through regional procurement and supply management mechanisms for critical commodities include ARVs, condoms, substitution drugs, testing kits, food supplements , training materials and etc.

| Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Very poor | | | | | | | | | | Excellent |
| 2009 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | **9** | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | **6** | 7 | 8 | 9 | 10 |
| 2005 | 0 | 1 | 2 | **3** | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- ✓ In Ethiopia, an incredible scale up of the treatment, care and support services is documented. To facilitate the scale up of ART and effective implementation of the "Road Map II", various guidelines, standard operating procedures and training manuals have been revised and their standardizations has been ensured. As part of an advocacy program on universal access to HIV/AIDS treatment by 2010, Ethiopia is already using task shifting to scale-up access to HIV/AIDS treatment and care. The transfer of health services responsibilities from higher to lower health care providers has contributed towards enabling more individuals to access life saving treatment especially for rural dwellers. Availability of supportive supervision and mentorship program which is introduced recently and functional in most regions of the country is one of the good lessons in addressing the quality of services being provided while implementing a task shifting strategy. The health network model has been a key instrument for the smooth transition of patients from hospitals to the health centers and sample transfer from health centers to hospitals and regional laboratories. Huge efforts have been made to avail diagnostic equipments. (e.g. CD4 machines in most health facilities). Moreover, the nutritional assessment and the early identification of PLWHAs on pre ART and ART have improved the access to nutritional services created.
- ✓ The Global Fund and PEPFAR technical and financial support was quoted by most of the stakeholders as additional achievements of 2009 for treatment, care and support programs in Ethiopia. And, thus, the HCT has been promoted well and uptake increased significantly, HIV care and treatment site expansion has continued and enrollments to both care and treatment have also increased significantly. And, currently at all levels, attention is given to improve access, service quality and adherence rates with the support of all the potential stakeholders.

What are remaining challenges in this area:

- ✓ It is observed from various sources (annual review meetings' proceedings, annual M&E report and relevant informants) that the following are the major challenges in the area of treatment services that need to be addressed in order to achieve the universal access;
- ✓ Low coverage of pediatric treatment, shortage of human resources for health, high level of patients lost to follow up from HIV care and treatment
- ✓ Getting resources for nutritional assistance is still a challenge. Hence addressing nutritional assistance needs in the emerging regions had been difficult.
- ✓ Low attention was given to low HIV prevalence rural/remote areas of the country which tended to gives rise to the spread of HIV from urban to rural areas
- ✓ High turnover of professionals in the service delivery sites basically due to current economic crises & inflation

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

- ✓ NO – However, OVC care and support standard and service delivery guideline drafted by Ministry of Women Affairs (MOWA)

5.1. IF YES, is there an operational definition for orphans and vulnerable children in the country? NO

5.2. IF YES, does the country have a national action plan specifically for orphans and vulnerable children? YES

5.3. IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions? YES

IF YES, what percentage of orphans and vulnerable children is being reached?

- ✓ Most of the interviewed informants could not estimate the proportion of OVC being reached. Only some of the service providers were estimating that so far, 30% - 35% orphans and vulnerable children are being reached.

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

| Very poor | | | | | | | | | | | Excellent |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2009 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | **7** | 8 | 9 | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| 2005 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | **7** | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- ✓ Since 2007, the key achievements in the area of OVC are the development of the draft OVC care and support standard and service delivery guideline by Ministry of Women Affairs (MOWA) and the program scaling-up to ensure the need of orphans and other vulnerable children. Moreover, the Ministry of labor and social Affairs, Ministry of Education, and Ministry of Health with involvement of NGOs, CBOs, FBOs and the private sectors has really made a number of steps to provide the necessary and basic needs of the OVC using income generating activities through their guardians Support by the community and government through AIDS funds. Respondents have also reported that currently there is a strong partnership between government, NGOs and private sectors to address the huge unmet need of OVC and to ensure the sustainability of the OVC supports.
- ✓ Moreover, Efforts to meet HIV-related needs of orphan and other vulnerable children is improved and understanding of the needs particularly, the emotional/psychological needs of OVC has been created among the coordinating bodies, care takers and the communities. A draft strategy is in the early stages of development. There is a proclamation that addresses children in general. At present the national OVC task force, including FBOs and CBOs, is working on the plan of action on implementation, decentralization, regional service standardization, advocacy and experience sharing on best practices. Thus, 250,000 orphans in 50 of the most vulnerable districts in the country, benefited from micro-credit schemes, cash grants and interventions that included alternative foster-care provisions, peer counseling, life-skills training, primary education, facilitation of succession planning and the provision of psychosocial support. Out of the 214,480 children affected by AIDS that were planned to be supported by HAPCO, 194,299 (91%) received educational support while 136,096 (42,600 initially planned) were provided with food and shelter. Most informants have acknowledged the efforts exerted by UNICEF to technically guiding the care and support interventions in 2008.

What are remaining challenges in this area:

- ✓ In general, the lack of nationally recognized coordinating bodies and absence of national OVC strategy/policy to guide interventions are the key challenges to address the OVC in need. As a result, the coverage of care & support interventions to reach out the needy orphans and vulnerable children are very limited, insufficient efforts in the quality of services and M&E systems very limited Psychosocial/emotional support services provided to the infected & affected children. Of course, more concern is being shown to the problems of OVC than before. However, the issue is so complicated and immense

1. Does the country have one national Monitoring and Evaluation (M&E) plan? IN PROGRESS

   1.1 IF YES, years covered: 2009-2013

   1.2 IF YES, was the M&E plan endorsed by key partners in M&E? YES

   1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV? YES

   1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan? YES, MOST PARTNERS

2. Does the national Monitoring and Evaluation plan include?

| | |
|---|---|
| - a data collection strategy<br>o IF YES, does it address:<br>- routine programme monitoring<br>- behavioral surveys<br>- HIV surveillance<br>- Evaluation / research studies | YES<br><br><br>YES<br>YES<br>YES<br>YES |
| - a well-defined standardized set of indicators | YES |
| - guidelines on tools for data collection | NO |
| - a strategy for assessing data quality (i.e., validity, reliability) | NO |
| - a data analysis strategy | NO |
| - a data dissemination and use strategy | NO |

3. Is there a budget for implementation of the M&E plan? IN PROGRESS

4. Are M&E priorities determined through a national M&E system assessment? YES

   IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves:

   The M&E assessment was done in 2009 using the M&E Assessment Tool developed by the MERG and consisting of 12 components structured as checklists to comprehensively assess the policy, programme and project capacity to collect, analyze, use and report accurate, valuable and high quality M&E data.

5. Is there a functional national M&E Unit? YES

   5.1 IF YES, is the national M&E Unit based in the National AIDS Commission (or equivalent)? YES

5.2 IF YES, how many and what type of professional staff are working in the national M&E Unit?

| | | |
|---|---|---|
| Number of permanent staff: 12 | | |
| Position: M&E OFFICERS 5 | FULL TIME / Part time? | Since when?: 2006 |
| Position: M&E Director 1 | FULL TIME / Part time? | Since when?: 2006 |
| Number of temporary staff: 2 | | |
| Position: M&E OFFICERS 2 | FULL TIME / Part time? | Since when?: 2009 |

5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system? YES

IF YES, briefly describe the data-sharing mechanisms:

- ✓ The compiled data is shared through posting at the national HIV prevention and control office web sites and it also shared at the periodical review meetings.

What are the major challenges?

- ✓ Some partners are not sending their report on time

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities? YES, MEETS REGULARLY

6.1 Does it include representation from civil society? YES

IF YES, briefly describe who the representatives from civil society are and what their role is:

- ✓ Faith base This advisory committee includes representation from different stakeholders; Governmental organizations, civil society organizations, Faith based organizations, Network of people living with HIV, Professional associations and other relevant bilateral and multilateral organizations, Network of people living with HIV, NGOs, Professional associations

7. Is there a central national database with HIV- related data? NO
   - ✓ The country has separate databases at various offices for the HIV M&E related activities (i.e. FHAPCO for routine programmatic data, EHNRI for surveillance & Survey data, FMOH/PPD for HMIS data and CSA for DHS and other demographic data). However, there are efforts to develop a central national database that captures both the health facility and community level HIV- related data at all levels.

7.1. IF YES, briefly describe the national data base and who manages it: NO

7.3 Is there a functional* Health Information System?

| | |
|---|---|
| At national level | YES |
| At sub national level<br>IF YES, at what level(s)? Health facility Level | YES |

(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analyzed and used at different levels)

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data? YES

9. To what extent are M&E data used:

- ✓ The M&E data are used by all the stakeholders for evidence based planning and decision making activities (i.e., for the revising of the national strategy, for budget allocation and for programme improvement). For instance, recently the SPMII is revised based on the evidences obtained from the M&E reports and routine program monitoring data are highly being used for making corrective measures.

9.1 in developing / revising the national AIDS strategy?:

Low High

0 1 2 3 **4** 5

Provide a specific example: Recently the SPMII or five year strategic planning is developed based on the evidences obtained at the M&E reports.

What are the main challenges, if any? Absence of recent sero-Survey results (Surveillance, Population based surveys and survey findings among high risk groups)

9.2 for resource allocation?:

Low High

0 1 2 **3** 4 5

Provide a specific example: Budget is allocated based on the projection and estimation of positive population of particular regions using the data obtained from the M&E or surveillance reports

What are the main challenges, if any?

9.3 for programme improvement?:

Low High

0 1 2 3 **4** 5

Provide a specific example: Routine program monitoring data highly being used for making corrective measures

What are the main challenges, if any? Lack of standard definitions for some indicators and/ or harmonization of indicators can also be considered as one of key challenges.

10. Is there a plan for increasing human capacity in M&E at national, sub national and service-delivery levels? Yes, but only addressing some levels, at national and regional levels

10.1 In the last year, was training in M&E conducted

| | |
|---|---|
| At national level? | YES |
| IF YES, Number trained: | 30 |
| At sub national level? | YES |
| IF YES, Number trained: | Xxx |
| At service delivery level including civil society? | YES |
| IF YES, Number trained: | Xxx |

10.2 Were other M&E capacity-building activities conducted other than training? YES

IF YES, describe what types of activities:

✓ In the past two years, several M&E related capacity-building activities were conducted at national, regional and service delivery sites levels. Recently in Ethiopia, in order to build the capacity of the M&E staffs, the government of Ethiopia in collaboration with PEPFAR Ethiopia and the local universities, has been implementing a masters level graduate program in the area of Health monitoring and evaluation, FELTP[138] and Biostatistics. Moreover, regional level M&E training were held in most parts of the country by the federal government concerned bodies (FHAPCO[139], FMOH/PPFD[140], EHNRI [141]and regional HAPCOs) on M&E need assessment, Planning, monitoring and evaluation strategies, HMIS[142], and HIV Surveillance (ANC based HIV surveillance, TB/HIV surveillance, STI surveillance and so on).

| Overall, how would you rate the M&E efforts of the HIV programme in 2009? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2009 | Very poor | | | | | | | | | | Excellent |
| 2009 | 0 | 1 | 2 | | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 | |
| 2005 | 0 | 1 | 2 | **3** | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

Since 2007, what have been key achievements in this area: The 2010 NCPI informants were asked to indicate the key achievements observed in the area of M&E since 2007. And, therefore, the following are some of the key achievements observed by the informants and documented at the FHAPCO as a progress improvement report in the area of the national M&E:

- ✓ The development & distribution of the Annual national performance report of 2008/9 at the 12th national NAC.
- ✓ The preparation and dissemination of the multi-sectoral HIV/AIDS M&E Annual English report (2008/9).
- ✓ The implementation of the Annual (2008/9) and bi-annual Joint review meetings in Bahirdar and Awassa respectively. And, accordingly, the review meeting proceedings were prepared and distributed to the potential stakeholders.
- ✓ The execution of the SPMI (2004 – 2008) evaluation and the dissemination of this evaluation report to all stakeholders for evidence based planning and decision making activities.
- ✓ The development of SPMII (2010 – 2014, ) and national surveillance and survey strategy documents can also be considered as one of the key achievements.
- ✓ The development of the national M&E framework and costed five year plans, jointly with the civil societies and other multilateral and bi-lateral funding agencies.
- ✓ There is an encouraging plan to rollout the HMIS in all regional health facilities. Moreover, the government has also initiated the non – ANC based surveillance (TB/HIV, STI, MARPs and so on), as part of the second generation surveillance system.
- ✓ The implementation of the regular strategic information TWG meetings (i.e., national M&E advisory committee, national surveillance and survey TWG, national HMIS advisory group and national DHS TWG) with the involvement of the major relevant stakeholders.
- ✓ The major partners have been sharing their data/report with key stakeholders (FMOH/HAPCO, EHNRI, UNAIDS, WHO, PEPFAR) to reconcile and reach consensus on a single national value for each indicators as part of the three one principles.

What are remaining challenges in this area: To strengthen the national HIV/AIDS M&E system, the informants have also indicated the followings as some of the challenges that need to be improved by collaborative efforts;

- ✓ Shortage of skilled M&E human resources at all levels to meet the M&E mandate.
- ✓ Lack of clear coordination mechanism between different concerned government bodies (FHAPCO, EHNRI, CSA and FMOH/PPD) to execute different surveys, surveillances and other small scale program evaluation activities as well as to develop system for dissemination and discussion of research and evaluation.
- ✓ Lack of clear roles and responsibilities, indicator definitions, reporting formats, reporting schedules and data quality assurance mechanism for federal, regional and woreda levels.
- ✓ Lack of national central database for both the health and non-health indicators that interface with the regions that need to be easily accessible by all potential stakeholders at all levels

## HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (Including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.) YES

   1.1 . IF YES, specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision:

   - ✓ In Ethiopia, mandatory HIV testing for employment is strictly prohibited in the country's Labor law (Labor Proclamation No. 262/2001 and 377/2003 Article 14.1 d). Additionally, the Civil Service Workplace HIV/AIDS Guideline of the country has also protects People living with HIV from discrimination by employers.

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations? YES

   2.1. IF YES, for which populations?

| | |
|---|---|
| a. Women | YES |
| b. Young people | YES |
| c. Sex Workers | YES |
| d. Prison inmates | YES |

   IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

   - ✓ The national Monitoring and evaluation framework has a mechanism to ensure the implementation of these laws and regulations. As a result, some governmental sectors and NGOs have been strongly working for the implementation of these laws and regulations (e.g. Ethiopian Human rights Commission, Federal Ministry of Labor and Social Affairs, Federal Ministry of women Affairs, Ethiopian women lawyers Association, Women Coalition, Women PLHIV network and others).

   Briefly describe the content of these laws:

   - ✓ Gender based violence
   - ✓ Family law
   - ✓ Youth Package

   Briefly comment on the degree to which they are currently implemented:

   - ✓ Moderate level

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations? NO

   IF YES, briefly describe the content of these laws, regulations or policies: NO. But, the main content of the national laws, regulations or policies have included the following key points;

   - ✓ The need to review/reform legislatives to the rights of people infected and affected by HIV/AIDS to non-discrimination, health, information, education, employment, social welfare and public participation

- ✓ The implementation of codes of conduct, human right principles, professional responsibilities and practices
- ✓ The establishments of supportive and enabling environment for women and other vulnerable groups through community dialogue
- ✓ The coordination of free legal support services through the government and professional associations , and so on

4. Is the promotion and protection of human rights explicitly mentioned in any IV policy or strategy? YES

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

- ✓ The promotion and protection of human rights of people infected and affected by HIV is explicitly mentioned In Ethiopian HIV/AIDS policy (1998 ART. 8). It is also explicitly called for in FHAPCO SPMI (2004 – 2008) and SPMII (2010 -2014).

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations? NO

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation? YES

IF YES, describe some examples

- ✓ There has been an effort to involve particularly associations of PLWA, women group, worker associations, youth associations and organizations working on OVC Moreover, at woreda level HIV/AIDS planning and implementation meetings: CBOs, FBOs, private sector and local NGOs as well as in school and out of school anti AIDS clubs are also involved.

- ✓ The Most at risk populations and PLHIV always get a space and a resource for their engagement during the formulation and development process of HIV/AIDS related policy, guidelines, strategic plan documents as well as well as other HIV/AIDS related materials

7. Does the country have a policy of free services for the following:

| | |
|---|---|
| a. HIV prevention services | YES |
| b. Antiretroviral treatment | YES |
| c. HIV-related care and support interventions | YES |

IF YES, given resource constraints, briefly describes what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

- ✓ Capacity strengthening of service providers, construction/upgrading of health service outlets to increase access, standardization of services

- ✓ Resource mobilization at international, national and local level. And, community mobilization at different level. Thus, there have been some encouraging progresses, such as the scaling up of ART services down to the health center level.

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support? YES

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth? YES

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support? YES

IF YES, briefly describe the content of this policy:

- ✓ The policy includes the right to have HIV/AIDS information, the right to have counseling and testing, treatment, care and support

9.1. IF YES, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations? YES

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

- ✓ Special intervention strategies are in place to ensure equal access for different subpopulation groups such as mobile HCT and condom distribution services, community conversation among different community groups like for taxi drivers, sex workers and youth.

- ✓ The strategy addresses targeted intervention to MARPs

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination)? YES

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee? YES

11.1. IF YES, does the ethical review committee include representatives of civil society including people living with HIV? YES

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work: YES

- Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment: YES

- Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts: NO

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained/sensitized to HIV and human rights issues that may come up in the context of their work? YES

14. Are the following legal support services available in the country?

- Legal aid systems for HIV casework: YES

- Private sector law firms or university-based centers to provide free or reduced-cost legal services to people living with HIV: YES

- Programmes to educate, raise awareness among people living with HIV concerning their rights: YES

15. Are there programmes in place to reduce HIV-related stigma and discrimination? YES

IF YES, what types of programmes?

| | |
|---|---|
| Media | YES |
| School education | YES |
| Personalities regularly speaking out | YES |

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2009?

| | Very poor | | | | | | | | | | Excellent |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2009 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | **6** | 7 | 8 | 9 | 10 |
| 2005 | 0 | 1 | 2 | 3 | **4** | 5 | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- ✓ Incorporating of the human rights issues in the SPMII while the national AIDS plan developed. The training on human rights related issues given for different population groups, both for the implementers and decision making bodies. As a result, the understanding of people increased on human rights issues in HIV plans and programs.
- ✓ The Confederation of Ethiopian Trade Unions (CETU), Ministry of Agriculture and Rural Development, Education Ministry and Ministry of Transport and Communications have developed workplace AIDS policies. Thus, discrimination and stigma has been reduced and PLHIV are getting empowered to fight against their rights.

What are remaining challenges in this area:

- ✓ Some of the remaining challenges that need to be improved in this area are; the level of commitment at lower level to ensure an adequate integration of human right issues in the design and implementation of HIV/AIDS plans and programs, and the poor monitoring and evaluation system in place to ensure the implementation of human rights related HIV/AIDS programs at different level. Moreover, there is lack of technical and financial support for partners' engagement on rights advocacy related to HIV/AIDS.

| Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2009? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Very poor | | | | | | | | | | | Excellent |
| 2009 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | **8** | 9 | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | **6** | 7 | 8 | 9 | 10 |
| 2005 | 0 | 1 | 2 | 3 | 4 | **5** | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- ✓ Overall, there is some progress in drafting specific HIV/AIDS related legislation and revising the HIV policy to promote and protect human rights in relation to HIV/AIDS in 2009 compared to the past reporting periods. Moreover, there are some encouraging achievements to enforce the existing policies, laws and regulations. Overall, there is some progress in drafting specific HIV/AIDS related legislation and revising the HIV policy to promote and protect human rights in relation to HIV/AIDS in 2009 compared to the past reporting periods. Moreover, there are some encouraging achievements to enforce the existing policies, laws and regulations.

What are remaining challenges in this area:

- ✓ The policies, laws and regulations are not up-to-date and popularized to address the current policy gaps arise through time to all stakeholders and even at community level.

## CIVIL SOCIETY* PARTICIPATION

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

| Low | | | | | High |
|---|---|---|---|---|---|
| 0 | 1 | 2 | **3** | 4 | 5 |

Comments and examples:

- ✓ Currently, some of the civil society played a front line role in the fight against HIV/AIDS, thereby demanding the top leaders by their commendable activities. CSOs established youth centers and youth anti-AIDS clubs as youth friendly prevention approaches to reach youth with HIV/AIDS information.

- ✓ The CSOs sectors have limited access to follow and advocate for effective implementation and management of universal commitments and declarations. However, they participated in different meetings and planning workshops, like FHAPCO SPM development

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

| Low | | | | | High |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | **4** | 5 |

Comments and examples:

- ✓ Their involvement has been strengthened on planning, monitoring and evaluation of HIV/AIDS activities at national level. However, at regional level this varies. In general, the civil society representatives are invited to important HAPCO meetings and they usually use this opportunity to air their views through their forum representatives to different level decision makers. However, this needs to be strengthened further to include more of these organizations.

3. to what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a. the national AIDS strategy?

| Low | | | | | High |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | **4** | 5 |

b. the national AIDS budget?

| Low | | | | | High |
|---|---|---|---|---|---|
| 0 | 1 | 2 | **3** | 4 | 5 |

c. national AIDS reports?

| Low | | | | | High |
|---|---|---|---|---|---|
| 0 | 1 | **2** | 3 | 4 | 5 |

Comments and examples:

- ✓ The extent to which the CS inputs is reflect in the national plans and reports was assessed as part of the SPM review process and it was found to be insufficient. The assessment result also revealed that most activities and resources committed for HIV/AIDS program by the CSOs is not clearly reported and reflected in the national reports.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. developing the national M&E plan?

| Low | | | | | High |
|---|---|---|---|---|---|
| 0 | 1 | 2 | [3] | 4 | 5 |

b. participating in the national M&E committee / working group responsible for coordination of M&E activities?

| Low | | | | | High |
|---|---|---|---|---|---|
| 0 | 1 | 2 | [3] | 4 | 5 |

c. M&E efforts at local level?

| Low | | | | | High |
|---|---|---|---|---|---|
| 0 | 1 | 2 | [3] | 4 | 5 |

Comments and examples:

- ✓ The CSOs involvement in the whole process of planning, monitoring and evaluation of HIV/AIDS responses at different level are improving from year to year. However, most of them have limited human and financial resources to be fully engaged on the whole processes.

- ✓ The civil society is involved in the monitoring and evaluation of the national as well as the regional level responses through various mechanisms. They are also invited for the annual and other important review meetings where key issues are raised as one of the mechanism to monitor and evaluate the HIV/AIDS responses at different levels. At the local level, today, the CBOs and FBOs are playing key roles through community conversations using different social gatherings like IDIRS.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

| Low | | | | | High |
|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | [4] | 5 |

Comments and examples:

- ✓ The current CS networks are also not diverse themselves as they are expected for instance there is no network for sex worker). There is still a need to strengthen the capacity of the CSOs who are working in the area of HIV/AIDS to full represent the CS effectively in the fight against HIV/AIDS. However; those that exist have been given the opportunity to contribute the expected inputs in the planning, monitoring and evaluation processes at different levels. But, there is a progress documented by the CSOs that the Civic societies are contributing in the fight against HIV/AIDS through their prevention and Care & Support Interventions.

- ✓ There is also a progress that networks of PLHIV, organizations of CSWs, FBOs and other CBOs are currently fully represented.

6. To what extent is civil society able to access?

a. adequate financial support to implement its HIV activities?

Low High

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|

b. adequate technical support to implement its HIV activities?

Low High

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|

Comments and examples:

✓ CS member's access to information on sources and modalities of financial support is adequate. But, most respondents believe that they have been accessing a relatively better level of technical support, mainly in terms of training.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

| | |
|---|---|
| Prevention for youth | 51–75% |
| Prevention for most-at-risk-populations<br>- Injecting drug users<br>- Men who have sex with men<br>- Sex workers | 51-75% |
| Testing and Counseling | <25% |
| Reduction of Stigma and Discrimination | 51–75% |
| Clinical services (ART/OI)* | <25% |
| Home-based care | 51–75% |
| Programmes for OVC** | 51–75% |

Overall, how would you rate the efforts to increase civil society participation in 2009?

| | Very poor | | | | | | | | | | Excellent |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2009 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | [7] | 8 | 9 | 10 |
| 2007 | 0 | 1 | 2 | 3 | 4 | 5 | [6] | 7 | 8 | 9 | 10 |
| 2005 | 0 | 1 | 2 | 3 | [4] | 5 | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- ✓ Since 2007, the overall efforts to increase the civil society participation in the national AIDS strategy, national AIDS budget allocation, and national AIDS reporting and programming have been improved. CSOs believed that overall they are well represented and they make a significant input to political commitment and policy formulation. However, nearly all felt they were under-funded and complained of inadequate technical support.

- ✓ As a result of this, the civil society has made considerable achievements over the past two years in the fight against HIV/AIDS; more and more PLHIV association has been strengthened and now they are in everywhere to fight against HIV in collaboration with other stakeholders. Moreover, the faith based organizations have also come to the forefront. And, thus, both of them won the Global Fund award (principal recipient of GF R7) which boosted the image and involvement of CS in the AIDS response. Most of the informants hoped that both awardees will use this opportunity to build their capacity to deliver services and have a breakthrough in the fight against HIV/AIDS. Some NGOs have also become well known and more active in the fight against HIV/AIDS program like NEP+, EIFDDA, and OSSA are good examples among the indigenous civil societies currently working in all regions of the country.

What are remaining challenges in this area:

- ✓ Lack of recognition and reflection of the role and contribution of the CS in the plan, budget and report of the national AIDS response

- ✓ Less technical and capacity building support plan from the development and government side. In general, the civil society organizations have believed that a lot need to be done to increase their participation in the joint plan, monitoring and reporting of the national HIV/AIDS responses. Thus, the development partners and hosting government concerned offices need to increase their technical and capacity building support plan to the civil society.

## PART B. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes? YES
   IF YES, how were these specific needs determined?

- Through programmatic feedbacks and analysis of the sero-surveillance and other behavioral survey results. And, therefore, now the government gives more emphasis for Scaling up of the Prevention program to reduce the new infection rates of both the general and high risk population groups.

1.1 To what extent has HIV prevention been implemented?

| HIV PREVENTION COMPONENT | THE MAJORITY OF PEOPLE IN NEED HAVE |
|---|---|
| Blood safety | Agree |
| Universal precautions in health care settings | Agree |
| Prevention of mother-to-child transmission of HIV | Don't Agree |
| IEC* on risk reduction | Agree |
| IEC* on stigma and discrimination reduction | Agree |
| Condom promotion | Agree |
| HIV testing and counseling | Agree |
| Harm reduction for injecting drug users | N/A |
| Risk reduction for men who have sex with men | N/A |
| Risk reduction for sex workers | Agree |
| Reproductive health services including sexually transmitted infections prevention and treatment | Agree |
| School-based HIV education for young people | Agree |
| HIV Prevention for out-of-school young people | Agree |
| HIV prevention in the workplace | Agree |

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2009?

| 2009 | Very poor | | | | | | | | | Excellent |
|---|---|---|---|---|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- Through millennium AIDS campaign, there was a massive work on HIV counseling and testing as one approach for prevention
- The national prevention summit has also changed the prevention strategy from focusing from general to most at risk populations without forgetting the general population prevention strategies. Thus, now, Consensus reached to address MARPs through focused programs
- The expansion of the Health Services(HCT,ART,Care) Site/coverage expansions and community conversations at different level

What are remaining challenges in this area:

- Defining, mapping, estimating the size of MARPs
- Limited target based interventions on MARPs
- Less attention was given for prevention activities both from government and donors side

## IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the specific needs for HIV treatment, care and support services? YES

IF YES, how were these specific needs determined?

- The needs were determined when the multisectoral plan of action for the universal access to HIV prevention, treatment, care and support was designed. Participatory needs assessment and planning process was under taken.
- Specific needs were determined based on accelerated access to HIV/AIDS prevention, care and treatment in Ethiopia – (Road Map 2007 – 2010) based on the national single point estimates and National quantification exercises done by the national treatment TWG
- A single-point HIV prevalence estimate was agreed to be used as for immediate planning and management purposes, as Ethiopia finalizes its plans to launch the National HIV/AIDS Road Map for Universal Access spanning 2007 to 2010

1.1 To what extent have HIV treatment, care and support services been implemented?

| HIV TREATMENT, CARE AND SUPPORT SERVICE | THE MAJORITY OF PEOPLE IN NEED HAVE ACCESS |
|---|---|
| Antiretroviral therapy | Agree |
| Nutritional care | Don't Agree |
| Pediatric AIDS treatment | Agree |
| Sexually transmitted infection management | Agree |
| Psychosocial support for people living with HIV and their families | Agree |
| Home-based care | Agree |
| Palliative care and treatment of common HIV-related infections | Agree |
| HIV testing and counselling for TB patients | Agree |
| TB screening for HIV-infected people | Agree |
| TB preventive therapy for HIV-infected people | Agree |
| TB infection control in HIV treatment and care facilities | Agree |
| Cotrimoxazole prophylaxis in HIV-infected people | Don't Agree |
| Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape) | Don't Agree |
| HIV treatment services in the workplace or treatment referral systems through the workplace | Don't Agree |
| HIV care and support in the workplace (including alternative working arrangements) | Don't Agree |

| Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes i 2009? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 2009 | Very poor | | | | | | | | | | Excellent |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Since 2007, what have been key achievements in this area:

- There had been an overall scale up of all treatment, care and support services. On nutrition support national nutrition strategy was put in place by the MOH. National nutrition implementation guidelines are issued to standardize services. The nutritional assessment and the early identification of PLWHAs on pre ART and ART have improved and access to nutritional services created.
- The technical support from Global fund and PEPFAR could be cited as additional achievements of 2009 for treatment, care and support. And, therefore, the HCT has been promoted well and uptake increased significantly, HIV care and treatment site expansion has continued and enrollments to both care and treatment have also increased significantly. And currently at all levels attention is given to adherence rate growth.
- With support of different stakeholders, Community Home-Based Care (CHBC) networks comprised of CSOs were established in different regions to improve access and service quality.

What are remaining challenges in this area:

- Low coverage of pediatric treatment, shortage of human resources for health, high level of patients lost to follow up from HIV care and treatment
- Getting resources for nutritional assistance is still a challenge. Hence addressing nutritional assistance needs in the emerging regions had been difficult. Linking of PLWHAs to sustainable livelihood initiatives after PLWHAs are nutritionally well is also a challenge.
- Low access to OI, nutritional support, Palliative care centers and resources
- Low attention was given to low HIV prevalence rural/remote areas of the country which tended to gives rise to the spread of HIV from urban to rural areas
- Limited government sector capacity in implementing planned activities& resource absorption, coordination and networking

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children? NO – But it is in a draft stage.

IF YES, what percentage of orphans and vulnerable children is being reached? 28% - 32%

| Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009? | | |
|---|---|---|
| 2009 | Very poor | Excellent |

0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

- Some vulnerable families living in different parts of the country were provided with cash transfers/ micro-loans and access to basic social services as part of a new child-focused social welfare programmes. Moreover, Social cash transfers/ micro-loans were provided to households after they received training in business skills and management to support OVC
- Advocacy training on OVC given for those organizations who are actively working on OVC. Moreover, OVC package development to support more OVCs
- More concern is being shown to the problems of OVC than before. However, the issue is so complicated and immense.
- Scale up of OVC care services through functional linkages between community OVC program & facility based services to create a comprehensive care is the key achievements
- Efforts to meet HIV-related needs of orphan and other vulnerable children is improved and understanding of the needs particularly, the emotional/psychological needs of OVC has been created among the coordinating bodies, care takers and the communities.
- A draft strategy is in the early stages of development. There is a proclamation that addresses children in general. At present the national OVC task force including FBOs and CBOs is working on the plan of action on implementation, decentralization, regional service standardization, advocacy and experience sharing on best practices.
- 250,000 orphans in 50 of the most vulnerable districts in the country, benefited from micro-credit schemes, cash grants and interventions that included alternative foster-care provisions, peer counseling, life-skills training, primary education, facilitation of succession planning and the provision of psychosocial support..
- Out of the 214,480 children affected by AIDS that were planned to be supported by HAPCO, 194,299 (91%) received educational support while 136,096 (42,600 initially planned) were provided with food and shelter. UNICEF was instrumental in technically guiding the care and support interventions in 2008.

What are remaining challenges in this area:

- Scaling-up of care & support interventions to reach out the needy PLWHA and children infected and affected by HIV/AIDS ( limited coverage)
- Mandate issues between HAPCO & MOWA regarding vulnerable children including HIV infected and affected children, makes decision making process so slow
- Lack of national OVC strategy/policy to guide interventions. Thus, there is lack of coordination and linkage
- Resources to address the needs of more OVC is still a challenge
- Insufficient efforts in the quality of services and M&E systems – unstandardized definitions of indicators
- Very limited Psychosocial/emotional support service to the infected & affected children
- Increased foreign adoption & undermined the traditional adoption/child care system within the community of origin

## Annex II: Monitoring and Reporting on the Health Sector Response to HIV/AIDS

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