Ethiopia Report NCPI

NCPI **Header**

is indicator/topic relevant?: Yes
is data available?: Yes
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Additional information related to entered data. e.g. reference to primary data source, methodological concerns::
Data related to this topic which does not fit into the indicator cells. Please specify methodology and reference to primary data source::
Data measurement tool / source: GARPR

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Describe the process used for NCPI data gathering and validation: The NCPI assess progress made in development and implementation of national AIDS policies, strategies and laws necessary for an effective response to HIV. It has two parts: A; for government officials; and B for civil society, bilateral and multilateral organisations, respectively. Part A covers strategic plan, political support and leadership, human rights, prevention, treatment, care and support, and monitoring and evaluation. Part B covers civil society involvement, political support and leadership, human rights, prevention, treatment, care and support. The two are complementary and designed to get views from two groups of respondents on similar issues. The NCPI tool was completed using desk reviews, self-administered questionnaires, individual interviews and consensus building meetings with HIV focal persons from public and non-public sector organisations, and associations of PLHIV. The findings were compiled and presented at a validation workshop. 31 organisations (fourteen CSO/NGOs, six UN agencies, and eleven government organisations) provided inputs. More than 50 participants actively participated and reviewed the consensus responses at a validation workshop. Moreover, to support responses with evidence, reference was made to M&E reports, policy/strategic documents such as the AIDS policy, Education and Workplace HIV and AIDS Framework, and the previous GARPR report of 2012 to assess progress.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions: The participants of the consensus building meetings deliberated on each of the questions. Where there were differences in opinion, further information was sought using reference documents; and a vote was taken to decide on scoring. By and large, there were no major points of disagreements and at the end of discussion; the consensus reached by most of the participants was recorded with justifications. At the end of the consensus building meeting and validation workshop, the consultant summarized the key findings and where there were was a need to reconcile any differences and to provide justifications factual evidence (references) was used to decide. These references include the national HIV/AIDS policy, the National Strategic Plans, the Minimum Package for Interventions for MARPs, National TB and HIV and ART guidelines and annual M&E performance reports.

Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like): To minimize misinterpretation, non-response rates and ensure data quality, the appropriate parts (either A or B) of the NCPI tool were sent to focal point experts on HIV/AIDS in each organisation with contacts to seek clarifications where needed. Each respondent was encouraged to answer on areas where s/he feels is fully

informed and understands the meaning of the question. The individual responses to the questionnaires were compiled and presented to the consensus building meetings where respondents provided justifications for the assessment scores; and consensus was reached. Finally, feedback from the consensus meetings was compiled and incorporated to the final report.

NCPI - PART A [to be administered to government officials]

Organization	Names/Positions	Respondents to Part A
Ministry of Water, Industry & Energy	Zelalem Asfaw /Head, HIV/AIDS Office	A2,A4
Ministry of Mines	Fetene Merga/ Senior Expert, HIV/AIDS	A2,A4
Ministry of Labor and Social Affairs	Wondie Mulugeta/Expert, HIV/AIDS Office	A2,A3,A4
Sugar Corporation	Kasech Shibeshi/ Head, HIV/AIDS Office	A2,A4
Transport Authority	Geleta Gelcha/Senior Expert, HIV/AIDS	A2,A4
Ministry of Education	Feyesa Regassa (Dr)/ Programme Coordinator, HIV/AIDS	A2,A3,A4
Ministry of Health	Mizan Kiros (Dr)/ Programme Officer, HIV/AIDS	A1,A2,A3,A4,A5,A6
Federal HAPCO	Nestanet Haneko/ Senior Expert, M&E	A1,A2,A3,A4,A5,A6
Ministry of Mines	Temesgen Mulleta/ Head, HIV Prevention and Control	A2,A4
Sugar Corporation	Amare G/Yesus/Director, Health Directorate	A2,A4
Federal Police Commission	Kalkidan Gezahegn/M&E Coordinator	A2,A4

NCPI - PART B [to be administered to civil society organizations, bilateral agencies, and UN organizations]

Organization	Names/Positions	Respondents to Part B
Management Sciences for Health (MSH)	Bud Crandall/ Chief of Part	B1,B2,B3,B4,B5
Federation of Ethiopian National Assoc of Persons with Disabilities (FENAPD)	Woyneshet Gelacha/Project Facilitator	B1,B2,B3,B4,B5
Confederation of Ethiopian Trade Unions (CETU)	Serkalem Shiferaw/Programme Coordinator, HIV/AIDS	B1,B2,B3,B4,B5
Abt/PHSP-Ethiopia	Tilaye Tasew/Regional Manager	B1,B2,B3,B4,B5
PSI (Population Services International)	Felleke Tadesse/Program Leader	B1,B2,B3,B4,B5
NASTAD (National Association of State and Territorial Apprenticeship Directors)	Wubeshet Denboba/Advisor, Health systems strengthening	B1,B2,B3,B4,B5
Ethiopian Inter-Faith Forum for Development Dialogue and Action (EIFDDA)	Habtamu W/Yes/ HIV Unit Coordinator	B1,B2,B3,B4,B5
World Learning/MULU Project	Wasihun Andualem/Senior M&E Manager	B1,B2,B3,B4,B5
USAID/TransACTION/Save the Children	Younis Musema (Dr)/Senior Project Coordinator	B1,B2,B3,B4,B5
MSH/ENHAT-CS	Yosef Alemu/ Program Advisor	B1,B2,B3,B4,B5
Abt/PHSP-Ethiopia	Mohammed Dawd/ Program Manager	B1,B2,B3,B4,B5
Columbia University/ICAP	Tsigereda Gadisa (Dr)/Director of Program/HIV/AIDS	B1,B2,B3,B4,B5
Network of Networks of HIV Positives in Ethiopia (NEP+)	Getachew Gonfa/M&E Manager	B1,B2,B3,B4,B5
Christian Relief and Development Association (CRDA)	Dilu Gashaw /Programme Coordinator	B1,B2,B3,B4,B5
WHO	Fekadu Adugna (Dr)/Programme Coordinator	B1,B2,B3,B4,B5
UNICEF	Wondwossen Temiess/ Programme Specialist, HIV/AIDS	B1,B2,B3,B4,B5
UNFPA	Meron Negussie/ National Programme Officer, HIV/AIDS	B1,B2,B3,B4,B5
UNAIDS	Elisabetta Pegurri/ Strategic Information Advisor	B1,B2,B3,B4,B5
UNAIDS	Hiwot Haile-Selassie/ Strategic information consultant	B1,B2,B3,B4,B5
UNAIDS	Seblesilassie Getachew /Prog Assistant, Community Mobilization	B1,B2,B3,B4,B5

A.I Strategic plan

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

IF YES, what is the period covered: The second strategic plan for intensifying the mulisectoral HIV and AIDS response in Ethiopia (SPM II) covers the years between 2010/11 to 2014/15

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one. IF NO or NOT APPLICABLE, briefly explain why.: Ethiopia had also developed SPM I (for 2004/5-2008/9) and based on evaluation results of implementation, it developed the SPM II (2010/11-2014/15). There are differences between the SPM I and II in terms of thematic areas; the former(SPM I) has six thematic areas whereas the SPM II has five thematic areas and also thematic areas slightly differ in content: SPM II gives more attention for prevention and addressing most at risk population groups (to ensure balance between different prevention, treatment, care and support intervention packages). The process of the development of SPM II was participatory with active involvement of key stakeholders. It is a result of a collective effort of key government sectors, faith-based organisations, civil societies and associations of PLHIV, the private sector, and bilateral donors and multilateral organisations.

IF YES, complete questions 1.1 through 1.10; IF NO, go to question 2.

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?: The Federal HIV Prevention and Control Office (HAPCO) and Federal MoH play a lead role in the coordination of development and implementation of the Multisectoral HIV strategy. Other key public sectors working in education, women, children youth, agriculture and industry; and those responsible for social affairs also play an important role.

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

Education:

Included in Strategy: Yes

Earmarked Budget: No

Health:

Included in Strategy: Yes

Earmarked Budget: No

Labour:

Included in Strategy: Yes

Earmarked Budget: No

Military/Police:

Included in Strategy: Yes

Earmarked Budget: No

Social Welfare:

Included in Strategy: Yes

Earmarked Budget: No

Transportation:

Included in Strategy: Yes

Earmarked Budget: No

Women:

Included in Strategy: Yes

Earmarked Budget: No

Young People:

Included in Strategy: Yes

Earmarked Budget: No

Other: Defense; Communication

Included in Strategy: Yes

Earmarked Budget: 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 national strategic document (SPM II) has allocated budget not by sector but by thematic area and for specified activities. Each sector is expected to earmark HIV-specific cost (2% of budget) as part of HIV Mainstreaming.

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS:

Discordant couples: Yes

Elderly persons: Yes

Men who have sex with men: No

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Sex workers: Yes

Transgender people: No

Women and girls: No

Young women/young men: Yes

Other specific vulnerable subpopulations: No

SETTINGS:

Prisons: Yes

Schools: Yes

Workplace: Yes

CROSS-CUTTING ISSUES:

Addressing stigma and discrimination: Yes

Gender empowerment and/or gender equality: Yes

HIV and poverty: Yes

Human rights protection: Yes

Involvement of people living with HIV: Yes

IF NO, explain how key populations were identified?: The strategy does not identify MSM, transgender, and IDUs as key populations. Key populations are identified based on existing evidence and in consideration of the Ethiopia legal and cultural context to implement the interventions. Nevertheless, there are on-going efforts to establish the extent and role of MSM and IDU in the dynamics of HIV/AIDS.

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country?

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific key populations/vulnerable subpopulations [write in]::

: No

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

1.6. Does the multisectoral strategy include an operational plan?: No

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?: No

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

IF ACTIVE INVOLVEMENT, briefly explain how this was organised.: CSOs are part of the development process of the SPM II. They are also engaged in the preparation of annual operational plans and their implementation. The government has put in place mechanisms to ensure their full participation not only in planning and implementation, but also in preparing Global Fund proposals, and in joint supportive supervision, and annual performance reviews. There is an established system for joint planning of the national response, and the SPM II was developed using this framework, although there is a need to do more to promote national programme ownership during implementation. Overall, the national HIV/AIDS programme reflects the active participation of a wide-range of stakeholders at all stages which plays an critical role in the response.

IF NO or MODERATE INVOLVEMENT, briefly explain why this was the case.:

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, all partners

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

2.1. Has the country integrated HIV in the following specific development plans?

SPECIFIC DEVELOPMENT PLANS:

Common Country Assessment/UN Development Assistance Framework: Yes

National Development Plan: Yes

Poverty Reduction Strategy: Yes

National Social Protection Strategic Plan: N/A

Sector-wide approach: N/A

Other [write in]: Health Sector Development Plan (HSDP)

: Yes

2.2. IF YES, are the following specific HIV-related areas included in one or more of the develop-ment plans?

HIV-RELATED AREA INCLUDED IN PLAN(S):

Elimination of punitive laws: Yes

HIV impact alleviation (including palliative care for adults and children): 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

Treatment, care, and support (including social protection or other schemes): Yes

Women's economic empowerment (e.g. access to credit, access to land, training): Yes

Other [write in]:

: Yes

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

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evalua¬tion informed resource allocation decisions?: 4

4. Does the country have a plan to strengthen health systems?: Yes

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications and children: Ethiopia has developed and implemented the national Growth and Transformation Plan (GTP) and the Health sector development plans (HSDP) which contributed to rapid expansion of infrastructure (roads and health facilities), training and deployment of healthcare workers including innovative approaches (such as Health Extension Workers -community health workers that provide health education and referral and linkage into health services), the Health Development Army (a network linking one model family to five households introduced as a strategy for community mobilization), and fast-track procurement and distribution of ART commodities to address stock outs and delays at health facility level. Direct distribution of HIV commodities from the national Pharmaceutical Fund and Supply Agency (PFSA) to the health facilities instead of passing through different layers of the commodity management system (regional and zonal levels).

5. Are health facilities providing HIV services integrated with other health services?

a) HIV Counselling & Testing with Sexual & Reproductive Health: Many

b) HIV Counselling & Testing and Tuberculosis: Many

c) HIV Counselling & Testing and general outpatient care: Many

d) HIV Counselling & Testing and chronic Non-Communicable Diseases: Many

e) ART and Tuberculosis: Many

f) ART and general outpatient care: Many

g) ART and chronic Non-Communicable Diseases: Many

h) PMTCT with Antenatal Care/Maternal & Child Health: Many

i) Other comments on HIV integration: :

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?: 8

Since 2011, what have been key achievements in this area: • The national strategic plan (SPM II) was operationalized by developing a roadmap for its implementation which also identifies key outputs and milestones to track performance. • Based on the SPM II, annual operational plans have been prepared and implemented at national and regional levels. • The implementation progress have been monitored by routine reporting systems, and based on these, annual M&E reports are regularly produced. • Know your Epidemic/Know Your Response studies have been completed in Tigrai, Gambella and Oromia regions, and others are in process. The findings provide evidence for planning and targeted interventions.

What challenges remain in this area:: • Mainstreaming: despite the continued effort to encourage HIV Mainstreaming, there is a slow pace in implementation mainly in non-public sector organisations. • Strategic Information: while the HIV Syntheses studies, DHS, ANC surveillance, studies on key populations, and M&E reports provide evidence for strategic plan development, there are gaps in the extent and role of some at risk populations such as MSM, IDUs, and migrant workers. • Access/coverage: challenges in ensuring access to remote and hard-to-reach populations with prevention, treatment and care services.

A.II Political support and leadership

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

A. Government ministers: Yes

B. Other high officials at sub-national level: Yes

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?: Yes

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership: - H.E. the President delivered a speech on national HIV/AIDS day and he also made public speeches on his working tours to different parts of the country. - The Honourable Minister of Health made several public speeches at different fora - H.E. the First Lady visited Gambella region to promote public ownership, rally commitment from the high level government and thereby promote the HIV response. - The government adopted Option B+ for ART programme latest WHO 2013 ART guidelines and implementation has started.

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

IF NO, briefly explain why not and how HIV programmes are being managed::

2.1. IF YES, does the national multisectoral HIV coordination body:

Have terms of reference?: Yes

Have active government leadership and participation?: Yes

Have an official chair person?: Yes

IF YES, what is his/her name and position title?:

Have a defined membership?: Yes

IF YES, how many members?:

Include civil society representatives?: Yes

IF YES, how many?:

Include people living with HIV?: Yes

IF YES, how many?:

Include the private sector?: Yes

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?: Yes

3. Does the country have a mechanism to promote coordinationbetween government, civil societyorganizations, and the private sector for implementing HIV strategies/programmes?: Yes

IF YES, briefly describe the main achievements:: The national HIV/AIDS Council has broad representation including from public and non-public sectors; and this promotes coordination of stakeholders in national planning, implementation, supervision and monitoring. As a result, there is broad participation of the private sector, CSOs, CBOs, faith-based organisations, PLHIV, women's groups, the Ethiopian Business Coalition for HIV, and higher learning academic institutions among others.

What challenges remain in this area:: - The meeting of national and regional HIV coordination committees i.e. AIDS Councils are not regular. - The number and scope of organisations working in HIV/AIDS is fast changing, calling for periodic mapping. - There are gaps in capacity for coordination and leadership at lower levels (region, zone, woreda/district)

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?: 2

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

Capacity-building: Yes

Coordination with other implementing partners: Yes

Information on priority needs: Yes

Procurement and distribution of medications or other supplies: Yes

Technical guidance: Yes

Other [write in]:

: No

6. Has the country reviewed national policies and laws to determine which, if any, are incon-sistent with the National HIV Control policies?: No

6.1. IF YES, were policies and laws amended to be consistent with the National HIV Control policies?: No

IF YES, name and describe how the policies / laws were amended:

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies::

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?: 8

Since 2011, what have been key achievements in this area:: -There is a very strong political support by the Federal and most of the regional government shown with reiteration of their commitment at different fora including New Year and AIDS day speeches. -There is close follow-up of programme performance by both the Federal and Regional Parliaments. -The national Growth and Transformation Plan (GTP); and Health Sector Development Plan (HSDP) explicitly state the HIV response as an integral element; and identify key activities. - Implementation of the five-year multisectoral HIV/AIDS Strategic Plan (SPM II) is coordinated by FHAPCO & MoH with guidance from the National AIDS Council chaired by H.E. the President.

What challenges remain in this area:: In few regional administrations, gaps exist in ownership, thus the need for improving political leadership for a coordinated AIDS response. The move by FHAPCO for rallying the political support by organising visits by the First Lady; and the visit of high-level officials to regions is expected to address this challenge.

A.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups? Select yes if the policy specifies any of the following key populations and vulnerable groups:

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:

: No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?: Yes

IF YES to Question 1.1. or 1.2., briefly describe the content of the/laws:: - Article 25 of the Federal Constitution; "All persons are equal before the law and entitled without any discrimination to the equal protection of the law...without discrimination....." - Labour Proclamation 262/2001 and 377/2003; and Civil Service Workplace Guidance prohibit mandatory HIV testing for employment purposes; and protect the right of PLHIV at workplace.

Briefly explain what mechanisms are in place to ensure these laws are implemented:: - Enforcement agencies such as police and judiciary to ensure implementation of relevant laws - Government sector organisations such as the Ministry of Labour and Social Affairs, Ministry of Justice, Ministry of Women, Youth and Children Affairs and Ministry of Health implement relevant policies. - The Human Rights Commission and Ombudsman also oversee the implementation of these laws.

Briefly comment on the degree to which they are currently implemented:: Implementation of laws is inadequate due to lack of knowledge and awareness of legislation and policy of some individuals involved in enforcement and implementation.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?: No

IF YES, for which key populations and vulnerable groups?:

People living with HIV: No

Elderly persons: No

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: Yes

Prison inmates: No

Sex workers: No

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

Briefly describe the content of these laws, regulations or policies:: Under the national leglisaltion MSM activties and use of illicit drugs are prohibited.

Briefly comment on how they pose barriers:: The above three population groups (MSM, transgendered people, IDUs) are not recognized as these are illegal acts under the national legal system. Moreover, the extent and their role in the dynamics of the epidemic remains undetermined. As a result, specific programmes targeting these populations do not exist. Nevertheless, services for the general population are also available for use by these groups.

A.IV Prevention

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

IF YES, what key messages are explicitly promoted?:

Delay sexual debut: Yes

Engage in safe(r) sex: Yes

Fight against violence against women: Yes

Greater acceptance and involvement of people living with HIV: Yes

Greater involvement of men in reproductive health programmes: Yes

Know your HIV status: Yes

Males to get circumcised under medical supervision: Yes

Prevent mother-to-child transmission of HIV: Yes

Promote greater equality between men and women: Yes

Reduce the number of sexual partners: Yes

Use clean needles and syringes: No

Use condoms consistently: No

Other [write in]::

: No

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 to promote life-skills based HIV 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 include

a) age-appropriate sexual and reproductive health elements?: Yes

b) gender-sensitive sexual and reproductive health elements?: 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 communi-cation and other preventive health interventions for key or other vulnerable sub-populations?: Yes

Briefly describe the content of this policy or strategy:: The national AIDS policy places importance on creating public HIV awareness through IEC/BCC activities. The SPM II (2010/11-2014/15) incorporates IEC as a key component of prevention, care, treatment and support. IEC activities aim at both promoting preventive behaviour, voluntary testing, uptake and adherence to services. The MARPs intervention package identifies also IEC as a key strategy for prevention of HIV among key populations.

3.1. IF YES, which populations and what elements of HIV prevention does the policy/strategy address?

People who inject drugs:

Men who have sex with men:

Sex workers: Condom promotion,HIV testing and counseling,Targeted information on risk reduction and HIV education,Vulnerability reduction (e.g. income generation)

Customers of sex workers: Condom promotion,HIV testing and counseling,Reproductive health, including sexually transmitted infections prevention and treatment,Targeted information on risk reduction and HIV education

Prison inmates: HIV testing and counseling,Targeted information on risk reduction and HIV education

Other populations [write in]::

:

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?:

Since 2011, what have been key achievements in this area:: The national HIV/AIDS policy was endorsed more than a decade ago and the support for its implementation has been very high from top government officials to non-government actors. The development of a workplace HIV/AIDS framework and the Education Sector HIV/AIDS policy and relevant strategies to implement these, are all examples of strong political support. The continued commitment of the leadership as demonstrated by policy speeches and close monitoring of the national response by the National AIDS Council & Parliament.

What challenges remain in this area:: - Coverage of services: challenges with ensuring access to remote areas and mobile populations. - Resources: gaps in implementation capacity at regional/ sub-regional levels for delivery of services - Ownership: differences in leadership and support among regions do exist with need for more work to address this - Mainstreaming: process is slow in public and non-public sector organisations

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

IF YES, how were these specific needs determined?: - Evidence-based decision making process was used to determine specific prevention needs. Sources for evidence included: - Data from DHS (2011), ANC sentinel surveillance, annual M&E reports - Specific studies such as MARPs studies; national and regional HIV syntheses - Joint supervision and review meeting reports and recommendations

IF YES, what are these specific needs? : - The minimum package of services for most at risk populations (MARPs) details the needs and suggested response for key population groups (youth, prisoners, mobile populations and sex workers) - Recently identified risk population groups such as seasonal workers and mobile popuations should be included in national strategies (SPM II) - Based on findings from recent regional syntheses need to tailor interventions during operational planning to regional and local contexts and dynamics

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…:

Blood safety: Strongly agree

Condom promotion: Strongly agree

Economic support e.g. cash transfers: Agree

Harm reduction for people who inject drugs: N/A

HIV prevention for out-of-school young people: Agree

HIV prevention in the workplace: Strongly agree

HIV testing and counseling: Strongly agree

IEC on risk reduction: Strongly agree

IEC on stigma and discrimination reduction: Strongly agree

Prevention of mother-to-child transmission of HIV: Strongly agree

Prevention for people living with HIV: Strongly agree

Reproductive health services including sexually transmitted infections prevention and treatment: Strongly agree

Risk reduction for intimate partners of key populations: Agree

Risk reduction for men who have sex with men: N/A

Risk reduction for sex workers: Strongly agree

Reduction of gender based violence: Agree

School-based HIV education for young people: Strongly agree

Treatment as prevention: Disagree

Universal precautions in health care settings: Strongly agree

Other [write in]::

:

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2013?: 9

A.V Treatment, care and support

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?: Yes

If YES, Briefly identify the elements and what has been prioritized:: • Provider initiated HIV counselling and testing at health facility level • Pre-ART care including provision of cotrimoxazole prophylaxis • ART programmes • Adherence tracing and support

Briefly identify how HIV treatment, care and support services are being scaled-up?: • The government in coordination with key stakeholders has invested on rapid expansion of ART sites • Training of ART adherence counsellors to educate, trace and support PLHIV to adhere to ART • Capacity building for counsellors and clinicians for improving quality of service • The WHO recommended Option B+ has been adopted and implemented as of December 2013 as well as the new WHO 2013 ART guidelines (although treatment for HIV negative partners in serodiscordant couples not adopted)

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

The majority of people in need have access to…:

Antiretroviral therapy: Strongly agree

ART for TB patients: Strongly agree

Cotrimoxazole prophylaxis in people living with HIV: Strongly agree

Early infant diagnosis: Strongly agree

Economic support: Strongly agree

Family based care and support: Strongly agree

HIV care and support in the workplace (including alternative working arrangements): Strongly agree

HIV testing and counselling for people with TB: Strongly agree

HIV treatment services in the workplace or treatment referral systems through the workplace: Strongly agree

Nutritional care: Strongly agree

Paediatric AIDS treatment: Strongly agree

Palliative care for children and adults Palliative care for children and adults: Strongly agree

Post-delivery ART provision to women: Strongly agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): Strongly agree

Post-exposure prophylaxis for occupational exposures to HIV: Strongly agree

Psychosocial support for people living with HIV and their families: Strongly agree

Sexually transmitted infection management: Strongly agree

TB infection control in HIV treatment and care facilities: Strongly agree

TB preventive therapy for people living with HIV: Strongly agree

TB screening for people living with HIV: Strongly agree

Treatment of common HIV-related infections: Strongly agree

Other [write in]::

:

2. Does the government have a policy or strategy in place to provide social and economic support to people infected/affected by HIV?: Yes

Please clarify which social and economic support is provided: The main support provided to PLHIV and OVCs (although coverage rates remain low, particularly for OVC) include: • Income generating activities such as life skill training, training on small business/ entrepreneurship and provision of start-up capital • Food and nutritional support to those in need through health facilities and NGOs • Care and support components such as shelter, home-based care and legal support

3. Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?: No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitu-tion medications?: No

IF YES, for which commodities?:

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?: 9

Since 2011, what have been key achievements in this area:: The national programme has registered significant achievements in terms of treatment care and support. Important achievements include: - Rapid expansion of ART sites throughout the country leading to increased enrollment of PLHIV in HIV services - Adherence counsellors trained and deployed throughout the country in coordination with the Network of PLHIV (NEP+) - Improved access to care and support for PLHIV and OVC (although coverage still very low, particularly for OVC) - Adoption of WHO 2013 guidelines: CD4 <500, option B+, and treating all under 15 children as eligibility criteria for initiation of ART - Improvement of HIV/TB programme coordination

What challenges remain in this area:: - Despite the rapid and remarkable expansion of services, access to remote areas still remains a challenge. - Treatment adherence is improving, yet more is required to ensure that all enrolled comply to treatment programme. - Paediatric ART coverage is still very low. There is a need to identfiy HIV positive children and refer them to treatment and care services . - More efforts are required to improve the PMTCT programme- the new plan for the Elimination of Mother-to Child Transmission of HIV is expected to improve both coverage and effectiveness of PMTCT. - Rapid turnover of trained personnel including counsellors and clinicians. - Limited capacity for CD4 monitoring: currently limited to a few referral centres (need for expansion).

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?:
Yes

6.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: Yes

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

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?: 6

Since 2011, what have been key achievements in this area:: - The government recently developed a national social protection policy which has also incorporated OVC. The policy is expected to be soon ratified by the Parliament. - Public sector organisations incorporated PLHIV and OVC support to their plan and allocated funds. - National strategy for addressing OVC has been developed and is being implemented. - SPM II incorporates support for OVC under thematic area 4 (strengthening care and support services to mitigate the impact of HIV and AIDS) and identifies targets and HIV related activities.

What challenges remain in this area:: - There are gaps between available services and demand. Resources do not match the needs. - Timely and updated data on number and situation of OVC does not exist (estimates used) - Organisations working on OVC are poorly coordinated (some respondents suggested the need for a forum/consortium) - HIV testing not currently promoted among OVC (and particularly orphans) that could represent a group with higher HIV prevalence due to higher levels of HIV exposure at birth

A.VI Monitoring and evaluation

1. Does the country have one national Monitoring and Evaluation (M&E) plan for HIV?: Yes

Briefly describe any challenges in development or implementation:: Major challenges include ensuring ownership of the M&E system by all key stakeholders who often have programme/agency specific monitoring and reporting requirements. As a result, although there is consensus on the "three-one principles" (one-national plan, one-budget and one M&E system), implementation remains a challenge. In addition their have been significant delays in implementing at full scale the Multisectoral Information System - the national M&E system for capturing the non clinical HIV response from all levels (district, zonal, regional and national). More over HMIS although fully operational at national scale does not capture a number of key HIV clinical indicators (including infant ARV prophylaxis) and the data that is captured is not sufficiently disaggregated by sex or age. Finally national efforts in M&E have focused more on routine monitoring and less on evaluation.

1.1. IF YES, years covered: The multisectoral strategy (SPM 11) for 2010/11 to 2014/15 incorporates M&E under theme 5 " Generation and utilization of strategic information".

1.2. IF YES, have key partners aligned and harmonized their M&E requirements (including indi-cators) with the national M&E plan?: Yes, some partners

Briefly describe what the issues are:: Some non-government sector stakeholders (NGOs) have specific reporting needs and requirements and thus using additional indicators from those in SPM II M&E . As a result there is no harmonization of reporting among key partners and the national M&E system due to different reporting formats and requirements. However, it is worth noting that there is a general understanding on the need to align and harmonize M&E with the national system.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy: Yes

IF YES, does it address::

Behavioural surveys: Yes

Evaluation / research studies: Yes

HIV Drug resistance surveillance: Yes

HIV surveillance: Yes

Routine programme monitoring: Yes

A data analysis strategy: Yes

A data dissemination and use strategy: Yes

A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate): Yes

Guidelines on tools for data collection: Yes

3. Is there a budget for implementation of the M&E plan?: Yes

3.1. IF YES, what percentage of the total HIV programme funding is budgeted for M&E activities?: 5

4. Is there a functional national M&E Unit?: Yes

Briefly describe any obstacles:: - With the national M&E Unit (FHAPCO) there is a shortage of staff to support regions and stakeholders. - Lack of adequate human resources for supervision, monitoring and timely reporting from Woreda (district), to Regional Offices. - Differences in M&E capacity among stakeholders (some NGOs do not have adequate personnel or expertise in M&E)

4.1. Where is the national M&E Unit based?

In the Ministry of Health?: Yes

In the National HIV Commission (or equivalent)?: Yes

Elsewhere?: No

If elsewhere, please specify:

4.2. How many and what type of professional staff are working in the national M&E Unit?

POSITION [write in position titles]	Fulltime or Part-time?	Since when?
Director of Plan, Monitoring and Evaluation Directorate	Full-time	2006
Senior M&E officers	Full-time	2005
Senior M&E officers	Full-time	2013
Senior M&E officers	Full-time	2013
M&E officer	Temps plein	2005
Planning expert	Full-time	2012
Data manger	Full-time	2005
Data manager	Full-time	2005

POSITION [write in position titles]	Fulltime or Part-time?	Since when?

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?: Yes

Briefly describe the data-sharing mechanisms:: • Annual Joint Review Meeting (JRM) where all stakeholders from federal and regional levels participate and contribute to process • Joint Supportive Supervision and relevant feedback meetings •

National and Regional AIDS Council/Board meetings • Production of one annual comprehensive M&E report document (distributed to stakeholders as draft and then finalized with inputs)

What are the major challenges in this area:: Despite the above mechanisms which contribute to strengthen the M&E system, there are gaps in timely reporting and sharing of information from district to regional levels-which in turn is transferred to the national M&E unit. For instance, the reports from sector organisations and higher education institutions are often not complete due to limited capacity to compile and share performance data on a timely basis.

5. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?: Yes

6. Is there a central national database with HIV- related data?: No

IF YES, briefly describe the national database and who manages it.:

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?:

IF YES, but only some of the above, which aspects does it include?:

6.2. Is there a functional Health Information System?

At national level: Yes

At subnational level: No

IF YES, at what level(s)?:

7.1. Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?: Estimates of Current and Future Needs

7.2. Is HIV programme coverage being monitored?: Yes

(a) IF YES, is coverage monitored by sex (male, female)?: No

(b) IF YES, is coverage monitored by population groups?: Yes

IF YES, for which population groups?: Pregnant women, female sex workers and OVC

Briefly explain how this information is used:: M&E data is used for planning purpose, advocacy, and to review and revise programme interventions. Moreover, information is also used to track progress of implementation by each region.

(c) Is coverage monitored by geographical area?: Yes

IF YES, at which geographical levels (provincial, district, other)?: - M&E data provides information by country, region/city administration, and sub-regional level (district/woreda) - It assesses performance of each level compared to set targets for each geographic area and type of intervention.

Briefly explain how this information is used:: - The geographic information is used to assess performance of each region and woreda/district compared toplanned targets. Based on the level of performance, necessary feedback is provided to programme implementers. - Where there is poor performance, necessary changes are made to improve implementation; and lessons learnt and good practices are also shared with others.

8. Does the country publish an M&E report on HIV, including HIV surveillance data at least once a year?: No

9. How are M&E data used?

For programme improvement?: Yes

In developing / revising the national HIV response?: Yes

For resource allocation?: Yes

Other [write in]::

: No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:: The annual multisectoral M&E report is used for evidence-based decision-making including planning, review of programmes and resource allocation. (NB it does not include HIV surveillance data. ANC surveillance data is published in a separate report every two years). The national multisectoral strategic plan (SPM II) was developed on the basis of epidemiological and programme performance data from various sources including annual M&E reports, the ANC sentinel HIV surveillance and DHS data. It also incorporated recommendations from a review of the first strategic plan for the HIV multisectoral response (SPM I). The main challenges include data quality and timeliness of reporting as well as gaps in data for some at risk population groups.

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

At national level?: Yes

IF YES, what was the number trained:: 22

At subnational level?: Yes

IF YES, what was the number trained: 32

At service delivery level including civil society?: Yes

IF YES, how many?: 6

10.1. Were other M&E capacity-building activities conducted other than training?: Yes

IF YES, describe what types of activities: Federal HAPCO/MOH and Regional HAPCO/Health Bureaus conducted supportive supervisions jointly with stakeholders, organized periodic performance reviews, and annual planning and review meetings

11. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?: 8

Since 2011, what have been key achievements in this area:: - Periodic joint supportive supervisions were conducted to regions and woredas (districts) - Annual M&E reports produced and shared with all key stakeholders - M&E capacity building/training sessions were organised at different levels - Know Your Epidemic/Know Your Response studies were conducted at national level and in three regions (on-going in two additional regions) - Piloting of Multisectoral Information System conducted and currently being scaled-up and rolled out throughout the country

What challenges remain in this area:: - Weak M&E capacity among regional, district (woreda) offices and other stakeholders - Delays and incomplete data reporting - Shortage of trained personnel on M&E to ensure data quality at all levels of reporting - Rapid turn-over of trained personnel . - Irregular meetings of regional AIDS councils/boards creating gaps in timely follow-up and guidance - Significant delays in the implementation of the multisectoral HIV information system - HMIS currently not capturing all key HIV clinical indicators and data disaggregated by sex and age is not available

B.I Civil Society involvement

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contrib¬uted to strengthening the political commitment of top leaders and national strategy/policy formulations?: 4

Comments and examples:: - Established relationship with Parliament and conducted collaborative work (e.g. Orientation Programme for Members of Parliament on different HIV/AIDS related issues such as the findings of the stigma Index, and Greater Involvement of PLHIV (GIPA) studies) - CSOs/NGOs represented in high-level national Task Forces and GF Country Coordination Meetings (CCM). - Directly engage political leadership in strengthening HIV/AIDS response and contribute to political commitment evidenced by speeches of President, Prime Minister & The First Lady.

2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society repre¬sentatives 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)?: 4

Comments and examples:: - High participation in the development of the multisectoral plan (SPMII), FHAPCO's Care and Support technical working group (TWG) and prevention TWG, high participation in joint supportive supervisions (JISS). - CSO/NGOs and Bilateral Agencies participate in annual review and planning meetings to discuss performance, issues relatedd programmes implementation and agree on recommendations/ follow up. - CSOs/NGOs including PLHIV through NEP+ and faith-based organisations are represented at GF CCM, task forces and committees. The participation of AIDS service organisations through their consortium (Consortium of Christian Relief and Development Associations) is strong both in CCMs and also at various task forces for planning, review and monitoring of the HIV response. - General consensus that CSOs representation at national level was high. However, there is a need to do more to ensure representation of CSOs/NGOs in planning and budgeting at regional and district levels.

3. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?: 4

b. The national HIV budget?: 3

c. The national HIV reports?: 3

Comments and examples:: - CSO's draft heir own budget and submit to either bilateral donor funds (ex PEPFAR) or to FHAPCO (mainly GF sources) for support. While there is funding for well-established NGOs, small NGOs/CBOs often find it difficult to access resources (limited capacity in designing/preparation of project proposals). - CSOs/NGOs take an active role in reviewing national HIV reports and planning at joint review meetings. - Most CSOs share activity reports with district and regional HIV/Health Offices but reports may not be included in the national M&E report (need to ensure that CSO activities are incorporated by citing data sources).

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?: 4

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?: 3

c. Participate in using data for decision-making?: 3

Comments and examples:: - CSOs participate in the joint integrated supportive supervision (JISS) and joint annual review meetings. - CSOs have opportunities to participate in planning, M&E and technical & policy committees/ task forces. - Overall, broad participation of CSOs through associations of PLHIVs (NEP+), faith-based NGOs and NGOs through the largest network of local and international CSOs/NGOs (CCRDA).

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, community based organisations , and faith-based organizations)?: 4

Comments and examples:: - CSOs are represented at national fora including the National HIV Review Board, CCM and TWGs. - Involved in policy formulation, strategic planning, implementation and review of programmes. - Take part in joint integrated supportive supervision activities to regions and district-level implementation. - key players in the national HIV response including in prevention, care and support activities. - Among the most active CSOs are: PLHIV associations, faith-based organisations, NGOs, women & youth groups. - The national HIV programme is inclusive. However, some CSOs take part only in Review Board or joint review meetings; not in implementation and mainly at the national level

6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?: 4

b. Adequate technical support to implement its HIV activities?: 3

Comments and examples:: - CSOs can access GF and PEPFAR resources including in the form of grants, sub-grants and technical inputs. - Moreover, some also access technical and financial support from multilateral agencies such as the UN. Examples include technical support from UNAIDS, WHO, UNICEF, UNFPA, World Bank, ILO through the UN Joint Programme of Support and UN Development Framework (UNDAF). - CSOs also can access support from government bodies such as FHAPCO, and bilateral agencies. However there are gaps between need and available resources.

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

Prevention for key-populations:

People living with HIV: 25-50%

Men who have sex with men:

People who inject drugs:

Sex workers: 51–75%

Transgender people:

Palliative care : 51–75%

Testing and Counselling: <25%

Know your Rights/ Legal services: 25-50%

Reduction of Stigma and Discrimination: 51–75%

Clinical services (ART/OI): <25%

Home-based care: >75%

Programmes for OVC: 51–75%

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?: 8

Since 2011, what have been key achievements in this area:: - Sustained effort to promote broad and direct participation of CSOs in the national response by FHAPCO. (Examples include in developing national guidelines and tools e.g. ART adherence guideline and Prevention Package (guideline) for key populations and the Investment Case for the country) - Other activities to promote CSO participation in implementation of the HIV response, mainly in prevention include involvement in the Community Conversation (CC), school CC programme, peer education for MARPs and workshops where CSO were trained by FHACO to improve implementation capacity and coordination . - There is high representation in the GF Country Coordination Mechanism (half of its members are from CSOs).

What challenges remain in this area:: - Limited technical expertise for timely Implementation and quality of programme activities. - Lack of clarity on CSO Law with reference to interpretation of what constitutes administrative and operational costs. Law requires CSOs to use not more than 30% of budget for admin costs. However some of the activities of organisations which are considered as admin such as salaries for technical support are taken as admin costs where these should be operational costs. This is reported to reduce the implementation capacity of CSOs.

B.II Political support and leadership

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?: Yes

IF YES, describe some examples of when and how this has happened:: - There is high government commitment which has set examples by involving key populations such as PLHIV and women's associations in planning, development and implementation of programmes supported through Global Fund; and extending its support so that key populations are targeted in the HIV response. - PLHIV (through NEP+ and Women Associations) are Core Team Members and fully participate in need identification and development of the Investment Case for Ethiopia (that will be the basis for/constitutes the next HIV strategy). Other key populations such as female sex workers are represented by CSOs and NGOs working with these groups. - However, direct participation of vulnerable population groups such as mobile populations, remain a challenge as these are not organised through some form of associations. No data available or participation from MSMs and IDUs.

B.III Human rights

1.1. Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: Yes

Men who have sex with men: No

Migrants/mobile populations: Yes

Orphans and other vulnerable children: Yes

People with disabilities: Yes

People who inject drugs: No

Prison inmates: Yes

Sex workers: Yes

Transgender people: No

Women and girls: Yes

Young women/young men: Yes

Other specific vulnerable subpopulations [write in]:: OVC

: Yes

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?: Yes

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:: Ethiopia has ratified UN Charter (1948), Universal Declaration on Human Rights (1949) , Conventions of children, and elimination of all forms of discrimination against women (CEDAW). The Family Law and The National Population Policy (1993) protect the right of women and children. - Article 25 of Constitution of Ethiopia (1995) states "All persons are equal before the law and are entitled to equal rights without discrimination to the equal protection......". - Civil and Criminal Codes protect vulnerable populations against discrimination and violence. - National Civil Service/Labor Law (2002) protect rights of citizens for fair recruitment without discrimination - MSM activities currently illegal

Briefly explain what mechanisms are in place to ensure that these laws are implemented:: - Law enforcement institutions such as the judiciary and police - Local administrations with conflict arbitration and settlement courts at woreda/district levels - National Human Rights Commission and the Ethiopian Human Rights Committee - Institution of Ombudsman

Briefly comment on the degree to which they are currently implemented:: - Although there is strong political will and commitment to implement existing laws, implementation is limited. Lack of awareness and capacity among some individuals within enforcement agencies are key factors. - The national Civil Society Organisations (CSO) law bars NGOs whose source of funding is external from advocacy and participating in human rights work; unless these organisations are funded with local sources, that limits enormously the availability of resources and scope of work.

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?: Yes

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS:

People living with HIV: No

Men who have sex with men: Yes

Migrants/mobile populations: No

Orphans and other vulnerable children: No

People with disabilities: No

People who inject drugs: Yes

Prison inmates: No

Sex workers: No

Transgender people: Yes

Women and girls: No

Young women/young men: No

Other specific vulnerable populations [write in]::

: No

Briefly describe the content of these laws, regulations or policies:: - The SPM II has incorporated objectives aimed at risk and vulnerable population groups such as sex workers, youth, mobile populations, PLHIV, discordant couples, OVC. However, there is no mention of MSM and injecting drug users (IDUs) - The national civil and criminal codes that outlaw same-sex relationships guidelines that ban distribution and possession of condoms in prisons limit targeted interventions for these groups. However, these groups can access prevention, treatment and care services with the general population.

Briefly comment on how they pose barriers:: Although the extent and role of MSM and IDU in the dynamics of HIV/AIDS in Ethiopia is not known; isolated studies indicate that both are practiced with high risk of HIV infection. Lack of official recognition of these groups creates barriers for developing specific intervention for them.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?: Yes

Briefly describe the content of the policy, law or regulation and the populations included.: - Penal code (Revised) : Punishes the crimes of abduction, rape and other forms of sexual assaults, FGM (female genital mutilation), endangering the lives or causing bodily injury to pregnant women and children through harmful traditional practices; trafficking women and children and early marriages, and widow inheritance. - Family Code: guarantees equality of spouses-during the conclusion, duration and dissolution of marriage; raised the legal age of marriage from 15 to 18 years, allows for joint administration of common marital property. Importantly, the law places civil law above customary and religious laws. - National Women Policy: underscores the protection of the rights of women although not specific to HIV

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?: Yes

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:: - National HIV/AIDS policy (1998) acknowledges respect for human right and reducing stigma associated with HIV/AIDS. Guidelines on GIPA (greater involvement of PLHIV) are developed and consistent to the national policy. - SPM II: incorporates specific objectives to fight stigma and discrimination against PLHIV; and to ensure access to health and social services including for HIV prevention, treatment, care and support services. - Workplace HIV/AIDS Framework and Guideline (and the soon to be ratified policy, drat 2013) underscore rights of candidates and employees to non-discrimination on the basis of their HIV status.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?: Yes

IF YES, briefly describe this mechanism:: Although these are not specific for recording discrimination. The eStigma Index Study 2012 and DHS collect specific information on prevalence of stigma against PLHIV. Police data provide useful information on discrimination such as GBV. Law enforcing agencies such as police, family arbitration courts, and legal services provide support to address GBV cases. However, these are not sufficient and a lot more is desired to record, document, and address all forms of discrimination

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle "yes" or "no" as applicable).

Antiretroviral treatment:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV prevention services:

Provided free-of-charge to all people in the country: Yes

Provided free-of-charge to some people in the country: No

Provided, but only at a cost: No

HIV-related care and support interventions:

Provided free-of-charge to all people in the country: No

Provided free-of-charge to some people in the country: Yes

Provided, but only at a cost: No

If applicable, which populations have been identified as priority, and for which services?: - Identified MARPs includes female sex workers, uniformed forces, long distance drivers, discordant couples, refugees in some regions, and migrant labourers, including cross-border and mobile populations. - PLHIV access free ART and treatment for opportunistic infections (although latter to a lesser extent). - MARPs access free HIV prevention services such as condom distribution at health facilities, although there is need for more targeted interventions and to bring the programme to scale - General public access free IEC/BCC messages, free condoms at facilities and workplace, but at subsidised cost in condom social marketing outlets; students access free IEC, peer education and school community conversation (a social mobilisation programme which enables discussion and sharing of information on HIV) . - OVCs access care and support services such as educational materials for free (although capacity and resources are limited).

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?: Yes

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?: Yes

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?: Yes

IF YES, Briefly describe the content of this policy/strategy and the populations included:: The national AIDS Policy (1998), SPM II (2009-2014), Accelerated Plan for Scaling-up PMTCT (2011) and eMTCT Plan, Workplace AIDS Framework (and draft policy 2013), and MARPS Intervention Package (2012) identify key populations including female sex workers & their male clients, mobile/migrant workers, truckers, OVC; discordant couples, and in and out-of-school adolescents for targeted-interventions. However, other key populations such as injecting drug users and MSM are not included in national documents.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?: Yes

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:: Both the SPM II and MARPs Intervention Package have identified activities and different approaches to reach and ensure access to key populations. However, other universally accepted MARPs notably IDUs, MSM, are not included in national programmes since these are illegal activities, and the extent, and role in the HIV epidemic is unknown. For prison inmates HIV services are available but include condom distribution and promotion since the practice of sex in prison is illegal.

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?: Yes

IF YES, briefly describe the content of the policy or law:: - The national HIV/AIDS Policy prohibits forced HIV screening for any reasons including for employment without consent of the person. (with the exception of the air force and military - The national Civil Code Art. 20(1) states "A person may at any time refuse to submit himself for medical or surgical examination or treatment". - The national Workplace HIV/AIDS framework and guideline prohibits forced HIV screening.

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

a. 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

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts: No

IF YES on any of the above questions, describe some examples::

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)?: Yes

b. Programmes for members of the judiciary and law enforcement46 on HIV and human rights issues that may come up in the context of their work?: Yes

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

a. Legal aid systems for HIV casework: No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV: No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?: Yes

IF YES, what types of programmes?:

Programmes for health care workers: Yes

Programmes for the media: Yes

Programmes in the work place: Yes

Other [write in]:: School youth and the general population

: Yes

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2013?: 6

Since 2011, what have been key achievements in this area:: - Anti stigma and discrimination programme implementation and training manual was printed and distributed. - National Workplace HIV Policy prepared with leadership of Ministry of Labour and Social Affairs (MOLSA) and Confederation of Ethiopian Trade Unions (CETU) is finalized for ratification by Parliament

What challenges remain in this area:: - Low awareness of the public on existing policies and laws (on their rights and how to protect them) - Weak implementation capacity and commitment of law enforcement agencies to fully implement the existing anti discrimination laws and policies - Difficulties i working with certain key populations (IDUs, MSM) due to existing laws/ regulatiosn and lack of data on those populations

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?: 6

Since 2011, what have been key achievements in this area:: - Sensitization, education and training on human rights issues including follow-ups and reports to Parliament. - Political statements by government officials including the President, the Speaker of Parliament, the Prime Minister and First Lady on HIV/AIDS issues including at visits to regions, factories and commercial farms.

What challenges remain in this area:: - Low public awareness on human right issues calls for more sensitization on the subject. - Weak capacity for implementation underscores the need for further training of individuals from law enforcement agencies. - Directive/circular from the prison administration that does not comply with the national HIV policy and the MARPs strategy by prohibiting access to condoms for prison inmates. - Despite improvements in accepting attitudes of PLHIV and improving discrimination, the stigma index study reported different forms of discrimination, underscoring the need for greater effort to address this issue.

B.IV Prevention

1. Has the country identified the specific needs for HIV prevention programmes?: Yes

IF YES, how were these specific needs determined?: - Data from the annual M&E reports, the HIV Syntheses studies at national level and in three regions, national DHS, ANC sentinel study, and MARP studies (sex workers, truckers) were used to determine specific needs. - Moreover, information from programme specific assessments such as ART and PMTCT are used in planning. - Task forces and expert working groups on prevention are in place and lead the organisation of national prevention summits among others.

IF YES, what are these specific needs? : Targeting HCT to higher risk groups, including children that were vertically infected, accelerated implementation of eMTCT plan, and specific intervention programmes for MARPs. Specifically: - There is a need to address the needs of emerging at risk population groups such as seasonal and migrant workers in large development schemes, some report school youth in universities although evidence is lacking, house maids and girls engaged in transactional sex. - Other important needs include accelerate implementation of the 2013 WHO treatment guidelines and Option B+ for PMTCT and the newly developed strategy on elimination of mother-to-child transmission of HIV (e-MTCT plan, 2013). - Finally there is a need to adapt region-specific interventions and approaches based on epidemiological data and taking into account the dynamics and context of each region. The regional HIV Syntheses studies provide invaluable inputs for this.

1.1 To what extent has HIV prevention been implemented?

The majority of people in need have access to...:

Blood safety: Strongly agree

Condom promotion: Strongly agree

Harm reduction for people who inject drugs:

HIV prevention for out-of-school young people: N/A

HIV prevention in the workplace:

HIV testing and counseling: Strongly agree

IEC on risk reduction: Strongly agree

IEC on stigma and discrimination reduction: Agree

Prevention of mother-to-child transmission of HIV: Agree

Prevention for people living with HIV: Agree

Reproductive health services including sexually transmitted infections prevention and treatment: Agree

Risk reduction for intimate partners of key populations: Disagree

Risk reduction for men who have sex with men: N/A

Risk reduction for sex workers: Agree

School-based HIV education for young people: Strongly agree

Universal precautions in health care settings: Strongly agree

Other [write in]:: Truck drivers and their assistants

: Disagree

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2013?: 7

Since 2011, what have been key achievements in this area:: - MARPs (sex workers, youth, inmates, mobile populations) minimum package of services developed. - Minimum HIV prevention service package for out of school youth developed. - Minimum HIV prevention service package for secondary school youth developed. - National coordination mechanism established for HIV prevention. - Roll-out plan for accelerated PMTCT; and strategy for elimination of mother to child transmission developed and disseminated. - Adoption of initiation of treatment at CD4 < 500 (WHO 2013 Guidelines) and Option B+ treatment policy.

What challenges remain in this area:: - Scale-up for targeted intervention for key populations and development schemes is still inadequate. - Barriers to develop specific interventions for MSM and IDUs because of the illegality of these acts and lack of information on the extent and role of these groups in the HIV epidemic in Ethiopia - Slow pace of HIV mainstreaming in public and non-public sector organisations. - Weak programmes for hard-to-reach and remote populations (efforts to bridge by the health development army). - Some respondents from CSOs feel that the is not adequate budget for prevention (in particular since GF focuses on treatment in Ethiopia) and less funds are accessible to CSOs to implement prevention activities.

B.V Treatment, care and support

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?: Yes

IF YES, Briefly identify the elements and what has been prioritized:: - The SPM II includes clinical, biomedical and social interventions for treatment and care opportunistic infections for PLHIV. - Treatment with improved access to ARVs througha fast-tracking mechanism for procurement and distribution from national level to service facilities via a shorter route and time to minimize delays. - WHO 2013 treatment guideline with initiation of treatment at CD4 < 500 has adopted nationally

and under implementation

Briefly identify how HIV treatment, care and support services are being scaled-up?: - Further expansion of VCT and ART sites - Fast track mechanism for procurement and distribution of ARVs, kits and supplies. - Increased involvement of CSOs and CBOs in care and support services

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

The majority of people in need have access to…:

Antiretroviral therapy: Strongly agree

ART for TB patients: Strongly agree

Cotrimoxazole prophylaxis in people living with HIV: Agree

Early infant diagnosis: Disagree

HIV care and support in the workplace (including alternative working arrangements): Disagree

HIV testing and counselling for people with TB: Strongly disagree

HIV treatment services in the workplace or treatment referral systems through the workplace: Disagree

Nutritional care: Disagree

Paediatric AIDS treatment: Strongly agree

Post-delivery ART provision to women: Agree

Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault): Disagree

Post-exposure prophylaxis for occupational exposures to HIV: Agree

Psychosocial support for people living with HIV and their families: Agree

Sexually transmitted infection management: Agree

TB infection control in HIV treatment and care facilities: Agree

TB preventive therapy for people living with HIV: Agree

TB screening for people living with HIV: Agree

Treatment of common HIV-related infections: Agree

Other [write in]::

:

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 7

Since 2011, what have been key achievements in this area:: -WHO 2013 treatment guidelines adopted - Scale up and site expansion for enrollment of more PLHIV to the ART programme - Strong implementation of Provider Initiated Counselling and Testing (PICT) in healthcare facilities - Involvement of community health workers to supervise adherence to ART programmes - Deployment of the health development army to access rural communities with services including HIV education

What challenges remain in this area:: - Hard-to-reach and remote populations have limited access to ART programmes - Adherence/support services need strengthening as the proportion of defaulters is still high - Issues on timely procurement and distribution OI supplies needs to be addressed - Gaps in quality of counselling services need to be addressed to reduce missed opportunities for testing and counselling and ART referral

2. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?: Yes

2.1. IF YES, is there an operational definition for orphans and vulnerable children in the country?: Yes

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

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?: 6

Since 2011, what have been key achievements in this area:: - Mainstreaming of care and support through AIDS funds (contributions of employees salaries) to support OVC of employees at workplace - OVC standard guideline (2013) to protect their rights is developed and widely distributed - Social protection policy for the protection of vulnerable population groups including but not limited to OVCs has been developed by the Ministry of Labour and Social Affairs and submitted for ratification by parliament

What challenges remain in this area:: - Resource gaps as the estimated number of OVCs is large compared to those currently accessing services - Limited capacity of implementing organisations to provide support for OVCs. - Services currently available for OVCs are not comprehensive and for the most part cover education and food. - A situation analysis and national information management system for OVCs is not in place but is needed.