Country Progress Report on HIV/AIDS Response, 2012

Federal Democratic Republic of Ethiopia

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Contents

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARDs	Anti-retroviral Drugs
ART	Antiretroviral Therapy or Treatment
ARV	Antiretroviral
BCC	Behavioural Change Communication
BSC	Balanced Score Card
BSS	Behavioural Surveillance Survey
CBHIS	Community Based Health Information System
CPT	Co-trimoxazole Preventive Therapy
CSWs	Commercial Sex Workers
DAC	Department of AIDS Control
DHS	Demographic and Health Surveys
EHNRI	Ethiopian Health and Nutrition Research Institute
EID	Early Infant Diagnosis
EIFDAA	Ethiopia Interfaith Forum for Development, Dialogue and Action
EMSAP	Ethiopian Multi-sectoral AIDS Project
FMoH	Federal Ministry of Health (Ethiopia)
FHAPCO	Federal HIV/AIDS Prevention and Control Office
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOE	Government of Ethiopia
HEW	Health Extension Worker
HSDP	Health Sector Development Plan
IGAD	Inter-Governmental Authority on Development
IPT	Isonized Preventive Therapy
MARPs	Most-at-Risk and/or Highly Vulnerable Populations
MDGs	Million Development Goals
MSM	Men Having Sex with Men
MTCT	Mother to Child Transmission
NASA	National AIDS Spending Assessment
NEP	Network of Networks of HIV Positives in Ethiopia

NCTPE	National Committee on Traditional Practices of Ethiopia
NNPWE	Network of Positive Women Ethiopia
OVCs	Orphans and Vulnerable Children
PASDEP	Program for Accelerated and Sustained Development to End Poverty
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SPM	Strategic Plan Management
SWOT	Strengths, Weaknesses, Opportunities and Threats
UNDAF	UN Development Assistance Framework
VAW	Violence against Women
VCT	Voluntary Counselling and Testing

I. Status at a Glance

The emergence of the HIV epidemic is one of the biggest public health challenges the world has ever seen in recent history. In the last three decades HIV has spread rapidly and affected all sectors of society- young people and adults, men and women, and the rich and the poor. Sub-Saharan Africa is at the epicentre of the epidemic and continues to carry the full brunt of its health and socioeconomic impact. Ethiopia is among the countries most affected by the HIV epidemic. With an estimated adult prevalence of 1.5%, it has a large number of people living with HIV (approximately 800,000); and about 1 million AIDS orphans.

Despite these mounting challenges, the global response has been a reason for hope and optimism in fighting the epidemic. Application of effective and feasible preventive interventions to avert infection, use of Highly Active Antiretroviral Therapy (HAART), and sustained global and national commitment continue to register success in the response to the epidemic. These interventions have yielded tangible results. From the early days of the epidemic, Ethiopia has shown commitment to prevent its spread and mitigate its impact. To this end, it has rallied support from national and global partners, including mainstreaming of HIV prevention programmes to public and private sector businesses, and engagement of community-based organisations. During the earlier years, the government adopted a national AIDS policy and developed and implemented several effective strategies.

Despite the multi-faceted challenges caused by HIV/AIDS, Ethiopia has demonstrated that with commitment and effective strategies, there is hope for reversing the trend and minimizing the impacts.

These concerted efforts have yielded encouraging results in reversing the rate of new infections and in mitigating the multi-faceted impacts of the epidemic. In fact, recent reports show that Ethiopia is one of the sub-Saharan countries demonstrating more than a 25% decline in new HIV infections. ANC sentinel surveillance data show that prevalence of new infections among pregnant women 15-24 years of age has declined from 5.6% in 2005, to 3.5% in 2007, and 2.6% in 2011. Likewise, DHS data show that use of preventive methods and the number of people who were tested for HIV and utilising treatment and care services has increased. For example, the number of people tested for HIV annually has increased from forty-thousand in 2005 to nearly ten million by 2011. Similarly, the proportion of women aged 15–49 who received an HIV test in the last 12 months and who know the results has increased from just 1.9% in 2005 to 20.0% by 2011. The proportions for men increased from 2.3% to 20.7%, respectively. It is also worth noting that the national programme has established an in-built monitoring system-indispensable to track progress and guide implementation of activities.

While the above progress is a reason for hope and encouragement, the fight against HIV/AIDS is far from over. The problem is still huge as nearly 800,000 are living with HIV, more are orphaned, and the rate of new infections is declining but still high, and possibly expanding to newer population groups and geographic areas. This calls for a more robust and targeted response while at the same time scaling-up existing interventions among high-risk population groups. Key challenges during the reporting period, among others, include low utilisation of some of the existing services (especially PMTCT), emergence of new at-risk population groups (young girls engaged in transactional sex),and low coverage of interventions for MARPs, and ensuring quality of available services.

This progress report provides a summary of the HIV/AIDS epidemiological update-situation among different population groups and geographic areas, progress in programme implementation, best practices and lessons, and key challenges and needs in programme implementation. The report also provides brief update on the role of development partners in enhancing the ongoing national response and highlights monitoring mechanisms, and results from assessment of the national commitment and policy instrument (NCPI).

The information contained in this report was compiled from official documents both published and unpublished, articles from journals, programme reports, and interviews and discussions with key stakeholders and informants. Furthermore, the main sources of information on the epidemiological situation and status of programme performance were compiled from evaluation and monitoring reports, national demographic and health surveys, and the sentinel surveillance system.

The report is prepared in response to the UN Political Declaration on HIV/AIDS on scaling up response (UNGASS 2001 and High Level Meeting on AIDS, June 2011) that call upon Member States to provide reports on status of progress in responding to HIV/AIDS. The government of Ethiopia, coordinated by the Federal HIV/AIDS Prevention and Control Office (HAPCO), supported by UNAIDS and other agencies coordinated the preparation of the report. The report in addition to fulfilling the global requirements on response progress reporting also provides useful information on further strengthening ongoing efforts.

Target	*Indicator*				
Target 1 *Reduce sexual transmission of HIV by 50% by 2015* *General population*			**DHS 2000 (%)**	**DHS 2005 (%)**	**DHS 2011 (%)**
	1.1	Percentage of young women and men 15-24 years who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission Female 15-19 years 20-24 years Male 15-19 years 20-24 years	No DHS data available on specific indicator	F= 20.5 M= 33.3 21.1 19.7 32.1 34.8	F= 23.9 M= 34.2 24.0 23.6 31.8 37.4
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 years Female 15-19 years 20-24 years Male 15-19 years 20-24 years	F= 16.0 M= 4.3 13.5 19.4 5.1 3.2	F= 15.8 M= 1.7 11.1 21.9 1.7 1.7	F= 10.9 M= 1.2 7.1 16.0 1.2 1.3
	1.3	Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months Female 15-19 years 20-24 years 25-49 years Male 15-19 years 20-24 years 25-49 years	No DHS data available on specific indicator	F= 0.2 M=4.1 0.4 0.6 0.1 3.9 5.0 3.5	F= 0.5 M= 3.5 0.3 0.6 0. 4 0.5 1.6 5.3

Target	*Indicator*				
	1.4	Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months who report use of condom during their last intercourse Female 15-19 years 20-24 years 25-49 years Male 15-19 years 20-24 years 25-49 years	*No data collected on specific indicator*	*No data collected on specific indicator*	F=47.0 M=15.5 - - - - 36.9 11.3
	1.5	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results Female 15-19 years 20-24 years 25-49 years Male 15-19 years 20-24 years 25-49 years		F= 1.9 M= 2.3 2.4 3.6 1.1 1.5 4.0 2.0	F= 20.0 M=20.7 18.8 24.5 19.2 16.5 24.8 21.1
			ANC 2005	**ANC 2007**	**ANC 2009**
	1.6	Percentage of young women aged 15–24 years living with HIV (ANC)	5.6%; unadjusted	3.5%; unadjusted	2.6%; unadjusted

Target	***Indicator***				
Sex workers *(Remarks: Study planned for 2012 and results expected early 2013)*				**2005**	**2009/2010/2011**
	1.7	Percentage of sex workers reached with HIV prevention programme *Note: No national representative data.*	N/A	N/A	42.3% were reached by outreach programme along the main road transport corridors (Source: TransACTION, 2009)
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client *Note: No national representative data. Different sources, sample size and geographic sites*	N/A	98.3% (Source: BSS 2005)	99.4% use of condoms with paying clients; 65.7% with non-paying clients (Source: DKT, study on 1200 CSWs in 5 regions, 2009) 96.5% with paying; and 54.6% non-paying client (Source: TransACTION data; study on 400 CSWs along main transport corridors, 2009)
	1.9	Percentage of sex workers who have received HIV test in the past 12 months and know their results *Note: No nationally representative data*	N/A	28.2% had HIV test; and 97.3% knew results (Source: BSS 2005)	44.8% HIV test in last 3 months (Source: TransACTION, 2009)
	1.10	Percentage of sex workers living with HIV *Note: No nationally representative data*	N/A	N/A	25% (Source: Abt Associates, CSWs VCT clients, urban, 2009)

Target	Indicator				
Men having sex with men *(Remarks: No national data available on MSM. No specific intervention programme. National study 2012; results expected early 2013)*	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	N/A	N/A	N/A
	1.12	Percentage of men reporting the use of condom last time they had anal sex with male partner	N/A	N/A	N/A
	1.13	Percentage of men who have sex with men who have received HIV test in the past 12 months and know their results	N/A	N/A	N/A
	1.14	Percentage of men who have sex with men who are living with HIV	N/A	N/A	N/A
Target 2 *Reduce transmission of HIV among people who inject drugs by 50 percent by 2015* *(Remarks: No national data available on IDUs; no intervention programme. Study planned for 2012; results for early 2013)*	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programs	N/A	N/A	N/A
	2.2	Percentage of people who inject drugs who report the use of condoms in their last sexual intercourse	N/A	N/A	N/A
	2.3	Percentage of people who inject drugs who report using sterile equipment the last time they injected	N/A	N/A	N/A
	2.4	Percentage of people who inject drugs who have received HIV test in the past 12 months and know their results	N/A	N/A	N/A
	2.5	Percentage of people who inject drugs who are living with HIV	N/A	N/A	N/A

Target	*Indicator*				
Target 3 *Eliminate mother-to-child transmission of HIV by 2015 & substantially reduce AIDS-related maternal deaths*			**2009 Programmatic Data**	**2010 Programmatic Data**	**2011 Programmatic Data/EPP Spectrum**
	3.1	Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission Total Single Dual ARV (maternal AZT) Mothers on ART for life	 7579 3279 3278 1022	 7844 1010 5721 1113	 10,302/42,900 =24% 199 5280 4823
	3.2	Percentage of infants born to HIV+ women receiving virological test for HIV within 2 months of birth	N/A	N/A	11% (4,753/42,900)
	3.3	Mother-to-child transmission of HIV (Spectrum/EPP modelled)	N/A	N/A	17% at 6 weeks 30% (13,000/42,900) including breastfeeding

Target	Indicator				
Target 4 *Have 15 million people living with HIV on antiretroviral treatment by 2015*	4.1	Percentage of adults and children currently receiving antiretroviral therapy Disaggregation by age Adults; 15 years and above Children; Under 15 years of age Disaggregation by sex (Not available)	 167,816 10,350	 209,360 13,000	 249,174/289,900 = 86% (CD4 cutoff < 200) 16,000/82,100=20% (WHO 2007 guidelines)
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy *(Similar study ongoing, results for end of 2012)*	72.5% on ART (Source: ART Scale-up, 2009)	N/A	N/A
Target 5 *Reduce tuberculosis deaths in people living with HIV by 50% by 2015*	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV Note: Disaggregated data NOT available	N/A	40.6% (Source: FMOH 2010)	39% of identified HIV positive TB patients on ART. (Source: FMOH 2011; WHO Global TB report, 2011)
Target 6 *Reach a significant level of annual expenditure in low and middle income countries*	6.1	Domestic and International AIDS spending by categories and financing source *Note: NASA study is ongoing; results late 2012*	Refer to 2008/2009 NHA	No data available	No data available

Target	*Indicator*				
Target 7 *Critical enablers & synergies with development sectors*	7.1	National commitment and policy instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination, and monitoring and evaluation)	Ref UNGASS report 2008	Ref UNGASS report 2010	Ref Annex 1
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male partner in the last 12 months	N/A (no national data)	N/A (no national data)	N/A (no national data)
	7.3	Current school attendance in orphans and non-orphans aged 10-14	235,558 OVCs received educational support	325,201 OVC received educational support	354,660 OVC received educational support
	7.4	Proportion of the poorest households who received external economic support in the last three months	70,927 PLHIV received food; 18,733 money/yr	104,399 PLHIV food and 43,843 money/yr	103,659 PLHIV food & 36,028 money/yr

II. Overview of the AIDS epidemic in Ethiopia

The 2011 UN High Level Meeting, at its Political Declaration on HIV/AIDS, set ten targets and commitments which among others include halving sexual transmission of HIV, ensuring that no children are born with HIV infection, increasing access to antiretroviral therapy to 15 million people and halving tuberculosis deaths in people living with HIV, by 2015. The declaration also clearly underscores an urgent need to increase access to HIV services, particularly for those most at risk; and pledges to address gender-related inequalities without delay. It also called for monitoring of progress in implementation commitment and requires the UN General-Secretary to issues regular progress reports.

This fifth progress report is prepared in accordance with the UN Declaration of Commitment on HIV/AIDS which calls upon all Member States and Parties to report on the status of the epidemic, achievements in national response, and lessons and challenges. The report covers an overview of the HIV/AIDS epidemic, national response, best practices, major challenges and actions to address them, and support of stakeholders in responding to the epidemic.

2.1. Introduction

Ethiopia, officially known as the Federal Democratic Republic of Ethiopia, is located in East Africa commonly recognised as The Horn of Africa. It is the tenth largest country in Africa. The population of Ethiopia in 2007 was estimated at 74 million. Currently, based on projections from the national census of 2007, it is estimated at 83 million, making the nation the second most populous country in Africa. The majority (83.9%) reside in rural areas. The average household size is 4.7. The average life expectancy is 51 years for males and 53 years for females. Population distribution by age group shows a pyramidal age structure, with 44% less than 15 years. While the sex ratio between male and female is almost equal, women in the reproductive age group constitute 24% of the population (1, 2).

Figure 1 Ethiopia: Administrative Regions

Source: FMOH; Map not to scale

The country has nine Regional States and two City Administrations. The Regional States and City administrations are subdivided into 817 administrative woredas (districts) which are further divided into kebeles, the smallest administrative unit in the governance.

Ethiopia is one of the countries with the lowest per capital income, estimated at 390 USD per annum. It is estimated that 32.7% of the population live below the absolute poverty line. Nevertheless, in recent years, the country has seen rapid progress in economic growth, expansion of social infrastructure, and in improving healthcare. Ethiopia has one of fast growing economies among non-oil producing countries in sub-Saharan Africa (3).

Ethiopia has ratified the Millennium Development Goals (MDGs) and is committed to the attainment of these goals. Health is at the centre of the national Programme for Accelerated and Sustained Development and Ending Poverty (PASDEP) (4). The country has endorsed a Health Sector Development Plan (HSDP) which focuses on prevention and mitigation of priority health problems such as HIV/AIDS, tuberculosis, malaria, diarrheal diseases and common childhood and maternal illnesses. Since 1997/98, three cycles of HSDPs were developed and implemented; and currently the country is implementing the fourth plan (5). To expedite the implementation of the HSDP, the government launched the Health Extension Programme in 2003 to deliver a package of basic and essential healthcare, including HIV preventive services. To date, more than 30,000 health extension workers have been deployed. This innovative approach has registered encouraging results in addressing disparities in basic healthcare, including HIV prevention services (6).

Ethiopia has made significant strides in healthcare delivery. Service coverage has remarkably expanded with sharp increase in healthcare facilities and training and deployment of health extension workers. This demonstrates that with commitment, clear policies and innovative strategies success in improving healthcare is feasible in low and middle income settings.

The sustained high level commitment including the increase in allocation of national health budget has made significant improvements in basic healthcare. The number of health facilities and health work force has steadily grown in the last two decades, increasing coverage and use of healthcare.

The rapid expansion of healthcare facilities has contributed to improved health status of the population, notably in maternal and child health. Infant mortality rate has decreased from 77 in 2005 to 59 deaths per 1,000 births in 2010. Similarly, under-five mortality has decreased from 123 to 88 per 1,000 births. Under-five malnutrition has declined from 47.6 percent in 1990 to 35% in 2010. Similarly, the percentage of women who received antenatal care (ANC) from a trained health professional at least once for their last birth has increased from 28% in 2005 to 34% in 2010. However, wide regional and urban/rural variations are observed. While 76 percent of urban women had ANC only 26 percent of rural women did so, underscoring the challenge for overcoming barriers for access and use of services among the latter group (7).

2.2. HIV in General Population (Ref. Indicator 1.6)

2.2.1. Prevalence by Time

Indicator	*2005*	*2007*	*2009*
Percentage of young people aged 15–24 years living with HIV	*5.6%; unadjusted (ANC 2005)*	*3.5%; unadjusted (ANC 2007)*	*2.6%; unadjusted (ANC 2009)*

According to ANC surveillance results, HIV prevalence among pregnant women aged 15-24 declined from 5.6% in 2005, to 3.5% in 2007, and then to 2.6% in 2009; showing a declining HIV prevalence trend. DHS 2011 data show an overall prevalence of 1.5% among the general population. EPP/Spectrum estimates show 789,900 people currently living with HIV/AIDS (607,700 adults and 182,200 children aged 0-14 years); and 952,700 AIDS orphans.

HIV infection probably began in the late 1970s or early 1980s with the first AIDS cases reported in 1986 (8). Similar to other Sub-Saharan countries, the predominant strain is HIV-1 subtype C, predominantly spread through unprotected heterosexual intercourse (9).

In the early stages of the epidemic, HIV prevalence increased rapidly, initially among high risk groups like CSWs, men in uniform and long distance truck drivers. Most of the HIV surveys, therefore, were focused on these well-recognised risk groups in major urban centres. However, the data generated did not provide much information on what was happening in the general population. Based on available research and survey data, the first systematic national report on HIV was produced in 1996. This synthesis report documented a progressive rise of HIV prevalence from 1% in 1989 to 5.2% in 1996, indicating a generalised epidemic (9). The findings showed that the epidemic steadily increased, then reached a plateau and seemed to decline. This observation was more evident with the expansion of ANC sentinel sites to more geographic areas that yield more representative data compared to earlier years.

Sustained effort, declining new infections. Data indicate a declining trend of HIV prevalence: a success and cause for optimism! However, with nearly 800,000 people living with HIV, Ethiopia remains a country highly affected by the epidemic.

Sentinel surveillance provides data in a specified age group of population and helps to monitor trends in HIV prevalence over the years. In Ethiopia, one important source of such data is sentinel surveillance among ANC clinic attendee women. Although earlier ANC surveillance sites were limited in number and largely distributed in urban areas, expansion of these sites has provided an opportunity to monitor trend among the ANC attendees and to generate more representative data.

Findings from the most recent ANC sentinel surveillance data show a declining prevalence of infection rates among women age 15-24 years attending ANC, from 5.6% in 2005, to 3.5% in 2007, to 2.6% in 2009. This trend was marked both in urban and rural areas. In urban centres the prevalence has halved, declining from 11.5 % in 2003 to 5.5% in 2009. The declining trend is even steeper in rural areas where prevalence declined from 4% in 2003, to 1.4% in 2009. Generally, 94% of the sentinel sites showed absolute decrease of which half of these were statistically significant (7).

Ethiopia is one of the few sub-Saharan countries showing a decline of more than 25% in new HIV infections (10).

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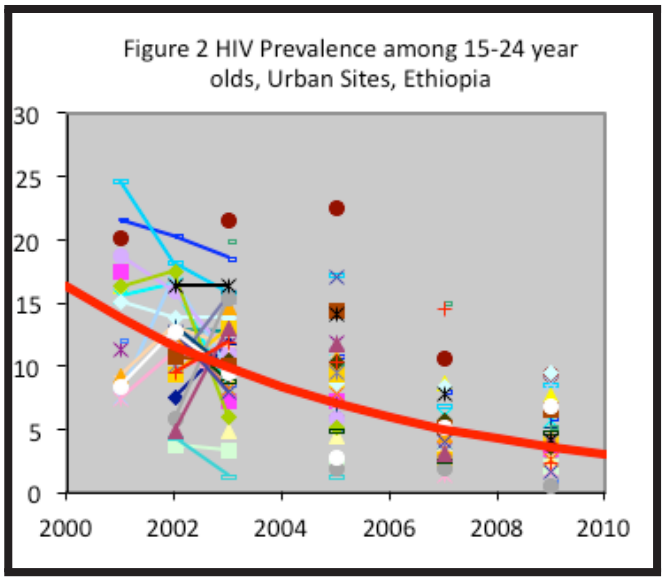
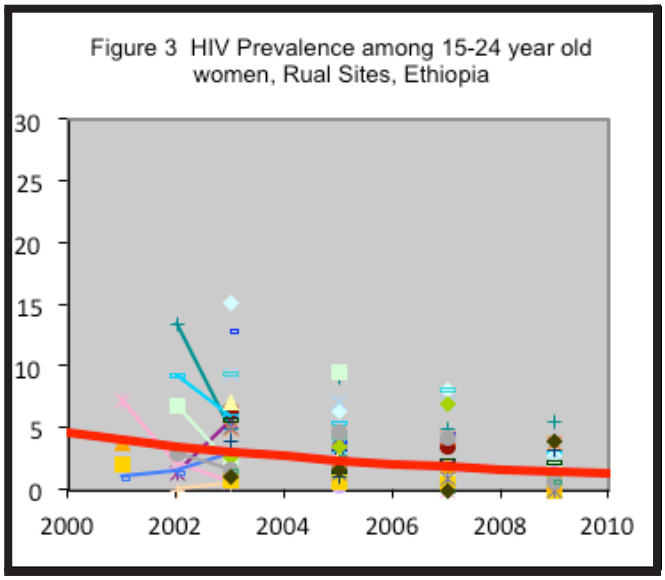




ource: ANC sentinel surveillance, ENHRI (with predicted prevalence for 2010)

Another important source of HIV prevalence data in the general population is the Ethiopian Demographic and Health Survey (EDHS). Results from the 2005 EDHS indicate that 1.4% of Ethiopian adults age 15-49 were infected with HIV. Data for 2011 EDHS show a prevalence of 1.5%. For both men and women HIV prevalence levels rise with age, peaking among women in their early to mid 30s and among men in their late 30s. The age patterns suggest that young women are particularly vulnerable to HIV infection compared with young men (11, 12).

According to mathematical modelling estimates there are nearly 789,900 people currently living with HIV/AIDS (607,700 adults and 182,200 children aged 0-14 years); and 952,700 AIDS orphans (EPP/Spectrum estimates 2011). Overall, analysis of various sources of data indicates that overall the epidemic is generalised with HIV firmly established in the general population. However, an epidemiological synthesis report of available published literature indicates the epidemic may be more heterogeneous than previously believed (9).

2.2.2. Geographic Distribution

The latest ANC sentinel surveillance data show that HIV prevalence varies widely between urban and rural settings. This is confirmed by DHS 2011: urban adult HIV prevalence was 4.2% while rural adult HIV prevalence was 0.6%. ANC results also document wide variations among urban settings in different parts of the country. Similar variations were also observed among rural settings.

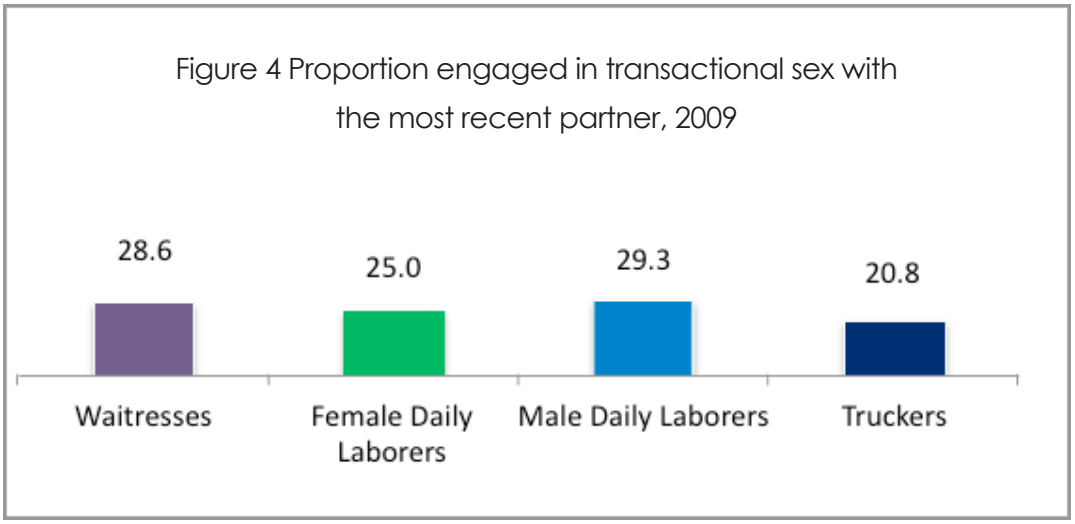
Variations were also observed among administrative regions. According to the Ethiopian Demographic and Health Surveys HIV prevalence ranges from 0.9% in SNNP and 1.0% in Oromiya region to 5.2% in Addis Ababa and 6.5% in Gambella region (7).

There is wide variation in HIV prevalence among administrative regions, and between urban and rural settings. The epidemic is more heterogeneous than previously believed.

As indicated above urban-rural disparities have long been noted, with the disease more prevalent in urban areas. Nonetheless, synthesis of epidemiological data also indicates that while the epidemic has stabilised and declining in most of urban areas, the rate of new HIV infections seems to be increasing in smaller towns (9). However, as these observations are based on studies from locations which are more urban and along trading routes there is a need for further study to generate more geographical representative data. Yet, the possibility of a sharp increase in the rate of new HIV infections in small towns is worrisome as these can potentially bridge further spread of HIV to rural settings. Bridging populations link low prevalence rural areas with high prevalence urban, semi-urban and small town communities. These include those who frequently travel for employment, trade, education or social reasons. Most farmers, migrant labourers and rural commercial farmers often visit local small towns for social and business/work purposes. Disproportionate access to information including limited information on preventive measures and related services such as IEC/BCC and VCT can further increase the risk of HIV infection among rural populations.

2.3. HIV in Most-at-risk Populations

The distribution of HIV varies among different population groups due to socio-demographic, awareness, behavioural, and other factors. The Government of Ethiopia has identified populations who are most-at-risk and/or highly vulnerable populations (MARPs) to HIV infection. A MARP is defined as a group within a community with an elevated risk for HIV, often because group members engage in some form of high-risk behaviour; in some cases the behaviours or HIV sero-status of their sex partner may place them at risk. Available data indicate that sero-discordant couples, sex workers, men in uniformed services, long-distance truckers, mobile workers and cross border populations are among most-at-risk populations. Other emerging at-risk-groups include young women who are often engaged in trans-generational sexual networks with older men in return for money and gifts. The other emerging most-at-risk groups engaged in transactional sex include domestic workers, daily labourers, and waitresses (13). However, the size and distribution of these emerging at-risk- groups, their sexual networks and bridging populations remains largely unknown, making determinations of the epidemic scope in these groups largely speculative. Moreover the involvement of these populations in the informal sex trade makes it more difficult to reach them with preventive services.



Source: PSP Ethiopia MARP Survey, 2009

While the factors for vulnerability and the degree may differ, these groups share a higher risk of HIV infection that differs from the general population. While some of these groups could be categorised as mobile populations, others fall into economically deprived groups who are likely to engage in high risk unprotected sexual practices. A recent study in selected towns showed that these high risk behaviours including unprotected sex with multiple sexual partners are prevalent among some groups such as sex workers, daily labourers, truckers, and waitresses. The study also indicated that, despite an increased risk of HIV infection observed among the groups, targeted HIV prevention is either often lacking or when available, inadequate (14).

Data on at risk-population-groups indicate higher prevalence of HIV compared to the general population. A study among sex workers in Amhara region revealed a prevalence of 11.6% to 37.0% which was considerably higher than the national urban population prevalence (15). However, due to a small sample size and non-representativeness of the study sites, these findings cannot be generalised and thus need to be interpreted with caution. Further study to better understand the full extent of the problem in different at-risk-population groups and in more geographic representative sites is warranted.

2.3.1. Commercial sex workers (Ref Indicators 1.7, 1.8, 1.9, 1.10)

Indicator	*2005*	*2008/09*
Percentage of sex workers reached with HIV prevention programme	-	42.3% (TransAction 2009)
Percentage of sex workers reporting the use of condom with their most recent client (Note: data indicated here is for paying client)	98.3% (BSS 2005)	99.4 % (DKT 2009) 96.5 % (TransACTION, 2009)
Percentage of sex workers tested for HIV in the past 12 months and know results	28.2% tested; 97.3% knew result (BSS 2005)	44.8% had test (TransACTION, 2009)
Percentage of sex workers living with HIV	-	25% (Abt, 2008)

In Ethiopia sex trade is not legal but a tolerated practice although it is considered a low profile job in the society. As a result, the number of women engaged in commercial sex is not registered and thus the exact size of the population is hard to estimate. Nevertheless, a study in Ethiopia documented that transactional and cross-generational sexual practices are common, and the size exacerbated by rural-urban migration and poverty is growing, and increasingly younger girls are joining the trade (16).

Formally engaged commercial sex workers perceive a high risk of HIV infection with paying clients thus consistently use condoms. However, condom use with non-paying partners is not as high. Unfortunately, women who are engaged in transactional sex have low risk perception; and thus are inconsistently using condoms.

An epidemiological synthesis report, citing a study in Addis Ababa, and results of a behavioural study on sex workers in several towns, indicated that an increasing number of young women are joining the sex trade with low awareness on protective methods (9). This could further increase their risk of infection (8). However, it is worth noting that over the years there is an increase in awareness and risk perception among sex workers. As a result, the proportions of sex workers reporting using condoms during their most recent paid sex has risen from just 5.3% in 1989 to 96.5% in 2009 (17, 14). However, these studies also indicate that while condom use with paying partners is high and almost universal, this is much lower with non-paying partners. With this regard, a 2009 study documented that while nearly all (99.4%) reported using condoms with their most recent paying clients (during last seven days); 86.2% reported using condoms consistently with their paying clients over the 30 days preceding the interview. However, only 65.7% and 56.3% reported doing so respectively with their most recent non-paying partners (18).

Condom use behaviour is influenced by several other factors, especially substance abuse, refusal of paying client, offer of higher payment; and instructions given by the owner of the working place

not to use condoms to comply with requests from paying customers. Other reasons cited by commercial sex workers for inconsistent condom use with non-paying partners include love and trust, objection of partners, and cost of condoms (18, 19).

Table 1 Condom use among commercial sex workers by type of clients and factors, 2009

Paying Clients in the past 7 days	**%**
Condom use	96.5
Consistent condom use	92.4
While drunk	87.6
While high on khat	77.6
Non-Paying Clients in the past 3 months	
Condom use	54.6
Consistent condom use	49.7
Condom use while drunk	57.1
Condom use while high on khat	48.5

Source: PSP Ethiopia MARP Survey, 2009

Contrary to the early days of the epidemic (20), HIV prevalence studies on sex workers in the last decade are scanty, limiting our understanding of the situation in this population group. To bridge the current gap in information, a behavioural and sero-prevalence study on sex workers has started in 2012 and results will be available in early 2013 (ENHRI).

2.3.2. Informal sex workers

While the above observation on condom use holds mainly for formal commercial sex workers in major urban sites, a recent study in Amahra region in medium and small towns show that condom use among informal sex workers, who often are engaged in transactional and cross-generational sex, and are mostly petty traders and house maids from rural backgrounds, is low. This is partly due to their lower awareness about the benefits and the unwillingness of their male clients to use them.

Young girls engaged in transactional sex have low risk perception; and thus inconsistently use condoms.

Furthermore condom use in these relationships is low because of the emotional ties with male partners and the association of condom use with commercial sex work (16).

2.3.3. Truck and inter-city bus drivers

Truck and inter-city bus drivers are among high risk groups due to their mobility and their stay away from home for long periods of time where they meet commercial sex workers in bars and hotels. However, as depicted in the below table, compared to other MARPs, truckers have high risk perception and thus consistently use condoms during their sexual relations with female sex workers, casual sex workers and even with their regular partners. Recent data on the prevalence of HIV is not available (16).

Table 2 Condom use behaviour of truckers compared to other MARPs, 2009

	Waitresses (%)	Female daily labourers (%)	Male daily labourers (%)	Truckers (%)
Regular Partners				
Condom Use	40.9	25.3	38.4	50.0
Consistent Condom Use	32.2	21.7	25.3	43.2
Casual Partners				
Condom Use	63.3	50.0	58.1	77.8
Consistent Condom Use	51.0	35.0	51.4	74.1
Sex Workers				
Condom Use	-	-	89.8	91.9
Consistent Condom Use	-	-	81.4	91.9

Source: PSP Ethiopia MARP Survey, 2009

2.3.4. HIV sero-discordant couples

The 2005 DHS data documented that the majority of couples who were HIV positive were discordant (1.8% out of a total of 2.1% of HIV positive couples), that is, one partner is infected and the other is not. In the 2011 DHS over 6,000 cohabiting couples were tested for HIV and in 0.6% both partners were HIV positive. Discordant couples accounted for 1.1% of those tested; in 0.4% of couples the male partner is positive and the female partner is negative, while in 0.7% of couples the opposite is true.

HIV sero-discordant couples are one of the highest at risk population groups. However, the magnitude of the problem and its extent in spreading HIV in Ethiopia is not well documented. Furthermore, the risk is high in societies where fear of stigma and discrimination against the HIV positive partner hinders discussion and decision on use of preventive methods. The situation is even more dire for women as they are less likely either to share their positive status or to freely ask for the HIV status of their partner due to gender, economic, and cultural barriers.

A study in Ethiopia indentified that gender-related issues, specifically fear of abandonment and divorce, and stigma following discovery of HIV positive status were cited by women as barriers for freely seeking VCT services (21). Other studies also document that even among those who are aware of the availability of prevention of mother to child transmission (PMTCT) services, many do not use them due to fear of discrimination and abandonment by their spouses and other immediate families; and dislike of being seen in VCT rooms (22).

2.3.5. Internally displaced populations and refugees

Internal displacement from conflicts, drought, floods and other humanitarian crises result in disruption of social and economic support system of families and individuals making them vulnerable to sexual exploitation and informal sex trade. Refugees, like internally displaced people, flee their home due to either war, famine or other civil strife leaving behind any social and economic support system, and thus are among the most vulnerable population groups. Inadequate health and social services in host countries, where settlement camps are often in remote border areas, further compounds their situation. Furthermore, mobility may reduce people's access to HIV prevention, awareness and treatment services, through differences in language, cultural practices and traditions. They may be forced into HIV high-risk behaviour, resulting from poverty, displacement, conflict or discrimination. Sometimes, displaced and mobile populations may be viewed as spreading HIV infection, and thus be discriminated against. However, it is important to note that HIV is transmitted through certain high-risk behaviours, not groups.

Nevertheless, studies on the impact of displacement and conflict on HIV show mixed results. A study among Sudanese refugees residing in Ethiopia revealed that sexual contact between refugee men and female sex workers from host country was frequent and the prevalence of HIV and other STIs was high (23). On the other hand, a synthesis report of research in 12 sets of refugee camps, reported that nine had a lower prevalence of HIV infection, two a similar prevalence, and one a higher prevalence than their respective host communities. This shows that there is insufficient data to support the assertions that conflict and displacement always increase HIV prevalence or refugees spread HIV infection in host communities as shown by recent data among Eritrean refugees in Tigrai (northern Ethiopia) which reported a prevalence of only 0.0% and 0.4% in 2010 in two refugees camps (24).

However, the fact that most of the refugees are women makes them economically vulnerable which could predispose them to violence and unsafe transactional sex. Recognising this fact, the UNHCR and its implementing partners in Ethiopia have a special programme on HIV prevention including IEC, condom distribution, STI treatment, VCT and PMTCT services. In 2011, the programme achieved 98% PMTCT coverage, and all HIV positive patients were screened for TB and necessary treatment and care was provided to HIV positive refugees (25).

2.3.5. People living with disabilities

People living with disabilities are among vulnerable groups of society due to their physical, mental, or psychosocial limitations which also often makes them economically disadvantaged, and among the poor, and thus less able to access health services including HIV prevention and care. Health education materials for those with hearing and sight disabilities are often not easily available. As a result, they are less informed, and hence at risk of making choices and decisions on sexual matters that, expose them to sexual violence and HIV infection. However, there are no studies to ascertain the extent of the problem in Ethiopia. The gap of knowledge on status of HIV/AIDS and factors that may predispose people with disabilities hinders the capacity of the national programme to devise targeted interventions that would address the needs of this vulnerable group. In view of this, it would be appropriate to conduct a study to assess the situation and generate information that could guide programme intervention for people with disabilities.

III National Response to the AIDS Epidemic

3.1. National Commitment and Policy Instruments

3.1.1. HIV/AIDS Policy and Strategy Development (Ref Indicator 7.1)

Indicator (Refer to NCPI 2009, 2011 for progress towards targets)	*2010*	*2011*
National commitment and policy instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination, and monitoring and evaluation)	Ref to 2010 UNGASS report	ref below Annex 1

The NCPI shows that the government of Ethiopia has demonstrated strong leadership support by creating an enabling policy environment, as evidenced by the different policies, strategies, and multi-sectoral plans on HIV/AIDS response. During the reporting period, the third strategic plan (SPM II) on intensified multi-sectoral response was developed and a road map on its implementation was finalised.

Results of the NCPI assessment indicated that the participation of civil society in HIV/AIDS prevention and control efforts has increased over the years. Most NGOs and CBOs have been involved in identifying priorities, designing, implementing and monitoring HIV/AIDS programme interventions. There are laws and policies to ensure equitable access to prevention, treatment, care and support interventions. Furthermore, there are focal points within kebeles and woredas to monitor HIV related human rights abuses and discrimination in areas such as housing and employment. However, there are no national performance indicators or benchmarks for assessing level of compliance with human rights standards in the context of HIV/AIDS efforts (Ref to Annex 1 for details).

Ethiopia has developed a comprehensive package of HIV treatment, care and support services. In fact, the HIV/AIDS programme is integrated and in part mainstreamed into national development plans including the Poverty Reduction Strategy. In line with this, the country has developed its second national multi-sectoral strategic plan (SPM II) to respond to HIV; covering the period 2010/11 to 2014/15. This strategic plan focuses on creating a programme enabling environment through capacity building, utilisation of strategic information for action, and on intensifying targeted interventions with a focus on most-at-risk-populations. Assessments indicate progress in the implementation of specific HIV prevention programmes with improved access to these programmes and services. Overall, the NCPI exercise shows that there is marked progress with respect to HIV/AIDS prevention programmes in 2011 (6.3) compared to that of 2009 (average score of 4.7 out of 10). The rating for implementation of HIV treatment, care and support programmes in 2011 showed significant progress (average score of 7.1 out of 10) compared to that of 2009 (average score of 5.9 out of 10). With respect to the efforts made in the implementation of HIV treatment, care and support programmes for OVC in 2011, the overall rating was 6.5 out of 10.

Two outstanding issues that emerged from the national assessment (NCPI) were non-inclusiveness of HIV programmes and services; and low utilisation rates of some of the existing services. Despite the observed improvements in comprehensiveness of programme design and implementation, as yet there are no specific

programmes designed for people who inject drugs and men who have sex with men. The main constraint in designing targeted programmes for these at-risk groups is lack of information on the extent and their role in the HIV epidemic. To address this gap in knowledge, studies are planned for 2012. Furthermore, although there is progress in expanding access to HIV prevention, care and treatment services; utilisation of these services, particularly for PMTCT, remains very low. Recognising this, the government has developed national strategies and implementation plans, notably, for ensuring universal access to HIV prevention, treatment, care and support, and for intensifying and scaling-up ART and PMTCT.`

In general, the NCPI found that the national HIV/AIDS programme environment can be characterised as conducive, with high political commitment, strong coordination and monitoring mechanisms, and with an increasing trend to accommodate and engage stakeholders including civil society, PLHIV, bilateral and multilateral partners. The national programme has mechanisms to periodically review its performance and identify emerging needs and gaps.

The government of Ethiopia committed itself to strengthen prevention and control activities soon after evidence of HIV/AIDS in Ethiopia. In 1998, a National HIV/AIDS Policy was endorsed by parliament. The main objectives of the policy are to encourage government sectors, non-governmental organisations, private sectors and communities to take measures in order to alleviate the social and economic impact of HIV/AIDS; and to promote proper care and support for people living with HIV and orphans. Additionally, the policy underscores the need to empower women, the youth and other vulnerable groups to take action to protect themselves against HIV/AIDS. It also stresses the rights of individuals living with HIV for access to information, preventive and care services (26). After more than a decade of implementation, the national HIV/AIDS policy is currently under revision incorporating lessons to date and new developments in HIV response including in treatment and care.

The HIV/AIDS national response has strong political support demonstrated by the existence of the national AIDS council, relevant parliamentary committees and AIDS secretariats. There are defined coordination, implementation and monitoring mechanisms with involvement at national, regional, and sub-regional levels.

In 2001, the Strategic Framework for National Response to HIV/AIDS in Ethiopia was launched. Recognising the seriousness of the epidemic and its multi-faceted impact, in 2002, the government declared AIDS as a national public health emergency. In 2002, the Federal HIV/AIDS Prevention and Control Office (HAPCO) with mandates to coordinate and lead implementation of the national HIV/AIDS policy, was established. The Federal HAPCO took a lead role in organising the National HIV/ADS Council, National and Regional HIV/AIDS Secretariats and Advisory Boards, and the National Partnership and Donors' Forum against HIV/AIDS (27). Furthermore, to facilitate implementation of the national policy, several strategies and guidelines were developed, implemented and further revised as necessary, including on voluntary counselling and testing (VCT), antiretroviral therapy (ART) and on prevention of Mother-to-Child Transmission (PMTCT) of HIV. Furthermore, a road map for accelerated access to HIV prevention, treatment and care in Ethiopia (2007-2010), and the Plan of action for universal access to HIV prevention, treatment, care and support were also developed.

The first five-year strategic plan (SPM I) was implemented from 2004-2008. Evaluation of its implementation has shown remarkable progress in expanding access to HIV services. Response capacity in the health sector was scaled-up significantly. The number of health facilities providing HIV prevention, care and support services has substantially expanded. Over 30,000 health extension workers, who play a vital role in creating public awareness were deployed throughout the country. Key to the success of this scale-up was the building of

leadership capacity in the health sector, involvement of civil societies and the community in implementation, and strengthening of monitoring and evaluation capacity. Equally important was the engagement of bilateral and multilateral partners, in the process of planning and implementation of SPM I (28).

Annual monitoring results show implementation of planned activities is on track and encouraging progress is being registered in expanding access to HIV prevention, care and support services. Nevertheless, more is desired to increase demand and utilisation of services.

In 2011, the second five year strategic plan (SPM II 2010/11-2014/15) was developed based on lessons and experiences from implementation of SPM I, and gives due consideration of the current state of the epidemic. The SPM II has five thematic areas: creating an enabling environment; intensifying HIV prevention; increasing access to and improving quality of chronic care and treatment; intensifying mitigation efforts against the epidemic; and strengthening the generation and utilisation of strategic information (29). Moreover, in 2011, a road map for implementation of SPM II was finalised, manuals on a minimum service package for orphans and vulnerable children, for Most at Risk Populations, on HIV/AIDS mainstreaming, and on partnership, and a framework for behavioural communication were developed. An annual implementation plan for SPM II for 2010/11 was finalised and implemented. Results of programme monitoring show that overall implementation of SPM II is on track (30). The above strategies, national plans and implementation guidelines incorporate managerial, technical and clinical developments accepted nationally and internationally.

In summary, the NCPI shows that the formulation of the national HIV/AIDS policy, and other national policies including on health, development, women and reproductive health, have provided opportunities for implementation of strategies in a harmonised manner. The establishment of relevant bodies and mechanisms for implementation of the multi-sectoral HIV/AIDS plan at various levels of response exemplify a high level commitment and an enabling policy environment.

3.1.2. AIDS Spending

Progress towards target 6

3.1.2.1. Resources and Expenditure (Ref. Indicator 6.1)

Indicator	*2010*	*2011*
Domestic and International AIDS spending by categories and financing source (ref tables below for details)	*Refer to NHA 2010 (covering 2007/08)*	*NA*

A total of about 120 million USD was mobilized by FHAPCO alone (56% of planned to mobilize in 2010/11); about 100 million was utilised and settled (67% of plan for the same year). According to Ethiopia's Fourth National Health Accounts, 2010 report; some regions have achieved 15% of the target for annual expenditures for health while many public sector organisations have earmarked 2% of their annual budget for HIV/AIDS response. National AIDS Spending Assessment (NASA), planned for 2012, will provide more comprehensive information.

The National Health Accounts Survey indicated that national HIV/AIDS expenditure amounted to USD$248,000,114 in 2007/08. This was the largest spending on a specific disease in the country accounting for more than 20% of total spending in the health sector. The bulk of this, i.e. 84%, was from external sources, while government spending constituted 11% of the total expenditures. Out of pocket expenditures for HIV diagnosis,

treatment and care accounted for 3.5% of the total expenditures. In fact, PLHIV shoulder the brunt of expenditures, spending more than five-folds of the amount the general population spent on healthcare. Other sources, including private sector and local NGOs accounted for 1% of the expenditures (31). While the trend most likely remains unchanged, the planned NASA for 2012 will provide more detailed information on the current status of expenditure.

During the reporting period, the government has made tremendous effort to mobilise resources for the implementation of the first year plan of SPM II. As a result of the continued commitment of stakeholders and their active engagement in responding to the epidemic, 56% of the proposed budget (about USD$120 million) was mobilised by FHAPCO alone (30). The resource mobilised by stakeholders was even more significant considering the global economic downturn.

Major donors and sources of HIV/AIDS funding in the country, among others, include the Global Fund, the US Presidential Emergency Program for AIDS Relief (PEPFAR), the World Bank (phased out in 2011) and the UN system. The National AIDS Spending Assessment (NASA), to be conducted in 2012, will fill the existing information gap on actual HIV/AIDS expenditure for 2010 and 2011.

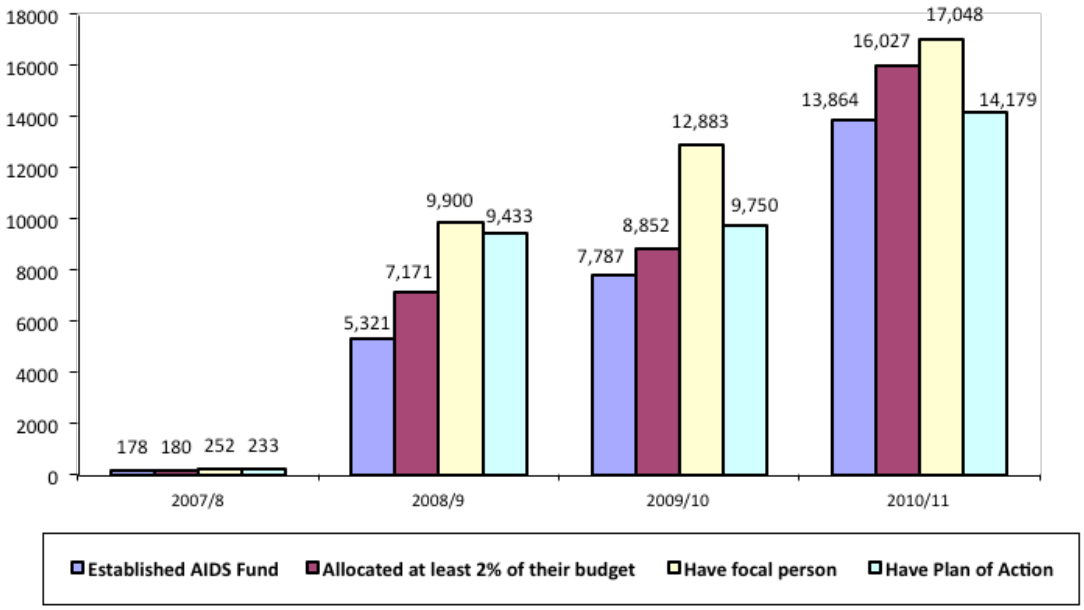
3.1.2.2. Mainstreaming of HIV Programme (Indicators 6.1, 7.1)

While most of the funding for HIV/AIDS is donor-assisted, it is worth noting that of late the Ethiopian government has taken steps to integrate HIV/AIDS into public sector organisations work plans. The purpose of this mainstreaming is to ensure continued funding, and financial sustainability, for programmes that aim to protect employees from HIV and to ensure provision of treatment, care and support for the already infected and affected employees and their families; and to contribute to prevention efforts and minimise the vulnerability of the community in which the organisation functions. To this end, more and more public sector organisations have committed up to 2% of their annual budget for HIV/AIDS programme implementation. Moreover, several public organisations have also established AIDS funds and collect 0.5% of staff salaries to support employees and their families affected by HIV/AIDS (30).

Bridging funding gaps. Health in general and the response to the HIV/AIDS epidemic is a national priority as evidenced by steadily increasing health expenditure: some regions have allocated 15% of public expenditure; public and some private sector organisations have earmarked 2% of their annual budget for the HIV/AIDS response.

Furthermore, workplace HIV/AIDS interventions including education and communication have also been initiated in several private sector institutions. In 2010/11, a total of 1,049 private organisations had allocated up to 2% of their annual budget for HIV/ AIDS activities. In addition to those which have incorporated a HIV/AIDS programme budget to their annual plan, several organisations have planned and implemented workplace interventions. These include workshops, dissemination of IEC/BCC materials, counselling, and condoms distribution (30). This trend depicts increasing local ownership of the HIV/AIDS response efforts over the years.

Figure 5 Mainstreaming of HIV to Government Organisations, 2011



Source: Federal HAPCO

3.2 Programme Implementation

3.2.1. Prevention

Progress towards target 1: Reduce Sexual Transmission of HIV by 50% by 2015

3.2.1.1. Reducing transmission among general population (Ref. Indicators 1.1, 1.2, 1.3, 1.5)

Indicators	***DHS 2005***	***DHS 2011***
Young women and men 15-24 years who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	W=20.5% M=33.3%	*W=23.9%* *M=34.2%*
Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 years	W= 15.8% M= 1.7%	*W=10.9%* *M=1.2%*
Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 month	*W=0.2%* *M=4.1%*	W=0.5% M= 3.5%
Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results	W= 1.9% M= 2.3%	W= 20.0% M=20.7

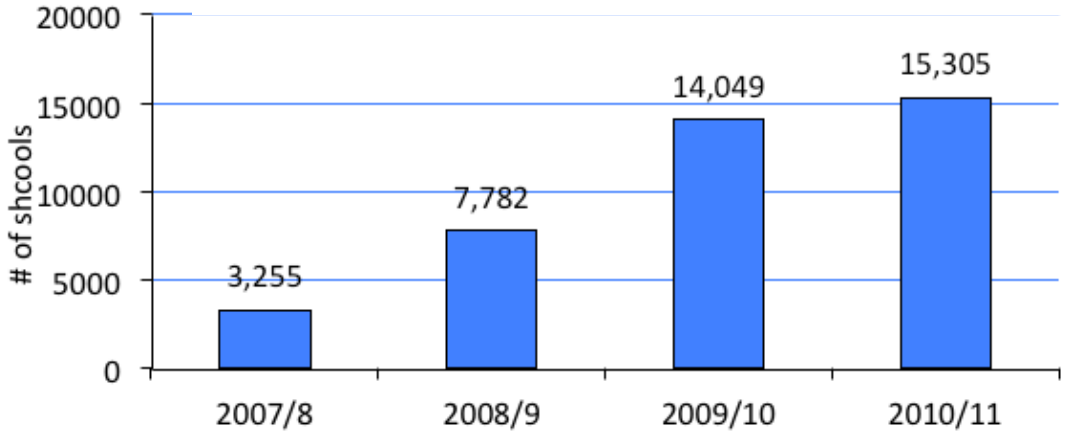
Knowledge and behaviour

According to DHS 2011 results, 23.9% of women and 34.2% of young men aged 15-24 years correctly identify methods of HIV prevention and reject common misconceptions about HIV transmission. 10.9% of young women and 1.2% men aged 15-24 had sexual intercourse before they reached 15 years of age. Less than 1% of women and 4% of men between 15-49 years had intercourse with more than one partner in one year period.

Behavioural Change Communication is one key strategy to reduce the risk of sexual transmission of HIV/AIDS through promotion of abstinence, having one sexual partner, and use of condoms. Recognising this, the Government of Ethiopia has been engaged in intensifying public awareness and behaviour change communication activities. To this end, several communication methods and events such as social gatherings, mass media (radio, television, and newspapers), posters and billboards, leaflets and brochures and peer education were employed to disseminate information to the public. The government has scaled-up HIV prevention efforts by promoting community, workplace and school-based IEC/BCC activities.

Furthermore, prevention of sexual transmission of HIV among youth was given due emphasis in the fight against the HIV epidemics. One important strategy was creating awareness among youth through information and communication. To this end, schools were supported to establish school HIV/AIDS clubs, HIV/AIDS was incorporated to school curricula, and school conversation programmes were organised. As a result, over the past four years, school community conversations were implemented in all regions of the country. While in 2007/8, there were 3,255 schools which had organised school community conversations, in 2010/11 the number of schools which organised such activities quadrupled (30). This achievement indicates the potential to reach schools universally as per SPM-II target by 2015.

Figure 6 Trend of covergae of schools with community coversation, 2007/8 - 2010/11



Source: Federal HAPCO

Likewise, community-level and workplace social mobilisation activities, aimed at improving awareness and knowledge on prevention of HIV/AIDS were conducted in collaboration with local administrations. In 2010/11 alone, 89% of local administrative units in the country have successfully conducted community conversations. In addition, 65% of the local administrative units have developed a plan of action on the priority issues that came out of the completed community conversation cycles (30).

The above concerted efforts on empowering the general public and the youth through various communication strategies and channels have contributed to improve knowledge on prevention of HIV infection. As a result, the latest DHS data show that awareness is almost universal with 97% of women and 99% of men having heard about HIV/AIDS. Knowledge of HIV prevention methods has also somewhat increased. In 2005, only 35 percent of women knew that HIV could be prevented by using a condom

and by limiting sexual partners. This has increased to 43 percent in 2011. Among men aged 15-49 years, there was slight increase, from 57 percent in 2005 to 64 percent in 2011. However, regional variations with regard to knowledge, attitude and behavioural patterns do exist, as functions of the varying socio-economic and cultural factors as well as other forces. Analysis shows urban residence and educational levels were positively associated with appropriate knowledge about HIV prevention methods (11, 12).

Adolescents and Young people

Several studies document that young people have high risk taking behaviours including as a result of peer pressure, ignorance and lack of access to preventive services. A review of research work among in-school-youth and out-of-school-youth documented that 49.7% were sexually active; and more than half of these (53.3%) reported two or more sexual partners (32). A study among Addis Ababa University students revealed that 34.2% of respondents were sexually active during the survey. Of these, 23.8% had sexual intercourse with their partner or someone in the last 6 months. The study also identified watching pornographic films; alcohol, chewing khat (a mild stimulant locally grown green leaf), and cigarette smoking were associated with risk taking behaviour (33). Similarly, a study among high-school students in northwest Ethiopia documented that a quarter of the study group had previous sexual intercourse and were exposed at least to one risk behaviour (34).

Similarly, a study among out-of-school youth documented that high risk taking behaviour is prevalent. Among those who are sexually active, 33% had sexual intercourse with non-regular partners (40.6% among males and 24.7% among females, indicating that males were more likely to have sex with non-regular sexual partners than females). Furthermore, consistent condom-use among those who had sex in exchange for money was low, only 36%. Alcohol intake, chewing of khat, low educational background, and being male were significantly associated with having sex with either a commercial or a non-regular sexual partner (35).

As a result of these risk taking behaviours and limited awareness of prevention methods, adolescents and young people are vulnerable to HIV infection. However, ANC sentinel surveillance showed a declining trend in HIV prevalence, from 5.6% in 2005, to 3.5% in 2007, and 2.6% in 2009 among pregnant women 15-24 years of age (7).

High risk taking behaviour is often attributed to inadequate knowledge on risk of HIV infection and prevention methods, which in turn lead to low risk perceptions. With this regard, studies conducted among young people on status of their HIV knowledge and behaviour show mixed results. While most in-school and out-of school youth have heard about HIV/AIDS there are still high levels of misconceptions about the modes of transmission, methods of HIV prevention, and high risk taking behaviour.

While the concerted efforts during the last several years have made significant contributions in improving knowledge on HIV transmission and prevention, several studies document that risk taking behaviour among the general public and youth is still prevalent. In fact, research and DHS data show that a significant proportion of adults and young people do have risky behaviours such as inconsistent use of condoms (11,12). There is a need for more sustained effort and designing targeted and innovative approaches to increase risk perception, especially among youth. The observed low risk perception despite almost universal comprehensive knowledge in the general public, calls for more in-depth behavioural studies to understand the missing link in translating acquired knowledge to safe practice. Recognising the need to do more in reducing new infections, SPM II has set targets to reduce incidence by half by 2014/15 (29).

Condom promotion and distribution (Ref Indicators 1.4)

Indicators	*2010*	*2011*
Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report use of condom during their last intercourse	--	W= 47.0% M= 15.5%

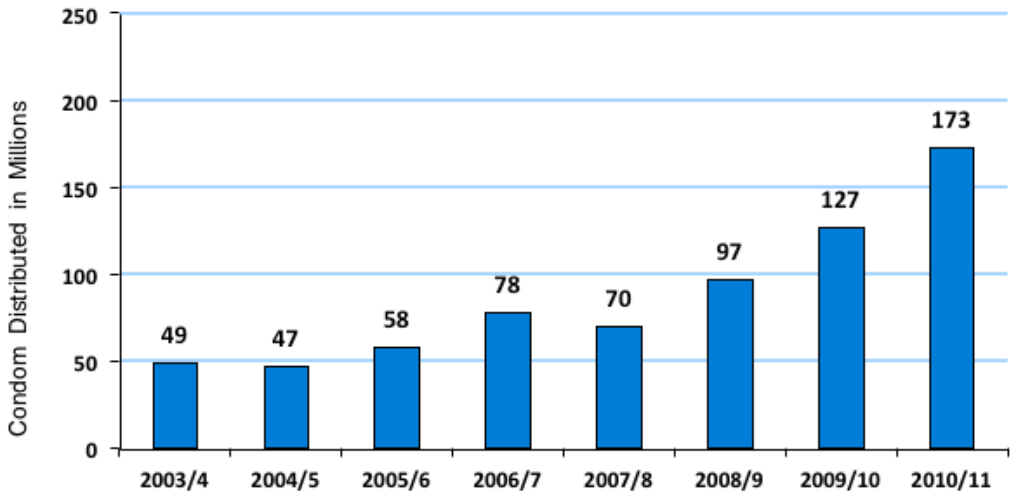
Results from DHS 2011 show that 47.0% of women and 15.5% of men between 15-49 years who had more than one sexual partner during the 12 months preceding the survey reported using a condom during their last intercourse. A total of 173 million condoms were distributed, an increase by 46 million from the preceding year.

Consistent and correct use of condoms is one of the interventions to reduce the risk of HIV infection, especially among high risk groups, such as commercial sex workers, and others who have multiple partners, and discordant couples. As part of the prevention strategy, sustained efforts were made to increase awareness and increase availability of condoms through social marketing. As a result, there is evidence of increased demand and use of condoms by most-at-risk populations (MARPs) such as commercial sex workers and their clients, uniformed forces, discordant couples, migrant workers and truck drivers.

Using condoms, yet not enough. There is evidence of a growing demand, and hence steady increase in social marketing of condoms. Yet, the proportion of at risk populations using condoms during last sexual intercourse remains low. Therefore, more is required to ensure consistent and appropriate condom use to reduce the risk of sexual transmission of HIV.

To meet this increasing demand, through a social marketing approach, the number of condom outlets has increased. This has led to an increasing trend of condom distribution, with a sharp increase from just 50 million in 2003/4 to 127 million condoms in 2009/10. Compared to 2009/10, 46 million additional condoms were distributed during 2010/11, reaching 173 million. However, the achievement in the overall distribution of condoms during the budget year amounts to only 46% of the SPM II target set for the year 2010/11 (30).

Figure 7 Trend of condom distribution, 2003/4 - 2010/11



Source: FMOH, Performance monitoring and evaluation reports

3.2.1.2. Reducing HIV transmission among commercial sex workers (Ref Indicators 1.7, 1.8, 1.9)

Indicator	*2005*	*2008/09*
Percentage of sex workers reached with HIV prevention programme	-	42.3% (TransAction 2009)
Percentage of sex workers reporting the use of condom with their most recent client (Note: data indicated here is for paying client)	98.3% (BSS 2005)	99.4 % (DKT 2009) 96.5 % (TransACTION, 2009)
Percentage of sex workers tested for HIV in the past 12 months and know results	28.2% tested; 97.3% knew result (BSS 2005)	44.8% had test (TransACTION, 2009)
Percentage of sex workers living with HIV	-	25% (Abt, 2008)

During the early phase of the epidemic in Ethiopia, much of the surveillance and survey data were mainly targeted at commercial sex workers (20). These studies, which were primarily conducted in major urban centres and along the main trading routes of the country, showed very high infection rates. As a result, prevention of sexual transmission of HIV was focused among this group and their clients-mainly truckers and inter-city bus drivers. These interventions include IEC/BCC, condom promotion, and counselling and testing services. As the epidemic stabilised and spread to the general public, the interventions were more comprehensive and directed to the general public, though prevention programmes to reach most-at-risk populations including commercial sex workers and youth groups also continued.

The sustained national effort has resulted in high self-risk perception leading to use of preventive services, especially consistent condom use, by commercial sex workers with their paying clients. With this regard, BSS 2005 revealed that condom use during the most recent sex among sex workers has not only increased significantly since 2002, but has reached almost universal (10). This positive trend is presumed to result in a lower incidence of HIV infection among sex workers and their clients. But, absence of recent HIV prevalence data makes this assumption difficult to prove.

3.2.1.3. Reducing sexual transmission among men having sex with men (Ref Indicator 1.11, 1.12, 1.13, 1.14)

Indicator	**2010**	**2011**
Percentage of men who have sex with men reached with HIV prevention programmes	*N/A*	*N/A*
Percentage reporting use of condom last time they had anal sex with male partner	*N/A*	*N/A*
Percentage of men who have sex with men who have received HIV test in the past 12 months and know their results	*N/A*	*N/A*
Percentage of men who have sex with men who are living with HIV	*N/A*	*N/A*

Currently, there are no specific programme interventions designed for men having sex with men; nor is the extent of this practice in Ethiopia well known as reliable data are not available. However, a study is planned for 2012 and results will be available in early 2013.

A 2008 study documented that the practice of homosexuality remains largely not only a taboo and a secret not discussed in public, but also condemned by the public. The study revealed that although MSM are emerging as an at risk population group; no prevention efforts were made to target them (36). In fact, the degree of the practice of men having sex with men (MSM) in Ethiopia and its importance in the spread of HIV infection remains largely unknown. In view of the gap in information in Ethiopia, a study has started in 2012 and results are expected by early 2013.

3.2.1.4. Prevention of HIV transmission among people who inject drugs

Progress towards Target 2 (Ref Indicator 2.1- 2.5)

Indicator	2010	2011
Number of syringes distributed per person who injects drugs per year by needle and syringe programs	*N/A*	*N/A*
Percentage of people who inject drugs who report the use of condoms in their last sexual intercourse	*N/A*	*N/A*
Percentage of people who inject drugs who report using sterile equipment the last time they injected	*N/A*	*N/A*
Percentage of people who inject drugs who have received HIV test in the past 12 months and know their results	*N/A*	*N/A*
Percentage of people who inject drugs who are living with HIV	*N/A*	*N/A*

Currently, there are no specific programmes targeted at people who inject drugs, nor is the extent of the practice and its role in HIV epidemic well documented. To bridge this gap in information, a study to understand the extent of the problem and its role in the spread of HIV infection is underway and results will be available in 2013.

People who inject drugs, particularly those using unclean and shared needles, are at high risk of blood-borne infections, including HIV. Studies have well documented that the rate of HIV infection is much higher among these population groups. There are several indications that substance abuse is a growing problem in Ethiopia. But, much of the available literature is largely on use of alcohol and khat. Literature on the magnitude of injectable drug use and its role in the spread of HIV infection in Ethiopia is not available. As a result of the current gaps in information, there are no specific interventions designed for prevention of HIV transmission among this group. To address this, a study is planned for 2012 and results are expected at the end of the year.

3.2.1.5. Blood Safety

During the reporting period, 47,539 units of blood were collected, 100% were tested for HIV, 98.4% were negative for HIV and distributed for use.

The national policy on blood transfusion is to ensure mandatory testing of every unit of donated blood for HIV. The National blood bank, under the Federal Ministry of Health (FMOH), with strong technical support from Red Cross Society, coordinates the blood safety programme in Ethiopia. Currently, 12 blood bank centres exist in different parts of the country.

In 2008/9 a total of 38,245 units were collected out of which 799 (2.1%) were HIV positive and thus discarded. In 2010/2011, a total of 47,539 blood units were collected, all samples were tested (100%); out of which 750 (1.6%) tested HIV positive and thus were discarded (30). This declining trend of HIV positivity among blood donors was consistent with findings of a recent study in northwest Ethiopia. The study documented sero-prevalence of HIV among donated blood samples was 5.0% in 2003, then decreased to 3.6% in 2004, and slightly increased to 4.0% in 2005 but subsequently decreased to 3.2% in 2006 and 3.1% in 2007 (37).

3.2.1.6. Prevention of Mother-to-Child Transmission of HIV

Progress towards Target 3 (Ref. Indicators 3.1, 3.2, 3.3)

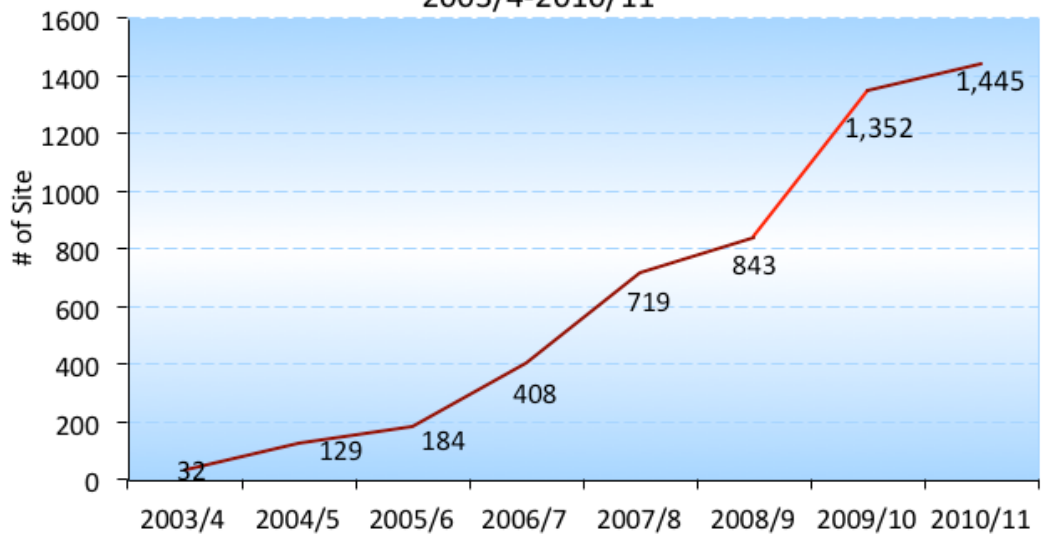
Indicators	***2010***	***2011***
Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	7844	10,302/42,900 =24%
Percentage of infants born to HIV-infected mothers receiving virological test for HIV within 2 months of birth	N/A	11% (4,753/ 42,900)
Mother-to-child transmission of HIV (modelled)	N/A	17% at 6 weeks 30% including breastfeeding (13,000/42,900) (EPP/Spectrum)

The number of facilities providing PMTCT services reached 1,445. However, less than a third of all estimated eligible pregnant women (24%), were provided with ARV prophylaxis to prevent mother-to-child HIV transmission.

In 2001, Ethiopia developed a national guideline on Prevention of Mother-to-Child Transmission (PMTCT) of HIV infection. This was further reviewed and updated in 2007 and 2010 incorporating latest managerial, technical and clinical developments accepted nationally and internationally. The guideline adopts the PMTCT strategy of WHO/UNICEF/UNAIDS emphasising primary prevention of HIV infection, prevention of unintended pregnancies among HIV infected women, prevention of HIV transmission from infected women to their infants, and treatment, care and support of HIV infected women, their infants and their families. Most recently, a revised strategy for accelerated implementation of the PMTCT programme was endorsed (38).

In the last several years there has been progress in implementation of PMTCT services through integration to ANC clinics which are also provided free of charge. As a result, the number of facilities providing PMTCT services has increased from 32 in 2003/4 to 1,352 in 2009/10; and reached to 1,445 by the end of June 2011. This is an increase by nearly 4 fold in the last 5 years and forty-five increase over the last ten years (30).

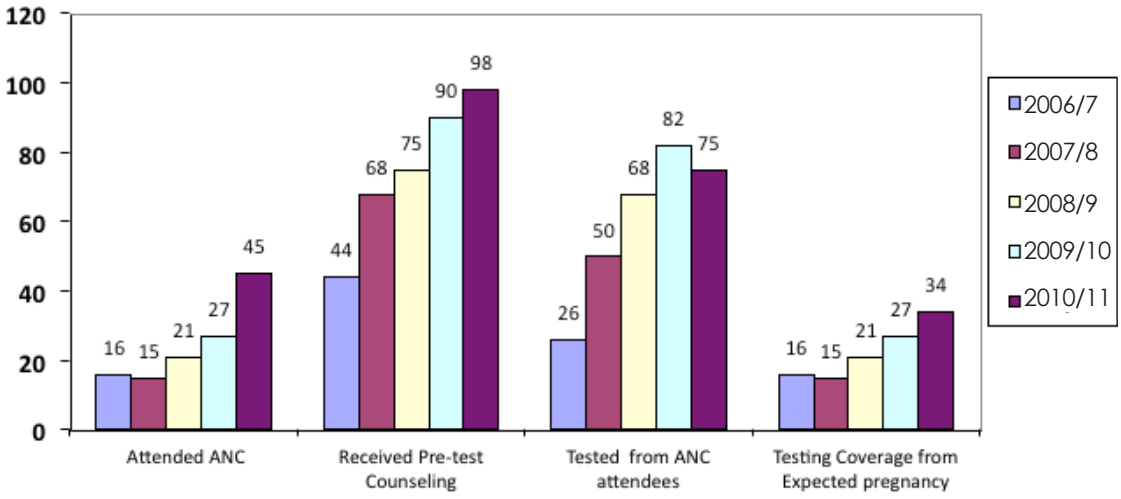
Figure 8 PMTCT Services Site Expansion 2003/4-2010/11



Source: Federal HAPCO

Along with the expansion of services, the number of pregnant mothers who receive PMTCT services has also increased. For example, the number of pregnant mothers who received pre-HIV test counselling has increased from 711,341 in 2009/10 to 1,261,752 by the end of June 2011. Of the total pregnant women who received ANC services in health facilities which also provide PMTCT services, 79% tested for HIV, and overall the coverage of HIV testing out of the total expected pregnancies increased from 16% in 2009 to 34% in 2010 (30). Furthermore, during 2011, a total of 10,302 HIV positive pregnant women received ARV prophylaxis for PMTCT. However, overall coverage of PMTCT still remains as low as 24% of the expected eligible population (EPP/Spectrum estimates 2011).

Figure 9 Percentage of pregnant women attending ANC and receiving HIV testing, 2006-2011



Source: Federal HAPCO

Notwithstanding this remarkable expansion, a significant number of healthcare facilities still do not avail PMTCT in their package to their clients. Low coverage of PMTCT services has been a consistent problem. While 82% of women accessed ANC services at least once during their most recent pregnancy, PMTCT services were available only in 54% of all facilities. Furthermore, even in those facilities where PMTCT services are available, there are many missed opportunities as a significant proportion did not use available services. In fact, performance data show that while 98% of pregnant women attending ANC clinics providing PMTCT services were 'counselled'; a quarter were not tested for HIV, and even among those who were HIV positive, 60% were not provided with ARV prophylaxis for PMTCT (38).

Missed opportunities. ANC facilities have fast increased, so have those providing PMTCT services- a remarkable achievement! But, only a low proportion of those attending ANCs receive ARV prophylaxis. A down-ward cascade of events leading to far too many missed opportunities.

Recognising these challenges, in 2011, the government developed an accelerated plan to guide programme implementation and coordination which is intended to rapidly increase service provision sites, improve quality of services, and increase demand, and ultimately service utilisation. The goal is to provide ARVs for PMTCT to 85% of eligible pregnant women by 2015. To rapidly expand PMTCT service facilities, the government has developed a rollout plan comprising systematic preparation, planning, capacity building, strengthening logistics and supply, coordination of concurrent activities at national, regional and woredas/ district levels. Furthermore, efforts to create demand will be enhanced including through deployment of community-based health workers. Likewise, focus will be on improving service quality by instituting structured quality improvement framework complemented by regular supportive supervision and monitoring and evaluation (38). On the same line, the five-year strategy for intensifying multi-sectoral response underscores the need for concerted effort to address current gaps in prevention, treatment and care, including strengthening PMTCT services (39).

3.2.2. Treatment and Care

Progress towards Targets 4 and 5

3.2.2.1. HIV Counselling and Testing (Ref Indicator 1.5)

Indicator	***2010 DHS 2005***	***2011 DHS 2011***
Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results	W= 1.9% M= 2.3%	W= 20.0% M=20.7%

During the reporting period, the number of HCT sites has reached 2,309 (125 newly started in 2010/11). A total of 9.4 million people received counselling and testing. Among these, 125,511 people (1.3%) were HIV positive, of which 66,592 (1.6%) were females and 50,352 (1.1%) were males.

HCT is an important entry point to achieve improved access to HIV prevention, treatment and support services. For those who test HIV negative, the knowledge of their HIV status and the post-test counselling may be sources of motivation to reduce their risk of exposure to HIV so that they stay negative. For the others who test HIV positive, knowing their results will help to prepare themselves for a positive living, as well as for timely initiation of HIV care and timely treatment.

HIV counselling and testing (HCT) services were started in Ethiopia following the endorsement of the national AIDS policy in 1998. The first National Guideline on HCT was developed in 2000. This was further revised, and a national plan of action to increase access to HIV services was developed in 2007 incorporating recent developments in HIV/AIDS care; and emphasising universal access to prevention, treatment, care, and support services (40). Accordingly, over the past years, the health sector response to HIV focused on scaling up HTC services to new sites and strengthening existing ones to provide optimal services at all levels. This national effort was guided by the Strategic Planning on intensifying multi-sectoral response to HIV/AIDS. Reviews of SPM implementation show that nearly all regions in the country are on track to meet the SPM II targets of service expansion. During 2011 alone, 125 health facilities have newly begun the provision of HTC services. As a result of the sustained national effort, the number of HCT sites has expanded rapidly: from just 658 in 2004/5, to a sharp increase reaching 2,184 in 2009/10, and 2,309 in 2010/11 (29, 30).

The rapid expansion of HCT services both at public and private facilities have resulted in a sharp increase in the number of people who had HIV tests from 5.8 million in 2009/10 to a record 9.4 million in 2010/11. The results show that among the 9.4 million tested, 1.3% were HIV positive (1.1% for males; and 1.6% for females) 30). The observed increase in the number of HIV tests is consistent with the findings of DHS 2011 which also documented more than 20% of the adult population tested for HIV in the previous year and may account for the high ART coverage in adults (12).

3.2.2.2. Antiretroviral Therapy (Ref. Indicator 4.1, 4.2)

Indicators	2010	2011
Percentage of adults and children currently receiving antiretroviral therapy	209,360 13,000	249,174/289,900= 86% (CD4 cutoff< 200) 16,000/82,100*=20% (WHO 2007 guidelines)
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	72.5% (ART Scale up, 2009)	-

*The large number of children that live with HIV appears to be overestimated. This is possibly due to the low coverage of PMTCT in the past years, the high breast feeding practice in the country and the high survival rate of children even without ART (20% of children with HIV are assumed to live up to 15 years without ART). Nevertheless, this estimate will be further refined as more evidence becomes available.

During the reporting period, a total of 333,434 people had ever started ART. There were 249,174 adults (86% of eligible) and 16,000 children currently on treatment (20% of eligible) by the end of 2011.

The discovery of antiretroviral therapy (ART) was a breakthrough in reducing mortality and improving the quality of life of PLHIV. Today, antiretroviral therapy (ART) has become an integral part of the continuum of HIV prevention and care.

Recognising the benefits, the Ethiopian government has made concerted and sustained effort over the last several years to introduce and scale-up counselling and testing services and use of antiretroviral drugs both for treatment and prophylaxis. A National Guideline on the use of ARV drugs was developed and the Antiretroviral Treatment (ART) programme was launched in 2003. Subsequently, in 2004, a free ART programme was initiated in three government hospitals in Addis Ababa. Since then the geographic distribution and number of centres providing ART services have increased. These efforts have led to marked increase in the number of health facilities and sites providing HIV treatment and care services. While there were 550 facilities providing ART in 2009/10, this reached 743 public and private health facilities in 2010/11 fiscal year (41).

Furthermore, mainstreaming of HIV/AIDS within many public sectors, non-government and private sector organisations have contributed to improve awareness, increase access and utilisation of HCT and ART. As a result of this rapid expansion of service facilities and improved awareness, the number of patients on ART rose sharply over the years to reach 333,453 in 2010/11 (42). However, in some regions 40% of patients who were enrolled to ART dropped out from treatment; a situation that requires serious attention (30).

Overall, with the increase and fast expansion of facilities providing ART, coverage has increased over the years. As a result, currently the ART coverage for adult populations is high (86% of estimated eligible) for a CD4 cutoff less than 200. However, the coverage of children is low (only 20% of estimated eligible) and this requires further attention to identify possible factors for low performance and develop strategic actions to improve coverage rates.

3.2.2.3. Management of TB-HIV co-infection (Ref. Indicator 5.1)

Indicator	*2010*	*2011*
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	40.6% (FMOH 2009)	39% of identified TB cases and HIV positive (FMOH /WHO 2011)

Approximately 41% of identified HIV positive new cases of TB had received treatment for TB and HIV in 2009/10. Data for 2010 shows that 43% of notified TB patients were tested for HIV, 15% had HIV co-infection. Among the identified HIV positive TB patients, 69% were given co-trimoxazole prophylactic therapy, while 39% were given ART. On the other hand, 44% of HIV positive clients were screened for TB and 6.6% of HIV positive people were provided with isonized prophylactic therapy (43).

HIV/TB co-infection increases the risk of developing active disease, re-infection and relapses. People living with HIV who are co-infected with TB are more than twenty times more likely to develop TB diseases compared to those who are HIV negative. As a result, tuberculosis is often the commonest infection and leading cause of death among PLHIV. Globally in 2010, there were an estimated 0.35 million deaths from TB among people living with HIV. To reduce these avoidable deaths the global TB partnership set a target to halve the mortality rate by 50% by 2015. To help countries achieve the target, it is recommended that collaborative TB/HIV activities are intensified. The recommended interventions, among others include, HIV

testing of TB patients, provision of ART and co-trimoxazole preventive therapy (CPT), intensified TB case finding and isonized preventive therapy for PLHIV who do not have active TB disease (44).

Cognizant of the need to tackle HIV and TB together, Ethiopia has started implementation of joint TB-HIV activities including testing and treatment of active TB cases among HIV positive people. The Federal Ministry of Health of Ethiopia in collaboration with its development partners has prepared a guideline on standardising and maintaining quality of TB/HIV services. Furthermore, a guideline for integrated management of TB and HIV was developed (43).

3.2.3. Impact alleviation

Progress towards Target 7

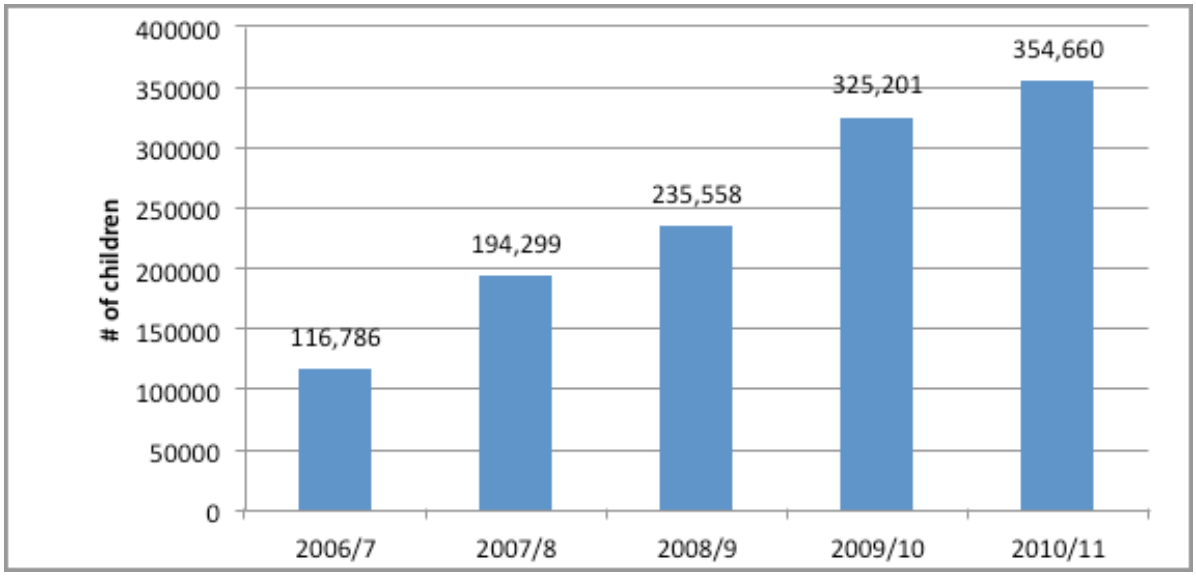
3.2.3.1. Care and Support to orpahns and vulnerable children (Ref Indicator 7.3)

Indicators	20010	2011
Current school attendance in orphans and non-orphans aged 10-14 years	N/A	N/A

This constitutes education, food, shelter, and financial support to orphans and vulnerable children (OVCs) and people living with HIV (PLHIV). One of the main impacts of HIV/AIDS in Ethiopia is the growing number of childen whom either one or two parents have died from the epidemic (EPP/Spectrum estimates for 2011 estimate orphans due to AIDS at about 952,700). The total number of orphans are estimated at 4.6 million. These children are left vulnerbale at the time of their greatest need due to loss of family support.

To alleviate the problem faced by orphans and vulnerable children, the government in coordiantion with various international and local organisations continues to provide financial and material support, including for education. In 2010/11, a total of 354,660 OVC received educational support, more than double the number during 2006/2007 (30).

Figure 10 Educational Support to Orphans and Vulnerable Children, 2006-2011



Source: Federal HAPCO

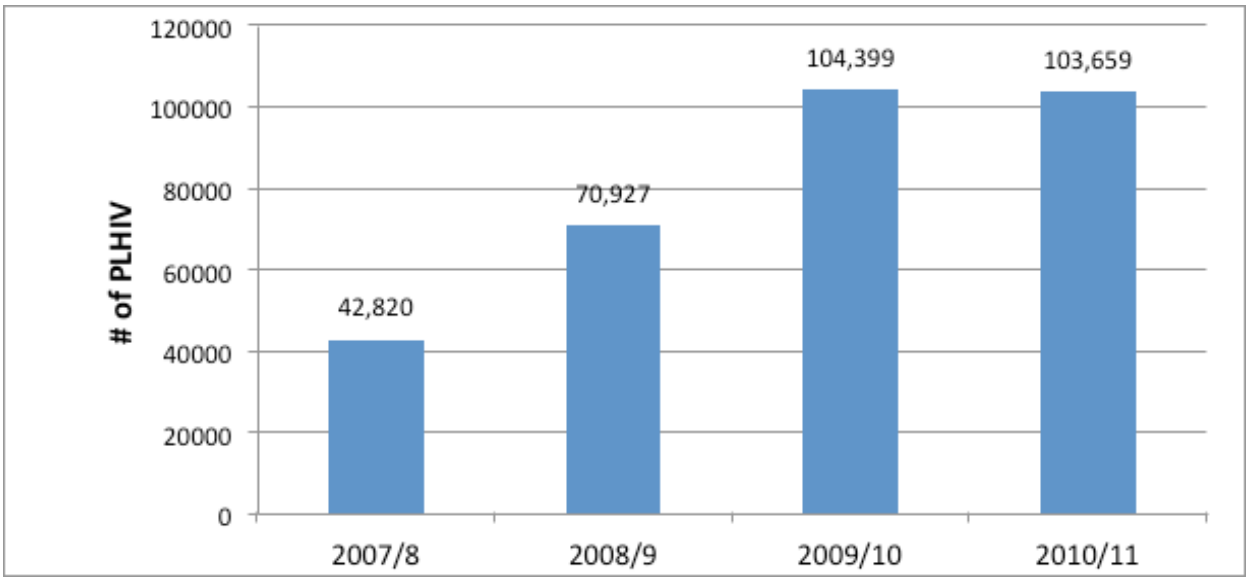
The number of children who received food and shelter support has also increased from 104,399 in 2009/10 to 251,505 by the end of June 2011. Furthermore, a total of 43,256 orphans and vulnerable children received training on income generating activities, out of them, 37,209 received startup capital (30). However, considering the total number of needy children, the support provided is far from adequate. To address this gap, the government has taken an initiative to mobilise communities tp provide necessary support through a community-based approach-where support is provided through adopting extended families. This approach has dual benefits- it provides material supoort with much needed pyschosocial support from extended families and community members.

3.2.3.2 . Support to poor people living with HIV (Ref Indicator 7.4)

Indicator	2010	2011
Proportion of the poorest households who relieved external economic support in the last three months	NA	NA

In 2010/11, the number of poor peope living with HIV who received food support increased from 70,927 in 2008/09 to 103,659 by the end of June 2011. Moreover, 56,300 PLHIV received training on income generating activities, and 36,028 received initial capital. HAPCO has also supported a network of people living with HIV and provided economic support to those affected by the epidemic.

Figure 11 Trend of Food Support for PLHIV, 2007-2011



Source: Federal HAPCO

3.2.3.3. Eliminate Gender-based Violence (Indicator 7.2)

Progress towards target 7:

Indicator	*2010*	*2011*
Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male partner in the last 12 months	*N/A*	*N/A*

While there are no nationally representative data on violence against women, research data indicate it is prevalent as was shown by a community-based study which documented that 55.0% of women had at least once in the past 12 months experienced violence by an intimate partner.

Gender-based violence is often used interchangeably as violence against women (VAW) since women are disproportionately affected than men. Violence against women which could be expressed in the form of physical, sexual or psychological harm or threats also deprives women their rights including on reproductive choices. Sexual violence increases the risk of sexually transmitted infections and HIV. Violence against women has its roots with gender disparities where women play a subordinate role in decision making at household and community level. The most common and universally occurring form of VAW is that perpetrated by a husband or other intimate partners. A community-based study conducted in 2011 documented that 61.6% of the women had experienced at least one incident of sexual violence in their lifetime and 55.0%, had done so at least once in the past 12 months (45). Gender disparities play an important role in access to basic services such as healthcare and education. As such, gender is an important determinant to health status. Women in developing countries, in most cultures, have limited decision-making power. Societal expectations for female modesty and propriety exclude an open and frank discussion or exchange of information (46, 47). Women's position in gender and sexual relations in Ethiopia is characterised by their relative lack of power compared to men (48). As a result, most women remain ignorant and passive about sexual matters, including on sexually transmitted diseases and HIV/AIDS (45, 49).

While the proportion for both sex groups still remains relatively low, recent national survey showed that, a lower proportion of women than men have comprehensive and correct knowledge about HIV/AIDS and related issues (50). This was consistent with the latest DHS 2011 findings which documented that only 23.9% of females aged 15-24 years compared to 34.2% of men 15-24 years had comprehensive knowledge of HIV (12). Furthermore, traditional practice of marriage with elder men not only increases young women's risk of infection, but also hinders the chance of open discussion on sexuality and reproductive health issues (48). Vulnerability of women and girls to HIV infection results from biological, social, cultural, economic, legal and other factors that adversely affect their capacity to protect themselves from the risk of HIV infection. Furthermore, lack of access to relevant HIV prevention, treatment and care services and information places girls and women at increased risk of infection (51). In traditional societies like much of Ethiopia, early marriage and young age at sexual debut (often with much older and sexually experienced males), lack of information on prevention and absence of decision making rights on their sexual and reproductive choices, make females vulnerable. While young people in general are vulnerable, girls and young women have a much higher prevalence, amply demonstrating that while young people are more at risk, young women are much more so compared to their male counterparts.

As a result of the above complex factors, women are at higher risk of HIV infection. Comparison of HIV prevalence data from blood donors, factory workers, police recruits and community-based studies have documented that females have a higher prevalence (8). Similarly, data from DHS showed that the difference was more marked among urban populations (female/male ratio of 3.2), but there was no difference among rural communities (12).

Gender disparity also negatively influences health seeking behaviour (51). A study in Addis Ababa documented that gender inequality at the household level where women felt the need to have their husbands' consent was an important barrier to access and use of PMTCT services. Women who felt the

need for obtaining their husbands consent were less likely to accept HIV testing than those who do not; while most pregnant women who accepted HIV testing had to obtain their partners consent before doing so. A study showed women often refuse enrolment to PMTCT programmes and HIV testing; and discontinue ART because of fear of revealing their HIV status to their husbands (52). Conversely, another study showed that women who discuss with their husbands or spouses were more likely to seek PMTCT services compared to those who do not discuss with their spouses (53).

The government of Ethiopia, cognizant of the need to redress the social inequities that exist among gender lines has endorsed women and reproductive health policies. On the same line, the national poverty alleviation and growth and transformation strategic plans place women empowerment as an essential prerequisite for social development (refer to national policies on women, reproductive health, and strategic plans).

IV Best practices

Coordination of partners and various stakeholders

The Federal HAPCO successfully coordinated regular meeting of national and international stakeholders including bilateral and multilateral/UN organisations and regional HIV/AIDS Secretariats. Furthermore, the Federal HAPCO organised several coordination meetings of The National HIV/AIDS Prevention Task Force, the M&E Task Force, the National Partnership Forum, the Task Force of Orphans and Vulnerable Children, the Behavioural Change Communication (BCC) Technical Working Group, and the Social Mobilisation Task Force. The sessions were effective in advocacy, programme updates and resource mobilisation, and promoting transparency and accountability in resource allocations, utilisation and to monitor progress in programme implementation. As a result of these efforts, stakeholder's engagement is strengthened as demonstrated by their participation in programme implementation.

Mainstreaming of HIV/AIDS into pubic and non-public sectors

Although commitment in implementing HIV mainstreaming by some sectors was insufficient, various sectors and organisations, including six government ministries, eight government agencies, one non-governmental organisation and one faith-based organisation have integrated HIV/AIDS prevention and support activities into their routine programmes. According to recent report, several organisations/offices conducted advocacy activities on the HIV/AIDS policies, distributed the policy documents, and provided trainings on HIV mainstreaming (30). The Ministry of Agriculture, Ministries of Transport, Education, Mines and Women's affairs are notable examples that have managed to establish a task force, which coordinates the regular activities on prevention of HIV at the workplace and also mitigation of affected individuals or families by creating an AIDS fund. Dialogue on how to prevent HIV infection is conducted regularly to employees and IEC/BCC materials are also distributed. Promotion of HIV testing and counselling is also conducted. In order to mitigate the impact of AIDS on affected employees, various care and support interventions have been provided to PLHIV and to OVC, including economic support through the provision of seed money.

Grass-roots participation and ownership

Another best practice that epitomizes the effective community based response to the epidemic is the engagement of community-based self-help groups such as 'Idirs'. These are community-based neighbourhood associations which are often organised to support families in funerals and the bereavement process. However, in recent years these groups have broadened their scope. Currently Idirs in many parts of the country are organised and capacitated to mobilise resources and coordinate financial and material support to HIV affected families and OVCs. Some have also amended their bylaws to help individuals while alive in addition to support during funeral services.

Scale-up of health extension programme and initiatives to urban areas

Based on the experience gained through the rural health extension programme and to reduce the existing disparity of health services in urban areas, FMOH designed and implemented an urban health extension programme. The programme was originally piloted successfully in Addis Ababa and rolled out to other major cities in the country. Unlike the rural counterpart, the urban programme enrolled clinical nurses to be trained for three months before their deployment. The curriculum incorporates introduction to HSDP and health policy in Ethiopia together with a package of 15 services. After deployment, one urban health extension worker (UHEW) is in charge of 500 households and focuses on prevention, promotion and

rehabilitative services targeting the households, youth centres and schools. These services are rendered alongside the health network model through referral and linkages to the nearby public health centre. Although its effectiveness has not yet been determined, the programme has created the platform for strengthening PMTCT and community based palliative care programmes in major cities like Addis Ababa.

Ethiopia successfully hosted ICASA

The government of Ethiopia in collaboration with its key stakeholders, development partners, private sector and CSOs successfully coordinated the XXII International Conference on AIDS and Sexually Transmitted Diseases in Africa. The conference, hosted by the Ethiopian Government, brought together more than ten-thousand researchers, public health experts and activists from around the world. This conference is one of the biggest such events annually organised specifically on HIV/AIDS. The participants' deliberated on the progress made to date, emerging challenges and needs and identified key strategic actions to intensify ongoing efforts against the epidemic.

The conference was not only a forum for advocacy and technical deliberations on intensifying the global response to the HIV epidemic, but also an indispensable opportunity that provided important lessons on effective coordination of various stakeholders ranging from policy-decision makers, technical experts, logisticians, to media and funding agencies. The experiences from organising the conference give impetus to the ongoing national effort and are invaluable to improve coordination among national and international partners on the fight against AIDS.

V Major Challenges and Remedial Actions

5.1 Progress in addressing challenges from 2009/10

Several challenges, ranging from the need to scale-up interventions on HIV prevention among the general public, youth and MARPs groups, to PMTCT, and to monitoring and evaluation were identified during the previous reporting period. Progress has been made in several of these areas including the development of strategic plans to scale-up services, and steps to address gaps in information among most at risk population groups were taken. Furthermore, programme monitoring and evaluation has been strengthened through adaptation of indicators to track progress in HIV prevention and response. However, in view of the annual response progress reporting requirements, the current monitoring indicators need further adaptation so that information generated can be used not only for national policy and programmatic needs, but also for global reporting.

5.2 Challenges in implementation during reporting period (2010/11)

Overall, encouraging results were achieved in HIV/AIDS control, with combination of stable HIV prevalence, sustained prevention efforts and increased ART coverage. However, there was a very low PMTCT coverage, reflecting the inadequate access to PMTCT services as well as their poor integration with maternal services. Hence emphasis should be given to strengthening service delivery at existing sites and the public systems that support them and expanding the number of service delivery sites.

Low PMTCT utilisation

Although there has been significant expansion of health facilities which provide ANC services, PMTCT services were available where only 54% of women attend ANC. Another challenge is the low utilisation of available PMTCT services. Among those who attended ANC clinics at health facilities which provide PMTCT services, more than a quarter were not tested for HIV. Other challenges include limited access to and utilisation of early infant diagnosis and low percentage of deliveries attended at health institutions. While only 40% of identified HIV positive pregnant women received ARV prophylaxis (24% of estimated need), less than a quarter of newborns to HIV positive women received prophylaxis (39). Some of the factors for this low performance include weak referral linkages, poor male partner involvement, inadequate awareness on the benefits and availability of PMTCT services.

In view of these challenges, there is a need to strengthen the PMTCT programme including in the areas of education and communication to increase demand for and use of existing services, further improving access and ensuring quality and integrated PMTCT programmes during ANC, labour and delivery. Similarly, efforts need to be made to provide appropriate care, monitoring and follow-up to the newborn (e.g. cotrimoxazole prophylaxis, at-risk child consultations) until his/her HIV status is determined and support the mother's ARV treatment. This will be possible by specifically encouraging pregnant mothers to attend and follow ANC and have institutional delivery, and for those HIV positive pregnant and lactating mothers to ensure complete uptake of ARV prophylaxis or HAART as per guidelines,

including follow-up during the breastfeeding period. HIV positive mothers need to be linked for appropriate care that includes CD4 testing and ART, community level PMTCT services and appropriate nutritional counselling. Due emphasis should be placed on follow up of mother infant pairs to ensure early infant diagnosis (EID), mothers adherence to infant feeding choice made and improved PMTCT prophylaxis coverage.

Inadequate care and support

There is an incremental trend in the performance of care and support rendered to individuals or family members infected and/or affected by HIV/AIDS. These include in the areas of educational and funding support to orphans and vulnerable children, food and shelter to PLHIV, and income generating activities. However, it was noted that the provision of shelter support and the nature of the approach vary from place to place calling for standardisation of the service package. Moreover, due to the enormity of the care and support problem, the service package provided to OVC and PLHIV seems to be insignificant. This is compounded by limited resources compared to demand and weak referral and linkages to the various care and support services to ensure better efficiency.

Interventions to MARPs

Current interventions are largely targeted to the general population and to some extent to commercial sex workers. However, the effectiveness of current intervention targeting CSWs needs further documentation (as consistent condom use with their non-paying clients is low and rate of infection is high). Furthermore, it is also worth noting that recent data indicate transactional sex workers (including high school and university students, out of school youth, daily labourers in cities and farms and house maids) are an important emerging group of MARPs. Likewise, although the extent of practice of MSM and IDU are not well documented, available information indicate that these are also groups of at risk populations. In view of these emerging facts, it is timely to review current programmes to address these challenges.

Mapping of stakeholders and services

Lack of comprehensive information on planned and ongoing support, care and prevention activities by various stakeholders underscores the need for a mapping of various activities. To address this issue, the Federal HAPCO and its partners have initiated coordination mechanism which also discusses on status of funding, planned and on-going activities and also reviews progress made in programme implementation. However, in view of the various stakeholders involved with diverse source and different mechanisms of resource mobilisation, it remains a challenge to streamline activities and services. While the National AIDS Spending Account (NASA) which is planned for 2012 will contribute to the process, a comprehensive mapping of partners, services and resources in HIV/AIDS prevention and response would also help to identify gaps in programmes and address emerging programmatic needs.

Other challenges and actions

- Gaps in availability of strategic information including biological markers on MARPs, coverage and needs of orphans and vulnerable children, role of MSM and IDU in the HIV epidemic in Ethiopia;
- To ensure timely release, utilisation and settlement of funds (in particular GF resources), capacity building has been undertaken along with periodic follow-ups and supervisory visits;
- Advocacy activities have been conducted to improve leadership commitment of lagging sectors regarding HIV mainstreaming;
- The Community Information System (CIS) – a routine monitoring system for non-clinical HIV activities - is in its pilot stage, after which it will be reviewed and scaled up to the entire country.

In view of the above challenges, it is imperative to consolidate gains made to date and further scale up prevention, care and support services. Key scale up of services include: 1) counselling and testing (encouraging couple counselling, disclosure and counselling for discordant couples, ensuring linkages to services for individuals found to be HIV infected); 2) laboratory services; 3) prevention of mother-to-child transmission (PMTCT); 4) paediatric care and treatment; 5) the prevention, diagnosis and treatment of HIV-TB co-infection; 6) scaling up interventions for MARPs (transactional sex workers, school and out-of school youth, MSM and IDU) and 7) full implementation of the Health Management Information System (HMIS) and Community Information System (CIS).

VI Support from Development Partners

In addition to mobilisation of resources internally, the Government of Ethiopia (GOE) has mobilised resources from external donors to support the national HIV programmes. In this regard Ethiopia has been a major recipient of international aid in recent times. The major sources of external funding to support the HIV programme include the Global Fund, PEPFAR, the World Bank (up to 2011), United Nations and other bilateral organisations through the HIV Governance pooled fund. These development partners support the country's goal to attain universal access to quality prevention, care and treatment for those who need the services and improving the health system.

The **Global Fund** to Fight AIDS, Tuberculosis and Malaria (GFATM) is the major source of funds for the multi-sectoral HIV/AIDS response in Ethiopia. The Global Fund resources are channelled through principal recipients who include Federal Ministry of Health (FMO), Federal HIV/AIDS Prevention and Control office (FHAPCO), Network of Networks of HIV Positives in Ethiopia (NEP+) and Ethiopia Interfaith Forum for Development Dialogue and Action (EIFDAA). Hitherto, Ethiopia has received three rounds of funding (i.e. Round 2, 4, 7 and RCC) from the GFATM. In 2010, USD 136.9 million was approved for Federal HAPCO through R7 and RCC HIV grant out of which USD 70.1 million was disbursed into the country. The amount for 2011 was USD 126.5 million and USD 122.5 million, respectively. Moreover, USD 13,320,308 was approved and 13,212,875 disbursed for Jan 2010- Dec 2011 period to EIFDAA. NEP+ also received funds from the Global Fund for 2010 and 2011.

The **World Bank** has provided about 30 million USD to the AIDS response over the last four years through the multi-sectoral HIV/AIDS Project (EMSAP II). The project was closed on September 30th 2011 and the total disbursement was nearly 100% (99.96%). The overall development objectives of EMSAPII were a) to increase access to prevention services for youth, in particular females aged 15-24, and other most-at-risk population groups and b) to sustain access to care and support for PLHIV and orphans. The main focus of the project was HIV prevention. The World Bank resources were used to strengthen institutional capacity at all levels, supported implementation of HIV/AIDS in sector ministries to strengthen the multi-sectoral response and provide funds to strengthen the community response to the HIV/AIDS epidemic.

The **United Nations** and the Government of Ethiopia jointly formulated a UN Development Assistance Framework (UNDAF) which is a strategic planning instrument designed to guide the UN's contributions to implementation of the country's development plan. The previous (UNDAF) was implemented from January 2007 to December 2011 in support of the PASDEP. The previous UNDAF had focussed on five priority thematic areas which included 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 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. The Joint UN Team on AIDS with participation from 12 UN agencies developed the operational plan for HIV outcomes also known as the first Joint UN Programme of Support on AIDS for Ethiopia (2007 – 2011). It was implemented between January 2007 and December 2011. For 2010/2011 the UN budgeted for a total of USD 29,843,504 for HIV/AIDS related interventions (allocated to different HIV outputs and implementing agencies). UNDAF outcomes for HIV were aligned to SPM II and HSDP as well as other key sectoral strategies and plans. Below is a summary of the results matrix for 2010/11.

Table 3 UNDAF Outcome Matrix, 2011

Outcome: By 2011, vulnerability to HIV infection, especially of women and girls, and impact of the epidemic on affected populations are reduced.			
Country UNDAF	**Country UNDAF Outcome 1:** Enabling environment is created for sustainable and effective HIV response at all levels	**Country UNDAF Outcome 2**: Existing HIV prevention response facilitates reduced risk of sexual and vertical HIV transmission	**Country UNDAF Outcome 3:** Increased provision and utilisation of treatment, care and support services for people living with or affected by HIV/AIDS
Outputs to reach Outcome	**Output 1.1:** Legislative/policy and governance framework for delivery of essential HIV services to all those in need strengthened	**Output 2.1:** Guidance for targeted HIV prevention responses in place	**Output 3.1:** Updates of all relevant treatment, care and support policies, technical guidelines and protocols supported/facilitated
	Output 1.2: Functioning of systems and relevant capacities for HIV response coordination enhanced	**Output 2.2:** Evidence-informed quality implementation of HIV prevention facilitated	**Output 3.2:** Institutional and technical capacity of service providers to implement comprehensive care (including ART) and support interventions enhanced
	Output 1.3: Availability of strategic information on the HIV epidemic for response planning systematised	**Output 2.3:** Identification and documentation of prevalent high HIV risk behaviours strengthened	Output 3.3: Systematic monitoring and capturing of progress against key HIV service delivery and outcomes strengthened (overall health sector M&E HMIS; patient monitoring including ART cohort, pre- ART, TB/HIV etc): prevalence estimates (including forecasting); incidence estimates (including forecasting); HIV drug resistance; pharmacovigilance; service coverage; LMIS; HRMI)

Previous reviews on the contribution of UNDAF have shown that the support was critical in improving technical capacity of implementing agencies; and the technical (expertise and guidelines and tools) and financial inputs had added values to the success of HIV prevention, care and treatment.

The **US Government** provides extensive support for strengthening national response to the HIV epidemic through its various programmes and channels including notably the Presidential Emergency Programme for AIDS Relief (PEPFAR), the US Agency for International Development (USAID), and the Centre for Disease Control (CDC).

Presidential Emergency Programme for AIDS Relief (PEPFAR) - Ethiopia is one of the largest recipients of PEPFAR support. PEPFAR supports the GOE's HIV and AIDS programme with activities implemented through the United States Agency for International Development (USAID), Centres for Disease Control and Prevention (CDC), the Department of Defence, Peace Corps and the Department of State Refugee Bureau. To date Ethiopia has received US $1.4 billion in PEPFAR funding to support a comprehensive HIV/AIDS prevention, care and treatment programme. The programme supports prevention of sexual transmission, prevention of mother-to-child HIV transmission (PMTCT), counselling and testing (CT), behavior change communications, condoms and other forms of prevention. For those impacted by or living with HIV/AIDS, PEPFAR-Ethiopia offers basic palliative care, care and support for orphans and vulnerable children (OVC), support for treatment services and the provision of antiretroviral (ARV) drugs and other essential HIV and AIDS commodities. Support for the essential health care systems required to deliver this comprehensive programme includes infrastructure improvements, training of health workers, and development of health care financing, supply chain and laboratory systems.

The **CDC Global AIDS Programme** provides extensive technical expertise in Ethiopia in the areas of blood safety, antiretroviral treatment services, laboratory infrastructure, and strategic information through 23 implementing partners including its US based universities i.e. university of Washington (I-TECH), Columbia University (ICAP-CU), Johns Hopkins University (JHU-TSEHAI), University of California at San Diego (UCSD) and other international and local partners. CDC is supporting the government's efforts to rapidly scale up antiretroviral treatment in public and private health facilities, while also ensuring quality services, by facilitating innovative approaches including: outreach to paediatric age groups and pregnant mothers, improving the linkages among services (such as antenatal care, immunization programmes, and" Under Five Clinics"), establishing and strengthening early infant diagnosis. CDC is strengthening the palliative care programme by bolstering human resource capacity, and building the capacity of indigenous organisations to provide sustainable care services. CDC partners with the Ethiopian Health and Nutrition Research Institute (EHNRI), to provide laboratory training and technical assistance to strengthen the nation's entire health system through improved laboratory infrastructure and human capacity. CDC has supported training of Ethiopian laboratory technicians and the establishment of the Ethiopian Public Health Laboratory Association, as well as strengthened the existing Ethiopian Medical Laboratory Technicians Association.

The **U.S. Agency for International Development (USAID)** provides technical and financial support for HIV/AIDS programmes in Ethiopia in the areas of sexual prevention focusing on MARPs and the workplace, PMTCT, care and treatment for PLHIVs, orphans and vulnerable children (OVC) support, health systems strengthening and local institutional capacity building to promote country ownership and sustainability. Support for HIV programmes is funded primarily through PEPFAR but also leverages maternal and child health, reproductive health, tuberculosis and economic growth funds for wraparound programmes that expand coverage of services and improve programme efficiencies. Working through international and local partners, USAID is supporting targeted expansion of HIV/AIDS treatment services at the health centre level with technical support for logistics, laboratory, human resources, mentorship, and community outreach. USAID also works to improve the engagement of the private sector in the provision of counselling and testing, ART, TB/HIV and other HIV services. In addition, USAID is supporting the GOE's multi-sectoral OVC programme within the existing community and social structures. Working closely with PFSA, FMHACA and EHNRI, USAID supports the strengthening of logistics and pharmaceutical systems, ensuring the availability of HIV/AIDS commodities. USAID is also supporting the expansion of facility and community based PMTCT services including innovative approaches such as the Mothers Support Groups (MSGs) and is supporting the GOE's successful Health Extension Worker programme, both urban and rural, which is playing a significant role in addressing loss-to-follow-up, stigma reduction and community level demand creation. By supporting the construction of new health centres and renovations of existing ones, USAID is helping to ensure the quality and availability of basic health services across the country.

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 programmes 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 Irish Aid, Italian Cooperation and UNFPA (DFID was formerly a donor but has withdrawn).

While the above descriptions provide some of the main partner organisations providing technical and funding support to the ongoing HIV/AIDS response, it should be noted that the list is not exhaustive. In fact, several other development partners continue to provide both direct and indirect support for and are engaged in HIV/AIDS prevention, treatment and care. As the number and the areas of programme support may vary from time to time with the changing dynamics of the epidemic, it is invaluable to periodically review and update the list through mapping of key stakeholders and programme areas.

VII Monitoring and Evaluation

7.1. Overview of M&E

In 2003, Ethiopia developed its first national Monitoring and Evaluation Framework for the Mutisectoral Response to HIV/AIDS. The main purpose of the National M&E system is to provide the necessary data that are essential to track the progress made in implementation of SPM I (2007-2010), and the current SPM II (2011-2015) and to facilitate informed decision-making. Evaluation and national assessment conducted on the M&E system during the SPM I period, led to development of national/multi-level, harmonized, result based, and multi-sectoral HIV/AIDS M&E framework and costed plan in order to improve the performance of the HIV/AIDS response in Ethiopia.

M&E is critical in the HIV response. With a clear roadmap, measurable benchmarks, and mechanism for monitoring and evaluation, progress in the HIV/AIDS response is feasible.

The M&E Framework has 12 components grouped into three broad categories encompassing capacity building; information generation; and data dissemination and use. Planning and M&E activities are interlinked. The SPM II, the Road Map and HSDP IV serve as the main planning documents, including targets to be achieved at each result level. Key results and targets in the SPM II are thus directly linked to key HIV indicators and data collection tools in the M&E system. The key principle of the framework are standardisation/consistency (using agreed upon indicators, data collection instruments), coordination/integration (including one national M&E plan shared by all partners), and simplification (analysing and interpreting only the information that is immediately relevant to performance improvement makes best use of scarce resources). These principles are linked with the 'Three Ones' principle for rapid and effective HIV response which includes one agreed country-level M&E System (54).

7.2. Surveillance and Surveys

HIV epidemiological and behavioural studies, sentinel surveillance, demographic and health surveys, and behavioural surveillance surveys provide useful information for planning interventions, monitoring HIV trend and programme performance, and evaluating the impact of interventions. In the initial phase, emphasis was on strengthening routine data recording and reporting, and conducting surveys among high risk groups. While periodic surveys among high risk groups, especially commercial sex workers, provided useful information on the emerging epidemic, these were limited in scope and could not provide a reliable picture about HIV in the general population. Thus, in 1989, **Sentinel Surveillance** among ANC attendees was established in one urban site. Since then sentinel surveillance sites have expanded reaching to 144 by 2009; a remarkable expansion both in numbers and geographic distribution.

Behavioural Surveillance Survey (BSS) was introduced in 2002 to complement the ANC sentinel surveillance and a passive HIV surveillance systems instituted nationally. It was intended to serve as a surveillance tool to track trends in HIV/AIDS-related knowledge, attitudes, behaviours and practices among sub-populations at particular risk of infection, including CSWs, uniformed personnel, mobile populations and youth. In 2005, the second-round Behavioural Sentinel Surveillance was conducted.

Moreover, the **Demographic Health Survey** (DHS) which also collects data on HIV/AIDS related information among the general population and provides disaggregated data by sex and age-groups, was started in 2000 (excluding HIV prevalence), 2005 and the third round was conducted in 2011. The information generated through DHS has been invaluable in monitoring trends on HIV testing, knowledge and behaviour among different population groups in representative sites across the country. This generates information useful to design targeted interventions.

7.3. Achievements, Challenges and Next Steps

FHAPCO's mandate is to coordinate and lead the multisectoral HIV/AIDS response in Ethiopia including coordination of monitoring and evaluation of progress in programme implementation and further strengthen the M&E system. However, improvements in the M&E system require capacity building and strengthening in terms of availability of human resource, and technical as well as managerial skills. This was identified as a critical need and emphasis is given in the framework to address the need.

The Federal HAPCO coordinated a review of implementation of SPM I and application of M&E. The review identified a number of challenges that require remedial actions including gaps in strategic information such as up-to-date scientific epidemiologic data on MARPs, national standardised indicators for use by all stakeholders to track programme implementation, and lack of capacity at various levels to implement M&E.

To address some of the emerging challenges a mechanism of joint review meetings was established and every six months all partners meet to review progress and devise the way forward. Joint review meetings were conducted and reports were produced in 2010 and 2011. A system of Joint Supportive Integrated Supervision (JSIS) is also in place. Furthermore, the Multi-sectoral HIV and AIDS response CIS (Community Information System) was established at Federal level to ensure quarterly reports regarding performance of regional HIV programmes. The CIS will be fully scaled up in 2012.

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ANNEX

Global AIDS Response Progress Reporting, 2012

Country(ETHIOPIA) Progress Report

National Commitments and Policy Instrument (NCPI)

Federal HIV/AIDS Prevention and Control Office,

Addis Ababa, Ethiopia

March 31, 2012

National Commitments and Policy Instrument (NCPI) 2012

NCPI – CONTACT DETAILS

Country: Ethiopia

Name of the Officer in Charge of NCPI submission and who can be contacted for questions, if any:

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Date of submission:

March 31, 2012

Data Gathering and Validation Process

Describe the process used for NCPI data gathering and validation:
In order to fill the NCPI indicator, an independent consultant was recruited under the oversight of the multi-partners GAPR task force (government, UN, civil society, other donors) in Ethiopia. Data gathering using the National Commitments and Policy Instrument (NCPI) 2012, was carried out in the month of January and first week of February 2012. To initiate the NCPI survey, identification of key stakeholders was done by the NCPI consultant in close consultation with Federal HIV/AIDS Prevention and Control Office (HAPCO) and UNAIDS-E. The questionnaire was distributed to a representative list of partners: • Part A of the NCPI Questionnaire was distributed to staff of HAPCO, Federal Ministry of Health (FMOH), Oromiya Regional Health Bureau, Ministries (Education, Defence, Agriculture, Labour and Social Affairs, Women's Affairs), Federal Police, Electric Light and Power Authority and Ethiopian Road Authority. • The NCPI Part B Questionnaire was distributed to major NGOs engaged in HIV prevention and control activities, networks of PLHIV, umbrella civil society organizations, bi-lateral and multi-lateral development agencies, and the Ethiopian Human Rights Commission. Thus, the NCPI Parts A & B were completed by a wide range of stakeholders. The questionnaire was mainly sent to national partners (with HQ based in the capital Addis Ababa and operating in different areas of the country). However, to gather a regional perspective, the questionnaire was also distributed to Oromia Regional Health Bureau and to NEP+, Ethiopian Inter Faith Forum for Development, Dialogue and Action (EIFDDA), and Organization for Social Services for AIDS (OSSA) which are among the indigenous civil societies currently working in all regions of the country. The methodology applied to measure the progress in the implementation of the national HIV response comprised of making desk review, interviewing key informants, compilation and synthesis of data and presentation for discussion at a validation workshop attended by the concerned governmental and civil society representatives and other stakeholders. The independent consultant summarised and calculated the average score for the questionnaires completed by the respondents. For some of the questions, Key Informants were used (for example, the Human Rights Commission for the legislative framework, and FHAPCO for the Strategy Planning and Monitoring and Evaluation component). To measure the progress made in the HIV response over time the trend of the ratings made by part A and Part B respondents has been calculated and incorporated in the report. A validation workshop was organized on March 23, 2012 in Addis Ababa (with participants from the Federal level and from some of the regions). During the workshop, respondents and other stakeholders participated in discussion sessions and validated the average/summary answers to NCPI questions by consensus.
Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions:
There were no disagreements on the responses to specific questions.
Highlight concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like):
None

NCPI Respondents

TABLE 1: LIST OF PART A RESPONDENTS

Organization	Names/ Positions	Respondents to Part A					
		A.I	A.II	A.III	A.IV	A.V	A.VI
1.Federal HAPCO	Meskele Lera, D/DG	A.I	-	-	-	-	-
2. Federal HAPCO	Ms. Eleni Seyoum, Netsanet Haniko, Abenet Aseffa and Yezihalem Atnafu Plan, M&E Directorate	A.VI	-	-	-	-	-
3. Federal HAPCO	Alemu Ano, Multi-sectoral Coord. Directorate	A.1	A.II	-	A.IV	V	VI
4.Federal HAPCO	Dr. Achamyeleh, Plan, M&E Directorate	A.I	A.II	A.III	A.IV	A.V	A.VI
5. Oromia Health Bureau	Girma Ashenafi	A I	A.II	A.III	A.IV	A.V	A.VI
6. Ministry of Labour and Social Affairs	Mesfin Lemma	A.I	A.II	A.III	A.IV	A.V	A.VI
7. Ethiopian Road Authority	Fantahun Gobeze, Project Coordinator	A.I	A.II	A.III	A.IV	A.V	A.VI
8. Ministry of Women's Affairs	Tiruwork Akle	A.I	A.II	A.III	A.IV	A.V	A.VI
9. Ministry of Defence	Dr. Yeheyis Aytenfesu, HPDP Directorate, HIV/AIDS/STI & TB Prevention, Control & Care Version, Head	A.I	A.II	A.III	A.IV	A.V	A.VI
10. Ministry of Education	Haddis G/Tensai, Resource Mobilization Senior Expert	A.I	A.II	A.III	A.IV	A.V	A.VI
11. ELPA	Ahmed Bedasso, HIV/AIDS Prevention and	A.I	-	-	A.IV	A.V	A.VI

	Control Office Head						
12. Ministry of Agriculture	Wassihun Amenu, HIV/AIDS Mainstreaming Senior Expert	-	-	-	A.IV	A.V	-
13. Federal Ministry of Health	Dr. Mengistu Hailemariam, Urban Health Promotion & Disease Prevention Directorate	A.I	A.II	A.III	A.IV	A.V	A.VI
14. Federal Police	Tsegaye Tekleab	-	-	-	A.IV	A.V	-
15. UNAIDS	Elisabetta Pegurie, M&E	A.I	-	-	-	-	-
16. Pharmaceutical Fund and Supply Agency (PFSA)	Belay Mekonnen	-	-	-	A.IV	A.V	-
17. Ethiopian Health and Nutrition Research Institute (EHNRI)	Wegene Tamene	A.I	A.II	A.III	A.IV	A.V	A.VI

TABLE 2: LIST OF PART B RESPONDENTS

Organization	Names/ Positions	Respondents to Part B				
		B.I	B.II	B.III	B.IV	B.V
1.CRDA	Focal person	B.I	B.II	B.III	B.IV	B.V
2. MSF Holland	Focal person	B.I	-	-	B.IV	B.V
3. Dawn of Hope	Program officer	B.I	B.II	B.III	B.IV	B.V
4. NEP+ (National network of PLHIV)	Focal person/M&E	B.I	B.II	B.III	B.IV	B.V
5. WNPWE (Network of Women Living With HIV)	Representative	B.I	B.II	B.III	B.IV	B.V
6. UNAIDS	All staff	B.I	B.II	B.III	B.IV	B.V
7. Mekdem – Ethiopia	Focal person	B.I	B.II	B.III	B.IV	B.V
8. Ethiopian Human Rights Commission	Focal person	-	-	B.III	-	-
9. Confederation of Ethiopian Trade Unions	Focal person	B.I	B.II	B.III	B.IV	B.V
10. ICAP	Focal person	B.I	B.II	B.III	B.IV	B.V
11.UC San Diego University	Focal person	B.I	B.II	B.III	B.IV	B.V
12. Organization for Social Services for AIDS (OSSA)	Focal person	B.I	B.II	B.III	B.IV	B.V
13. Integrated Service for AIDS Prevention and Support Organization (ISAPSO)	Focal person	B.I	B.II	B.III	B.IV	B.V
14. National Network of Positive Ethiopian Women	Program Manager	B.I	B.II	B.III	B.IV	B.V
15. Ethiopian Inter Faith Forum for Development, Dialogue and Action (EFIDDA)	Focal person	B.I	B.II	B.III	B.IV	B.V
16. WHO	Focal person	B.I	B.II	B.III	B.IV	B.V
17. CDC Ethiopia	Focal person	B.I	B.II	B.III	B.IV	B.V
18. PEPFAR	Director	B.I	B.II	B.III	B.IV	B.V
19. USAID	Focal person	B.I	B.II	B.III	B.IV	B.V
20. IOM	Focal person	B.I	B.II	B.III	B.IV	B.V
21.Italian Development Cooperation	Focal person	B.I	B.II	B.III	B.IV	B.V
22. FAO	Focal person	B.I	B.II	B.III	B.IV	B.V
23. UNICEF	Focal person	B.I	B.II	B.III	B.IV	B.V
24. Clinton Health Access Initiative (CHAI)	Director & Focal person	B.I	B.II	B.III	B.IV	B.V

National Commitments and Policy Instrument (NCPI)

Part A

[To be administered to government officials]

1. STRATEGIC PLAN

1. ***Has the country developed a national multi-sectoral strategy to respond to HIV?*** (Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes ✓	No

IF YES, what was the period covered *[write in]*:

2010/11 – 2014/15 (SPM II)

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.
IF NO or NOT APPLICABLE, briefly explain why?

- There are modifications made in the current national strategy based on lessons learned from the evaluation of SPM I (2004-2008). As a result SPM II has clear Goals and Results across five Thematic areas (Creating an Enabling Environment; Intensifying HIV Prevention; Increase access to and Improve Quality of Chronic Care and Treatment; Strengthen Care and Support Services to Mitigate the Impact of AIDS; and Strengthen Generation and Utilization of Strategic Information). According to the Joint Assessment of the Ethiopian HIV and AIDS Strategy (JANS) "the thematic areas and interventions seem sound and implementable, and a notable strength is inclusion of health and community systems strengthening". SPM II gives more emphasis to capacity building with focus on key strategic sectors while consolidating on the capacity of the health sector and communities; scaling up prevention services to MARPs; adopting combination prevention approaches (Behavioural, Structural, Biomedical); and strengthening the generation and utilization of strategic information. It includes special population groups like people with disabilities and the elderly and the treatment part emphasizes adherence.

- SPM II was developed in a context of expanded HIV response and decentralization of HIV services. Since SPM I several more sectors are engaged in the HIV response; and targets of SPM II are much more ambitious (Towards Zero New Infections/ Zero AIDS-related Deaths/ Zero Discrimination).

- SPM II was developed in a participatory manner and it took time to be finalized. Some challenges remain with lack of prioritization in certain areas and incomplete /outdated evidence on the epidemic (Little data exists on MARPs; DHS 2011was not yet available at the time of developing SPM II). Also, SPM II offers a good national guidance on areas for HIV response but fails to differentiate across different regional epidemics/HIV driving factors. According to the JANS Final Report of September 2011, SPM II could benefit from clearer prioritization of the strategies and interventions within each of the thematic areas; specific assessment of risks and appropriate mitigation strategies; finding ways to ensure that ongoing attention is given to more meaningful involvement of stakeholders across the multi-sectoral response. An outline of available resources, updated cost estimates and a financial gap analysis for the SPMII are in process of being finalized at the time of this reporting (after March 2012).

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?*

Name of government ministries or agencies *[write in]*:

FHAPCO/ Ministry of Health

1.2. *Which sectors are included in the multi-sectoral strategy with a specific HIV budget for their activities?*

SECTORS	**Included in strategy**		*** Earmarked Budget**	
Education	Yes ✓	No	Yes ✓	No
Health	Yes ✓	No	Yes ✓	No
Labour	Yes ✓	No	Yes ✓	No
Military/Police	Yes ✓	No	Yes ✓	No
Transportation	Yes ✓	No	Yes	No
Women	Yes ✓	No	Yes ✓	No
Young People	Yes ✓	No	Yes	No
Other *[write in]*: Defence, Communication, Mining, Water and Energy, Agriculture, Civil Service, Urban Development and Construction, Federal Affairs, Ministry of Finance & Economic Development	Yes ✓	No	Yes	No

*It is not at a level of earmarked budget since the Strategic Plan is to be used for resource mobilization too. However, responses in the above sectors are definitely included in the SPM II costing. All sectors are required to allocate budget to mainstream HIV. Still, this needs strengthening in particular for sectors other than health such as Education, Women, and Youth etc. Other sectors such as Labour and Social Affairs have annual budget marked for annual activities together with additional funds from Global Fund and ILO.

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?
Funding through sectoral mainstreaming including budgeting; and activity based financing through respective projects. In line with the Strategic Plan many sector offices had initiated allocation of up to two percent of their budget for HIV-specific activities. Additional funds are also raised through voluntary individual contributions of 0.5 % to 1 % of staff salaries, mainly to augment care and support activities.

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		
Men who have sex with men	Yes	No ✓
Migrants/mobile populations	Yes ✓	No
Orphans and other vulnerable children	Yes ✓	No
People with disabilities	Yes ✓	No
People who inject drugs	Yes	No ✓
Sex workers	Yes ✓	No
Transgendered people	Yes	No ✓
Women and girls	Yes ✓	No
Young women/young men (out-of-school/in-school)	Yes ✓	No
Other specific vulnerable subpopulations[31] Prisoners, refugees, uniformed services, discordant couples	Yes ✓	No
SETTINGS		
Prisons	Yes ✓	No
Schools	Yes ✓	No
Workplace	Yes ✓	No
CROSS-CUTTING ISSUES		
Addressing stigma and discrimination	Yes ✓	No
Gender empowerment and/or gender equality	Yes ✓	No
HIV and poverty	Yes ✓	No
Human rights protection	Yes ✓	No
Involvement of people living with HIV	Yes ✓	No

Generally, the Strategy places due focus on MARPs and to the vulnerable populations as the epidemic in the country is heterogeneous. There is an ongoing national MARPs Survey to know the size estimate of these population groups, their distribution, sexual patterns, predisposing factors, and their potential to spread the epidemic among themselves and to the population at large

IF NO, explain how key populations were identified?

31. Other specific vulnerable populations other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners and refugees).

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

KEY POPULATIONS
Key populations identified in the multi-sectoral strategy include: Female sex workers, long distance truck drivers, uniformed services , discordant couples, migrant workers, IDPs/refugees, OVC, Out-of-school youth, prisoners, in school youth and people living with disabilities.

1.5. Does the multi-sectoral strategy include an operational plan?

Yes ✓	No

1.6. Does the multi-sectoral strategy or operational plan include:

a) Formal programme goals?	Yes ✓	No	N/A
b) Clear targets or milestones?	Yes ✓	No	N/A
c) Detailed costs for each programmatic area?	Yes ✓	No	N/A
d) An indication of funding sources to support programme implementation?	Yes ✓	No	N/A
e) A monitoring and evaluation framework?	Yes ✓	No	N/A

1.7. Has the country ensured "full involvement and participation" of civil society[32] in the development of the multi-sectoral strategy?

Active Involvement ✓	Moderate Involvement	No Involvement

32. Civil society includes among others: networks and organizations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; workers organizations, human rights organizations; etc. Note: The private Sector is considered separately.

IF ACTIVE INVOLVEMENT, briefly explain how this was organized:
The SPM II has been developed through a collective effort and active participation of faith-based organizations, community-based organizations, civil societies and associations of people living with HIV, the private sector, multilateral and bilateral donors and active participation of key government sectors. CSOs have been part of the development process of SPM II, as there is an established system of joint planning, joint supervision, and joint review of the multi-sectoral response. They were involved in the development of SPM II through active participation at workshops, series of large group consultative meetings organized during the preparation of the Plan, review of several drafts of the document and by advocating inclusion of certain population groups or areas of HIV response (e.g. people with disabilities). The capacity of PLHIV associations has been strengthened by empowering them to have a decisive role in the governance, management and service delivery of the HIV/AIDS response. For instance, the Network of Networks of HIV Positives in Ethiopia is a member of the National HIV Council, National Management Board, and Country Coordinating Mechanism for GFATM and Review board. Despite the above response, the JANS Review identified as a critical issue: the lack of ownership of the Strategic Plan by key stakeholders, in particular civil society stating that "There is a need to find ways to ensure that ongoing attention is given to more meaningful involvement of stakeholders across the multi-sectoral response".

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

1.8. Has the multi-sectoral strategy been endorsed by most external development partners (bilaterals, multi-laterals)?

Yes	No	N/A
✓		

1.9. Have external development partners aligned and harmonized their HIV-related programmes to the national multi-sectoral strategy?

Yes, all or most of the Partners	Yes, some Partners	No	N/A
✓			

Only two respondents said that it is only some partners who have aligned their HIV-related programs to the national multi-sectoral strategy but have not indicated for which areas there is no alignment.

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

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 ✓	No	N/A

2.1. IF YES, is support for HIV integrated in the following specific development plans?

***SPECIFIC DEVELOPMENT PLANS**			
Common Country Assessment/UN Development Assistance Framework	Yes ✓	No	N/A
National Development Plan	Yes ✓	No	N/A
Poverty Reduction Strategy	Yes ✓	No	
Sector-wide approach	Yes ✓	No	N/A
Other *[write in]*:	Yes	No	N/A

* There is government enforcement to make HIV/AIDS, Gender and Environment cross cutting issues across all sectors.

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

HIV-RELATED AREA INCLUDED IN PLAN(S)			
HIV impact alleviation	Yes ✓	No	N/A
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes ✓	No	N/A
Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support	Yes ✓	No	N/A
Reduction of stigma and discrimination	Yes ✓	No	N/A
Treatment, care, and support (including social security or other schemes)	Yes ✓	No	N/A
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes ✓	No	N/A
Other[write in below]:	Yes	No	N/A

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

Yes	No ✓	N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation 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 ✓	No

5. Has the country followed up on commitments made in the 2011 Political Declaration on HIV/AIDS? [33]

Yes ✓	No

33. Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, A/RES/65/277, 10 June 2011

5.1. Have the national strategy and national HIV budget been revised accordingly?

Yes ✓	No

5.2. 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 ✓	Estimates of Current Needs Only	No

*In general, targets for the National Strategy are ambitious and aligned to the 2011 HLM targets. For prevention among Drug Users, studies are ongoing to assess the extent of the problem and need for a response. For Resource Gaps, strategies are being devised to increase national resources and sustainability. However, a long-term Financing Mechanism including Resource Planning scenario needs to be put in place. SPM II could be strengthened by a section on Resource Mobilization.

5.3. Is HIV programme coverage being monitored?

Yes ✓	No

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

Yes ✓	No

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

Yes ✓ (CIS)	No

IF YES, for which population groups?
• Women • Pregnant mothers • OVC Coverage is not yet monitored by population groups apart from gender and age disaggregation. However, the Community Information System (CIS), piloted in 2011 and to be scaled up in 2012, foresees data on HIV services coverage disaggregated by key population groups (sex workers, mobile populations and out of school youth).
Briefly explain how this information is used:
It is used for planning future needs estimation, for revision of plans and to design strategies.

(c) Is coverage monitored by geographical area?

Yes ✓	No

IF YES, at which geographical levels (provincial, district, other)?
• National, Regional, Zonal, Woreda (district) level, urban/rural • A Community Information System (CIS) was piloted in 2011 and will be scaled up in 2012. Indicators in CIS are disaggregated by Population Groups (sex, key populations). Therefore, disaggregated information should be available and used from 2012 onwards. The new CIS will provide data disaggregated by district and possibly lower levels.
Briefly explain how this information is used:
The information is used for program evaluation/ to assess performance of different regions and take remedial measures where applicable, for resource allocation purposes, to measure access to prevention, treatment, care and support; and to prioritize activities for the respective geographical levels. It also allows for sharing of knowledge/experience across regions.

5.4. Has the country developed a plan to strengthen health systems?

Yes ✓	No

Please include information as to how this has impacted HIV-related infrastructure, human resources and capacities, and logistical systems to deliver medications:
It has led to: • Infrastructure development-health centre renovation, construction and equipping accomplished; and increased access through expansion and scaling up of primary health care facilities and services. • Laboratory system has been strengthened • HMIS and LMIS have been strengthened • Human resource development has been accelerated • Supply procurement, distribution system and related infrastructure has been developed SPM II is aligned with the Health Sector Development Program IV and HIV is integrated in the health sector response.

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 2011?*

	Very poor										Excellent
2011	0	1	2	3	4	5	6	7	**8**	9	10
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 2009, what have been key achievements in this area:

- Strategic plan has been developed in 2011(SPM II)
- The development of Road Map to operationalize SPM II
- The development of National M&E Framework to monitor SPM II results
- The development of tools for Regional operational planning in line with SPM II. All stakeholders at the regional level participate in the planning exercise.
- Strengthening of health systems
- Development of Community Information System: the national monitoring system for the non health response – piloted in 2011 and to be scaled up in 2012
  The overall rating given by key informants to the strategy planning efforts in the country's HIV programs has showed significant progress since 2005. The average score in 2011 was 8.3 out of 10; slightly less than the score of 9 out of 10 rating given in 2009.

What challenges remain in this area:

- Human resource challenges-turnover, shortage etc.
- Resource constraints
- The availability of resources at the regional level (apart from Global Fund whose funds are allocated to Regional HAPCOs by Federal HAPCO) is not always known in advance by coordinating authorities (Regional Health Bureau & Regional HAPCO). The disaggregation of resources available at regional level for different sectors is also not fully known. Gaps in knowledge in terms of resource availability make planning more difficult at the regional level.
- Availability of timely strategic information (e.g. MARPS, drug resistance surveys etc.)

2. Political Support and Leadership

Strong political support includes: government and political leaders who regularly speak out about HIV/AIDS and demonstrate leadership in different ways: allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

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 ✓	No

   b. *Other high officials at sub-national level*

Yes ✓	No

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?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes ✓	No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:
• H.E the President of the country has delivered official messages on World AIDS Day (WAD) • H.E the Prime Minister of the FDRE opened the ICASA Forum held in Addis Ababa in December 2011. • Almost all Presidents of Regional States delivered speeches during WAD, and National VCT Day • The First Lady is involved in HIV work nationally and globally • The level of commitment and active involvement of leaders from federal to woreda level has increased • Parliamentarians were trained to incorporate and monitor HIV activities in their respective constituencies. Members of the House of People's Representatives visited and monitored the multi-sectoral response at woreda (district) level. They gathered information and gave supportive direction as well.

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

Yes ✓	No

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

2.1. IF YES:

IF YES, does the national multisectoral HIV coordination body:		
Have terms of reference?	Yes ✓	No
Have active government leadership and participation?	Yes ✓	No
Have an official chair person?	Yes ✓	No
IF YES*, what is his/her name and position title?* H.E Girma Wolde-Giorgis, President of the FDRE	Yes	No
Have a defined membership?	Yes ✓	No
IF YES*, how many members?* **90**	Yes	No
Include civil society representatives?	Yes ✓	No
IF YES*, how many?* **11**	Yes	No
Include people living with HIV?	Yes ✓	No
IF YES*, how many?* **5**	Yes	No
Include the private sector?	Yes ✓	No
Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes ✓	No

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 ✓	No	N/A

IF YES, briefly describe the main achievements:
• The private sector and civil society are working on HIV/AIDS prevention, treatment and care activities; in accordance with the National Plan. Many private health facilities provide HCT, ART, PMTCT • Non-government sectors are mainstreaming HIV • Realization of one plan: Joint planning has become a custom starting from lower levels to federal level which includes large numbers of civic societies at all levels • Active involvement of the Ethiopian Business Coalition against HIV/AIDS
What challenges remain in this area:
• Limited participation of the private sector in this endeavour • Resource constraints • Lack of updated mapping • Referral linkage • Sustainability

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

Up to 2 % (Response of Ministry of Labour and Social Affairs)

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 ✓	No
Coordination with other implementing partners	Yes ✓	No
Information on priority needs	Yes ✓	No
Procurement and distribution of medications or other supplies	Yes ✓	No
Technical guidance	Yes ✓	No
Other [write in below]:	Yes	No

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

Yes	No ✓

6.1. *IF YES, were policies and laws amended to be consistent with the National HIV Control policies?*

Yes	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 2011?***

	Very poor										Excellent
2011	0	1	2	3	4	5	6	7	8	**9**	10
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

Overall on a scale of 0 to 10 (where 0 is "very poor" and 10 is "Excellent"), the rating given by nine respondents to the political support for the HIV programs in 2011 was 9.0. This is an improvement over the average rating of respondents in 2009 which was 8.0.

Since 2009, what have been key achievements in this area:
• High level political leadership has given due attention to the HIV Program • Considerable support for the HIV program from members of Parliament to ensure HIV/AIDS mainstreaming in all sectors especially in key/strategic sectors. Members of Parliament are actively monitoring the response. • Ethiopia's selection to host the 16th ICASA Conference and the convening of the Conference in Addis Ababa in December 2011 • High commitment of leaders at all levels • Involvement of the First Lady in HIV work • The rate of HIV transmission has been slowed down through collaborative efforts of stakeholders • Significant increase in enrolment for pre-ART and ART care has been witnessed
What challenges remain in this area:
• Lack of uniformity in degree of commitment across sectors and regions • Lack of training • Limited capacity building efforts for non-health sectors • Very low uptake of PMTCT services • Lack of leadership at institutional/sectoral level • Weak coordination among different partners

3. 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** ✓	No
Men who have sex with Men	Yes	**No** ✓
Migrants/mobile populations	**Yes** ✓	No
Orphans and other vulnerable children	**Yes** ✓	No
People with disabilities	**Yes** ✓	No
People who inject drugs	Yes	**No** ✓
Prison inmates	**Yes** ✓	No
Sex workers	**Yes** ✓	No
Transgendered people	Yes	**No** ✓
Women and girls	**Yes** ✓	No
Young women/young men	**Yes** ✓	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

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

Yes ✓	No

***IF YES* to Question 1.1 or 1.2, briefly describe the contents of these laws:**
• The FDRE constitution Art. 25 states, "All persons are equal before the Law and are entitled without any discrimination to the equal protection of the Law. In this respect, the Law shall guarantee to all persons equal and effective protection without discrimination on grounds of race, nation, nationality or social origin, colour, sex, language, religion, political or other opinion...or other STATUS". • Labour Proclamation No. 262/2001 and 377/2003 Article 14.1d prohibits mandatory HIV testing for employment • The Civil Service Workplace HIV/AIDS Guideline (2005) protects against discrimination of a person on his or her HIV status while at work. There are additional guidelines that prevent discrimination and protect in the work place the rights of people living with HIV. • There are other proxy laws that protect people from STI, rape, abduction and early marriage.
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
• There are sector ministries responsible for implementation of the relevant laws, regulations or guidelines. For example, there are mechanisms in place to ensure implementation of the Labour Law such as through developing collective agreements, through formulating HIV/AIDS workplace policy and through enforcement of the Labour Law by Labour Inspectors. With respect to the Armed Forces, the mechanisms include awareness raising sessions, using the national ARC hot line, and informing focal persons. • Women's Affairs Offices at the kebele level (grassroots level) monitor implementation of laws/guidelines related to the rights of women such as protecting women from harmful traditional practices (HTPs), violence against women etc. • The national OVC taskforce that includes FBOs and CBOs monitors the Plan of Action for OVC support and care implemented by grassroots CBOs and FBOs.
Briefly comment on the degree to which they are currently implemented:
• In general, these are poorly implemented due to serious constraints with respect to shortage of law enforcement staff, lack of budget for implementation activities etc. • As to the level of implementation at workplaces, such mechanisms are practiced in formal enterprises often with trade union structures. • The implementation of policies and guidelines within the military is good currently but needs more effort and regular monitoring to deepen the implementation process as there is high turnover and new recruits.

2. Does the country have laws, regulations or policies that present obstacles[34] to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes ✓	No

IF YES, for which key populations and vulnerable groups?		
People living with HIV	Yes	**No** ✓
Men who have sex with Men	**Yes** ✓	No
Migrants/mobile populations	Yes	**No** ✓
Orphans and other vulnerable children	Yes	**No** ✓
People with disabilities	Yes	**No** ✓
People who inject drugs	**Yes** ✓	No
Prison inmates	Yes	**No** ✓
Sex workers	Yes	**No** ✓
Transgendered people	**Yes** ✓	No
Women and girls	Yes	**No** ✓
Young women/young men	Yes	**No** ✓
Other specific vulnerable subpopulations [35]*[write in]*:	Yes	**No** ✓

34. These are not necessarily HIV-specific policies or laws. They include policies, laws or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc.

35. Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Briefly describe the content of these laws, regulations or policies:
Absence of laws that facilitate effective HIV prevention, treatment, care and support services for some key vulnerable groups such as MSM, People who inject drugs and Transgendered people is considered as an obstacle.
Briefly comment on how they pose barriers:
Programs cannot be developed for subgroups that are not recognized as beneficiaries of prevention, treatment, care and support services.

4. Prevention

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

Yes ✓	No

IF YES, what key messages are explicitly promoted?		
Abstain from injecting drugs	Yes	No ✓
Avoid commercial sex	Yes ✓	No
Avoid inter-generational sex	Yes	No ✓
Be faithful	Yes ✓	No
Be sexually abstinent	Yes ✓	No
Delay sexual debut	Yes ✓	No
Engage in safe(r) sex	Yes ✓	No
Fight against violence against women	Yes ✓	No
Greater acceptance and involvement of people living with HIV	Yes ✓	No
Greater involvement of men in reproductive health programmes	Yes ✓	No
Know your HIV status	Yes ✓	No
Males to get circumcised under medical supervision	Yes ✓	No
Prevent mother-to-child transmission of HIV	Yes ✓	No
Promote greater equality between men and women	Yes ✓	No
Reduce the number of sexual partners	Yes ✓	No
Use clean needles and syringes	Yes ✓	No
Use condoms consistently	Yes ✓	No
Other [write in below]:	Yes	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 ✓	No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes ✓	No

2.1.

Is HIV education part of the curriculum in:		
Primary schools?	Yes ✓	No
Secondary schools?	Yes ✓	No
Teacher training?	Yes ✓	No

2.2. Does the strategy include age-appropriate, gender-sensitive sexual and reproductive health elements?

Yes ✓	No

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

Yes ✓	No

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

Yes ✓	No

The country has a policy (National AIDS Policy) and Strategy to promote IEC and other preventive health interventions for key or other vulnerable sub-populations. Thematic Area Two in the Strategic Plan elaborates on behavioural HIV prevention addressing the general population and MARPs. This is a key component of the combination prevention intervention strategy.

Briefly describe the content of this policy or strategy:
One of the thematic areas addressed by Strategic Plan II (2010/11- 2014/15) is intensifying HIV prevention. The strategy indicates the need to expand and make all preventive services available to the broader population in both urban and rural areas. It states that these services should be expanded to specific population groups including sex workers, in-school and out-of-school youth, uniformed services, migrants, residents of small market towns and new business opportunity sites (large scale farms, construction sites, mining etc...) refugees and displaced populations including cross-border populations and populations with special needs like people with disability and the elderly.

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

✓ Check which specific populations and elements are included in the policy/strategy

	IDU[36]	**MSM[37]**	**Sex workers**	**Customers of Sex Workers**	**Prison inmates**	**Other Populations[38] *[write in]***
Condom promotion			✓	✓		✓ General population
Drug substitution therapy						
HIV testing and counseling			✓	✓	✓	Project workers-Electric Light and Power Authority + general population
Needle & syringe exchange						
Reproductive health, including sexually transmitted infections, prevention and treatment			✓	✓	✓	Out-of-school youth + general population
Stigma and discrimination reduction			✓	✓	✓	General population + People living with HIV
Targeted information on risk reduction and HIV education			✓	✓	✓	General population + University students, mobile populations
Vulnerability reduction (e.g. income generation)			✓		✓	Orphans

36 IDU = People who inject drugs

37 MSM = men who have sex with men

38 Other vulnerable population other than those listed above, that have been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people, internally displaced people, prisoners, and refugees.

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 2011?

	Very poor										Excellent
2011	0	1	2	3	4	5	6	7	**8**	9	10
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

Overall, on a scale of 0 to 10 (where 0 is "very poor" and 10 is "Excellent"), the average rating of respondents to the policy efforts in support of HIV prevention in 2011was 8.0; equal to the rating in 2009.

Since 2009, what have been key achievements in this area:

- Commitment of leaders at all levels has increased
- Efforts underway to identify key population groups
- Regions turned their efforts with focus on identified population groups
- Scale up of social mobilization and all other prevention interventions
- The spread of HIV has been slowed down
- Awareness of the population has increased significantly
- Workplace HIV policy and strategies are in place
- HIV/AIDS has been mainstreamed both in workplaces and at some project sites
- A number of peer educators, managers and staff have been trained on HIV mainstreaming
- Access or coverage of HIV/AIDS services has increased
- Increased demand for VCT, ART and other health services has been created

What challenges remain in this area:

- Difficulties in addressing remote areas and population groups like MSM, IDUs etc.
- Problem of fully mainstreaming HIV especially at project sites
- Technical, financial and HR problems in undertaking effective and sustainable HIV mainstreaming
- Lack of necessary attention for HIV by some managers
- Low PMTCT coverage

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

Yes ✓	No

***IF YES,* how were these specific needs determined?**
The needs for preventive work were determined based on: • Available epidemiological data, lessons learned on effectiveness of HIV preventive services and consideration of cultural issues. • Various studies (DHS 2011, MARPS study, ANC surveillance 2009) are being used for prioritization currently (according to which changes can be made). • So far, previous pieces of information (DHS 2005, Synopsis of HIV epidemiology) conducted trends, and traditionally known key population groups, including high risk corridor, development schemes, known regions of low prevalence, male circumcision, community conversation information are used.

IF NO, how are HIV prevention programmes being scaled-up?

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3 ✓	4	N/A
Condom promotion	1	2	3	4 ✓	N/A
Harm reduction for people who inject drugs	1 ✓	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3 ✓	4	N/A
HIV prevention in the workplace	1	2	3 ✓	4	N/A
HIV testing and counselling	1	2	3	4 ✓	N/A
IEC[39] on risk reduction	1	2	3 ✓	4	N/A
IEC on stigma and discrimination reduction	1	2	3 ✓	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3 ✓	4	N/A
Prevention for people living with HIV	1	2	3 ✓	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3 ✓	4	N/A
Risk reduction for intimate partners of key populations	1	2	3 ✓	4	N/A
Risk reduction for men who have sex with men	1 ✓	2	3	4	N/A
Risk reduction for sex workers	1	2	3 ✓	4	N/A
School-based HIV education for young people	1	2	3 ✓	4	N/A
Universal precautions in health care settings	1	2	3 ✓	4	N/A
Other*[write in]*:	1	2	3	4	N/A

39 IEC = information, education, communicatio

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 2011?

	Very poor										Excellent
2011	0	1	2	3	4	5	6	7	**8**	9	10
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

Overall on a scale of 0 to 10 (where 0 is "very poor" and 10 is "Excellent"), the average rating of respondents to the implementation of HIV prevention programs in 2011 was 8.0 equal to the rating in 2009. This rating is consistent with their response about the majority of people in need having access to a wide range of preventive interventions.

The Key Achievements in this area include:

- Spread of the epidemic has been slowed down
- Reduction of HIV/AIDS related deaths is apparent
- The awareness of the population has increased significantly
- Community mobilization has been scaled up
- Increased demand for VCT, ART and other health services has been created
- Access or coverage of HIV/AIDS services has increased
- Commitment of leaders at all levels has increased
- Condom utilization has increased
- Workplace HIV policy and strategies are in place
- There is an ongoing study on most-at-risk populations.
- The implementation of a community information system (CIS) is in its final stages.

The challenges in this area include the following:

- Difficulties in addressing remote areas and other vulnerable populations like MSM and IDU
- Low PMTCT coverage
- Inadequate coverage of MARPs
- Problem of fully mainstreaming HIV interventions especially at project sites

5. Treatment, Care and Support

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

Yes ✓	No

If YES, Briefly identify the elements and what has been prioritized:
• Increasing number of patients enrolled in care services • Availing free ART drugs • Enrolling >300,000 adults and adolescents eligible for treatment into ART program • Care to OVC, PLHIV • Care to vulnerable women • Scaling up PMTCT

Briefly identify how HIV treatment, care and support services are being scaled-up?
Based on assessment of high demand. • By increasing number of facilities providing service • By increasing training of health workers • Increasing drug availability • Increasing awareness on treatment and care • Worker's financial contribution (Solidarity Fund) • Organizing PLHIV and training them on home-based care (HBC) 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...	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3 ✓	4	N/A
ART for TB patients	1	2	3 ✓	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3 ✓	4	N/A
Early infant diagnosis	1	2	3 ✓	4	N/A

HIV care and support in the workplace (including alternative working arrangements)	1	2	3 ✓	4	N/A
HIV testing and counselling for people with TB	1	2	3 ✓	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	3 ✓	4	N/A
Nutritional care	1	2 ✓	3	4	N/A
Paediatric AIDS treatment	1	2	3 ✓	4	N/A
Post-delivery ART provision to women	1	2	3 ✓	4	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	2	3 ✓	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	3 ✓	4	N/A
Psychosocial support for people living with HIV and their families	1	2 ✓	3	4	N/A
Sexually transmitted infection management	1	2	3 ✓	4	N/A
TB infection control in HIV treatment and care facilities	1	2	3 ✓	4	N/A
TB preventive therapy for people living with HIV	1	2	3 ✓	4	N/A
TB screening for people living with HIV	1	2	3 ✓	4	N/A
Treatment of common HIV-related infections	1	2	3 ✓	4	N/A
Other *[write in]*:	1	2	3	4	N/A

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

Yes ✓	No

Please clarify which social and economic support is provided:

- Psychosocial support provided through civil society organizations
- Income Generating Activities (IGA) and other types of financial support for PLHIV provided by government institutions as well as NGOs
- Educational, food and shelter support and IGA and financial support to OVC

3. ***Does the country have a policy or strategy for developing/using generic medications or parallel importing of medications for HIV?***

Yes ✓	No

4. ***Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy medications, condoms, and substitution medications?***

Yes ✓	No

IF YES, for which commodities?
• Drugs-ARV • Condoms • OI drugs The Pharmaceutical Fund and Supply Agency under the Ministry of Health, handles the overall logistics system in the country including HIV/AIDS related commodities. The Agency is responsible for overall supply chain functions i.e. selection, quantification, procurement, storage, distribution to service delivery points and capacity building to ensure rational use of medicines.

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 2011?***

Very poor											Excellent
2011	0	1	2	3	4	5	6	7	**8**	9	10
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

Overall on a scale of 0 to 10 (where 0 is "very poor" and 10 is "Excellent"), the average rate given by respondents to efforts in implementation of HIV treatment, care, and support programs in 2011 was 8.0; a rating that is one percentage point lower than that of 2009.

Since 2009, what have been key achievements in this area:
• The number of people enrolled in treatment and care has increased. 80,919 PLHIV were newly enrolled for chronic illness follow up at ART clinics while 33,434 new patients have started antiretroviral treatment during the fiscal year. 4,945 exposed infants have received ARV prophylaxis, while 113,386 STI cases have received treatment • 103,659 PLHIV were provided with nutritional support, while 56,300 and 36,028 have received training and start-up capital for income generating activities, respectively. • Rapidly rising service uptake • Uninterrupted supply of pharmaceuticals using a well established logistic system by PFSA
What challenges remain in this area:
• Scaling up paediatric ART • Adherence issues • Laboratory machines (availability) • High turnover of trained HR

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

Yes ✓	No	N/A

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

Yes ✓	No

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

Yes ✓	No

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

Yes ✓	No

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

*15% for educational material support

**** Source:*** FHAPCO: Monitoring and Evaluation Report, 2003 EFY (July 2010 – June 2011)

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 2011?

Very poor											Excellent
2011	0	1	2	3	4	5	6	**7**	8	9	10
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

Overall on a scale of 0 to 10 (where 0 is "very poor" and 10 is "Excellent"), the average rating given by respondents to efforts to meet the HIV-related needs of orphans and other vulnerable children in 2011 is 7.0 equal to the rating in 2009.

Since 2009, what have been key achievements in this area:
• Strategy for addressing OVC needs has been developed • A new guideline for service provision for OVC is in place • Better access of OVCs to care: Many OVC received educational support, food and clothing support and earned their own income through involvement in IGAs • Stronger community ownership
What challenges remain in this area:

- Reaching all OVC who deserve support is a challenge given the high number of OVC in need of support
- Poor coordination among partners
- Providing paediatric ART

6. Monitoring and Evaluation

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

Yes ✓	In Progress	No

Briefly describe any challenges in development or implementation:
The alignment and harmonization of the different M&E system (HMIS, EMIS etc.) was a challenge during the development phase of the M&E plan. The Plan was developed in line with SPMII – the availability of some of the indicators will depend on the successful scale up of the Community Information System (CIS).

1.1. IF YES, years covered [write in]:

2011 - 2015

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

Yes, (all) most Partners ✓	Yes, some Partners	No	N/A

Briefly describe what the issues are:
• The Health Management information System (HMIS) is not at full implementation yet and CIS is only at the piloting phase. • Most key partners have aligned and harmonized their M&E requirements with the national M&E plan. Some partners have their own M&E system in particular reporting format, indicators, funding mechanisms etc. As a result they have not yet aligned and harmonized their M&E requirement with the national M&E plan.

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy	**Yes** ✓	No
IF YES, does it address:		
Behavioural surveys	**Yes** ✓	No
Evaluation / research studies	**Yes** ✓	No
HIV Drug resistance surveillance	**Yes** ✓	No
HIV surveillance	**Yes** ✓	No
Routine program monitoring	**Yes** ✓	No

A data analysis strategy	**Yes** ✓	No
A data dissemination and use strategy	**Yes** ✓	No
A well-defined standardized set of indicators that includes sex and age disaggregation (where appropriate)	**Yes** ✓	No
Guidelines on tools for data collection	Yes	***No** ✓

*There is a separate CIS Technical Reference Guide and HMIS Manual.

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

Yes	In Progress ✓	No

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 ✓	In Progress	No

Briefly describe any obstacles:
Shortage of human resources

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

In the Ministry of Health?	Yes	No
In the National HIV Commission (or equivalent)?	**Yes** ✓	No
Elsewhere *[write in]*?	Yes	No

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

POSITION [write in position titles in spaces below]	Full time	Part time	Since when
Permanent Staff [Add as many as needed]			
Head of M&E, Plan (1)	✓		2006
M&E Senior Experts (4)	✓		2005
Data Managers and M&E Experts (2)	✓		2005
Data Clerks and IT support (2+ 1)	✓		2006
Total = 10	✓		
	Full time	Part time	Since when?
Temporary Staff [Add as many as needed]			

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 ✓	No

Briefly describe the data-sharing mechanisms:
• National Joint Review meetings and proceedings • National AIDS Council meetings • Joint supportive supervision findings feedback • Web site of key institutions (FHAPCO, EHNRI, ARC) • Dissemination of annual M&E reports • National and regional workshops

What are the major challenges in this area:
• Timely reporting • Getting feedback from partners

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

***Yes** ✓	No

*Even then, monthly meetings are not held regularly as per the TOR.

6. ***Is there a central national database with HIV- related data?***

*Yes ✓	No

*DEV-INFO is currently piloted at Federal HAPCO level.

IF YES, briefly describe the national database and who manages it.
The national database (DEV-INFO) is specific for the routine program reports. It is managed by the M&E Directorate within HAPCO. There are two data clerks and a manager. The analysis is done by senior M&E experts.

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?*

Yes, all of the Above	Yes, but only some of the above ✓	No, none of the above

IF YES, but only some of the above, which aspects does it include?
It includes geographical coverage of HIV services disaggregated by age and sex.

6.2. Is there a functional Health Information System[40]?

At national level	**Yes** ✓	No
At sub-national level	**Yes** ✓	No
IF YES, at what level(s)? *[write in]* At facility, regional and national levels		

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

*Yes ✓	No

*HIV surveillance data is generated and published every two years.

8. How are M&E data used?

For programme improvement?	**Yes** ✓	No
In developing / revising the national HIV response?	**Yes** ✓	No
For resource allocation?	**Yes** ✓	No
Other *[write in]*: For knowledge generation, accountability, and decision-making.	**Yes** ✓	No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:
M&E data are used for planning, advocacy, decision making and to correct or revise programs whenever weak performance is encountered. The main challenges with respect to use of data are related to data quality, timely reporting, and evidence-based data not tailored for use of decision-makers etc.

40. Such as regularly reporting data from health facilities which are aggregated at district level and sent to national level; data are analyzed and used at different levels)?

9. *In the last year, was training in M&E conducted?*

At national level?	**Yes (CIS)**	No
IF YES, what was the number trained: 60		
At sub-national level?	**Yes (CIS)**	No
IF YES, what was the number trained: 1831		
At service delivery level including civil society?	***Yes** ✓	No
IF YES, how many? *1831 under sub-national level includes those trained at service delivery level. At Electric Light and Power Authority (ELPA) 51 management and HIV Focal persons and 25 officials, a total of 76 were trained in M&E.		

9.1. Were other M&E capacity-building activities conducted other than training?

Yes ✓	No

IF YES, describe what types of activities
• Staff are in place at woreda level • Technical support has been provided to Regional HAPCOs, RHBs and selected woredas.

10. 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 2011?

	Very poor										Excellent
2011	0	1	2	3	4	5	6	7	8	**9**	10
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

Overall on a scale of 0 to 10 (where 0 is "very poor" and 10 is "Excellent"), the average rate given by respondents to the HIV-related monitoring and evaluation (M&E) in 2011 was 8.5; a rating that is higher than the two previous ratings in 2007 and 2009.

Since 2009, what have been key achievements in this area:

- M&E framework has been developed
- The Multisectoral HIV and AIDS response Community Information System (CIS) database was established at Federal level; and the pilot phase of the CIS was launched in all regions and city administrations except Gambella and Oromya regions.
- Large scale national surveys were conducted on ART and PMTCT
- Joint supportive supervision and Joint Review Meeting have been conducted
- Annual National M&E reports have been produced.
- A behavioural survey was conducted in five Universities
- The experience of Ethiopia with respect to HIV/AIDS and the health-related MDGs has been articulated and published by HAPCO.

What challenges remain in this area:

- Lack of timely reporting (the new reform for HMIS has not been completed and not able to run the data reporting and recording)
- Lack of strong mechanism for ensuring quality of data
- Turnover of staff at lower levels
- Shortage of trained human resources
- Inadequate financial and material resources
- HAPCO not able to gather monthly ART reports from service delivery points

National Commitments and Policy Instrument (NCPI)

Part B

[administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations]

1. CIVIL *SOCIETY*[41] PARTICIPATION

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

LOW						HIGH
2011	0	1	2	**3**	4	5
2009	0	1	2	**3**	4	5

Comments and examples
• National policy on HIV 1998 SPM I & SPM II were drafted in consultation with CSOs and national networks • Participated in M&E tools development • Representatives of CSOs participate in Global Fund - CCM meetings as members • Civil Society Organizations are members of National AIDS Council, HAPCO Network Forum etc. • The average score given by eleven CSO respondents to civil society contribution to strengthening the political commitment of top leaders and national strategy/policy formulations was 3.2 out of five; which shows their high participation rate.

2. ***To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") 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
2011	0	1	2	**3**	4	5
2009	0	1	2	3	**4**	5

41. Civil society includes among others: Networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of vulnerable sub-populations (including MSM, SW, IDU, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

Comments and examples
• National policy on HIV (1998), SPM I & SPM II were drafted in consultation with CSOs and national networks of PLHIV. • The extent of involvement of civil society representatives in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan was rated as 3.2 out of 5 or 64%; which shows a satisfactory level of involvement.

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?

LOW						**HIGH**
2011	0	1	2	3	**4**	5
2009	0	1	2	3	**4**	5

   b. The national HIV budget?

LOW						**HIGH**
2011	0	1	2	**3**	4	5
2009	0	1	2	**3**	4	5

   c. The national HIV reports?

LOW						**HIGH**
2011	0	1	2	**3**	4	5
2009	0	1	**2**	3	4	5

Comments and examples
In SPM II it is stated that the monitoring and evaluation of the multi-sectoral response will be implemented through joint efforts in a coordinated manner, in line with the principle of "three ones". This includes data collection and reporting by CSOs.

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?

LOW						HIGH
2011	0	1	2	**3**	4	5
2009	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
2011	0	1	2	**3**	4	5
2009	0	1	2	**3**	4	5

   c. *Participate in using data for decision-making?*

LOW					HIGH
0	1	2	**3**	4	5

Comments and examples
CSOs and network organizations are invited by HAPCO to participate in review meetings, annual planning, mid-term evaluations, coordination of M&E activities as well as using data for decision making.

5. **To what extent *(on a scale of 0 to 5 where 0 is "Low" and 5 is "High")*is the civil society sector representation in HIV-related efforts inclusive of diverse organizations (e.g. networks of PLHIV, organizations of sex workers, faith based organizations)?**

LOW						HIGH
2011	0	1	2	3	4	**5**
2009	0	1	2	3	**4**	5

Comments and examples
• All CSOs working on development are mainstreaming HIV/AIDS in their activities • Some CSOs are working with most at risk groups like sex workers, mobile workers and PLHIV.

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?

LOW						**HIGH**
2011	0	1	**2**	3	4	5
2009	0	1	2	**3**	4	5

b. Adequate technical support to implement its HIV activities?

LOW						**HIGH**
2011	0	1	2	**3**	4	5
2009	0	1	2	**3**	4	5

Comments and examples
• Most CSOs operate through funds available from international organizations. • Some CSOs access technical support in the form of participation at training workshops, and by recruiting technical staff like M&E coordinator, and HIV/AIDS coordinator • The lowest score was registered for the ability of civil society to access adequate financial support to implement its HIV activities (2.4 out of 5).

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%**	25-50%	51–75%	>75%
Men who have sex with Men	N/A	25-50%	51–75%	>75%
People who inject drugs	<25% N/A	25-50%	51–75%	>75%
Sex workers	<25%	✓ **25-50%**	51–75%	>75%
Transgendered people	<25% N/A	25-50%	51–75%	>75%
Testing and Counselling	✓ **<25%**	25-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	✓ **51–75%**	>75%
Clinical services (ART/OI)*	✓ **<25%**	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	✓ **51–75%**	>75%
Programmes for OVC**	<25%	25-50%	✓ **51–75%**	>75%

**ART = Antiretroviral Therapy; OI=Opportunistic infections*
***OVC = Orphans and other vulnerable children*

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 2011?

	Very poor										Excellent
2011	0	1	2	3	4	5	**6**	7	8	9	10
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

The overall rating, since 2005, shows that the trend with respect to civil society participation is on the increase. However, the rating on the overall efforts made to increase civil society participation in 2011 (average rate 6.3) is slightly lower than the rate in 2009 (7.0).

Since 2009, what have been key achievements in this area:

- Since 2005, the overall efforts to increase civil society participation in the design of the national AIDS strategy, national AIDS budget allocation, and national AIDS reporting and programming have improved. CSOs are well represented and they make a significant input to political commitment and policy formulation. However, in their opinion they are not yet able to access adequate financial and technical support. Accordingly, CSOs have given relatively lower score for their ability to access adequate financial and technical support to implement their HIV activities (2.4 and 2.5 out of 5 respectively).
- Civil society has made considerable progress over the past three years in the fight against HIV/AIDS; more and more PLHIV associations have been strengthened; and CSOs are providing more than 50-75% of home-based care, programs for OVC and reduction of stigma and discrimination.
- As a result of CSO activities, there is increased community involvement in prevention, care and support activities e.g. Self-help community organizations, and trade unions are involved more and more in prevention of HIV/AIDS and in care and support of PLHIV.

What challenges remain in this area:

- Inadequate technical and capacity building support to civil society on the part of the government and development partners.

2. 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 ✓	No

IF YES, describe some examples of when and how this has happened:
Most of the CSOs (represented by CRDA, NEP+ etc) have been involved in the design and implementation of SPM I and SPM II. Through partnership with the Global Fund and different international NGOs; government is committed for better access of funds for PLHIV.

3. 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	Yes	No
People living with HIV	**Yes** ✓	No
Men who have sex with Men	Yes	**No** ✓
Migrants/mobile populations	**Yes** ✓	No
Orphans and other vulnerable children	**Yes** ✓	No
People with disabilities	**Yes** ✓	No
People who inject drugs	Yes	**No** ✓
Prison inmates	**Yes** ✓	No
Sex workers	**Yes** ✓	No
Transgendered people	Yes	**No** ✓
Women and girls	**Yes** ✓	No
Young women/young men	**Yes** ✓	No
Other specific vulnerable subpopulations *[write in]*:	Yes	No

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

Yes ✓	No

***IF YES* to Question 1.1 or 1.2, briefly describe the contents of these laws:**
The FDRE constitution Art. 25 states, "All persons are equal before the Law and are entitled without any discrimination to the equal protection of the Law. In this respect, the Law shall guarantee to all persons equal and effective protection without discrimination on grounds of race, nation, nationality or social origin, colour, sex, language, religion, political or other opinion...or other STATUS".
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Institutions were established for purposes of putting into effect the laws of the land such as: • Law enforcement bodies • National Human Rights Commission • Institution of Ombudsman • The media

Briefly comment on the degree to which they are currently implemented:
This would require further study, but overall the implementation of laws in this respect is poor.

2. ***Does the country have laws, regulations or policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?***

Yes ✓	No

2.1. *IF YES, for which sub-populations?*

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS	Yes	**No** ✓
People living with HIV	Yes	**No** ✓
Men who have sex with Men	**Yes** ✓	No
Migrants/mobile populations	Yes	**No** ✓
Orphans and other vulnerable children	Yes	**No** ✓
People with disabilities	Yes	**No** ✓
People who inject drugs	**Yes** ✓	No
Prison inmates	Yes	**No** ✓
Sex workers	Yes	**No** ✓
Transgendered people	**Yes** ✓	No
Women and girls	Yes	**No** ✓
Young women/young men	Yes	**No** ✓
Other specific vulnerable subpopulations [43]*[write in]*:	Yes	No

42. These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: "laws that criminalize same sex relationships", "laws that criminalize possession of condoms or drug paraphernalia"; "loitering laws"; "laws that preclude importation of generic medicines"; "policies that preclude distribution or possession of condoms in prisons"; "policies that preclude non-citizens from accessing ART"; "criminalization of HIV transmission and exposure", "inheritance laws/rights for women", "laws that prohibit provision of sexual and reproductive health information and services to young people", etc.

43. Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Briefly describe the content of these laws, regulations or policies
The main content of the national laws, regulations or policies include the following key points; • The need to review/reform legislation 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 rights 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
Briefly comment on how they pose barriers:
The absence of policies, laws, regulations or guidelines concerning recognition of MSM, people who inject drugs and transgendered people presents obstacles to effective HIV prevention, treatment, care and support for these groups.

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 ✓	No

Briefly describe the content of the policy, law or regulation and the populations included.
The Policy Framework recognizes that harmful traditional practices have seriously affected women in Ethiopia. But these were not addressed in the context of HIV/AIDS. The Policy framework in addressing the issue did not acknowledge seriously the effect of violence against women that increases their chance of infection with the virus such as rape, abduction and sexual abuse.

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

Yes ✓	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
National HIV/AIDS Policy in Ethiopia(1998, Art.8) acknowledges the need for more comprehensive response to the HIV/AIDS epidemic including the provision and monitoring of ART; voluntary counselling and testing for HIV; treatment of sexually transmitted infections; social, spiritual and peer support***; respect for human rights***; and reducing the stigma associated with HIV/AIDS. It is also explicitly called for in SPMII (2010 - 2014).

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	**No X**

IF YES, briefly describe this mechanism:

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).***

	Provided free-of charge to all people in the country		**Provided free-of charge to some people in the country**		**Provided, but only at a cost**	
Antiretroviral treatment	**Yes** ✓	No	Yes	No	Yes	No
HIV prevention services[44]	**Yes** ✓	No	Yes	No	Yes	No
HIV-related care and support interventions	Yes	No	**Yes** ✓	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?
• Free ART for eligible PLHIV • Family planning and HIV prevention services such as condom distribution for sex workers, transport workers, OVCs, refugees etc is provided to all people in particular to pregnant women and youth. • HIV-related care and support is provided for needy persons living with HIV, for OVCs and for destitute women.

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

Yes ✓	No

7.1. 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 ✓	No

44. Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of mother-to-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for young people, universal precautions in health care settings.

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 ✓	No

IF YES, Briefly describe the content of this policy/strategy and the populations included:
SPM II specifies that all preventive services need to be made available to the broader population in both urban and rural areas. These services should also be expanded to specific population groups including sex workers, in-school and out-of-school youth, uniformed services, migrants, residents of small market towns and new business opportunity sites (large scale farms, construction sites, mining etc.), refugees and displaced populations including cross-border populations and populations with special needs like people with disability and the elderly.

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 ✓	No

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 such as taxi drivers, sex workers and youth. • The strategy addresses targeted intervention to MARPs • Expansion of anti-HIV/AIDS Associations and clubs

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

Yes ✓	No

IF YES, briefly describe the content of the policy or law:
• HIV Policy prohibits forced medical examination • Civil Code Art. 20(1) states "A person may at any time refuse to submit himself to a medical or surgical examination or treatment".

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 ✓	No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	**No ✓**

IF YES on any of the above questions, describe some examples:
There exists a National Human Rights Commission that deals with the issue.

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)[45]*?*

Yes ✓	No

b. Programmes for members of the judiciary and law enforcement[46] *on HIV and human rights issues that may come up in the context of their work?*

Yes ✓	No

45. Including, for example, Know-your-rights campaigns – campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008)

46. Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners

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

a. Legal aid systems for HIV casework

Yes ✓	No

b. *Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV*

***Yes ✓**	No

*The Ethiopian Women Lawyer's Association provides legal services for women and young people.

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

Yes ✓	No

IF YES, what types of programmes?		
Programmes for health care workers	**Yes ✓**	No
Programmes for the media	**Yes ✓**	No
Programmes in the work place	**Yes ✓**	No
Other *[write in]*:	**Yes ✓**	No
Programs for school children		

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 2011?

Very poor											Excellent
2011	0	1	2	3	4	**5**	6	7	8	9	10
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

The overall rate given by the respondents showed that there is no significant progress concerning policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2011.

Since 2009, what have been key achievements in this area:
• Incorporation of human rights issues in SPM II • Workplace HIV/AIDS policies have been developed by the Confederation of Ethiopian Trade Unions and several ministries. Thus, discrimination and stigma has been reduced and PLHIV are becoming empowered to fight for their rights. • In the process of promoting human rights, the issue of HIV/AIDS was given attention by the Ethiopian Human Rights Commission and is being promoted as part of human rights issue.
What challenges remain in this area:
• The level of commitment at lower levels to ensure adequate integration of human right issues in the design and implementation of HIV/AIDS plans and programs, • Poor monitoring and evaluation system in place to ensure the implementation of human rights related HIV/AIDS programs at different levels. • Lack of technical and financial support for partners' engagement on rights advocacy related to HIV/AIDS. • Scaling up of BCC in rural areas

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 2011?

Very poor										Excellent
2011	0	1	2	3	4	**5**	6	7	8	9	10
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 2009*, what have been key achievements in this area**:
Since 2009, 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. For example: • The Labour Law No. 377/96 has been revised in EFY 2004 and is awaiting approval. The revision prohibits discrimination on grounds of nationality, sex, religion, political beliefs and HIV/AIDS. • The Ministry of Labour and Social Affairs (MOLSA) is exerting a lot of effort to implement the ILO Recommendation concerning HIV and AIDS and the world of work, 2010 (No. 200). • MOLSA has also prepared a draft National Policy on Occupational Health and Safety in EFY 2004. This policy framework explicitly states that HIV/AIDS prevention, control, treatment, care and support interventions should be provided at workplaces integrated with occupational health and safety services; and also stipulates that measures will be taken to protect workers living with the virus from stigma and discrimination. • Moreover, there are some encouraging developments to enforce the existing policies, laws and regulations at work places using the collective agreement and through participation of employers and trade union structures.
What challenges remain in this area:
• There are current policy gaps with respect to human rights related policies, laws and regulations (e.g. there are no policies or laws concerning provision of services for MSM, people who inject drugs and transgendered people) that are not addressed so far.

4. Prevention

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

Yes ✓	No

***IF YES*, how were these specific needs determined**?
• Based on needs assessments and available HIV evidence (epidemiology, level of current HIV response). Existing evidence is still incomplete e.g. data on MARPS is inadequate, no HIV synthesis studies available in all regions. • The PMTCT Guideline (4 prongs)
***IF NO*, how are HIV prevention programmes being scaled-up?**

1.1. To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	**4** ✓	N/A
Condom promotion	1	2	3	**4** ✓	N/A
Harm reduction for people who inject drugs	**1** ✓	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	**4** ✓	N/A
HIV prevention in the workplace	1	2	3	**4** ✓	N/A
HIV testing and counselling	1	2	3	**4** ✓	N/A
IEC[47] on risk reduction	1	2	3	**4** ✓	N/A
IEC on stigma and discrimination reduction	1	2	**3** ✓	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	**4** ✓	N/A
Prevention for people living with HIV	1	2	**3** ✓	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	**4** ✓	N/A
Risk reduction for intimate partners of key populations	1	2	**3** ✓	4	N/A
Risk reduction for men who have sex with men	**1** ✓	2	3	4	N/A
Risk reduction for sex workers	1	2	**3** ✓	4	N/A
School-based HIV education for young people	1	2	3	**4** ✓	N/A
Universal precautions in health care	1	2	**3** ✓	4	N/A

settings					
Other*[write in]*:	1	2	3	4	N/A

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 2011?***

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

There is good progress in the implementation of specific HIV prevention programs since 60 to 90 percent of the respondents acknowledged that the majority of people in need have access to most of the HIV prevention programs except for people who inject drugs and men who have sex with men.

Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), the efforts in the implementation of HIV prevention programs in 2011 were rated at 6.3. There is therefore marked progress with respect to HIV/AIDS prevention programs in 2011(6.3) compared to that of 2007 (average score of 4.7 out of 10).

***Since 2009*, what have been key achievements in this area**:
Government has taken responsibility for implementing the prevention component; and key achievements in this area include: • Steady increase in community conversation program • Good IEC/BCC materials have been developed and used by the media • Most of the CBOs participated in prevention activities e.g. Self-help organizations at community level are involved in prevention activities • Community mobilization has been scaled up
What challenges remain in this area:
• Access and quality gaps.

5. Treatment, Care and Support

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

Yes ✓	No

***IF YES*, Briefly identify the elements and what has been prioritized:**
• Chronic care and treatment services • TB/HIV collaborative activities • Laboratory and referral system • Supply management system in relation to availability of essential OI, ARV drugs and reagents • Treatment literacy and adherence counselling • Chronic care and treatment services in the private sector • Human resource issues • ART provision, IGA and psycho-social support are given priority.
Briefly identify how HIV treatment, care and support services are being scaled-up?
Other than the above mentioned strategies, care and support services are being scaled up by implementing the following strategies: • Strengthen the involvement of local communities in care and support-focus on accessibility to rural areas • Enforce the provision of standardized care and support to OVC and PLHIV-focus on quality and standards • Enhance school based OVC support. • Strengthen income generation activities to sustain the program-allow more resources for care and support

1.1. 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 to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	**4** ✓	N/A
ART for TB patients	1	2	3	**4** ✓	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	**3** ✓	4	N/A
Early infant diagnosis	1	2	**3** ✓	4	N/A
HIV care and support in the workplace (including alternative working arrangements)	1	2	**3** ✓	4	N/A
HIV testing and counseling for people with TB	1	2	3	**4** ✓	N/A

HIV treatment services in the workplace or treatment referral systems through the workplace	1	2	**3** ✓	4	N/A
Nutritional care	1	**2** ✓	3	4	N/A
Paediatric AIDS treatment	1	2	**3** ✓	4	N/A
Post-delivery ART provision to women	1	2	**3** ✓	4	N/A
HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault)	1	**2** ✓	3	4	N/A
Post-exposure prophylaxis for occupational exposures to HIV	1	2	**3** ✓	4	N/A
Psychosocial support for people living with HIV and their families	1	2	**3** ✓	4	N/A
Sexually transmitted infection management	1	2	**3** ✓	4	N/A
TB infection control in HIV treatment and care facilities	1	2	**3** ✓	4	N/A
TB preventive therapy for people living with HIV	1	2	**3** ✓	4	N/A
TB screening for people living with HIV	1	2	**3** ✓	4	N/A
Treatment of common HIV-related infections	1	2	**3** ✓	4	N/A
Other*[write in]*:	1	2	3	4	N/A

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 2011?*

Very Poor										Excellent
0	1	2	3	4	5	6	**7**	8	9	10

The overall rating given by the key informants to the efforts made in the implementation of HIV treatment, care and support programs in 2011, showed significant progress (average score of 7.1 out of 10) compared to that of 2007 (average score of 5.9 out of 10).

***Since 2009*, what have been key achievements in this area**:
• The HIV treatment, care and support program has been scaled up. The number of people under ART has increased mainly due to free ART service expansion; and this rapid scale up has increased access to service. ART sites expanded in a sustained and rapid way and ARV became freely available for patients. • There are no adequate interventions regarding nutritional care and support to PLHIV and treatment for cases with opportunistic infections.
What challenges remain in this area:
• Maintaining quality service is a challenge due to rapid rate of scale up, and lack of human and financial resources. • Still high losses to follow up among PLHIV enrolled in treatment and care.

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

Yes ✓	No

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

Yes ✓	No

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

Yes ✓	No

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

Yes ✓	No

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

Out of 2.3 million needy OVC, the percentage of those who received different services was as follows:

Educational support= 15%
Food support = 10%
Shelter Support = 1.0%
IGA Training = 1.9%
Financial Support = 1.6%

*Source: FHAPCO - Monitoring g & Evaluation Report, 2003 EFY (July 2010 – 2011)

11. 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 care and support programs for OVC in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

With respect to the efforts made in the implementation of HIV treatment, care and support programs for OVC in 2011, the overall rating given by the key informants was 6.3 out of 10.

***Since 2009*, what have been key achievements in this area**
• A guideline on the minimum service package for Orphans and Vulnerable Children (OVCs) was produced and distributed. Support to OVCs is undertaken at present on the basis of the new guideline which lays out a minimum service package to OVC. • The average score given by the eleven respondents is consistent with the performance of the multi-sectoral HIV/AIDS response elaborated in the M&E Report. Most of the respondents stated that the country has a strategy that addresses the additional HIV-related needs of orphans and other vulnerable children. In fact a new guideline which provides guidance in the provision of a minimum service package to OVC is in place. There is an operational definition as well as a national action plan specifically for OVC. The coverage in the provision of support to needy orphans and vulnerable children remains at a low level; however, despite the limited coverage, according to the M&E Report (2010/11) support to OVCs has steadily increased over the years. For example, educational support was provided to 352,201 OVCs in 2009/10 and to 354,660 in 2010/11.Food and shelter support increased from 104,399 in 2009/10 to 251,505 in 2010/11.
What challenges remain in this area:
Still a large number of OVC do not receive a minimum package of HIV services.