COUNTRY PROGRESS REPORT ON THE HIV RESPONSE, 2014

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Federal Democratic Republic of Ethiopia

Acknowledgement

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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
CPT	Co-trimoxazole Preventive Therapy
CSWs	Commercial Sex Workers
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
FMoH	Federal Ministry of Health (Ethiopia)
FHAPCO	Federal HIV/AIDS Prevention and Control Office
GARPR	Global AIDS Response Progress Report
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOE	Government of Ethiopia
HDA	Health Development Army
HEW	Health Extension Worker
HSDP	Health Sector Development Plan
IPT	Isoniazid Preventive Therapy
MARPs	Most-at-Risk Populations
MDGs	Million Development Goals
MRIS	Multisectoral Response Information System
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NASA	National AIDS Spending Assessment
NEP	Network of Networks of HIV Positives in Ethiopia
OVCs	Orphans and Vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SPM	Strategic Plan for intensifying the Multisectoral HIV and AIDs response
UNDAF	UN Development Assistance Framework
VAW	Violence against Women
VCT	Voluntary Counselling and Testing

GARPR core indicators

Target	*Indicator*				
Target 1 ***Reduce sexual transmission of HIV by 50% by 2015*** ***General population***	1.1	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	**DHS 2000 (%)** No DHS data collected on this specific indicator	**DHS 2005 (%)** F= 20.5 M= 33.3 21.1 19.7 32.1 34.8	**DHS 2011 (%)** 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	No DHS data available on specific indicator	F= 0.2 M=4.1 0.4 0.6 0.1	F= 0.4 M= 3.5 0.3 0.6 0. 4

		25-49 years Male 15-19 years 20-24 years 25-49 years		 3.9 5.0 4.0	 0.5 1.6 5.3
	1.4	Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months who report using a 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 this specific indicator*	*No data collected on specific this indicator*	F=47 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
	1.6	Percentage of young women aged 15–24 years living with HIV (ANC)	**ANC 2007** 3.3%; unadjusted	**ANC 2009** 2.6%; unadjusted	**ANC 2012** 2.3%; unadjusted

Sex workers	1.7	Percentage of sex workers reached with HIV prevention programme	**2011**	**2012**	**2013**
			N/A	N/A	N/A
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client *Note: No nationally representative data for 2011 and 2012*	N/A	N/A	98.4% (preliminary results, MARPs surveillance, 2013)
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results *Note: No nationally representative data for 2011 and 2012*	N/A	N/A	82.5% (preliminary results, MARPs surveillance, 2013)
	1.10	Percentage of sex workers living with HIV *Note: No nationally representative data for 2011 and 2012*	N/A	N/A	23.8% (preliminary results, MARPs surveillance, 2013)
Men who have sex with men *(Remarks: no national data on MSM. No specific intervention programme.)*	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 a condom the last time they had anal sex with a male partner	N/A	N/A	N/A
	1.13	Percentage of men who have sex with men who have received an 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
Male circumcision	1.22	Percentage of men 15-49 years that are circumcised	**DHS 2000** N/A	**DHS 2005** 92.5%	**DHS 2011** 91.8%

	1.23	Number of male circumcisions preformed *(MC almost universal at birth in Ethiopia – VMMC programme activities conducted in Gambella region where MC rates are lower and among the military)*	**Programmatic data 2011*** 8,236 (PEPFAR)	**Programmatic data 2012*** 12,445 (PEPFAR)	**Programmatic data 2013** 16,393 (PEPFAR)
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. A study on IDUs in Addis Ababa on going)*	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	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 an 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 3 Eliminate mother-to-child transmission of HIV by 2015 & substantially reduce AIDS-related maternal deaths	3.1	Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission Total 24,956 29,474 34,581 Maternal AZT Single dose nevirapine Mothers on ART for life	**2011 Programmatic Data** 10,302 5280 199 4823	**2012 Programmatic Data** 15,925 7,784 96 8,044	**2013 Programmatic Data** 55% = 18,285/33,200 (28,200-39,200) 5,961 16 4,219 ***newly initiated on ART***

* New indicator introduced in 2013

					8,089 ***already on ART before current pregnancy***
	3.2	Percentage of infants born to HIV+ women receiving a virological test for HIV within 2 months of birth	4,753	7,260	21% = 7,070/33,200 (28,200 – 39,200)
	3.3	Mother-to-child transmission of HIV (after the breastfeeding period) (Spectrum/EPP modelled)	35%	32%	25%
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	265,174 249,174 16,000	288,137 (M=117070 F=171067) 270,460 17,677	40%=317,443/793,700 (716,300-893,200) (Out of total no. of PLHIV) (M=124,870 & F=192,573) 50%=298,512/593,400 (540,100-668,300) (all adult PLHIVs) 9.5% = 18,931/200,300 (172,400 – 232,400) (eligibility all children <15 yrs)
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	72.5% on ART (ART scale up study 2009)	83.3% (5,788/6,943) (FHAPCO national ART study 2011)	81.3% (38,286/47,085) (PEPFAR programmatic data 2013)
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	N/A	34.9% (8,022/23,000) (Numerator: PEPFAR programmatic data; Denominator: WHO global tuberculosis report 2013)	30.7% (7055/23,000) (Numerator: PEPFAR programmatic data; Denominator: WHO global tuberculosis report 2013)

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	**Expenditure data for 2011** No national data available*	**Expenditure data for 2012** 405 million USD spent on HIV/AIDS in 2011/12 (54.4 million USD from public sources) (NASA 2014)	**Expenditure data for 2013** No national data available
Target 7 Eliminating gender equalities	7.1	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)
Target 8 Eliminating stigma & discrimination	8.1	Percentage of women and men aged 15-49 years who report discriminatory attitudes towards people living with HIV (*not willing to buy fresh vegetables from a HIV positive vendor*)	N/A¥	73.6%	59.9%
Target 9 Eliminate travel restrictions		***N/A no travel restrictions in Ethiopia for PLHIV***			
Target 10 Strengthening HIV integration			**DHS 2000**	**DHS 2005**	**DHS 2011**
	10.1	A. Current school attendance rate of orphans aged 10-14 primary school age, secondary school age	*No data collected on this specific indicator*	*No data collected on this specific indicator*	69.1%

* National Health Accounts (NHA) estimating expenditure in 2010/11 conducted but result yet to be finalized
EFY = Ethiopian Fiscal Year
¥ Indicator different in 2000 therefore data not comparable with DHS 2005 and 2011 results

		B. Current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent	*No data collected on this specific indicator*	*No data collected on this specific indicator*	76.5%
	10.2	Proportion of the poorest households who received external economic support in the last three months	*No data collected on this specific indicator*	*No data collected on this specific indicator*	*No data collected on this specific indicator*
	10.3	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)	2011	2012	2013
			Ref GARPR Report 2012	N/A	Ref Annex 2 of this report

I. Introduction

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 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 the reporting period January 2012 to December 2013**. It provides 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.

II. Overview of the AIDS epidemic in Ethiopia

2.1. Current HIV/AIDS Profile

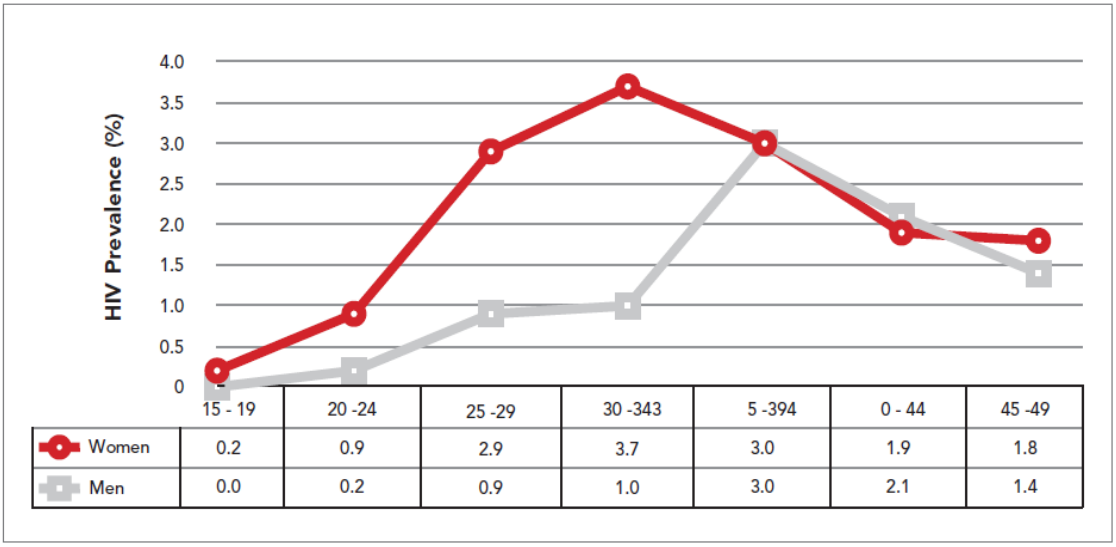
In 2013 there were an estimated 793,700 (716,300-893,200) people living with HIV including 200,300 (172,400 – 232,400) children according to the latest EPP/Spectrum modelling. As per the same modelling, the paediatric HIV population in Ethiopia are mostly older children who were vertically infected in earlier years when the coverage and effectiveness of PMTCT in the country was low/MTCT rates high (in 2013 163,800 HIV positive children were aged 5-14 years).

There were approximately 45,200 (36,500-55,200) AIDS related deaths in 2013 and about 898,400 (770,700 – 1,048,500) AIDS orphans in the same year. HIV adult prevalence is estimated at 1.5% in 2011, the year in which the last Ethiopian Demographic Health Survey (DHS) was conducted[1]. However prevalence varies according to age, sex, gender and geographical location. According to the 2011 DHS adult prevalence was almost twice as high among females compared to males at 1.9% versus 1.0% respectively. The distribution of HIV prevalence also varies by age, peaking earlier in females in the 30-34 years age group compared to 35-39 years in males[2]. Looking at the younger age groups it can be seen that young women have a two to six fold higher HIV prevalence than young men (ranging from 15-17 years: 0% males vs. 0.2% females to 20-22 years: 0.1% males vs. 0.6%

[1] Central Statistical Agency (Ethiopia) and ICF International. 2012. Ethiopia Demographic and Health Survey 2011. Calverton, Maryland, USA: Central Statistical Agency and ICF International.
[2] IBAN

females) [3]. Marked variation in urban rural prevalence is also reported in the 2011 EDHS with urban areas showing a seven fold higher HIV prevalence compared to rural areas (4.2% versus 0.6%).

Figure 1: Age and sex distribution of HIV prevalence (EDHS 2011)



	15 - 19	20 -24	25 -29	30 -343	5 -394	0 - 44	45 -49
Women	0.2	0.9	2.9	3.7	3.0	1.9	1.8
Men	0.0	0.2	0.9	1.0	3.0	2.1	1.4

Source: FHAPCO. HIV/AIDS in Ethiopia. An epidemiological synthesis, 2014

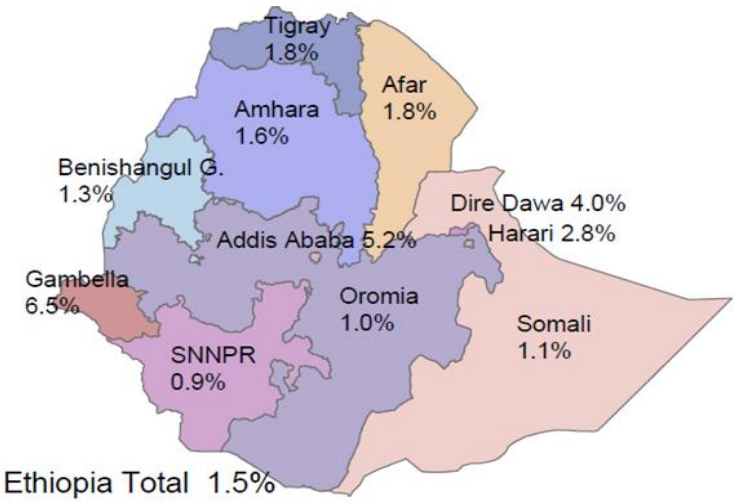
The HIV epidemic in Ethiopia is becoming more concentrated in urban areas and along major transport corridors. DHS 2011 data shows HIV prevalence in large towns including Addis Ababa the regional capital increased from 2005 to 2011. Higher prevalence in Addis Ababa and large towns may be associated with labour migration to large urban areas and large scale construction projects as well as a growing service industry. Moreover DHS 2011 analysis showed HIV prevalence is four times greater among populations that reside within 5km from a main asphalt road compared to those further away[4].

Variations in HIV prevalence were also observed among regions. According to the 2011 DHS Gambella region and the urban administrations of Addis Ababa and Dire Dawa have the highest prevalence while SNNPR and Oromia region the lowest (figure 2). However, due to their large population size, Oromia, Amhara and SNNPR regions have the largest PLHIV population. Thus although these regions have a lower HIV prevalence they still bear a significant proportion of the epidemic burden. Overall the HIV epidemic in Ethiopia can be summarized as both generalized and heterogeneous.

[3] DHS 2011 data analysed and reported in: HIV/AIDS in Ethiopia. An epidemiological synthesis. Federal HIV/AIDS Prevention and Control Office 2014 *(in press)*

[4] Federal HIV/AIDS Prevention and Control Office 2014. HIV/AIDS in Ethiopia. An epidemiological synthesis. *In press*

Figure 2: HIV prevalence by region, DHS 2011



Source: EDHS, 2011

2.2. Epidemic Trends

Prevalence by Time

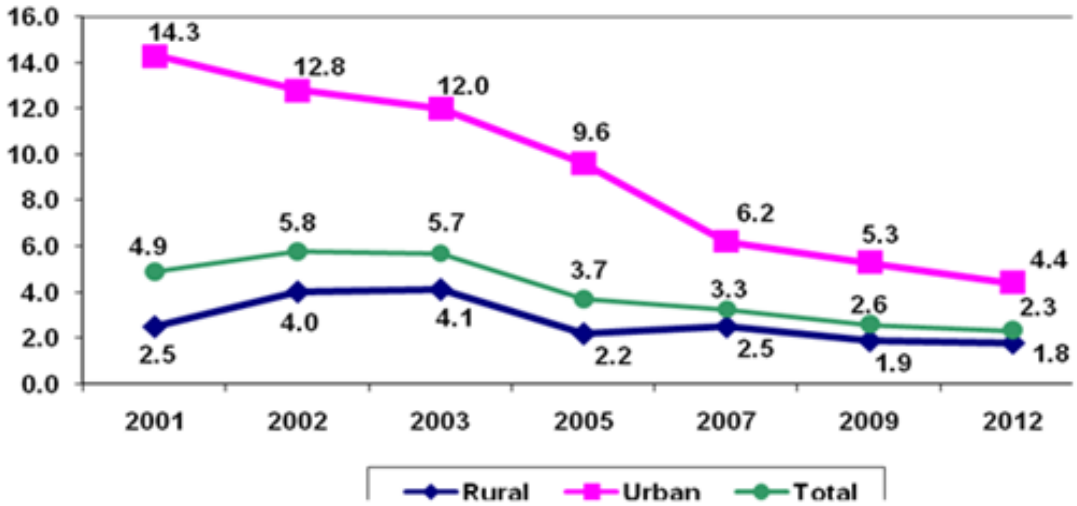
Indicator	*2007*	*2009*	*2012*
Percentage of young people aged 15–24 years living with HIV	*3.3%; unadjusted (ANC 2007)*	*2.6%; unadjusted (ANC 2009)*	*2.3%; unadjusted (ANC 2012)*

Findings from the most recent national antenatal care (ANC) sentinel surveillance show a declining trend in HIV prevalence among pregnant women aged 15-49 years in both urban and rural areas. Urban HIV prevalence declined from a peak of 14.3% in 2001 to 4.4% in 2012, while rural prevalence peaked in 2003 at 4.1% and remained at 1.9% in 2009 and 1.8% in 2012 (figure 3).

Similarly HIV prevalence among pregnant women aged 15-24 years attending ANC decreased from 3.5% in 2007, to 2.6% in 2009 and 2.1% in 2012; a proxy for a decline in new infections[5]. This trend was observed in both urban and rural areas. In urban areas the prevalence decreased by more than half from 9.1% in 2005 to 3.3% in 2012. Similarly rural prevalence among 15-24 year old ANC attendees declined from 2.4% in 2005 to 1.4% in 2012.

[5] Ethiopian Health and Nutrition Institute, Federal Ministry of Health. Report on the 2012 Round Antenatal Care based Sentinel HIV Surveillance in Ethiopia. December 2013

Figure 3: Trends in HIV prevalence among ANC clients in urban and rural sites, 2001-2012



Source: ENHRI and FMoH. ANC sentinel HIV surveillance 2012 report

2.3 HIV in Key Populations

High risk (or key) populations are 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 or in some cases the behaviours or HIV sero-status of their sexual partner may place them at risk.

High risk populations are diverse in Ethiopia and have not been monitored over time or well defined or although selected studies have been conducted including regional HIV synthesis[6,7] which have identified region specific high risk groups. Currently systematic monitoring efforts are focusing on female sex workers and long distance truck drivers[8].

Female sex workers:
According to the national MAPRs (Most at Risk Populations) surveillance study conducted by the Ethiopian Public Health Institute (EPHI) and Centre for Disease Control (CDC) in all regional capitals between July 2013 and January 2014, HIV prevalence among female sex workers was estimated at 23.8% overall (this is un weighted estimate. Weighted estimates will be published shortly by EPHI). However prevalence ranged from 15.0% in Hawassa (SNNP region) to 33.0% in Mekele (Tigrai region). Size estimates for sex workers and HIV prevalence data for long distance drivers from the EPHI/CDC MARPs study is expected to be released later in 2014.

Data on other key populations are sparse. The Federal HIV Prevention and Control Office identified the follow groups as most at risk populations in its HIV prevention package for MARPs and vulnerable groups: sex workers, mobile workers, in school youth aged 15-24 years, uniformed

[6] Tigrai Health Bureau/HAPCO. 2012. Tigrai regional state synthesis of the HIV epidemic and response.
[7] Gambella Health Bureau/HAPCO. 2013. Gambella regional stat synthesis of the HIV epidemic and response
[8] MARPS Surveillance study. EPHI and CDC 2013-2014. Preliminary results.

services and prison inmates[9]. Existing limited studies indicate the following groups may be at higher risk of HIV infection:

Mobile workers:

HIV synthesises of existing prevalence and behavioural data[10] and primary qualitative data from focus group discussions (FGDs) and key informant interviews (KIIs) in three regions (Tigrai, Gambella and Oromia) identified seasonal mobile workers employed in commercial farms, development sites such as sugar plantations and gold mines as a previously underappreciated but nonetheless high risk group. FGDs and KIIs in the three regions revealed a number of high risk behaviours among mobile seasonal workers including frequent alcohol use, casual sex and engagement in transactional sex. These sexual factors coupled with separation from families for long periods of time and low/non-existent targeted HIV prevention services were identified as rendering this group of mostly male workers particularly vulnerable to HIV infection. In addition analysis of routine HIV testing data from health facilities in the areas where large numbers of mobile seasonal workers are located were higher than the regional averages for all three regions[11,12,13].

University and high school students:

High risk sexual behaviours have been reported among university and high school students. However, no representative seroprevalence data for university students are available and seroprevalence data for high school students show minimum HIV prevalence.

According to one study of students from five universities 81% of male and 63% of female students had sex with a non-regular partner in the last 12 months. In addition among currently sexually active male students almost two thirds (64%) had sex with at least one female sex worker in the past year[14]. However preventative behaviours were also reported in the same study: 62% of students had ever used a condom and 54% reported always using condoms.

A recent bio behavioural survey conducted in 2012 among secondary schools along roadside and urban areas in Amhara found one case of HIV among the 1,317 students tested (0.07% HIV prevalence). However only 46% of those with casual partners reported using a condom at last sex; indicating the presence of some risk behaviour[15].

Uniformed services (police and armed forces):

Although comprehensive up to date data are not available for uniformed services the limited data suggest HIV prevalence is lower in this group than previously reported and declining. ANC surveillance data from Armed Forces hospitals shows a declining trend in HIV prevalence from 15.3%

[9] Federal HIV/AIDS Prevention and Control Office. 2011. HIV prevention package: MARPS and vulnerable groups.

[10] These include published studies, health facility testing data from Regional Health Bureaus, DHS 2005 and 2011 data, antenatal care surveillance data and mobile counselling at testing for Oromia region only.

[11] Tigrai RHB/HAPCO and UNAIDS. 2012 Tigrai regional State synthesis of the HIV epidemic and response.

[12] Gambella RHB/HAPCO and UNAIDS. 2013. Gambella regional State synthesis of the HIV epidemic and response.

[13] Oromia RHB/HAPCO and UNAIDS. 2013. Oromia regional State synthesis of the HIV epidemic and response. Draft report.

[14] Federal HIV/AIDS Prevention and Control Office. 2011

[15] CDC 2012. Serological and behavioural survey of students attending secondary schools in hotspot woredas with the Amhara Regional state.

in 2003 to 8.7% in 2012[16]. Studies conducted from 2000 onwards report HIV prevalence to be below 10%[17].

Prisoners:

A recent rapid assessment (still in a draft form) of HIV prevalence and knowledge and behaviours in prisons conducted across all regions of Ethiopia except Somali region estimated HIV prevalence among inmates to be 4.2% overall (4.3% in males vs. 3.8% in females). Prevalence was higher in Federal prisons compared with regional prisons at 4.5% and 2.5% respectively and among inmates in Gambella (11.4%). Nearly 30% of inmates consider themselves at risk of contracting HIV in prison and cited sharing of shaving equipment and piercing instruments as the main risk factors[18]. The level of knowledge on HIV prevention among inmates was lower than the general population. Findings from DHS 2011 show that 73.7% of males and 64.6% of females know the chance of becoming infected with HIV is reduced by limiting sexual intercourse to one uninfected partner who has no other partners[19]. Among prisoners however only about half (57.9% of males and 48.8% of females) of inmates reported this. Moreover knowledge on HIV transmission by anal and oral sex was limited among prisoners. Only 58.9% and 42.1% of respondents knew that HIV can be transmitted by anal sexual intercourse without a condom and by oral sex respectively[20].

FGDs with prisoners in the regional HIV synthesis studies in Tigrai and Gambella also identified a number of behaviours that could render prison inmates vulnerable to HIV infection including unprotected sex (during home visits) as well as unprotected sex with other male inmates, sharing of sharp objects such as razors, lack of condoms in prisons and limited knowledge of HIV transmission.

Truck drivers:

Truck drivers and their assistants are considered among the high risk groups due to their mobility, stay away from home for long periods of time and interaction with female sex workers. A surveillance study on HIV prevalence and behaviour data for truck drivers is on going. As per preliminary un-weighted results (weighted estimates will be published by EPHI shortly) HIV prevalence among truck drivers was 4.9%[21].

According to another study from a programme targeting mobile populations 27% of truck drivers reported having two or more sexual partners in the past year and 17% reported having paid sex with one or more commercial sex worker[22]. The three regional HIV syntheses identified the following self-reported high risk behaviours among truck drivers: multiple sexual partners across different truck routes, transactional sex with commercial sex workers, heavy alcohol use and low condom use.

[16] Ethiopian Health and Nutrition Institute, Federal Ministry of Health. Report on the 2012 Round Antenatal Care based Sentinel HIV Surveillance in Ethiopia. December 2013

[17] Federal HIV/AIDS Prevention and Control Office 2014. HIV/AIDS in Ethiopia. An epidemiological synthesis. *In press*

[18] Le Monde Health & Development Consultancy on behalf of UNODC. 2014. Rapid assessment of the HIV situation in prison settings in Ethiopia, preliminary results (draft report/ preliminary findings).

[19] Central Statistical Agency (Ethiopia) and ICF International. 2012. Ethiopia Demographic and Health Survey 2011. Calverton, Maryland, USA: Central Statistical Agency and ICF International.

[20] Le Monde Health & Development Consultancy on behalf of UNODC. 2014. Rapid assessment of the HIV situation in prison settings in Ethiopia, preliminary results (draft report/ preliminary findings).

[21] MARPs Surveillance study. EPHI and CDC 2013-2014. Preliminary results.

[22] TransACTION study. 2011.

Serodiscordant couples:

HIV serodiscordant couples represent a high risk group in Ethiopia who have not been well recognized or received adequate intervention. The DHS 2011 documented that among couples in which at least one partner was HIV positive approximately two thirds were serodiscordant and about 80% of sexually active PLHIV are currently married[23]. The large proportion of discordant couples together with stigma and fear of disclosure which is still high in Ethiopia means that discordant couples are an important group that require HIV services. According to the 2011 DHS only 31.8% of currently married women and 33.9% of currently married men who have ever tested positive and received their results disclosed their status to their partner.

Injecting drug users and men who have sex with men:

Data is lacking to assess the size of the population, risk behaviours and seroprevalence among injecting drug users (IDUs) and men who have sex with men although a bio behavioural study is underway among IDUs in Addis Ababa.

[23] DHS 2011 data analysed and reported in: HIV/AIDS in Ethiopia. An epidemiological synthesis. Federal HIV/AIDS Prevention and Control Office 2014 *(in press)*

III. National Response to the AIDS Epidemic

Target 1 – Reduce sexual transmission of HIV by 50% by 2015

3.1 HIV Prevention for the General Population

Indicators	*DHS 2005*	*DHS 2011*
Knowledge: 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	F=20.5% M=33.3%	F=23.9% M=34.2%
Sexual Debut: Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 years	F= 15.8% M= 1.7%	F=10.9% M=1.2%
Multiple partners: Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 month	F=0.2% M=4.1%	F=0.4% M=3.5%
Condom use: 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	N/A N/A	F= 47.0% M=15.5%
HIV testing: Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results	F= 1.9% M= 2.3%	F=20.0% M=20.7%
Male circumcision: Percentage of men 15-49 years that are circumcised	92.5%	91.8%
Number of male circumcision performed	12,445 (Gambella and military) Programmatic data 2012	16,393 (Gambella and military) Programmatic data 2013
	ANC 2009	***ANC 2012***
HIV incidence (proxy): Percentage of young women aged 15–24 years living with HIV (ANC)	2.6%; unadjusted	2.3%; unadjusted

The ANC data show steadily declining HIV prevalence among pregnant mothers in both rural and urban areas since 2001. HIV prevalence among young women aged 15-24 years old – often used as a proxy for HIV incidence, also shows a declining pattern.

High rates of male circumcision (92%) and low rates of reported premarital sex (under 10% for women, EDHS 2011) and extra marital sex (less than 1% for women and 3% for men) help explain the low intensity of the HIV epidemic in Ethiopia compared to other African settings.

The proportion of young women and men aged 15-24 years who have had sexual intercourse before the age of 15 years decreased from 2005 to 2011. No strong trends were observed in the proportion of adults reporting more than one sexual partner in the last year, which remains overall low. Risky partnerships were relatively more common among urban residents, males, and 20- to 29-year-olds.

While almost all Ethiopians have heard of HIV, **comprehensive knowledge** remains low on average, particularly among women (18%) compared to men (31%) and including for the young age groups. Moderate gains observed in this measure between 2005 and 2011 were limited to rural areas.

Knowledge about MTCT and prevention is generally stronger than knowledge about sexual transmission, while misconceptions regarding mosquitoes and transmission by supernatural means remain persistent. The gender gap in knowledge was particularly strong concerning the efficacy of condoms. Urban residents and men remain significantly better informed about HIV than rural residents and women, respectively.

Overall, 15.5% of men and 47% of women (small sample size for women) who had more than one sexual partner in the past twelve months reported using a condom the last time they had sex. Notable features of **condom** use are the steady decline of condom use and consistency with increased age and lower but increasing condom use in rural areas (EDHS, 2011). The number of condoms distributed in the country is increasing annually but evidence lacking to ensure its availability at the right time to adequately protect risky sexual behaviours. The distribution of condoms (social marketing) doubled in 2012/13 (147.3 million) compared to 2007/08 (about 70 million), although distribution performance in some regions such as Gambella and Somali remain low[24].

The national strategy calls for programmes at multiple sectors and levels to achieve **behaviour change** and reduce vulnerability to HIV. The core government intervention has been community conversation (CC), a community empowerment intervention designed to be implemented annually in each Kebele (smallest administrative unit of Ethiopia similar to a ward or a neighbourhood). The related school CC programme follows a similar strategy among in-school youth at primary and secondary levels.

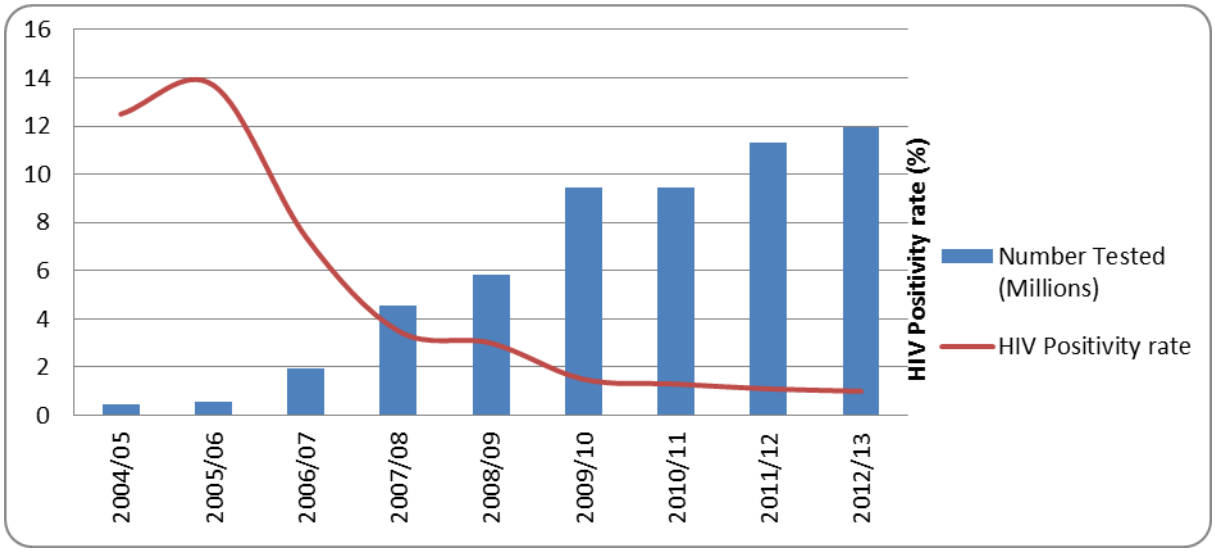
CC is conducted twice a month by organising groups at kebele level and assigning facilitators to help the group identify issues and facilitate discussion. Groups propose strategies to address identified issues and develop implementation plans. Upon completing a CC cycle the kebele administration organises a social mobilization conference to discuss and build on the proposed strategies and finally incorporate these into the kebele development plan. Currently the CC programme is moving towards being led by health extension workers (HEW) and health development armies (HDAs) to address health and social problems including HIV in a more integrated and effective manner. In 2012/13 CC were conducted in 15,319 kebeles, reaching about 7.6 million people. The number of individuals directly reached through CC increased significant in 2012/13 compared with the previous year (3.9 million). This dramatic rise largely reflects the high achievement of regions that have adopted the HDA approach (a flagship strategy adopted by the government of Ethiopia for community mobilisation. See section IV on best practices for further details).[25]

The efforts to engage the public at all levels through a CC strategy may have affected the marked increase in the uptake of HIV testing in the community. The 2011 EDHS demonstrated a 10-fold increase in reporting of **HIV counselling and testing** compared to 2005. A number of initiatives including introduction of lay counsellors and provider-initiated-testing at all public health facilities has greatly expanded access to test results. The number of health facilities providing HCT increased

[24] FHAPCO. 2005 EFY Multisectoral HIV/AIDS Response Annual Report. July 2012 to June 2013. September 2013. Ethiopia. Draft document.
[25] Ibid

by more than four fold in 2012/13 (3,040 HCT facilities, mainly public health centres outside Addis Ababa) when compared to 2004 (568 HCT facilities). Expanding service centres, combined with periodic national campaigns assisted in increasing the number of people tested for HIV from the tens of thousands to millions in the same 2004-2013 time period. In 2012/13, 11.9 million HIV tests were performed, more than 50% through PITC. Figure 4 below shows the increasing number of people tested over time whereas the HIV positivity rate among those tested decreased[26].

Figure 4: Number of individuals tested for HIV 2004/05-2012/13



HIV prevention activities implemented within schools (primary, secondary and higher education institutions) include: school CC, peer education, life skill education, strengthening and supporting anti AIDS clubs (AACs) and AIDS resource centres. In 2012/13 CC was implemented in 9,127 schools out of the total number of public and private schools (31,688) corresponding to a coverage of 28.8%. In addition 1,053,609 students were estimated to be reached through peer education from the total high school and TVET student population, which represents coverage of about 30%. A further 9,127 schools provided life skills education representing coverage of 28.2%; there were 1,010 functional youth centres and 901,265 students were estimated to have participated in school clubs[27].

Male circumcision at birth is widely practiced in most regions of Ethiopia. Currently 92% of adult males report being circumcised (EDHS 2011). In Gambella, lower rates of male circumcision are thought to contribute to the particular severity of the epidemic in the region[28]. Programmes to enable, promote and provide voluntary medial male circumcision to at least 80% of adult males are currently underway.

[26] Ibid
[27] ibid
[28] FHAPCO, GRHAPCO, UNAIDS. Synthesis of the HIV Epidemic and Response in Gambella. 2013.

3.2 HIV Prevention for Key Populations

Sex workers

Indicator	*2012*	*2013*
Percentage of sex workers reached with HIV prevention programme	N/A	N/A
Percentage of sex workers reporting the use of condom with their most recent client	N/A	98.4% (preliminary results, MARPs surveillance, 2013)
Percentage of sex workers tested for HIV in the past 12 months and know results	N/A	82.5% (preliminary results, MARPs surveillance, 2013)
Percentage of sex workers living with HIV	N/A	23.8% (preliminary results, MARPs surveillance, 2013)

Promoting consistent condom use has been one of the most commonly advocated preventive interventions for female sex workers in Ethiopia, together with HIV testing. Condom use at last sex with a paying partner was high at 98.4% but lower with a non-paying regular partner at 61.4%[29]. Similar findings were also reported in a previous study on high risk populations in Ethiopia (in which 99% of sex workers reported condom use at last sex with paying clients while consistent condom use with non-paying partners ranged from 40% to 60%)[30]. Encouragingly 82.5% of female sex workers in the 2013 MARPs surveillance study had received a HIV test in the past 12 months. PEPFAR reports that in 2013, 76,999 sex workers received HIV prevention services under their program.

A study conducted in 12 towns across Ethiopia (TransACTION, 2011) showed the majority of the recognised MARPs were not reached by service providers. Only 42% of sex workers, 25% of female daily labourers and 20% of waitresses were reached by HIV prevention outreach workers. Only 31% for male daily labourers and 15 % for truckers (potential clients of sex workers) were reached by outreach worker on HIV in the previous six months.

Peer education is one of the key interventions implemented to reach most at risk populations (MARPs) in Ethiopia. In 2012/13 368,733 MARPs were reached through peer education a significant increase on previous years. In the same period 35,562,166 condoms were distributed specifically to MARPs, a more than fourfold increase on the number distributed in the previous year (7.7 million). Additionally, in 2012/13 income generating activities (IGA) training was provided to 20,322 sex workers and vulnerable women and a further 17,483 received IGA start-up capital[31].

Other most at risk populations

While programmes targeting other populations at increased risk of HIV (e.g. seasonal workers, truck drivers etc.) exist the majority are not nationwide programmes. Moreover more often than not a full package of comprehensive HIV services is not available to these groups. A national HIV prevention package for MARPs and vulnerable groups was developed for populations including mobile workers and prisoners however to date this has not been implemented to the required scale.

[29] MARPs Surveillance study. EPHI and CDC 2013-2014. Preliminary results.
[30] TransACTION study. 2011.
[31] FHAPCO 2005 EFY (2012/13) Multisectoral HIV/AIDS Response Annual Report (draft version)

Men having sex with men and People who Inject Drugs (Target 2)

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.

Data on IDUs in Ethiopia is largely lacking, emphasizing the difficulty of drawing conclusions on HIV trends in this group. Though rates of IDU throughout Ethiopia are unknown, the current scarcity of IDU services (such as needle exchange programmes) should be assessed. A study for Addis Ababa by UNODC and UNAIDS is on-going and results expected by end 2014.

Target 3 – Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths

3.3 Prevention of Mother-to-Child Transmission of HIV

Indicators	*2012*	*2013*
Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	15,925	55% = 18,285/33,200 (28,200– 39,200)
Percentage of infants born to HIV-infected mothers receiving a virological test for HIV within 2 months of birth	7,260	21% = 7,070/33,200
Mother-to-child transmission of HIV (modelled) after the breast feeding period	32%	25%

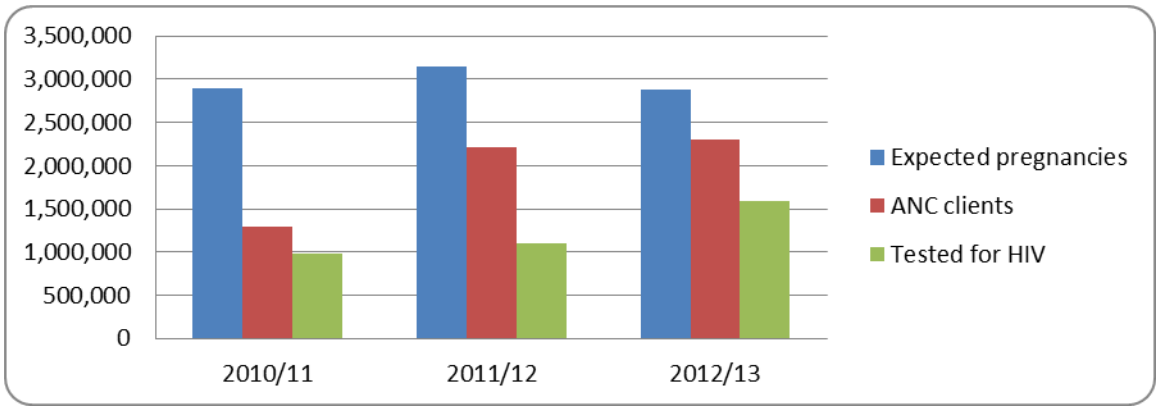
Since the introduction of the PMTCT service in 2001 and its scale up in 2003, the number of PMTCT sites has increased significantly. By 2012/13, the total number of health facilities that provided PMTCT reached 2,150[32]. This represents about 64.4% of public hospitals and health centres providing ANC.

In 2012/13 there were 2.9 million expected pregnancies and of these more than 80% attended ANC. The Multisectoral HIV response M&E Report for EFY 2005 (2012/2013) reports that among the women attending ANC less than 70% were tested for HIV. This represents a significant missed opportunity in the provision of PMTCT and could be as a result of mothers attending ANC in sites without PMTCT services, stigma and discrimination and inadequate counselling (Figure 5)[33].

[32] Multisectoral HIV response M&E report for 2012/13. FHAPCO, 2013. Draft version

[33] FHAPCO. 2005 EFY Multisectoral HIV/AIDS Response Annual Report. July 2012 to June 2013. September 2013. Ethiopia. Draft document.

Figure 5: Trends in ANC and HIV testing



17,742 pregnant women were found to be HIV positive in 2012/13 (1.2% of the pregnant women tested for HIV). Approximately three quarters of these identified HIV positive women and even fewer of their HIV-exposed infants received ARV propylaxis. The variability of performance was quite broad across regions[34].

18,285 women received PMTCT in 2013 (PEPFAR data) that is 55% of the estimated total number of HIV positive pregnant women (EPP/Spectrum, 2014): 12,308 were on lifelong ART of whom the majority (66%) were already on ART at the beginning of their current pregnancy. The remaing 5,961 received maternal Zidovudine (AZT) prophylaxis during pregnancy and delivery and an additional 16 women were on sdNVP. The MTCT rate at the end of the breastfeeding was estimated at 25% in 2013, down from 32% in 2012.

These data indicate the need to address the substantial gap in reaching all pregnant women and address demand and supply side barriers, which may include weak ANC and PMTCT service organisation in maternal newborn and child health (MNCH) (although introduction of option B+ has strengthened integration of MCH and PMTCT services) and primary health care settings including weak referral system; lack of PMTCT services in many ANC facilities and low skilled birth attendance, and post-delivery follow up, low male involvememnt in PMTCT, low awareness and fear of stigma and discrimination[35]. Large numbers of health extension workers (community health workers) and the health development army covering all of Ethiopia are good opportunities to enhance community awareness and create demand for services. Similarly efforts for PMTCT integration into maternal and child health programmes and reproductive health services offer opportunties for demand and awareness creation.

Recognising existing challenges, in 2013, the Government of Ethiopia developed a MTCT Elimination Plan (eMTCT) 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 Option B+ to 95% of HIV positive pregnant women by 2015; reduce new infections of HIV among reproductive women by 50%, reduce the unmet need for

[34] PEPFAR data for October 2012-September 2013 report 1,390,801 HIV positive pregnant women tested and received their results. Of those, 21,546 pregnant women were identified as HIV-infected.
[35] Mid Term Review Report, FHAPCO 2013

family planning to 10%, and reduce MTCT rate to less than 5%. Key EMTCT strategies include integration of ART into MNCH services through rolling out simplified regimen of Option B+ for pregnant women in the context of PMTCT, .capitalizing on the Health Expansion Program and Health development army to effectively engage communities and improve maternal and child health outcomes and improving the quality of integrated MNCH/PMTCT services at all levels.

Target 4 – Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

3.4 Antiretroviral Therapy

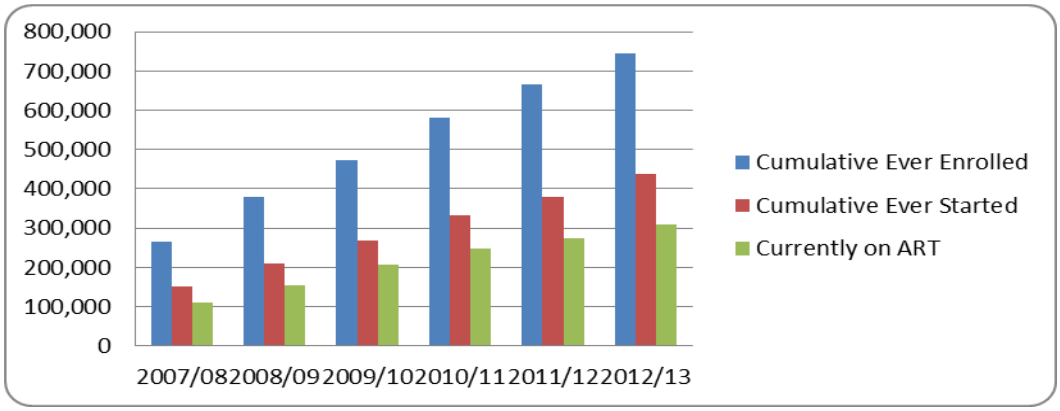
Indicators		2012	2013
Percentage of adults and children currently receiving antiretroviral therapy			40% = 317,443/793,700 (716,300 – 893,200) all PLHIV
	Adults	270,460	50% = 298,512/593,400 (540,100-668,300)of adult PLHIV
	Children	17,677	9.5% = 18,931/200,300 (172,400 – 232,400) all children)
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		83.3% (5,788/6,943) (FHAPCO national ART study 2011)	81.3% (38,286/47,085) (PEPFAR programmatic data 2013)

The scale up of free ART services has been one of the greatest achievements of the HIV programme response over the last decade. ART programme services have expanded on a large scale and have substantially decreased AIDS deaths and possibly contributed to the decline in HIV incidence since 2005. The number of facilities providing ART services has expanded in both health centres and hospitals, enabling the enrolment of hundreds of thousands of AIDS patients free of charge. The number of health facilities providing ART reached 913 in 2012/13, mainly public facilities.

By the end of June 2013 the number of people ever enrolled in chronic care reached 728,874 while the number ever started ART was 439,301 and 317,443 were currently receiving ART. Only 70.3% of individuals who ever started ART were currently on treatment indicating challenges in patients' retention (Figure 6)[36].

[36] FHAPCO. 2005 EFY Multisectoral HIV/AIDS Response Annual Report. July 2012 to June 2013. September 2013. Ethiopia. Draft document.

Figure 6: Trend in utilization of ART service 2007/08-2012/13



Of the estimated 593,400 (540,100 – 668,300) adults living with HIV at the end of 2013 (EPP/Spectrum estimates 2014); 298,512 were on treatment (50%). In December 2013, Ethiopia adopted the new WHO integrated guidelines for treatment, in which adults with CD4 below 500, all pregnant women and all TB patients independent of CD4 count are eligible for treatment.

Ethiopia has now reached a symbolic milestone for curbing the spread of the epidemic, where the number of newly started clients on ART (on average 58,000 adults each year) has surpassed the number of new infections in adults > 15 years (7,700 – 21,200).

However, patient loss to follow-up and ensuring adherence to ART regimens remain major challenges of the ART programme especially in some of the regions, as well as the inadequate capacity of some regions in the maintenance of laboratory machines[37]. One of the successes of the large scale free ART programme has been its equal access by both men and women. When ART was first introduced in Ethiopia, women had substantially lower access to treatment services[38].

A major challenge of the ART programme remains the very low coverage of children (all children below 15 years are eligible for treatment in Ethiopia as per recently adopted guidelines, December 2013). Of the 200,300 (172,400-232,400) children estimated to live with HIV in Ethiopia in 2013 (EPP/Spectrum guidelines, 2014), only 18,931 (9.5%) received ART in 2013. This requires urgent attention to identify possible factors for low performance; increase efforts to identify children living with HIV in the community, especially in the older age ranges and develop strategic actions to improve coverage rates.

[37] FHAPCO. 2005 EFY Multisectoral HIV/AIDS Response Annual Report. July 2012 to June 2013. September 2013. Ethiopia. Draft document.
[38] HIV/AIDS in Ethiopia. An epidemiological synthesis. 2014 edition. FHAPCO. Addis Ababa, Ethiopia. January 2014.

Target 5 – Reduce tuberculosis deaths in people living with HIV by 50% by 2015

3.5 Management of TB-HIV Co-Infection

Indicator	2012	2013
Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV (*Numerator: PEPFAR programmatic data; Denominator: WHO global tuberculosis report 2013*)	34.9% (8,022/23,000)	30.7 % (7055/23,000)

According to the 2012 WHO TB report, Ethiopia is one of twenty-two high TB burden countries in the world; ranking among the top five in Africa[39]. Recognizing the burden of TB-HIV co-infection in Ethiopia, the government identified TB/HIV collaborative activities both in the national TB Strategic Plan (2011-2015) and HIV SPM II. These include HIV testing for TB patients and providing ART; screening PLHIV for TB, and providing isoniazid prophylaxis therapy (IPT) for those eligible. Furthermore, the national TB strategy has intensified TB-case finding among PLHIV followed by TB treatment for active TB disease and IPT for those without active TB.

The proportion of TB patients tested for HIV increased from 16% in 2006/07 to 45% in 2009/10[40]. Similarly, TB screening for PLHIV increased and reached 82% by 2012[41]. TB/HIV co-infection declined from 15% (2010/11) to 8% (2011/12)[42]. Similarly, analysis of sentinel surveillance data from 56 health facilities documented that 92.4% of those newly enrolled to HIV care were screened for TB; and 7.8% of these had active TB disease. Conversely, among TB patients on direct-observed treatment short-course (DOTS), 86% had an HIV test; and 20% of these were HIV positive. Overall, integration of TB/HIV activities has contributed to the high rate of TB screening among PLHIV and HIV testing among TB patients. The percentage of HIV-positive TB cases that received ART treatment in 2012 was 82%[43]. All health facilities offering ART services also provide TB prevention & control services.

Nevertheless, there were significant missed opportunities in IPT and ART provision; uptake for both was as low as 18.2% and 50.5%, respectively[44]. In addition poor adherence to national guidelines on TB/HIV co-infection management in public and private health facilities and the lack of HIV/TB integration related indicators in the national M&E system are notable challenges in meeting and tracking progress towards this target.

[39] WHO. Global TB Report, 2013
[40] Annual TB bulletin, Federal MOH 2013
[41] PEPFAR annual 2012 report
[42] FMOH. Annual TB Bulletin No. 4, 2012
[43] WHO. Global TB Report, 2013
[44] Wegene T, et al. Findings of the Sentinel TB/HIV Surveillance System in Ethiopia; 2012

Overall, TB treatment success rate was maintained above 80% for the last five years, and TB mortality (excludes HIV+TB) declined to 18/100,000 in 2012 while mortality of HIV positive TB patients reached 6.1% in 2012[45].

Target 6 – Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22-24 billion in low-and-middle-income countries

3.6 AIDS Spending

Indicator	***2010/11*** *(EFY 2005)*	***2011/12*** *(EFY 2004)*	***2013***
Domestic and International AIDS spending by categories and financing source (ref tables below for details)	*On-going NHA*	*405 million USD (update) (NASA)*	*N/A*

The National AIDS Spending Assessment (NASA) (2011/12) is the first attempt to track all the HIV and AIDS spending in the country from all sources (excluding out-of-pocket) and across all sectors. The NASA provides an in depth examination of the HIV/AIDS by detailed categories of activities, providers of services and the beneficiaries. NASA applies a standardised and comprehensive methodology for collecting, coding and analysing of HIV expenditure. It allows countries to understand if they are allocating funds according to their priorities and for the greatest investment in terms of impact.

The total spending in Ethiopia on HIV and AIDS in 2011/12 (EFY 2004) was US$ 405 million, of which 86% came from external sources (US$ 350 million), 13% came from public revenue (US$ 55 million) and only US$ 680,000 (less than one percent) came from the private sector (although the business sector's contribution was underestimated and the private health care sector was not included). The last National Health Accounts Survey of 2007/08 (one for 2010/11 is still on going) had indicated that national HIV/AIDS expenditure amounted to USD 248,000,114. The bulk of this, i.e. 84%, was from external sources, while government spending constituted 11% of the total expenditures.

Of the **public funds,** a large portion was the spending through the Ministry of Health, based on the NHA estimates for EFY 2003 (2010/11), which represents an important but usually hidden cost carried by governments. Also of importance are the Mainstreaming Fund to which every Ministry contributes 2% of its total budget, and the AIDS Fund which is a voluntary contribution from the public employees. These are public initiatives that could be explored for future expansion.

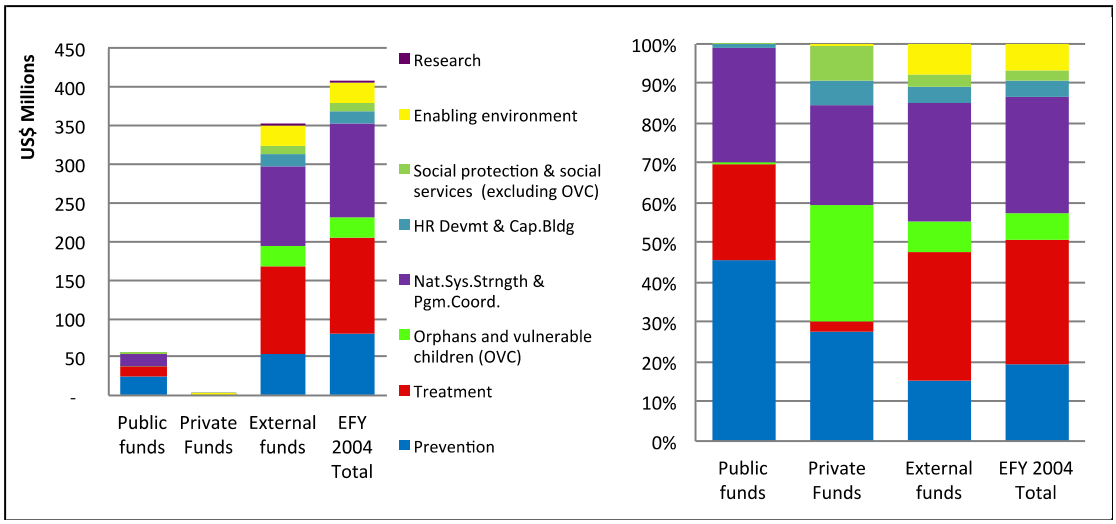
Of the **external sources,** PEFPAR was the greatest contributor, forming 51% of total spending on HIV and AIDS (US$ 206 million out of the country spending for Ethiopia), and the Global Fund was the next largest contributor (30%) at US$ 150 million. Numerous other bilateral, multilateral and international foundations also contribute to the response in Ethiopia, all less than 1% each in EFY 2004 (2011/12), but totalling around 10% of total spend.

[45] WHO. Global TB Report, 2013

In terms of the **agents** of the HIV/AIDS spending, that is, who controls how the money is spent, importantly the government managed 37% (US$ 152 million), while external agents managed 60% (US$ 242 million).

Considering the breakdown of the HIV/AIDS spending by **thematic area**, Ethiopia spent 19.5% (US$ 79 million) on prevention in 2004 (2011/12), 31% on treatment and care (US$ 125 million), 30% on national systems strengthening and programme management (US$ 120 million), 7% on OVC support (US$ 28 million), and 6.5% on enabling environment activities (US$ 26 million). Social protection activities (excluding those for OVCs) took 2.6% (US$ 11 million), and less than 1% (as was captured by NASA) went to research activities (US$ 250,000) (noting that surveillance and M&E spending were captured under national systems strengthening). This was due to non-response by the larger research entities and thus is not representative of the actual funds spent for research in the country.

Figure 7: HIV and AIDS Spending in Ethiopia by broad categories and by source of funds (US$, %, EFY 2004)



By source of funds, the largest portion of the total public funds went to prevention activities (45%), followed by national system strengthening and programme management (just under 30%) and then treatment and care (24%). For the two major external sources, PEFPAR's largest portion went to national systems strengthening and programme management (31%) and GF's portion to systems strengthening and programme management was 28%. GF money primarily went towards treatment (51%), while their prevention spending was only 9%. PEPFAR's second largest share of funding was for treatment and care (27%) and 17% went towards prevention.

Looking into the thematic areas, the **prevention activities** were dominated by a large amount (51%) that could not be disaggregated i.e. the information provided by the respondent did not indicate the type of prevention activity. This was partly the PEPFAR funding (US$ 18 million for non-disaggregated prevention) and the MOH's spending on 'prevention and public health' of US$ 24 million. Thereafter the next largest prevention activity was HIV counselling and testing (HCT) (16%) and then prevention of mother to child transmission (PMTCT) (14%). Other prevention activities received very little (although these activities may be captured under the non-disaggregated share):

behavioural change communications (BCC) 3.6%, community mobilisation 2.4%, vulnerable groups 1.8% and other activities less than 1%.

Within the **treatment and care category**, the largest proportion of spending in EFY 2004 went towards ART (55%, US$ 70 million), followed by HIV laboratory monitoring (11%, US$ 14 million). However, there was also a large portion (12%, US$ 15 million) that went towards out-patient services not disaggregated, which was primarily the MOH spending (provided from the NHA). Provider initiated testing and counselling (PITC) received 9% (US$ 11.6 million), nutritional support for ART received 7% (US$ 8.7 million), while the other activities received relatively small amounts: psychological support (1.9%), home-based care (1%), and palliative care (0.6%).

Of the total spending (US$ 120 million) on **national systems strengthening and programme management**, 35% (US$ 41.4 million) went towards planning and co-ordination activities, 19% (US$ 23 million) went to upgrading facilities, and 17.5% (US$ 21 million went towards transactional costs associated with managing funds. M&E activities took 15% (US$ 18 million) of this category, while only 2% (US$ 2.4 million) was reportedly spent on surveillance activities (due to non-reporting of the key research agencies). Considering this category by the sources of funds, the public funds spent 61% (US$ 9.4 million) on planning and coordination, which would be expected for their national coordination role, and 29% (US$ 4.5 million) on infrastructural development. For the PEFPAR funds, 35% (US$ 22 million) went towards planning and coordination, 22% (US$ 14 million) for M&E, and 20% (US$ 13 million) was transactional costs associated with the management of funds. Importantly USG contributed to information technology (US$ 7 million) and drug supply systems (US$ 5.3 million).

Regarding the beneficiaries of HIV/AIDS spending in Ethiopia, the degree of disaggregation of data was somewhat limited, with uncertainty regarding the beneficiaries of the USG data (which were not provided and thus had to be assumed based on the type of activity). Considering the broad categories, people living with HIV (PLHIV) benefitted from 34% of the total spending (US$ 138 million), followed very closely by non-targeted spending (31%, US$ 126 million), and then 24% (US$ 98 million) went to the general population. The spending on commercial sex workers was only US$ 1.3 million (0.3%) (although the USG funds were reportedly greater for this group but their expenditure analysis data did not show these), and then OVC and other vulnerable groups benefitted from 8.7% (US$ 35 million).

3.7 Gender-Based Violence

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*

Ethiopia has some of the highest rates of violence against women in the world[46,47]. Violence against women has its roots with gender disparities where women play a subordinate role in decision making at household and community level. Among others negative consequences, violence against women inevitably compromises their ability to negotiate safer sex. The most common and universally occurring form of gender-based violence 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[48]. DHS 2011 documented that 68.4% of women believe that a husband is justified in beating his wife for least one specified reason. Gender disparities play an important role in access to basic services such as healthcare and education.

Other cultural practices that may increase vulnerability of women to sexually transmitted infections include early marriage and sexual debut (often with much older and sexually experienced males), marriage by abduction, female genital mutilation, and widow inheritance[49] .

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. Data from DHS 2011 showed a difference in HIV prevalence that was more marked among urban populations (female/male ratio of 3.2) and in the young age groups. Only 23.9% of females aged 15-24 years compared to 34.2% of men 15-24 years had comprehensive knowledge of HIV.

Gender disparity also negatively influences health seeking behaviour[50]. 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. Also, some

[46] Berhane Y; Kullgren G et al. Country research team in WHO multi-country study on women's health and domestic violence against women. Initial results on prevalence, health outcomes and women's responses. Geneva, WHO. 2005

[47] Abeya S; Afework M, Yalew A. Intimate partner violence against women in western Ethiopia: prevalence, patterns, and associated factors. BMC Public Health 11: 913. 2011

[48] *ibid*

[49] Federal HIV/AIDS Prevention and Control Office 2014. HIV/AIDS in Ethiopia. An epidemiological synthesis. *In press*

[50] Ibrahim AE. Socio-Cultural Factors Affecting Sexual and Reproductive Health: The Roles of Traditional Institutions among the Borana Pastoralists of Oromiya, Southern Ethiopia, AAU, 2006.

women refused HIV testing and ART because of fear of revealing their HIV status to their husbands[51]. Relevant recommendations included the creation of support groups such as "mother to mother" peer groups, improved counselling, involving community organisations/systems in education efforts, and engaging men and families in ANC and PMTCT.

The government of Ethiopia, cognizant of the need to redress the social inequities that exist among gender lines has endorsed women reproductive and 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). The SPM II underscores economic empowerment as essential to reduce women's vulnerability to HIV, including vocational training for livelihood development and seed money support for low income women; integration of safety net programs for HIV/AIDS and inclusion of measures to ensure equality such as girls' education. However while policy and legal frameworks to protect women and girls from GVB exist (legal: National Policy on Ethiopian Women (NPEW); FDRE Constitution of 1995; Revised Family Law; Revised Criminal Code; Policies) enforcement of polices and laws is weak (see Annex 2 – national policy and commitments instrument).

A gender technical taskforce has been formed working on modalities to mainstream women, girls, gender equality and HIV issues and implement the Agenda Action for Women, Girls and Gender Equality. Other key initiatives include the sensitization of new members of parliament and members of the Women's Caucus, Social Affairs Standing Committee and the Women, Children and Youth Standing Committee on gender and HIV issues and support to high level women representatives to participate at the Global Power meeting to undertake high level advocacy with policy makers and institutions to put an agenda for Action in practice.

Target 8 – Eliminating stigma and discrimination

Indicators	EDHS 2005	EDHS 2011
Percentage of women and men aged 15-49 years who report discriminatory attitudes towards people living with HIV (*would not buy fresh vegetables from a HIV positive vendor)*	73.6%	59.9%

3.8 Stigma and Discrimination against PLHIV

Stigma against PLHIV remains a significant issue in Ethiopia. EDHS routinely include four attitudinal questions gauging stigmatising attitudes among the general population. These include needing to keep HIV in the family a secret, unwillingness to care for an HIV-infected relative, unwillingness to accept female PLHIV to serve as teachers, and unwillingness to purchase vegetables from a PLHIV

[51] NNPWE. An Assessment of SRH and PMTCT Services Needs of HIV Positive Women: Specific to Addis Ababa and Adama Towns, Addis Ababa, 2011

shopkeeper. In the 2011 DHS, slightly under half of urban residents harboured at least one of four negative attitudes. The same negative attitudes were more than twice as prevalent in rural than urban areas. Still, between 2005 and 2011, the prevalence of stigmatised attitudes fell significantly from an average of 1.00 to 0.82 (on a scale of 1 to 4) in urban areas and from 2.26 to 1.7 in rural areas. Focusing on the GARPR stigma related indicators (willingness to buy vegetables from a HIV positive vendor[52]) improvements were observed between DHS 2005 and 2011 with the proportion of respondents indicating they would not buy vegetables from a HIV positive individual decreasing from 73.6% to 59.9% respectively.

Nevertheless a large national survey among over 3,300 PLHIV carried out in 2010[53] found a substantial burden of felt and enacted stigma. Reported experiences ranged from gossip (60%), social exclusion (35%), family exclusion (22%) and physical assault (7%) in the last 12 months as a perceived result of HIV status alone. Strong regional variations were observed with Somali and Gambella the most affected settings.

Although difficult to quantify, public awareness campaigns including community conversations, workplace discussions, mass media and peer education to address stigma and discrimination against PLHIV were conducted in 2013. The national Network of PLHIV has programmes in all regions of Ethiopia to build capacity to address stigma and discrimination.

To bridge gaps in promoting the rights of PLHIV, the government launched an HIV/AIDS workplace policy in January 2012. The policy protects against mandatory HIV testing, defends the right of HIV positive employees to medical leave and job reallocation and provides guidelines for the establishment of AIDS funds to assist employees living with HIV. While the NCPI showed favorable polices and laws to protect the rights of PLHIV, it noted weak enforcement.

The above findings underscore the need for intensifying public awareness, ensuring greater involvement of people living with HIV and work at enforcing provisions in current policies and laws.

Target 9 – Eliminate travel restrictions

There are no travel restrictions for PLHIV in Ethiopia.

[52] Second GARPR stigma indicator agreement that HIV positive children should be allowed to attend school with HIV negative children not collected in the EDHS.
[53] Stigma Index, NEP+ 2011

3.9 Care and Support to Orphans and Vulnerable Children

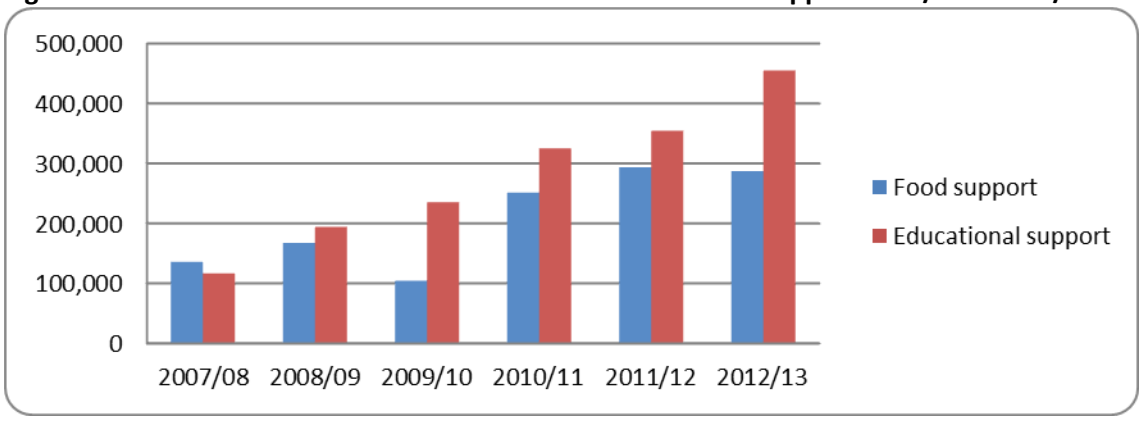
Indicators	EDHS 2005	EDHS 2011
A. Current school attendance rate of orphans aged 10-14 primary school age, secondary school age	N/A	69.1%
B. Current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent	N/A	76.5%

According to DHS 2011 69.1% of OVCs aged 10-14 years attended school compared with 76.5% of children whose parents are alive and live with at least one parent.

Care and support services for orphans and vulnerable children (OVC) constitutes education, food, shelter, medical, legal and financial support. 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 2013 orphans due to AIDS at about 898,400 (770,700 – 1,048,500). These chidren are left vulnerable at the time of their greatest need due to loss of family support.

In 2012/13, a total of 287,350 received food support. Educational support is provided to OVC to prevent school dropout and consists of provision of educational materials, school fees and sponsorship. In 2012/13 it was provided to 454,888 OVC. As shown in Figure 8, performance in provision of educational support to OVC showed an increasing trend from 2007/08 onwards. The number of OVC reached with nutritional support however decreased slightly in 2012/13. Psychosocial support was provided to 426,225 children.

Figure 8: Number of OVCs who received food and educational support 2007/08 – 2012/123



IGA support aims to strengthen the economic capacity of OVC and their families thereby reducing vulnerability and mitigating the impact of HIV. IGA support is provided directly to OVC aged 15 years and above and to guardians for younger children. During 2012/13, 41,788 and 84,118 (92.5%) received IGA training and start-up capital respectively. IGA training and start-up capital to OVC

showed a significant improvement in 2012/13 compared to 2011/12. However, considering the total number of children in need, the support provided is far from adequate[54].

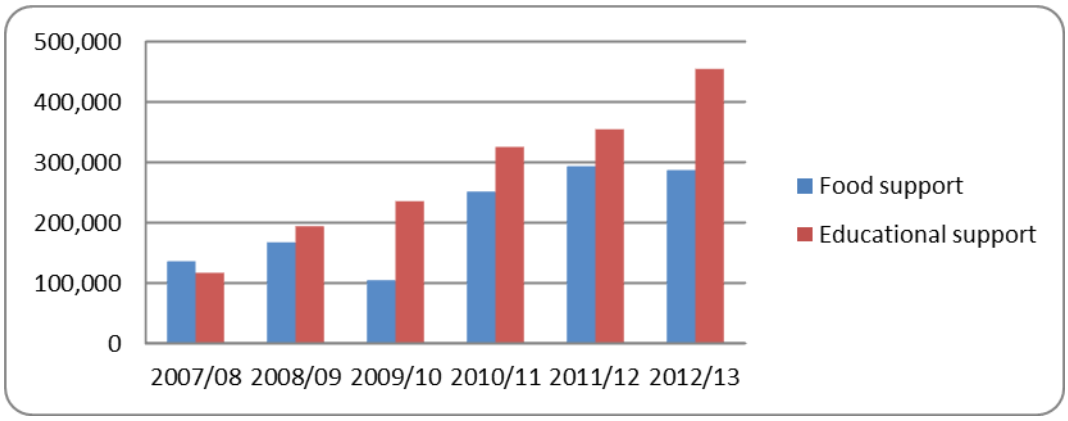
3.10 Support to People Living with HIV

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

Food and nutritional support is provided to improve the health status of PLHIV and strengthen adherence to ART. In 2012/13 food and nutritional support was provided to 104,810 PLHIV. Psychosocial support was provided to 194,600 PLHIV.

IGA support includes vocational and business skills training and following successful completion of training, provision of IGA start-up capital. In 2012/13 IGA training and IGA start-up capital were provided to 32,204 and 26,436 PLHIV respectively[55].

Figure 9: Number of PLHIV who received food and IGA support 2007/08-2012/13



As shown in figure 9 the number of people who received food and nutrition support has decreased in 2012/13 compared to the previous year, whereas the number of PLHIV receiving IGA support has improved from last year's performance.

3.11 HIV Integration/Sector Mainstreaming

The Ethiopia Growth and Transformation Plan, the national HSDP IV (National Health Plan), and the HIV National Strategic Plan (SPM II) all underscore the importance of effective coordination and integration of activities within and across programmes as key for a sustainable HIV response. To reduce duplication and efficiently use resources, defined coordination and lead roles for the

[54] FHAPCO. 2005 EFY Multisectoral HIV/AIDS Response Annual Report. July 2012 to June 2013. September 2013. Ethiopia. Draft document.
[55] *ibid*

HIV/AIDS response were designated to FHAPCO and FMOH; and with delegation of authority to regional HAPCOs/RHBs to coordinate the response in their respective administrative areas and mandate. Key stakeholders at both federal and regional level take an active part in joint annual planning, monitoring and evaluation (supportive supervision and review meetings), and periodic reviews.

Funding for HIV/AIDS in Ethiopia has encouraged health system strengthening efforts by leveraging human resource development at the grassroots level and infrastructure development. This includes strengthening the Health Extension Programme and expanding the number of health care facilities[56]. Positive HIV integration indicators into the broader health system are the gradual integration of HIV services (PMTCT, ART, HCT) into the reproductive, maternal and child health platform; HIV/TB collaboration; HIV prevention through the health promotion HEW programme and Development Army; partners willingness to channel resources more flexibly with a view to supporting broader health system strengthening, including health human resource development, the health monitoring information system, improved and coordinated supply chain management of HIV commodities and support to laboratory systems[57].

Although in some sectors there was a lack of commitment to establish functional HIV programmes, in 2012/13, at federal (national) level, 16 sectors had an AIDS fund with regular contributions from employees' salaries to fund HIV activities, mainly care and support and 21 sectors incorporated HIV activities into their business plans. At the regional level, 10,683 government organisations had established an AIDS fund, 12,828 allocated budget for HIV mainstreaming activities and 15,077 incorporated HIV activities into their organisational plans. Of note, mainstreaming in government organisations is stronger than in private and non-government organisations. In 2012/13, only 320 private organisations had an AIDS fund. Of concern, is the lack of an effective mechanism to ensure sectors' compliance with implementation standards.

3.12 National Commitment and Policy Instrument (NCPI)

Indicator	*2011*	*2013*
National commitment and policy instrument (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination, and monitoring and evaluation)	Ref to 2012 GARPR report	ref below /Annex 2

The National Commitments and Policy Instrument (NCPI) findings show that Ethiopia has made significant strides in strategic planning, political support and leadership, human rights, prevention, treatment and care, and monitoring and evaluation. However, there are still gaps in HIV services for sex workers and their clients and no progress in interventions for MSM, transgender and IDU as the

[56] Federal HIV/AIDS Prevention and Control Office 2014. HIV/AIDS in Ethiopia. An epidemiological synthesis. *In press*

[57] 2011 UNGASS. Mid-Term Review Report of the "Ten Targets" in Ethiopia. May 2013. Addis Ababa, Ethiopia. FHAPCO

latter three are neither recognised as key populations nor their extent and role in the HIV dynamic documented.

Ethiopia has enacted a comprehensive national AIDS policy, workplace HIV framework (including for schools and workplace), and implemented strategic plans (SPM I and II), and developed a standard interventions package for MARPs. There is broad participation of all key stakeholders in the preparation of annual operational plans, proposals for Global Fund and strategic documents such as the on-going development of the Investment Case. Through the Federal and Regional HIV/AIDS Council, HIV/AIDS Task Forces and Committees, there is strong participation of civil society organisations (CSOs-such as NGOs, faith-based organisations, associations of PLHIV) in every step of the national response. This includes in the development of strategic and operational plans (including budgeting and preparation of GF proposals) and programme implementation, joint supportive supervisions and performance reviews.

There is high level political support and leadership and the HIV response remains top among Ethiopia's development agenda as clearly stated in its Growth and Transformation Plan (GTP). The initiative to mainstream HIV in all public and non-public social and development sectors has been mentioned frequently by respondents to demonstrate the key role played by political leadership. Indeed, in the past year high level political leaders including the Federal Parliament, the President, the Prime Minister, and the First Lady have openly called upon all key stakeholders including the government and non-government sectors, and the public to intensify on going efforts in the HIV response. Notwithstanding these developments, there is concern that leadership and commitment in some administrative regions is weak and needs to improve. FHAPCO in collaboration with the Parliament and regional stakeholders is taking initiatives to address these challenges. For example, in early 2014, the First Lady who visited Gambella region called for a more coordinated response. Moreover, the Federal Parliament has directed sector ministries to report on mainstreaming of HIV in performance reports.

There is consensus among respondents to part A and B of the NCPI that although the legal system is protective, there are several bottlenecks in enforcement which are attributed to inadequate capacity and lack of awareness by both the public and law enforcement agencies. Except for the Stigma Index study (2012) there are no specific performance indicators or benchmarks for assessing compliance with human rights related to HIV/AIDS.

The key informants and participants to the NCPI consensus building meetings noted remarkable progress in ensuring the broad participation of CSOs in the national HIV response. There is general agreement that: "The national AIDS response is inclusive as CSOs including NGOs, religious organisations, and PLHIV are directly involved starting from planning to implementation and monitoring of progress". However, direct participation of key populations other than PLHIV, women and youth, in planning and review of HIV programmes is limited; mainly due to either the illegal nature of MSM and IDU, and/or the lack of associations of FSWs (which is also illegal but a tolerated practice).

All the participants noted the rapid expansion of prevention and treatment services in the country over the last two years. However, there was a difference between part A and B respondents with

regard to the comprehensiveness of care and support services for PLHIV and OVC. To bridge this gap, annual M&E reports from previous years were reviewed and showed a growing trend; yet gaps do exist in service provision for OVC and emerging at risk populations such as mobile/migrant workers. Underscoring the need for an inclusive and dynamic programme in addressing the needs of emerging at risk populations, a respondent and participant at the NCPI consensus meeting remarked "…Stakeholders have done a great job to register a remarkable reduction in the rate of new HIV infections in Ethiopia. Yet, we need to sustain our efforts to prevent new infections among mobile populations if we are to maintain these gains." To address some of the above gaps in reaching vulnerable population groups, Ethiopia has developed an intervention package for MARPs. The document identifies key populations and outlines appropriate interventions tailored to these groups. To ensure that interventions are adapted to the epidemic dynamics in each region, the country has conducted Know Your Epidemic/Know Your Response syntheses in three regions (Tigray, Gambella, and Oromia). Similar studies in others regions are either on going or planned.

National M&E is participatory and CSOs take part in supportive supervisions, periodic assessments and annual performance reviews. While this is a commendable progress, there is concern by some CSOs/NGOs that the annual report may not be comprehensive (in terms of capturing CSO/NGO activities) due to differences in reporting formats, lack of proactive submission of field reports of organisations to regional and federal HAPCO/Health Bureaus, and possible loss or delays in data transmission to FHAPCO. Highlighting the need for more inclusive reporting a CSO participant noted: "…We are not sure if our performances are reflected as there is no mention of sources of data and contributors to the annual M&E report". The consensus meeting participants suggested having a mechanism at the region level and a centre to track and ensure that the performance of CSOs/NGOs is included in the annual M&E report. The MRIS (multisectoral response information system) which is currently being rolled out will serve to address some of these issues by putting into place standard indicators and data collection formats to capture the activities of CSOs and NGOs.

In summary, there is an overall agreement that Ethiopia has made progress in several areas including in strategic planning, political support, and participation of civil society, and in expanding access and quality of prevention, treatment, care and support services. Despite these encouraging areas of progress, the NCPI assessment also identified areas that need further improvement such as in regional leadership, coordination, and in developing programmes for hard-to-reach and emerging at risk population groups (notably seasonal workers in fast-expanding large development schemes and other key mobile populations). There is also a need to intensify efforts to enforce current policies and laws, and roll out the accelerated PMTCT plan and the MARPs intervention package.

IV. Best Practices

Establishment of a health development army for community mobilisation and effective behaviour change communication

Ethiopia has adopted the health development army (HDA) strategy, an organised group whose members include the community, professionals at all levels and the political leadership. It involves networking one person to five individuals to share information, and provide mentoring as well as ensure, monitor and follow up the development and implementation of activity plans. The development army initiative is applied in both government offices and at the community level, and aims at creating a strong coordination mechanism and information sharing network to enhance implementation. At the community level networks have been established linking five households to one model family for the dissemination of health promotion and disease prevention messages. The HDA approach has supported intensive community mobilization and promotion efforts, increasing access to testing and treatment and referral for HIV care and support services. It has complemented the health extension programme - the primary vehicle for demand creation for HIV testing, PMTCT and ART, behavioural change and organisation and mobilisation at the community level. Although its effectiveness has yet to be determined, the HDA strategy has successfully harnessed human capital and community support structures to strengthen demand creation for services and community based prevention efforts.

Domestic financing of the HIV response through HIV mainstreaming and local budget allocation

As part of the Government of Ethiopia's efforts to mainstream HIV and boost ownership of the HIV response, government sector office have established AIDS funds through regular contributions from employees' salaries to fund HIV prevention, care and support activities. By June 2013 10,683 regional and 16 Federal government sector offices had established an AIDS fund. In addition a total of 106,601 USD was raised in EFY 2004 (2011/12) through this funding mechanism. The AIDS fund is an important part of mainstreaming efforts which seek to initiate and/or contribute to HIV prevention efforts in the community in which an organisation functions in order to reduce vulnerability to HIV. In the context of diminishing international funding and given the heavy reliance of the HIV response on external funding in Ethiopia, domestic financing is becoming increasingly important. Thus this initiative represents an important measure for diversifying funding sources and addressing the emerging funding gap. It also supports the implementation of the African Union Roadmap on Shared Responsibility and Global Solidarity for TB, Malaria and AIDS Responses in Africa, which calls for African countries to "fill … funding gaps together, investing their "fair share" based on ability and prior commitments".

HIV prevention in development schemes

Ethiopia is undergoing a period of rapid development and economic growth. A number of development schemes are currently under way across various regions in Ethiopia which employ large numbers of young workers who move to these areas predominately on a seasonal basis and are therefore highly mobile. Cognizant of this emerging underserved but yet important risk group

FHAPCO and partners have undertaken work place HIV prevention activities in development schemes in order to respond to the needs of this group, protect the surrounding communities and act swiftly to prevent the emergence of a sub epidemic in this group with the potential for onward transmission to the general population. At regional level HAPCOs have identified large scale development schemes in their regions and planned and implemented BCC/IEC activities in combination with management and owners of development sites. Partners such as World Learning have also implemented large scale programmes targeting labourers employed at development schemes and have leveraged corporate social responsibility as a means to provide HIV services for employees. A number of sectors are covered by the World Learning Mulu worksite programme including construction (~20%), cement, textile and industries (~20%) and farms and plantations (~60%). Combination prevention including condom distribution has been carried out as well as rapid assessments of worksites and available biomedical services. Preventing HIV infection at large scale worksites requires significant attitudinal and organisational changes. These initiatives represent important measures that begin to address the transformations that are required and reflect critical efforts in adapting and meeting the needs of the evolving HIV epidemic in Ethiopia.

Strengthening male involvement in PMTCT

Recognizing the low coverage of PMTCT, low rates of partner testing, low awareness of the importance of PMTCT at the community level and the critical role of male involvement in improving the uptake of PMTCT services, woreda health offices and health facilities in select districts have established male to male support groups. Sixty male partners were sensitised and trained in Amhara region to create awareness among the community and highlight the advantages of partner testing and accessing PMTCT services. Following the initial training rapid roll out of sensitisation forums were steered at community level resulting in more male partners accompanying their spouses for HCT. HIV testing among pregnant women also increased significantly at health centres in the district where the male to male initiative was implemented. The success obtained in this initiative is attributed to the intensive efforts made by health care staff, the town administration health office, the woreda HAPCO, urban health extension workers, volunteers and community health mobilizers. This approach is particularly exemplary as it can sustain itself without requiring funds or support from external donors as well as encouraging community involvement and fostering ownership from health care workers, community members and local authorities.

V. Major Challenges and Remedial Actions

The following section draws heavily on findings from the national Midterm Review of 2013; recommendations from annual joint review meetings; annual performance reports of the multisectoral response and from the recent National Synthesis of the HIV Epidemic.

i) ***HIV prevention to reduce sexual transmission of HIV by 50 percent by 2015.*** The observed declining trend of HIV prevalence among young pregnant women is encouraging. However, the recent National HIV Synthesis, three Syntheses at the regional level and the MARPs study have highlighted geographical hotspots and priority key populations including sex workers, mobile populations, seasonal/farm workers, workers in development schemes and discordant couples. These studies have also highlighted the limited scale and coverage of targeted prevention interventions for these key population groups. Similarly, NASA findings for EFY 2004 identified a very small proportion of HIV prevention funds are dedicated to key populations. There is an urgent need to scale up the minimum package of HIV services for those populations groups and to generate strategic information where lacking. For instance, data on the magnitude and role of emerging high risk groups in the HIV dynamics in Ethiopia is still scanty. Meanwhile, Ethiopia is developing an Investment Case to re-prioritize the HIV response. This is a golden opportunity to maximize use of existing HIV evidence and adopt a more targeted approached towards geographic areas and risk groups where HIV transmission is shown to be higher. Given the heterogeneous and declining nature of the epidemic, effective responses will need to be increasingly targeted and scaled in proportion to the number of new infections they may prevent.

ii) ***Prevention of mother to child transmission to eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths:*** despite increasing access to ANC and remarkable expansion of PMTCT sites, coverage was still 55% in 2013. As shown in this report, there are still missed opportunities and loss of women and children at every step of the PMTCT cascade. Referral systems, safe delivery and post-delivery care and follow up are weak. There is low male involvement in PMTCT programme and still low access to early infant diagnosis. This calls for efforts to increase demand and use of PMTCT services; improve quality of services and laboratory diagnostic capacity for early infant diagnosis. The government of Ethiopia has developed an ambitious eMTCT plan for 2012-15, recently adopted 2013 WHO guidelines and Option B+ (lifelong treatment for all pregnant women independent of their CD4 count) and deployed thousands of health development army workers to be engaged in community mobilization. The good level of HIV integration into other health services also offers good opportunities for PMTCT scale-up and sustainability.

iii) ***Provide treatment and care services to reach (globally) 15 million people living with HIV with lifesaving antiretroviral treatment by 2015.*** Ethiopia has made substantial gains in the ART programme by expanding access to PLHIV. Nevertheless, retention of enrolled clients in treatment services, capacity for laboratory screening and point-of-care

monitoring require further improvement. In view of the newly adopted WHO 2013 guidelines (remarkably increasing eligibility criteria for treatment: CD4 count cut off at 500 for all adults; treatment for all TB patients, pregnant women and all children below 15 years of age), it is necessary to scale-up institutional capacity including procurement and distribution of ARVs. Moreover addressing challenges in treatment adherence and retention is crucial as strengthening referral linkages between ART services and TB, STI and PMTCT services. Particularly, paediatric treatment coverage remains very low at about 9.5% in 2013 according to new Ethiopia Paediatric guidelines. The country is experiencing severe challenges in identification of HIV positive older children/adolescents (survivors from vertical transmission) that represent the majority of HIV positive children. More focus is needed to reach children, particularly in the vulnerable categories. Investment in strengthening the capacity for laboratory machine maintenance and quality control is also required. Looking forward the long term sustainability of ART funding should be reviewed and the feasibility of local/regional drugs and other commodities production assessed.

iv) ***Increase domestic HIV resources to close AIDS resource gap by 2015 and reach (globally) annual global investment of $22-24 billion in low- and middle-income countries***. Existing data indicate that much of the direct HIV investment in Ethiopia is still donor driven. 86% of current HIV financing is external (NASA 2011/12 results). This underscores the need for increasing both the domestic and private sector contributions, with more efficient use of available resources; where there is scope to save money or retarget certain spending (assuming external contributions might not be sustained). Importantly, there was a significant portion (37%) of the total spending being managed by public entities (NASA 2011/12), but there remains unpredictability and lack of transparency regarding the bulk of external funds coming into the country, making coordinated and strategic resource allocation challenging. Some progress has been made in the mobilization of domestic funds in particular through the establishment of the Mainstreaming and AIDS Funds – the former requires public entities to allocate 2% of their budget to HIV-related activities, and the latter involved the voluntary contribution of employees for the support of other employees affected by HIV/AIDS. Expanding these funds and improving their targeting, utilization and reporting should be considered. Enhancing the government's ability to manage public and external funds, in determining the best investment opportunities, and in mobilizing resources from the private sector would be important, as well as increasing the predictability and transparency of the external funds, so as to improve overall coordinated financial planning and resource allocation. To contribute to this, there is need to improve financial information systems to allow for the routine and systematic collection of HIV-related expenditure data, and for such data to be made publicly available for increased transparency and accountability.

v) ***Eliminate gender inequalities and gender-based abuse and violence and increase women and girls' ability to protect themselves from HIV infection.*** Gender inequalities and power imbalances contribute to women's vulnerability to HIV as a result of weak capacity to negotiate for safer sex and impeding access to and use of HIV interventions.

The policy and legal framework to protect women and girls from GBV exists but it is fragmented and there is weak enforcement. In addition notably Ethiopia has not yet ratified the Protocol to the African Charter on Human and People's rights on the rights of women in Africa (Maputo Protocol) although it is a signatory to the protocol. Elimination of HIV and gender-based violence are not feasible without advancing women's empowerment - a requisite to prevent new infections and improve the quality of life of women living with HIV as well as to prevent new infections among children. In spite of progress made in adopting policies, laws and strategies promoting gender equality and gender mainstreaming efforts by government, there are gaps in effective implementation. It is essential to ensure implementation through advocacy and sensitization of implementers, education of women, and promoting involvement of men.

vi) ***Eliminate stigma and discrimination against people living with and affected by HIV.*** The national stigma index study shows that reported stigma and discrimination are prevalent. Misconceptions about HIV by community members and service providers result in fear, stigma, and discrimination which may undermine access and use of HIV services. Thus, it is important to scale up and intensify public awareness activities, and to empower PLHIV in fighting stigma and discrimination. To this end, efforts must be made to strengthen the capacity of associations and networks of PLHIV particularly at the regional level. Moreover awareness activities focusing on PLHIV and other vulnerable groups to know and assert their rights should be supported and sensitization activities for law/policy implementing bodies on enforcing the rights of PLHIV conducted. The large numbers of health extension workers (more than 30,000 community health workers) and the health development army (a community mobilization initiative) covering all of Ethiopia are good opportunities not only to enhance community awareness and demand creation but also to address HIV stigma and discrimination.

VI. Support from Development Partners

In addition to mobilising 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, United Nations via the UNDAF 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.

Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) together with PEPFAR is one of the major sources of funds for the multi-sectoral HIV/AIDS response in Ethiopia. To date Ethiopia has received three rounds of funding (i.e. Round 2, 4, 7 and RCC) from the GFATM. The GFATM resources for HIV/AIDS are channelled through principal recipients who include 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). The grant being implemented by the Federal HIV/AIDS Prevention and Control Office (HAPCO) has focused on continuing a successful scale-up of prevention and treatment activities and aims to achieve near universal ARV coverage with a target reaching approximately 484,000 people on ART by 31st December 2014. In 2011 the RCC phase II proposal for the period 2012 to 2014 was approved and a USD 310 million grant agreement signed out of which USD 39,238,592 was received by FHAPCO during the Ethiopian Fiscal year 2005 (2012/13) and an additional USD 122,438,076 between July-Dec 2013 for the procurement of pharmaceuticals and health products, and implementation of program activities. At the end of the EFY 2005, the programme had successfully put 307,645 eligible adults and children on antiretroviral therapy as well as tested and counselled 11,727,485 people at risk of HIV infection. In addition, the two civil society Principal Recipients (PRs) have active HIV/AIDS grants in Round 7 - the Network of Networks of HIV Positives in Ethiopia (NEP+) and the Ethiopian Inter-Faith Forum for Development, Dialogue and Action (EIFDDA). The NEP+ grant focuses on supporting people living with HIV/AIDS through nutritional support and general care services. The EIFDDA grant focuses on the provision of shelter, food and clothing and income-generating support for orphans and vulnerable children and their families. The amount for 2012/13 disbursed to EIFDAA was USD 5,255,194.62. A further USD 4,248,906 was received by NEP+.

The ***United Nations*** in Ethiopia provides strategic support to the Government of Ethiopia (GoE) in accelerating HIV prevention, care and treatment as well as in the extension of social support. The UN is mandated by the UN Political Declaration on HIV/AIDS (2011) in realization of the MDGs. This is achieved through supporting the GoE in the delivery of the SPM II (2010/11 -2014/15). The UNDAF is a strategic planning instrument designed jointly by the UN Country Team UNCT and GoE, it defines UN support for the country. In March 2011, GoE and the UNCT signed the UNDAF 2012-2015, the third UNDAF for Ethiopia. The UNDAF is aligned with the GTP for 2011/12-2015/16.

The UNDAF five year HIV outcome has five outputs as outlined in the table below.

UNDAF Outcome 7	Improved Access to HIV prevention, treatment, care and support by 2015
UNDAF Output 7.1	Evidence informed HIV combination prevention programmes and services expanded and accessible to all especially, women, youth and key populations
UNDAF Output 7.2	PMTCT programmes expanded and integrated into SRH/MNCH services
UNDAF Output 7.3	Integrated quality treatment, care and support services strengthened and expanded with equitable access by all in need
UNDAF Output 7.4	HIV sensitive social transfers are incorporated into national social protection policies and programmes and implemented
UNDAF Output 7.5	Strategic planning and management of the HIV response strengthened and guided by strategic information

The Joint UN Team on HIV through **the Joint UN Programme of Support for HIV** is the vehicle through which the UN supports countries to respond to the HIV epidemic and reach the ten Political Declaration targets and commitments. The Co-sponsors participating in Ethiopia are **UNICEF, WFP, UNFPA, UNHCR, UNODC, ILO, UNESCO, WHO, International Organisation for Migration (IOM), UN Women** and **UNAIDS Secretariat**. In 2012-2013, total spending on HIV of the Joint Programme of Support for HIV reached USD 28.2 Million.

In 2012-2013, the Joint UN Programme of Support was central in supporting Ethiopia on a number of key achievements in the areas of working towards zero new infections through combination prevention, eliminating new infections among children and keeping mothers alive and generating strategic information to inform programming, planning and prioritization:

- The UN has supported the development of a HIV prevention package for most at risk populations and vulnerable groups; the preparation of a minimum package and training manual for HIV and AIDS interventions in emergency settings; the development of a national condom strategy and the roll out of medical male circumcision in regions where the practice of traditional circumcision is low.
- There were an estimated 200,300 (172,400 – 232,400) children living with HIV in Ethiopia in 2012 (EPP/Spectrum 2014). This is attributed to the low access and uptake of PMTCT services. Cognizant of this, Ethiopia signed the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. To meet this commitment, the UN supported Ethiopia to develop a National Accelerated Plan for Scaling up Prevention of Mother to Child Transmission (PMTCT). The overall aim of the accelerated plan for PMTCT is to ensure that all pregnant women living with HIV have access to prevention and treatment services, and that new HIV infections among children is eliminated by 2015. In addition a strategic plan for the elimination of MTCT was developed and fully costed and implementation is on going.
- The UN has supported regular national programme joint reviews, supportive supervisions, the 2012 ANC surveillance, a bio-behavioural survey among prisoners and the national HIV Synthesis and regional HIV syntheses in Tigrai, Gambella, and Oromia. These studies identified most at risk and vulnerable populations; the nature of the epidemic and response in these regions in order to better target HIV prevention. Strategic information from these studies as well as annual M&E

reports and joint reviews are being utilized to refine targeted interventions and review implementation plans.

The ***US government*** is a major supporter of the Ethiopian health sector both through PEPFAR and bilateral USAID funding. The country has made significant gains in health with major improvements in child mortality and the HIV epidemic. Ethiopia is one of thirteen countries that has reached the "tipping point" with annual number of people initiating ART treatment exceeding the number of people newly infected, resulting in both a 50% decrease in AIDS associated mortality and a 90% reduction in HIV incidence (now 0.03%) since the introduction of PEPFAR in Ethiopia in 2005. Vigorous PEPFAR supported prevention activities continue with a focus on geographic "hot spots" and Most at Risk Populations.

PEPFAR has been supporting the Ethiopian National HIV Care and Treatment Program for the past nine years. The support has enabled the successful implementation and scale-up of the HIV care and treatment activities in all regions of the country in more than 900 health facilities including public hospitals and health centres, Uniformed Services health facilities, private hospitals and non-governmental health facilities. During the 2012-13 period PEPFAR implementing partners provided continued site level support including training, mentoring, supportive supervision and building site level and regional capacity. USG agencies and implementing partners supported national level efforts in policy formulation, development of guidelines, program planning, implementation, coordination and evaluation. Through capacity building that has been on going, PEPFAR has prepared government agencies to take over health facility site support of the country's HIV treatment program. PEPFAR's support of health systems strengthening has also improved infrastructure, strengthened laboratory services, trained a broad cadre of health workers, strengthened the national supply chain system, worked with the Ministry of Health to develop and scale up the country's Health Management Information System, and is providing technical assistance in the development of health sector financing reform, health insurance, Hospital Reform Implementation Guidelines, and the Human Resources for Health (HRH) strategy. PEPFAR also supports orphans and vulnerable children, fostering community structures towards more sustainable approaches.

The 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 on going programmes. It has key activities such as improving capacity of HAPCO to manage the overall national response to HIV, mainstreaming of HIV 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.

While the above descriptions provide some of the main partner organisations providing technical and funding support to the on going 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 Environment

7.1. Overview of M&E

Ethiopia developed its first national Monitoring and Evaluation Framework for the Muti-sectoral Response to HIV/AIDS in 2003. The National M&E system collects data from all levels of administration (woreda, regional and Federal level) to track the progress made in implementation of the strategic plan for the multisectoral response in Ethiopia (SPM I; 2007-2010), and the current SPM II (2010/11-2014/15) to facilitate informed decision-making and programme implementation. An evaluation conducted on the M&E system during the SPM I period, led to development of the second national/multi-level, harmonized, result based, and multi-sectoral HIV/AIDS M&E framework and costed plan in line with the current SPM II (2010/11-2014/15) in order to improve the performance of the HIV/AIDS response in Ethiopia.

The M&E Framework has 12 components grouped into three broad categories: 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 a rapid and effective HIV response which includes one agreed country-level M&E system.

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 trends and programme performance, and evaluating the outcome and impact of interventions. Initially, 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 117 by 2012; a remarkable expansion both in numbers and geographical coverage.

Behavioural Surveillance Survey (BSS) was introduced in 2002 to complement the ANC sentinel surveillance and 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 forces, mobile populations and youth. The second-round of BSS was conducted in 2005 but has not since been repeated.

The ***Demographic Health Survey*** (DHS) is a population based nationally and regionally representative survey that collects data on HIV/AIDS related information among the general

population and provides disaggregated data by sex and age-groups. The first DHS was conducted in 2000 (excluding HIV prevalence but including HIV related knowledge, behaviours and attitudes), followed by the second in 2005 and the third round in 2011 which included HIV testing. The information generated through DHS has been invaluable in monitoring trends on HIV testing, knowledge, behaviour and HIV prevalence at national and by regional level. This generates information useful to design targeted interventions.

Very recently, in 2013 a behavioural and sero-prevalence study was conducted among female sex workers, and long distance truck drivers nationally to assess HIV related behaviour and prevalence of HIV among these most at risk populations in the Ethiopian context.

7.3. Achievements, Challenges and Next Steps

FHAPCO's mandate is to oversee the overall management of HIV programmes 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 skill. This was identified as a critical need and emphasis is given in the framework to address these needs. To this effect FHAPCO in collaboration with UNAIDS has adopted the standardized HIV M&E and strategic information training curriculum and provided training based on the customized M&E modules at national level. The training is going and will be cascaded to regional and sub regional levels shortly.

Federal HAPCO coordinated a review of implementation of SPM I and the M&E system during this period. 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 agree on the way forward. Joint review meetings were conducted and reports were produced in 2011 and 2012. A system of Joint Integrated Supportive Supervision (JISS) is also in place and takes place twice a year. Furthermore, the Multi-sectoral Response Information System (MRIS) was revised in order to standardize the indicators and reporting mechanisms for collecting data on the non clinical community HIV response. Support from FHAPCO to regional and sub regional levels have been further strengthened by providing financial support to conduct JISS, JRM and trainings; IT material infrastructure support and recruiting M&E officers at regional level.

Annex 1: Consultation/preparation process for the country report

The Ethiopia HLM targets progress report employed desk review of published and grey literature including research articles, official documents on policy, laws, strategies, plans, guidelines and monitoring and evaluation reports. It also utilized key informant interviews and discussions with key stakeholders including government sectors, CSOs and development partners to obtain first-hand information for the National Policy and Commitments Instrument (NCPI). Consultative meetings were held with different sectors e.g. CSO and government sectors separately to review the NCPI questions and obtain collective responses for Government and civil society. Finally, inputs from a multisectoral working group led by FHAPCO were incorporated and findings were discussed at a national stakeholders consultation meeting. The feedback from the consultation meeting was further incorporated into the report.

Types of activities undertaken:

- **Desk review of relevant documents:** Review of national policies, guidelines and tools on health and HIV-related topics were carried out from published and unpublished sources. Furthermore, documents on the global and regional HIV epidemic and response were also referenced as necessary.

- **Key Informants and discussions:** Information from HIV/AIDS stakeholders including Federal HAPCO, Ministry of Health, other ministries, UN organisations, civil society organisations and PEPFAR were collected through key informant interviews in order to collect responses to complete the NCPI.

- **Consultation meeting:** a one-day consultation workshop was organized with stakeholders working on the national HIV and AIDS response including from national programmes, key implementation partners from bilateral, multilateral, and civil society organisations, and people living with HIV. The participants reviewed and validated the findings and provided inputs in terms of data to be included in the report and for the GARPR/UA indicator reporting as well as comments on the progress report

- **Review and incorporation of feedback:** Feedback from a multisectoral working group led by FHAPCO and inputs from the consultation meeting were included in the current report.

Annex 2: National Commitments and Policy Instrument (NCPI)

Please refer to data available at the GARPR Online Reporting Tool accessible at http://aidsreportingtool.unaids.org