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Challenges of Containing New HIV Infections in Ethiopia: Unacknowledged Transmission Route

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Abstract

As one of the main goals of the Partnership Framework (PF) between the Government of Ethiopia (GoE) and the U.S. Government (USG), Ethiopia has set a national target of reducing new HIV infections by 50% by the end of 2014 (National Target). Funded by the USG, the PF provides a five-year joint strategic plan (2010-2014) for cooperation to support Ethiopia's national HIV/AIDS response (PEPFAR, 2010). Ethiopia has an estimated adult prevalence of 1.5% and about a million people living with HIV/AIDS (PLWHA) (ECSA & IFC, 2012), among countries most affected by the epidemic. The International Labor Organization (ILO) projection for 2015 indicates that as much as 8.5% of the Ethiopian labor force loss will be due to HIV/AIDS deaths (World Learning, 2012). On the other hand, since the PF took effect, USG funding to the program has been in constant decline. Moreover, the PF does not fully take into account context and development barriers due to the prevailing social, political, economic and development policies in the country. Participation of the private sector, independent civil societies and media in the development process has been severely curtailed. Contextual factors have been seriously challenging the prevention of mother-to-child transmissions (PMTCT) efforts. Furthermore, the country lacks a comprehensive strategy to fully address the issue of most-at-risk population (MARP) as drivers of the HIV epidemic; and the HIV/AIDS response excludes Men who have sex with Men (MSM), a "significant unacknowledged" but fast growing transmission route of HIV (Tadele, 2008). Drawing from literature review and practicum experience in Ethiopia, this paper examines the feasibility of Ethiopia's National Target. The main problem in the HIV/AIDS discourse in Ethiopia appears to be behavioral change, but not lack of knowledge. In addition, contrary to the widespread public belief that homosexuality is not Ethiopian, there exists a flourishing underground male-sex trade in Addis Ababa.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARC/NARC	National AIDS Resource Center
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBO	Community Based Organization
CCFDRE4	Criminal Code of the Federal Democratic Republic of Ethiopia 2004
CDC	Centers for Disease Control and Prevention
CSW	Commercial Sex Workers
CSAE	Central Statistical Agency of Ethiopia
CSOs	Civil Society Organizations
DFID	Department for International Development (UK)
EDHS	Ethiopia Demographic and Health Survey
EIFDAA	Ethiopian Interfaith Forum for Development Dialogue and Action
EPRDF	Ethiopian People's Revolutionary Democratic Front (The Ruling Party)
FDRE	Federal Democratic Republic of Ethiopia
FGM	Female Genital Mutilation
FHAPCO	Federal HIV/AIDS Prevention and Control Office (Ethiopia)
FMOH	Federal Ministry of Health (Ethiopia)
FSW	Female Sex Workers
GAMET	Global HIV/AIDS M&E Team (World Bank)
GDP	Gross Domestic Product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP	Gross National Product
GoE	Government of Ethiopia
GTP	Growth and Transformation Plan (Ethiopia)
HCT	HIV Counseling and Testing
HCT Guideline	FHAPCO Guidelines for HIV Counseling and Testing
HDI	UN Human Development Index
HEP	Health Extension Program
HIV	Human Immunodeficiency Virus
HIV-EMR	HIV Electronic Medical Record
HRW	Human Rights Watch
IDA	International Development Program (World Bank)
ILO	International Labor Organization
IRA	Informal Rapid Assessment
KII	Key Informant Interview
LGBT	Lesbian, Gay, Bisexual and Transgendered
MARP	Most-at-Risk Population
MDGs	Millennium Development Goals
MHS	Mandatory HIV Screening
MSM	Men who have sex with Men
MSP	Multiple Sexual Partner
MTCT	Mother-to-Child Transmission
MULU II	MULU II Workplace HIV Prevention Program (Ethiopia)

MULU Prevention	MULU Prevention Program for At-risk Populations (Ethiopia)
NAC	National AIDS Council (Ethiopia)
National Target	Ethiopia's National Target of Reducing New HIV Infections by 50% by the end of 2014
NEP+	Network of Networks of HIV Positives in Ethiopia
NGOs	Nongovernmental Organizations
ODA	Official Development Assistance (OECD)
OECD	Organization for Economic Co-operation and Development
OVC	Orphans and Vulnerable Children
PEPFAR	U.S. President's Emergency Plan For AIDS Relief
PFs	Partnership Frameworks
PITC	Provider-initiated HIV Testing and Counseling
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
SPM I	Strategic Plan for Intensifying Multisectoral HIV/AIDS Response in Ethiopia I (2004-2008)
SPM II	Strategic Plan for Intensifying Multisectoral HIV/AIDS Response in Ethiopia II (2010/11 - 2014/15)
STI	Sexually Transmitted Infections
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	UN Development Assistance Framework in Ethiopia
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Client-initiated, or Voluntary Counseling and Testing
WHO	World Health Organization

1. Introduction and Background

This paper examines GoE's response to the HIV/AIDS threat, and the feasibility of the National Target. Moreover, the paper looks into existing and emerging development challenges to Ethiopia's national HIV/AIDS response, and explores the following questions:

I What are the challenges for the GoE to incorporate the emerging and highly vulnerable MSM community into the national HIV/AIDS response?
II What are the factors that might help GoE to succeed in meeting the National Target?
III How is the GoE planning to promote host country ownership in terms of the HIV/AIDS response?

In order to answer the above research questions, I examined historical, social, and prevailing political and development challenges of Ethiopia. The next four sections provide an overview of country context and background of HIV/AIDS in Ethiopia. Drawing from primary and secondary literature review including the assessment of GoE HIV/AIDS publications and legal documents, PRs and donor profiles, and practicum experience in Ethiopia, subsequent sections investigate responses to the HIV/AIDS threat, and describe the ongoing challenges to the sustainability of the national HIV/AIDS response.

1.1 Country Overview

Ethiopia, one of the world's oldest civilizations and home to ancient orthodox Christian rites and traditions, is the second-most populous country in sub-Saharan Africa. Recent CIA estimates put Ethiopia's population at over 90 million. Landlocked in the Horn of Africa, Ethiopia shares a border with the Sudan, Eritrea, Djibouti, Somalia, Kenya and South Sudan. With a total surface area of approximately 1.1 million square kilometers, an area slightly less than twice the size of the U.S. state of Texas, Ethiopia's topography ranges from 4,533 meter peak above sea level to a low land of 125 meters below sea level (CIA, 2013).

Ethiopia is also identified with chronic poverty and famine; a place where democratic structures are still nascent and being defined; and instability along much of its borders and the region continues to persist. Despite the recent impressive economic growth that averaged 10.7 percent per year (among the top 12 fast growing economies in the World), Ethiopia remains a low-income country with a real per capita income of US $370 (World Bank, 2013a). According to the UN Human Development Index (HDI)[1], in 2012, Ethiopia ranks 173 out of 187 countries on overall index and the per capita Gross National Income (GNI) (2013). Moreover, Ethiopia is one of the least urbanized countries with more than 82% of the population living in rural areas. The average national household size is 4.6 persons; and while the sex ratio between male and female is almost equal, 38% of women and 67% of men aged 15-49 are literate (ECSA & IFC, 2012, p. 2).

In 2010, GoE launched a five-year Growth and Transformation Plan (GTP) that envisaged an annual Gross Domestic Product (GDP) base growth case scenario of 11% and a high growth case scenario of 14.9% mainly through public investment. Major objectives of the GTP were improving the quality of social services and infrastructure, ensuring macroeconomic stability, and enhancing productivity in agriculture and manufacturing (GoE, 2010). Since 2010, over 2.5 million people in Ethiopia have been lifted out of poverty (World Bank, 2012). Notable progress has been achieved in universal primary education and the country is on track to achieving the Millennium Development Goals (MDGs) in the areas of gender parity in education, child mortality, HIV/AIDS, and malaria (World Bank, 2013a). Yet, gender based violence remains a persistent social problem. Harmful practices include female genital mutilation (FGM), early marriage, and marriage by abduction (PEPFAR, 2012, p. 4). In urban areas,

[1] HDI measures and assesses countries long-term progress in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living.

women have fewer employment opportunities than men, and the jobs available do not provide equal pay for equal work (ECSA & IFC, 2012, p. 14).

Although surveillance indicates a steady decline in HIV prevalence in Ethiopia, there are still close to a million PLWHA, one of the highest to care for and treat in East Africa, placing substantial demand on already strained resources. HIV/AIDS is also characterized as a mixed epidemic across geographic areas and population groups in the country. Transmission is primarily driven by MARP, and small towns close to large-scale development zones are considered hot spots, forming a bridge for the extension of new infections into rural areas. According to the 2011 Ethiopia Demographic and Health Survey (EDHS), the total HIV prevalence in the country is 1.5 with marked difference along gender lines: 1.9% for women[2] and 1.0% for men, and an urban prevalence of 4.2 and rural 0.6 (0.8 for men and 0.5 for women) (ECSA & IFC, 2012, p. 13). HIV prevalence also varies by region; for example, in Gambela region HIV prevalence is 6.5%, compared with 0.9% in the SNNP region (ECSA & IFC, 2012, p. 13). Nonetheless, consistent with the reports, knowledge of HIV/AIDS among the population has progressively increased since 2004.

2.1 Political Context

For much of its history, Ethiopia was ruled by a monarchy in a centralized system of government. The current ruling party, the Ethiopian People's Revolutionary Democratic Front (EPRDF) came to power in 1991 overthrowing the brutal Communist regime that deposed the last Emperor in 1974. Since taking power, the EPRDF has led an ambitious political and economic reform, and undertook a peaceful transition of power following the death of Prime Minister Meles Zenawi.

[2] Women and men between the ages of 15-49

On the other hand, after the disputed 2005 election wherein hundreds of people were killed, much democratic ground has been lost; opposition groups were divided and crushed; and the size and control of the ruling party increased immensely (USAID, 2012, p. 8). In fact, it was evident from the 2010 Parliamentary election (EPRDF "won" 99.6% of the seats) that the political landscape in Ethiopia remains uneven.

The new Civil Society Organizations (CSOs) proclamation and the "anti-terrorist" legislation, which came into effect in 2009, severely restrict political space for independent civil society groups and media. The CSO law distinguished between organizations based on their funding sources. Organizations that receive 90% or more of their funding from Ethiopian citizens are classified as "local" organizations; those based in Ethiopia but that receive more than 10% of their funding from international sources as "resident" charities & societies; and those based outside of Ethiopia and funded from external sources as "international" organizations (GoE, 2009). The law dictated that only local CSOs can work on human rights, democracy and the rule of law (UK Govt, 2012). Moreover, the "anti-terrorist" legislation gave a "wide powers of arrest" for the government (USAID, 2012, p. 8), and literally decimated the independent media in the country (HRW, 2013).

3.1 Development Challenges

Ethiopia is faced with plethora of development challenges including: sustaining the progress made in recent years toward the MDGs, addressing the causes of poverty among its population, sustaining the large scale donor support, using aid effectively, improving governance and empowering local authorities, and for the government to become more accountable to its citizens (World Bank, 2013a). According to USAID Ethiopia, ten to fifteen percent of the Ethiopian population remains chronically food insecure, 82% dependent on subsistence

agriculture, and the country has one of Africa's highest rural and overall population growth rates (2012, p. 3).

Moreover, the lack of political competition and an enabling environment for independent CSOs, political parties and media are hindering democratic progress in Ethiopia. Corruption is endemic, and the economy is overwhelmingly dominated by state and ruling party enterprises (The World Bank, 2012). Although there is some progress, private sector investment remains "hobbled by red tape and arbitrary rules" (USAID, 2012, p. 3). According to a recent remark by World Bank Country Director for Ethiopia, "... the public investment rate of Ethiopia is the third highest in the world, while the private investment rate is the sixth lowest" (2013b). In fact, the full participation of the private sector, independent civil society and media in the development process would ensure sustainability and promote the shift to local ownership, a fundamental change for the realization of the national HIV/AIDS response.

Ethiopia's physical location at the drought prone and volatile Horn of Africa is a constant geopolitical and development challenge for the country. In addition to security challenges in the south eastern part of the country along the Somalia border (the Ogaden region), Ethiopia's ongoing counter insurgency operation in Somalia could make it an increasingly attractive target for terrorists and for terrorist recruiters. The unresolved border dispute with Eritrea has a potential to create further instability and increase refugee flow across common borders thereby increasing MARP as drivers of the HIV/AIDS epidemic.

The escalating water dispute with Egypt over the construction of the Grand Ethiopian Renaissance Dam is another emerging challenge for the country. The Grand Renaissance Dam, which has been under construction on Blue Nile River since 2011, is scheduled for completion in 2017. Blue Nile contributes over 80% of the Nile waters. When completed, according to GoE,

the dam will be the largest hydroelectric power plant in Africa and one of the largest in the world with a total of 6,000 MW power generating capacity. Egypt, which lies downstream and heavily relies on the waters of the Nile, firmly opposes the construction of the dam fearing reduction in the water volume it receives. Indicating the findings of an independent panel of experts, Ethiopia argues otherwise, and assures that the dam will be exclusively used to generate power (Milas, 2013). Ethiopia contends it needs more power to keep up with its fast growing economy and the burgeoning population. Recently, Egypt's political leaders have discussed methods to sabotage the construction of the dam (Hendawi, 2013). Any significant instability in the region is likely to exacerbate the development challenges and affect the national HIV/AIDS response.

4.1 HIV/AIDS Background in Ethiopia

HIV/AIDS remains one of the key development challenges in Ethiopia. Analysis by the World Health Organization (WHO) showed that HIV/AIDS has led to a seven-year loss in life expectancy, close to a million orphans, and the loss of productivity and income at workplace with severe effects on households and communities across Ethiopia (WHO, 2005, p. 2).

The first evidence of HIV infection in Ethiopia was documented in 1984, and the first two AIDS cases were reported to the Ministry of Health (MOH) in 1986 (FT & Zewdie, 1998, p. 139-145). HIV-1 subtype C, which mainly spreads through unprotected heterosexual intercourse, remains the predominant strain in the country (FHAPCO, 2012, p. 12).

Since the mid 1980s, HIV has been spreading in both urban and rural areas of Ethiopia. For instance, in 2003, Ethiopia had an estimated 950,000 to 2.3 million PLWHA, among the highest number in one country in the world (WHO, 2005, p. 1). Consequently, by the end of 2003, the national prevalence was 4.4%, and an estimated 120, 000 people died and 720, 000 children younger than 17 had been orphaned by the epidemic (WHO, 2005, p. 1). As in the

present, in 2003, women and young people between the ages of 15-24 were at higher risk of acquiring the disease. Ten years later in 2013, while the total adult prevalence has significantly declined, the number of PLWHA has not changed much (approximately 800,000), and number of children orphaned due to HIV/AIDS has increased by more than 22% (ARC, 2013; FHAPCO, 2012, p.1; USAID, 2013c).

Although heterosexual and mother-to-child transmissions (MTCT) were responsible for much of the epidemic in Ethiopia (FHAPCO & GAMET, 2008, p. 78), WHO studies indicate that the high incidence of sexually transmitted infections (STI), the prevalence of multiple sexual partners (MSP), traditional practices such as FGM and body piercing, blood transfusion, and unsafe medical practices have also contributed to the spread of the epidemic in the country (2005, p. 1). Neither official government records nor specific programs exist for HIV/AIDS intervention among MSM in the country. Nevertheless, despite the criminalization, denial and discrimination of homosexuality in the country, MSM do exist in Ethiopia and equally suffer from the HIV/AIDS epidemics (Tekleberhan, 2011; Gebreyesus & Mariam, 2009; Tadele, 2008). In fact, as most MSM in the country are likely to engage in heterosexual relationships ("cross bridging of HIV transmission"), educating them about HIV/AIDS has wider implications with regard to preventing the spread of HIV into the general public (Gebreyesus & Mariam, 2009, p. 277; Tadele, 2008, p. 171).

2. Literature, Documents and Donor Profile Review

2.1 GoE Response to the HIV/AIDS Epidemic

According to a joint GoE and World Bank analysis:

> Since the outbreak of the epidemic in 1985 into the late 1990s, HIV/AIDS intervention in Ethiopia was inadequate in scale; it was largely ineffective in implementation; it lacked sufficient stakeholder involvement in planning and implementation particularly at regional and community level; it was poorly coordinated across sectors and among service providers; and it received relatively low priority within government, society in general, and the international community, with a resultant low level of allocated financial and human resources. (FHAPCO & GAMET, 2008, p. 77)

However, since the late 1990s, the response to the epidemic has been a coordinated collective effort of GoE, multilateral and bilateral donors, national and international non-governmental organizations (NGOs). In 1998, GoE adopted HIV/AIDS policy that outlined strategies for HIV prevention, care and support. In 2000, the National AIDS Council (NAC) was established to oversee the implementation of federal and regional HIV/AIDS responses. Recognizing the seriousness of the epidemic and its multi-faceted impact, NAC declared HIV/AIDS a national emergency. In 2001, a Strategic Framework for the National Response to HIV/AIDS was adopted, and priority intervention areas such as condom distribution, Voluntary Counseling and Testing (VCT), STI and PMTCT were identified. The framework was multisectoral and engaged public and private sectors, local and international NGOs, and civil society, faith and community-based organizations. In 2002, the Federal HIV/AIDS Prevention and Control Office (FHAPCO) was established with mandates to coordinate and lead implementation of the national HIV/AIDS policy.

In January 2005, GoE launched a Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response 2004-2008 (SPM I); and a free antiretroviral therapy (ART) rollout program aimed at reducing HIV transmission, mitigating HIV/AIDS related morbidity and

mortality, and alleviating burdens on individuals, families and the society. According to FHAPCO, SPM I implementation was based on multisectoralism, shared sense of urgency, gender sensitivity, integration of PLWHA and result oriented interventions; as well as the best use of resources through allocation, harmonization, efficiency and accountability. Moreover, capacity building, community mobilization and empowerment, integration with health programs, leadership and mainstreaming, and networking and targeted response were at the core of SPM I. Furthermore, a road map for accelerated access to HIV prevention, treatment and care in Ethiopia (2007-2010); and plan of action for universal access to HIV prevention, treatment, care and support were also developed.

While the federal HAPCO coordinated national and regional level responses to the HIV/AIDS threat, regional HAPCOs galvanized interventions at zonal, district and neighborhood levels. Making PMTCT, treatment and care strategic priorities, the federal HAPCO established HIV/AIDS resource centers and introduced the health extension program (HEP), a community-based approach for addressing health and HIV/AIDS issues. HEPs train female health extension workers and assign them at rural health posts to provide outreach services to households. For instance, since the implementation of SPM I (between 2004 - 2008), the deployment of over 30,000 health extension workers in rural posts across the country helped start public conversation about HIV/AIDS, expanded HIV/AIDS service facilities, increased utilization of HIV/AIDS services, and created social transformation. In fact, evaluation of the SPM I implementation has shown remarkable progress in expanding access to HIV services and scaling-up response capacity. Key to the success of the scale-up was the building of leadership capacity in the health sector, involvement of civil societies and the community, and engagement of bilateral and multilateral partners in the process of planning, implementation, monitoring and evaluation

(FHAPCO, 2012, p. 21-22). However, since the passage of the restrictive civil society law in 2009, hundreds of independent NGOs and CSOs have vanished from the country; and indispensable engagements by both local and international NGOs in the development process have been significantly affected (Ravelo, 2013; Worku, 2011, p. 29-31). As the recent World Bank Ethiopia economic update pointed out, the country's government intensive development strategy is simply unsustainable in the long-run (World Bank, 2013b).

As a result of the implementation of multisectoral approach to HIV/AIDS response, between 2001 and 2006, GoE claims the following successes:

- An increased level of awareness and positive trends in behavioral change
- An increased demand for VCT
- An increasing trend in condom distribution and utilization
- Integration and expansion of VCT
- Initiation of PMTCT and AVR services
- Positive trends in openness, and reduction of stigma and discrimination
- Encouraging trends in involvement of PLWHA in the response

Nevertheless, studies indicate that compared to the magnitude of the epidemic, the achievements were very modest. For example, some of the factors that limited the full implementation of the SPM I include leadership challenges, rapid expansion of the epidemic to rural areas, lack of qualified human resource mainly at regional and district levels, addressing the rapidly growing service demand and sustaining it, and resource availability and absorption capacity (FHAPCO, 2004, p. 43-44).

In 2011, as SPM I phased out, FHAPCO developed SPM II (2010/11-2014/15) with emphasis on five thematic areas: creating an enabling environment, intensifying HIV preventions, increasing access to and improving quality of chronic care and treatment, intensifying mitigation efforts against the epidemic, and strengthening the generation and utilization of strategic information. HAPCO claims that the overall implementation of SPM II is

on track, and according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), between 2001 and 2011, new HIV infection rate in Ethiopia had dropped by 90%, among the highest achievers in the world (2012, p. 10).

However, during my stay in Ethiopia working on a practicum with World Learning (January - April 2013), from observations, various informal interview and surveys I conducted traveling across the country, I learned that the introduction of ART in the country did impact morbidity and mortality from AIDS in a major way; and that HIV/AIDS awareness was universal. But the real challenge appeared to be accountability and translating the awareness of HIV risk into changes in behavior. Almost all of the participants I spoke to including people who work in the HIV/AIDS field and university students refused to be held accountable for risky sexual behaviors. Unless supplemented by other means including legal accountability, high level of awareness alone may not be enough to contain the HIV/AIDS epidemic in Ethiopia.

I also learned that non-adherence to ART was increasingly becoming an issue; and that criminalization of homosexuality complicated HIV/AIDS risk among the MSM community and the population at large. In fact, as Getnet Tadele rightly argued, denial, discrimination and criminalization of homosexuality could lead to "A significant unacknowledged transmission route of HIV," which "… may hamper all other public health campaigns against HIV transmission in Ethiopia and make the cost of such campaigns needlessly wasteful" (2008, p. 4).

Moreover, I realized that the flourishing sex tourism in Ethiopia has involved young boys in historical places like Lalibela; gender based violence remained a pervasive social problem; and that contextual factors were hampering PMTCT efforts.

2.2 The International Community Response

Ethiopia has been one of the major international aid recipient countries in the world in recent years. For instance, in 2006, net Official Development Assistance (ODA) to Ethiopia amounted to US$1.94 billion, the 7th largest among development aid receiving developing countries (Alemu, 2009).

GoE's major development partners for the national HIV/AIDS response include the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), Presidential Emergency Programme for AIDS Relief (PEPFAR), the World Bank (up to 2011), UN Development Assistance Framework (UNDAF) and the HIV Governance Pooled Fund. The national HIV/AIDS response aims at attaining universal access to HIV prevention, care and treatment; and improving the health system in Ethiopia (FHAPCO, 2012, p. 44-47).

2.2.1 The Global Fund

The Global Fund is the major source of funds for the national multisectoral HIV/AIDS response in Ethiopia. The Global Fund resources are channeled through the Federal Ministry of Health (FMOH), FHAPCO, Network of Networks of HIV Positives in Ethiopia (NEP+) and Ethiopian Interfaith Forum for Development Dialogue and Action (EIFDAA). From 2003-2013, Ethiopia has received US$803, 728,322 from Global Fund; and 270,000 people are on ART as a result of the support (Global Fund, 2013). U.S. is the largest single contributor of the Global Fund, and Ethiopia received more funding from Global Fund than any other country in the last decade (Glassman, 2012). However, PEPFAR's contribution to Global Fund that peaked in 2010 has decreased by 50% in 2012; and a further funding cut is likely given the recent trend of decreasing funds and the challenging budget environment in the U.S. (Glassman, 2012).

2.2.2 PEPFAR

USG provides extensive support for the national HIV/AIDS response. Funds are mainly channeled through PEPFAR, the US Agency for International Development (USAID), and the Centres for Disease Control and Prevention (CDC).

PEPFAR is a USG initiative to help save the lives of those affected by HIV/AIDS, and the largest component of the President's Global Health Initiative. PEPFAR - Ethiopia is one of the largest recipients of PEPFAR, and its projects are implemented through USAID, CDC, the Department of Defense, Peace Corps and the Department of State Refugee Bureau. From the fiscal years 2004 - 2011, Ethiopia has received close to US$1.8 billion in PEPFAR funding to fight HIV/AIDS (PEPFAR, 2010). PEPFAR funding supports STI Prevention, PMTCT and HCT programs, awareness creation, condom distribution and behavior change communications; ART provision; care and support for PLWHA; Orphans and Vulnerable Children (OVC); and capacity building programs (health infrastructure improvements, health workers training, development of health care financing, and supply chain and laboratory systems). PEPFAR also looked to expand their work with new partners, such as NGOs and private healthcare providers to ensure quality service and sustainability, and support the shift towards host country ownership. In 2011, through direct PEPFAR support, the following progress was achieved (PEPFAR, 2010):

- 237,400 individuals receiving ART
- 1,156,900 HIV-positive individuals received care and support (including TB/HIV)
- 493,200 OVCs received support
- 815,100 pregnant women with known HIV status received services
- 10,300 HIV-positive pregnant women received ART for PMTCT
- 5,580,100 individuals received HCT services
- 3,174 estimated infant HIV infections averted

Due to changing HIV/AIDS epidemiological trends in Ethiopia (e.g., the lowering of prevalence) and improved efficiency, in 2013, PEPFAR Ethiopia experienced 79% reduction

(US$191 million cut) in PEPFAR funding (Glassman, 2012; State Dept, 2013). The impact of such drastic funding cut, particularly to the National Target and on the shift towards host country ownership is yet to be seen. Though there is evidence that countries are experiencing severe challenges including a slowdown in treatment scale-up as a result of the PEPFAR funding cut (MSF-USA, 2012). In absence of reasonable progress towards host country ownership or continued follow-through on earlier PEPFAR investments, future cost increases and loss of gains are highly likely, and in the worst-case scenario, epidemics currently in decline could rebound.

2.2.3 USAID

USAID Ethiopia provides technical and financial support for HIV prevention programs with particular focus on MARPs, PMTCT and Workplace HIV intervention. It also supports care and ART programs for PLWHA and OVCs, health extension programs, and invests on capacity building to buttress the shift to host country ownership. USAID Ethiopia works to improve the private sector engagement in HCT, ART and TB/HIV services provision as well (USAID, 2013c).

One of PEPFAR's HIV Prevention initiatives undertaken by USAID is the five year (2012-2017) MULU Prevention Program for At-risk Population (MULU Prevention). The name "MULU," an Amharic word, translates "complete," symbolizing the broad scope of the prevention interventions under the initiative. MULU Prevention has two parts: MULU II Workplace HIV Prevention Program, and Interventions for MARPs and other highly vulnerable populations in non-workplace contexts. MULU Prevention aims to contribute to the National Target, and works in development zones such as large scale farming, construction and mining investments (USAID, 2013b).

The primary implementing partner of MULU II Workplace HIV Prevention Program (MULU II) is the World Learning, a U.S. based international development organization. Other implementing partners include two U.S. based international organizations, Population Services International (PSI) and FHI360, and the International Labour Organization (ILO), a specialized UN agency (USAID, 2013a). During my practicum with World Learning in Ethiopia, I was assigned to MULU II, which was planned to be implemented across 100 large-scale worksites in the country. Under the supervision of the MULU II team, which was composed of senior practitioners from the implementing partners, I was able to accomplish the following:

- Conducted Informal Rapid Assessment (IRA) of HIV/AIDS risks and behaviors (both qualitative and quantitative) among MULU worksite employees[3] in Bahir Dar and Western Gojam development zones (Bahir Dar Textile Factory, Bir Farm Development, Ayehu Farm Development and Tana Beles Integrated Sugar Development Project).
- Translated 234 pages of HIV/AIDS qualitative IRA responses from Amharic into English, and transcribed the data into excel file
- Organized 494 HIV/AIDS qualitative IRA responses for analysis work in excel file and involved in editing the final narrative
- Moderated HIV/AIDS Peer Educators Training programs conducted in Addis Ababa, Kombolcha, Ambo and Makale regions
- Produced a 30 page practicum report

Moreover, I had the opportunity to visit Bahir Dar, Gondar, Makale and parts of southern Ethiopia including Awassa and Arbaminch.

2.2.4 The CDC Global AIDS Program

The CDC Global AIDS Program provides extensive technical expertise in areas of blood safety, antiretroviral treatment services, laboratory infrastructure, and providing strategic information. CDC works in cooperation with 23 other implementing partners including U.S. based universities (e.g., Universities of Washington, Columbia and Johns Hopkins), and other local and international partners. For instance, in partnership with the Ethiopian Health and

[3] Employees of large scale development zones, e.g., commercial farms with 500 or more employees

Nutrition Research Institute (EHNRI), CDC provides laboratory training and technical assistance to strengthen the nation's health system (FHAPCO, 2012, p. 46).

2.2.5 The World Bank

The World Bank has provided US$30 million from 2007 – 2011 to scale-up HIV preventive services for the youth and MARP, to sustain access to care and support for PLHIV and OVCs, and to strengthen institutional capacity across sectoral ministries. The World Bank project was closed in September 2011 (FHAPCO, 2012, p. 44).

2.2.6 UNDAF

UN agencies (such as WHO, UNICEF, UNAIDS, UNDP) and GoE jointly formulated UNDAF as a strategic planning instrument to guide and appropriate contributions for Ethiopia. From January 2007 - December 2011, UNDAF programs supported humanitarian responses, recovery and food security, basic social services and human resources, HIV/AIDS, good governance, and enhanced economic growth. In 2010/11, UNDAF invested US$30 million on HIV/AIDS (FHAPCO, 2012, p. 44-45).

2.2.7 HIV Governance Pooled Fund

The HIV Governance Pooled Fund was established in 2008 by a number of international organizations including the Irish Aid, Italian Cooperation, United Nations Population Fund (UNFPA), and the UK Department for International Development (DFID) (FHAPCO, 2012, p. 46-47). The fund focuses on improving governance of the HIV/AIDS response through ensuring accountability, improving capacity and promoting responsiveness among implementing institutions such as the FHAPCO. Between 2008 – 2010, DFID contributed UK£2 million to the pooled fund (DFID, 2012). DFID is not part of the Pooled Fund anymore.

The above list is not exhaustive; it only describes some of the main partner organizations engaged at the national HIV/AIDS response. Several other development partners not listed above continue to support GoE.

2.3 The Origin of the National Target

On October 27, 2010, the GoE-USG Partnership Framework was signed for HIV/AIDS Prevention and Control in Ethiopia. The framework illustrates the leadership of GoE in addressing the HIV epidemic that is mainly driven by MARP. The framework identified promoting sustainability through a multi-sectoral approach, targeting programming to effectively meet the health needs of the most vulnerable populations, and host country ownership as priority areas of intervention. Moreover, the framework provides a five-year joint strategic plan (2010-2014) for cooperation between GoE, USG, and other stakeholders to support a collaborative response to HIV and improve health service provision for PLWHA. The National Target of reducing new HIV infections by 50% by 2014 is one of the four main goals of the PF (State Dept, 2011), also incorporated into Ethiopia's Strategic Plan for Intensifying Multisectoral HIV/AIDS Responses II.

2.4 Challenges to the National Target

2.4.1 HCT Shortfalls

Studies have shown that lack of infrastructure including comprehensive HIV counseling and testing guidelines and information and communication systems, is considered a barrier to successful HIV/AIDS response and treatment. According to the FHAPCO Guidelines for HIV Counseling and Testing (HCT Guideline), there are three types of HIV testing in Ethiopia: Client-initiated, or Voluntary Counseling and Testing (VCT), Provider-initiated testing and counseling (PITC), and Mandatory HIV Screening (MHS) (2007a). While PICT is recommended

and promoted during treatment as part of standard clinical management and care in all health facilities, MHS is permissible for all voluntary blood, tissue and organ donors; and in exceptional cases by order of a court of law (FHAPCO, 2007a).

However, a critical preventive and legal element was missing in the HCT Guidelines. HCT is not only important for individuals and couples to learn about their HIV status and make an informed decision about their future, but it is also important in preventing the spread of the epidemic. Citizens should be educated and held accountable in the event intentional crime against public health occurs. Actually, in regards to intentional spreading of human disease, Article 514 of the Criminal Code of Ethiopia states:

> Whoever intentionally spreads or transmits a communicable human disease, is punishable with rigorous imprisonment not exceeding ten years. When the offender spreads or transmits a disease which can cause grave injury or death, out of hatred or envy, with or without intent of malice or a base motive; and when an offender transmits an epidemic the punishment shall be rigorous imprisonment not exceeding twenty years, or in grave cases, with rigorous imprisonment for life or death. However, when the crime is committed negligently, the punishment shall be simple imprisonment or fine.(FDRE, 2005)

There is no better opportunity than during HCT sessions to educate citizens about the law and prevent further spreading of the epidemic. Unfortunately, neither the national HCT guideline nor the Intervention Protocol mentions the provisions of the law in the event of intentional spreading of the epidemic. For example, when addressing risk reduction strategy with HIV infected clients, counselors do not mention the criminality of intentionally spreading the HIV virus (FHAPCO, 2007a; FHAPCO, 2007b, p. 19-25, 38-40, 43-44, 55, 65). In addition, when a client fails to disclose HIV positive status to his/her partner for any reason, the guideline reiterates that the endangered partner has legal right to know the positive partner's HIV status (FHAPCO, 2007a, p. 6). However, the guideline does not extend the same legal and disclosure right to others with whom the affected person might engage in risky sexual activity.

On the other hand, during my stay in Ethiopia, I learned from colleagues that intentionally and or negligently infecting others was rampant; and non-adherence to ART and tracking non-adhering clients has increasingly become a problem. ART package is paid for by U.S. and several other donor countries tax payers. Hence, a tracking mechanism needs to be implemented; and clients should be educated and held accountable for their actions if an intentional and or negligent spreading of the epidemic occurs. Moreover, although assessing the extent of the problem is not the purpose of this paper, due to the lack of a database or HIV Electronic Medical Record (HIV-EMR) system, knowledge sharing between projects and storing data (captured demographic data, clinical assessment, laboratory investigations, social circumstances and ART regimen) at local, regional and national level appears to be an issue in Ethiopia. This in turn could lead to unnecessary laboratory tests, medical and statistical errors and make the tracking of non-adherence to ART challenging. Moreover, the reliability of HIV prevalence and new infection rate estimates may come into question.

2.4.2 The PMTCT challenge

MTCT is one of the two major routes of HIV transmission in Ethiopia. According to a qualitative study published in June 2012, MTCT of HIV accounts for more than 90% of pediatrics AIDS in Ethiopia (Adedimeji et al., 2012, p. 2). Despite marked improvements in HIV/AIDS service delivery and implementation of PMTCT services, the number of pregnant women accessing the services remains very low. For example, since the goal of universal access was established in 2007, in one southern region, less than 7,000 HIV positive pregnant women received ART, representing about 19% of the annual targets; and at national level, only 8% of eligible HIV positive pregnant women were on ART in 2012 (Adedimeji et al., 2012, p. 2,4). The 2012 GoE report on HIV/AIDS also indicated low PMTCT coverage (a consistent problem),

inadequate access to PMTCT services, and poor integration with maternal services as the main challenges of 2010 and 2011(FHAPCO, 2012, p. 30-32, 41-42). This is a major setback for the GoE's goal of universal access and increased HIV/AIDS service delivery to PMTCT, and the National Target.

The GoE blamed weak referral linkages, poor male partner involvement, inadequate awareness on the benefits and availability of PMTCT services for the poor performance. However, the qualitative study findings implicated varying contextual and structural matters (e.g., socio-cultural, health system and operational barriers) for the continued constraints on many pregnant women from accessing the services across the country, thereby increasing the risk of vertical transmission of HIV to newborns. Other factors that contributed to low utilization of HIV/AIDS services include societal stigma; health workers stigma (e.g., reluctance or refusal of health workers to assist HIV positive women child birthing for fear of contracting the virus); the desire to prevent knowledge of serostatus; lack of appropriate follow-up mechanisms; inadequate access to ATR; and poorly equipped manpower. The study concluded that the effectiveness of PMTCT interventions not only rests on a well functioning health system but also on the realities where HIV positive pregnant women live. Therefore, without meaningfully addressing the contextual factors that are impeding PMTCT efforts, it would be impossible to significantly reduce new HIV infection rate in the long run. Let alone by the end of 2014.

2.4.3 MARP as Drivers of the HIV Epidemic

HAPCO defines MARP as "… a group within a community with an elevated risk for HIV, often because group members engage in some form of high risk [sexual] behaviour; in some cases the behaviors or HIV serostatus of their sex partner may place them at risk" (2012, p. 14). MARP include female sex workers (FSWs), young girls engaged in transactional and cross-

generational sex, uniformed forces, long distance drivers, discordant couples (one partner is infected and the other is not), refugees, and migrant laborers or cross-border and mobile populations. Recent studies indicate that MSM in Ethiopia are fast emerging as MARP (Morris & Brundage, 2012, p. 4; Tadele, 2010; Gebreyesus & Mariam, 2009; Tadele, 2008).

MARP share a higher risk and prevalence of HIV compared to the general population. For instance, a study among sex workers in Amhara region revealed a prevalence of 11.6% to 37.0%, which is considerably higher than the national prevalence of 1.5% (FHAPCO, 2012, p. 15). Mobility and economic depravity appear to be the two most important factors that drive MARP into high risk and unprotected sexual practices (FHAPCO, 2012, p. 15).

Although determinant factors that drive the epidemic and sexual behaviors among MARP are not adequately explored, according to SPM II findings, a low level of comprehensive knowledge about HIV/AIDS; a low level of perceived risk and threat of HIV/AIDS; an increased population migration; high prevalence of unprotected sex through concurrent multiple partnerships; intergenerational transactional sex; high prevalence of STI, alcohol and substance abuse; gender inequality; and poverty could be cited as some of the major drivers of the epidemic (FHAPCO, 2010, p. ix). Moreover, MARP targeted HIV prevention is either "often lacking or when available, inadequate" (FHAPCO, 2012, p. 15). Furthermore, as discussed above, HCT counseling sessions fail to use the opportunity to educate MARP about the law of crimes against public health and the legal consequences of knowingly spreading the epidemic (FHAPCO, 2007a; HAPCO, 2007b, p. 19-25, 38-40, 43-44, 55, 65). Therefore, the national target of reducing new HIV infections by 50% by the end of 2014 appears to be more ambitious than feasible in the current context of Ethiopia.

2.4.4 Country Ownership Assessment of the HIV/AIDS Response

Foreign aid has played a pivotal role in Ethiopia's development effort in the last few decades. According to Getnet Alemu, following a regime change in 1991 and with the implementation of World Bank's structural adjustment program in 1992/93 in particular, Ethiopia received a significant amount of foreign aid (2009).

Ethiopia's HIV/AIDS response is mostly donor-assisted. For instance, in 2004/05, from the estimated US$ 208.7 million needed to support the scaling-up of ART to reach the treatment target of 100 000 by the end of 2005, Ethiopia contributed only 21%. The remaining 79% was covered by foreign funding (WHO, 2005). Similarly, in 2007/08, according to National Health Accounts Survey, Ethiopia's national HIV/AIDS expenditure was US$248,000,114, accounting for more than 20% of the total health sector spending (the largest spending on a specific disease in the country). While 84% of the total expenditure came from external sources, GoE contributed 11%; citizen's out of pocket expenditures for HIV diagnosis treatment and care accounted for 3.5%; and other sources such as the private sector and local NGOs accounted for 1% of the total expenditure (FHAPCO, 2012; Glassman, 2012).

Nevertheless, although the move towards country ownership appears to be very slow, GoE has taken steps to integrate HIV/AIDS into public expenditure work. For example, in 2010/11, FHAPCO alone was able to mobilize US$120 million, 56% of the proposed HIV/AIDS budget (FHAPCO, 2012, p. 22-23). In addition, according to the Fourth National Health Accounts report, while some regions were able to secure 15%, many public sector organizations earmarked 2% of their annual budget for HIV/AIDS response, and established AIDS funds to help support employees living with HIV/AIDS. Several private sector organizations have incorporated workplace HIV/AIDS intervention strategies and earmarked budget for it as well.

For instance, in 2010/11, a total of 1,049 private organizations had allocated up to 2% of their annual budget for HIV/ AIDS activities. Although this will not make a dent in the overall national HIV/AIDS response budgetary gap, in the long-run if significantly scaled-up, the trend, in fact, depicts increasing local ownership of the HIV/AIDS response efforts.

On the other hand, according to PEPFAR, though GoE is committed to addressing HIV/AIDS and strengthening the health sector, the transition to host country ownership may have been affected by the weak support for the roles of independent civil society and the private sector with barriers under the new CSO law for more active engagement by NGOs (PEPFAR, 2012, p. 12). Furthermore, as discussed under the "International Community Response" section above, abrupt funding cuts by PEPFAR and Global Fund in particular, would put the shift to local ownership and the National Target in total jeopardy.

2.4.5 Impact of the Denial, Stigmatization and Criminalization of Homosexuality

In this paper, I use the phrase MSM and homosexuality interchangeably. In some cultures where the society strongly promotes marriage, MSM may not regard themselves as "homosexual" or "bisexual," and could be married to a woman, so that they might avoid living under cloud of suspicion (Tadele, 2008, p. 1).

The Ethiopian public at large still holds the myth that homosexuality is alien to the country. Moreover, homosexuality is not only considered a sin but also a criminal offense. The perception of homosexuality both as a criminal offence and sin might have stemmed from the fact that state and religion in Ethiopia have always been inseparable from the monarchical dynasties of the last two thousand years to the current government. For instance, Article 629 and 630 of the Criminal Code of Ethiopia (as amended after 48 years in 2005), prohibit:

> "Homosexual Acts" between same-sexes with a penalty of one year to ten years' "simple imprisonment." The general aggravation to the crime include taking unfair advantage of

> the material or mental distress of another or of the authority one exercises over another by virtue of one's position; and when the offender "makes a profession of such activities ...." Moreover, the punishment becomes rigorous imprisonment of three years to fifteen years when the offender uses violence, intimidation or coercion, trickery or fraud, or takes unfair advantage of the victim's inability to resist or defend or of his feeble-mindedness or unconsciousness; when the offender subjects his victim to acts of cruelty or sadism, or intentionally infects the victim with a venereal disease; and when a victim is driven to suicide by distress, shame or despair of the act. For homosexual acts performed on minors between the ages of 13 and 18 and below 13, Article 631 prescribes rigorous imprisonment of three to twenty five years. (FDRE, 2005)

What is more, like many communities around the world still do (Robinson, 2013, p. 20), most Ethiopians link homosexuality (which often is consent based) with pedophilia, the crime of sexual preying on children (Tadele, 2008, p. 7). Consequently, the crime of male sexual abuse is not yet part of the public discourse; and unlike abuse against girls, parents don't discuss the dangers of male sexual abuse, and children are not educated about pedophiles and other sexual abusers (Kassaye, 2013). In fact, the existence of the flourishing male sex trade in Addis Ababa and other large cities in a country where homosexuality is not talked about is quite surprising.

Earlier accounts by scholars indicate that the practice of homosexuality existed in Ethiopia (Murray & Roscoe, 1998; citing Bieber, 1909; Messing, 1957; Gamst, 1969; Hallpike, 1972; Donham, 1990). Recent literature (Aderaw, 2012; Gebreyesus & Mariam, 2009; Tadele, 2008) confirm early findings and clearly show the widespread existence of the practice and male sex workers in Addis Ababa and other parts of the country. Furthermore, in 2011, a book authored in Amharic (Ethiopic language) titled "*YeSodom Nefsat*," translated as the "Lives of Sodom," claims to tell a true life story of a 36 years old ex-homosexual man who happened to contract HIV/AIDS while leading a homosexual life (Aderaw, 2012, p. 17; Tekleberhan, 2011b). In addition, though hard to verify, according to a Rainbow-Ethiopian LGBT/MSM Sexual Health Education and Promotion Initiative, 5,000 of the estimated 50,000 sex workers in Addis Ababa alone are "young male sex workers" who during the night engage in various acts of sex including

orgies, oral and anal intercourse with paying clients from all walks of life; and during the day, search for monogamous relationships (Tekleberhan, 2011).

Failure to address HIV among MSM goes beyond criminalization, and their marginalization increases the risk of spreading HIV/AIDS among the general population. Especially, due to myths and misconception surrounding the community, awareness of the proper and consistent use of condoms among MSM has not been fully developed yet; sex between men is perceived as less risky than sex between a man and a woman; and washing the genitals or defecating after unprotected sex is believed to be an effective way of preventing HIV transmission (Tadele, 2008, p. 169). Thus, given that MSM (when it involves unprotected anal sex) carry much higher risk of acquiring HIV/AIDS than any other sexual practice and are likely to engage in heterosexual relationships, not only are MSM more vulnerable to HIV/AIDS but also are a "significant unacknowledged" route of transmission to the greater public (Gebreyesus & Mariam, 2009, p. 277; Tadele, 2008, p. 4). So far, the GoE has no specific program intervention design for MSM and nor did it make a concerted effort to study the extent of the practice and its importance in spreading HIV in the country (FHAPCO, 2012, p. 28-29).

The widespread public and religious denial, stigmatization and criminalization of homosexuality has caused a number of social and public ailments: it disallowed the recognition and importance of MSM for HIV/AIDS prevention and made it difficult to obtain adequate epidemiological data about MSM; it created difficulty in designing MSM specific HIV intervention plan; it fueled the crime of male sexual abuse; it resulted in a lack of open discussions about sex and sexuality; and it created hostile and intolerant behavior towards homosexuality and its adherents. One of the major reflections of this kind of culture of silence

and intolerance towards sexuality and homosexuality could be the epidemic nature of HIV/AIDS in Ethiopia.

3. Methodology

To examine the national HIV/AIDS response, and gain further insight into HIV transmission routes in Ethiopia, I studied various GoE HIV/AIDS publications and bilateral PF documents, donor profiles and carried out extensive literature review that is captured in various sections of this paper.

Moreover, during my practicum in Ethiopia, the MULU II team designed an informal rapid assessment (IRA) to collect information on health, HIV risks and behaviors, and HIV services provided at MULU worksites[4]. I took no part in designing the IRA. The IRA was divided into three parts:

a Key Informant Interview (KII): 19 semi-structured qualitative interview questionnaires, designed to collect HIV/AIDS related information and challenges from worksite management, and regional and zonal HAPCO personnel
b Quantitative IRA: 72 interview questionnaires for worksite employees including daily-laborers, technical and support staff
c Biomedical assessment (solely carried out by PSI personnel)

I joined the Bahir Dar MULU II team as support personnel, and between January 21 and February 04, 2013, we conducted a total of 80 IRAs in Western Gojam zone (250 – 350 miles north of the capital Addis Ababa) at four MULU worksites: Bir Farm Development (± 2700 workforce), Ayehu Farm Development (workforce of ± 10,000), Tana Beles Integrated Sugar Development Project (±11,000 workforce), and Bahir Dar Textile Factory (workforce ±1300). The IRA was a cross-sectional design that employed both quantitative and qualitative methods. Similar studies were carried out in other parts of the country. The qualitative part of the

[4] Large-scale development zones with 500 or more employees (e.g., commercial farms, construction sites, textile/leather factories, horticulture farms, dam projects) partnered with MULU HIV Prevention initiative.

assessment used semi-structured KII guides to explore the overall situation of health, HIV risk factors and behaviors within and around worksites. Five key informants were purposely selected and interviewed from each worksite using the semi-structured interview guide. The interview was conducted in Amharic and the key informants were worksite management personnel and representatives from zonal HAPCO and administration. A total of 109 individuals (86 worksite management personnel and 23 zonal HAPCO and administration representatives) in 26 worksites were interviewed.

Being native Ethiopian, I had the advantage of speaking, writing and reading Amharic, and got along very well with the participants and the community. Subsequently, I translated 234 pages of qualitative KII responses from Amharic into English, and recorded and transcribed the data in excel file (a total of 494 qualitative responses). The World Learning Ethiopia Monitoring and Evaluation department did the initial analysis. For the purposes of this paper, I summarized the findings as follows:

- In general, HIV/AIDS knowledge appears to be universal in the country
- Economic depravity (e.g., low wage), gender inequality and low literacy primarily drive women daily-laborers into sex for extra income
- Alcohol and *khat* (a mildly narcotic plant) abuse among the youth, crowded living space in camps, nature of farm work (men and women working side by side for long hours in bushy areas) and nature of factory work (e.g., late night shifts) made women vulnerable to sex abuse and unprotected sex
- The presence of multiple large-scale development projects, and institutions such as federal prison, military camp and tourist sites around towns and communities attract large number of mobile labor force, visitors, bars, commercial sex workers (CSW) thereby increasing vulnerability to HIV/AIDS
- The misconception that women working in leather factories could be infertile made unprotected sex inevitable to young women (the society highly values family life)
- HIV/AIDS related light duty assignments, and frequent absenteeism and sick leaves have led to a reduced productivity, and incurred large medical bills on companies
- The most mentioned at-risk population were female daily-laborers
- In terms of HIV/AIDS prevention and awareness activities, not much has been done in the last 12 months preceding the IRA (some respondents associated it with availability of ART)

- HCT services and ART were provided free of charge in almost all worksites and communities. Most respondents indicated a sharp decline in HIV/AIDS related death, and described the HIV/AIDS impact as moderate since ART was made available to citizens

The field experience and the participation in the IRA helped me comprehend some of the socio-cultural, political and economic barriers to the national HIV/AIDS response. It also provided me an opportunity to meet and converse with high level GoE officials, city duelers, farmers, University Students, and commercial sex workers (both men and women) in various parts of the country. Moreover, during my stay in Ethiopia, I attended various HIV/AIDS related trainings in Addis Ababa, Kombolcha, Makale and Ambo.

4. Conclusion and Recommendations

4. 1. Conclusion

Coordinated and targeted HIV Prevention strategies such as the MULU HIV Prevention, certainly contribute to the success of the National Target. The MULU HIV Prevention initiative uses a collaborative approach and engages citizens, the private sector, government agencies and international development organizations to tackle the epidemic. On the other hand, although MTCT is the second major transmission route of HIV in Ethiopia, low PMTCT coverage has been a consistent challenge for the government. GoE needs to bring aboard grass-roots CBOs, CSOs and the private sector to untangle contextual and structural matters that hamper the PMTCT efforts. Yet, the new CSO and "anti-terror" legislations render weak support for the roles played by independent CSOs and media. Moreover, ongoing and drastic funding cuts by the Global Fund and PEPFAR threaten the success of the national HIV/AIDS response and the feasibility of the National Target.

Contrary to the widespread public belief that homosexuality is not Ethiopian, scholarship indicates that not only the practice of homosexuality did exist in the country but also a

flourishing underground male-sex trade. This, in fact, warrants attention for the prevention of HIV/AIDS among the MSM and the general public. The main problem, in the HIV/AIDS discourse in Ethiopia appears to be not a lack of knowledge about HIV, but a lack of accountability and willingness among citizens in acting on what they know. Conversely, among the MSM community, a lack of knowledge and misperceptions about HIV transmissions appear to be the case. In general, there is persisting misconception among the MSM community that sex between men is less risky than sex between a man and a woman. This has alarming implications because the reverse is true when unprotected sex is involved. Though it is evident that HIV/AIDS knowledge by itself is not enough to bring about behavioral change among the population, interventions aimed at preventing the spread of HIV from the general public could benefit from an approach that addresses the MSM community. In addition, even though legal and societal resistances further complicate the HIV prevention efforts among the MSM, considering the scale of the practice and vulnerability of the MSM, discussion on the issue is long overdue.

4. 2. Recommendations

- The GoE needs to ease legal and funding restrictions on independent CSOs and the media, create an enabling environment for private sector investment and research, and encourage and reward innovative approaches that help educate and address the issue of lack of accountability and behavioral change among citizens.
- To examine the relationship between GoE and independent CSOs, I used Coston's model and typology of government-NGO partnership framework (1998). In fact, the relation between CSOs/NGOs and GoE is both repressive and of rivalry. It is repressive because the operating environment for independent CSOs and media in the country is very restrictive; and it is rivalry and obstructive because GoE sought to control independent CSOs and media through

stringent regulations. This sore relationship must be changed to competitive one, where both GoE and CSOs can be attentive to the HIV/AIDS threat, and focus on ownership of the development process (Coston, 1998, p. 358-382).

- Expand the operational scope of the Global Fund, PEPFAR, USAID and HIV Governance Pooled Fund and other NGOs to work directly with the private sector, CSOs, and grass-roots and community based organizations.
- As an agency of social justice, GoE should outlaw hate crimes, discriminatory healthcare practices, and solicit citizens' participation in designing MARP, PMTCT and MSM targeted intervention plans to contain the HIV epidemic.

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