

Challenges Faced by Healthcare Providers in Providing Services to Key Population at Risks of HIV in Ethiopia

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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.

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) Ethiopia's National Target of Reducing New HIV Infections by 50% National Target 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

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:

1. What are the challenges for the GoE to incorporate the emerging and highly vulnerable MSM community into the national HIV/AIDS response?
2. What are the factors that might help GoE to succeed in meeting the National Target?
3. 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.

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).

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 women² 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.

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.

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.

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).

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).

Literature, documents and donor profile review

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 Multispectral 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.

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.

As a result of the implementation of multispectral 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

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).

The global fund

The Global Fund is the major source of funds for the national multispectral 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).

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).

- 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.

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).

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

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).

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).

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 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.

Challenges to the national target

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.

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).

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).

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).

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

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 worksites⁴. I took no part in designing the IRA. The IRA was divided into three parts: 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 Quantitative IRA: 72 interview questionnaires for worksite employees including daily-laborers, technical and support staff

C. Biomedical assessment (solely carried out by PSI personnel 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 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).

Conclusion and recommendations

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.

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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