Battling HIV/AIDS in Ethiopia

U.S. Approach Needs Nuance, Flexibility

A Report of the CSIS HIV/AIDS Delegation to Ethiopia May 23–28, 2004

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The CSIS Task Force on HIV/AIDS is cochaired by Senators Bill Frist (R-TN) and Russell Feingold (D-WI) and is funded by the Bill and Melinda Gates Foundation. Now in its second two-year phase, the Task force seeks to build bipartisan consensus on critical U.S. policy initiatives and promote U.S. leadership in strengthening prevention, care, and treatment of HIV/AIDS in affected countries. It places special focus on states affected by the pandemic's "second wave": the Ethiopia mission follows Task Force delegations in early 2004 to India and China and precedes delegations to Russia and Nigeria in early 2005. CSIS is grateful to Senators First and Feingold for their leadership and to the Gates Foundation for its continued support and vision.

The CSIS HIV/AIDS Task Force Delegation to Ethiopia May 23–28, 2004

SUMMARY

Ethiopia has entered a moment of opportunity, heightened risk, and change in its struggle against HIV/AIDS. Significant international resources to fight the pandemic are beginning to flow, and senior leaders in the Ethiopian government have identified HIV/AIDS as a threat second only to food insecurity. Nonetheless, Ethiopia is a long way from getting ahead of the pandemic. The Ethiopian government is arriving relatively late to HIV/AIDS. Although awareness is high, the government is still in the early stages of thinking through and articulating its priorities, recognizing the breadth and cost of what an effective response will require, and building effective partnerships with donor and nongovernmental groups.

The advent in Ethiopia of the President's Emergency Plan for AIDS Relief (PEPFAR) is clearly a boon for Ethiopia, but at the same time has highlighted complex policy issues that reveal how difficult quick implementation will be. Ethiopia's scale, the profundity of its development challenges, and the weakness of its healthcare system will make it one of the most challenging of the PEPFAR focus countries. Ethiopia illustrates the urgent need to craft a U.S. response that is tailored to the unique set of circumstances and challenges of each recipient country. Targets in prevention, care, and treatment are important—as benchmarks for progress and as measures of accountability. But they should not be pursued dogmatically or narrowly at the expense of priorities less easily measured—most importantly in Ethiopia's case, the acute vulnerabilities of women and girls—or in a way that undermines a long-term sustainable response to HIV/AIDS and other infectious diseases.

Success in Ethiopia is far from assured, and much is at stake, with respect to both Ethiopia's future and the credibility and effectiveness of the U.S. PEPFAR initiative. To be most effective, the U.S. approach needs to be backed by greater capacity and informed by greater political and programmatic nuance. The CSIS HIV/AIDS Task Force delegation to Ethiopia strongly recommends that the Office of the U.S. Global AIDS Coordinator pursue a modified strategy that:

- emphasizes caution, consultation, and flexibility in setting targets for treatment, care, and prevention, and encourages regular reassessment of targets and timeframes;

- devolves maximum flexibility and authority to the embassy, and ensures a close, open exchange between the Coordinator's office and the embassy;

- maintains close and persistent engagement with the government of Ethiopia to be responsive to Ethiopia's evolving strategy and to consistently push for realism and leadership from top government officials in fully understanding the resources and capacities that will be required for an effective response, in acknowledging the government's responsibility in empowering women and girls to protect themselves from sexual predation and HIV/AIDS; and in recognizing the positive and vital role that NGOs can play in effecting a genuinely national response;

- places a premium on active diplomatic outreach to nongovernmental organizations and other donors, works as much as possible through existing coordination mechanisms, and supports the convening role of the United Nations, particularly UNAIDS. It should systematically work to align and coordinate its priorities with those of the Global Fund and the World Bank, the two major donors to Ethiopia's HIV/AIDS response;

- creates rapid response capacities within the Global Coordinator's Office to meet urgent requirements: e.g., to place senior PEPFAR managers into embassy teams; deploy training teams and detail skilled personnel to host governments to plan and manage programs; and ensure a reliable supply chain of critical medical supplies;

- establishes specific gender programs and targets, with explicit objectives and activities targeting women and girls in HIV/AIDS programs; and

- supports the development and implementation of a comprehensive, common HIV/AIDS monitoring and evaluation framework for Ethiopia.

INTRODUCTION

A priority of the CSIS Task Force on HIV/AIDS is to examine the special challenges of combating the threat of a generalized HIV/AIDS epidemic in large, populous "second- wave" states. Much like the missions to China and India it had undertaken earlier in 2004, CSIS assembled a team of senior public health and policy experts to visit Ethiopia from May 23 through May 28, 2004. Dr. Kathleen Cravero, deputy executive director of the Joint United Nations Program on HIV/AIDS (UNAIDS), and Ambassador Princeton Lyman, Ralph Bunche

Senior Fellow for Africa Policy Studies at the Council on Foreign Relations, kindly agreed to cochair the group. Jennifer Cooke, deputy director of the CSIS Africa Program, and J. Stephen Morrison, executive director of the CSIS Task Force on HIV/AIDS and director of the CSIS Africa Program, organized the delegation.

The 14-person team comprised prominent members of the foreign policy, philanthropic, public health, and advocacy communities, nongovernmental organizations (NGOs) engaged directly in HIV/AIDS programs, the corporate sector, Senate staff (from the office of Senator Mike DeWine), and the United Nations. The U.S. Embassy in Ethiopia and representatives from the U.S. Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC) provided valuable guidance and participated in a number of the delegation's meetings. The delegation also benefited enormously, especially during its regional site visits, from the assistance provided by the in-country offices and staff of Family Health International, the David and Lucile Packard Foundation, and UNAIDS.

The delegation met with Ethiopia's senior political leadership, including President Girma Woldegiorgis and Prime Minister Meles Zenawi, health officials at the federal, regional, and zonal levels; nongovernmental activists; health professionals; community educators; home-based care providers; religious leaders, including the patriarch of the Ethiopian Orthodox Church and the chair of the Supreme Islamic Council; people living with HIV/AIDS; and people affected by it. In three separate subgroups, delegates traveled to Awassa, the regional capital of the Southern Nations, Nationalities, and Peoples Region (SNNPR); Makele, the regional capital of Tigray; and Gondar, a town in the Amhara region.

The delegation sought to deepen its understanding of the status and distinct drivers of the epidemic in Ethiopia, the threat that it poses, the emerging character of the Ethiopian national response, and the early implementation of the President's Emergency Plan for AIDS Relief (PEPFAR). Three primary thematic interests shaped the delegation's work and its recommendations:

- the centrality of leadership—both governmental and nongovernmental—in combating the pandemic;

- the urgent need to address the acute vulnerabilities of women and girls to HIV; and

- the challenge of harmonizing the multiplicity of bilateral, multilateral, national, and nongovernmental programs and priorities proliferating in Ethiopia, with special attention to the essential contribution of the United Nations.

As one of the largest and most complex of the PEPFAR focus countries, Ethiopia will be an important bellwether for implementation of the initiative. Nowhere in Africa is the need greater for careful consultation and coordination; an appropriate balance among prevention, care, treatment, and broader health-related goals; and a balance between a short-term emergency response and a long-term sustainable strategy. While the delegation focused on Ethiopia's specific circumstances, final recommendations have broad relevance for U.S. policy in PEPFAR states and beyond. Ethiopia illustrates the urgent need to craft a U.S. response that is tailored to the specific circumstances and challenges of each recipient country. Targets in prevention, care, and treatment are important—as benchmarks for progress and as measures of accountability—but they should not be pursued at the expense of priorities that do not always lend themselves to easily measured targets, for example, the status of women and girls, or in a way that undermines a long-term sustainable response to HIV/AIDS, other infectious diseases, and other development challenges.

Success in Ethiopia is far from assured. Moreover, there is a great deal at stake in ensuring success, with respect to both Ethiopia's future and the credibility and effectiveness of the U.S. PEPFAR initiative. The delegation concluded that to be most effective, the U.S. approach to HIV/AIDS in Ethiopia will need to be backed by greater capacity and informed by greater political and programmatic nuance.

ETHIOPIA'S CONTEXT: A CONSTELLATION OF CHALLENGES

HIV/AIDS occurs within Ethiopia's exceptionally challenging environment of multiple threats and constraints, among them abject poverty, low investments in public health, a stagnant economy, high unemployment, recurrent food crises, a heavy disease burden, and exceptionally weak state social service capacities. Many of these constraints are present in the other 14 countries targeted by PEPFAR and indeed in most other Sub-Saharan African countries, but by and large they are conspicuously more acute in Ethiopia. The 2004 Human Development Report of the United Nations Development Program (UNDP) ranks Ethiopia 170 out of 177 on the Human Development Index; 92 out of 95 on the Human Poverty Index; and 137 out of 144 on the Gender-related Development Index.[1] Further, Ethiopia's sheer size—70 million citizens—compounds the difficulty of addressing these constraints effectively.

[1] UNDP's human development index (HDI) focuses on three measurable dimensions of human development: living a long and healthy life, being educated, and having a decent standard of living. The human poverty index (HPI) focuses on the proportion of people below a threshold level in basic dimensions of human development. The gender-related development index (GDI), uses the same indicators as the HDI but captures inequalities in achievement between women and men. The greater the gender disparity in basic human development, the lower is a country's GDI relative to its HDI.

Stability too has proven elusive. War dominated the country between 1974 and 1991, and resumed in 1992 in the Oromo region and in the period 1998–2000 between Ethiopia and Eritrea, the latter at painfully high cost—well over 100,000 lives lost, over $1 billion in wealth diverted to the conflict, and hundreds of thousands of people displaced. Shortly after the war ceased, famine rebounded and by 2003 threatened the lives of upward of 15 million persons, requiring massive, emergency transfers of food relief to avert catastrophe. Today, the border demarcation dispute between Ethiopia and Eritrea—a root factor in the onset of war in 1998—remains unresolved and indeed threatens a potential return to armed conflict.

To date, the starkest manifestation of Ethiopia's exceptional challenges is its vulnerability to recurrent food insecurity and famine. Ethiopia suffers from fundamental and pervasive food insecurity, with an estimated 5 million people classified as chronically food insecure. Periodic rain shortages, dependence on subsistence farming and outdated cultivation techniques, land degradation, deforestation, and low levels of agricultural productivity are immediate catalysts of food insecurity, but it is the depth and magnitude of Ethiopia's poverty and lack of infrastructure that allow even small disturbances in food production or distribution to translate into widespread food crises. Ethiopia has received approximately 800,000 metric tons of food assistance per annum from the international community during the past 15 years, with little or no effect on persistent food insecurity or malnutrition. During the country's 2002–2003 drought, 21 percent of Ethiopians required food and other forms of emergency assistance. In that period, the United States provided a record $553.1 million in assistance, of which $471.7 million was food aid. Indeed, over the years, levels of USAID emergency food assistance have dwarfed development and health-related assistance (see table 1).

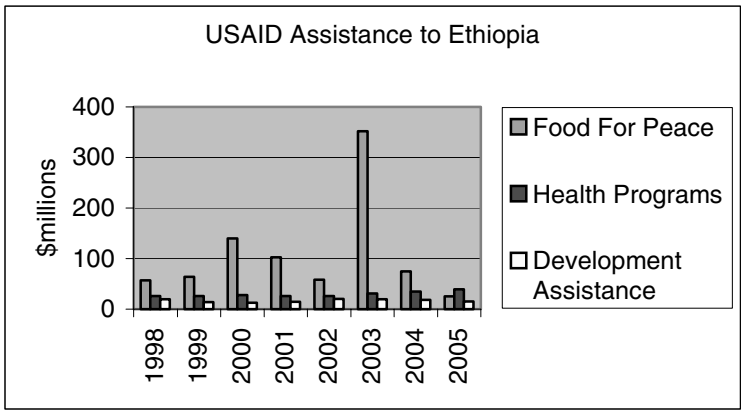
There is now growing consensus among the donor community that emergency assistance alone will do little to address the sources of food insecurity and that a longer-term, more sustainable response is required. In April 2004, USAID Administrator Andrew Natsios cited ending famine in Ethiopia as one of the agency's six top priorities, along with building a free and prosperous Iraq; winning the peace in Afghanistan; championing peace in Sudan; and fighting global HIV/AIDS.[2] USAID has resolved to revise its current strategy "to correct the imbalance between humanitarian assistance and development assistance" and to build resiliency in Ethiopia to withstand and manage through [sic] shocks, while laying the foundation for sound economic growth."[3] At the G-8 meeting on

[2] Written testimony of Administrator Andrew S. Natsios, U.S. Agency for International Development, testimony before the Subcommittee on Foreign Operations, Committee on Appropriations, U.S. House of Representatives, April 1, 2004, http://www.usaid.gov/press/speeches/2004/ty040401.html.

[3] "Congressional Budget Justification 2005," U.S. Agency for International Development, http://www.usaid.gov/policy/budget/cbj2005/afr/et.html.

Sea Island, Georgia, in June 2004, member states agreed to support a new initiative to break the cycle of famine in the Horn of Africa, with Ethiopia as the first recipient. Together with the World Bank and other donors, G-8 members have committed to work with the Ethiopian government to support land reform, expand rural infrastructure, develop agricultural markets, and facilitate regional integration. By creating a "productive safety net," the initiative aims to provide within three to five years an alternative to emergency assistance for Ethiopians who are chronically food insecure.

Table 1



The evolution of international thinking on an effective response to Ethiopia's chronic food insecurity may hold important lessons for responding to HIV/AIDS. Ultimately, curbing HIV/AIDS in Ethiopia will require a broad-based, self-sustaining strategy that addresses those factors that drive the epidemic. A stovepiped, overly "medicalized" approach to HIV/AIDS that does not take into account the fragility of Ethiopia's socioeconomic circumstances will have a high probability of failure.

ETHIOPIA'S RESPONSE: A MOMENT OF OPPORTUNITY AND CHANGE

One powerful impression shared within the delegation is that Ethiopia has entered a moment of opportunity, heightened risk, and change in its struggle against HIV/AIDS. Significant resources to fight the pandemic are beginning to flow, principally from U.S., Global Fund, and World Bank channels. Public awareness is high. Senior leaders in government now clearly perceive the HIV/AIDS threat and indeed have identified it as a top priority of the country, second only to food insecurity. Internal deliberations within ruling circles are expected to result soon in an updated national strategic plan that will place the health system at the forefront of efforts against HIV/AIDS and spell out plans for national prevention, care, and treatment programs. Nongovernmental organizations and community groups are acquiring an ever greater voice and operational responsibility in educating the public on HIV/AIDS and helping individuals and families cope with its impacts. Today, a growing number of

communities and associations of people living with HIV/AIDS are vocally challenging the stigma associated with the virus, encouraging compassion and care, and, as an HIV-positive man in Gondar declared, taking steps to "make sure the virus stops with us."

ETHIOPIA'S NATIONAL LEADERSHIP

Despite these hopeful signs, Ethiopia is a long way from getting ahead of the pandemic. The Ethiopian government, by comparison with many states in East Africa, is arriving late to HIV/AIDS. Unlike Uganda and Kenya, for instance, Ethiopia is still in the early stages of thinking through and articulating its priorities and building effective partnerships with donor and nongovernmental groups. As yet, there is no clear national consensus around goals, power relations, and respective roles. In this respect, the rapid implementation of the ambitious President's Emergency Plan for AIDS Relief is inherently more complex and challenging than the introduction of PEPFAR programs in other more settled settings in eastern and southern Africa.

The government's revised national plan places additional burdens and responsibility on the healthcare system as "the key stakeholder" on HIV/AIDS. There are indications, for example, that the Ethiopian HIV/AIDS Control and Prevention Office (HAPCO), the mechanism mandated with mobilizing a broad multisectoral approach, is being increasingly subsumed into the Ministry of Health. Yet Ethiopia's public health system is exceedingly weak. It has little experience and no successful model of mounting broadscale public health programs. Furthermore, according to the World Health Organization, Ethiopia's per capita government spending on health—just over $1.00 in 2001—is the lowest in Africa, less than in Chad, Niger, or Sierra Leone. Total per capita health expenditure—$3.00—is second-lowest in Africa, barely edging out Liberia. Currently, there are 2,032 physicians in Ethiopia—one doctor for every 34,000 people—and 40 percent of the population has no access to modern healthcare of any kind.

The Ministry of Health has traditionally been one of Ethiopia's weaker ministries. Despite an impending surge in HIV/AIDS resource flows, the ministry currently has only three personnel assigned to HIV/AIDS within the Department of Disease Prevention and Control. The government is under increasing pressure to work with international and nongovernmental partners to recruit, provide incentives to, and retain adequate numbers of competent administrators, accountants, and technical personnel to quickly expand the ministry's response and avoid incipient bottlenecks in reviewing proposals and disbursing funds to regional and local health bureaus. At the same time, the government is challenged to ensure the authority, independence, and capacity of the federal HAPCO so that potential bottlenecks and delays within the Health Ministry do not further inhibit the response at the regional level.

Ethiopia's HIV epidemic is largely concentrated in urban/peri-urban communities, with urban adult prevalence averaging 13.7 percent and in some cities exceeding 20 percent. In contrast, prevalence in rural areas (where some 85 percent of Ethiopian citizens live, often in remote, isolated communities) is purportedly much lower, at approximately 3.7 percent (it is important to note that surveillance is extremely limited outside of urban centers, and this number almost certainly underestimates actual prevalence). International estimates of Ethiopia's overall adult HIV prevalence have declined in recent years from 9.3 percent in 1997 to 4.4 percent in 2001, with a high estimate of 6.7 percent.[4] Experts do not believe that this decline represents an actual reduction in the rate of infection—rather, it is due to improvements in the methodology and data on which the estimates are based. Nonetheless, the Ethiopian government argues that the urban/peri-urban epidemic has reached a plateau, and that transmission to rural communities is contained. Only dramatically improved surveillance will clarify what forces are driving the epidemic along what trend lines, and whether the Ethiopian government's relative optimism is grounded in fact.

Fundamentally, the ruling party—the Ethiopian People's Revolutionary Democratic Front (EPRDF)—sees the country's rural peasantry as its core constituency. According to Prime Minister Meles Zenawi, the government's revised national plan will move away from costly prevention strategies that are based on urban-centered, elitist workshops and seminars, which, according to the prime minister, are creating a self-perpetuating "small-industry" for NGOs, and which create awareness largely unconnected at a popular level to actual behavior change. The government envisions instead a sustained populist social mobilization for prevention at the grass roots that emphasizes individual personal responsibility for behavior change and community-based provision of care. The delegation was informed that a new category of women trained as extension health workers—two per village in up to 20,000 villages—will be a central element of the strategy. The government intends to rely heavily on EPRDF party structures, mass organizations, elders, religious leaders, and others to intensify awareness and social pressures.

The delegation strongly suspects that this strategy underestimates the true costs and the technical and support inputs needed for such a nationwide mobilization. The strategy also carries a decidedly statist bias, an implicit emphasis on maintenance of social and political control shaped by a wariness of international and national NGOs, whose role, the government argues, should be confined to the provision of technical information, care and support, equipment, medicine, and training of skilled treatment providers. As the government envisions it, this approach will save on resources, which instead can be directed to treatment priorities.

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[4] Ethiopia: Epidemiological fact sheets on HIV/AIDS and sexually transmitted infections, 2002 update, UNAIDS, January 2004, http://www.who.int/GlobalAtlas/PDFFactory/HIV/EFS_PDFs/EFS2004_ET.pdf.

Currently, an estimated 5,000 individuals in Ethiopia receive antiretroviral (ARV) treatment on a paying basis. The government plans to steadily increase the availability of treatment, initially through expansion of prevention of mother-to-child transmission (PMTCT) programs, ARV treatment to the security services, and treatment on a sliding price scale based on ability to pay. As demand increases, the government will confront the difficult issue of prioritizing treatment for those who cannot afford to pay. It is not clear how quickly demands for treatment will rise in the future, nor how the government intends to finance this future expansion, beyond PEPFAR and other donor support.

The Ethiopian government conveyed to the delegation at multiple points a deep-seated wariness of both national and international NGOs—allegedly, their aggressive recruitment of government workers and specialists at salaries that the Ethiopian government cannot possibly match, their excessive emphasis on workshops and seminars, and their relative independence from government control. The government evinced little recognition that NGOs already fulfill critical, life-saving services in areas that are currently beyond the national or regional governments' reach, and that in the future they could serve as critically important bridging institutions between vulnerable and marginalized populations and the Ethiopian healthcare system. Given the acute weakness of federal and regional health structures and the complexity and diversity of Ethiopia's multiple communities, it is doubtful that an effective national strategy to provide prevention, care, and treatment can be realized without systematically leveraging non-state actors—both Ethiopian and international—through flexible partnerships, rather than rigid control mechanisms animated by mistrust. Heavily influencing current deliberations on the role that NGOs should play in combating HIV/AIDS, the delegation observed, are carryover tensions between the Ethiopian government and bilateral donors and NGOs, which intensified dramatically during the 2003 famine. During the famine, these tensions were partly eased by interlocutors like the United Nations, but levels of suspicion between state and non-state actors remain high.

ETHIOPIA'S REGIONAL LEADERSHIP

Ethiopia's federal structure decentralizes health and other social services to the regional and district level. Once supply and support mechanisms are in place, this structure may encourage more enterprising and regionally tailored responses and help accelerate expansion of programs. In the initial start-up phase, however, the decentralized structure will raise challenges in communication, coordination, and capacity. Further, said one observer, in practice Ethiopia's federal structure makes direct engagement with regional governments difficult for international donors. Regional entities must be seen and engaged (both by the federal government and by international donors) as full partners of Ethiopia's government. In spite of rhetoric of decentralization, long-term dependence on centralized authority has resulted to some extent in passivity and lack of initiative at the periphery.

Leadership and commitment at the regional level vary widely across Ethiopia. Capacity in regional governments is thin and access to national and international resources unreliable. At present, several critical factors are not yet in place: timely and efficient transfer of resources to regions; reliable shipments of key medications like nevirapine and HIV test-kits; and competent skilled managers to devise and execute operational plans.

In separate subgroups, delegates traveled to three cities outside of Addis Ababa: Awassa, the regional capital of the Southern Nations, Nationalities, and Peoples Region (SNNPR); Makele, the regional capital of Tigray; and Gondar, a town in the Amhara region. It is important to note that while each of these regional sites faces significant challenges, they cannot be considered entirely representative of Ethiopia's various regional responses. All three are relatively advantaged compared to more remote marginal areas within, for example, the Afar, Somali, or Oromia regions. Nonetheless, the challenges are real. SNNPR has a population of over 14 million; Amhara has a population of 17.1 million; and Tigray, 5 million. These populations are largely rural, with less than half having access to primary health care, and health infrastructure, including personnel, is thin (see table 2). Nonetheless, delegations saw a number of promising initiatives that signal rising awareness of the disease and that tap into as yet underutilized regional and local capacities.

Table 2
Regional Health Capacity

	Tigray	SNNPR	Amhara
Estimated Population	4,006,008	13,686,002	17,669,006
Hospitals	14	14	17
Health Centers	35	118	81
Health Stations	183	508	371
Doctors	85	187	162
Health officers	55	123	129
Nurses	1,222	1,661	1,593

Tigray

Tigray, societally and institutionally, today has an exceptional coherence and focus, a reflection of the mobilization born during the 17-year war waged by the Tigrean People's Liberation Front, followed by the movement's ultimate victory in 1991 and ascent to dominant power in Ethiopia over the past 13 years. Historically, Tigray has been acutely impoverished, marginalized politically, and vulnerable to drought. Poverty and risk of drought are still present, but Tigray has since 1991 been very favorably positioned— in its special power relations with the ruling party and the advantage that regional authorities enjoy in leading in the development of new national policies and competing for scarce resources. This

regional exceptionalism shows in many ways and has had a significant bearing on the approaches taken within the region to HIV/AIDS.

The capital, Mekele, has a conspicuous dynamism, manifest through its new university, which includes a medical school; new small industry; and much new commercial and residential construction. A dynamism also suffuses the region's evolving approach to HIV/AIDS. The regional HAPCO is well-organized and consciously plays a vanguard role nationally. Its plan of action is detailed and compelling, and it is moving forward a pilot program to place female health extension workers into each *woreda* (district) to raise awareness and increase prevention efforts. It is the federal government's intention to make this approach a national program; hence, early outcomes achieved in Tigray carry an import beyond the region's boundaries and can be expected to shape the future approaches taken elsewhere in Ethiopia.

At least officially, there is no doubt that the regional leadership has made HIV/AIDS a priority and is aggressively seeking a significant share of the rising flow of resources for HIV/AIDS programs flowing to the federal center in Addis Ababa. The regional leadership is also seeking to establish direct contact with donors. There were no complaints of delays in receiving federal resource allocations. But how the region's policies are understood locally, and how well they are implemented in Tigray's far-flung villages, is difficult to estimate. Certainly in Mekele, the mass organizations—for youth, agriculture, and especially the powerful Tigray Women's Association—are fully engaged. The latter, quite remarkably, convenes regular discussion groups at the community level that combine commercial sex workers with religious figures, teachers, elders, and others. The CSIS team members were strongly impressed by the group's refreshingly open approach.

SNNPR

In the regional capital of Awassa, senior regional officials, including SNNPR President Haile Mariam Dessalegn, are seized with the gravity of the crisis and its rising toll on the public. SNNPR leadership seeks to coordinate governmental and civil society activities to stimulate mass mobilization and behavior change and mainstream HIV/AIDS into all government agencies. In the past, said President Haile, "people wouldn't shake hands with you [if you had HIV/AIDS]; they'd expel you from a rented house, your children couldn't go to school. Now, people are starting to understand that it's a problem everywhere – it's knocked on the door of everyone, including myself. I lost my brother." As part of the effort to combat stigma and to promote testing, the president arranged for the whole council to publicly go for an HIV test.

In education, the government has included HIV/AIDS in the school curriculum and has begun implementing programs to keep girls in school. The SNNPR

leadership considers police officers, who are regularly rotated from area to area away from their families or homes, an important target group. With the help of Family Health International, the regional HAPCO is working with the police force in a promising peer leadership program in which peer trainers are responsible for raising awareness around prevention, behavior change, care, and treatment. HAPCO has enlisted the support of the regional Justice Bureau staff, high-level police leadership, and zonal and special *woreda* police officers in the training program.

Representatives of the SNNPR police and judiciary have recognized the links between violence against women and HIV/AIDS, and acknowledge that their institutions have an important role in curtailing rape and abduction. To this end, they have begun training female police officers as investigators, and the number of reported rapes and abductions has risen significantly. Still, there are relatively few women in the police force and judiciary, and many communities and law enforcement officials often accept or tolerate such abuses.

Nongovernmental organizations are playing an increasingly important role, often using innovative strategies to provide HIV/AIDS information, services, and care to their communities. Community-based funeral organizations, known as Idirs, have responded to the rising number of deaths by providing HIV/AIDS prevention information to their communities and by caring for the sick and the survivors. The "community conversations" facilitated by the Kembatti Mentti Gezzima (see the box on page 15) are challenging traditional social norms and empowering communities to examine and discuss issues relating to gender inequality and HIV/AIDS. Home-based care programs have expanded, and some are seeking to provide economic and social support along with basic care for AIDS patients.

Amhara Region

Discussions in the town of Gondar highlighted gaps in capacity at the zonal level as well as bottlenecks in communication and delivery among the various levels in Ethiopia's decentralized health system. Procurement has proven a difficult challenge. For example, demand for voluntary testing and counseling has increased in Gondar, but there are persistent shortages of test kits at voluntary counseling and testing (VCT) sites, sometimes lasting three or four weeks. One health professional at the University of Gondar Teaching Hospital told the delegation that 90 percent of the test kits that do arrive in Gondar are past their expiration date and are used instead for display purposes only. Procurement from the regional and federal HAPCOs is slow, and delivery of equipment is unreliable. This is true not only for test kits, but for a whole range of needed medical goods, and raises grave concerns regarding the implications for expanded ARV treatment and possible "stock-outs" as demand increases.

Communication with the regional HAPCO in Bahar Dar and with the federal HAPCO in Addis Ababa has likewise proven problematic. Proposals and requests to the regional and federal HAPCO by Gondar Teaching Hospital often go unanswered—one proposal languished for almost three years at the federal level. This may be a function of the hospital's status as a teaching college, which places it under the sole purview of the Ministry of Education rather than Health. Given the dual role that teaching hospitals play—both in serving local populations and in training urgently needed health professionals—there is a strong argument for the Ministry of Health to become more invested in these institutions and at a minimum work in closer collaboration with the Ministry of Education to ensure that they receive adequate resources and attention.

What the delegation observed in Gondar suggests that there may be capacities at the local level that are underutilized because of bureaucratic obstacles. A number of existing community networks are already reaching large segments of Amhara's rural populations and could be used to quickly expand HIV/AIDS outreach (see the box on page 14). Direct engagement by external organizations with regional institutions could help to a certain extent in this regard. UNICEF, for example, bypassed the central bureaucracy and has provided training directly to the Gondar Teaching Hospital staff to carry out PMTCT programs. Now, the program needs supplies.

Opportunities for Quick Impact: Building on Successful Models

To quickly and efficiently reach remote rural communities with HIV/AIDS information and programming, the donor community should build on existing models and networks of government and nongovernmental coordination that have been developed at the regional level. For example, the Amhara and Oromia development associations, which traditionally focused on community mobilization for basic training, road construction, investment, and natural resource conservation, now include in their outreach to local communities information and supplies to help families postpone their next pregnancy and avoid sexually transmitted diseases. These collaborations have trained and fielded community workers, established logistic channels and referral systems, and trained government and nongovernment clinic staff alike in the provision of clinical reproductive health services. Millions of people have received family planning information through community-based agents, and hundreds of thousands of families are using contraception as a result. Using these already-established networks to expand efforts to combat HIV/AIDS has a number of obvious advantages: agents are well known to the community; they are already providing information about sexually transmissible diseases; and they have experience in managing and accounting for funds.

Building HIV/AIDS components into existing family planning programs makes obvious sense. In Gondar, for example, the primary mission of the Family Guidance Association of Ethiopia is to promote access to family planning, address the sexual and reproductive needs of adolescents, train family planning workers, and build institutional capacity building. The association has now integrated HIV/AIDS voluntary testing and counseling into its existing program and has made HIV/AIDS education an important part of its youth outreach strategy.

WOMEN AND GIRLS AT RISK: THE NEED FOR A BROAD-BASED RESPONSE

New momentum and open public discourse over women's special vulnerabilities are evident throughout the country, supported by the growing range of community activism, some of it driven by government, some by nongovernmental organizations and community-based organizations. Yet the subordinate economic and social status of women in Ethiopia, reflected in high levels of gender-based violence and gender inequality, continues to increase women's risk of HIV infection and exacerbate the epidemic. The issues that make women and girls vulnerable to HIV are varied and complex, ranging from the economic dependency arising from illiteracy among women and obstacles to education for girls, to limited access to primary and reproductive healthcare, to harmful traditional practices and lack of legal protections.

Despite these challenges, this is an opportune moment to be addressing the links between HIV/AIDS and gender inequality in Ethiopia. Novel approaches to HIV prevention and care—including networks of people living with HIV/AIDS, youth anti-AIDS clubs, and "community conversations" that are engaging

Community Conversations *by Anurita Baines*

In the village of Alaba, under a tree, one of the most fascinating HIV/AIDS initiatives in Africa is taking place. For the last 18 months, hundreds of villagers—men, women, girls, and boys—gather fortnightly to engage in open and animated discussions on a wide range of community and interpersonal issues using HIV/AIDS as the entry point.

Led by a well-trained facilitator who has been trained by Kembatti Mentti Gezzima, a local NGO, the discussions range from polygamy to female genital mutilation (FGM), from wife sharing to abduction. The issues in the "Community Conversations," as the forum is called, are raised with surprising candor.

And if the discussions weren't enough, what is truly remarkable is that the conversations have sparked change in behavior of the most intimate kind among many in the community. FGM has dropped from 100 percent among girls in Alaba to 10–15 percent in the span of two years. The religious elder in the community speaks of how the practice of wife sharing has stopped, and that the community's constitution has been amended to ban child abduction. In one recent case, he explains, an abductor was caught, charged, and sentenced to jail. The Muslim leader also spoke proudly of a recent event he organized: He gathered over 100 men in the village to join him for a public HIV test. It was important to set an example, he explains, that others could follow. A middle-aged woman tells of how what she had learned in the Community Conversations allowed her to speak to her husband about polygamy. Her husband, after discussing the risks of polygamy with his wife, decided not to take a second wife. Two teenage girls speak loudly and strongly about the risks of female genital cutting and how they will never allow it to happen to their daughters. One girl tells a spirited story about being courted by various boys and how she will never marry unless her groom-to-be has an HIV test. And all in the presence of their village elders, who sat and listened quietly.

Community Conversations in Alaba are supported by UNDP, which uses a wide range of participatory methodologies—the conversations are a facilitated process that employ story telling and active listening in order to identify shared concerns.

The villagers meet twice a month, and with the ongoing support of a local NGO and HAPCO, the regional AIDS body, there is a real sense that traditional norms and harmful social and cultural practices are being challenged. The work with the community is being done daily by those in the community. It is difficult to know what exactly makes it all work—what it is that has struck a chord and moved people collectively and individually to change their behavior. Is it the strong leadership at the community level? Or is it perhaps that if communities are allowed the time and space to talk and learn and share, they will? Regardless of what it is, a chord has been struck.

community members and beginning to address subjects long considered taboo—are emerging in different parts of the country. These efforts at community mobilization are a critical element of an effective and sustainable national response to HIV/AIDS, and building their capacity and supporting their activities for women and girls should be an important element of HIV/AIDS programs.

Ethiopian officials acknowledge the epidemic's disproportionate impact on women and girls, but the government has yet to formulate an effective gender dimension within its HIV/AIDS strategy. Similarly, the U.S. PEPFAR program, while acknowledging the importance of addressing gender gaps, lacks specific gender mandates and targets. In the quest to meet fixed targets in prevention, treatment, and care, PEPFAR may neglect or defer action on critical drivers of the pandemic, like gender inequities, which lend themselves less easily to measurement and for which no specific targets are set.

This is an important moment for the United States and other international actors to promote programs on gender and AIDS in Ethiopia, and there are many opportunities to engage both government and nongovernmental initiatives. Public awareness and discourse on the epidemic's impact on women and girls have taken on new prominence and provide new entry points for action. The challenge now is to incorporate gender targets and measure implementation within the broader strategy.

Reproductive Health Care and Family Planning: Key Entry Points

Improving access to basic health care for women and girls should be an essential component of HIV/AIDS programs. Women in Ethiopia face considerable obstacles in accessing health care, especially in rural areas, and as a result the country's fertility, infant mortality, and maternal death rates are among the highest in the world. Contraceptive use in Ethiopia is very low, but studies indicate that significant proportions of Ethiopian women would like to prevent or delay pregnancy if reproductive health and family planning services were accessible.

This demand for reproductive health and family planning services offers an opportunity to reach women with HIV counseling and services. Rather than creating parallel structures for HIV interventions, the government, with the support of the international community, should consider reinforcing these reproductive health and family planning structures as important entry points for more targeted HIV services, notably voluntary testing and counseling; PMTCT and PMTCT+ (which in addition to preventing mother-to-child transmission offers treatment to mothers and immediate family members); antiretroviral treatment and treatment of opportunistic infections; and post-exposure prophylaxis, particularly for survivors of rape.

Access to Treatment for Women and Girls

Currently, treatment programs require payment of 230–250 birr per month, as well as proof of a salary above 800 birr per month. There are still only a very limited number of PMTCT sites in the country, and although government officials express interest in enhancing these programs to provide treatment for HIV-positive mothers, these efforts remain in the planning stages. As the Ethiopian government develops plans to roll out treatment programs, it will have to address the gender-related barriers to health care, which are compounded by HIV/AIDS, and establish clear targets to ensure that women have access. In fact, using PMTCT programs for prevention of transmission and treatment of mothers, partners, and other family members is an important strategy for expansion of treatment.

Since August 2003, when ARV drugs became available in Ethiopia, approximately 5,000 Ethiopians have begun treatment, 60 percent of them men. The treatment program at Zewditu Hospital reveals a lot about the challenges of ensuring equal access to treatment. The percentages of women and men coming in for testing have been about equal, but the HIV prevalence among women was 60 percent. The actual number of people on treatment was the reverse, however, with the majority being men, underscoring the economic disparities between women and men that lead to inequitable access to treatment. It is not clear that the Ethiopian government or PEPFAR administrators have a strategy to address this imbalance.

Violence against Women

Violence against women, including rape, abduction, and domestic violence, is a serious, but underreported problem in Ethiopia. Traditional cultural practices, including female circumcision and widow inheritance, contribute to women's vulnerability to HIV infection. Despite constitutional guarantees of equal rights, women in Ethiopia are subjected to a range of abuses, and perpetrators are rarely investigated or punished.

Rape and abduction are criminal offenses under Ethiopian law, but the majority of cases are not reported or prosecuted. Anecdotal evidence suggests that many communities and law enforcement officials accept or tolerate such abuses. Rape within marriage is not considered a crime, and married women are increasingly at risk. Marriage abduction—effectively, forced marriage, in which a man abducts a young woman who is compelled to marry him—is practiced in several parts of the country. Once a girl is abducted, it is assumed she has been raped and is therefore "flawed." In many cases, a family will not want her back under these conditions, and her fate is effectively sealed. Rather than report an incident to police, communities may prefer to arbitrate the case themselves, sometimes with the assistance of the church, and arrange for the perpetrator to marry his victim. A considerable number of rape cases—more than half, according to the police in

Awassa—are dropped during the investigation, because of involvement by community elders, or marriage between the victim and the perpetrator, or arbitration by police. This practice continues, despite recent changes to family law that prohibit arbitration of criminal cases.

In some areas, regional governments have made efforts to recruit more female police officers, some of whom are tasked with investigating rape cases. Female police also tend to be involved in the police force's child protection units. Some regional police forces note a considerable increase in reporting cases of abduction and rape. Nonetheless, the medical and legal handling of rape and abduction cases remains poor, in part because of a lack of established procedures, lack of technical capacity to gather evidence and medical specimens, and attitudes among law enforcement officials themselves.

Recruitment of female officers is a positive step, but given that for the foreseeable future the vast majority of police will be men, leadership at all levels will need to deliver a clear and consistent message of zero-tolerance for rape and to establish a policy of holding police and prosecutors accountable for enforcement. An important step will be to provide training for police and law enforcement about the link between gender-based violence and HIV/AIDS. Training should focus on technical assistance in investigating and prosecuting cases of rape, abduction, and domestic violence, and in the enforcement of women's and children's rights.

Economic Empowerment and Education for Girls

Women in Ethiopia have substantially less access to economic opportunities than men do, which places them in economically dependent situations that make leaving or avoiding risky relationships or negotiating condom use very difficult. Women without viable economic alternatives may adopt survival strategies, including engaging in high-risk, transactional sex. Accordingly, the economic empowerment of women—including access to credit, skills training, and enforcement of inheritance and property rights—remains key to combating HIV/AIDS in Ethiopia.

Programs to keep girls in school and to expand HIV/AIDS education in school curricula are critical interventions to curb the spread of HIV/AIDS in Ethiopia. While in some parts of the country there has been an increase in girls' enrolment in primary schools, girls generally drop out at a much higher rate than boys do. There are also significant problems relating to girls' safety in school and on their way to school, notably concerns about sexual violence and abduction. When parents become ill or die from HIV/AIDS, the burden of care often falls to the eldest girl. These girls are often at risk of dropping out of school and becoming targets of exploitation. Such orphans and vulnerable children also face the loss of property and inheritance rights, thus increasingly their economic marginalization.

The Ethiopian Government Response

The Ethiopian government recognizes that gender inequality fuels the spread of HIV/AIDS, and it identifies women's access to information and services and gender equality as key goals. In his meeting with the delegation, Prime Minister Meles stressed that women's vulnerability to HIV is a function of their inequality of rights, and that the government needed to take special steps with women and girls to "bend the stick the other way to straighten it," especially in terms of access to treatment.

Yet several officials, including the prime minister, placed the onus on women themselves to demand a change in their status. As one regional official put it: "Women themselves should come out of stigma. It is the women who feel inferior." Clearly, educating women and encouraging them to claim their rights will be an important step forward. But it is not clear that Ethiopia's leadership recognizes the realities that girls or women will face in standing up to the disapprobation of families and communities or in confronting a law enforcement and judicial system that is hostile or indifferent. Ethiopia's top leadership will need to signal, in rhetoric and action, that enforcement of women's rights is both a priority and a necessary step in the fight against HIV/AIDS.

The minister of health acknowledged that women bear "the brunt of the problem" and that despite government measures on a policy level, implementation lags behind. He further stressed that access to education and health care constitutes a serious problem for women in Ethiopia, and said that the government's response was to bring primary care services closer to the communities. The government is considering establishing hiring quotas to address gender imbalances, and plans to recruit women as health extension workers and teachers, professions that are currently dominated by men. A new initiative from the Ministry of Health will establish health posts in 10,000 villages in the next five years, and the government intends to fill all these posts with women. Whether such a policy will be sustainable or effective in addressing gender inequities remains to be seen.

A new response to women and AIDS is the National Coalition for Women Against HIV/AIDS, created in October 2003 to promote women's leadership at all levels. Although the initiative is legally a nongovernmental organization, it comprises ministers and state ministers and many of the ruling party's elite women, including the prime minister's wife, Azeb Mesfin. The coalition has an opportunity to bring high-level attention to the links among gender disparity, violence against women and HIV/AIDS, and, given the political status of its membership, to press for meaningful policy change in a wide range of sectors.

A coordinated response to HIV/AIDS will need to include measuring parity in the treatment available to men and women. Preventing mother-to-child transmission programs could be reinforced and expanded and can serve as an

entry point for access to antiretroviral treatment for mothers, partners, and family members. The government should be encouraged to report on comprehensive measures to improve the status of women, including gender differentials in education at all levels and among professions and promoting women's economic empowerment. To combat the spread of HIV/AIDS effectively, the government will need to address gender-based violence as a risk factor for HIV/AIDS transmission and provide treatment and counseling for rape and abduction victims.

SHARP UPTURN IN U.S. ENGAGEMENT: A CRITICAL NEED FOR CAPACITY AND CONSULTATION

At the same time that the Ethiopian leadership grapples with building an effective national response to HIV/AIDS, international engagement is poised to rise dramatically. Perhaps most notable is the President's Emergency Plan for AIDS Relief, which brings significant new resources ($43 million in FY2004) to Ethiopia's fight against HIV/AIDS and sets exceptionally ambitious benchmarks for progress in Ethiopia in the areas of prevention, care and support, and treatment. By the end of 2008, the initiative aims to provide treatment to 210,000 individuals; to prevent more than 550,000 new HIV infections; and to deliver care and support services to 1,050,000 people, including orphans and vulnerable children. PEPFAR's arrival in Ethiopia, steadily gathering speed from late 2003, has brought forward many complex policy issues and created multiple stress points that reveal how difficult quick, effective implementation of PEPFAR will be in a country like Ethiopia.

In retrospect, the hectic pace of events between late 2003 and mid-2004 left little opportunity to anticipate these challenges, much less to begin to address them systematically. These emerging problems can be fixed, however, with sufficient leadership, political will, innovation, and resources. Success will require that at strategic moments the pace be slowed deliberately; that diplomacy, consultations with Ethiopian counterparts—both governmental and nongovernmental—and planning be accorded much higher priority; and that careful coordination and open communication between Washington and the embassy be sustained. In addition, decision power and flexibility should be devolved to the maximum extent to the embassy, and the Global AIDS Coordinator should acquire substantial, rapid response capacities to strengthen embassy staffing, assist the Ethiopian government with its training and immediate skill needs, operationalize gender concerns, and put in place a credible monitoring and evaluation system.

The early implementation phase has revealed important, tough lessons and has highlighted specific areas where rapid adjustments appear to be warranted if the PEPFAR program is to succeed. A number of the delegation's findings track

closely with the report of the U.S. General Accounting Office issued in July 2004,[5] which draws on interviews with U.S. field staff in all PEPFAR countries.

First, PEPFAR placed sudden conceptual, diplomatic, and managerial burdens on the U.S. embassy in Addis Ababa, yet without the addition of any new professional staff. The Global AIDS Coordinator's Office did not anticipate this stress, but could begin to alleviate it quickly if given the capacity to quickly place a senior PEPFAR coordinator into the embassy and to supplement him or her with an expert team operating beyond a one- or two-week mission. In addition, the Global AIDS Coordinator's Office would benefit significantly if it possessed a capacity, on a rapid, urgent basis, to provide governments such as Ethiopia's with interim skilled HIV/AIDS planners and managers to fill a glaring gap on the Ethiopian side. CDC-Ethiopia has begun important work in this regard, working in close collaboration with the Ministry of Health and a range of national and regional entities in developing models of intervention and sites, delivery of services such as prevention of mother-to-child transmission, or PMTCT, and voluntary counseling and testing. This kind of technical assistance will need to be expanded to help ensure that PEPFAR's goals are met.

Second, PEPFAR called for a realignment of U.S. policy priorities on HIV/AIDS with a strong new emphasis on treatment. There is a sense that this sudden shift, and the sizeable resource flows that accompany it, may be driving the Ethiopian government to shift its priorities and resources to treatment as well and to place the Ministry of Health and the health system at the forefront of the national response. This may not be the ultimate intention of the U.S. response, but because Ethiopia's policies are themselves still in flux, and its managerial and planning capacities are weak, external pressure and resources may shape, rather than complement or strengthen, the Ethiopian response or may result in a heavily treatment-focused HIV/AIDS program implemented at the expense of prevention. There is strong concern that healthcare personnel will gravitate to the provision of ARV drugs, as that is "where the money is," and that flooding a woefully inadequate health care system with antiretrovirals will skew the healthcare system and pull health personnel out of underserved areas. The delegation's clear impression is that extensive, prior consultations and a much heavier investment in U.S. diplomacy, carefully coordinated between Washington, the U.S. embassy, and Ethiopians themselves, are essential to resolve communication and prioritization gaps.

Third, the advent of PEPFAR and the rapid expansion of treatment programs highlight the urgent need for improved monitoring and evaluation. Although there are already several treatment programs under way in Ethiopia (on a paying basis), there is currently little coordination or monitoring of compliance rates,

[5] "Global Health: U.S. AIDS Coordinator addressing some key challenges to expanding treatment, but others remain," U.S. General Accounting Office, GAO-04-784, July 2004.

epidemiological factors, or other measures of effectiveness. The same appears true of VCT, care, and prevention programs. The lack of baseline data and the absence of any meaningful evaluation mechanisms will make measuring PEPFAR's effectiveness problematic and could have grave implications for public health in the long term. Further, the unresolved question of what ARV medications the U.S. strategy will likely support could be a major complicating factor in expanding treatment programs that will be sustainable and in providing appropriate training to the health professionals who will be called upon to administer and monitor drug regimens.

The question arises of how U.S. HIV/AIDS programs are to be monitored and evaluated and how they are to relate to other donor commitments to broad development aims (nutrition, reproductive health and family planning, child survival, education); how concern with gender is to be operationalized; and how the United States is to consult with other donors and integrate planning. The result has been anxiety and confusion within the embassy over how its programs will be held to account, and uncertainty within the donor community regarding U.S. plans and intentions. The delegation heard strong concern from Ethiopians and donor representatives alike about the sustainability of the initiative, including the burden that PEPFAR's treatment goals will put on an already strained health system, and the impact it will have on a genuinely multisectoral approach. Despite these considerable reservations, both in terms of funding strategies (e.g., direct budget vs. project support, AIDS-specific vs. broader poverty reduction) and program content (e.g., the relative balance between prevention and treatment), most international donor staff at country-level seem anxious to keep everyone "in the tent" and to create as coherent and as collaborative an approach as possible among themselves and vis-à-vis the government.

As PEPFAR moves into its next phase, it is essential that the United States pursues coordination more broadly. In this process, the United States should engage, and seek to coordinate with, a wider range of relevant partners, including the Ethiopian government, other international donors, indigenous NGOs, and the United Nations. While it is understandable that rapid rollout of PEPFAR did not initially allow for extensive external consultations, as the initiative moves into its next, longer-term phase, the United States should expand the scope of its consultative partners. Through more extensive information-sharing with a broad range of partners, the United States can help to enhance collaboration without compromising its overall focus on achieving specific outcomes. This will also increase the likelihood that U.S. investments will be complemented by the supporting funds of other donors, and thereby accelerate progress toward realization of the PEPFAR targets.

Finally, the Global Coordinator's Office will need to pay special attention to how PEPFAR programs are harmonized with other U.S. government programs that directly or indirectly strengthen Ethiopia's ability to combat HIV/AIDS. It is

vitally important that PEPFAR not overwhelm or displace ongoing efforts in family planning and reproductive health, child survival, education, and gender-related programs.

A SURGE OF RESOURCES AND PROGRAMS REQUIRES CAREFUL COORDINATION: THE UN CAN PLAY A VITAL ROLE

PEPFAR is only one of many bilateral and multilateral HIV initiatives in Ethiopia. In 2004, international assistance to Ethiopia on HIV/AIDS—$100 million—will equal the Health Ministry's entire annual budget, with profound effects on Ethiopia's overall health response. HIV initiatives, said one observer, "are swallowing the best and the brightest in Ethiopia's health sector," depleting human resources in other vitally needed healthcare sectors. International resources and attention are "a great gift to Ethiopia," said another, "but there is a real danger that they will create an AIDS response that is totally separate from the existing health sector" or that they will undercut a truly multisectoral approach.

In light of the substantial HIV/AIDS assistance accruing to Ethiopia from a variety of sources (the Global Fund, the World Bank, PEPFAR, and others), there is an urgent need to harmonize resources and priorities to ensure a broad-based, multisectoral approach that will be sustainable in the long run. In this regard, the United Nations has a pivotal role to play. The UN has long served as a major development partner in Ethiopia, including during reccurring food and drought emergencies—most recently with the food crisis of 2003—and is seen in Ethiopia as a credible partner by donors, the national government, the private sector, NGOs, faith-based organizations, and associations of people living with HIV/AIDS.

With the sudden upsurge of donor resources and activities, demands for UN technical assistance have expanded dramatically. To date, the UN Theme Group on HIV/AIDS has provided support to the development of Ethiopia's multisectoral AIDS strategy and to HAPCO. The UN is currently also providing support to numerous subnational mechanisms, including the regional HAPCOs, helping to strengthen their linkages with the national authority and with key partners at the district and local level, even though, as field visits by the delegation revealed, critical gaps in this area remain. Earlier this year, the UN assisted the Ethiopian government in launching the National Partnership Forum (NPF), and UNAIDS has been specifically asked by the Ethiopian government to serve as secretariat for the NPF (in support of HAPCO), and by international donors working in Ethiopia to fill a parallel position in the NPF's Donor Sub-Forum. In addition, UNAIDS provided technical support to the development and submission of Ethiopia's proposals to the Global Fund, which has been acknowledged as an important component of the application's approval.

To meet increasing demand and build credibility, UN agencies will need to strengthen and expand their coordination, monitoring and evaluation, and programming capacities around HIV/AIDS in Ethiopia, devoting greater financial and human resources to HIV/AIDS activities. And as the central UN agency coordinating work on HIV/AIDS, UNAIDS will need to make the case to donors and demonstrate its value-added.

In addition, for coordination to be effective, large donors—especially the United States—must exercise the political will required to harmonize their goals and priorities with those of others. This may not require fundamental shifts in strategy, but will likely necessitate flexibility in tactics and time lines, and a stronger recognition of the additive benefits, to both PEPFAR and Ethiopia, of donor funds complementing, rather than competing with, one another.

To meet the growing need for coordination, especially among donors, more effectively in April 2004 UNAIDS, the United States, and the United Kingdom cohosted a high-level meeting in Washington, D.C., at which over 20 key donors endorsed the "Three Ones" principles, which provide a framework to guide coordinated, coherent, and concerted action against AIDS at the country level. In endorsing the Three Ones, donors committed themselves to work through one HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multisectoral mandate; and one country-level monitoring and evaluation system. Despite this important agreement at the international level, its true utility depends on translating it into concrete action. From what the delegation observed, this has not yet happened in Ethiopia.

To guide this process forward, these donors, including the United States, have designated UNAIDS to take the lead, "affirm[ing] and support[ing] the role for UNAIDS at the country level as a facilitator and mediator between stakeholders in country-led processes for following up these commitments." In Ethiopia, the delegation observed that donors clearly understand that effective coordination and harmonization, as called for in the Three Ones, is critical, but noted that significant work must be done to bring on-the-ground realities in line with the vision set forth by these coordination principles. To this end, donors are cofinancing a post in the UNAIDS country office to facilitate this process.

RECOMMENDATIONS: U.S. POLICY AND LEADERSHIP

For all the challenges they have in common, PEPFAR's 14 focus countries vary dramatically in relative stability, strength of leadership, clarity and sophistication of government policies to fight HIV/AIDS, availability of skilled managers and health personnel, surveillance capacity, and strength of partnerships with donors, NGOs, the United Nations, and other international organizations such as the

Global Fund. In some of PEPFAR's target countries, circumstances are generally predictable and favor the steady expansion of treatment, care, and prevention programs, as envisioned under PEPFAR. In others, beset by civil strife, acute scarcity of skilled personnel, incomplete surveillance data, and barely nascent operational plans, implementation of PEPFAR will be far less predictable. What is appropriate in Botswana will almost certainly not be feasible or appropriate in Cote d'Ivoire; what works in Haiti or Guyana may fail in Nigeria.

Ethiopia stands out among the PEPFAR states, largely because of its massive scale but also because of the many other challenges present there—competing development priorities, the threat of return to armed conflict, a paucity of health personnel, a profound lack of health infrastructure, and leadership that is conflicted and relatively late in responding to HIV/AIDS. Too, while Ethiopia is already acutely affected with HIV/AIDS (with over 2 million adults infected), it is also a second-wave state—where adult prevalence is still relatively low and where the most pressing and urgent challenge—and the country's best hope—lies in preventing new infections.

Ethiopia illustrates the urgent need to craft a U.S. response that is tailored to the specific circumstances and challenges of each individual recipient country. Targets in prevention, care, and treatment are important—as benchmarks for progress and as measures of accountability—but, they should not be pursued at the expense of priorities that do not lend themselves to easily measured targets, for example, the status of women and girls, or in a way that undermines a long-term sustainable response to HIV/AIDS, other infectious diseases, and other development challenges that relate directly or indirectly to HIV/AIDS.

To be most effective, the U.S. approach needs to be backed by greater capacity and informed by greater political and programmatic nuance. The CSIS HIV/AIDS Task Force delegation to Ethiopia strongly recommends that the Global AIDS Coordinator's Office pursue a modified strategy that accomplishes the following:

1. **Emphasizes caution and flexibility in setting targets for treatment, care, and prevention, and encourages regular reassessment of targets and, as warranted, a slowdown in the pace of implementation.**

   Ethiopia is simply too uncertain an environment to know today whether the targets that have been set are achievable, and there is mounting evidence that the targets may in fact be unrealistic in the current time frame. A process of regular review and adjustment will be essential.

2. **Devolves maximum flexibility and authority to the U.S. embassy and ensures a close, open exchange between the Coordinator's office and the embassy.**

Decision power needs to be as close to the implementation level as possible. Sustaining trust and good will between Washington and the embassy is essential.

3. **Creates rapid response capacities within the Global Coordinator's Office to meet urgent requirements—for example, to place senior PEPFAR managers into embassy teams; ensure a reliable supply chain of critical medical supplies; deploy specialized teams; and create a database and mechanism for monitoring and evaluation.**

   Critical gaps will inevitably appear in these states, and the AIDS Coordinator needs to be in a position to cover them expeditiously, in a way that is premeditated, and not ad hoc. This means identifying teams of people who may be deployed for special training. It may include detailing skilled personnel to host governments to assist in planning and management. Special attention must be given to logistics, namely to ensure an uninterrupted supply of antiretrovirals and other critically needed medical supplies through the procurement and supply chain to the local level in all recipient states.

4. **Maintains close and persistent engagement with the government of Ethiopia to be responsive to Ethiopia's evolving strategy.**

   The U.S. administration should consistently push for realism and leadership from top Ethiopian government officials in fully understanding the resources and capacities that will be required for an effective response; in acknowledging the government's responsibility in empowering women and girls to protect themselves from sexual predation and HIV/AIDS; and in recognizing the positive and vital role that NGOs can play in effecting a genuinely national response.

5. **Places a premium on active diplomatic outreach to the host government, other donors, and the United Nations, and leverages new partnerships with non-state organizations.**

   Ongoing, careful diplomacy matters profoundly to PEPFAR's future success—in allaying fears that PEPFAR will distort ongoing development work; in building trust and confidence that the program is sound and achievable; and in leveraging new operational partnerships with competent NGOs, the United Nations, and others. It is clear that host governments alone will simply not be able to carry the burden of implementation. For PEPFAR to succeed, it will be essential to make maximum use of other non-state organizations. In Ethiopia, this will require a concentrated effort to build the Ethiopian government's confidence in NGOs and to establish a better understanding of the

respective and mutually reinforcing goals that the government and NGOs can play in combating HIV/AIDS.

It is important to recognize and build on ongoing health sector efforts (both governmental and nongovernmental) in fields closely related to HIV/AIDS, such as family planning, and to avoid the very real possibility that capacity will follow the funds to the detriment of established programs.

The U.S. government, along with other donors, should work to the greatest extent possible through established donor coordination mechanisms in Ethiopia in combating HIV/AIDS, and encourage and support the role of the Ethiopian HIV/AIDS Prevention and Control Office as a broad-based multisectoral authority to enhance collaboration among donors, the Ethiopian government, and other partners.

To enhance its own response to HIV/AIDS in Ethiopia and in other PEPFAR countries, and to better coordinate with other donors and the Ethiopian government, the United States should recognize and actively support the brokering role of the UN, particularly UNAIDS, and the important technical capacity that it provides to both the donors and the Ethiopian government.

6. **Establishes specific gender programs and targets, with explicit objectives and activities targeting women and girls in HIV/AIDS programs.**

This will require setting measurable targets for equity in treatment, care, and prevention programs for women and girls. The embassy team should establish a gender advisory group to provide input and guidance for PEPFAR plans for Ethiopia, which should include representatives from civil society, including women living with HIV/AIDS, women's organizations, and service providers.

Treatment programs should be designed to address the barriers women and girls face in accessing health care, including cost of transportation, health card registration, childcare, and price of medicines. A strong focus should be to improve access to reproductive health and family planning services, and to integrate HIV/AIDS services into existing health care services for women and girls. Particular attention should be addressed to issues of gender violence and commercial or transactional sex, as they enhance vulnerability to HIV/AIDS infection and transmission.

PEPFAR's implementation should not come at the expense of other U.S., bilateral, and Ethiopian efforts to increase girls' access to education, enhance economic empowerment and skills training for women, and

sensitize police and the legal system to the dangers and gravity of gender-based violence. Rather, PEPFAR should be implemented with a view to strengthening and complementing such programs.

One of the most important avenues of expansion of antiretroviral treatment is to build on and expand PMTCT programs. Such programs are designed to provide treatment for the mothers and other family members, with the additional goal of encouraging pregnant women to come forward for testing by giving them hope for treatment themselves.

In addition, HIV/AIDS interventions should be linked to the broader social and economic factors that put women and girls at risk. These should include programs to keep girls from AIDS-affected communities in school, designing appropriate HIV/AIDS curricula in the schools with a special focus on the dangers of gender inequality and gender-based violence, implementing programs to keep girls safe from sexual violence and exploitation at school or en route to school, and increasing economic empowerment and skills training for women and girls affected by HIV/AIDS. A gender advisory group could ensure that these issues are not overlooked in PEPFAR and other HIV/AIDS programs.

7. **Supports the development and implementation of a comprehensive, common HIV/AIDS monitoring and evaluation framework.**

As assistance to HIV/AIDS programs expands—in Ethiopia and worldwide—the need for establishing comprehensive and standardized monitoring and evaluation systems is increasingly important. At present the quality of data collection in Ethiopia, especially at regional and local levels, is limited. In addition, little attention has been paid to addressing key operational research questions.

Effective and efficient data collection is essential, especially as programs grow, to ensure accountability, track progress, and reduce duplication of effort. To date, donors have developed divergent indicators, rather than coalescing around a single monitoring and evaluation framework. Continuing in such a fashion will lead to numerous and often conflicting monitoring and evaluation systems and unnecessary duplication and inefficiency. The United States should work closely with the donor community, particularly with UNAIDS and the Global Fund, to resolve this challenge.

The Ethiopian government is particularly concerned about the complex and labor-intensive requirements by donors in connection with HIV/AIDS funding. There is a fear that this situation will grow even more complex as assistance to HIV/AIDS programs expands (drug procurement systems, contract modalities, etc.). This will not only

complicate the comparability of data across projects and countries, but also further burden Ethiopia's already overstretched capacity, consuming scarce human and financial resources for paperwork rather than programs.

Therefore, the United States and other donors should support development of a common monitoring and evaluation system that reflects national priorities, that simplifies reporting requirements, accounting procedures, and proposal formats, and that is solidly rooted in national institutions to ensure ownership and sustainability. In addition, this system must satisfy essential donor requirements for accountability and proper resource utilization—allowing donors to continue the substantial allocation of funds required to fight AIDS effectively.

APPENDIX A: CSIS HIV/AIDS DELEGATION TO ETHIOPIA

DELEGATION COCHAIRS

Dr. Kathleen Cravero
Executive Deputy Director, UNAIDS

Ambassador Princeton N. Lyman
Ralph Bunche Senior Fellow for Africa Policy Studies, Council on Foreign Relations

DELEGATES

Sarah Clark
Director of Population Program, David and Lucile Packard Foundation

Anne Claxton
Director of International Program Development, WorldVision

Jennifer G. Cooke
Deputy Director, CSIS Africa Program

Mary Fisher
Board Member, Global Coalition on Women

Janet Fleischman
Chair, Committee on Gender, CSIS Task Force on HIV/AIDS

Abby Kral
Legislative Assistant, Senator Michael DeWine (R-Ohio)

Jessica Krueger
Program Coordinator, CSIS Africa Program

Peter Lamptey
President, Institute for HIV/AIDS, Family Health International

J. Stephen Morrison
Executive Director, CSIS Task Force on HIV/AIDS and Director, CSIS Africa Program

Susan Packard Orr
Chair, David and Lucile Packard Foundation

Lebo Taunyane
Regional Director, Diflucan Program Pfizer Inc., South Africa

OBSERVERS

Anurita Bains
Special Assistant to Stephen Lewis, UN Secretary General's Special Envoy on HIV/AIDS to Africa

David Haroz
Technical Officer, UNAIDS

APPENDIX B: DELEGATION AGENDA

Sunday, May 23

- Briefing by officials from USAID, CDC, and the U.S. Embassy in Addis Ababa.

Monday, May 24

- Site visit to Hiwot HIV/AIDS Prevention, Care, and Support Organization (HAPCSO) Home Based Care Site.

- Site visit to Addis Ketema (a health center with integrated voluntary counseling and testing [VCT] and antenatal care) and Zewditu Hospital (including VCT, HIV/TB clinic, and antiretroviral therapy).

- Site visit to Ossa (a stand-alone VCT center) and ISAPSO (a nongovernmental prevention and education program for low-income women).

- Site visit to Addis Ababa Area Development Program (training for women and youth; support for people living with AIDS, orphans, and vulnerable children).

- Meeting with Kebede Tadesse, Minister of Health.

- Luncheon with HAPCO leadership: Negatu Mereke, director, HAPCO; Teshome Toga, Minister of Youth, Sports, and Culture and HAPCO board member; and Mulu Ketsela, Deputy Minister of Finance and HAPCO board member.

- Meeting with members of the National Youth Network.

- Meeting with Hassan Abdella, Minister for Labor and Social Affairs, responsible for orphans and vulnerable children.

- Public forum in collaboration with InterAfrica Group on *Leadership and HIV/AIDS*. Addresses by Kathleen Cravero; Bience Gawanas, commissioner for Social Affairs, African Union; Princeton Lyman; Dawit Yohanes, speaker, Ethiopia House of People's Representatives; C. Jack Ellis, mayor of Macon, Georgia; and Arkebe Oqubay, mayor of Addis Ababa.

- Dinner discussion with UN Theme Group on HIV/AIDS.

Tuesday, May 25

- Breakfast with Technical Donor Group.

- Meeting with President of Ethiopia Girma Woldegiorgis.

- Public Forum with the Ethiopian National Coalition of Women against HIV/AIDS and UNDP on *Addressing the Acute Vulnerabilities of Women and Girls to HIV/AIDS*. Addresses by State Minister for Women's Affairs Gifti Abasiya; Mary Fisher; Kathleen Cravero; Susan Packard Orr; and Janet Fleischman.
- Meeting with His Holiness Abuna Paulos, patriarch of the Ethiopian Orthodox Church.

- Meeting with Sheik Elias Redman, chair of the Supreme Islamic Council.

- Roundtable with health professionals and counselors at Zewditu Hospital.

- Roundtable with Mekdim, an association of People Living with HIV/AIDS.

Wednesday, May 26–Thursday, May 27: Regional Visits

- Gondar, a city in the Amhara region: discussions with Gondar Zonal Administration, Zonal Health Bureau, and HIV/AIDS Secretariat; visits to Fire Hiwot, a center for people living with AIDS (PLWA); to a government-run VCT center; to the Family Guidance Association of Ethiopia's youth and PMTCT/VCT centers; discussions with community-based rural health agents and program beneficiaries at the Amhara Development Association and Amhara Credit and Saving Institution, and with doctors and university officials at Gondar Medical College.

- Mekele, regional capital of Tigray: consultations with Tigray government officials and HAPCO board members; visits to Tigray Women's Association's Commercial Sex Workers Project; to Save Your Generation–Tigray, an association of PLWA; the Tigray Youth Association; the Yeha Music Band anti-AIDS club; and Mums for Mums, a project helping single mothers help themselves and support their family.

- Awassa, regional capital of SNNPR: meeting with SNNPR President Haile Mariam Dessalegn; briefing with SNNPR vice president, police commissioner, and Justice Bureau head on HIV programming within the police force; visits to VCT service in the government-run Awassa Health center; to the Tilla Association of Women Living with HIV; with the Kembetta Women's Development Project (advocates for women's educational, reproductive, and legal rights); with Save the Generation Association of Awassa Idirs (a community-based association providing counseling, care, and support to PWLA).

Thursday, May 27

- Meeting with Prime Minister of Ethiopia Meles Zenawi in Addis Ababa.
- Reception hosted by U.S. Ambassador Aurelia Brazeal.

Friday, May 28

- Debrief with Ambassador Aurelia Brazeal and key embassy staff.

Appendix C: Embracing the Risk of Leadership
An address by Mary Fisher

Mary Fisher was the keynote speaker at the public form entitled "Addressing the Acute Vulnerabilities of Women and Girls to HIV/AIDS," cohosted by the Ethiopian National Coalition of Women against HIV/AIDS and UN Development Program in Ethiopia on May 24, 2004.

It's an honor to be in Addis Ababa with all of you. We've gathered in Ethiopia, the cradle of all humanity, where some anonymous and ancient mother gave birth to mankind. It's both fitting and ironic that, in this setting, we are taking up such issues as women's diminished status and their vulnerability to manipulation and violence.

By way of introduction, let me note that I'm keenly aware of the enormous sacrifice that has been made by men who are with us today. This is more than a token comment. As women, we covet your continued work with us. Unless men of integrity speak to power structures lacking integrity, girls and women will continue to face a gravely darkened future. We need men as our partners if we are to make the changes so desperately needed. Therefore, I ask your forgiveness for speaking, this morning, almost exclusively to my fellow-women.

As an American woman—and a woman with AIDS—I treasure the expertise and wisdom my fellow-travelers bring with them. Susan, Kathleen, Janet and others have knowledge and gifts I do not have. My only strength is, in fact, captured in my identity: I am a woman, and a woman with AIDS. I've spent more than a dozen years walking with other pilgrims who have been found by the virus.

Some of what I've learned on the road to AIDS is painful: Stigma and discrimination are brutal and universal. Hypocrisy mars every level of every government response to AIDS. The world, including my own nation, dulls its response to AIDS by pandering to racism and moral judgmentalism. Global powerbrokers can accept 16 million distant orphans more readily than they can accept political challenges at home. These are painful confessions, especially for an American woman.

I recognize that, as a group, women with AIDS are branded by others more than we are defined by ourselves. We are not seasoned fighters who know how to battle societal judgments. When our cultures tell us that AIDS is a dirty illness belonging to dirty people, we do not want to be identified as infected. We fear our families' rejection and our communities' isolation. Our fear keeps us from being tested, blocks us from seeking treatment, and, ultimately, condemns us to a slow and inevitable death.

What we, who are women with AIDS, need most—and most urgently—is the redemption of our status as human beings and as women. We need other women to champion our cause until we gather enough strength and courage to champion it ourselves.

We are desperate for leaders who will define women as strong, valued and worthy, no matter our HIV status. We need other women to help us shake off the aura of "victims" —as if we are feeble and passive objects—to become powerful ambassadors for compassion and healing.

We need a campaign for dignity as much as a crusade for intervention. It is dignity that inspires our courage and emboldens our speech. Dignity raises our faces that were lowered in shame; dignity straightens our backs when they have been beaten, and strengthens our character when we've been assaulted.

Language matters. It can be used to lift and inspire us, or to demean and break us. Language is the single most important weapon in the arsenal of those who abuse power, exceeding even the power of the fist and the gun. If powerful people tell us we are dirty, we feel unworthy. If they tell us we are societal problems, we feel guilt. If they tell us we are fallen women, evil women, useless women, then we have no ability to be women at all. The language of our culture defines us in ways we cannot define ourselves.

Silence is as potent as speech. If you have the power to lift us up and heal us, but say nothing about us, we know by your silence that we are not worthy. Silence as well as speech can build our hope or break our will, lead us to service or bring us to suicide.

So here we are, women (and men) gathered in the birthplace of humanity at a momentous time in world history. Those here, and those who will receive our reports, have immeasurable power to revise the lessons I've learned along the road to AIDS. Language that has been used to cripple women around the globe can also be used to empower them. Media that carry streams of demeaning images and victimizing slogans can be employed, instead, to beam messages of education and encouragement. Where culture and language have been used to weaken girls and immobilize women, we have the capacity to signal an end to such violations.

How many women are in the global company of AIDS today? Perhaps 20, 25 million? Imagine the impact we could make if we, here, today committed to a campaign that taught these women to embrace service instead of shame: to nurture and care for others, including one another, rather than seeking refuge in undeserved shame. We could equip an army of compassion and healing whose ambition would be war against ignorance and illness. Believe it or not, we have the capacity to do this: We have the knowledge, we have the power and we have the influence—if only we will use it.

If we lack anything at all, it is leadership. I mean no offense to any of you who have devoted yourself to this cause. I'm already in your debt; I don't want also to be in your "dog house." But it's true: What women with AIDS lack most is role models, heroines of courage, leadership.

When women with power and prestige are willing to step forward, to lead in the cause of women who feel weak and humbled, the crusade toward dignity will have begun. When women most admired in our cultures speak out—not just once, but consistently—on behalf of those with AIDS, then women with AIDS will dare to seek testing and treatment.

Until women of stature and courage step to the head of this campaign, we will struggle and stammer with issues of powerlessness and futility. But when such women step forward they will be, at that instant, both our most important resource and our greatest heroes.

I'd never minimize the risk that comes with a leader's role, especially for women in cultures where AIDS is despised (which is nearly every nation on earth). It is not easy, and it may not be immediately popular, to counter myths and challenge bigotry. A price may be paid by those courageous and wise enough to challenge injustice and champion the oppressed. But the cost of such leadership must be measured against the knowledge that, as we call for such leadership this week, another five thousand Ethiopians will have been inducted into the global AIDS community by new infections before we adjourn.

Near the close of his life, one of my American heroes—Dr. Martin Luther King—said to all of us, "In the end, we will remember not the words of our enemies but the silence of our friends."

I did not want to speak out in public 12 years ago; I still do not want to do it today. But if we truly believe that life's purpose is found in serving others, then those of us with power to speak must cry out for those driven into fearful silence. If we remain in comfortable silence, our children may never be forgiven. But if we speak out – no matter the cost or opposition – we will never be forgotten by powerless pilgrims on the road to AIDS.

I am in a room full of my heroes. To each of you, my thanks for your presence and for your courage.

On behalf of each of you, I will continue to offer this ancient prayer: "Grace to you, and peace…."