GENDER ASSESSMENT OF THE NATIONAL HIV RESPONSE IN ETHIOPIA

ADDIS ABABA, ETHIOPIA
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CONTENTS

Participants of March 8 Celebrations in Adami Tulu Digdo Woreda, Oromia March2019
Photo Credit- Fikirte Abebe/UN Women

ABBREVIATIONS

ART	Anti-retroviral treatment
AYRH	Adolescent and Youth Reproductive Health
BCC	Behavioral change communication
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CETU	Confederation of Ethiopian Trade Unions
COVID-19	Corona Virus Disease-2019
CSA	Central Statistical Agency
CSE	Comprehensive Sexuality Education
CSOs	Community based organizations
DFID	Department for International Development
EDHS	Ethiopia Demographic Health Survey
EPHIA	Ethiopia Population-Based HIV Impact Assessment
FBO	Faith-Based Organization
FDRE	Federal Democratic Republic of Ethiopia
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FHAPCO	Federal HIV Prevention and Control Office
FSW	Female Sex Workers
GA	Gender Assessment
GAT	Gender Assessment Tool
GATSC	Gender Assessment Technical Sub-Committee
GATT	Gender Assessment Technical Team
GBV	Gender-based violence
GF	Global Fund
GII	Gender inequality index
GNP	Gross national income per capita
GRB	Gender Responsive Budgeting
GTP	Growth and Transformation plan
HDI	Human development index
HIV/AIDS	Human immune deficiency virus/Acquired Immuno Deficiency Syndrome
HPV	Human Papilloma Virus
HSTP	Health Sectoral Transformation Plan
HTPs	Harmful traditional practices
IDI	In-depth interview
IGAD	Inter-Governmental Agency Development
KII	Key Informant Interview
MARPs	Most at Risk Populations
MDGs	Millennium Development Goals
MTCT	Mother to child transmission
NAP-GE	National Action Plan for Gender Equality
NEP+	Network of HIV Positives in Ethiopia
NGOs	Non-governmental Organization
NNPWE	National Network of Positive Women Ethiopians
NSP	National Strategic Plan
OVC	Orphan and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-initiated testing and counseling
PLHIV	People Living with HIV
PPP	Purchasing Power Parity
PrEP	Pre-exposure prophylaxis
PWDs	Persons with Disabilities
RCC	Revised Criminal Code
RFC	Revised Family Code
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STI	Sexual Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on AIDS/HIV
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNWOMEN	United Nations Agency Entity for Gender Equality and the Empowerment of Women
USAID	United States Agency for International Development
VAWG	Violence Against Women and Girls
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

BACKGROUND

Gender inequality and the failure to recognize and defend women's human rights are realities of the daily lives of women. In many circumstances, women and girls face the most oppressive: gender inequality and unequal power relations at household and intimate relationship levels. The socio-cultural and economic factors driving the HIV epidemic have gender dimensions that are also built in the same power relations which segregate the differences in the roles and responsibilities of men/women and boys/girls. Ethiopia's commitment towards curbing gender-discriminatory systems or acts are supported with its signatory for international and regional agreements that promote and protect women's rights, including the Convention on the Elimination of Discrimination against Women, and the Protocol to the African Charter on the Rights of Women in Africa, and the Maputo Protocol on African Women's Rights.

Although Ethiopia, like many other countries, is dedicated to addressing gender and reducing vulnerabilities of women, girls, men, boys and key populations in accessing HIV information and related services related to HIV by employing a gender-sensitive approach, it is usually difficult to objectify that each of the necessary gender dimensions is addressed in each aspect of the national strategic interventions and responses. Hence, the main aim of the gender assessment was to analyze the national HIV epidemic and its contexts and evaluate the degree to which the country's response to HIV recognizes gender and its associated inequalities as key determinants of the epidemic

THE GENDER ASSESSMENT APPROACH AND METHODS

This gender assessment exercise was guided by UNAIDS gender assessment tool (GAT) which has a structured set of guidelines to guide and support the process of analyzing to what extent national responses to HIV in both generalized (HIV spread in the general population) and concentrated epidemics (HIV spread in subpopulation) consider the critical goal of gender equality. The gender assessment design and methods employed both quantitative and qualitative approaches using rigorous desk reviews and analysis of secondary data as well as key informant interviews and in-depth interviews with members of key stakeholders and with different individuals representing key and priority populations as well as the general population including PLHIV, FSWs, daily laborers, persons with disabilities (PLHIV and negative/ unknown status), youth groups, and health workers including health professionals at health centers level and Health Extension Professionals.

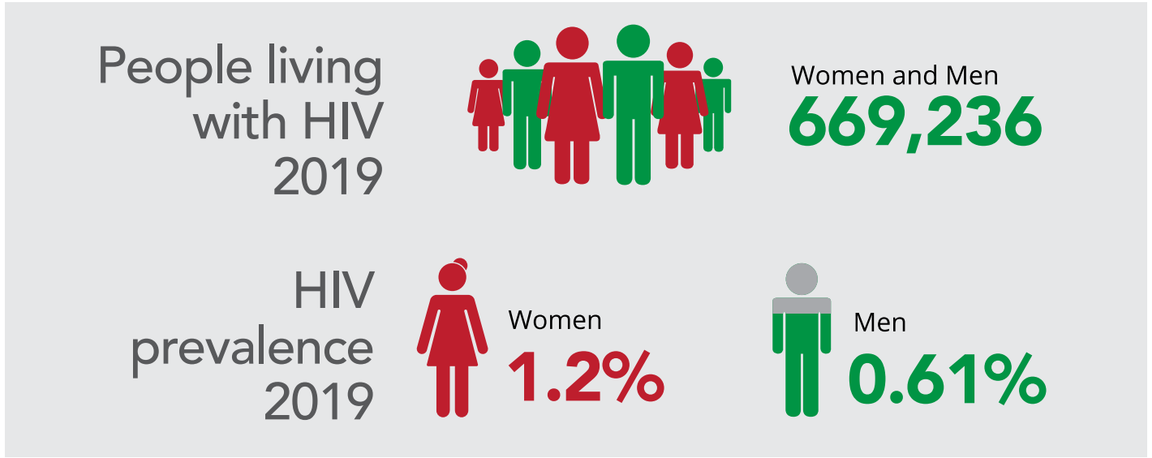
"Both men and women need to work together to address the vulnerability of women. With so many women in leadership positions today, it is important for women in charge to focus on women's issues and work for other women to reach the top"

President Sahle-Work Zewde, Ethiopia

NATIONAL HIV EPIDEMIC AND CONTEXT

GENDER DYNAMICS OF THE HIV EPIDEMIC

The number of new HIV infections has decreased between 1990 and 2018, but more in adult men than adult women and even less among young women than young men. Estimates show that in 2019 there were 669,236 people living with HIV out of which 62% were women. As such, HIV was 1.9 times more prevalent in women than in men. Knowledge about HIV transmission and prevention was higher among adult men than adult women. The gender disparity in knowledge about HIV prevention methods persisted among age groups, regions, educational level and wealth quantile.



SOCIOECONOMIC AND CULTURAL FACTORS

Gender-based violence is still common in Ethiopia with 1 out of 4 (26 percent) of women age 15 – 49 experiencing physical and/or sexual violence by an intimate partner or non-partner in their lifetime. Poverty affects women more than men in Ethiopia. Ethiopia's gender inequality index (GII) is among the lowest at 0.508 in 2018, ranking 123rd from 162 countries. Ethiopia has shown significant improvement in almost all spheres of HDI in the last two decades. Women and girls in Ethiopia are heavily disadvantaged compared to boys and men in several areas, including literacy, employment, health, and livelihoods. Gender norms which are directly or indirectly related to HIV including early marriage, harmful traditional practices, and cultural norms are quite common in Ethiopia.

LEGAL AND POLITICAL FACTORS

There are legal provisions such as the Constitution, the Revised Family Code, the Revised Criminal Code, and the international and regional commitments to ensure gender equality and women empowerment. However, their enforcement is limited. There are legal frameworks that protect the rights of people living with HIV and women and girls; however, there are no similar protections to the rights of key populations, including female sex workers.

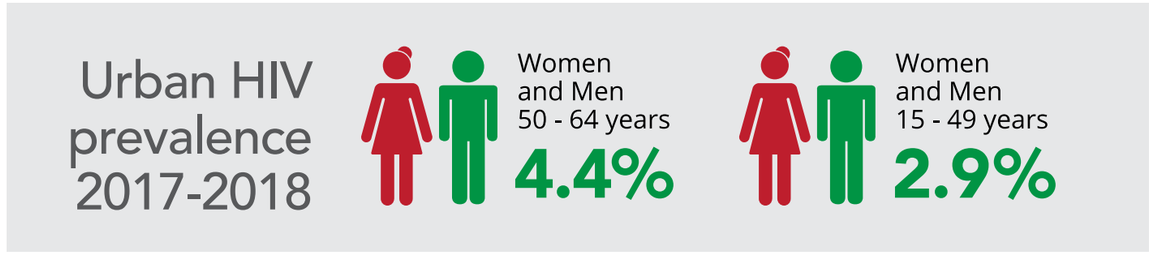
THE NATIONAL HIV RESPONSE

HIV POLICIES AND PROGRAMMES

The Ethiopian government developed and have been implementing a five-year NSP (2015-2020) to intensify the multi-sectoral response in line with the 1998 HIV/AIDS Policy. An HIV Prevention Roadmap (2018-2020) was also developed for this strategy with a guiding principle to integrate a gender-sensitive approach that provisions the different needs of women, girls, men, and boys in accessing HIV information and services. It is complemented with the National HIV Service Quality Improvement Toolkit which aims to contribute to the provision of standardized high-quality HIV service.

SPECIFIC NEEDS OF WOMEN, GIRLS, AND KEY AND VULNERABLE POPULATIONS

Ethiopia has targeted to reach 90% of medium- and high- risk and vulnerable populations with comprehensive behavioral and biomedical prevention programs by 2020. While the 2015-2020 NSP addresses the 15-24 years and the 15-49 years with gender equality being part of the agenda, older people seem to be neglected. The EPHIA 2017-2018, the prevalence of HIV is much higher among those aged 50-64 years at 4.4% compared to those aged 15-49 and 0-14-years groups at 2.9% and 0.3%, respectively. The strategies are not indicated on how the national HIV response addresses the needs of men and boys versus women and girls differently. The different strategic documents fail to identify impactful strategies to address the strategic and practical needs of women and girls at individual, household, and community levels.



MEANINGFUL PARTICIPATION

The 2015-2020 strategic document recognizes the technical and financial contributions of different actors ranging from donors to community-based implementing partners. The CSOs and FBOs are involved in the implementation of BCC, condom promotion and distribution, HIV testing & counseling, and ART adherence counseling and education. However, the discriminatory cultural norms, unequal gender relation and decision-making power, lack of education and awareness still significantly affect women's decisions-making ability and impedes their participation in the HIV response activities.

FUNDING AND EXPENDITURE

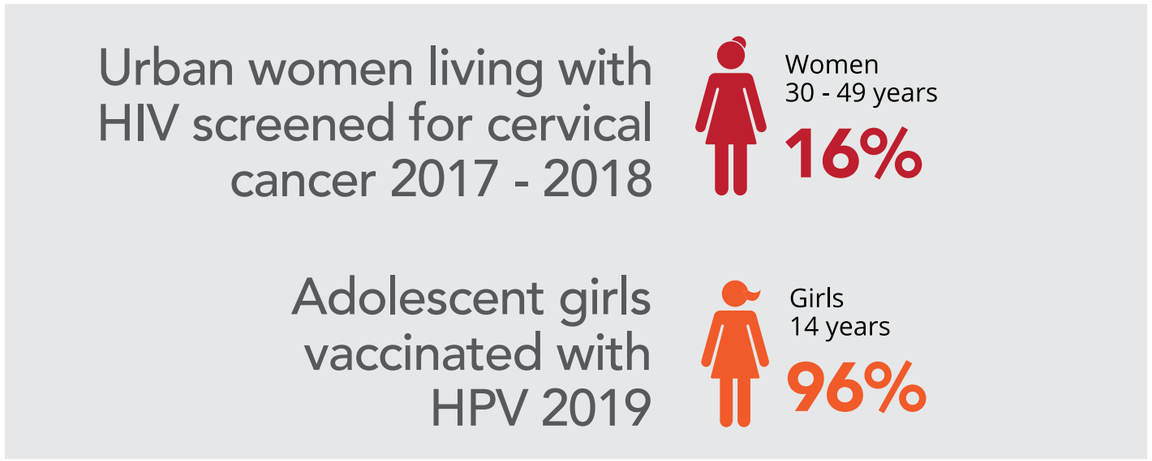
According to the 2010/11 National Health Accounts Spending on HIV, TB, and malaria accounted for 36% of total health expenditure. The national HIVAIDS expenditure constituted the largest amount of spending on a specific disease in the country while PLHIV shouldered a higher financial burden for their health care in the national HIV response efforts.

However, the success of the country's HIV response has largely been driven by external funding- 90% of total funding for HIV between 2011 and 2019. Donor funding has also declined by more than two-thirds (69%) since 2010/11. By 2018, domestically generated resources accounted for just 1%. In the 2015-2020 NSP, care and treatment took nearly half of the overall budget allocation followed by investing on critical enablers, and implementation of high impact and targeted prevention programs. It is difficult to know what proportion of the resources goes to addressing the strategic and practical needs of women and girls. Lack of publicly accessible data related to expenditures on prevention and care and treatment or expenditure on antiretroviral therapy, and cash transfers for young women and girls among others.

COMPREHENSIVE RESPONSE

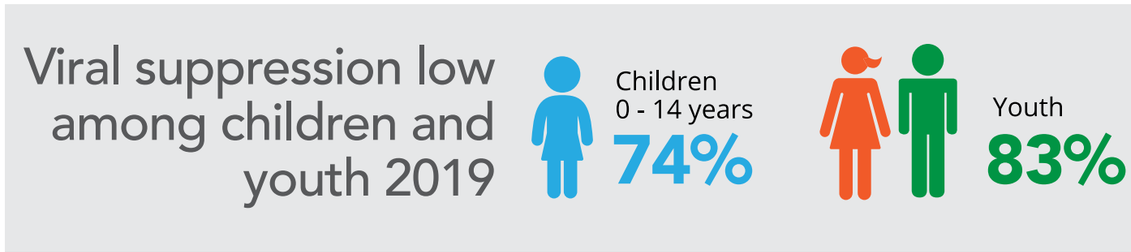
HIV PREVENTION

Ethiopia started rolling out pre-exposure prophylaxis (PrEp) in late 2019 targeting female sex workers and HIV discordant couples. VMMC procedures have been performed mainly in Gambella region where it has been less practiced. The percentage of men that underwent VMMC in Gambella increased from 10% in 2016 to 71% in 2019. In Ethiopia (2017-2018), only 16% of urban HIV-positive women aged 30-49 years reported being screened for cervical cancer. Ethiopia launched an HPV vaccination pilot project in December 2015, targeting adolescent girls aged 9-13 years. 96 percent of girls aged 14 were vaccinated across the country by July 2019. Prevention and screening of cervical cancer are included among the key elements of chronic HIV care in the national guideline for comprehensive HIV prevention, care, and treatment but not in in the national HIV strategic plan (2015-2020).



HIV TREATMENT

In Ethiopia, free ART services were initiated in 2005 later transitioned to “Treat All” positives combined with re-testing before ART initiation, and then to same-day ART initiation in 2016. By end of 2019, the 90-90-90 target reached 79-90-91 with viral suppression being low among children of 0-14 years (74%) as well as among adolescents and youth (83%).



Participant of a Panel ‘Intergenerational dialogue on Gender Equality’ organized by UNW and Center for Human rights – AAU March 2020
Photo Credit-Biniam Masresha / UN Women

GENDER CONSIDERATIONS ACCORDING TO THE COMMUNITY

Women and girls: Ethiopia has done a lot in terms of putting a policy framework in place to protect the rights of women and girls – to address their vulnerability to HIV. Despite these efforts, because the policies were enacted two decades ago, the National Policy on Women – does not explicitly address HIV in general, intimate relationships, PLHIV, and the role of men in gender equality. Similarly, the 1998 HIV policy does not address the role of men involvement in addressing gender inequalities, newly emerging gender-related agenda.

Men and boys: Most HIV responses in Ethiopia are gender-sensitive which largely focused on the experiences of women and girls. Experiences gained through working with men and boys in addressing marginalization from the differences between men and women or girls and boys are usually missed. The HIV/AIDS policy and the National Policy on Women do not boldly recognize the role of men or their active participation and involvement in addressing gender-related cultural norms and expectations. However, the 2015-2020 strategic plan for HIV/AIDS recognized low male involvement as one of the major demand-side constraints for PMTCT. Yet, the strategies to tackle this problem are not addressed explicitly.

Beneficiaries of JP-RWEE Project by UN Women and partners, Dubti, Afar
Photo Credit- Fikirte Abebe/UN Women

Key populations: The 1998 National HIV/AIDS Policy gave priority in educational efforts to high-risk groups. However, none of the policy or strategy documents touched issues of other international key populations including people who use injectable drugs and others. There is also a scarcity of evidence about the magnitude of problems for such population groups and the challenges in accessing services in the Ethiopian context which may limit our understanding of the specific contexts and needs of these populations.

Young people: The different national youth related policies and strategies recognize the challenges of adolescents and young people. The 2004 Revised Family Code allows adolescents and youth to use contraceptives without parental consent. The national guideline for comprehensive HIV PCT also grants mature minors and adolescents above 15 years to access HIV treatment and care services by giving self-consent. However, the RH related youth education and services are still inadequate despite the youth are affected by problems related to unwanted pregnancies, unsafe abortion, STIs, and, most of all, HIV. Ethiopia's National Youth Policy did not also address issues of parental consent for adolescents to access SRH and rights services and HIV PCT, including post and Pre-exposure prophylaxis.

GENDER ASPECTS OF COMMUNITY AND HOME-BASED CARE AND SUPPORT FOR PLHIV

The National HIV/AIDS policy encourages psychosocial, economic, and medical support to PLHIVs and affected members on a scheme of ability to pay. The national guideline for Comprehensive HIV PCT of Ethiopia also gives focuses on addressing barriers to access testing, prevention, and treatment services including the measures that need to be taken to reduce stigma and discrimination including the promotion of gender equality and prevention of gender-based violence, and economic empowerment. However, these policies, strategies, and recommendations do not have clearly stated strategies for addressing the problems of women living with HIV through a gender lens.

HUMAN RIGHTS VIOLATIONS IN SERVICES AND PROGRAMMES

The Revised Family Code and criminal laws protect the rights of women and children and promote gender equality and equity. The practice of domestic violence against women has been decreasing in recently, though still comparably high. Contextual factors like limited male partner support, stigma, and discrimination and fear of disclosure were identified as existing challenges related to PMTCT. The HIV policy and the 2015-2020 NSP have identified community or women empowerment as one strategy to gender equality and equity though the documents lack clarity or are shy in indicating empowerment of key populations as one strategy so they know and claim their rights.

IMPACT OF COVID-19 ON HIV RELATED SERVICES UPTAKE

Though there are limited pieces of evidence that show the impact of COVID-19 on PLHIV, the pandemic is affecting service provision related to HIV in many ways. As such, PLHIVs may fear to go out to health services to access their medicine and getting counseling as well as other health services as per their schedules. Such impacts of COVID-19 may create long term effects on the quality of life of PLHIV and other segments of the community that may need HIV related services. It may also have a huge impact on the achieving the 90/90/90 targets.

DATA OR INFORMATION GAPS

Despite the strong national commitments of promoting gender equality as witnessed by the presence of different policies and strategies with various degrees of engagement as well as intended outcomes or long-term goals, there is a critical gap of data on gender-specific as well as gender-sensitive/transformative indicators. For instance, there are critical gaps in quantitative data that may provide strong evidence on gender roles, access to and control over resources; there are gaps in data related to budget expenditure by type of HIV/AIDS program i.e., prevention, care, and support as well as treatment; there are no data on the pattern of violence against female sex workers; no data on reasons for national or regional disparities in the knowledge of people on HIV/AIDS prevention methods; and there are no data on knowledge about HIV, attitude and sexual practices among the wider priority populations as well as globally recognized key populations and their sexual partners. Even the available data from household surveys are not usually properly analyzed to generate evidence on the gender perspectives to the expected level.

RECOMMENDATIONS FOR GENDER-RESPONSIVE INTERVENTIONS

The following recommendations are forwarded based on the gender assessment findings on the national HIV epidemic context as well as the national response efforts.

POLITICAL COMMITMENT AND GENDER RESPONSIVE RESOURCE ALLOCATION

- The country needs to strengthen its effort towards ensuring the commitments made under the 2016 United Nations Political Declaration on Ending The AIDS Epidemic By 2030 while giving more emphasis to gender transformative AIDS responses.
- A gender-responsive and gender-transformative HIV programming and implementation, gender-responsive budgeting should be a high-level agenda for the country.

LEGAL AND POLICY FRAMEWORK

- The existing HIV, women, and youth policies should be revised from a gender perspective to provide a more enabling environment and to ensure the necessary and appropriate attention is given to gender and human rights.
- Ensure the systematic mainstreaming of gender into HIV policies, strategies, programmes, and guidelines apart from putting gender solely as a crosscutting agenda.
- Ensure the engagement of men in challenging gender stereotypes and norms, develop the institutional capacity of networks of WLHIV and key populations to advocate against discrimination.
- Strengthen the enforcement of the relevant provisions in the law to address stigma and discrimination.

ADDRESSING GENDER EQUALITY AND THE STRUCTURAL BARRIERS

- Ensure accountability mechanisms are in place for the translation of laws and policies on gender equality into action through the implementation of HIV responses with measurable indicators and targets that can be tracked through systematic monitoring.
- Address the underlying/structural (social, cultural and economic) causes of gender inequality through the successful implementation of policies or legal frameworks.
- Address gender-based violence through ensuring the enforcement of the existing laws and penal codes that are enacted to fight violence against women and applying the laws more stringently.

ENSURING UNIVERSAL ACCESS TO HIV SERVICES

- Gender-responsive budgeting should be mainstreamed in the national HIV response with clear guidelines and indicators to monitor and ensure systematic attention to all elements that address women and girls across programmes.
- Ensure equitable access to preventive programmes, and treatment and care support across the regions through designing context-specific approaches.
- Unique response mechanisms and platforms need to be in place to reach women and girls in the general population as well as among key and priority populations through comprehensive and holistic treatment, and care and support approach.
- It is also imperative that the necessary attention be given to persons with disabilities to minimize multiple burdens especially for women and girls with disabilities as well as those living with HIV.

COMMUNITY ENGAGEMENT AND MEANINGFUL PARTICIPATION

- Current programmes and policies on gender-transformative interventions should be informed by the realities of those most affected in Ethiopia and ensure their ownership and participation during implementation.
- Mechanisms for and indicators to track the meaningful participation of women, networks, and organizations that represent PLHIV, women's rights, SRH, gender equality, youth and key populations in developing policies, guidelines and strategies relating to their health including preventing the MTCT should be in place.
- Conduct regular national AIDS spending assessment to ensure that there is a formal system of accountability for the HIV response.
- Parents, school community, community gatekeepers including religious leaders as well as other community structures should be meaningfully involved in the prevention of violence against women and girls and promote gender equality.

STRENGTHENING MONITORING AND EVALUATION ON GENDER-TRANSFORMATIVE RESPONSES

- The national HIV response should have strong monitoring and evaluation framework as a strong foundation for results- to ensure data is used for accountability, transparency and impact through efficient utilization of resources.
- Data disaggregation among key and priority populations is required for decision-making. Thus, disaggregated survey and program data should be collected to inform the response.

EVIDENCE GENERATION AND ENHANCING UNDERSTANDING OF THE HIV EPIDEMIC AND RESPONSE

- There is a need to examine the situation of women and girls as well as the invisible key population groups through rigorous studies with clearly stated and measurable gender-sensitive/transformative indicators.
- There is a need to generate local evidence that documents the relationship between gender and access to and utilization of HIV prevention, care, and treatment services.

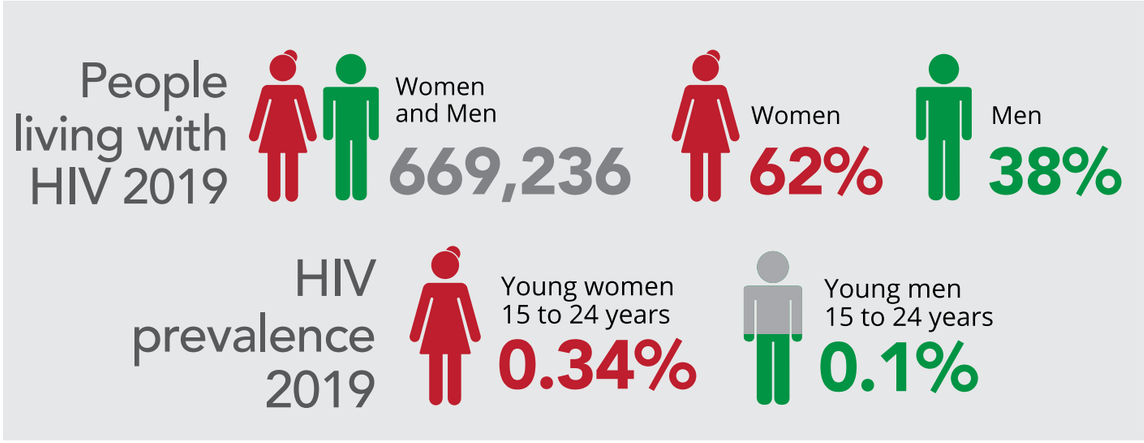
"The seeds of success in every nation on Earth are best planted in women and children."

Joyce Banda, Former President of Malawi

1. INTRODUCTION

1.1 BACKGROUND

In 2019, an estimated 669,236 people were living with HIV in Ethiopia, more than 62% of whom were women[1]. The HIV prevalence rate in 2017 was 1.2% among women with peak prevalence reaching up to 3% among those aged 40-44 compared to 0.6% among men with a peak prevalence of 1.6% in a wider age range of 40-49 years. HIV prevalence among adolescent girls and young women aged 15-24 (0.34%) is three times higher than boys in the same age group at 0.1%[2].



With regards to the two key populations defined in Ethiopia's context, the prevalence of HIV was 23% among commercial sex workers[3] while it was 4.2% among prisoners[4]. Among those categorized as priority populations in the Ethiopian context which include widowed, separated or divorced women; long distance truck drivers; PLHIV and their partners; people working in hotspot areas, both mobile and resident[5], the prevalence of HIV ranges from 1.5% in mobile and resident workers to 28% among PLHIV partners[6]. The most alarming issue is that only 20 percent of women and 38 percent of men aged 15-49 have comprehensive knowledge about HIV transmission and prevention[7].

Since the beginning of the HIV epidemic, Ethiopia has been striving hard to alleviate the impact of the pandemic on health, social, economic and demographic issues ranging from developing the HIV/AIDS policy, establishing the National HIV/AIDS Council and the Federal HIV/AIDS Prevention and Control Office which created a platform for leadership and coordination of the multisectoral response in the country. The country has also developed different strategic frameworks or national strategic plans including the current ones - 2015-2020 Strategic Plan and 2018-2020 HIV Prevention Roadmap. Since then, Ethiopia has observed remarkable progress between 2000 and 2017 in reducing HIV prevalence rate from 3.3 percent in 2000 to 0.9 percent in 2017, and AIDS-related deaths declined by more than 80% in nearly two decades from 83,000 deaths in 2000 to 15,600 in 2017.

The number of new HIV infections in Ethiopia decreased by about 21% between 2010 and 2019 although the new infection rate nearly doubled among women aged 15 years and above compared to men of the same age groups[8]. In its effort to achieve the 90-90-90 global targets of knowing HIV status, being put on ART, and reducing viral suppression, by 2018, Ethiopia's progress reached on 82% of PLHIV (83% in females vs 85% in males) knew their status; 91% (with equal percentage in both females and males) of eligible PLHIV were on ART, and 89% (with equal percentage in both females and males) of those on ART have attained viral suppression[9].

1.2 THE RATIONALE FOR THE GENDER ASSESSMENT

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic, or social condition.[10]"

Women shall, in the enjoyment of rights and protections provided for by this Constitution, have equal rights with men[11].

Gender inequality and the failure to recognize and defend women's human rights are realities of the daily lives of women manifesting in terms of gender-based violence; the denial of their sexual and reproductive health rights (SRHR); their poor access to and control over resources; violence and stigma and discrimination; and the socially embedded division of labor which gives more benefit to men compared to women among others. In many circumstances, women and girls face the most oppressive: gender inequality and unequal power relations at household and intimate relationships levels. This signifies the importance of translating into the action the laws, policies, and institutions that are created to ensure equal opportunities between men and women[12].

All age groups of Ethiopia's population are overburdened from both communicable and non-communicable diseases while children and women of reproductive age are affected disproportionately. Women and children are also disproportionately affected by the humanitarian crisis, a clear feature of the existing gender and socio-economic disparities.

The country in its 2015-2020 National HIV Strategic Plan recognized gender equality and equity as one of the critical enablers and a cross-cutting issue of the roadmap of the national HIV response[13]. The government of Ethiopia prioritized the implementation of interventions that address structural barriers including community socio-cultural norms and gender/GBV for adolescent girls, young women & their male partners and scale-up of structural HIV prevention interventions such as stigma and discrimination, protection, and gender in addressing key and priority population groups under the pillars of the five-year roadmap. Also, broader Gender affairs have been mainstreamed in the different Government sectors with the leadership of the Ministry of Women, Children, and Youth Affairs[14].

Cognizant of this as an opportunity and by drawing lessons from previous implementation experiences, Ethiopia conducted its national gender assessment (GA) of the national HIV response using the UNAIDS *2018 Gender Assessment tool: towards a gender-transformative HIV response*[15] as a guiding framework. The purpose of the gender assessment was to analyze the national HIV epidemic and its contexts and evaluate the degree to which the country's response to HIV recognizes gender and its associated inequalities as key determinants of the epidemic. This assessment has proposed evidence-informed suggestions and recommendations to enhance efforts to address the different gender dimensions in its response as part of the next five-year HIV Prevention and Control Strategy Plan (2021-2025). The evidence also serves as an important input for the country's global fund application.

2. OBJECTIVES OF THE GENDER ASSESSMENT

THIS GENDER ASSESSMENT AIMS TO:

- Better understand how gender inequality has been shaping Ethiopia's HIV epidemic by assessing the HIV epidemic, context, and the national HIV response strategies and interventions from a gender, SRH, and human rights perspective.
- Examine the socio-cultural, economic, legal, and political factors that contribute to gender inequality and identify entry points for strengthening the integration of gender into HIV and sexual and reproductive health response.
- Analyze available data to inform strategic priorities for sustainable, gender transformative, and effective approaches in addressing the strategic interests and practical needs of women, girls and other key populations in a way to inform gender-transformative, equitable and rights-based policy development, advocacy and planning and programme implementation and monitoring in line with the 2021-2025 NSP on HIV response.

One girl even had a chance to have a selfie with the SG during his visit in February 2019 in relation to AU meeting in Addis Ababa
Photo Credit – Kenneth /UN Women

3. GUIDING PRINCIPLES FOR THE GENDER ASSESSMENT

4. THE GENDER ASSESSMENT APPROACH

If gender inequality and its underlying barriers are not addressed in a coordinated manner, it may end up with exacerbated disparities in population, health, and HIV outcomes. According to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the terms “equity” and “equality” are not synonymous or interchangeable. To achieve the de facto or “substantive equality” in every direction or dimension, states need to achieve equality of opportunities between men and women regardless of their race, ethnicity, a social or economic status which can be guaranteed through laws and policies and correct the inequalities of power between men and women as two important actions.

To achieve the principle of substantive equality, giving equal opportunities as men through designing of gender-sensitive laws and special policies is not adequate unless equality of results between men and women is ensured. Regardless of the obvious natural or biological differences between men and women, according to human rights theory and the principle of equality indicated in different constitutions[16] or laws[17], such differences should not have to be considered as pretexts to justify the prohibited inequalities.

In addition to dealing with gender-based inequalities, the differences in vulnerability to HIV between groups of different people such as between girls and women, FSWs and women, married and unmarried, etc. should come at the center of the gender assessment. There should be a clear understanding that merely dealing with the gender differences may mask the reality that ‘women and girls’ are not a homogeneous group, as gender is not the only factor that determines their vulnerability to the pandemic. This is particularly important in the context of Ethiopia with its features of concentrated epidemic whereby the prevalence of HIV is more pronounced in certain geographic localities or specific segments of the general population such as the key and priority populations.

In this gender assessment, critical gender issues are addressed at different levels to explore the areas on which more attention is needed in future national HIV response interventions including improving and strengthening of gender-sensitive and gender-transformative programming, implementation, monitoring & evaluation; and gender-budgeting. Hence, the gender assessment process followed a set of guiding principles in line with international standards[18],[19] for advancing the rights and health of women, girls, and key and priority populations. These principles were validated by the gender assessment technical subcommittee (GATSC) which is comprised of various government organizations, Civil Society Organizations, and development partners. The principles are outlined as follows:

- Respect and protect the rights of women and girls & key populations while engaging men and boys in line with international and national human rights principles including women and SRHR.
- Employ a gender-sensitive/transformative approach that caters to the different needs of women, girls, men, and boys, and other key and priority populations in accessing HIV information and related services[20] through ensuring their active participation. Such an approach helps to ensure that the process is informed by the realities of those most affected in Ethiopia and ensure their ownership during the assessment process as well as during future responses.
- Apply a multi-sectoral and forward-looking approach and partnership that builds on HIV being the responsibility of all sectors and constituencies with emphasis given to the meaningful participation of civil societies including people living with HIV (PLHIV) and other key affected populations.
- Ensure ethical, evidence-informed, and rights-based programming to ensure equity and fairness.
- Employ a more diversified view of factors that are often neglected which may include comorbidities such as cervical cancer, tuberculosis, human papillomavirus, and female genital schistosomiasis and gendered side effects of antiretroviral therapy (ART), etc. but not solely focusing on factors that aggravate their vulnerability to HIV- early, forced and child marriage, and gender-based violence among others.
- Address the specific issues and structural barriers including the policy and legal frameworks which aggravate the vulnerability of women in key affected groups including marginalized segments of the population and their partners to HIV.
- Ensuring accountability and transparency.

This gender assessment exercise was guided by UNAIDS gender assessment tool (GAT) which has a structured set of guidelines and questions that can be used to guide and support the process of analyzing to what extent national responses to HIV in both generalized (HIV spread in the general population) and concentrated epidemics (HIV spread in subpopulation) consider the critical goal of gender equality[21]. As a planned, systematic and deliberate set of steps and processes, the GAT examines and questions the status of the HIV response (plans and actions were undertaken by national governments to address HIV), specifically referring to its gender dimensions: the socially constructed roles, behavior, activities and attributes a given society considers appropriate for women and men, including members of key populations[22]. This gender assessment tool helps to ensure that national HIV responses have gender equality as a goal. The tool has been used by individuals and partners in government, civil society, the United Nations, and other multilateral agencies. This rigorous and well-structured assessment process involves knowing the country's HIV epidemic and its context from as well as the country's response from a gender perspective. The GAT and its findings lead us to identify evidence-informed gender-transformative interventions to strengthen HIV responses.

The gender assessment for the national HIV response of Ethiopia passed through four stages as clearly stipulated in the foundational UNAIDS GAT.

Stages of the GAT	Data dimensions
Stage 1: Preparing for the gender assessment of the national HIV response	• Ensuring high- level commitment • Develop a GA framework and resource plan • Establish a GA team • Inception report • Collect key documentation and data • Inception workshop with all relevant stakeholders • Planning
Stages 2: Knowing the national HIV epidemic and context	• HIV prevalence and incidence and behavioral information • Social, cultural and economic factors • Legal and political factors
Stages 3: Knowing the national HIV response	• Gender equality in HIV policies and programmes • Comprehensive HIV response • Gender considerations according to the community • [Women and girls, men and boys, Key populations, Young people]
Stage 4. Analyzing and using the findings of the gender assessment for a gender-transformative HIV response	• Epidemiological and context analysis • Response and gap analysis • Developing an advocacy brief

5. KEY CONCEPTS

Conceptual definitions of the key terms that are used in the gender assessment process are presented as follows:

Sex: The term sex refers to biological differences between females and males[23].

Gender: According to the WHO, gender refers to the roles, behaviors, activities, attributes, and opportunities that any society considers appropriate for girls and boys, and women and men. Gender interacts with but is different from, the binary categories of biological sex.[24] A socially constructed set of norms, roles, behavior, activities, and attributes that a given society considers appropriate for women and men and that is attached to masculinity and femininity and the people identifying themselves as transgender or genderqueer or expressing gender in various other forms[25].

Gender inequality: Refers to unequal chances or opportunities for groups of women and men to obtain and control social, economic, and political resources, including protection under the law (such as health services, education, and voting rights). Gender inequality determines differential, unequal, and negative health outcomes for women and men and girls and boys[26].

Gender-responsive programming: Policies or programmes that explicitly consider and address unequal gender norms and roles, power dynamics, and the distribution of resources according to gender and that counter discrimination faced by people in societies based on their gender or gender expression and improve their access to services.[27]

Gender sensitive programming: In a gender sensitive programming, the gender dimension is systematically integrated into every step of the process, from defining the problem, to identifying potential solutions, in the methodology and approach to implementing the project, in stakeholders analysis and the choice of partners, in defining the objective, outcomes, outputs, and activities, in the composition of the implementation and management team, in budgeting, in the monitoring and evaluation (M&E) process, and in policy dialogue[28]. Gender-sensitive indicatrs are indicators disaggregated by sex designed to demonstrate changes in relations between women and men in a given society over a period of time[29].

Gender transformative programming: Refers to a program that addresses the causes of gender-based inequalities and works to transform harmful gender roles, norms and power relations[30].

Gender transformative response: A response that seeks to understand the underlying causes of gender inequalities and takes effective action to transform the unequal power relations between men and women, resulting in an improved status of women and gender equality[31].

Gender-responsive budgeting: Gender Responsive Budgeting (GRB) is a tool that aims at integrating gender perspectives in the budgeting process. Gender-responsive budgeting aims at restructuring revenues and expenditures in such a way that the needs, interests, and priorities of both female and male citizens as well as of women and men among different groups in society are equally taken into account in the process of developing government budgets and policies[32]. This represents a planning and budgeting approach to costing, which looks at the benefits of gender-transformative approaches, and the long run budgeting impacts of society with increased gender equality[33].

Key populations: According to the 2015-2020 HIV/AIDS Strategic Plan, in Ethiopian context, key populations refer to female sex workers (FSW), prisoners, truck drivers, and daily or seasonal laborers[34]. However, the 2018-2020 National Roadmap for HIV Prevention in Ethiopia[35], key populations for Ethiopia are FSWs and prisoners. Priority populations are widowed, separated or divorced women; long distance truck drivers; PLHIV and their partners; people working in hotspot areas, both mobile and resident.

6. METHODS

This gender assessment was conducted by a team of national consultants under the active participation and technical guidance of the national Gender Assessment Technical Subcommittee (GATS) under the leadership of the Federal HIV Prevention and Control Office (FHAPCO). The Gender Assessment Technical Subcommittee has been guiding the assessment using the terms of reference. An international consultant also provided technical support remotely.

The gender assessment process including identification of relevant source documents, selection of the study population, the data collection approaches, and engagement of prominent stakeholders among others was guided by existing and broadly used standard frameworks or gender assessment approaches including UNAIDS Gender Assessment Tool (GAT) towards a gender-transformative HIV response[36], the World Health Organization (WHO) consolidated guideline on the sexual and reproductive health and rights of women living with HIV (WLHIV), WHO/UNAIDS tool for strengthening gender-sensitive national HIV and sexual and reproductive health (SRH) monitoring and evaluation systems[37], WHO/UNAIDS Technical guidance for Global Fund HIV proposal writing: cross-cutting issues in addressing gender inequalities[38], the WHO Consolidated Guidelines on HIV prevention, diagnosis, treatment and care for key populations[39] and the Framework for Women, Girls, and Gender Equality in National Strategic Plans[40].

As per the recommendation of UNAIDS GAT, the data collected in the gender assessment stages 2 and 3 are validated in line with the WHO/UNAIDS tool for strengthening gender-sensitive national HIV and sexual and reproductive health monitoring and evaluation systems[41]. This is vital in ensuring accuracy in measurement, adequacy of data sources, and appropriate disaggregation. This tool provides very useful step-by-step guidance on the process to analyze and triangulate data on the epidemic and identify contributing factors to the current situation by analyzing disaggregated data and analyzing jointly with data on potential explanatory factors (data on laws and policies or other relevant indicators), to identify potential reasons for differences.

The gender assessment design and methods employed both quantitative and qualitative approaches using rigorous desk reviews and analysis of secondary data as well as key informant interviews and in-depth interviews. These were then used to reaffirm and triangulate the collected data. Due to the COVID-19 pandemic, workshops were not held at national and regional/subnational levels to validate the desk review findings, the analysis, and come up with actionable recommendations of the assessment process. However, the assessment report was reviewed by stakeholders.

Desk review: A desk review and analysis of key documents including policy documents; strategic and operational plans; contextual evidence-based research including national and subnational surveys and both published and unpublished or grey literature; national HIV response reports, evidence-informed gender-transformative responses including concrete recommendations for policy and program actions, and records of best practices and success stories have been conducted (Annex 1).

In-depth/key informant interviews: The key informant interviews were conducted by the consultants themselves. Informed verbal consent was obtained from the study participants using the information sheet developed for this purpose. Since the data collection was conducted virtually (phone, zoom, and skype) because of the State of Emergency following the COVID-19 pandemic, we assume that the confidentiality of the study participants was maintained. In-depth interviews were conducted with members of key stakeholders based on the GAT to elicit their experiences and their recommendations while working on gender and HIV, and the interface between the two. The key informants included Public sectors (MOH/FHAPCO, RHBs, Ministry of Women, Children and Youth Affairs; Women's Affairs Standing Committee of the National Parliament, Ministry of Labor and Social Affairs); UN agencies (UNAIDS, UNWOMEN, UNDP, and UNFPA); Donor or Bilateral organizations (PEPFAR, USAID, DFID, GF, WB); NGOs engaged in the national HIV response efforts; HIV Societies or Associations (NNPWE; NEP+); and Academia and Research Institutes among others. Besides the key informants, in-depth interviews were also conducted with different individuals representing key and priority populations as well as the general population. The study participants were drawn from PLHIV, FSWs, daily laborers, persons with disabilities (PLHIV and negative/unknown status), youth groups, and health workers including health professionals at health centers level and Health Extension Professionals. Such diverse study population groups were selected to ensure that the voices of key and marginalized populations are included to elicit experiences and suggestions as inputs for the NSP for HIV response development. The final list of the study participants was decided in consultation with the gender assessment technical subcommittee of this GA process. Because of the state of emergency enacted following the COVID-19 pandemic, operationalizing of FGD was not possible though it was part of the initial plan of the gender assessment process.

Workshops[42]: Repeated and regular virtual meetings have been conducted at different stages of the gender assessment process including the introductory consultative or launching workshop, and the inception workshop. These meetings have been useful in the finalization of a final inception report containing a detailed work plan with a clear and agreed-upon timeline, and the roles and responsibilities of the consultancy team, the GATS, GATT, and other stakeholders. Though, national and regional consultation workshops were not conducted to analyze and use the findings to prepare results-based planning, the monitoring, and evaluation framework, and the gender-transformative response action plans, the gender assessment report was shared widely with the different stakeholders drawn from public sectors (national and regional), bilateral donors, UN agencies, implementing partners (NGOs) and civil societies including associations of WLHIV or PLHIVs, etc. One virtual national validation workshop was organized to solicit feedback and inputs based on the findings of the gender assessment. As such, the important feedback and reflections were considered in the finalization of this report.

Data collection: The data collection and analysis of the in-depth interviews/key informant interviews took place in Addis Ababa using semi-structured KII interview guides which were validated virtually by the gender assessment technical sub-committee and during weekly update meetings.

Data analysis: The consultancy team synthesized and integrated/triangulated the data from multiple sources (indicated above) in producing this comprehensive gender assessment report. Statistics are extremely valuable, but a statistic can tell only one part of the story. To ensure a more comprehensive HIV response, people's experiences, opinions, attitudes, and feelings have been included in the analysis.

Limitations: As this gender assessment was conducted during the COVID-19 pandemic, the gender assessment could only benefit from the active participation of regional and national level stakeholders virtually. Besides, perspectives and experiences of regional contexts especially those with limited internet connectivity were not also fully addressed because of movement restrictions. Considering the vast socio-cultural diversities of the country, future efforts need to undertake multi-level analysis of gender perspectives down to the regional and sub-regional levels. This may help in designing targeted gender sensitive or transformative HIV responses.

Apart from the information obtained from the lived experiences of members of communities, key and priority populations defined in the country context, we could not address the experience of other universally defined key populations. This gender assessment mainly depended on desk review of available research and data which implies the need for further research to fill information gaps on specific issues. As is seen in some countries, the lack of readily available data in Ethiopia does not allow granular analysis.

"AIDS-related illnesses are the leading cause of death among women of reproductive age globally; every week 6000 adolescent girls and young women around the world are acquiring HIV—most of them in Africa; and women from key populations most impacted by the epidemic are between five to 19 times more likely to be living with HIV than other adult women. This is unacceptable, it is avoidable and it must end."

Winnie Byanyima, Executive Director of UNAIDS

7. SOCIODEMOGRAPHIC, ECONOMIC AND HEALTH CONTEXT

7.1 GEOGRAPHIC LOCATION AND CLIMATE

Ethiopia is located in the North-Eastern part of Africa, also known as the Horn of Africa. It lies between 30o N and 150o N Latitude and 330o E and 480o E Longitude. It is bordered by Sudan and South Sudan on the west, Eritrea and Djibouti on the northeast, Somalia on the east and southeast, and Kenya on the south.

The country occupies an area of 1.1 million square kilometers with the water bodies occupying 7,444 sq. km. The country has rich geographic diversity consisting of rugged mountains, flat-topped plateaus, deep gorges, and river valleys. Its erosion, volcanic eruptions, and tectonic movements over the ages have contributed to its diverse topography. More than half of the geographic landscape of the country lies above 1,500 meters. The country's altitude ranges from Ras Dashen mountain at 4,620m above sea level to the Danakil (Dallol) Depression at 1,500 m below sea level.

7.2 DEMOGRAPHIC PROFILE

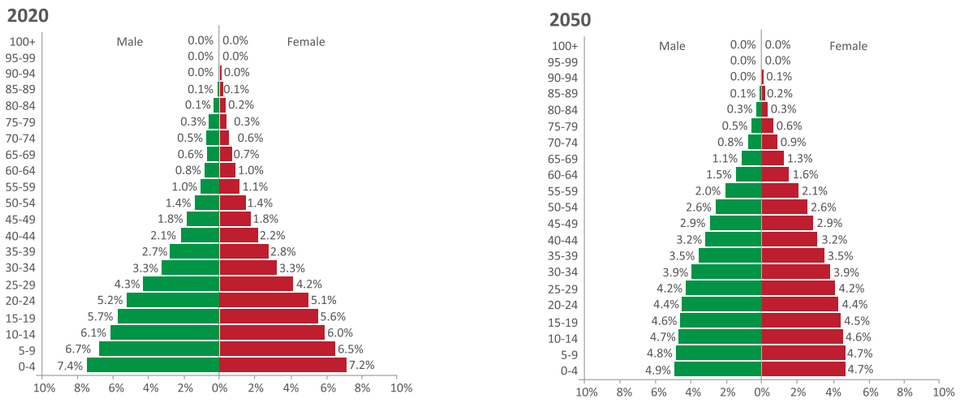
Ethiopia is the second-most populous country in Africa next to Nigeria followed by Egypt[43]. It ranks 12th globally. The country's population grew from about 18 million in 1950 to 40 million in 1984, and from 54 million in 1994 to 74 million in 2007. According to the 2007 population and housing census, the population of the country is projected at about 115 million by 2020[44] with an annual population growth rate of 2.6%. If it follows its current rate of growth, the population will reach nearly 200 million[45] or 171.8 million[46] by 2050.

Figure 1 shows Ethiopia's population pyramid (age structure) in the base year 2012 and 2032. The broad base of the population pyramid indicates a large proportion of young people. The young population aged 14 years or younger constitutes 41.5 percent of the total in 2012. Ethiopia's young population is also reflected in the low median age and high dependency ratio. While the sex ratio between males and females is almost equal, women of reproductive age constitute about 23% of the population. The population is predominantly rural with nearly 80% living in rural areas, mainly based on subsistence agriculture[47].

Ethiopia has the highest total fertility rate (TFR) of 4.6 births per woman (2.3 in urban areas and 5.2 in rural areas) and a corresponding crude birth rate of 32 per 1000 in 2016. The average household size is 4.6. In 2019, 41% of married women were using contraception compared to just 14% in 2005. There is also significant variation in TFR, desired family size, and contraceptive prevalence between regions and different socioeconomic groups. In the three years preceding the 2016 EDHS, TFR was highest in Somali at 7.2 children per woman and lowest in Addis Ababa at 1.8 children per woman. Similarly, the highest TFR was observed among women with no education (5.7) than women with more than secondary education (1.9 children). Unmet need for family planning is still high at 26.4% in 2016.

Given the majority young population, Ethiopia's population age structure may enable a demographic bonus or dividend if managed appropriately. This is attributed to the country's commitment to reducing infant and child mortality and improving reproductive health and family planning which resulted in the subsequent decline in total fertility. However, the country may benefit from this demographic dividend to improve the quality of life of its citizens if it is in a position to scale up investments in human capital while addressing regional as well as rural-urban disparities through the implementation of supporting policies, strategies, and transformative agendas. Ethiopia is home to more than 80 different ethnic groups. The two largest ethnic groups, the Oromos and Amharas, constitute more than 60% of the country's total population while Orthodox Christians constitute more than 43% of the population followed by Muslims[48].

FIGURE 1 POPULATION BY AGE AND SEX (PERCENTAGE)[49]



Migration, as an important demographic issue, has been given the necessary attention in Ethiopia's national development policies and strategies such as in the 2006 Plan for Accelerated and Sustained Development to End Poverty (PASDEP). The PASDEP recognized migration (internal) as an urban development problem that aggravates poverty, unemployment, and the spread of HIV[50]. However, the second Growth and Transformation Plans (GTP-II) failed to mention migration at all.

According to a World Bank survey, in Ethiopia, migrants account for a higher share of urban populations mainly in smaller towns. Addis Ababa and Dire Dawa have the lowest share of migrants compared to their total residents but Addis Ababa constitutes the largest proportion of total migrants (39.1%). Up to 17% of urban dwellers in 2013 came to the urban areas in the last five years up to 2013. Between 2008 and 2013, 34% of the total internal population movements constitute the rural to urban movements while 25% was inter-urban migration while intra-rural migration accounted for 23% of population movements between 2008 and 2014[51]. In Africa, Ethiopia and Kenya hosted the highest refugee population[52].

The work search is the main motivation of every type of migration while the shortage of land is an important motivation for rural-to-rural migration, especially for men. Looking for work is by far the main migration motivation for men while the same factor is combined with moving for marriage for women- young and relatively less educated women moving to Addis Ababa for domestic work and slightly older and better-educated rural dwellers moving to secondary urban centers to work in commerce, agriculture, and services. Young women also migrate to escape arranged marriages and traditional gender roles[53].

"Africa is facing multifold and complex challenges, from the kidnaping of girls by extremist groups who deny them access to education, to child marriage; from young women being infected with HIV, to marginalization from peace, security and political processes. We know that women's leadership is the key to addressing these issues. Until they have a voice, it is not only women and girls who will be left behind—but all of humanity."

Phumzile Mlambo-Ngcuka, Executive Director of UN Women

7.3 SOCIO-ECONOMIC SITUATION

Ethiopia is in a state of rapid and comprehensive development on the way to transition from poverty to sustainable and reliable growth and prosperity.

Ethiopia has implemented different macroeconomic policies, including a market-based and agriculture-led industrialization that aimed to ensure economic transformation from an agricultural to the industrial led economy. The country is a low-income country with the gross domestic product (GDP) per capita (current US$) of US$790 in 2018, up from about US$340 in 2010. It has been also one of the fastest-growing economies in Africa with an average of 10% annual GDP rate between 2017 and 2018 and 8.3% in 2019[54]. Agriculture, industry, and service sectors contributed the most in the country's GDP growth. The proportion of households living below the poverty line (below US$1.25 a day) reduced from 39% in 2004/05 to 29% in 2010[55]. The poverty levels fell by around 20% between 2011 and 2016 (World Bank, 2019).

Despite such remarkable signs of progress, Ethiopia is still among the poorest nations of the world. Income inequality continues to be a continuous challenge to the country[56]. Evidence shows that in Ethiopia married women tend to work fewer hours in the labour market and more in the household, while the reverse is true for married men. According to the 2011 EDHS, the average share of married women who were employed in the past 12 months was 56 percent compared to 99 percent for men who are married and work. Women are paid cash only or not at all due to the prevalence of casual/non-contractual and informal employment arrangements while men are more likely to engage in work and get decent wages[57]. In Ethiopia, women work much more than men on top of the very tiresome burden they have with household chores regardless of their employment status[58]. These facts indicate how Ethiopian women and girls are disadvantaged economically due to deep-rooted gender and social norms in the country.

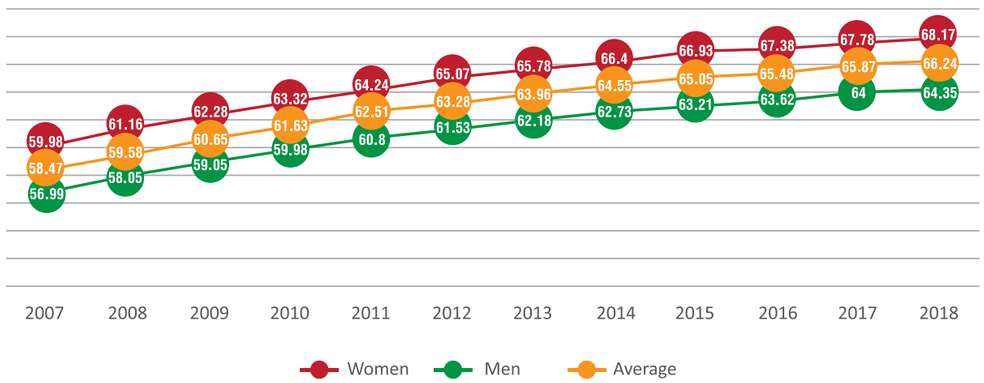
One important feature of the economic reform in Ethiopia is the empowerment of women through the creation of enabling environments to ensure their equal participation in the economic development of the country which is boldly stated in the constitution. According to the CSA report, the national income inequality coefficient has increased from 0.298 in 2010/11 to 0.328 in 2015/16. Ethiopia's HDI (Human Development Index) value 0.470 which put the country in the low human development category and positioning it at 173 out of 189 countries and territories[59]. While most people in Ethiopia still live at subsistence levels in rural areas, subscribers to mobile phones reached 61.6% of the population in 2017, an increase of almost 400% from 2010.

According to the 2019 Human Development Report, Ethiopia's gender inequality index (GII) is among the lowest at 0.508 in 2018, ranking 123rd from 162 countries[60]. Only 11.5% of women aged 25 years and above had at least some secondary education while 22 % of men of the same age had some secondary education, indicating that the female to male ratio was 0.52.[61] Youth unemployment was 1.8 times more common in females than in males while total unemployment was 1.85 times more common in females. Females spent on average five hours per day more than males aged 15 years and above on unpaid domestic chores and childcare work, almost three times more than what males spent on similar activities in 2018[62].

7.4 STATE OF HEALTH AND WELLBEING

Following its remarkable achievements in health indicators over the last decade, life expectancy at birth in Ethiopia increased by 14% between 2007 (58 years) and 2018 (66 years) (Fig. 2). Life expectancy at birth is higher for females (67.3 years) compared to that of males (64.7 years)[63],[64]. Despite such improvements in life expectancy at birth, stagnating premature death and suboptimal quality of life remain as major development challenges for the country. According to the WHO estimates, disability from poor health conditions in Ethiopia is equivalent to the loss of 8.5 years per person resulting in a healthy life expectancy at birth[65] of 57.5 years (58.9 for females and 56.1 years for males)[66]. Ethiopia's health adjusted life expectancy at birth is higher than the average for Africa region (54 years) and the low-income countries (55 years) while it is lower than the global average (63 years) and the middle-income countries (59 years)[67].

FIGURE 2: LIFE EXPECTANCY AT BIRTH AND THE ANNUAL RATE OF INCREASE (2007-2018)



All age groups of Ethiopia's population are overburdened from both communicable and non-communicable diseases while children and women of reproductive age are affected disproportionately.

According to EDHS, pregnancy-related mortality ratio showed a significant decline from 871 deaths per 100,000 live births in the 7 years before the 2000 EDHS survey to 412 deaths per 100,000 live births in the 7 years before the 2016 EDHS survey. Similarly, under-five and infant mortality rates decreased from 123 to 55 and 77 to 43 per 1000 live births between 2000 and 2019. However, the neonatal mortality rate (NMR) has consistently stagnated at around 30 deaths per 1000 live births with no sign of significant decline. Mortality during the neonatal period contributes 54.5% of the total risk of death during the first five years of life among Ethiopian children[68],[69].

In Ethiopia, a large but dispersed rural population coupled with increasing urbanization and peri-urban settlements has created huge demands on the primary health care (PHC) delivery system. The PHC depends upon external assistance for around 33% of its health care spending[70]. The country is at a critical juncture because of the anticipated further declines in development assistance for health and in government revenues due to the COVID-19 pandemic which will slow the economy. Hence, this prompts the need to mobilize and use health resources as economically and equitably more than ever. Like any other part of the world, it is already observed that health system resources are redirected towards the COVID-19 response. This affects the essential health services delivery and consequently the health outcomes. In the long-term, the health system and its resilience to maintain essential services while responding to recurrent shocks and emergencies will be critically hampered.

7.5 HUMANITARIAN IMPACT AND NEEDS

Ethiopia has never been without natural and man-made shocks and stresses. The repeated hazards have put a huge impact on households and infrastructures which challenged the resilience of the systems and institutions towards emergencies. In 2020, an estimated 8.4 million people need humanitarian assistance[71] and many of them did not recover from previous shocks which further exacerbates their coping mechanisms in responding to future crises. Women and children are disproportionately affected by the humanitarian crisis, a clear feature of the existing gender and socio-economic disparities. Specific to the health sector, 5.9 million people are estimated to have humanitarian needs of which 1.2 million are women and girls in need of family planning and maternal health services. Internally displaced people (IDP) are more vulnerable and require additional health services for pre-existing and new disease conditions, physical and mental trauma, and sexual and gender-based violence. IDPs also put additional pressure on already strained health systems with a critical shortage of healthcare workers, medicines, and essential supplies. Such emergencies exacerbate the challenges women are facing in relation to lack of access to health services, their exposure to gender-based violences including rape in IDP centers which makes them vulnerable to the risk of HIV infection[72], and their burden in managing household chores among others.

8. THE NATIONAL HIV EPIDEMIC AND CONTEXT

8.1 PREVALENCE, INCIDENCE AND BEHAVIOURAL INFORMATION

8.1.1 CURRENT HIV PROFILE AND THE TREND OF THE EPIDEMIC

There are significant gender and age disparity in HIV prevalence, incidence, and AIDS-related deaths in Ethiopia. With a prevalence of 0.93 % among adults (15 – 49 years), it was estimated that a total of 669,236 persons were living with HIV in 2019[73]. Of these, 413,547 (62%) were women. It was estimated that HIV was 1.9 times more prevalent in women than in men. Ethiopia Population-Based HIV Impact Assessment (EPHIA 2017-2018) has indicated that these gender differences in HIV prevalence are more observed in urban areas. While the prevalence of HIV among adults in urban Ethiopia in 2018 was 3.0%, it was 4.1% among women and 1.9% among men. These disparities were most pronounced among 30-34 year-olds. The prevalence was almost seven times higher among women (6.1%) than among men (0.9%). The same assessment indicated that HIV prevalence among women peaked at 9.1% among ages 35-39 years while HIV prevalence among women peaked at 5.7% among ages 40-44 years[74].

The HIV incidence among all age groups was estimated to be 0.16 per 1000 uninfected persons. The annual incidence was estimated to be 0.13 and 0.19 per 1000 in males and females, respectively. With this incidence, there were an estimated 14,843 persons who were newly infected with HIV in 2019, of which 8,830 (59%) were females while 6,013 were males, indicating that infection was still higher among women than men. It was estimated that a total of 11,546 people died from AIDS-related illnesses in 2019, of which 6,570 (57%) were females while 4,976 were males[75].

The existing gender disparity was also recognized by participants of the key informant interviews. All the interviewees agreed that HIV prevalence, incidence, and AIDS-related deaths was higher in women than in men. Table 1 shows the age and gender disaggregation of the estimated number of PLHIV, new infection, and AIDS-related deaths in Ethiopia in 2019.

More young women than young men are infected by HIV while AIDS-related deaths were almost equal among young women and men. With a prevalence of 0.34 %, it is estimated that 72,299 young adults (15 – 24 years) were living with HIV in 2019 of which 43,887 (61%) were young women. With an incidence of 0.02 per 1000 uninfected young adults, it is estimated that 4,512 young adults were newly infected during the same year, of which 3,375 (75%) were young women. A total of 1,412 young adults died from AIDS-related illnesses, of which 723 (51%) were young women[76].

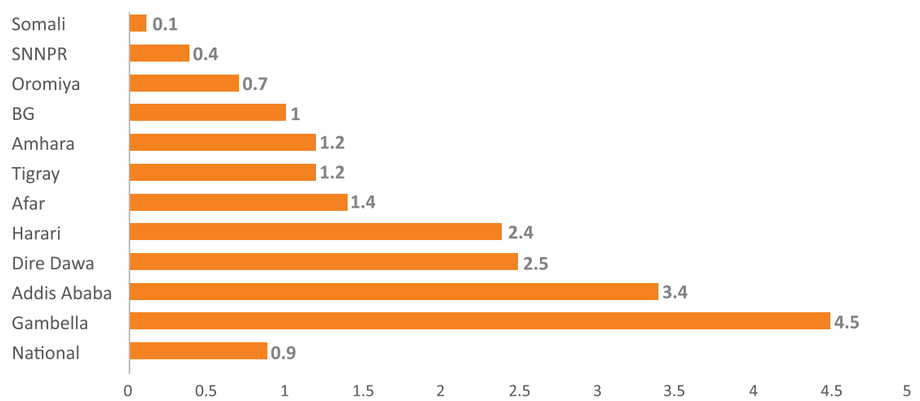
"Unlike our expectations, more women are accessing care and treatment … could this be because more women were living with HIV? Or could it be that men do not access care? We need to answer these questions. If the answer is 'yes' to the second question, then we should ask ourselves why males, particularly young men, are not accessing HIV care. Probably, we may consider 'male-friendly' services" [KII-2]

TABLE 1. NUMBER OF PLHIV, NEW HIV INFECTIONS, AND AIDS-RELATED DEATHS IN ETHIOPIA DISAGGREGATED BY AGE AND SEX, 2019[77]

AGE/SEX	PREVALENCE	INCIDENCE/ 1K	NUMBER LIVING WITH HIV	NEW HIV INFECTIONS	AIDS-RELATED DEATHS
All ages		**0.16**	**669,236**	**14, 843**	**11,546**
Male		0.13	255,689	6,013	4,976
Female		0.19	413,547	8,830	6,570
Adults (15 – 49 years)	**0.93**	**0.02**	**457,290**	**10,949**	**7,181**
Male adults	0.64		159,014	4,034	2,775
Female adults	1.22		298,276	6,915	4,407
Children (0 – 14 years)			**44,229**	**3,230**	**2,055**
Adolescents (10 – 19 years)			**46,066**	**1,713**	**1,191**
Male			21,258	232	625
Female			24,808	1,481	565
Young people (15 – 24)	**0.34**	**0.02**	**72,299**	**4,512**	**1,412**
Male	0.27	0.02	28,412	1,137	689
Female	0.42	0.03	43,887	3,375	723
People 50 years and more			**167,717**	**664**	**2,310**
Male			74,198	334	1,148
Female			93,520	330	1,162

There are different trends across the regions. According to EDHS 2016, there are significant variations in HIV prevalence among regions. The prevalence ranges from 4.8% in Gambella and 3.4 in Addis Ababa to less than 0.1 in Somali[78]. This difference in HIV prevalence among regions also reflects for young women and men aged 15 – 24 years. Overall, 0.2% of young women and men aged 15-24 are HIV positive. HIV prevalence among adolescent girls and young women age 15-24 is three times higher than boys in the same age (female 0.3% and male 0.1%). Among young women and men combined, prevalence ranges from less than 0.1% in Somali to 1.3% in Gambela[79].

FIGURE 3: HIV PREVALENCE AMONG REGIONS IN ETHIOPIA (DATA SOURCE: EDHS 2016)



Even if there is documentation on regional differences, there is no EDHS or other survey data disaggregated by mode of livelihood in these regions. According to a systematic review of the vulnerability of pastoralists and refugee communities to HIV and interventions targeting these groups in the IGAD countries, small studies in pastoralist areas in Ethiopia indicated that facility-based data showed HIV prevalence of up to 21% among pastoralists in Afar[80]. Gambella, Afar, Somali, Benshangul Gumuz, and some zones of Oromiya are considered pastoralist areas. This high prevalence of HIV, if confirmed by additional data, may need targeted intervention.

This concern was also reflected by one of the key informants:

> **"I think we need also to have data regarding the prevalence of HIV infection disaggregated by age and sex in pastoralist areas. In my country, boys in pastoralist areas are the ones who are usually out of school, increasing their vulnerability because of lack of awareness. We should know if this is the case in Ethiopia and craft appropriate interventions to reach this segment of the population." [KII-2]**

More women have been infected by HIV than men since the epidemic started. The prevalence of HIV has also been almost twice among adult women than men (Fig. 4a-b).[81]

FIGURE 4A: ADULTS WHO ARE LIVING WITH HIV IN ETHIOPIA: 1990-2018

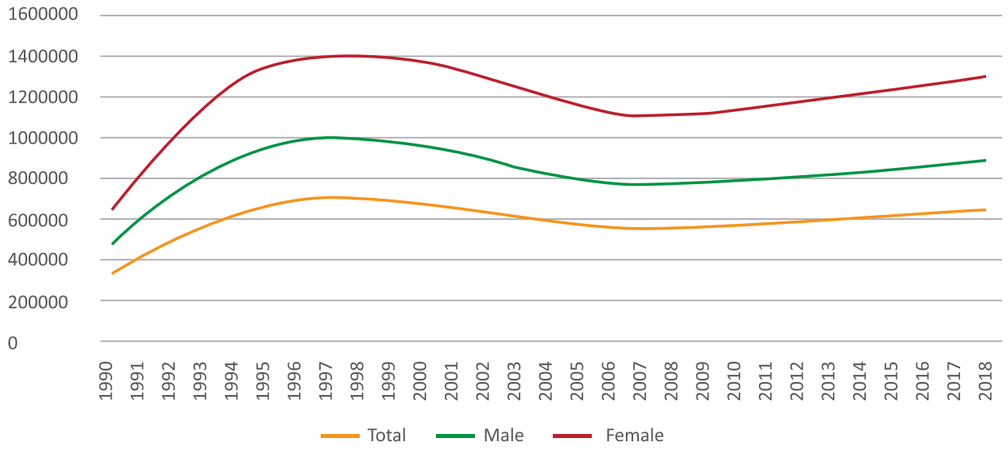
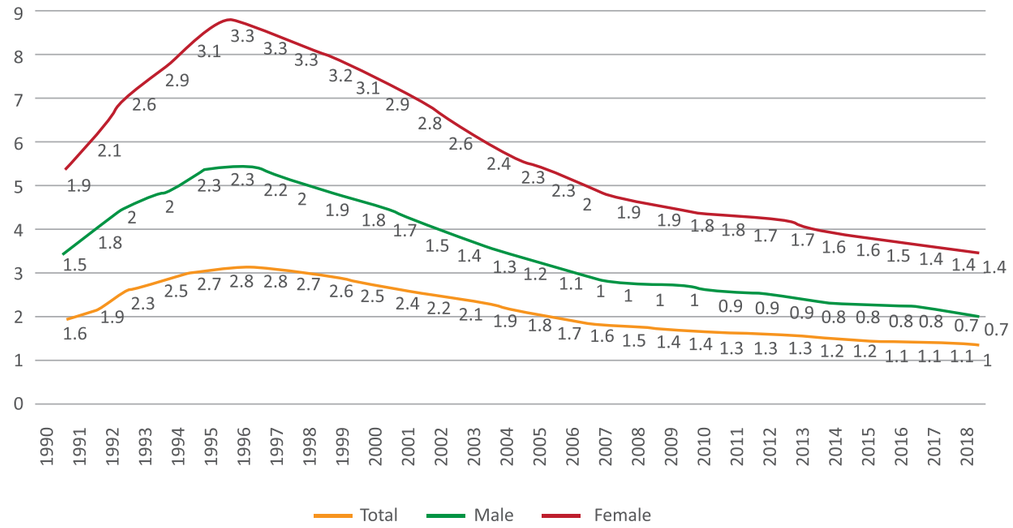
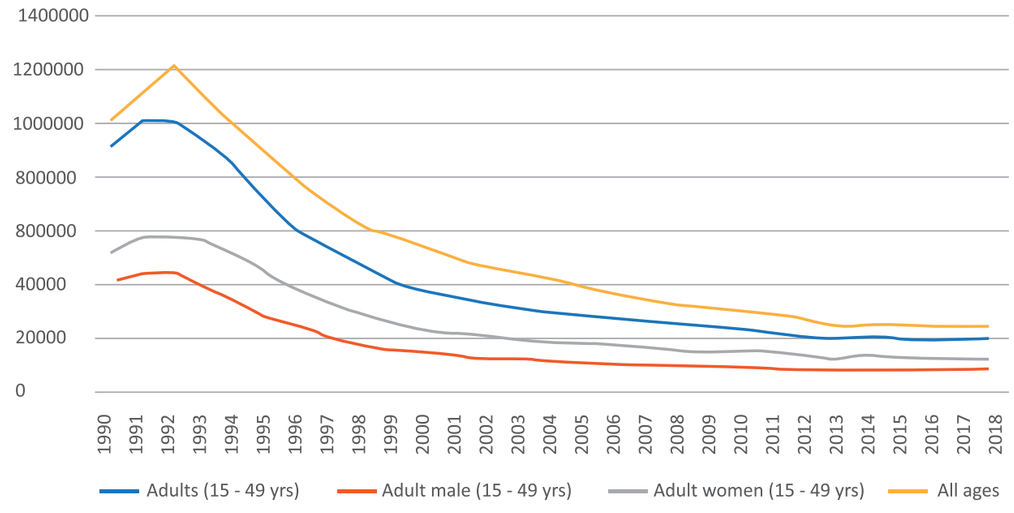


FIG. 4B: HIV PREVALENCE AMONG ADULTS IN ETHIOPIA BY SEX: 1990-2018



The trend in the epidemic also indicated that more infections occurred in young women than young men in Ethiopia since 1990.

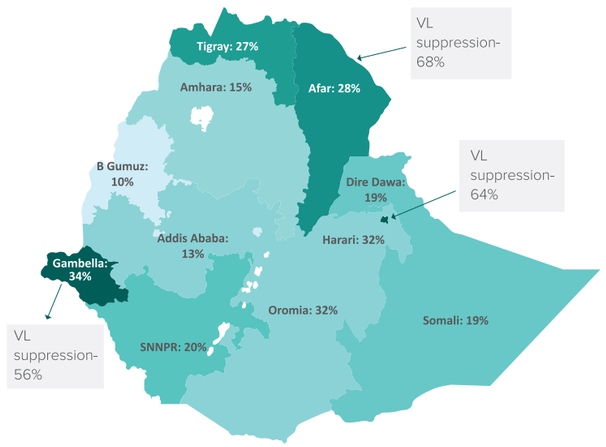
FIGURE 5A: NEW HIV INFECTIONS: GENERAL POPULATION AND ADULTS BY GENDER IN ETHIOPIA: 1990-2018



This was also reflected by two of the key informants and two in-depth interview participants. They recognized that there was higher infection among young women than young men. They attributed this to the existence of intergenerational sex and rural-urban migration of young girls whose awareness about HIV, its transmission and its prevention are low. These factors were among those attributed to the higher prevalence of HIV in young women than men[82].

The recent estimate of 13,071 new infections in Ethiopia indicates that there is an ongoing spread of HIV infection in the population; more than 60% of the new infections are occurring in Amhara, Oromia, SNNP, and Tigray. The burden of new infections in absolute numbers in these regions is attributed to their relatively large population size. In terms of incidence rate, other regions such as Gambella and Addis Ababa are more affected. There is also significant variation in the distribution of new HIV infection in the country with Gambella having the highest proportion of recent infection at 34% and compared to Benishangul-Gumuz with the lowest rate at 10% (Fig. 5b)[83]. Consequently, viral suppression is low in regions where the proportion of recent infections is high.

FIG. 5B PERCENT OF PROBABLE RECENT INFECTION BY REGION OF RESIDENCE, JULY 2019- FEB14 2020 (SOURCE: PEPFAR)[84]



Current Region	Percent recent	Recent	RTRI Valid
Gambella	34%	36	105
Harari	32%	14	44
Afar	28%	12	43
Tigray	27%	63	234
SNNPR	20%	79	392
Somali	19%	8	43
Dire Dawa	17%	14	81
Oromia	16%	163	1039
Amhara	15%	103	704
Addis Ababa	13%	174	1300
Benisghangul - Gumuz	10%	4	411

10% Min — Diverging — 34% Max

The number of new HIV infections has decreased between 1990 and 2018, but more in adult men than adult women and even less among young women than young men. The number of new infections decreased by 21% from 29,000 in 2010 to 23,000 in 2018. However, there was only a 14 % reduction in new HIV infections from 14,000 to 12,000 among adult women during the same period as compared to a 27% reduction from 15,000 to 11,000 among adult men. There was only a 16 % reduction in new infections among young people (15 – 24 years) from 9,300 to 7,800 and only a 13% reduction among young women as compared to a 17% reduction among young men. These data indicate that the reduction in new HIV infections from 2010 was more in men than in women[85]. Figure 5c shows the trend in new HIV infection disaggregated by age and sex (1990 – 2018).

FIGURE 5C: NEW HIV INFECTIONS IN ADOLESCENTS (10-19 YEARS) IN ETHIOPIA: 1990-2018

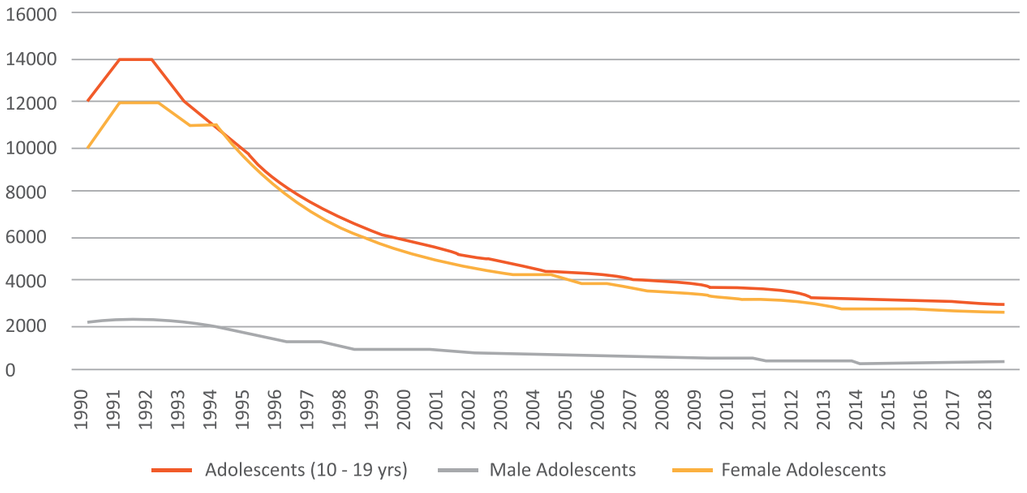
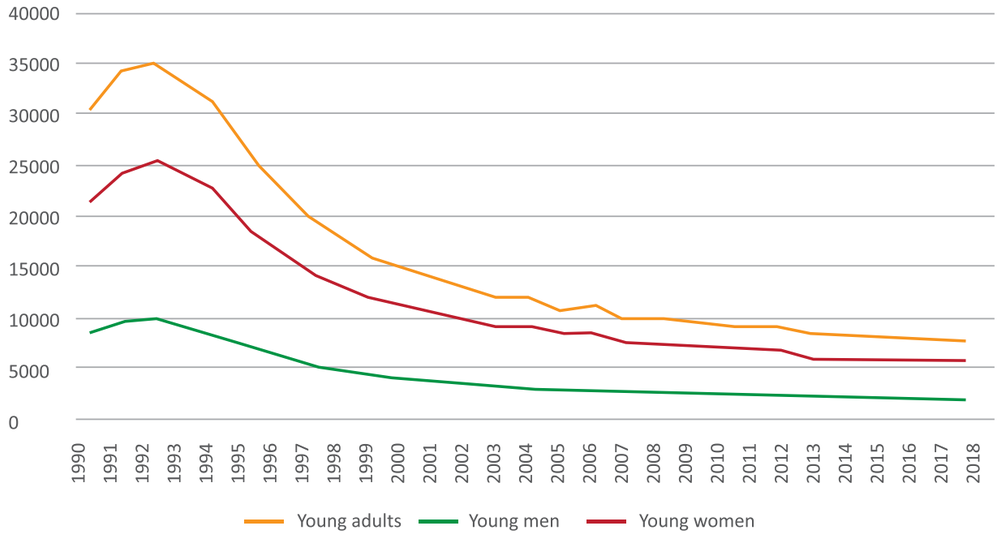
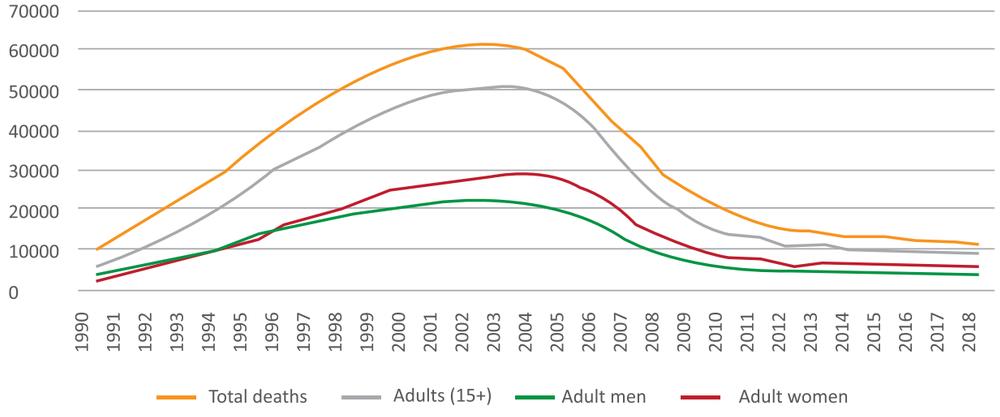


FIGURE 5D: NEW HIV INFECTIONS AMONG YOUNG ADULTS IN ETHIOPIA: 1990-2018



There has been progress made in the number of AIDS-related deaths since 2010. However, there was a lesser reduction among adult women and even lesser among young women than among adult men and young men. While there has been a 45% decrease from 20, 000 deaths in 2010 to 11 000 deaths in 2018 in the general population there has been only a 36% reduction among young people. AIDS-related death among adults reached a peak in 2003 with 51,000 deaths. There has been a reduction of 82% of deaths from 2003 to 2018 both among adults more than 15 years and female adults. However, the reduction in AIDS-related deaths was only 50% during the same period among young adults and adolescents[86]. Unfortunately, we could not find data regarding the reasons behind this lower reduction in mortality among young adults and adolescents. Fig. 6. summarizes the trend in AIDS-related deaths in Ethiopia disaggregated by sex.

FIGURE 6: AIDS-RELATED DEATHS AMONG ALL THE AGE GROUPS AND ADULTS IN ETHIOPIA: 1990-2018



With a reduction in HIV related deaths, the number of AIDS orphans has decreased significantly from 590,000 at its peak in 2007 to 290,000 in 2018, a 51% reduction in a decade.

8.1.2 KEY AND PRIORITY POPULATION GROUPS

Ethiopia's National HIV Prevention Road Map 2018-2020 has defined key and priority population groups considering local epidemiology. The key populations in Ethiopia are defined as FSWs and prisoners. Priority populations are widowed, separated or divorced women, long-distance drivers, PLHIV and their partners, and mobile and resident workers in hotspot areas. Adolescent girls and young women involved in transactional sex, and vulnerable adolescent girls and young women are also given due attention and prevention programs targeting this population group taken as one of the pillars. These population groups have a high risk of HIV infection, limited access to services, and some face stigma and discrimination though there is critical lack of evidence locally[87].

There were an estimated 210, 967 FSWs in Ethiopia in 2018[88]. There are no systematic estimates on the size of other key and priority populations. Estimates also show that there were 45,000 prisoners[89] and 15,000 long truck drivers in 2014[90] in Ethiopia. There are also 1,000,000 mobile and resident workers in hotspot areas by 2017[91]. HIV prevalence among key and priority populations was higher than the general public. Surveys have shown that the prevalence of HIV infection was 23% in self-identifying FSWs, 4.5% in truck drivers[92], 4.2% in prison settings[93], and 5.7% HIV among mobile workers. HIV prevalence among prisoners was estimated to be 4.2% (4.3% in males vs. 3.8% in females). This was higher than the global average of 3% for the same population group. The prevalence was greater in federal prisons (4.5%) compared with regional prisons (2.5%). The highest was reported among prisoners in Gambella (11.4%)[94].

On the other hand, no national data is indicating the prevalence of HIV in people who inject drugs. A survey involving 237 people done in 2015 in Addis Ababa showed an HIV prevalence of 6%[95],[96] which is lower than the global estimate and estimates of neighboring countries, 18.3% in Kenya, and 42% in Tanzania[97]. This study showed that HIV prevalence was higher among females who inject drugs even if only 4% of the study population were women (like the other studies in Africa which this study cites). It has also shown that there was a higher practice of needle sharing (60%) among those persons who were HIV-positive[98].

8.1.3 KNOWLEDGE ABOUT HIV

Knowledge about HIV transmission and prevention was higher among adult men than among women. According to EDHS 2016, 20% of women age 15-49 and 38% of men age 15-49 had comprehensive knowledge about the modes of HIV transmission and prevention. Forty-nine percent of women and 69% of men knew that consistent condom use and having sex with only one uninfected partner can reduce the risk of HIV infection; 58% of women and 77% of men knew that using condoms during sexual intercourse can reduce the risk of HIV. Also, 69% of women and 81% of men identified limiting sexual intercourse to one uninfected partner with no other partners can reduce the risk of HIV. There is an increasing trend in knowledge about HIV prevention methods both among women and men, but more in males than females[99], correlating with a change in HIV prevalence, incidence, and AIDS-related deaths.

FIGURE 7: PERCENTAGE OF WOMEN AND MEN AGE 15-49 WHO HAVE KNOWLEDGE OF HIV PREVENTION METHODS: EDHS 2000-2016

More young men have comprehensive knowledge than young women. According to EDHS 2016, Knowledge about HIV prevention among young people aged 15 – 24 was 30.5% and knowledge about HIV prevention among young women and men aged 15 – 24 was 24.3% and 39.1%, respectively[100].

The gender disparity in knowledge about HIV prevention methods persisted among age groups, regions, educational level and wealth quintile. Among women, knowledge of HIV/AIDS prevention decreases with age; 52% of women age 15-24 know that using condoms and limiting sexual intercourse to one uninfected partner can reduce the risk of HIV, compared with 43% of women age 40-49. Knowledge of the two methods of HIV prevention is higher among urban women and men than rural women and men. There are notable differences in knowledge of HIV/AIDS prevention methods by region, ranging from 66% among women and 84% of men in Tigray compared with 10% of women and 38% of men in Somali. For women and men, knowledge of prevention methods increases with education and wealth quintile[101]. However, the literature search failed to identify data, either national or local, on the reasons behind these disparities.

Men are likely to have more lifetime sexual partners than women and they are more likely to use condoms. According to EDHS 2016, The mean number of lifetime sexual partners among men (at 2.9) was more than among women (at 1.6). Less than 1% of women aged 15-49 and 3% of men reported having two or more sexual partners in the 12 months before the survey, and 2% of women and 7% of men had sexual intercourse in the past 12 months with a person who was neither their spouse nor lived with them. Among women with a non-marital, non-cohabiting partner, 20% of women and 51% of men reported using a condom during last sexual intercourse with such a partner[102].

Young men (15 – 24 years) are more likely to have more lifetime sexual partners than young women and they are more likely to use condoms. According to EDHS 2016, the mean number of lifetime sexual partners among young men (at 2.2) was more than among women (at 1.3). Slightly more than 2% of young men and 0.3% of young women reported having two or more sexual partners in the 12 months before the survey, and 9 % of young men and 2.8 % of young women had sexual intercourse in the past 12 months with a person who was neither their spouse nor lived with them. Among young men and young women with a non-marital, non-cohabiting partner, only 45.5 % and 21.8 %, respectively, reported using condoms during last sexual intercourse with such a partner[103].

There was the consistent use of condoms among FSWs. However, there are worrying signs that this practice might be declining. According to the 2013 national MARPs survey among FSWs from 89 towns in the nine regions and two city administrations, 98.8% of FSWs used condoms[104]. There are no recent nationally representative surveys. However, there are small scale studies that reported lower rates. Studies from Dire Dawa and Gondar showed that less than two-thirds (64.1%)[105] and less than half (48%)[106] of FSWs, respectively, used a condom with all partners.

There was no data regarding knowledge about HIV, attitude, and sexual practices among other priority populations and other globally recognized key populations and their sexual partners as they have not been studied.

This lack of data was also recognized by key informant participants. They underscored the relationship of the lack of data to the criminalization of these practices.

> **"Holding and using drugs, having sexual relationship except with the other gender is illegal in Ethiopia, making the collection of routine data and survey data among these group of populations difficult" [KII-1]**

8.1.4 GENDER-BASED VIOLENCE

Gender-based violence is still common in Ethiopia with 1 out of 4 (26 percent) of women age 15 – 49 experiencing physical and/or sexual violence by an intimate partner or non-partner in their lifetime. According to EDHS 2016, 23 % of women experienced physical violence since age 15 and 10 percent experienced sexual violence at some point in their lifetime by either a husband or anyone else. Four percent of women experienced physical violence during pregnancy. GBV is also common after marriage. Among ever-married women age 15-49, as many as 1 in 3 or 34 percent ever experienced spousal violence in the form of emotional, physical and/or sexual violence by their current or most recent husband/ partner (24 percent of ever-married women experienced emotional violence by their current or most recent husband/ partner, 24 percent experienced physical violence, and 10 percent ever experienced sexual violence)[107]. Despite scarcity of national level evidence, males also face sexual violence in Ethiopia. A study in Addis Ababa showed a 4.3%, and 68.2% life time prevalence of rape and sexual harassment respectively among boys[108]. The problem is more prevalent and diverse among street children in Addis Ababawith upto 28.6% of male street children being sexually abused[109].

A recent meta-analysis of 36 published articles with 23,782 participants (published in 2020) showed a higher figure than reported by EDHS. It showed that the overall pooled lifetime and the past 12 months VAW prevalence was 46.93% and 37.02%, respectively. The meta-analysis also showed that pooled lifetime physical, sexual and psychological violence were 38.15%, 39.33%, and 39.51%, respectively and the pooled lifetime prevalence of rape was 13.02%. According to this meta-analysis, nearly half of Ethiopian women experience lifetime violence against women, with substantial levels of physical, sexual, or psychological violence[110]. There was no national data on the pattern of violence against FSWs. However, local studies in Mekele, Adama, and Bahir Dar cities reported a prevalence rate of violence of 76%[111], 59%[112], and 24.5%[113], respectively.

When it comes to the association between GBV and HIV, evidences show that though women can become infected with HIV through rape or forced sex, a number of indirect pathways appear to be far more significant than the direct ones including sexual abuse in childhood which may lead to a range of risk behaviours – such as earlier sexual debut, more sexual partners and substance use. Another indirect pathway is that men and boys who abuse women and girls are themselves more likely to be HIV positive, which in turn increases risk of HIV acquisition among their partners[114]

8.2 SOCIAL, CULTURAL AND ECONOMIC FACTORS

8.2.1 SOCIAL AND STRUCTURAL DETERMINANTS

Poverty affects women more than men in Ethiopia. Ethiopia is one of the countries which has shown a significant reduction in the poverty level. According to the 2019 Human Development Report, Ethiopia ranked 173 with a human development index (HDI) of 0.47 in 2018. Its HDI has progressively increased from 0.283 in 2000 to 0.470 in 2018. However, the HDI was lower for females (0.428) than for males (0.507). According to the same report, estimated gross national income per capita (GNP) according to 2011 PPP $ equivalent was USD1,333 for females while it was USD 2,231 for males[115]. However, the Ethiopia Poverty Assessment Report of the World Bank Group for 2019 has indicated that poverty is lower for female-headed households (19%) than for male-headed ones (25%)[116]. This should, however, be analyzed together with the Ethiopia Gender Diagnostic Report of the World Bank Group (2019) which has shown that female farmers are less educated, have lower access to land and finance, less likely to attend extension programs and use agricultural inputs like fertilizers, pesticides, and herbicides, with lower agricultural productivity than male farmers[117].

According to the 2019 Human Development Report, Ethiopia's gender inequality index (GII) is among the lowest at 0.508 in 2018, ranking 123rd from 162 countries[118]. According to UNDP, the GII measures gender inequalities in three important aspects of human development: reproductive health, women empowerment, and economic status. Reproductive health is measured by maternal mortality ratio and adolescent birth rates. Women empowerment is measured by the proportion of parliamentary seats occupied by females and the proportion of adult females and males aged 25 years and older with at least some secondary education. Economic status is expressed as labor market participation and measured by labor force participation rate of female and male populations aged 15 years and older. GII measures the human development costs of gender inequality: the higher the GII the more disparities between females and males and the more loss to human development[119].

The existing gender inequality affects HIV prevention and control efforts. Studies are indicating the interface and complex relationships between gender inequality, power relations, and HIV in Ethiopia. For instance, Ayalew et al noted that inequitable gender norms govern HIV prevention, sexual intercourse, and physical violence in Ethiopia. They also noted that though there were many laws and policies in Ethiopia to ensure gender equality and women's empowerment, their implementation was limited[120].

Ethiopia has shown significant improvement in almost all spheres of HDI in the last two decades but performed badly on almost all three important aspects of human development which are used to measure gender inequalities. The maternal mortality ratio in Ethiopia, at 353 per 100,000 life birth was among the highest in the globe[121]. Adolescent birth rate (66.7 births per 1,000 women ages 15–19) was also among the highest. Women's participation in parliament stands at 37.5%, ranking 19th globally[122]. Only 11.5% of women aged 25 years and above had at least some secondary education while 22% of men of the same age had some secondary education, indicating that the female to male ratio was 0.52[123]. While 74.2% of females aged 15 and above participate in the labor force, 86.5 % of males of the same age do so[124].

Women and girls in Ethiopia are strongly disadvantaged compared to boys and men in several areas, including literacy, employment, health, and livelihoods. Female to male ratio in gross education enrollment was 0.95, 0.91, and 0.96 at pre-primary, primary, and secondary education, respectively[125]. Youth unemployment was 1.8 times more common in females than in males while total unemployment was 1.85 times more common in females. Females spent on average five hours per day more than males aged 15 years and above on unpaid domestic chores and childcare work, almost three times more than what males spent on similar activities in 2018[126].

> **“women are economically dependent on males. This has affected their risk of acquiring HIV infections. … I know of an instance where a woman got married to a male person who was living with HIV even though she knew that he was living with HIV” [IDI -1]**

HIV-related comorbidities affect women and girls more than men and boys in Ethiopia. For instance, cervical cancer was the second-most common cancer and second-deadliest cancer among Ethiopian women. This has to be viewed because cervical cancer is a quite common condition affecting WLHIV.

Access to sexual and reproductive health services is low. In 2018, the adolescent birth rate was 66.7 per 1000 live births. Antenatal care coverage, defined as at least one visit to a health facility was 62.4% while the proportion of births attended by skilled health personnel was 27.7%. Contraceptive prevalence stood at 40.1 % while unmet need for family planning was 20.6%[127].

8.2.2 ACCEPTANCE OF GENDER NORMS AND PRACTICES

Gender norms which are directly or indirectly related to HIV are quite common in Ethiopia. These gender norms include early marriage, harmful traditional practices, and cultural norms on sexuality and gender roles that contribute to creating barriers for HIV prevention and contributing to increasing the risk of HIV transmission in women and girls. All these norms are more common among rural women and girls than urban ones[128].

Women tend to marry considerably earlier than men. According to EDHS 2016[129], the median age at first marriage in Ethiopia was 17.1 years among women age 25-49 and 23.8 years among men aged 25-59. Fifty-eight percent of women and only 9% of men age 25-49 marry before their 18th birthday. The median age at first marriage among women age 25-49 has increased slightly since 2011, from 16.5 years to 17.1 years. During the same period, the percentage of women marrying before age 18 has declined from 63% to 58% though still very high. Eight percent of women married before their 15th birthday in 2011, as compared with 6% in 2016. If we consider absolute numbers, these figures may not show significant reductions to indicate improvements between 2011 and 2016. Among men aged 25-59, the median age at first marriage increased slightly from 23.1 years in 2011 to 23.8 years in 2016. When the data is analyzed by a cohort of women, defined by their age at the moment of the interview, those changes look more dramatic. The result shows that the percentage of women 45-49 married before age 15 is 29%, while this indicator is 14% for women 20-24 and 6% for the youngest women (15-19)[130].

Women living in urban areas marry later than women living in rural areas. The median age at first marriage is 2.6 years older among urban women than rural women (19.3 years versus 16.7 years). Median age at first marriage varies by region, from 15.7 years among women in Amhara to 23.9 years among women in Addis Ababa. Median age at first marriage increases with increasing education, from 16.3 years among women with no education to 24.0 years among women with more than secondary education[131].

According to EDHS 2016, 63% of Ethiopian women age 15-49 believe that a husband is justified in beating his wife in at least one of the five specified circumstances (she burns the food, she argues with him, she goes out without telling him, she neglects the children, and she refuses to have sex with him), compared with 28% of men. The percentage of men justifying wife-beating in at least one of the five specified circumstances has decreased significantly over time, from 76% in the 2000 EDHS to 28% in 2016 EDHS. The percentage of women who agree that wife-beating is justified in at least one of the five specified circumstances has also declined but at a much slower rate than among men, dropping from 85% in 2000 EDHS to 63% in 2016.

Tolerance of wife-beating is less common among women employed for cash than among other women – women employed who do not get cash and those who were not employed at all. According to EDHS 2016, 55% of women who are employed for cash agree that wife-beating is justified in at least one of the five specified circumstances, compared with 71% of women employed but not earning cash and 63% of women who are not employed. Wife beating is more acceptable in rural areas than urban areas; 70% of women and 31% of men in rural areas agree that wife-beating is justified in at least one of the five specified circumstances, compared with 39% of women and 15% of men in urban areas. Acceptance of wife-beating by women varies widely across Ethiopia’s regions. Just over two-thirds of women in Affar and Oromiya (69% each) agree that wife-beating is justified in at least one of the five specified circumstances, compared with 23% of women in Addis Ababa. Acceptance of wife-beating decreases with increasing education level and wealth quintile. For example, 72% of women with no education agree that wife-beating is justified in at least one of the five specified circumstances, compared with 26% of women with more than secondary education. Similarly, 71% of women in the lowest wealth quintile agree that wife-beating is justified in at least one of the five specified circumstances, as compared with 43% of women in the highest wealth quintile.

In general, the findings of the key informant interview indicated that there were gender norms and practices in Ethiopia which were barriers to HIV prevention, increase risk of HIV transmission, and reduce adherence to care and treatment. KIIs suggested mechanisms through which these norms and practices affect the above factors. Accordingly, Women are more likely to contract HIV infections because of existing socio-cultural norms and harmful traditional practices that perpetuate gender inequality, women’s inferior status, domestic violence, and negative attitudes against women and girls. Culturally accepted norms and strongly held gender-discriminatory beliefs, sexual violence, and negative stereotypes of women, as well as traditional practices including child/early forced marriage, female genital mutilation/cutting, widow inheritance, are known to increase the risk of HIV transmission. It has also to be noted that women and girls are forced to sell sex because of the poverty they have.

8.2.3 STIGMA AND DISCRIMINATION

Despite legal and policy protections against stigma and discrimination toward PLHIV, there is still widespread stigma and discrimination toward PLHIV. The 2016 EDHS found that discriminatory attitudes are higher in women than in men. For instance, 48% of women and 35% of men thought that children living with HIV should not be able to attend school with children who are HIV negative, while 55% of women and 47% of men would not buy fresh vegetables from a shopkeeper who has HIV. Considerable differences in discriminatory attitudes are observed between urban and rural areas; 28% of women and 27% of men in urban areas have discriminatory attitudes, compared with 73% for women and 60% for men in rural areas. Discriminatory attitudes are higher in the Somali Region (78% for women and 73% for men), and lower in Addis Ababa (18% for women and 17% for men). Discriminatory attitudes decrease with education level; 80% of women and 67% of men with no education have discriminatory attitudes, compared with 12% of women and 20% of men with more than secondary education. Discriminatory attitudes decrease with wealth quintile. The discriminatory attitudes toward PLHIV decreased from 81% and 67% among those in the lowest wealth quintile to 33% in the highest wealth quintile among women and men, respectively.

In addition to the EDHS, the 2011 PLHIV stigma index indicated that stigma and discrimination were common in Ethiopia and had multiple manifestations[132]. According to this study, PLHIVs felt that stigma and discrimination was reducing, but still prevalent. However, stigma was more felt in PLHIVs living in Gambella, Benshangul Gumuz, and Somali regions. Participants of the Stigma index study noted that there was no significant difference between men and WLHIV. However, the literature search did not show recent studies.

8.3 LEGAL AND POLITICAL FACTORS

8.3.1 LAWS OR POLICIES THAT MAY DIRECTLY AFFECT WOMEN AND GIRLS, MEN AND BOYS AND KEY POPULATIONS CONCERNING HIV

Ethiopia's commitment towards curbing gender-discriminatory systems or acts is supported with its signatory for international and regional agreements that promote and protect women's rights, including the Convention on the Elimination of Discrimination against Women[133], and the Protocol to the African Charter on the Rights of Women in Africa[134]. The country has also ratified the Maputo Protocol on African Women's Rights[135].

The 1994 constitution of Ethiopia promotes the equality of men and women in the socio-economical, legal, and political system. The constitution grants equal citizenship rights for both men and women; automatically forbids gender-based discernment; affirms women's equal rights during marriage, divorce, and decision-making during the marriage; and more specifically grants affirmative action against women as compensation for historical discriminations. Polygamous marriage is considered a criminal act in Ethiopia except in cases where polygamy is recognized under civil law in conformity with tradition and moral usage" (Article 617)[136]. Though the constitution doesn't address it, homosexuality is a punishable act in Ethiopia with simple imprisonment as indicated under the Penal Code of Article 600[137]. The book also addresses the state's obligation for eliminating traditions or norms that harm women mentally or physically[138]. Though marital rape was not boldly addressed by the country's Penal Code, it is punishable following the ratification of the Maputo Protocol on Women's Rights[139].

In addition to the Constitution, the Women's Policy of Ethiopia reiterates the Government's commitment to gender equality[140]. According to the 2000 revised family law of Ethiopia, women are entitled to spousal property rights if they lived with their partners for three years or longer[141]. The 2004 Penal Code of Ethiopia also gives protection to women against violence. The new Code states that "sexual violence against women and minors, and harmful traditional practices (HTPs) such as female genital mutilation (FGM), and early marriage and abduction [including with the intent to marry] practices to which women and girls are especially vulnerable are punishable by law"[142].

Ethiopia has recognized HTP in different national policy documents as a detrimental factor to the status of women and girls and the violation of their rights. HTPs have been given attention to be dealt with appropriate policies and strategies. In this regard, the 1993 National Policy on Ethiopian Women and the 1997 Culture Policy[143] aimed to eliminate or abolish all forms of harmful traditional practices while the 1993 Ethiopian Health Policy aspires the equality of women and the provision and expansion of health services to the most vulnerable and marginalized section of the society most importantly women and children. Similarly, the 1993 National Population Policy[144] intended to remove all customary practices against the full enjoyment of economic and social rights by women. The 1994 Education and Training Policy[145] recognizes that education enables men to identify HTPs and fight them while the 1996 Developmental Social Welfare Policy provisions appropriate measures to be taken to protect women from social problems through designing educational programmes towards eliminating HTPs. The 1998 Policy on HIV/AIDS also recognizes that, although smaller in magnitude, harmful indigenous practices are important causes for HIV transmission in Ethiopia and states that appropriate measures shall be taken to stop HIV transmission through HTPs.

The National Strategy for the Elimination of HTP envisions to see a society free of all forms of HTPs in which women and children enjoy their human rights and economic and social opportunities without compromising their life choices[146]. The country has also launched a roadmap to end CM and FGM (2020–2024) that aims to eliminate child marriage and FGM/C by 2025 in line with SDG 5 that targets to eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation[147]. The general objective of the strategy is to institutionalize mechanisms to create an enabling environment for the prevention and elimination of all forms of harmful traditional practices and to ensure the availability of multi-sectoral mechanisms to support women and children through prevention, protection and the provision of services[148]. The road map focuses on empowering adolescent girls and their families, ensuring community engagement, enhancing systems, accountability and services across sectors, creating and strengthening an enabling environment and evidence-informed decision making[149].

Youth participants of the 'Intergenerational dialogue on Gender Equality' organized by UNW and Center for Human rights – AAU March 2020
Photo Credit-Biniam Masresha / UN Women

Ethiopia has also put the obligatory institutional mechanisms in place at federal and regional levels, such as the Ministry of Women, Children, and Youth Affairs Offices; Child and Women Protection Units within various police units; and a Special Bench that deals with violence against women cases within the federal criminal court[150]. In line with such constitutional orders, the different policies and strategies of the country have adopted the laws even down to the program level. The Federal Democratic Republic of Ethiopia (FDRE) has declared its commitment to gender equality with the announcement of the National Policy on Women[151]. Accordingly, assurance of health care for all segments of the population is one of the top priorities in Ethiopia's Health Policy and it states that special attention shall be given to the health needs of women and children among others[152]. The promotion of women, youth, and other vulnerable segments of the population received significant attention in Ethiopia's Growth and Transformational Plan (GTP) which is a key step towards achieving the state's development goals[153]. In 2017, the country has also designed a Development and Change Strategy for women[154]. The strategy aims to ensure that women have equal participation in the country's socio-economic and political development and leadership. The strategy document also aspires to bring attitudinal change with regards to gender in the society through building the confidence of and empowering women and bringing change on the patriarchal gender stereotype; to ensure women's participation in the economic, political, leadership, and structural developments, and maximizing their benefits; and ensure the participation and benefit of women and girls that need special attention including street children and women, women with disability, women living with HIV, FSWs, returnees from migration, and victims of HTPs among others.

Multiple legal provisions have direct relevance to HIV among women and girls. Ethiopia does not have VAWG legislation or domestic violence laws. However, multiple laws address gender-based violence. There are also legal provisions to ensure gender equality and women empowerment. The Revised Family Code Proclamation No. 213/2000 is one such legal instrument that ensures gender equality. The Family Code sets the minimum age of marriage to 18. The Family Code gives women the right to access, use, and control property, including land.

The Revised Criminal Code criminalizes sexual violence (Articles 620-628), intimate partner violence in the context of marriage or irregular union, in the event the violence leads to grave or common injuries to physical or mental health (Article 564), and violence leading to physical injury and/or mental health problems outside the context of intimate partner relationships (art. 555-560). Although rape is addressed in Article 620, the language limits its scope to rape "outside of wedlock"; thus, the law does not recognize rape within the context of marriage or irregular unions. The Code defines irregular union as a situation "when a man and a woman live together as husband and wife, on a day-to-day basis, sharing the same roof in the same house considering themselves as married". However, the law fails to define the duration of this union.

Sexual harassment has also been addressed in the Revised Penal Code of 2005. However, the law only covers circumstances whereby a person in a position of authority demands sexual favors in return for other benefits. Excluded from the law are situations of sexual harassment whereby hostile working, living, and/or learning environments are created due to the threat caused by demands of sexual favors. Sexual harassment is categorized as a crime punishable with simple imprisonment, a treatment that some national VAWG experts contend is not commensurate with the crime and debilitating impact that sexual harassment can have on women and girls who are most often the victims of sexual harassment. Also, neither the RFC of 2000 nor the RCC of 2005 adequately address psychological violence and/or economic violence against women in the context of marriage and family.

Harmful traditional practices that constitute different forms of VAWG are also addressed in the revised Family Code and the revised Penal Code. These Codes address: crimes against persons or health with particular provisions on abduction (Articles 587-590); female genital mutilation (Articles 565 and 566); early marriage (Article 649); and endangering the lives of pregnant women and children through harmful traditional practices (Articles 561 and 562). The RFC of 2000, in particular, requires the fulfillment of essential conditions of marriage (age and consent), thereby banning child, early, and forced marriage. However, these laws fail to treat some forms of VAWG as serious crimes, particularly when the act of violence does not cause bodily injury or impairment of health. Depending on the severity of injuries and/or damages inflicted, legal penalties can range from small fines to imprisonment for up to 5 to 20 years.

Although acts of sexual violence, domestic violence, sexual harassment, and harmful practices are illegal under the law, government enforcement of such laws is inconsistent. The challenge for VAWG survivors is access to justice, as cases of domestic violence and rape are often given a low priority in the justice system and face significant delays due to, in part, poor documentation and inadequate investigation. Some of the barriers to reporting among survivors include perceived and experienced stigma in health settings and in the wider community, lack of awareness of services, and inability to protect children while mothers sought services[155].

"Despite these incredibly good laws, the practice of violence against women and girls is high in Ethiopia. There might be many reasons. However, one important reason is that they remain unreported. … Why the incidences remain unreported? … Because the perpetrators are not accountable, because the cases are not taken seriously by the police. Because the police compare them with other crimes that they consider are more serious. And in some instances, because the victims are harassed by the police themselves. … I think the capacity of the first responders should be built" [KII-5]

There are strong punitive measures towards drug traffickers and people who use drugs in Ethiopia. Under Ethiopian law, drug use and the possession of even small amounts of drugs are criminal offenses – and no distinction is made between possession and trafficking offenses. Article 525 of the revised Penal Code of Ethiopia stipulates that "Whoever plants, buys, receives, makes, possesses, sells or delivers [drugs] to be privately used by himself or another; or uses or causes to be used one of these substances without medical prescription or in any other unlawful manner, is punishable with rigorous imprisonment not exceeding seven years, and fine not exceeding fifty thousand Birr." It is also an offense to own injections such as needles and syringes.

The purposeful transmission of communicable diseases is illegal in Ethiopia. Article 503 of the revised penal code penalizes the transmission of communicable diseases knowingly.

Homosexuality is a criminal activity in Ethiopia. Penal Code of Art. 600. – "Whosoever performs with another person of the same sex an act corresponding to the sexual act, or any other indecent act is punishable with simple imprisonment."

Sex work is not criminalized in Ethiopia. However, other associated activities are criminalized. For instance, Article 604 prohibits "Whoever, for gain, makes a profession of or lives by procuring or on the prostitution or immorality of another, or maintains, as a landlord or keeper, a disorderly house". However, there are other laws against public indecency and outrage of morals that could be used against sex workers.

However, at least one of the key informants argued that this should not be an excuse not to provide services for key and priority populations:

> **"even if it is an offense to carry drugs and not reporting such practices, there are constitutional provisions on the universal coverage of health services. Health is a human right and the State has the obligation to ensure universal health and other social services regardless of any attributes of the citizens. There are also legal provisions in the civil and criminal codes of the country that protects the confidentiality of medical information gained during professional practice. Health professionals are obliged to keep the information they got during their practice and they have legal protection against such disclosure." [KII-2]**

The penal code of the country penalizes polygamy (Article 616). However, it provides an exception to "cases where polygamy is recognized under civil law in conformity with tradition and moral usage" (Article 617). The Revised Family Code (Proclamation No. 213/2000) prohibits polygamous marriage (Article 11). Article 33 also provides that a polygamous marriage would be dissolved. While polygamous marriage is formally abolished by the above provision, the practice is still common in Ethiopia. EDHS 2016 reported that 11% percent of currently married women age 15 – 49 reported that their husband has multiple wives while 5% of men reported having more than one wife. The percentage of women who report being in a polygynous union has declined slightly over time, from 14% in 2000 and 12% in 2005 to 11% in both 2011 and 2016. Older women are much more likely than younger women to have co-wives. The percentage of women with co-wives ranges from 4% among those aged 15-19 to 18% among those aged 45-49. Women living in rural areas are more likely to report having co-wives (12%) than women living in urban areas (5%). The Somali region has the highest percentage of women who report being in a polygynous union (29%) while the Amhara region has the lowest percentage (1%). Women with no education were much more likely to have co-wives (14%) than women who have attended school (7%).

8.3.2 LEGAL FRAMEWORKS THAT PROTECT THE RIGHTS OF PLHIV, WOMEN AND GIRLS AND OTHER KEY POPULATIONS

There are legal frameworks that protect the rights of PLHIV and women and girls; however, there are no similar protections to the rights of key populations, including FSWs. Ensuring the human rights of PLHIV is one of the policies in the National HIV Policy of Ethiopia.

> **"well, there are so many laws and policies that protect the right of PLHIV and women and girls. The only problem probably is their enforcement" [KII-4]**

The Constitution of the Federal Democratic Republic of Ethiopia, the supreme law of the land, contains multiple articles and sub-articles regarding gender equality and women empowerment. These articles of the Constitution underscore that women and men have equal rights and protection as provided for by the constitution. Particularly, they have an equal rights to that of men in marriage and divorce and to get equal wages. The constitution calls for affirmative action to compensate for past and current constraints that have inhibited women from achieving their potentials. It also provides protection against harmful traditional practices. It also provides for the right to the full consultation in the formulation of national development policies, the designing and execution of projects, and particularly in the case of projects affecting the interests of women. In general, the Constitution provisions the equal participation of women with men in all economic and social development endeavors. It has also provisions to protect women from all forms of violence, including gender-based violence, and harmful traditional practices.

Ethiopia has ratified several international and regional treaties and commitments that ensure gender equality and women empowerment and protect women from all forms of violence including gender-based violence. These include Convention for the Elimination of All Forms of Discrimination against Women, the Beijing Platform for Action, the Sustainable Development Goals, and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women. These international and regional treaties and commitments are instruments to ensure gender equality and women empowerment.

There are also several laws and proclamations in the country to protect the rights of women and to ensure gender equality and women empowerment. The Rural Land Administration and Use Proclamation have provided women with ownership rights to rural land. The country has made labor law reforms to ensure the equal participation and benefit of women in the labor force. The Civil Servant Proclamation has provided for affirmative actions in recruitment, promotion, transfer, redeployment, education, and training of women. Labor Law recognizes the special needs of women workers. It prohibits discrimination based on sex, promotes affirmative action, and provides for extended maternity leave. The Revised Family Code gives women the right to access, use, and control property, including land.

The awareness about these policies and legal provisions among the public and even government officials is limited.

> **"The question now is: Are the public or more importantly women and girls, men and boys aware of the existence of such laws that protect their rights and ensure gender equality and women empowerment?" [KII-1]**

Some multiple policies and strategies are enacted to ensure gender equality and women empowerment. The National Policy on Ethiopian Women, the National Population Policy, Ethiopian Education and Training Policy are some of the national instruments enacted by the Government of Ethiopia to address issues related to gender equality and women empowerment in the country. The national micro and small enterprise strategy resulted in the economic empowerment of women ensuring access to finance through saving and credits, capacity building and training in business and entrepreneurship, and creating and strengthening market access for women entrepreneurs. The Growth and Transformation Plans of the country recognize that the successful implementation of the plan calls for the active participation of women. Gender equality and women empowerment are one of the seven pillars of both the first Growth and Transformation Plan and of the nine pillars of the second Growth and Transformation Plan.

All ministries are expected to mainstream gender in all the policies, laws, development programs, and projects they formulate. They should benefit women, children, and youth. Each sector is expected to develop its mainstream guidelines. However, the accountability mechanisms are not well crafted and put in place.

The Government of Ethiopia has also undergone significant structural changes to ensure gender equality and women empowerment. It has established the Ministry of Women, Children, and Youth at the federal level, Bureaus of Women, Children, and Youth at the regional level, and Women Affairs Directorates in all line ministries, agencies, and commissions to ensure the protection of constitutional and human rights of women.

8.3.3 DISCRIMINATORY PRACTICES IN HEALTH-CARE SETTINGS

There are no national recent surveys on discriminatory practices in health care settings toward PLHIV. The 2011 PLHIV stigma Study showed that PLHIV had a relatively better level of confidence in health personnel than any other group. That study found that more than 90 percent of the PLHIV who participated in the survey indicated that they did not face any discrimination at health facilities or denial of services, willingly disclosed their HIV status to a health professional, and got a supportive responses from them. There were small studies done in different parts of Ethiopia that were done after the stigma index study. These studies indicated that there was some sort of stigma and discrimination by health professionals toward PLHIV[156]. For instance, however, these studies are limited in geographical scope and in the number of study participants to reach a meaningful conclusion[157]. One such systematic reviews which were done in Ethiopia to describe international literature reporting on interventions that addressed HIV related stigma and discrimination at healthcare settings identified training popular opinion leaders, modular interactive training, multifaceted educational programs, and contact strategy (Workshops bringing PLHIV and Healthcare workers together) as important interventions to address stigma and discrimination in the healthcare setting[158]. There were no data regarding discrimination against key and priority populations in healthcare settings.

8.4 THE IMPACT OF COVID-19 PANDEMIC

The COVID-19 pandemic has gendered effects. Women, particularly those with low income and those who depend on petty trade, are disproportionately affected. Women are more likely than men to be frontline workers in essential services, to engage in high-contact, economically insecure, informal work, and to get involved in caregiving of those infected by the virus and get diseased. The vulnerability of women to gender-based violence increases and access to maternal, sexual, and reproductive services is significantly affected. Cognizant of this, the Government of Ethiopia has established several task forces, including the COVID-19 Task Force and the Essential Services Task Force that monitors and strategize to mitigate the impact of COVID-19 on essential services including sexual and reproductive, maternal, neonatal and child services. MNCAH service utilization and gender-based violence and access to service by survivors of GBV are among the indicators regularly monitored by these task forces.

8.4.1 COVID-19 AND HIV

Additional precautions are required among PLHIV even if evidence does not exist to show that PLHIV who are clinically and immunologically stable who are on ARVs are at an increased risk of COVID-19 and its complications. There is no global or local data to indicate stable PLHIVs have a higher risk than the general population[159]. However, since the epidemic, in general, has a relatively higher negative impact on PLHIV if infected as their immune system is already weak, they could be more at risk of facing dire consequences or complications related to COVID-19 infection. It could be more life-threatening for them.

COVID-19 related service disruptions may reverse the gains in HIV/AIDS-related deaths. According to modeling exercise organized by the WHO and UNAIDS, there would be more than 500,000 additional deaths because of service disruptions caused by COVID-19 in 2020/21[160] . The same trend may extend for the next five years. According to the same exercise, gains from the successes in the PMTCT program may be lost and the number of HIV infections may increase by 162%. The same model has also shown that possible interruptions in prevention services, such as voluntary medical male circumcision, condom availability, and HIV testing counseling would increase HIV incidence in Sub-Saharan Africa[161].

8.4.2 COVID-19 AND GENDER EQUALITY AND WOMEN EMPOWERMENT

It is expected that COVID-19 will affect women more than men. They are at the forefront of the response to the pandemic as caretakers within and outside the house. Women are at increased risk of loss of livelihoods, resulting in a loss in the gain regarding gender equality and women empowerment.

8.4.3 COVID-19 AND GENDER-BASED VIOLENCE

Anecdotal data and newspaper reports have shown that gender-based violence, particularly intimate partner violence is on the rise. According to a UNWOMEN report[162], there has been an increase in gender-based violence during the COVID-19 pandemic and the lockdown that was undertaken by governments worldwide. It was also reported that services to victims of gender-based violence were disrupted. The disrupted services include services provided at health facilities, judiciary, shelters for survivors, schools and communities.

This increase in GBV due to COVID-19 is also reflected by one of the key informants.

> **"As you might have heard, GBV, particularly intimate partner violence is increasing globally because of the lockdown. Ethiopia is not in total lockdown. However, the movement of people is significantly reduced, increasing the risk of violence against women and girls" [KII-5]**

9. THE NATIONAL HIV RESPONSE

> **"...the African woman has climbed every mountain, walked every pathway, and swum every river to remove the shackles that sought to keep her a passive partner in the transformation of her society[163]."**
>
> H.E. Mrs. Tadellech Hailemichael

9.1 GENDER EQUALITY IN HIV POLICIES AND PROGRAMMES

9.1.1 THE OVERALL HIV RESPONSE

There are critical interventions that should be implemented to address the gender dimensions of HIV including strong and targeted prevention programme that addresses the strategic interests and needs of women and girls; accessible and appropriate treatment, care and support services targeted for women and girls; reducing gender-related barriers including ending stigma and discrimination against women and men living with HIV and key populations at families and community levels; and fighting gender inequality and ensuring women's rights to access and control of resources, access to SRH and rights information and services[164].

The Ethiopian government introduced a five-year national HIV and AIDS strategic plan (2015-2020) to intensify the multi-sectoral response in line with the HIV/AIDS Policy. A Roadmap (2018-2020) was also developed for this strategy with a guiding principle to integrate a gender-sensitive approach that provisions the different needs of women, girls, men, and boys in accessing HIV information and related services. The five-year strategic plan and its roadmap are complemented with the National HIV Service Quality Improvement Toolkit[165] which aimed towards contributing to the provision of standardized high-quality HIV service- for HIV positive pregnant and lactating women, including evidence-based PMTCT service during ANC, labor, and delivery, and postnatal period.

The four strategic objectives of the "HIV/AIDS strategic plan (2015-2020) in an investment case approach" for Ethiopia include:

- Implementing a high impact and targeted prevention program
- Intensifying targeted HIV testing and counseling services
- Attain virtual elimination of MTCT
- Optimize and sustain quality care and treatment

The four priority programs of the prevention program are behavior change communication, condom distribution and use, prevention and control of sexually transmitted infections, and blood safety. The target population group for the behavioral change communication include FSWs, truck drivers, migrant/seasonal/daily laborers, urban and hot spot area dwellers, out of school adolescents, workforces in mega projects and surrounding communities, uniformed forces, prisoners, PLHIV and serodiscordant couples. The country targeted to reach 90% coverage of medium and high risk and vulnerable populations (FSWs, laborers, truck drivers) with comprehensive behavioral and biomedical prevention programs by 2020. Persons with disabilities are also targeted by the behavior change communication (BCC) intervention of the strategic plan through producing disability-focused HIV/AIDS intervention guidelines developed by Federations of Ethiopian National Associations of persons with disabilities. Persons with disabilities are also targeted under the HTC section of the national HIV testing and counseling guideline[166].

However, the attention given to PWDs is still low. HIV would have a greater burden on women and girls with disabilities. As witnessed by key informants, some of the major problems to them include the difficulty of access to HIV testing centers, lack of tailored counseling approaches, poor participation of PLWDs in the national HIV response (during planning, implementation, and monitoring), and limited availability of evidence on the intersectionality between HIV and disability.

> **"It is not uncommon to hear some surprising things about PLWDs and the difficulty of access to friendly services. I had the chance to study the challenges PLWDs face in accessing health services. To your surprise, a pregnant PLWD was told, 'how come you get pregnant?'. Service providers have a wrong attitude or don't expect that PLWDs shouldn't get pregnant. It is an irony that they forgot to avail services that are appropriate to such population segments." [KI-9]**

The same key informant added,

> **"Apart from endorsing the CRPD [Convention on the Rights of Persons with Disabilities], the country doesn't have a comprehensive legal framework for PLWDs. The only law related to PLWDs is the PLWDs' proclamation on the right to employment which is not still comprehensive enough by itself…..There is no legal framework on inclusive education which is one way of ensuring PLWDs' access to education on HIV. There is no also detailed law or legal framework that enforces the ensuring of PLWDs' access to information in a simplified form like for the deaf and the blind."**

On the other hand, the targeted HIV testing employs provider-initiated testing and counseling (PITC) and voluntary counseling and testing (VCT) that aims to reach couples who will get married or remarried, pregnant women, widowed, most at-risk population such as FSWs, daily laborers, and truck drivers, TB patients, STI cases, discordant couples, orphans and vulnerable children, sexually active high school and university students, HIV Exposed children/contacts/family index cases, adults or adolescent with medical indications or suggestive signs & symptoms of HIV, uniformed forces, and prisoners.

While the 2015-2020 national HIV strategic plan addresses young people aged 15-24 and the childbearing age group of 15-49 years with gender equality being part of the agenda, older people seem to be neglected. According to the Ethiopia Population-Based HIV Impact Assessment (EPHIA 2017-2018)[167], the prevalence of HIV is much higher among those aged 50-64 years at 4.4% compared to those aged 15-49 and 0-14-years groups at 2.9% and 0.3% respectively. Besides, strategies are not indicated on how the national HIV response addresses the needs of men and boys versus women and girls differently. In this regard, apart from targeting for an intensified effort to fight FGM and integration of girls' clubs in schools and scaling-up and implementation of HIV prevention interventions targeting particularly adolescent girls and young women as priority population groups[168], the different strategic documents fail to identify impactful strategies to address the strategic and practical needs of women and girls at individual, household, and community levels[169]. The traditional way of targeting to reach boys and girls through similar strategies disregards the critical gender dimension within the younger age cohorts.

According to findings from key informants, the implementation of the translation into action of the existing strategies and policies has been challenged with clear gaps. Not all the gender issues related to HIV have been properly addressed including the needs of women, girls, and key populations, including their socio-cultural and economic condition as most intervention programs are not designed to bring sustainable change and result.

9.1.2 MEANINGFUL PARTICIPATION

The 2015-2020 strategic document recognizes the technical and financial contributions of different actors ranging from donors to community-based implementing partners including CSOs, FBOs, Trade unions, and private for-profit organizations. The CSOs and FBOs are involved in the implementation of BCC, condom promotion and distribution, HIV testing & counseling, and ART adherence education. These organizations have better access to high risk and vulnerable populations such as FSWs, OVC, street children, and destitute women (separated/divorced/widowed). To ensure access to HIV education and services of persons with disabilities, the national HIV response programme planned to involve Federations of Ethiopian National Associations of persons with disabilities in the development of service delivery guidelines.

Community engagement and the participation of WLHIV and women members of other key populations are crucial. It also stated the importance of community participation, including community and religious leaders, women's groups, youth organizations, farmers' associations, council members, health extension workers, teachers, development agents, and NGOs and the empowerment of individuals, families, institutions, and the community at large. A key HIV prevention objective of the HIV/AIDS Strategy is strengthening a woman-centered 'health development army. The WDAs along with health extension workers lead 'community conversations', a community empowerment programme, where members discuss and develop action plans addressing issues underlying HIV vulnerability by engaging women's group leaders, traditional and religious leaders, and CBOs[170].

The discriminatory cultural norms, unequal gender relation, and decision-making power, lack of education, and awareness affect women's decisions making ability and impedes and hinder their participation in the HIV response activities which compromises the effectiveness of HIV prevention strategies and creates barriers to effective HIV care and treatment[171]. Although the HIV/AIDS response strategic plan indicated that any intervention in HIV/AIDS has to be gender-sensitive and women must be actively involved in the prevention, care, and support activities and despite the positive policy, the legislative environment created for women in Ethiopia, their participation in HIV prevention activities are very limited. Mechanisms for and indicators to track the meaningful participation of women, networks, and organizations that represent PLHIV, women's rights, sexual and reproductive health, gender equality, youth and key populations in developing policies, guidelines and strategies relating to their health including preventing the mother-to-child transmission of HIV are also lacking.

There is also a lack of evidence or information to check whether decision-making processes in the HIV response consider the views, needs, and rights of key populations as part of the formal partnership forums, working groups, or other coordinating mechanisms. According to the key informant interview findings, there is a limited engagement of women and girls, boys and men as well as a key population in program designing, implementation, and periodic stakeholder's lead follow-up assessment, monitoring, and evaluation system.

9.1.3 COORDINATION OF GENDER EQUALITY WITHIN THE HIV RESPONSE

The national HIV programme involves a multi-sectoral response that ensures the engagement of the different stakeholders including government sectors, multilateral and bilateral organizations, non-governmental organizations, CSOs, and CBOs. With the understanding of the link between gender and HIV, the government has reformed legal frameworks to facilitate the coordination of Government and NGO's, developed and implemented several national plans to the advancement of gender equality. In line with this, the 2018-2020 National HIV Prevention Road Map renews the commitment of all stakeholders and partners, particularly the political leadership, implementers, and donors, to focus and strengthen the HIV prevention response across all levels[172].

Ethiopia's coordination mechanisms of HIV prevention have been done through sectoral integration and developing a multi-sectoral HIV/AIDS response strategic plan. Gender has been integrated into policies and programs to address gender inequalities and make the services more responsive to the social, economic and cultural realities of users and beneficiaries also created an enabling environment to support individual behavior change and risk reduction[173]. The strategic plan also incorporated the establishment of HIV/AIDS forums in women's associations, in Kebele's, NGOs, and CBOs level as well as the promotion of women's economic empowerment and the implementation of laws that promote the rights of women and increasing women's legal protection[174]. However, it is not evident to ensure that the national HIV coordination mechanism includes a dedicated working group or other mechanisms that focus on gender equality.

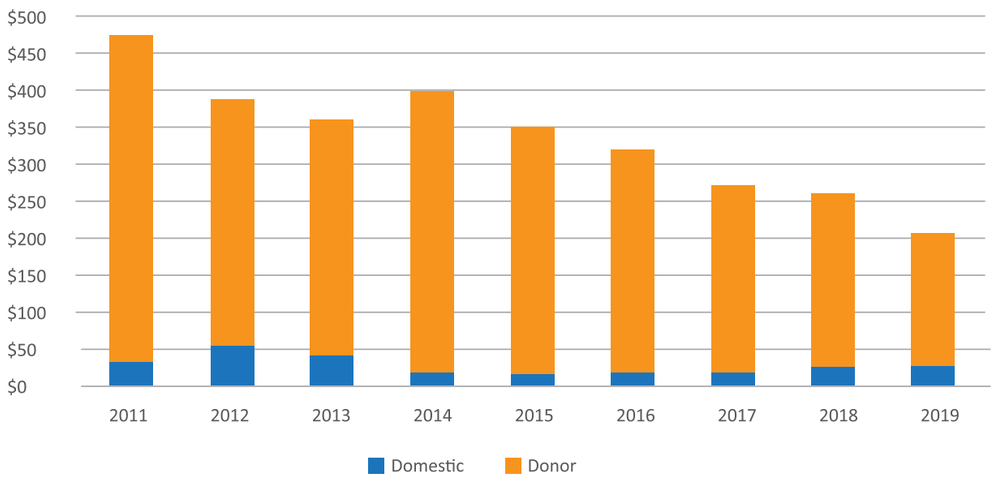
9.1.4 BUDGETARY ALLOCATION AND EXPENDITURE

Budget allocation for HIV/AIDS

Ethiopia has conducted only one national AIDS spending assessment back in 2012. In this gender assessment, we used different sources of financial or resource documentation. Ethiopia has limited availability of resources for health and is heavily dependent on donor financing. According to the 2010/11 National Health Accounts (NHA) of Ethiopia, spending on three priority disease areas, HIV, TB, and malaria accounted for 36% of total health expenditure. These three diseases accounted for 58% and 26% of external and domestically generated government financing respectively for health. In this regard, the national HIV/AIDS expenditure of nearly US$306 million in 2010/11 constitutes the largest amount of spending on a specific disease in the country[175]. The national HIV/AIDS subaccount findings show that PLHIV shouldered a higher financial burden for their health care in the national HIV response efforts.

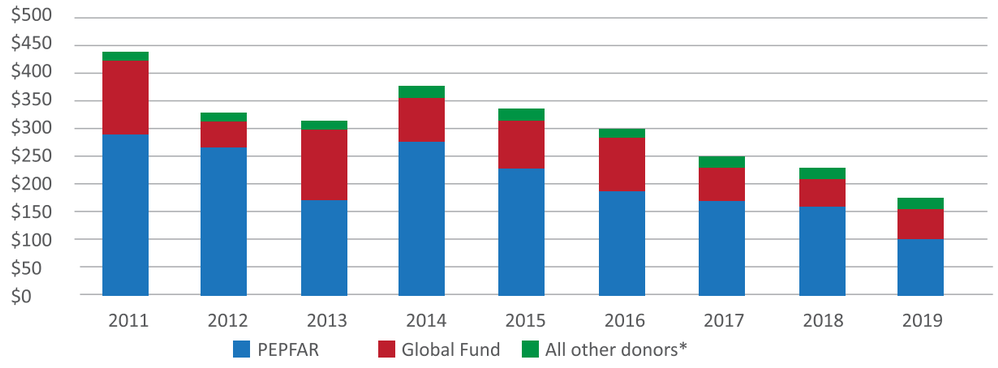
The success of the country's HIV response has largely been driven by external funding from development partners accounting for 90% of total funding for HIV between 2011 and 2019. However, donor funding has declined by more than two-thirds (69%) since 2010/11 (EFY 2003). U.S. Government funding through PEPFAR has declined by US$237 million (79%). Global Fund resources have declined by US$68 million (51%). Less than US$10 million / year are provided through other donors. External support has been the sole source of financing for key components of the HIV response, including all commodities for HIV testing and treatment. In 2017, the Global Fund spent $60 million on antiretroviral drugs and rapid test kits, and PEPFAR spent $11 million, primarily on laboratory commodities and reagents[176].

FIG 8. HIV FINANCING TRENDS BY SOURCE TYPE IN ETHIOPIA[177]



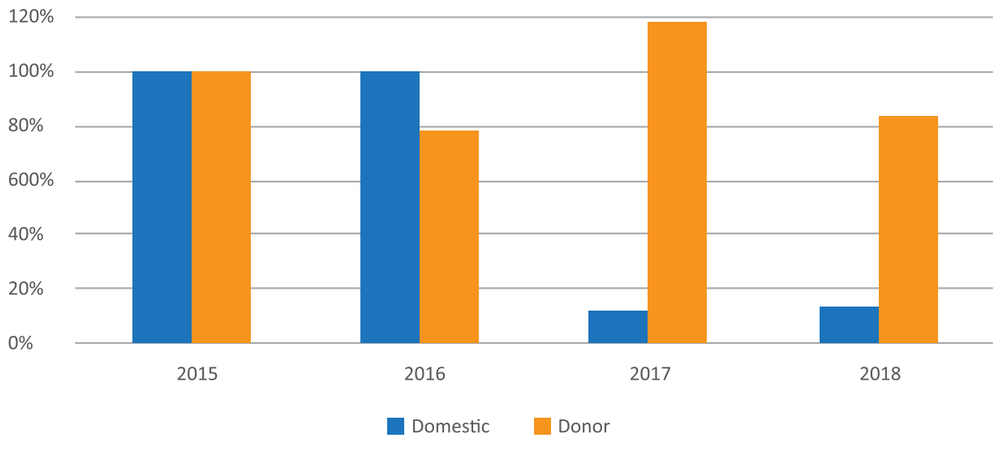
The HIV response has been a major donor priority in Ethiopia. Since the early 2000s, Ethiopia has received more than $4 billion in external financing for its HIV program- an average of more than $250 million per year (Figure 9). Donor financing support peaked between 2010 and 2011 at well over $400 million annually but has since declined by more than half. In 2019, only around $170 million was allocated by donors for the HIV response[178].

FIGURE 9. EXTERNAL FUNDING SOURCES FOR ETHIOPIA HIV RESPONSE[179]



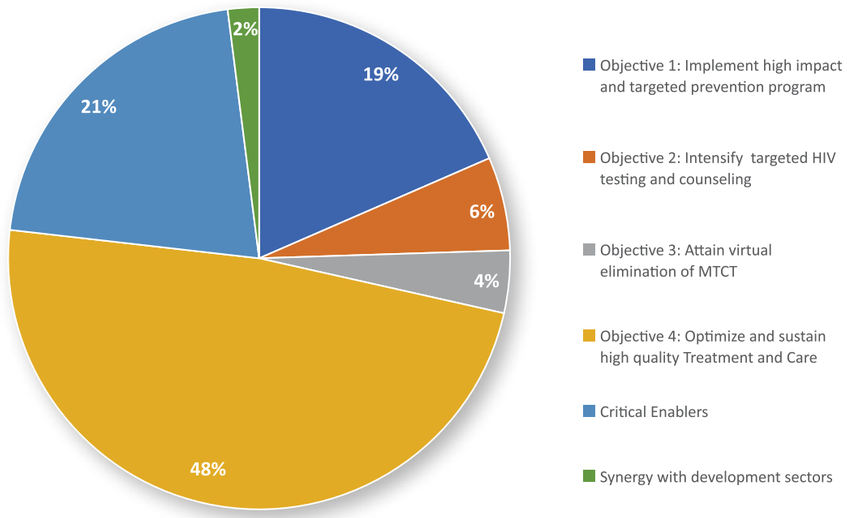
While domestically generated resources had represented 21–28% of the MOH's HIV budget over 2015–2017, by 2018 they accounted for just 1%. And, while the MOH allocated 2.6% of its domestically generated budget to HIV in 2016 and 1.8% in 2017, in 2018 it allocated just 0.04%[180] (Figure 10).

FIGURE 10: MOH HIV BUDGET EXECUTION BY FUNDING SOURCE (2015–2018)[181]



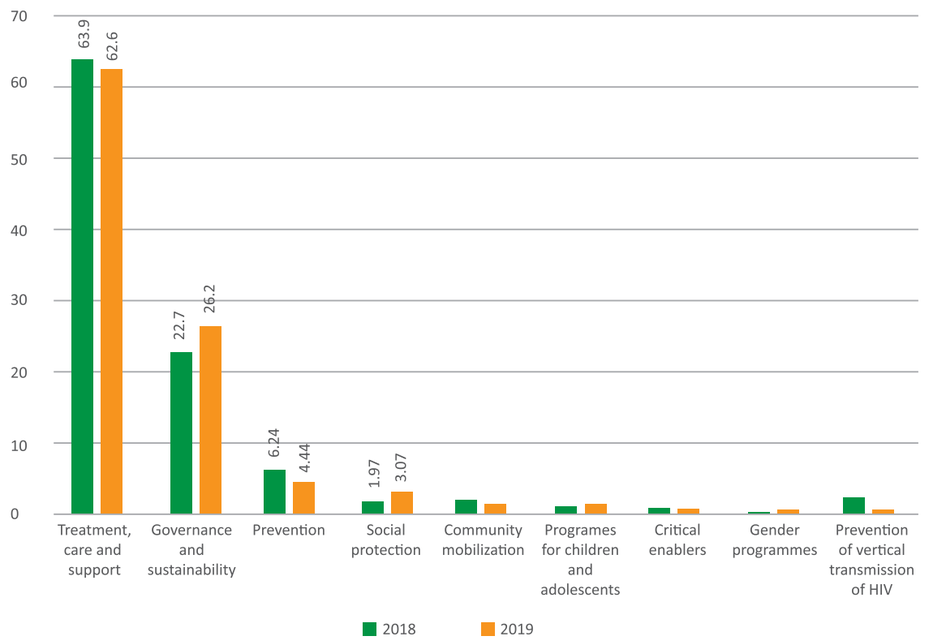
According to the resource allocation of the 2015-2020 HIV/AIDS strategic plan, care and treatment took nearly half of the overall budget allocation followed by investing on critical enablers (increasing domestic resources, effective partnership, and addressing gender-related barriers to access services), and implementation of high impact and targeted prevention programs (Fig. 11). The strategic plan lacks indicating gender-transformative budgeting. As such, it is difficult to know what proportion of the resources goes to addressing the strategic and practical needs of women and girls.

FIG. 11: DISTRIBUTION OF REQUIRED RESOURCE BY STRATEGIC OBJECTIVES AND CRITICAL ENABLE, 2015-2020



A preliminary data analysis based on data[182] availed for the National AIDS Spending Assessment (NASA) of the period 2018 and 2019 shows that the majority of the budget in the national HIV response went to treatment, care and support at 63.9% and 62.6% in 2018 and 2019 respectively followed by budget utilized for governance and sustainability (Fig. 12). Gender programmes had a share of only less than 5% of the total annual budget in both fiscal years.

FIGURE 12: BUDGET UTILIZATION OF THE NATIONAL HIV RESPONSE IN ETHIOPIA, 2018-2019



The current declining donor financing will continue which may be challenging for the country in the national HIV response efforts[183]. The HIV strategy directs resource mobilization for the health sector from different sources including the government, development partners, private sector, and households that have positively transformed the health sector financing[184]. Despite a heavy reliance on external financing for health over the past two decades, the National Health Accounts demonstrate that between 2010/11 and 2013/14 most new money for health in Ethiopia came from domestic sources, with 53% of the increase coming from the government (domestic revenues) and 33% coming from households[185]. The country's high number of new HIV cases annually signifies the need for sustained investment in prevention activities to avoid continued growth in the number of PLHIV and in the need for testing and treatment[186],[187]. Hence, increasing health spending focusing on increasing domestic financing would have paramount importance in availing more sustainable financing to the HIV response.

Budget expenditure on HIV/AIDS

According to estimates of governmental spending on HIV/AIDS, in sub-Saharan Africa, spending per prevalent case of HIV/AIDS varied substantially ranging from as low as below $25 on prevention per prevalent case in Mozambique, Nigeria, and Somalia to more than $110 in Ethiopia and Namibia. The study shows that Ethiopia's expenditure on HIV/AIDS is much higher than that of high-prevalence countries like Mozambique and South Africa[188].

While the government of Ethiopia's HIV expenditures has consistently exceeded the Global Fund's co-financing requirements, domestic public HIV expenditure showed a significant decline from US$54 million in 2012 to US$46 million in 2016[189],[190]. Cumulative expenditure data between 2016 and 2019 shows that the share of domestic expenditure has grown over the years though still very minimal at 2.2% at the end of 2019. On the other hand, the share of expenditure from international sources shows a slight decline between 2018 and 2019 (Table 2).

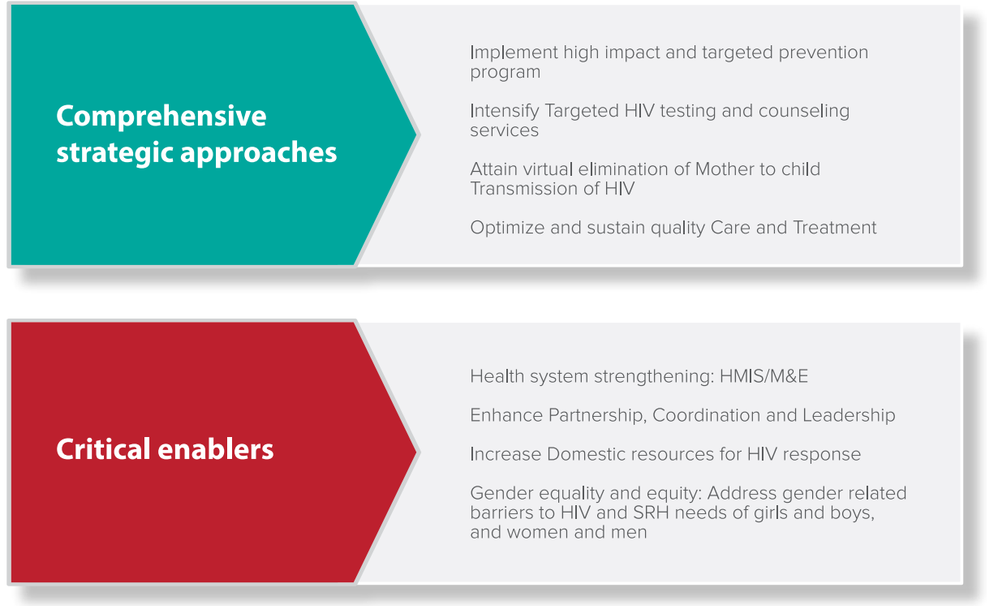
However, there are no accessible data related to expenditures on prevention (HIV education, condom promotion and distribution, testing and counseling, and preventing the mother-to-child transmission of HIV among others) and on care and treatment or expenditure on antiretroviral therapy, and cash transfers for young women and girls among others. The absence of periodic national AIDS spending assessment for the country may contribute to information gaps. Hence, it is difficult to examine whether the budget allocated to the national HIV response considers or meets the specific needs of women, girls, men, boys, and the needs of key and priority populations.

TABLE 2: ETHIOPIA'S REPORTED BUDGET EXPENDITURE BY SOURCE OF FINANCING, 2016-2019[191]

FISCAL YEAR	DOMESTIC EXPENDITURE (MILLION)	INTERNATIONAL EXPENDITURE (MILLIONS)	TOTAL EXPENDITURE (MILLIONS)	GOVERNMENT HIV EXPENDITURES AS A % OF TOTAL EXPENDITURE
2019	38.3	1,694.80	1,733.10	2.21
2018	17.2	1,710.80	1,728.00	0.99
2017	11.3	1,691.40	1,702.80	0.67
2016	7.5	891.9	899.5	0.84

9.2 COMPREHENSIVE HIV RESPONSE

Ethiopia has adopted the global goal to attain 90-90-90 targets. The country's 2015-2020 HIV/AIDS Strategic Plan, in an investment case approach, has four strategic objectives and four critical enablers (see the diagram below).



9.2.1 HIV PREVENTION

In line with the above strategic interventions, the five-year strategic plan has identified six pillars of comprehensive HIV prevention including:

a. Combination prevention packages for adolescent girls, young women, and their male partners
b. Combination prevention programmes for key and priority populations
c. Strengthened national condom programmes
d. Voluntary medical male circumcision (VMMC) for men and boys
e. Pre-exposure prophylaxis (PreP) for population groups at substantive risk and with high levels of HIV incidence, particularly FSWs and discordant couples. HIV self-testing has been found to be a promising and successful option among FSWs and men[192].
f. Prevention and control of sexually transmitted infections (STIs)

Statuses of some of the major preventive activities or methods are addressed more specifically as follows:

Condom use among key populations: There was the consistent use of condoms among FSWs. However, there are worrying signs that this practice might be declining. According to the 2013 national MARPS survey among FSWs from 89 towns in the nine regions and two city administrations, 98.8% of FSWs used condoms[193]. There are no recent nationally representative surveys. However, there are small scale studies that reported lower rates. Studies from Dire Dawa and Gondar showed that less than two-thirds (64.1%)[194] and less than half (48%)[195] of FSWs, respectively, used a condom with all partners.

Pre-exposure prophylaxis (PrEP): Ethiopia started rolling out PrEP in late 2019 targeting FSWs and HIV discordant couples. For the initial phase, 15,400 FSWs and 4,762, couples in discordant relationships were targeted. By December 2019, the number of people screened for PrEP services was 4,128, of which 1589 were found eligible, 971 were initiated while 601 declined. The program is available in public health facilities and community drop-in centers[196].

Voluntary medical male circumcision: Male circumcision rates are generally high in Ethiopia with, based on self-reporting, rates from 93% in the 2005 EDHS and above 90% in the 2016 EDHS. The VMMC program started in Ethiopia in 2009 in Gambella where HIV prevalence was high (6.5% at that time) and there was low male circumcision coverage (<10%) among the indigenous Gambella population, new military recruits and the refugee population, Since then, through PEPFAR support, more than 120,000 VMMC procedures were carried out among adult men in Gambella region through the end of September 2019, which is 71% coverage out of the total 171,704 VMMC eligible population in the region[197].

Cervical cancer screening: WLHIV have up to five times higher risk of pre-cancer and invasive cervical cancer[198]. Every year, more than 260 000 women more predominantly (90%) from low- and middle-income countries, die from preventable cervical cancer aggravated by poverty and poor health systems[199]. WHO recommends that all women with HIV should be screened for cervical cancer, regardless of age[200]. According to the Ethiopia Population-Based HIV Impact Assessment (EPHIA) 2017-2018, only 16% of urban HIV-positive women aged 30-49 years reported being screened for cervical cancer[201]. A facility-based cross-sectional survey conducted in Hawassa showed that more than 40% of WLHIV were screened for cervical cancer[202] while another hospital-based study showed only a 10% life-time uptake of cervical cancer screening among HIV positive women[203].

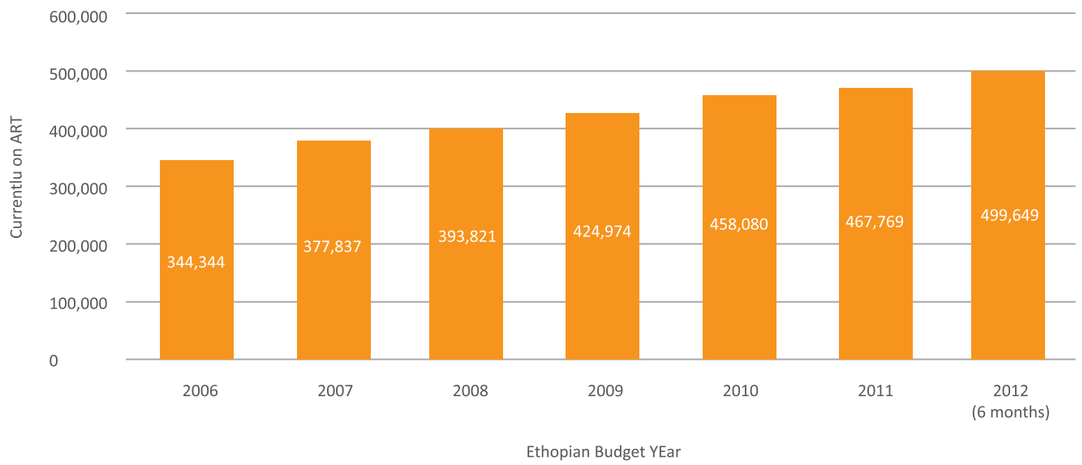
Cervical cancer is neglected in the national HIV strategic plan with no mentioning of it at all and the strategies on how to address the problem. However, prevention and screening of cervical cancer are listed among the key elements of chronic HIV care in the national guideline for comprehensive HIV prevention, care, and treatment . Cervical cancer screening for WLHIV is also well addressed in the guideline for cervical cancer prevention and control in Ethiopia .

Human papillomavirus vaccination: To prevent cervical cancer, Ethiopia launched a Human Papilloma Virus (HPV) vaccination pilot project in December 2015 targeting adolescent girls aged 9-13 years.[206] Subsequently, the country launched the National Human Papillomavirus (HPV) vaccine in December 2018 to vaccinate over one million girls who are 14 years of age[207]. Human Papillomavirus (HPV) vaccine was offered to 96 percent of girls aged 14 across the country during the past Ethiopian year which ended on July 7, 2019[208].

9.2.2 TREATMENT

Free ART services were initiated in 2005, transitioned to "Treat All" positives combined with re-testing before ART initiation, and then to same-day ART initiation which was started in November 2016. ART services are provided in more than 1,100 public, private, and NGO health facilities and demonstrate a strong program with good referral and registration systems. As of January 2020, of the 79% of estimated PLHIVs who know their status, 89% were on ART and 91% were virally suppressed. The percentage of children <14 years however is considerably lower; 26% for children 0-4 years, 46% for those aged 5-10 years, and 58% for those 10-14 years old[209]. There are large regional variations in ART coverage from 28% in Somali to 81% in Harari. As Ethiopia increases its ART coverage (Fig .13), identification of new HIV infected individuals, linking them into treatment, and ensuring that patients are not lost to follow-up is critical.

FIGURE 13: THE NUMBER OF PLHIV WHO WERE ON ART (EFY 2002 -2011)[210]



In its effort to achieve the 90-90-90 global targets of knowing HIV status, being put on ART, and reducing viral suppression. By 2018, Ethiopia's progress reached on 82% of PLHIV(83% in females vs 85% in males) knew their status; 91% (with equal percentage in both females and males) of eligible PLHIV were on ART, and 89% (with equal percentage in both females and males) of those on ART have attained viral suppression . The EPHIA data indicates that 79.0% of adults living with HIV knew their HIV status in urban Ethiopia (83.3% among women vs 70.0% among men) in 2018. The same assessment has indicated that 97.1% of PLHIV living in urban areas were on ART (96.4% for women vs 98.9% for men). In addition, 87.6% (86.1% among women vs 91.1% among men) of those who were on ART achieved viral suppression. These data indicate that there is room for improvement in access to HIV testing among men.

KII participants also noted this gender related disparity.

> **"Unlike our expectations, more women are accessing care and treatment … could this be because more women were living with HIV? Or could it be that men do not access care? We need to answer these questions. If the answer is 'yes' to the second question, then we should ask ourselves why males, particularly young men, are not accessing HIV care. Probably, we may consider 'male-friendly' services" [KII-2]**

Viral suppression is similar among the pregnant, and breastfeeding women, and between males and females ranging from 88- 92%. However, it is low among children of 0-14 years (78.9%) as well as among adolescents and youth (81.8%)[213].

9.3 GENDER EQUALITY AND HIV: THE LEGAL AND POLICY CONTEXT

The main purpose of this section of the gender assessment was to identify and analyze the laws and policies that govern national responses in addressing inequalities in both HIV and gender. The assessment also intends to identify opportunities, gaps, and challenges related to gender inequality given the current practices related to HIV responses. While this assessment focuses on identifying issues that are specific to women and girls, and other key populations regardless of the strengths of Ethiopia's HIV response, outlining the enabling environments is worth the degree of the national response.

9.3.1 GENDER CONSIDERATIONS ACCORDING TO THE COMMUNITY

Women and girls: gender policy or policy for women and girls In Ethiopia

Ethiopia has been doing a lot in terms of putting a policy framework in place to protect the rights of women and girls to directly or indirectly address their vulnerability to HIV. Different sector-level policy or strategy documents have attempted to address the issue in addition to the 1993 National Policy on Ethiopian Women[214] and the National HIV/AIDS Policy. The 1994 Constitution[215] of the country which has several provisions relevant to women's rights, many other laws have been either enacted or revised in a gender-sensitive manner including the 2000 Revised Family Law[216] and the 2004 Revised Penal Code[217]. The government has developed the National Action Plan for Gender Equality (NAP-GE) 2006-2010 which

Girl Coders from African Girls Can Code initiative by UN Women and Partners
Photo Credit Bethlehem Negash/UN Women

is considered as its commitment to the Beijing Plan of Action, the Women's Affairs Office (WAO)[218]. The NAP-GE aimed to attain the objectives of gender equality uttered in the 1995 Ethiopian Constitution, the 1995 Beijing Platform for Action (BPA)[219], the 2000 Beijing+5 Political Declaration and outcome document, the Millennium Development Goals (MDGs).

The qualitative data findings also show that, because the HIV policy was enacted two decades ago, it does not address particularly the emerging gender-related agenda that emanated from the globalization and development process. The HIV policy or the response strategy also does not address and respond to the specific needs and problems of those children who are born with HIV, the fact that they now reached adolescent age, and they have different, reproductive health, HIV, and gender-related problems. On the other hand, as the national HIV strategic plan considered gender as a cross-cutting issue and diffused it into other sectors and/or priority areas, gender issues are given less attention in HIV response. Moreover, a specific budget is not allocated for gender-transformative work. There is also a lack of integrated and collaborative work between concerned sector offices like HAPCO, MOH, WCYA, Education, Labor, and Social Affair and NGOs, other partners, and stakeholders- such dispersed effort cannot bring any sustainable result on gender equality and gender-related problems on HIV prevention.

While the government has declared its commitment to gender equality with the announcement of the National Policy on Women, the policy document is shy to address issues related to HIV while it failed to utter the term "HIV" not even once. Nevertheless, the policy document recognizes the collective unparalleled health and health-related challenges faced by Ethiopian women including malnutrition, poor skilled delivery assistance, poor access to family planning, and the very high rate of maternal death. On the other hand, the policy grants women's and girls' access to economic empowerment and education opportunities, and social services.

As it was stipulated in the NAP-GE, following the 1995 Beijing conference, Ethiopia identified seven priority areas that should be tackled to ensure gender-equitable development.

i. Poverty and Economic Empowerment of Women and Girls
ii. Education and Training of Women and Girls
iii. Reproductive Rights, Health and HIV/AIDS
iv. Human Rights and Violence against Women and Girls
v. Empowering Women in Decision Making
vi. Women and The Environment
vii. Institutional Mechanisms for the Advancement of Women

Access to economic empowerment opportunities

With regards to creating economic empowerment opportunities, the national policy on women is committed for ensuring the full development and advancement of women and guarantees them the enjoyment of their democratic and human rights to ensure their participation in the economic, social and political life of their country on an equal basis with men. The national HIV/AIDS policy on the other hand gives provisions to create self-supportive and income-generating opportunities for PLHIV as the need arises[220].

Access to educational opportunities (including comprehensive sexuality education) for women and girls

While the national policy on women emphasizes creating a conducive environment for informing and educating communities about such harmful practices as circumcision and the marriage of young girls before they reach puberty, the NAP-GE asserts women's and girls' Reproductive Rights and aimed to improve their health and HIV/AIDS Status through ensuring access to gender-sensitive health information by men & women and boys and girls. Women, children, and youth are given a priority focus for health promotion, related to HIV/AIDS.

Comprehensive sexuality education is recognized as an effective method of sexual health education especially in school settings[221]. Ethiopia is one of the countries that ratified the Ministerial Commitment to comprehensive sexuality education and the sexual and reproductive health services for adolescents and young people in Eastern and Southern Africa in 2013[222]. However, its implementation status is not that satisfactory[223]. Most programs for young people in Ethiopia do not meet the unique service and information needs of young people. Services and strategies are not also effectively segmented by factors known to have maximum effect on their SRH needs and or status. Most of the services and information provided to young people are not tailored by age and gender which fails to address the distinct needs of girls versus boys at different ages, as well as the unique needs of married adolescent girls[224].

Access to legal and/or law enforcement institutions for key populations

While the national policy on women encourages the facilitation of the legal protection of the rights of women and ensuring fair trial in a court of law for women compared to men without mentioning of gender-based violence, the NAP-GE emphasized informing women of their rights to seek justice and provision of access to justice and related services (shelter, legal, counseling, rehabilitatio …) to victims of violence, and implementing medico-legal guidelines for victims of sexual violence against women emphasizing on those with special needs (elderly, youth, disabled…), and enforcing the constitutional and legal prohibition of violence against women. However, these two documents did not address the issues of access to legal and/or law enforcement institutions for key populations in the context of HIV.

Access to social services and social protection

The Government of Ethiopia is committed to facilitating conditions conducive to the participation of women in both the elaboration and decision-making process as regards to community developments, social welfare, division of land property, education and basic social services; and it has been striving to ensure that women have the right to have easy access to basic health care facilities, information about traditional and modern family planning method- including suckling – and other services[225]. Ensuring access to free/low-cost social services like health, education, housing), with special emphasis given to reach women living under severe poverty and disability was also one priority area mentioned in the 2006-2010 NAP-GE[226].

Gender equality in intimate relationships and within the family

The National Policy on Women does not address gender equality in intimate relationships and within the family. However, violence against a marriage partner or a person cohabiting in an irregular union is punishable as per the Criminal Code of the Federal Democratic Republic of Ethiopia[227].

Gender equality in employment and workplace policies

The 1994 Constitution of the Transitional Government of Ethiopia grants women the right to equality in employment, promotion, pay, and the transfer of pension entitlements[228]. Besides, according to Article 35 of this constitution, “women are entitled to remedial and affirmative measures”. Similarly, the National Policy on women asserts women should be made beneficiaries on an equal basis with men of equal pay for equal work and of promotions, of appointments, of desirable transfers or termination of employment and training including decision- making in both their local communities and at the national level[229]. Discrimination against women is also unlawful as per the labor proclamation 377/2003[230] while the Civil Service proclamation No.262/2002[231] provides equal employment opportunities for men and women. The Family Code recognizes that women have the right to share any assets the household had accumulated if only a couple had been living together for at least three years in an irregular union[232].

The 1998 Policy on HIV/AIDS of the FDRE guarantees that the right of HIV/AIDS individuals for access to employment and associated privileges, educational and/or training facilities, public facilities such as places of entertainment public eating and drinking places sporting facilities, etc. shall be ensured[233]. In line with this policy, the 2001 Workplace HIV/AIDS Guide of the Confederation of Ethiopian Trade Unions (CETU), stresses that the gender dimension of HIV/AIDS should be well addressed at workplaces, understanding that women are more likely to be infected or affected by HIV/AIDS epidemic than men, due to biological, sociocultural, and economic reasons[234].

Meanwhile, according to the 2018 urban employment unemployment survey conducted by CSA, women have a low level of participation in the labor market compared to men with population to employment ratio of 28.4% for women and 62.0% for men while the average monthly payment rate was less by 40% for women compared to men[235].

Protection against gender-based stigma and discrimination against PLHIV

HIV status is a prohibited ground of discrimination under the ‘rights to equality’ of the FDRE Constitution [Article 25] that guarantees to all people’s equality before the law and the equal and effective protection of all persons without any discrimination. Ethiopia’s international commitments on the rights of PLHIV are guided by the Universal Declaration of Human Rights (Article 25/1), International Convention on Civil and Political Rights (Articles 2 and 26), International Convention on Economic, Social and Cultural Rights (Article 2), Convention on the Rights of the Child (Article 2), African Charter on Human and People‘s rights, and African Charter on the Rights and Welfare of the Child (Article 3)[236].

The NAP-GE recognizes that the most common and highly prevalent practices of violence against women including female genital mutilation, early marriage, abduction, polygamy, and wife inheritance put women and girls at a higher risk of HIV infection[237]. The National HIV/AIDS Policy also aims to safeguard the human rights of PLHIV and avoid discrimination against them through making the necessary provision of care and support to PLHIV and their affected family members.

Despite all these legal and policy frameworks, the issues of gender-based stigma and discrimination against PLHIV is not well addressed in specific terms apart from the overall gender and women related laws and policies. The National Policy on Women didn’t give explicit guidance to the HIV policy, strategy and response by recognizing and addressing both the gender aspects of the HIV epidemic and the specific HIV-related risks and vulnerabilities of women and girls (including those from key populations).

“Nothing will help women and girls more than ensuring that everyone, everywhere, can benefit from quality health services when and where they need them, without fear of falling into poverty when using them.”

Dr. Tedros Adhanom Ghebreyesus

9.3.2 MEN AND BOYS

Men and boys also have specific needs that must be met. Just as one example, truck drivers are mobile and require flexible hours for accessing care and services. Though most HIV responses in Ethiopia are gender-sensitive which by large are focused on the experiences of women and girls, they do not usually take into account experiences gained through working with men and boys in addressing marginalization from the differences between men and women or girls and boys. For instance, the National Policy on Women does not boldly recognize the role of men or their active participation and involvement in addressing gender-related cultural norms and expectations that may negatively affect both vulnerabilities to HIV infection and access or adherence to HIV services. Neither did the national HIV/AIDS policy identify working with men and boys as an important strategy in alleviating such problems. Usually, the failure to involve men in dealing with the issues on gender equality is attributed to the perception that women are the ones suffering from inequalities between the sexes and gender works focus on women that are primarily carried out mainly by women.

With this understanding, the NAP-GE identified male involvement as one of the strategies in improving the RH and HIV status and rights of women and girls[238]. On the other hand, while the current National HIV Strategic Plan (2015-2020) has also indicated low male involvement as one of the major demand-side constraints for PMTCT, the strategies to tackle this problem are not well addressed explicitly[239] apart from identifying the creation of enabling environment through the renovation of infrastructures, training of human resource, and enhancing couple counseling as strategies to solve supply-side barriers as part of the 2013-2015 strategic plan of eMTCT[240]. While several issues including stigma and discrimination from domestic and labor relations many women and girls face, unequal power relations between men and women and between boys and girls, and the rights of women, girls and key populations are acknowledged in the policy documents, issues related to internationally recognized key populations. The later might be due to the existing legal framework that makes such relationships punishable in Ethiopia[241].

The coming into existence of the National Policy on Women and the national HIV/AIDS policy have resulted in national programs or initiatives to ensure a structured approach for the national HIV response efforts including:

- The Strategic Framework for the National response to HIV/AIDS in Ethiopia (2001-2005)
- The Strategic Plan for Intensifying Multi-sectoral HIV and AIDS response in Ethiopia (SPM-I, 2004-2008)
- The Strategic Plan for Intensifying Multi-sectoral HIV and AIDS response in Ethiopia (SPM-II, 2010-2014)
- HIV Prevention in Ethiopia: National Roadmap 2018 – 2020
- The HIV/AIDS Strategic Plan: 2015-2020 in an Investment Case Approach
- National Action Plan for Gender Equality (NAP-GE) 2006-2010
- Ethiopian Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response (2004- 2008)
- The WHO 2013 consolidated HIV guidelines adopted and implemented in all the regions[242].
- The Intensifying Multi-sectoral HIV/AIDS Strategic Plan (SPM II, 2011-2015)[243]

The five years Growth and Transformation Plan (GTP) 2010-2015), Health Sector Development Plan (HSDP IV, 2010-2015) and Health Sector Transformation Plan (HSTP-I, 2015/16-2019/20) of the MOH included important strategic interventions to guide the implementation of the national HIV responses.

Participants of the First Coding Camp of the African Girls Can Code Program - Sharing experiences at Paris Peace Forum (November 2019)
Photo Credit Bethlehem Negash/UN Women

9.3.3 KEY POPULATIONS

Cognizant of the risks and vulnerabilities to HIV of specific population groups, the National HIV/AIDS Policy, gave priority in educational efforts to high-risk groups such as commercial sex workers, and their clients, mobile groups, (long-distance truck drivers, military personnel) youth groups, street children, refugees, prisoners, and others[244]. On the other hand, according to the national HIV/AIDS Strategic Plan (2015-2020), the key and priority populations in Ethiopia's context include FSWs, prisoners, truck drivers, and migrant/seasonal laborers. The priority populations include widowed, separated, or divorced women; long-distance truck drivers; PLHIV and their partners; people working in hotspot areas, both mobile and resident, drug and other alcoholic abusers [245]. No policy document or strategic plan has touched issues of other internationally defined key populations. There is also a scarcity of evidence about the magnitude of problems for such population groups and the challenges in accessing services in the Ethiopian context which may limit our understanding of the specific contexts and needs of these populations and in maximizing gender-transformative responses.

The National HIV policy and response strategy included key populations based on the Ethiopian context. As such, there are some segments of the population including people who use injectable drugs and others, not included in the policy and strategic plan. This may affect their access to HIV services as well as protection of their sexual and reproductive health rights.

According to the findings from the qualitative data, young adolescents and girls, especially those coming from rural areas enter sex work and they are at higher risk of acquiring HIV because of their low level of awareness as well as other social and structural determinants such as poverty and other forms of marginalisation. FSWs also face challenges from their clients because of the absence of protection mechanisms when there is violence committed on them.

African Girls Can Code Initiative - National Coding Camp Participants- Addis Ababa October 2019
Photo Credit Elias Berhanu/ UN Women

Critical enablers or structural interventions addressed through HIV policy guiding programmes and initiatives

Addressing gender-based stigma and discrimination

The country's 2010/11–2014/15 strategic plan on HIV and AIDS[246] recognizes that women are at greater risk of HIV infection. Enhancing the fight against stigma and discrimination was indicated as one strategy to optimize and sustain quality Care and Treatment-related to HIV/AIDS while enforcing the existing anti-discriminatory laws of the country and improving the involvement of PLHIV in the service delivery. Contextual factors like limited male partner support, stigma, and discrimination and fear of disclosure were identified as existing challenges related to PMTCT.

However, the 2015-2020 strategic plan on HIV is less pronounced in identifying specific strategies for addressing key populations in the context of gender-based stigma and discrimination in an articulated manner. For example, women are experiencing intimate partner violence during index case testing and partner notification. According to key informants of this assessment, if a woman is asked to bring her partner when she tests positive, she may face intimate partner violence and there is a critical social implication in this regard. These things are not well addressed in the national HIV response programmes or strategic documents from a gender perspective.

Addressing gender-based violence against key populations

The Government of Ethiopia revised its family and criminal laws in 2000 and 2004 respectively aiming at protecting the rights of women and children and to promote gender equality and equity. Undeniably, the practice of domestic violence against women has been decreasing in Ethiopia in recent decades though the magnitude is still comparably high. The government of Ethiopia is also committed to build capacities of local administrations and organizations including youth Associations, Women Associations, CSOs, and FBOs, and to empower communities to promote gender equality and prevent gender-based violence as well as to fight any harmful traditional practices in the community. Despite these commitments, strategies on how these initiatives would target or benefit specifically key populations are lacking.

Empowering key populations to know and claim their human rights

The National HIV/AIDS Policy gives guidance on the need to empower women, youth, and other vulnerable groups to take action to protect themselves against HIV/AIDS to address critical enablers. Though both the HIV policy and the current five-year HIV strategic plan (2015-2020) identified community or women empowerment as one strategy to gender equality and equity, the documents lack clarity or are shy in indicating empowerment of key populations as one strategy so they know and claim their human rights.

Reducing gender barriers to prevention, diagnosis, treatment, care, social protection, and economic empowerment

The National HIV/AIDS policy encourages psychosocial, economic, and medical support to PLHIVs and affected members through eliciting established patient's familial and social network. In this regard, it also gives special attention to people who are abandoned and helpless though these groups are not addressed in the policy document. The policy encourages health care providers to PLHIV on a scheme of payment according to ability with special assistance given to those who cannot afford to pay.

According to the 2015-2020 national HIV Strategic Plan ensuring gender equality and equity through addressing gender-related barriers to HIV and SRH needs of girls and boys, women and men were identified as one of the four critical enablers that are necessary for the HIV Investment Case to deliver results. Gender mainstreaming for HIV services, enhanced community mobilization against harmful traditional practices such as early marriage, Female genital mutilation, and HIV vulnerability reduction among women through strengthening economic interventions were also implemented in the SPM-II period[247]. Besides, the latest national guideline for Comprehensive HIV Prevention, Care and Treatment of Ethiopia also gives focus to addressing barriers to access testing, prevention and treatment services, particularly those faced by key populations and the measures that should be taken to reduce stigma and discrimination, the promotion of gender equality and prevention of gender-based violence, economic empowerment[248]. However, these strategies and recommendations do not see addressing the problems of key populations through a gender lens.

9.3.4 YOUNG PEOPLE

Policy and regulations on young people within the HIV and/or health framework that address young people's vulnerabilities and needs in SRH and rights

Ethiopia has been vigorously striving to improve the status of adolescent and young citizens through laws and policies. To this end, the country has formulated the National Youth Policy[249] in 2004 followed by the National Adolescent and Youth Health Strategy (2016-2020). The National Youth Policy of Ethiopia defined youth as those between the ages of 15-29 years. The National Youth Policy recognizes the inadequacy of the RH related education and services that are provided by different partners and the government while the services do not specifically focus on youth. As a result, the youth are exposed to unwanted pregnancies, unsafe abortion, STIs, and most of all HIV[250]. It is always important to note the diversity of young peoples in a community with various needs and contextual realities.

The most pertinent issues included in the youth policy[251] related to HIV and SRH and rights include:

- Ensure their participation in fighting harmful traditional practices that are detrimental to their health
- Creating a favorable environment for the youth to mobilize themselves on HIV prevention, control and bringing behavioral change;
- Ensuring that the youth benefits from HIV related Information, education, communication and counseling services
- Increase their participation in the fight to HIV and reduce their vulnerability to problems that Increase their vulnerability to the pandemic
- Provide care and support to young PLHIV including AIDS orphans;
- Encourage and create a favorable environment for the young PLHIVs in the fight against stigma and discrimination

Despite the above issues included as priorities of the policies, the policy doesn't boldly address issues of gender inequality amongst young people. However, the national AYRH Strategy (2016-2020) identified empowering of adolescents to challenge gender stereotypes, discrimination, and violence within peers/families, educational institutions, workplaces, and public spaces; and mainstreaming of gender and address its concerns in all AYH programs as important strategies. The strategy guides health programs to recognize and address the needs of adolescents and youth of both genders in an equitable, non-discriminatory manner that is free from stereotyping.

Following the 2004 National Youth Policy, Ethiopia's first (AYRH) Strategy was developed in 2006 and implemented from 2007 to 2015 followed by the 2016-2020 AYRH strategy. Apart from these, other policies, strategies, and legislation that recognize and prioritize the health of

adolescents & youth including their HIV related issues include the National HIV Policy, National Policy on Women, the Health Sector Vision 2016-2035, and HSTP 2015/16-2019/20), 2006-2015 National Reproductive Health Strategy, among others.

Issues addressed through the policy on young people

Parental consent for adolescents to access SRH and rights services and HIV prevention, testing and treatment

The presence of enabling laws and policies that authorize the provision of health and social interventions to adolescents indicate political commitments and serve as the basis to formulate strategies and allocate resources needed for the provision of SRH services. Absence of enabling laws or the presence of contradictory laws significantly affect young people's access to services and their power and freedom to exercise their SRH rights. Laws that require parental consent for adolescents and youth significantly affect access to health services including contraceptive information and services, safe abortion services, and HIV testing and counseling services[252].

Ethiopia's National Youth Policy doesn't address Issues of parental consent for adolescents to access sexual and reproductive health and rights services and HIV prevention, testing, and treatment, including post-exposure prophylaxis and pre-exposure prophylaxis (PrEP). However, according to the 2004 revised family law, Ethiopia has set the minimum age of marriage to be 18 years without exceptions for males and females. This law also allows adolescents and youth to use contraceptives without parental consent. Similarly, the 2005 abortion law improved access to and use of comprehensive abortion care services253. According to the national guideline for comprehensive HIV prevention, care and treatment, mature minors and adolescents above 15 years can access HIV treatment and care services by giving self-consent[254].

Policies that guide the delivery of life skills-based HIV and comprehensive sexuality education

In Ethiopia, schools have been used poorly as a platform to reach In-school adolescents and youth through life skills-based sexuality education[255]. Cognizant of this, the 2015-2020 HIV Strategic Plan had a plan to evaluate school HIV programs and redefine the operation and content of life skill education about curricular and co-curricular HIV education implementation modalities[256]. The 2016-2020 AYH Strategy also gives provisions on technical assistance to the Ministry of Education (MOE) and MOYAS/MOWCA to integrate comprehensive life skills, family life, sexuality education, and nutrition into in-school and higher learning programs and training curricula and to avail comprehensive sexuality and life skills education, and for counseling, treatment and referral services at the primary and higher education level[257]. The 2012 National School Health and Nutrition Strategy states that all schools and learning institutions have the responsibility of addressing HIV, AIDS, and STIs through education by developing skills and values and attitude changes to promote positive behaviors. Despite such efforts, until recently, there has been no provision of structured Comprehensive Sexuality Education (CSE) and it is not yet included as part of the national school curricula in Ethiopia. The national youth policy doesn't also address sexual health-or sexuality education.

Human papillomavirus vaccination for girls (9–14 years old)

In Ethiopia, the most prevalent cancers among adults are breast cancer (30.2%) and cervical cancer (13.4%). Over 80% of cervical cancer cases are detected at a late stage due to a lack of information and weak prevention services[258]. In Ethiopia, out of about 6,300 new cases of cervical cancer diagnosed annually, nearly 77.5% of them die each year[259]. The current AYH Strategy has also targeted to increase the proportion of adolescents aged 9-13 years vaccinated for HPV from 0% in 2015 to 50% in 2020 while it is committed to promoting and scale-up implementation of HPV vaccine programs for adolescents[260].

"The improvement of access to education is directly linked to health outcomes for women – specially on reproductive health issues."

President Sahle-Work Zewde, Ethiopia

Prevention of female genital schistosomiasis

Evidence shows that female genital schistosomiasis is one of the most neglected gynecological diseases even though it is the highest-burden among the 17 neglected tropical diseases[261] even though It can be prevented at a low cost. FGS is responsible for up to a 3-4-fold increase in the horizontal transmission of HIV/AIDS[262], [263], [264]. In sub-Saharan Africa, each S. haematobium infection per 100 individuals resulted in a 3% relative increase in HIV prevalence[265].

WHO's strategy to control schistosomiasis focuses on reducing transmission of the disease through periodic, targeted treatment with praziquantel through the large-scale treatment of affected populations[266]. Women who have been treated with praziquantel at least once in their lifetime are 50% less likely to develop FGS later in life. Shreds of evidence also show that young women infected with schistosomiasis have a higher chance of acquiring HIV[267]. Female genital schistosomiasis is not addressed in any of the policies and strategies in Ethiopia which signifies the little attention given to the risk it poses on women. There is limited evidence about the magnitude of the problem and measures taken against this problem.

Early or forced child marriage

The NAP-GE recognizes that early marriage, abduction, polygamy, and wife inheritance put women and girls at a higher risk of HIV infection[268]. Early marriage has been a common practice in Ethiopia with varied prevalence across the regional states. In Ethiopia, a 10-17% prevalence rate of HIV has been found among married girls age 15-19[269].

In an attempt to address early and forced marriage and other harmful traditions, the country enacted different policies and legal frameworks. The country's cultural policy necessities the changing in the erroneous conception about women and for abolishing all sorts of harmful traditional practices they are suffering from[270]. According to Article 648 of the revised Criminal Code of Ethiopia, whoever concludes marriage with a minor apart from circumstances permitted by relevant Family Code is punishable with: a) rigorous imprisonment not exceeding three years, where the age of the victim is thirteen years or above; or b) rigorous imprisonment not exceeding seven years, where the age of the victim is below thirteen years[271]. The revised family law that came into effect in 2004 with the principle of gender equality set the minimum legal age of marriage to be 18 years. This law states that ' neither a man nor a woman who has not attained the full age of eighteen years shall conclude the marriage[272].

In recent years, the percentage of women who believe that a husband is justified in beating his wife declined from 85% in 2000 to 63% in 2016[273]. During the same period, the proportion of women married by age 15 has declined from 14.4% to 5.7% among those aged 15-19 and from 19.1% to 14.1% among those aged 20-24 years over the same period. Worth-mentioning in here is that the COVID-19 pandemic is impacting girls' lives in different forms. The closure of schools following this pandemic, could reverse the positive efforts made over recent years. In the last two months alone, over 500 girls have been rescued from child marriage in northern Ethiopia since schools were shut due to the new coronavirus[274].

HIV Response programmes and services that focus on the needs and rights of young members of key populations

Even though key populations are among the priority groups in the national HIV strategic plans and guidelines, there are no clearly stated strategies to addressing young members of the key populations in line with the national HIV response activities.

9.3.5 IMPACT OF COVID-19 ON HIV RELATED SERVICES UPTAKE

Though there are limited quantitative pieces of evidence locally that show the impact of COVID-19 on PLHIV, qualitative data from key informants show that the pandemic is affecting service provision related to HIV in many ways.
In this regard, a key informant [KII-3] said,

> ***"There could be interruption of HIV services and AIDS commodities. In addition, persons with HIV may also be afraid to visit health facilities for fear of acquiring COVID-19."***

The KI's idea was concurred by a health service provider from a health center-

> ***"We have started to observe that the number of PLHIV coming to health facilities decreasing. As a result some of our clients have stopped taking the drugs, resulting in an increase defaulter rates" [IDI-2]***

Because of the different measures taken by the government, including physical distancing, PLHIVs are fearful to go out to health services to access their medicine and get counseling as well as other health services as per their schedules. Moreover, at the beginning of the COVID-19 outbreak, most of the health centers were giving priority for COVID-19 related responses giving less attention to HIV related as well as other essential health services. Physical distancing and movement restriction are also affecting their social protection and support system. PLHIV do also face transportation (cost and fear of using public transport) problems; some ART sites are dedicated to COVID_19 treatment and clients transferred out which may result in loss of follow up.

There is also a critical shortage of condom provision because of the difficulty of importing. Such impacts of COVID-19 may create long term effects on the quality of life of PLHIV and other segments of the community that may need HIV related services. It may also have a huge impact on the national HIV response by hampering efforts made towards achieving the 90/90/90 targets concerning international standards.

Key informants also believe that because of the discriminatory gender norms, stigma, and poverty, particularly women, girls, FSWs, persons with disabilities and living with HIV, daily laborers as well as street venders will be more affected by COVID-19 than any other population groups.

“COVID-19 may affect HIV services. For instance, some of the health facilities where the patients take their ARVs might be now treatment centers for COVID-19, resulting in disruption of HIV services in those health facilities. As you know, some of the PLHIV take their drugs far away from where they live. The transport interruptions and the potential increase in costs may deter PLHIV from visiting health facilities and taking their drugs” [KII-2]

9.4 DATA OR INFORMATION GAPS

Despite the strong national commitments of promoting gender equality as witnessed by the presence of different policies and strategies with various degrees of engagement as well as intended outcomes or long-term goals, there is a critical gap of data on gender-specific as well as gender-sensitive indicators. For instance, there are critical gaps in quantitative data that may provide strong evidence on gender roles, access to and control over resources; there are gaps in data related to budget expenditure by type of HIV/AIDS program i.e., prevention, care, and support as well as treatment; there are no data on the pattern of violence against FSWs; no data on reasons for national or regional disparities in the knowledge of people on HIV/AIDS prevention methods; and there are no data on knowledge about HIV, attitude and sexual practices among the wider priority populations as well as globally recognized key populations and their sexual partners. On the other hand, though there are several household surveys including the DHS, data are not usually properly analyzed to generate on the gender perspectives to the expected level which hamper the culture of data and evidence use for decision-making in the country at all levels of the different sectors. Such gaps prompt the need for sex-disaggregated data collection systems at the grassroots level and ensure their timely utilization. In the absence of adequate sex or gender-disaggregated data, accountability for gender mainstreaming may not be ensured.

10. RECOMMENDATIONS FOR GENDER-TRANSFORMATIVE HIV RESPONSE

As it is evident in the Constitution and other policy and legal frameworks including the national policy on women, the youth policy, the HIV/AIDS policy, and the commitments made in response to international treaties and gender frameworks and women rights, Ethiopia has palpable political commitments towards HIV and gender equality. Based on the findings of the gender assessment, the following issues are flagged to seek more attention to the intersections of HIV and gender.

10.1 POLITICAL COMMITMENT AND GENDER RESPONSIVE RESOURCE ALLOCATION

While Ethiopia is on the fast-track to achieving the targets for HIV testing, ART, viral suppression, and AIDS-related deaths, more effort is needed for further reductions in new HIV infections, discriminatory attitudes, and equity including the relatively low coverage for HIV testing and ART among FSWs, the high burden of HIV infection and AIDS-related deaths among women than men, and the geographic disparities[275],[276]. Hence, the country needs to strengthen its effort towards ensuring the commitments made under the 2016 United Nations political declaration on ending the AIDS epidemic by 2030[277] while giving more emphasis to gender transformative AIDS responses to ensure equality through empowering women and girls.

As an important component of a gender-responsive and gender-transformative HIV programming and implementation, gender-responsive budgeting[278] should be a high-level agenda for the country and should be included as an important strategic approach in the coming five-years Strategic plan for the national HIV response with clear indicators to monitor and ensure systematic attention to all elements that address women and girls across programmes.

10.2 LEGAL AND POLICY FRAMEWORK

Different laws and policies are put in place to guide and regulate programmes to ensure gender equality in the HIV response. Given the timing of the instatement of the laws, there are rooms for amending the existing laws and policies to provide a more enabling environment in line with international standards to which Ethiopia has been committed such as in responding to CEDAW Committee's recommendations[279]. It is also important to systematically mainstream gender into all HIV-related laws, policies, and technical and implementation guidelines, based on sound existing evidence in Ethiopia.

- Revise the existing HIV policy, national policy on women, and youth policy from a gender perspective and in line with the international conventions including CEDAW, to ensure the necessary and appropriate attention is given to gender and human rights related to women and girls in every segment of the community including key and priority populations.

- Ensure that women, girls, and key populations are adequately addressed through systematic mainstreaming of gender into HIV policies and strategies rather than putting gender solely as a crosscutting agenda including the National HIV Strategic Plan (2021-2026) and associated programmatic monitoring and evaluation, and financial frameworks through reviewing and thorough analysis of the existing frameworks. Particularly,
  - Engage men in challenging gender stereotypes and norms.
  - Develop the institutional capacity of networks of WLHIV and key populations to advocate against discrimination.
  - Strengthen the enforcement of the relevant provisions in the Law on HIV and other legislation to address stigma and discrimination towards WLHIV and women in key populations.

- The HIV prevention, care, and treatment service package should include a minimal service package for survivors of GBV and those involved in the care of PLHIV should have adequate understanding about prevention and response to GBV.
  - Ensure appropriate, effective, and free legal services are part of the responses to both gender-based violence and HIV.
  - In addition to service providers that provide direct care, it is good to ensure that law enforcement and judicial officers have adequate knowledge about HIV and gender-based violence issues, and their inherent relationship with the promotion and protection of people's human rights.

- Programmes should be designed to increase awareness of people working in the judiciary as well as legal entities about the existing national policy and legal instruments to ensure gender equality and women empowerment and to protect the rights of women and girls and men and boys.

- Ensure accountability mechanisms are in place for the translation of laws and policies on gender equality into action concerning the implementation of HIV responses with measurable indicators and targets that can be tracked through systematic monitoring, clearly stated timelines and assigning of responsibilities, and evaluation of allocation and utilization of resources.

- There is little mention of HIV and gender-based violence in the national policy on women. Hence, it may be important to revise the policy to ensure that such gender-related issues and HIV responses are addressed appropriately guided by pragmatic policy.

- The National HIV response strategic plans and implementation guidelines should be gender transformative to addressing the gender-specific aspects of HIV. Guidelines should provide clear approaches for proper implementation of interventions that transform the underlying discriminatory social structures and social norms that perpetuate gender inequalities and increase GBV.

"Truly women have a place, truly women have a face and truly the world has not been functioning well without the input, in every sphere, of women."

Nobel Laureate Leymah Gbowee

a Famer beneficiary from JP-RWEE Project by UN Women and Partners
Photo Credit- Fikirte Abebe/UN Women

10.3 ADDRESSING GENDER EQUALITY AND THE STRUCTURAL BARRIERS

Regardless of the huge signs of progress made in Ethiopia in alleviating problems related to gender inequality which can be exemplified with the most recent ministerial-level political representation, women's vulnerability to HIV and gender-based violence including intimate partner violence and their access to and control over resources is still at stake which may be attributed to the deep-rooted patriarchal social norms and cultural excuses. They remain unarguably destitute. Hence:

- There should be interventions that address the underlying/structural (social, cultural and economic) causes of gender inequality including ensuring the successful implementation of the policy or legal changes by ensuring the presence of accountability mechanisms, creating an enabling environment, addressing harmful traditional practices and social norms, and empowering women and girls, men and boys, key populations and communities. Implementations should be done in an integrated manner and through inter-sector collaboration including education, women and children, and other sectors.

- There is a need to address gender-based violence through ensuring the enforcement of the existing laws and penal codes that are enacted to fight violence against women through creating a more enabling environment and by applying the laws more stringently;

- Engage men and boys in addressing marginalization from the intersectionality between men and women or girls and boys through creating an enabling environment for them to challenge social and gender norms.

- Raising the awareness of men and boys including those living with HIV and those with high degree of vulnerability to HIV may contribute a lot in reducing the vulnerability of women and girls to HIV.

- Continuous awareness creation works also need to be done at the community and grass root level in a way to bring sustainable attitude change in the community.

- More intense gender awareness training needs to be given for health service providers, decision-makers, law enforcement bodies as well as increase media involvement on GBV, strengthen the capacity of PLHIV associations, and strengthen the supportive supervision, the monitoring, and reporting system.

10.4 ENSURING UNIVERSAL ACCESS TO HIV SERVICES

Ethiopia's response to HIV has been paramount. Nevertheless, as adult women and young women including adolescents aged 10-14 years are more affected by the HIV epidemic and the national HIV response which are evident by the unproportioned knowledge on HIV prevention methods, low level of ART utilization among FSWs, and high domestic and sexual violence among women and girls among others. In addition, there are huge geographic disparities in the prevalence of HIV among regions.

Hence,

- There is a need to ensure equitable access to preventive programmes, and treatment and care support across the regions through designing context-specific approaches. As most of the HIV response activities lie under prevention programming, all elements of the prevention programme need to address the realities of women and girls and how gender inequality heightens risk. Key recommendations might include the below specific ones when we unpack them but I believe the stated has all.
    - Develop targeted IEC and BCC materials and programmes that address diverse groups of women and girls at risk. Those who have lower levels of literacy.
    - Ensure that women-friendly harm-reduction programmes are available and accessible to women who use drugs. This will require research and a pilot project that could later be scaled up.
    - Train counselors to address the specific issues faced by women and girls around testing, diagnosis, and disclosure/ confidentiality.
    - Integrate awareness and prevention messages about violence against women and HIV into broad and comprehensive campaigns.
    - Encourage and promote male involvement at different stages of the national HIV response including during planning, implementation, and monitoring and evaluation of programmes and projects. Specific implementation strategies need to be further explored through active participation of stakeholders.
    - Ensure that user-friendly and one-widow HIV services are put in place integrated with SRH services.
    - Ensure that women receive adequate support for the care of their children, family members, and community members living with HIV. Challenge the social norms around HIV caregiving by engaging men and boys. Ensure that the caregiving role is reflected and cost in HIV national strategic plans and operational plans.

- Unique response mechanisms and platforms need to be in place to reach women and girls in the general population as well as among key and priority populations through comprehensive and holistic treatment, and care and support approach with special emphasis given to the gender dimensions of the HIV responses.

- Strengthen synergies/interlinkages to achieve programme efficiencies, and scale-up services for women from multiple entry points including, by integrating HIV services with those related to gender-based violence and family planning/sexual and reproductive health services. This would mean such services could reach a wider group of women, including women from key populations and others with specific vulnerabilities.

- To meet the unique service and information needs of young people, services and strategies should be segmented by identifying most impactful intervention strategies.

- It is also imperative that the necessary attention be given to persons with disabilities to minimize multiple burdens especially for women and girls with disabilities as well as those living with HIV including:
    - ensuring access to HIV counseling, testing and treatment centers;
    - Availing tailored or customized counseling services that are appropriate to persons with disabilities including the deaf and blind;
    - Providing training for health service providers on disability inclusion including their rights to information and services to ensure that appropriate services are provided to PLWDs
    - Ensuring the meaningful participation of PLWDs in the national HIV response (during planning, implementation, and monitoring)
    - Data disaggregation to show the number and proportion of PLWDs that are reached through information and services. Variables or indicators related to PLWDs should be integrated with the monitoring and evaluation framework of the national HIV response to ensure accountability.
    - Researching the intersectionality between HIV and disability to explore the potential multiple burdens of HIV positivity and disability including discrimination.
    - The HIV-response budgeting should ensure that an adequate budget is allocated for disability inclusion.

- To address stigma and discrimination in the healthcare settings, there is a need for interative training for popular opinion leaders, multifaceted educational programs, and contact strategy be in place.

10.5 COMMUNITY ENGAGEMENT AND MEANINGFUL PARTICIPATION

Community engagement and the participation of PLHIV and women members of other key populations are identified as crucial components of the national HIV response. The five-year strategic plan also recognizes the importance of community participation including women's groups and youth organizations and the empowerment of individuals, families, institutions, and the community at large. However, their participation in HIV prevention activities is very limited.

- Hence, mechanisms for and indicators to track the meaningful participation of women, networks, and organizations that represent PLHIV, women's rights, youth, and key populations in developing policies, guidelines, and strategies need to be in place. One of the mechanisms could be through building the institutional capacity of women networks and organizations of WLHIV, women most affected by HIV to ensure women's and girls' voices are heard and define meaningful participation of women and girls living with and affected by HIV.

- While there is also lack of evidence or information to validate whether decision-making processes in the HIV response consider the views, needs, and rights of key populations as part of the formal partnership forums, working groups, or other coordinating mechanisms, the upcoming national HIV strategic plan should consider the realization of the meaningful participation of such individuals and groups at all levels.

- So far, Ethiopia has conducted one national AIDS spending assessment in 2012 . To ensure that there is a formal system of accountability for the HIV response that enables civil societies, multilateral agencies, and citizens to monitor the priority-setting process and spending on gender equality within the HIV response, the country may need to conduct regular national AIDS spending assessment.

- Ethiopia's current HIV strategy plan incorporated the establishment of HIV/AIDS forums in women's associations, in kebeles, NGOs, and CBOs level as well as the promotion of women's economic empowerment and the implementation of laws that promote the rights of women and increasing women's legal protection . However, there is a need to ensure that the national HIV coordination mechanism includes a dedicated working group or other mechanisms that focus on gender equality while ensuring the participation of WLHIV, women most affected by HIV, and women from key population groups.

Participants of March 8 Celebrations in Adami Tulu Digdo Woreda, Oromia March2019
Photo Credit- Fikirte Abebe/UN Women

- Furthermore, parents, school community, community gatekeepers including religious leaders as well as other community structures should be meaningfully involved in the prevention of violence against women and girls and promote gender equality as well as sexual and reproductive rights of women and girls, men and boys, and key populations. There has to be also more investment to strengthen the school girls club, to make youth centers and health clinics gender-sensitive and youth and girls' friendly and should provide integrated services including psychosocial support, HIV, SRH, and GBV related services. Such structures should also be well equipped.

10.6 STRENGTHENING MONITORING AND EVALUATION ON GENDER-TRANSFORMATIVE RESPONSES

The national HIV response should have strong monitoring and evaluation as a solid foundation for results whereby gender-sensitive and gender-specific indicators are integrated and tracked to ensure data is used for accountability, transparency and impact through efficient utilization of resources.

- Data disaggregation among key and priority populations is required for decision-making. Thus, disaggregated survey and program data should be collected to inform the response.

- Gender-sensitive indicators should be included in the national information management systems (e.g. HMIS) at all levels to ensure accountability and inform the response.

- It would be good if data on HIV/AIDS knowledge, attitude, and practice, HIV transmission, and access to care and treatment be disaggregated by key and priority populations and special groups within regions (e.g. farmers, pastoralists).

- Due consideration should be given to analysis and identification of the causes for the lower reduction in mortality among adolescents and young adults, and among young women more than young men to facilitate evidence-informed decision-making.

10.7 EVIDENCE GENERATION AND ENHANCING UNDERSTANDING OF THE HIV EPIDEMIC AND RESPONSE

There has been a growing body of evidence and knowledge on the HIV epidemic in Ethiopia including the epidemiological patterns, the sociodemographic determinants, and burdens of the epidemic, etc. However, there are still gaps in knowledge, especially on responses and attention given to women and girls among key populations including prisoners, daily laborers, and intimate partners. Besides, there is a lack of in-country data or evidence on epidemiology as well as HIV responses to people who inject drugs and other internationally defined key populations. Hence,

- there is a need to examine the situation of women and girls as well as the invisible key population groups through rigorous studies with clearly stated and measurable gender-sensitive indicators. Result based monitoring and evaluation systems should be put in place at each, federal, regional, and woreda level as well as at the community level.

- More qualitative data is required to identify underlying causes of gender disparity in knowledge about HIV prevention methods and to craft targeted intervention.

- There are outdated studies, including the Stigma index study, the key population surveys. It is recommended that such surveys be done, and evidence updated regularly as they may help the program assess the direction the epidemic is going and the response to interventions. In addition, studies documenting the relationship between HIV and violence against women and girls, men and boys, and key populations and the relationship between HIV and violence and the impact of interventions should be undertaken. In addition, surveys regarding discrimination in health care setting against PLHIV and key populations need to be undertaken.

- There is also inadequate local evidence that documents the relationship between gender and access to and utilization of HIV prevention, care, and treatment services.

10.8 TACKLING THE IMPACT OF COVID-19 ON THE HIV RESPONSE

- Mechanisms should be put in place as part of the five-year HIV Strategic Plan on how to curb the long-term impact of COVID-19 on women's and girls' access to SRH and HIV services and the impact of socio-cultural norms on their SRH rights including the dangers of early and forced marriage.

- The national HIV response should be able to track the socioeconomic status and gender of those affected by COVID-19 and extend this effort to track the multi-dimensional effect of the pandemic on key and priority populations including the poor.

- It is important that the HIV response programme improves supply chains and ensure that people already on treatment can stay on treatment through adopting or reinforcing strategies such as multi-month dispensing of antiretroviral therapy, appointment spacing and transferring out to reduce requirements to access health-care facilities for refilling and reducing the burden on overwhelmed health systems.

- Advocacy efforts should be strengthened to ensure that COVID-19 should not be an excuse to reduce HIV funding and interrupt the supply of HIV commodities.

- More research should be conducted on the net effect of the pandemic on PLHIV and key populations in a gender lens.

10.9 ENSURING THE IMPLEMENTATION OF RECOMMENDATIONS OF THIS GENDER ASSESSMENT

FHAPCO and MOWYC, as the primary stakeholders of the gender assessment process, and other stakeholders need to remain committed to ensure the following issues will happen subsequently including taking the responsibility of ensuring the GA findings are integrated into the five-year HIV strategic plan (2021-2025). In this regard, there is a need to ensure strong collaboration with pertinent stakeholders including individual experts of gender equality and organizations engaged in gender equality issues in further analyzing and using the findings of the gender assessment for a gender transformative HIV response while addressing: advocacy and policy monitoring; service delivery and access; training and capacity-building; and documentation and research among others.

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