GENDER-TRANSFORMATIVE HIV RESPONSE FOR ETHIOPIA:

ADDRESSING STRATEGIC INTERESTS AND SPECIFIC NEEDS

DISCLAIMER

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SUMMARY

This gender assessment was conducted 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.

Gender inequality and the failure to recognize and defend women's human rights are realities of the daily lives of women in Ethiopia. In many circumstances, women and girls face the most oppression: gender inequality and unequal power relations at household and intimate relationships 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 on 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 inequality and reducing vulnerabilities of women, girls, men, and boys and marginalized key populations in accessing HIV information and related services by employing a gender-sensitive approach, it is usually difficult to objectify that each of the necessary gender dimensions is addressed in the national strategic interventions and responses. This signifies the importance of translating the laws, policies, and institutions that are created to ensure equal opportunities between men and women into action.

Hence, to ensure a gender-transformative national HIV response, there needs to be a strong political commitment to amending the existing laws and policies including the HIV policy, national policy on women, and youth policy from a gender perspective to provide a more enabling environment and to systematically mainstream gender equality into all HIV-related laws and policies by ensuring the presence of accountability mechanisms. Ensuring universal access to HIV services and strengthening community engagement and meaningful participation of women, girls, boys, men, and key populations in developing policies, guidelines and strategies, and in the implementation and monitoring of the HIV response is also critical. Gender-responsive budgeting or resource allocation should be an important component of a gender-transformative HIV programming and implementation. In this regard, the country's high number of new annual HIV cases signifies the need for sustained investment focusing on increasing domestic financing in prevention activities to avoid continued growth in the number of PLHIV and the need for targeted testing and treatment. The impact of COVID-19 on the HIV response should also be seen systematically through the gender lens. Finally, a strong monitoring and evaluation framework should be part of the national gender-transformative response effort to ensure impact, transparency, and accountability by using data for timely decision-making while considering gender-sensitive and gender-specific indicators as core components of the tracking system.

Gender assessment team: Consultants with the technical guidance of the national Gender Assessment Technical Subcommittee

Methods: Employed desk reviews and analysis of secondary data mixed with qualitative data obtained through in-depth interviews with government experts, partners, and beneficiaries of the national HIV response. The gender assessment was guided by the UNAIDS standard gender assessment tool.

Stakeholders involved: Government agencies, civil society organizations, United Nations agencies, development partners, and donors

RECOMMENDATIONS FOR GENDER-RESPONSIVE INTERVENTIONS

Based on the findings of the national gender assessment, a set of recommendations were identified for better integration of the gender equality dimensions as part of the national HIV and AIDS response through a rights-based approach. Detail recommendations are included in the comprehensive gender assessment report.

Revision of policy: To provide a more enabling environment in line with international standards to which Ethiopia has been committed and 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 population the existing HIV, women, and youth policies should be revised from a gender perspective and in line with the international conventions including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

Mainstreaming of gender into HIV policies and strategies: Ensure the systematic mainstreaming of gender into HIV policies and strategies apart from putting gender solely as a crosscutting agenda the National HIV Strategic and associated programmatic, monitoring and evaluation, and financial frameworks through reviewing and thorough analysis of the existing frameworks. As such, ensure the engagement of men in challenging gender stereotypes and norms, develop the institutional capacity of networks of women living with HIV and key populations to advocate against discrimination, and strengthen the enforcement of the relevant provisions in the law to address stigma and discrimination.

Translation of laws and policies on gender equality into action: 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, clearly stated timelines and assigning of responsibilities, and evaluation of allocation and utilization of resources.

Address the underlying causes of gender inequality: There should be interventions that address the underlying structural, social, cultural, and economic causes of gender inequality through the successful implementation of policies or legal frameworks 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.

Gender-responsive budgeting: To showcase the country's political commitment towards gender equality and HIV response, 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.

Conduct regular national AIDS spending assessment: 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.

Ensure meaningful participation: Despite the positive policy and the legislative environment created for women in Ethiopia, their participation in HIV prevention, care, and support activities is very limited. Hence, strong monitoring and evaluation systems for and indicators to track the meaningful participation of women, networks, and organizations that represent people living with HIV, 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 should be in place.

Active participation of most affected people: Current programmes and policies on gender-transformative interventions should be informed by the realities of those most affected in Ethiopia (for instance sex and sexuality education in school settings) and ensure their ownership and participation during implementation by employing a gender-sensitive approach that caters for the different needs of women, girls, men, and boys and other key and priority populations in accessing HIV information and related services through ensuring their active participation.

Gender-sensitive monitoring and evaluation: The national HIV response should have strong monitoring and evaluation as a strong 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. HIV response efforts of sectors other than MOH or FHAPCO such the education sector should also be tracked through standardized monitoring mechanism. Results-based monitoring and evaluation system should also be put in place at each, federal, regional, and woreda level as well as at the community level.

Further evidence generation: 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 including gender-based violence among female sex workers.

THE NATIONAL HIV EPIDEMIC AND CONTEXT

GENDER DYNAMICS OF THE HIV EPIDEMIC

HIV prevalence, incidence, and AIDS-related deaths: There are significant gender and age disparities in HIV prevalence, incidence, and AIDS-related deaths in Ethiopia. Since the start of the epidemic, more women have been infected by HIV than men. The prevalence of HIV has been almost twice among adult women and young women than adult men and young men during this period. In 2019, the HIV prevalence among adults (15 – 49 years) was 0.93%- a total of 669,236 persons were living with HIV. Women accounted for 62% of PLHIVs. HIV was 1.9 times more prevalent in women than in men. The HIV incidence among all age groups in 2019 was estimated to be 0.16 (0.13 among males vs 0.19 among females) per 1000 uninfected persons. Fifty-nine percent of persons newly infected with HIV were females. It was estimated that a total of 11,546 people died from AIDS-related illnesses, of which 57% were females. Similarly more young women than young men were infected by HIV. Young women accounted for 61% of young PLHIV and 75% of new HIV infections among young adults (15 – 24 years).

The decrease in the number of new HIV infections in Ethiopia in the last decade was lower among adult women than adult men and even lesser among young women than young men. Between 2010 and 2018, there was only a 14% reduction among adult women (21% national-level reduction) as compared to a 27% reduction among adult men. There was a 13% reduction among young women compared to a 17% reduction among young men. There was a similar trend in AIDS-related deaths. During the same period, there has been only a 36% reduction among young people compared to a 45% national-level reduction. Between 2003 (the peak year for AIDS-related mortality in Ethiopia) and 2018, there was only a 50% reduction in AIDS-related deaths among young adults and adolescents compared to the 82% reduction among adults.

Key and priority population groups: The key populations in Ethiopia are female sex workers (FSWs) and prisoners. Priority populations include widowed, separated or divorced women, long-distance drivers, PLHIVs and their partners, and mobile and resident workers in hotspot areas. These population groups have a high risk of HIV infection, limited access to services, and face stigma and discrimination. Surveys have shown that HIV prevalence was 23% in self-identifying FSWs, 4.5% in truck drivers, 4.2% in prison settings, and 5.7% in mobile workers. Though there was no national data on HIV prevalence in people who inject drugs, a survey conducted in 2015 in Addis Ababa showed a prevalence of 6% with a higher HIV prevalence among females who inject drugs and a higher practice of needle sharing (60%) among PLHIV. Despite these data, there are no systematic estimates on the size of key and priority populations in Ethiopia except for FSWs.

Knowledge about HIV: According to the 2016 EDHS, adult men had twice more comprehensive knowledge about the modes of HIV transmission, and a lesser percentage of women than men knew about HIV prevention methods. The gender disparity in knowledge about HIV prevention methods persisted across all age groups, regions, educational level, and wealth quantile.

Sexual behavior: EDHS data shows that men are likely to have more lifetime sexual partners than women and they are more likely to use condoms-based on self-reported responses. Young men (15 – 24 years) are also more likely to have more lifetime sexual partners (at a mean of 2.2) than young women (1.3) and they are more likely to use condoms (45.5% vs 21.8%). Some literature evidence shows that there has been consistent use of condoms among FSWs with 98.8% of female sex workers using condoms in 2013 from 89 towns in the nine regions and two city administrations. However, two recent small-scale studies showed a low rate of condom use ranging from 48%- 64.1% among FSWs.

SOCIAL AND STRUCTURAL DETERMINANTS AND SOCIOECONOMIC AND CULTURAL FACTORS

Women's socioeconomic status: Poverty affects women more than men in Ethiopia, one of the countries which have shown significant reduction in the level of poverty in the last two decades. Its human development index (HDI) has increased progressively from 0.28 in 2000 to 0.47 in 2018. However, the HDI was lower for females (0.428) than for males (0.507). The gross national income per capita in 2019 was USD 1,333 for females and USD 2,231 for males. Ethiopia has also a high gender inequality index, indicating gender inequalities in three important aspects of human development: reproductive health, women empowerment, and economic status. Female-to-male ratios in gross education enrollment were 0.95, 0.91, and 0.96 at pre-primary, primary, and secondary education, respectively. The female to male ratio of those who had some secondary education was 0.52 (11.5% of women vs 22% of men aged 25 years and above). There was lower labor market participation of women than men (74.2% of females vs 86.5% of males aged 15 and above) and youth unemployment was 1.8 times more common in females than in males.

Gender norms and practices: Gender norms including early and child marriage, harmful traditional practices, and cultural norms on sexuality and gender roles are quite common in Ethiopia. These gender norms contribute to creating barriers for HIV prevention and increasing the risk of HIV transmission in women and girls. Early marriage has been a common practice in Ethiopia. Women tend to marry considerably earlier than men despite a decreasing trend. According to EDHS 2016, 58% of women and only 9% of men age 25-49 marry before their 18th birthday. Women living in urban areas marry later than those living in rural areas and its prevalence varied across the regional states. Age at first marriage is lowest in Amhara and highest in Addis Ababa. Age at first marriage increases with increasing educational level and wealth quantile. Other gender norms- such as women believing that a husband is justified to beat his wife under certain circumstances- are quite common and have similar patterns.

Gender-based violence (GBV) is still widespread in Ethiopia with a quarter of women age 15-49 years experiencing physical and/or sexual violence by an intimate partner or non-partner in their lifetime. GBV is common both before and after marriage. Among ever-married women age 15-49, as many asone in three have ever experienced spousal violence in the form of emotional, physical, and/or sexual violence by their current or most recent husband/partner. According to a meta-analysis of data from 36 published studies with 23,782 participants, nearly half of Ethiopian women experience violence in their lifetime. There was no national data on the pattern of violence against FSWs or other key or priority population groups though small-scale studies indicate that violence against FSWs is significant.

Stigma and discrimination: Despite the policy stipulations and legal protections and the observed declining trends, there is still widespread stigma and discrimination toward PLHIVs in Ethiopia- discriminatory attitudes are higher toward women than men PLHIV. Discriminatory attitudes are more common in rural areas than in urban areas and are higher in the Somali Region (2016 EHDS). They decrease with educational level and wealth quintile.

LEGAL AND POLITICAL FACTORS

Discriminatory laws and policies: There are legal measures towards homosexuals, drug traffickers, and drug users as these are criminalized acts in the revised penal code of Ethiopia. Under Ethiopian law, drug use and the possession of even small amounts of drugs are criminal offenses. Homosexuality is also a criminal act. While sex work among females is not criminalized, there are other laws against public indecency and outrage of morals that could be used against sex workers.

Legislation protecting the rights of women, men, and key populations: Some legislations protect the rights of PLHIV and women and girls. However, there are no similar protections to the rights of key populations, including FSWs. The National HIV Policy of Ethiopia grants ensuring the human rights of PLHIV. The Constitution, the Family Code, and the Penal Code underscore that women and men have equal rights and protection, including the rights in marriage and divorce and the right to equal wages and to access, use and control of properties, including land. They also protect against harmful traditional practices and all forms of violence against women. Besides, Ethiopia has ratified several international and regional treaties and commitments and developed several policies and strategies that ensure gender equality and women empowerment and protection from all forms of violence. However, the awareness about these policies and legal provisions among the public and even government officials is limited.

THE NATIONAL HIV RESPONSE

HIV POLICIES AND PROGRAMMES

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 1998 HIV/AIDS Policy. A roadmap (2018-2020) was also developed for this strategy with a guiding principle to integrate a gender-sensitive approach with provisions for the different needs of women, girls, men, and boys in accessing HIV information and services. The five-year strategic plan and its roadmap are 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: In its current five-year strategic plan, Ethiopia has targeted to reach 90% coverage of medium and high risk and vulnerable populations (female sex workers, laborers, truck drivers) with comprehensive behavioral and biomedical prevention programs by 2020. 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 population-based HIV impact assessment (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. 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, 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. The translation into action of the existing strategies and policies has been also 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 conditions as most intervention programs are not designed to bring sustainable change and result.

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, Networks of PLHIV, 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 counseling and education. On the other hand, strengthening a women-centered 'health development armies' has been a key HIV prevention objective of the country's HIV/AIDS Strategy - 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. 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 and hinders their participation in the HIV response activities. These challenges compromise the effectiveness of HIV prevention strategies and create barriers to effective HIV care and treatment.

Funding and expenditure: According to the 2010/11 National Health Accounts (NHA), spending on HIV, TB, and malaria accounted for 36% of total health expenditure. The national HIVAIDS expenditure of nearly USD 306 million in 2010/11 constituted the largest amount of spending on a specific disease in the country. 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 from development partners accounting for 90% of total funding for HIV between 2011 and 2019. Donor funding has also declined by more than two-thirds (69%) since 2010/11. While domestic resources had represented 21–28% of the MOH's HIV budget over 2015–2017, by 2018 they accounted for just 1%.

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. The strategic plan lacks specific 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. On the other hand, there is no 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. The critical lack of publicly available evidence or source of data about resource allocation and utilization related to HIV in Ethiopia may be attributed directly to the absence of periodic AIDS spending assessments.

COMPREHENSIVE 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 - implementing high impact and targeted prevention program, targeted HIV testing and counseling services, virtual elimination of mother to child transmission of HIV, and optimizing and sustaining quality care and treatment; and four critical enablers including health system strengthening, enhancing partnership, coordination and leadership, increasing domestic resources for HIV response, and gender equality and equity.

HIV PREVENTION

As part of the combination prevention approach of the 2015-2020 strategic plan, the behavior change communication component largely targeted the general population, in school youth, and MARPs. Ethiopia started rolling out pre-exposure prophylaxis (PrEp) in late 2019 targeting female sex workers and HIV discordant couples. As part of the prevention program, though male circumcision rates are generally high in Ethiopia (90%) (2016 EDHS), the country carried out VMMC procedures for more than 120,000 people in Gambella region where HIV prevalence was high (6.5%) and where there was low male circumcision coverage (<10%) in 2009. Through the end of September 2019, the coverage increased to 71%. Women living with HIV have up to five times higher risk of pre-cancer and invasive cervical cancer. Hence, WHO recommends all women with HIV be screened for cervical cancer regardless of age. In Ethiopia, between 2017- 2018, only 16% of urban HIV-positive women aged 30-49 years reported being screened for cervical cancer. To prevent cervical cancer, Ethiopia launched a Human Papillomavirus (HPV) vaccination pilot project in December 2015 targeting adolescent girls aged 9-13 years. Subsequently, the country provided the Human Papillomavirus (HPV) vaccine to 96 percent of girls aged 14 across the country by July 2019. Worth noting is that cervical cancer is neglected in the national HIV strategic plan (2015-2020) with no mentioning of it at all and the strategies on how to address the problem. However, prevention and screening of cervical cancer are included among the key elements of chronic HIV care in the national guidelines 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.

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

HIV TREATMENT

In Ethiopia, 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. In its effort to achieve the 90-90-90 global targets, by 2019, 79% of PLHIV knew their status; 90% of eligible PLHIV were put on ART, and 91% of those on ART have attained viral suppression. 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 (74%) as well as among adolescents and youth (83%). In Ethiopia, women are also more likely to discontinue antiretroviral therapy for fear of revealing their HIV status to their husbands to avoid the risk of negatively affecting their marriage or getting divorced.

GENDER CONSIDERATIONS ACCORDING TO THE COMMUNITY: WOMEN AND GIRLS, MEN AND BOYS, KEY POPULATIONS

Women and girls: 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 and the National HIV/AIDS Policy. Besides the 1994 Constitution 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 and 2004 Revised Penal Code. Besides, the government has developed the National Action Plan for Gender Equality (NAP-GE) 2006-2010 which is considered as its commitment to the Beijing Plan of Action. HIV status is a prohibited ground of discrimination under the 'rights to equality' of the FDRE Constitution [Article 25] that guarantees all people's equality before the law and the equal and effective protection of all persons without any discrimination. Ministries have also subsequently tried to mainstream gender in all the policies, laws, development programs, and projects they formulate to ensure women, children, and youth benefit from it.

Despite all these efforts, because the HIV policy was enacted two decades ago, it does not address particularly the new 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 born with HIV, the fact that they now have reached adolescence, and they have different, reproductive health, HIV, and gender-related problems. Besides, though the National Policy on Women recognizes the collective unparalleled health and health-related challenges faced by Ethiopia, it is shy about addressing issues related to HIV as it failed to mention the term "HIV" even once. It is also important to recognize that women and girls are not homogenous while they have diverse needs and experiences as gender is not the only factor that affects their vulnerability to HIV.

Men and boys: Though most HIV responses in Ethiopia are gender-sensitive which by and 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.

The NAP-GE identified male involvement as one of the strategies in improving the RH and HIV status and rights of women and girls. Besides, while the National HIV Strategic Plan (2015-2020) also indicated low male involvement as one of the major demand-side constraints for PMTCT, the strategies to tackle this problem are not addressed explicitly. Usually, the failure to involve men and boys 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. On the other hand, it is also important to recognize that men and boys are not homogenous groups but diverse with various needs and experiences like that of women and girls. Worth-mentioning is that rape and sexual harassment among boys is also a growing threat mainly in urban areas in Ethiopia.

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 FSWs and their clients, mobile groups, long-distance truck drivers, military personnel, youth groups, street children, refugees, prisoners, and others. However, none of the policy documents or the strategic plans have touched issues of other international key populations including people who use injectable drugs and others. There is also a scarcity of evidence on 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. This may in turn affect their access to HIV services as well as protection of their sexual and reproductive health rights.

Young people: 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 in 2004 followed by the National Adolescent and Youth Health Strategy documents (2007-2015 and 2016-2020, respectively). Besides, other policies, strategies, and legislation that recognize and

prioritize the health of adolescents & youth comprising 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. The 2004 Revised Family Law allows adolescents and youth to use contraceptives without parental consent. Similarly, the national guideline for comprehensive HIV prevention, care, and treatment grants mature minors and adolescents above 15 years to access HIV treatment and care services by giving self-consent.

However, the RH related education and services that are provided by different partners and the government are inadequate and 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. Ethiopia's National Youth Policy does not also 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).

GENDER ASPECTS OF COMMUNITY AND HOME-BASED CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV

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 and on a scheme of ability to pay by giving special attention to people who are abandoned and helpless. Besides, the national guideline for Comprehensive HIV Prevention, Care, and Treatment of Ethiopia also focuses on addressing barriers to access testing, prevention, and treatment services particularly key populations. The document outlines the measures that should 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 see strategies for addressing the problems of women living with HIV through a gender lens.

HUMAN RIGHTS VIOLATIONS IN SERVICES AND PROGRAMMES

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. The practice of domestic violence against women has been high in Ethiopia despite various efforts. The country's 2010/11–2014/15 strategic plan on HIV and AIDS 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 to HIV/AIDS while enforcing the existing anti-discriminatory laws 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. Though both the HIV policy and the current five-year HIV strategic plan (2015-2020) identified community or women empowerment as one strategy towards achieving gender equality and equity, the documents lack clarity and do not elucidate the implementation of empowerment of key populations within the strategy so they know and claim their rights.

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

IMPACT OF COVID-19 AND HIV AND GENDER

Though there are limited pieces of evidence that show the impact of COVID-19 on PLHIV, the pandemic may affect service provision related to HIV in many ways. Because of the different measures taken by the Ethiopian government including physical distancing, PLHIVs are fearful to go out to health services to access their medicine and getting counseling as well as other health services as per their schedules. Disruptions in supply chains may also affect PLHIV's adherence to their ART. 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. Besides, it may have a huge impact on the national HIV response by hampering efforts made towards achieving the 90/90/90 targets.

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 achievements regarding gender equality and women empowerment. There is also a tendency to an increased risk of gender-based violence during the COVID-19 pandemic compounded by disrupted services to victims of gender-based violence.

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"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."

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

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