The Health Problems in Sub-Saharan Africa and the Role of Development Aid in Addressing Them: The Case of Ethiopia

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HIV/AIDS Current Situations in Ethiopia

Situational Analysis:

Ethiopia is the second most populous country in Sub-Saharan Africa heavily affected by HIV/AIDS. Ethiopia’s population reached an estimated 73 million in mid-2005, and is expected to grow by over 2.0% annually through 2025. Ethiopia’s population is young with 43% under the age of 15 years. Eighty-four percent of the population is rural.

In 2005, it is estimated that a total of 1,320,000 people are living with HIV/AIDS, of which 634,000 are living in rural areas and 686,000 in urban areas. In the 15-29 age groups, there were more women living with HIV/AIDS than men; conversely in the 30+ age group, there were more men living with HIV/AIDS than women. It is also estimated, a total of 137,500 new AIDS cases, 128,900 new HIV infections including 30,300 HIV positive births, and 134,500 AIDS deaths occurred. It is estimated that there are a total of 744,100 AIDS orphans aged 0-14 of which 529,800 were maternal, 464,500 paternal, and 250,200 dual orphans. HIV/AIDS accounted for 32% of the estimated 141,000 of TB cases in 2005. The estimated total number of persons requiring ART in 2005 is 277,800 (including 43,100 children). Over all AIDS accounted for an estimated 34% of all 15-49 adult deaths, in urban areas it accounts for 66.3% of all adult deaths. Of the total 564,351 VCT clients reported during Ethiopian Fiscal Year 1998 (July 1, 1997 – June 30, 1998), 13.7% were HIV positive (15.7% among females and 11.6% among males).

Although these estimates indicate some encouraging signs of that the epidemic is showing a slowly decline, the change is not sufficient enough compared to the desired goals of the response against the epidemic. Given the
magnitude of the problem, it will take a number of years to see significant declines in HIV prevalence and incidence reductions with consorted and sustained efforts. Although there are advances in the availability, accessibility and utilization of HIV/AIDS prevention, care, support and treatment services; improvements in the management of the epidemic and the increasing resource availability, Ethiopia still face a situation unlikely to give respite in the near future. Despite all the challenges, the government of Ethiopia and its partners are working hard to contain the epidemic and the achievements so far are encouraging.

National Responses

The Government is credited for creating the necessary policy framework, structures, and guidelines to respond to the HIV/AIDS epidemic. This includes adoption of a comprehensive national HIV/AIDS policy in 1998, establishment of the National AIDS Council and Secretariat in 2000, and launching of the Strategic Framework for the National Response. The HIV/AIDS Prevention and Control Office (HAPCO) was established in 2002. It had developed and implemented a five years (2000-2004) national strategic framework as part of the national response to HIV/AIDS. The framework identifies 9 priority areas: IEC/BCC, condom promotion, VCT, STDS management, blood safety, PMTCT, care and support, legislation/human rights surveillance & research. The strategic plan for the succeeding four years (2005-2008) focuses on the provision of preventive, care, support and treatment services and stipulated ambitious targets. According to the plan, the implementation of all the programs were to be based on the principles and approaches of multi-sectoralism, decentralization, community mobilization and ownership, partnership and the principles of “the three ones”. Encouraging achievements were seen with in the last one and half years of the start of the implementation of the five years strategic plan. These include training and deployment of health extension workers who are implementing the health extension package, the construction and furnishing of various health institutions specially in rural areas, the massive scale-up of ART, HCT and PMTCT services and the massive involvements of communities in the provision of IEC/BCC, social care and support and other activities. Although much has improved since the restructuring, national implementation capacity remains a major challenge. The launching of the National Partnership Forum against AIDS in Ethiopia in March 2004 represents an attempt to address the coordination issues at a national level.
HIV was first detected in Ethiopia in stored sera collected in 1984 and the first two AIDS cases were reported in 1986. A National HIV/AIDS taskforce was established in 1985 and the National AIDS Control Program (NACP) was established at a Department level at the MOH in 1987. There are many factors that promote the spread of the disease including the presence of sexually transmitted infections, gender inequality, multiple sexual partners, prostitution, unsafe blood transfusion, and transmission from infected mother to her fetus/child during pregnancy and breast-feeding.

**Prevention and Control**

The first anti-HIV/AIDS program developed by the Ministry of Health shortly after the discovery of the first HIV infections in 1985. Major achievements of the NACP include the establishment of a surveillance system, education, mobilization of vulnerable groups (CSWs and truck drivers) and providing them with psychosocial and material support.

The government developed collaborative HIV/AIDS programs with several governments with the aim of building capacity in the national collaborating institutions. Some model and exemplary tasks are accomplished through these collaborations in the area of biomedical research and in setting primary prevention programs. However, much of the desired capacity has not been built due to many reasons, including high turn-over of staff at all levels, bureaucratic hurdles and poor resource absorption capacity.

The increasing awareness of HIV/AIDS in the population and increased accessibility of condoms have generally boosted preventive behaviors, although progress has been uneven and much less than what is needed to curb the epidemic. Although condom sales in Ethiopia increased negative attitudes toward condom use persist. A psychosocial study of risk and preventive behaviour among high school students concluded that greater condom acceptance was possible if attitudinal barriers can be reduced. Deep seated religious beliefs in the value of fertility which consider condom use as sinful and unacceptable may only gradually be overcome. Fear of stigma continues to prevent private and public disclosure of HIV status and discussion of safer sex practices and the prevention of mother-to-child transmission, and the moral issue of HIV prevents many people from participating in prevention activities. Preventive services, including VCT, are still scarce in Ethiopia but the demand is high and increasing throughout the country. Besides the scarcity, lack of standardization and quality are major problems for the services available.

**Prevention of Mother-to-Child Transmission (PMTCT)**
Only about one-third of pregnant women receive any antenatal care in Ethiopia and less than 10% of them deliver in a health care facility. It is estimated that annually 115,000 HIV-infected pregnant women give birth, and approximately 40,000 newborns are infected through mother-to-child transmission. The National Guideline on Prevention of Mother-to-Child Transmission was published by MOH in 2001. The Nigat Project had been the only PMTCT program in the country until 2003. PMTCT services are being provided at three referral hospitals and 20 health centres in Addis Ababa. Over 20,000 mothers have received PMTCT Services, of which some 800 mother/infant pairs received Niverapine.

In August 2003, as part of The National PMTCT scale-up Program under the President’s Mother and Child HIV Prevention Initiative formed locally by the US Government Partners Forum called “The Hareg Project” was established. The Hareg program, a National Implementation Framework, completed baseline assessments of the 27 sites; conducted training of care providers and program managers from the selected regions; held regional planning meetings; and developed site level plans. Through the President’s Mother and Child HIV Prevention Initiative, provision of PMTCT services were initiated in March 2004 in 14 hospitals and 13 health centres. Several rounds of trainings on PMTCT and Infection Prevention (IP) have been conducted. Since September 2003 some 80 health care providers were trained in PMTCT knowledge and skills. The Annual report for Ethiopian Fiscal year 1998 (July 1, 1997 – June 30, 1998) indicates that a total of 52,428 pregnant women were tested for HIV. Among these, 4,172 (8%) tested HIV positive. Of these, 2,208 (52.9%) of the pregnant women and 1,341 (32%) of their babies received Niverapine for PMTCT.

Treatment

The ART program in Ethiopia was launched in July 2003 mainly for people who can afford to pay for the treatment. At the start of the program the cost range was 30 to 90 $US per month, depending on the drug selected for treatment. This cost did not include the 36 to 80 $US needed for CD4 counts. The current ART delivery model is hospital and Health centres based and largely run by physicians. Training of ART teams from selected hospitals has been provided to ensure quality of services. Each team consists of a physician, a nurse/counsellor, a pharmacist and a laboratory technician. Only trained physicians and pharmacists are allowed to prescribe and dispense ARV drugs. There are a number of initiatives that are working to expand the availability of ART in Ethiopia, including the Global Fund (GF) and the President’s
Emergency Plan for AIDS Relief (PEPFAR), Ethiopian North American Health Professionals Association (ENAHAPA) and Ethiopian Red Cross Society initiatives, of which those of the GF and PEPFAR are the largest. One site supported by MSF Holland in Tigray has initiated free delivery of ART, although on a limited scale, with few patients enrolled each month. The Ministry of Health has issued guidelines for the use of antiretroviral drugs and voluntary HIV counselling and testing as well as a handbook on HIV/AIDS home care and a policy on antiretroviral drugs supply and use to facilitate the use of proper procedures and drug regimens and for training health workers in patient treatment and care

In January 2005, the government of Ethiopia launched the “Accelerating Access to HIV/AIDS Treatment in Ethiopia, Road map 2004-2006.” The plan aims to provide universal access to ART for all AIDS patients by the year 2008. According to the Road Map, the plan was to enrol 100,000 patients by the end of 2006. By the end of December, 2006, 100,000 patients had ever started on ART at 132 facilities across the country. Of these around 53,000 were on treatment currently and 18,384 were enrolled in the first six months of 2006. A total of 277,757 persons including 213,306 (76.8%) adults in the age group 15-49 years and 43,055 (15.5%) children in the age of 0 to 14 years are estimated to require ART in 2005.

**Care and Support of PLWHA**

The rapidly increasing number of AIDS cases in Ethiopia and the over occupancy of hospitals demand adequate, appropriate and sustainable home-based care and support services involving mainly families and faith-based institutions, NGOs and private institutions. Ethiopia adopted home-based care as a strategy and issued national guidelines in 1996 and 2001 to help organize these services and prepared a training manuals and guidelines in 2006. While most families care for and support PLWHA, the quality and duration of care are uneven, largely due to stigma and lack of resources, and some PLWHA are even abandoned. Persistence of stigma and discrimination in the family and community settings cause many PLWHA to delay disclosure. Among other groups and individuals who are increasingly rendering care and support to PLWHA, NGOs and other community-based organizations, health care workers and institutions, volunteers as well as PLWHA are considered to be particularly suitable in providing education, counselling, primary medical care and social support services.
The Ethiopian Behavioural Surveillance Survey (BSS).

The first Behavioural Surveillance Survey (BSS) in Ethiopia was conducted in 2002 to complement the ANC-based and other HIV surveillance systems instituted nationally so that it will serve as a monitoring and evaluation tool designed to track trends in HIV/AIDS-related knowledge, attitudes, behaviours and practices among sub-populations at different levels of risk of HIV infection such as female sex workers (FSW), uniformed services, long distance drivers, pastoralists, and youth.

Summary findings from the BSS round two revealed that more than 98% of the study population were aware of HIV/AIDS except in pastoralists (80%). Almost all the study population knew at least one prevention method; about 86% knew two of the three preventive methods, and nearly 55% knew all three. Knowledge of prevention methods increased with increasing exposure to HIV/AIDS messages in various media sources (radio, TV, and printed media). The study also indicated increased knowledge with increasing education level, especially among In-School Youth.

**HIV/AIDS Estimates**

In 2005, the fitted national HIV prevalence was 3.5% (10.5% for urban and 1.9% for rural areas). The combined HIV prevalence for the country suggests a slowly declining trend. Based on these estimates, a total of 1,320,000 (590,000 males and 730,000 females) persons were living with HIV/AIDS in the country in 2005. There were a total of 137,499 new AIDS cases in 2005. The number of new AIDS cases in urban areas peaked in 2003-2004 and declined 2005 onwards. It has been increasing from 1988 to 1992 after which it started to decline until 2002. It is projected to remain stable for the next five years. The estimated HIV incidence for urban areas of Ethiopia for in 2005 was 0.99%. It showed a rapid increase in the late 1980’s and early 1990’s peaking in 1992 followed by decline until 2002. HIV incidence in urban areas showed a relative stability after 2002 and is expected to remain stable in the subsequent five years. The HIV incidence in rural Ethiopia for 2005 is estimated at 0.12%. The rate started to increase in the early 1990s and reached its highest levels in the mid 1990s. HIV incidence began declining in 1996 onwards and is projected to stabilize in the coming five years. The above incidence rates translate to a total of 128,922 new HIV infections in 2005 including 30,338 HIV positive births (mother-to-child infections). The number of new infections for urban areas had been greater than that of the rural areas until 1994; beginning 1995, the number of new infections in rural areas had surpassed that of urban areas until 2001. It was estimated that there were 105,675 (urban 45,982 and rural 59,693) HIV-infected pregnant women in 2005.
In 2005, it is estimated that there were 134,450 AIDS deaths in the country including 20,929 children. The number of adult AIDS deaths in urban Ethiopia is estimated to have been larger than that in rural Ethiopia until 2005 but were projected to be higher in rural Ethiopia from 2006 onwards due to the greater availability of ART in urban areas. However, AIDS deaths in both rural and urban areas are expected to decline from 2006 onwards though more pronounced in urban areas. Of the estimated 20,929 AIDS deaths among children 0-14 years in 2005, 83.6% were estimated to have occurred amongst children under five years old and among these 60% likely occurred in rural areas. Due to the planned PMTCT program and ART among children, the number of under-five AIDS deaths is expected to decline from 2006 onwards and is projected to be 41% lower in 2010 compared to 2005.

In 2005, it was estimated that there were a total of 4,885,337 orphans aged 0-17 years; of which, 744,100 were AIDS orphans. Of the total number of AIDS orphans, 529,777 were maternal, 464,506 paternal, and 250,195 dual orphans. For total orphans, the number of dual orphans is subtracted from the sum of maternal and paternal AIDS orphans.

The national HIV prevalence in 2005 is estimated to be 3.5%; 3% among males and 4% among females. Of the estimated 1.32 million PLWHA in 2005, 730,000 (55%) were females. Females also accounted for 54.5% of AIDS deaths and 53.2% of new infections in 2005. In the age group 15-29 years, there were more women living with HIV/AIDS than men; in the age group 30+ years, there were more men living with HIV/AIDS than women. The Annual report for Ethiopian Fiscal year 1998 (July 1, 1997 – June 30, 1998) indicates that a total of 564,351 VCT clients received counselling and testing services. The proportion of males and females was nearly equal. The overall HIV prevalence among VCT clients was 13.7%; and was 15.7% amongst female and 11.6% amongst male VCT clients.

Impacts of HIV/AIDS

HIV/AIDS has had a detrimental socio-economic impact on Ethiopia. Findings from the ANC-based sentinel surveillance and studies conducted at schools, workplaces, and among orphans all indicate similar impacts. HIV/AIDS accounted for about 32% of the estimated 141,000 total TB cases in 2005. The cumulative number of AIDS deaths was 1,267,000 by 2005 and is projected to reach 1.9 million by 2010 if present trends continue. Adult (15-49 years) deaths due to AIDS progressively increased up to 2005 when they accounted for 35% of young adult deaths and are expected to dramatically decline up to 2009. The main reason for the decline is the anticipated univer-
sal ART coverage as per the MOH’s plan. The HIV prevalence is expected to increase as the number of people taking ART increases. Assuming a successful implementation of the MOH’s ART rollout plan, the number of AIDS deaths will start to decline from 2005 onwards. By the year 2010, there will be 41% fewer AIDS deaths compared to a projection without an ART program. The massive scale-up of ART as planned should also decrease the number of AIDS orphans by preventing the death of HIV-infected parents. The estimated number of AIDS orphans could be 13% lower with universal ART access by 2010.

**HIV/AIDS Funding in Ethiopia**

The bilateral and multilateral organizations have significantly increased their technical and financial supports of which Global Fund PEPFAR and World Bank are among the major ones to be mentioned. Following the Global Fund to Fight AIDS, Tuberculosis and Malaria, President’s Emergency Plan for AIDS Relief (PEPFAR) is the second largest donor in the HIV/AIDS sector in Ethiopia. The World Bank MAP has been one of the major sources of funding of Ethiopia’s five-year strategic framework (2001-2005) with a soft loan of USD 63.4 million. Additional sources now include the planned WHO 3x5 Strategy, as well as other bilateral, multi-lateral, non-governmental organizations, and private foundations.

According to the Strategic Framework for the National Response to HIV/AIDS, obstacles to implementing an effective response include:

- Improving access and overall quality of HIV/AIDS/STD services;
- Addressing the social stigma attached to persons living with HIV/AIDS;
- Addressing professional resistance to introduction of syndromic management of STDs;
- Addressing the lack of power among women to negotiate condom use;
- Reversing negative attitudes toward condom use among men;
- Addressing religious and cultural barriers to gender equality; and
- Establishing a coordinating mechanism for partnerships among government, NGOs and the private sector.

**Conclusion**

Available evidence from Ethiopia presented in this chapter corroborates earlier studies in Africa indicating that individual HIV/AIDS risk factors need
to be examined in the context of the socioeconomic, cultural and political environment for a more comprehensive understanding of the driving forces of the epidemic for prevention and control purposes. Although the major driving forces of the epidemic: poverty, gender inequity and stigma, have been considered by the Multi-sectoral HIV/AIDS Strategy, many pathways along which they operate remain to be identified. As more epidemiological and behavioral information becomes available for different population groups relationships between direct and indirect effects of these macro forces can be elucidated for effective interventions. It is also evident that HIV/AIDS prevention and control activities require considerably more resources, inter-sectoral, inter-institutional and inter-disciplinary interaction, broadly based community participation, innovative approaches, and international support than what has been achieved so far.

Although the current major driving forces of the epidemic have been addressed by the Ethiopian government through poverty reduction programs, social policies and other legislation, and national and international collaborative programs, the intransigence of these problems and weak capacity continue to impede prevention and control programs.

The recent reports of reductions in high risk sexual behavior and HIV infection rates in some urban populations and government agencies indicate that the various constraints in facing interventions can be overcome through focused, well managed programs. However, most methods used may not be applicable to rural populations, which require the mobilization of community-based organizations and the strengthening of capacity. Recent findings of reduced risk behavior from programs initiated by faith-based organizations and other community-based groups in rural areas, stigma reduction and PLWHA care and support call for follow-up evaluations with a view to upgrading and upscaling programs at the national level. Relatively low infection rates in children provide a window of hope if educational programs that promote preventive behavior by the time they become sexually active can be strengthened and the socioeconomic environment of AIDS orphans and street children improved.

All activities and programs will require an enabling, proactive environment facilitated by poverty reduction, a stronger health and social infrastructure, intersectoral collaboration, proper mainstreaming and proactive leadership at all levels of the government, the private sector, civil society and the international community. Sustaining and upgrading programs to regional and national levels during the current economic and environmental crisis consti-
tutes a major challenge for the Ethiopian Government and the people at large. Strong emphasis needs to be given to large-scale and coordinated interventions in order to achieve success in the prevention and control of the HIV epidemic.

References


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