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**World Health Organization**



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**3 by 5 Country Emergency Mission to  
ETHIOPIA**

*MISSION REPORT*



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## **Table of Contents**

<b>Contents</b> .....	1
<b>Acronyms</b> .....	2
<b>Executive summary</b> .....	3
<b>Introduction</b> .....	6
<b>The 3 by 5 Initiative</b>	
The declaration .....	7
The core premises .....	7
The WHO strategy.....	7
Experience.....	8
<b>The current situation and plans for ART in Ethiopia</b>	
ART in Ethiopia.....	9
Processes and products.....	9
<b>Assessment of Ethiopia’s capacity to achieve the 3 by 5 target</b>	
The Ethiopia 3 by 5 target.....	11
Strengths, which support scale up and speed up.....	11
Challenges.....	13
<b>The way forward</b>	
Aktacha (Direction) .....	16
Proposed steps and WHO proposed support.....	17
<b>Conclusion</b> .....	18
<b>Annexes:</b>	
Annex I: Health Services Organisation and Delivery.....	19
Annex II: HAPCO financial table .....	24
Annex: III: Itinerary of the Planning Mission.....	25
Annex IV: Debriefing Presentation –MOH.....	29

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## Acronyms:

AAU	Addis Ababa University
AIDS	Acquired Immune Deficiency Syndrome
AMDS	AIDS Medicines and Diagnosis Service
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control (US)
DACA	Drug Administration and Control Authority
EMSAP	Ethiopian Multi-Sectoral AIDS Programme
EHNRI	Ethiopian Health and Nutrition Research Institute
ENA	Essential Nutrition Action
FBO	Faith Based Organization
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
HAPCO	HIV/AIDS Prevention & Control Office
HIV	Human Immunodeficiency Virus
M & E	Monitoring and Evaluation
MOD	Ministry of Defense
MOH	Ministry of Health
NAC	National AIDS Council
NGO	Non-governmental Organization
OI	Opportunistic Infections
PASS	Pharmaceuticals and supplies service
PEPFAR	President Bush's Emergency Plan for AIDS Relief
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RHB	Regional Health Bureau
STI	Sexually Transmitted Infections
TB	Tuberculosis
TWG	Technical Working Group (UN)
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

## **Executive Summary**

### **Introduction:**

1. HIV/AIDS is hitting Ethiopia in its fundamental wealth, claiming an estimated toll of as many as 220.000 lives annually, most of which are young and in the prime of their productive age. This annual death toll might even increase up to 300.000 deaths every year (MoH 2003) unless effective prevention and treatment strategies are made available to contain the disease. Antiretroviral therapy is known to be feasible and effective in reducing morbidity and mortality. It could also have an important impact on the transmission of the infection.
2. There is an obvious emergency context.
  - Soon after the adoption of the UNGASS Declaration of Commitment, in June 2001, the National AIDS Council of Ethiopia has declared HIV/AIDS a National Emergency.
  - On the 22<sup>nd</sup> of September 2003, the WHO's Director General has declared the lack of access to anti-retroviral therapy (ART) a global health emergency.
3. Financial resources for HIV/AIDS are available and should be mobilized for ARV in response to the strong hope and demand that ARVs will be made available, accessible and affordable to all in the country.

### **The 3 by 5 Initiative and the scoping mission.**

4. To respond to this emergency situation, WHO has set an ambitious 3 by 5 target: challenging the world to deliver, by the end of 2005, antiretroviral treatment to 50% (3 million) of those who need the treatment worldwide. This is an interim step towards the goal of universal ARV access for all.
5. If this principle is adopted by the Ethiopian Government, the national 3 by 5 target would be *150,000 PLHA on ART in Ethiopia by the end of 2005*.
6. The Ministry of Health in Ethiopia was among the first to respond to the 3by5 initiative and has invited WHO to send a mission to the country. This mission has visited Ethiopia to present, discuss and advocate for the 3 by 5 Initiative, to assess the current ART situation in the country and its potential for scaling up ART in line with the 3 by 5 target, and to identify opportunities and steps for building up an emergency response.

### **The current and planned situation of ARV in Ethiopia**

7. An ART programme was launched in July 2003, based on selected hospitals. To date, around 4,500 paying patients have been included, in 7 regions. There are plans to expand this programme, under the same conditions, to all regions.
8. However, viability of the programme is challenged by the financial capacity of the few able to pay. As the cost is the major constraint to care-seekers, this approach brings up the question of equity.

### **Assessment of the country capacity to scale up ART programme in line with 3 by 5**

9. The Ministry of Health is currently chairing HAPCO, the HIV/AIDS Prevention and Control Office, which, at federal level, coordinates the implementation of the country's HIV/AIDS policy. Each region has its own regional health bureau and an HAPCO.

Through the ongoing decentralization process, the capacity building of regional and district hospitals, the health system is strengthened mainly at the referral level. Communities need to be empowered in their access to care and treatment, including ARV's. Appropriate ART delivery models based on hospitals and health centers, will contribute to increase demand, and create the appropriate interface between communities and health services.

10. There is a strong commitment of all stakeholders, and a significant amount of financial resources is available within the HIV/AIDS multi-sectoral framework (HAPCO financial plan, annex VI) In addition to those secured resources, the CCM has indicated his intention to submit a proposal to the GFATM to support ARV delivery.

11. Guidelines, norms and regulations for ARV delivery have been issued, and although in urgent need of review and update, they constitute precious and solid instruments. The health delivery system is disciplined and committed to make the system working. A human resource plan is however urgently needed to deliver ART on the 3 by 5 scale.

### **Way forward**

#### **Aktacha (Direction)**

12. As presented to the Ministry of Health and the main partners, the strengthening of the HIV/AIDS technical co-ordination unit within the Federal MoH represents a necessary step to ensure technical expertise and co-ordination capacity to the ART programme. The existing unit should include senior staffs, cover a range of technical areas and be technically supported by WHO and other partners.

The Regional Health Bureaus would also require support to strengthening their technical and coordination capacity for managing ART .There is a need for their early involvement in the planning of 3 by 5 programme.

The existing ART taskforce would be structured into a steering committee, with the participation of the active TB/HIV working group. In order to provide maximum support to the HIV/AIDS unit of MoH, respective roles and responsibilities of major HIV/AIDS stakeholders would need to be clearly defined (MoH, at large and PASS in particular, HAPCO, DACA, ENHRI).

13. Some key steps towards a national ART programme will include National Human Resource and Financial Plans, updated ART policy and the development of a roll out plan.

14. The strengthening of a technical platform will also address the design of training modules and tools, the development of a laboratory plan, an IT supported M&E system, and a communication strategy.

15. To ensure extended ART services delivery, strategies will be developed to strengthen the links between communities and health services as well as to the establishment of public- private fora.

16. There is an opportunity to apply to the GFATM for additional resources needed to scale up the ART national programme.

**Next step proposed for WHO support:**

17. It has been proposed that over the next months, WHO (CO, RO and HQ) and other interested partners will support the Ministry of Health in implementing an emergency plan, including:

- Provision of the necessary expertise for the strengthening of the HIV/AIDS unit in the MoH,
- Establishment of the ART steering committee.
- Development of the CCM proposal for the 4<sup>th</sup> round of submission to the GFATM addressing specific ARV needs.
- A consensus workshop to review and update the national ARV policy, the national ART technical platform (guidelines and strategies).
- A Human Resources plan with a capacity building approach.
- A phased ART roll out plan with targets and costing.

**Conclusion**

18. Ethiopia faces a tremendous challenge: the 3 by 5 target brings the fight against HIV to a very high scale. While being one of the most affected countries of the world, Ethiopia is also one of the poorest. If adapted and correctly designed 3 by 5 could have an important impact and a leverage effect in enhancing the overall capacity of the health system.

## **Introduction.**

19. It is estimated that 2.2 million people are living with HIV/AIDS in Ethiopia, including, 220,000 AIDS cases (MoH 2002). The average prevalence rate of HIV infection in the adult population is estimated at 6.6% (with respectively 13.2 % in urban and 3.7 % in rural areas). HIV transmission occurs mainly through heterosexual contact, with the highest incidence in the age group 15 to 24, predominantly affecting women.

Morbidity and mortality associated with HIV/AIDS have a strong impact on the Health Sector, and are among the major impediments to the delivery of quality care to its full capacity. It is estimated that the bed occupancy rate due to AIDS may well exceed 40%.

HIV/AIDS is not only a health problem, but also one of the major challenges for the overall development of the country: it is linked to a 7 year loss in life expectancy, an estimated 1.2 millions orphans, and a loss of productivity and income at the workplace with serious implications at household and community levels.

The annual death toll may even increase up to 300,000 by 2010, unless effective prevention and treatment strategies are implemented to contain the disease. In this regard, it is known that antiretroviral therapy reduces morbidity and mortality, but could also have an impact on the transmission of the infection.

20. This emergency situation is calling for urgent action.

The National AIDS Council of Ethiopia has declared HIV/AIDS a National emergency in June 2001.

On September 22, 2003, the WHO's Director General has declared the lack of access to anti-retroviral therapy (ART) a global health emergency.

The HIV/AIDS situation and the need for ART should then be envisaged as an emergency, treated as such, rapidly, and efficiently with appropriate technical and financial resources. There is no space for debate but for action and the 3 by 5 initiative gives the ground to do it.

21. The Ministry of Health of Ethiopia was among the first to manifest interest in joining 3 by 5 and requested WHO to send an emergency team.

The mission, responding to that request was assigned to:

- Present and discuss 3 x 5 with the Government of Ethiopia and key institutional partners,
- Review the current ART situation and identify opportunities for scale up,
- Review the delivery model and assess its potential for rapid scale up,
- Identify needs & discuss options for ART scale up,
- Identify priority areas for technical support and strengthening WHO responsiveness.

22. Human and financial resources are available and there is a strong hope and demand in the country that ART will be made available, accessible and affordable to all those in need.

## The 3 by 5 Initiative

### The declaration

*“Lack of access to antiretroviral treatment is a global health emergency...To deliver antiretroviral treatment to the millions who need it, we must change the way we think and change the way we act”* Dr Lee Jong-wok

22. Dr JW Lee, with Mr. Kofi Annan, UN Secretary General, and Dr. Peter Piot, UNAIDS Executive Director issued this declaration before the UN General Assembly on 22<sup>nd</sup> September 2003. This unprecedented step was taken against a backdrop of slow progress towards the UNGASS declaration and the 2015 Millennium Development Goals.

Earlier last year, WHO’s Director General, Dr JW Lee, had already designated HIV/AIDS a priority area of work for the Organization and adopted the target of 3 million PLHA in resource constrained settings on ART by the end of the year 2005.

Upon announcement of 3 by 5, WHO invited appeals for immediate help from the worst affected countries and challenged partners to respond more appropriately to fill the treatment gap and for a change in working practice. In an emergency, action cannot be constrained by lack of knowledge on exactly how to do it. We need to learn by doing. This is not business as usual. An emergency response is needed.

### The core premises

24. World wide, six million people infected with HIV are in need of ART, and without it, 3 million people will die this year, next year and for the foreseeable future.

Currently only 400,000 people have access to these life saving drugs in resource limited settings, most of whom live in Brazil. In Africa, a mere 100,000- of 4.4 million in need of ART now - have access to it.

25. **The 3 by 5 goal is for** WHO and its partners to make, within the context of a comprehensive response to HIV/AIDS, the greatest possible contribution toward the ultimate goal of universal access to antiretroviral therapy.

26. **The 3 by 5 target:** 3 million people living with HIV/AIDS in resource constrained countries on ART by the end of 2005.

### The WHO strategy

27. The five pillars of the WHO strategy to helping countries plan and implement the scale up are:

- Global leadership strong partnership and advocacy.
- Urgent and sustained country support.
- Simplified, standardized tools for the delivery of ART.
- Effective, reliable supply of medicines and diagnostics.
- Rapidly identifying and reapplying new knowledge and successes.

28. To these ends WHO will dedicate significant efforts to ensure that:
- Governments take the ownership and leadership in 3 by 5 planning.
  - Sufficient global resources are mobilized.
  - ART is delivered through standardized and simplified interventions.
  - ARVs and related diagnostic supplies are uninterrupted.
  - Communities are involved in ARV and prevention programmes.
  - Simple standard monitoring and evaluation systems will track progress and share strategic information.
29. To date WHO has:
- Made available treatment guidelines for first and second line anti-retroviral treatment regimens,
  - Published uniform tools to track progress ,
  - Started immediate training and capacity development,
  - Established an AIDS Drugs and Diagnostics Facility (AMDS)to assist countries procure best priced quality drug and diagnostic products.
  - Advocated for the mobilization of sufficient resources to close the treatment funding deficit,
  - Sent emergency missions to countries to assess the immediate needs and identify steps and opportunities towards the 3 by 5 target in these countries.

### **Experience**

30. Treatment with antiretroviral therapy has yielded remarkable results in affluent countries and some middle-income countries such as Brazil, where universal access to ART was introduced in 1996. The Government of Brazil has demonstrated the feasibility and cost-effectiveness of ART programme on a national scale. Results achieved between 1996 and 2002 include 60,000 AIDS cases, 90,000 deaths and more than 350,000 AIDS related hospital admissions averted. There is increasing evidence of the feasibility of ART programmes even in severely resource constrained settings, and many groups have shown that ART can be delivered with comparable effectiveness and benefits to that seen in more resourced settings. Recent publications on ongoing experiences are indicating the achievement of quality outputs such as compliance and adherence to treatment protocols.

## **Current Situation and Plans for ART in Ethiopia**

### **ART in Ethiopia**

31. The Ethiopian ART programme was launched in July 2003, although its preparation started as early as 2001, with the establishment of an ART taskforce.

32. The current Delivery Model is Physician led, and Hospital based, while Health Centers can provide ARVs for PMTCT programme only. ARVs are distributed by licensed pharmacists at authorized outlets. The service is provided only for those who can afford to pay for the drugs (30 to over 90USD per month depending of drugs selected) and laboratory costs (adding 36 to 80 USD for CD4 count). It is worth mentioning that the total annual expenditure for health per capita is 3.5 USD (annex III P 23).

33. Several ARVs of different classes have been identified and included in the LIDE (List of Drugs in Ethiopia). However, to date only the following products are available for distribution - Zidovudine, Lamivudine, Stavudine, Efavirenz, Nevirapine, Nelfinavir and a fixed combination of Zidovudine+Lamivudine (lamuzid<sup>®</sup> or combivir<sup>®</sup>)

34. At present an estimated 4500 PLWHA receive ART at 14 hospitals in seven regions. There are plans to extend the programme to 35 Hospitals in 8 regions and later to 115 hospitals countrywide. 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. Armed Forces Hospitals deliver free treatment for their military personnel and spouses, and there were 56 patients enrolled at the time of the visit.

35. To date no post exposure prophylactic treatment (PEP) is readily available to health workers, whereas it is included in the ARV guidelines.

36. After a pilot phase, the PMTCT programme is now being implemented in 4 regions through hospitals and few health centers. A PMTCT+ programme funded by the GFATM will be launched soon.

### **Processes and products**

37. The Federal Ministry of Health in collaboration with DACA, HAPCO and other partners has completed a number of key steps required to introduce ART on a wider scale. Other steps are in progress while more are being planned.

#### Completed Steps:

- A task force set up in February 2001 with members from MOH, HAPCO, DACA, ENHRI, MOD, AAU, WHO, CDC.
- Selection and inclusion of an initial group of ARV drugs in the List of Drugs of Ethiopia (LIDE), July 2001,(included in the list:ABC,ddI,3TC,d4T,ddC,ZDT, ZDT/3TC, ZDV/3TC/ABC, EFZ, NVP,LPV/r, NFV,RTV,SQV).
- A national policy for supply and use of ARV drugs approved by the Council of Ministers in July 2002. The policy provides tax exemption for ARVs and related supplies and defines the modalities of ARV delivery in the country.
- A booklet listing all registered ARVs and fixed combinations published, February 2003.
- Clinical Guidelines for use of ARV drugs in Ethiopia developed, February 2003.

- Guidelines for Procurement Distribution and Use of Antiretroviral Drugs in Ethiopia published, May 2003.
- Monitoring and Evaluation Framework for the Multi-Sectoral Response to HIV/AIDS in Ethiopia published including a section specific to care and ARV treatment.
- Procurement and distribution of ARV drugs to pharmacies facilitated. Currently only Red Cross and Municipality (Kenema) pharmacies are allowed to dispense ARV drugs. To date, countrywide, 22 retail drug outlets are distributing ARVs.
- Training of ART teams from selected hospitals. Each team consists of a physician, nurse/counselor, a pharmacist and a laboratory technician. Only trained physicians and pharmacists are allowed to prescribe and dispense ARV drugs. So far nine rounds of trainings have been conducted and 622 health and pharmacy personnel from 56 hospitals and 22 drug retail outlets have been trained. Training has consisted of a five-day course common to all health workers involved in ART delivery. Neither a structured approach nor specific materials have been developed for the training process.

#### Steps in progress

38. These processes and products are at different stages of development. Some are nearly finalized, others are at conception stage:

- Immediate expansion of services to additional 21 hospitals in 8 regions.
- A second phase of ARV procurement including different ARV dosages and paediatric preparations.
- Possibilities for developing capacity and necessary technology transfer for local manufacturing of ARV drugs (in two Pharmaceutical factories identified by a technical mission supported by the European Union).
- Procurement of CD4 count and viral load equipment, with funding by EMSAP. The equipment is to be installed at twelve sites identified as “referral sites” for ART.
- Negotiations to utilize some resources from GFATM allocated for PMTCT+ to purchase ARV drugs.
- An IEC programme to sensitize the public about HIV/AIDS, which includes a specific component on ARV “treatment literacy”.

## **Assessment of Ethiopia's capacity to achieve the 3 by 5 target**

### **The 3 by 5 Ethiopian target**

39. Based on currently available epidemiological data, it is estimated that 300,000 PLHA would benefit from ART in Ethiopia.

The 3 by 5 target for Ethiopia would therefore be around 150,000 patients on ART by 2005.

### **Scaling up**

40. To date, around 4,500 people have had access to ART.

The gap between the current level of access and the 3 by 5 target appears substantial. The proportion of patients expected to be able to afford the treatment cost is very limited. National Health accounts data for 2001 (Annex III) shows that private expenditure on health amounts to USD2.12 per capita annually with an out of pocket individual spending of USD1.81. Therefore, access to ART cannot be envisaged without a policy of free delivery for those who cannot afford it.

## **Strengths which support scale up and speed up**

### **Commitment:**

42. Government of Ethiopia recognizes the need to strengthen the response to HIV/AIDS at all levels, and within the health sector in particular. A high level of commitment is evident throughout all levels of Government.

The MoH is willing and ready to take on the challenge of scaling up of ART.

Frontline health workers have also expressed similar enthusiasm and commitment.

### **High Demand:**

43. There are calls for increasing access to treatment from PLHA and several partners (Associations of PLHA, care seekers, media, politicians, professional groups, etc.)

### **Health System:**

44. There are 115 hospitals and 412 health centers in the country. Although under-resourced, they represent a consistent infrastructure with potential to provide ART services to a large proportion of PLHA in need of ART.

45. There is in-country expertise on several technical aspects of the ART programme most of which composes a functional ART Taskforce. This includes highly qualified clinicians, lecturers of Addis Ababa University, public health specialists, members of MoH, DACA and HAPCO. The task force has played a crucial role in the development of national ART policies and guidelines. The different documents produced appear consistent with WHO recommendations, but would need updating towards a public health approach.

46. The country is consolidating its public health services into a four-tier system characterized by primary health units, districts –zonal-and referral /specialized hospitals.

The health management system includes the Federal Ministry of Health, eleven regional health bureaus, and 560 districts health offices. The decentralization process is still at an early stage, and has reached uneven levels amongst regions. It has devoted most efforts to strengthen the referral system (HSDP review, March 2003). This process could be further enhanced by a national ART programme in which referral hospitals will have a major role to play, and needs to be balanced and strengthened through the development of Health Centers at community level.

**Financial resources:**

47. US\$55 million are available from the Global Fund, covering a large range of HIV/AIDS activities (Annex V, p 32), for an initial 2-year period with implementation starting on December 2003. This includes a budget of US\$ 5.2 million to support PMTCT+ services. It is understood that some of these resources could be used for procurement of ARV drugs.

48. Ethiopia is one of the countries participating in the President's Emergency Plan for AIDS Relief [PEPFAR]) which has indicated a target of 210,000 patients on ART by 2008.

49. There is provision within the World Bank loan of US\$59 million for the Ethiopian Multi-Sectoral AIDS Programme (EMSAP) to support diagnostic capacity building, including procurement of equipment and consumables, training of personnel. Under this programme, twelve referral laboratories will be equipped with viral load and CD4 count machines.

**Partnership:**

50. The private sector, NGOs and FBOs have expressed a great interest to participate in ART. All levels of the society are concerned and there is a strong pressure from the civil society, private companies, national and international NGO's to contribute to ART. MSF Belgium is willing to support delivery of free ARVs to as many as 1.500 PLHA, including marginalized groups such as CSWs. Private companies have expressed their keen interest to provide ARV treatment to their employees.

The PEPFAR initiative will most likely operate through USAID, CDC and FHI as well as with other partners.

There is a cooperative agreement between CDC and WHO's Regional Office for Africa to support the implementation of an essential package for HIV/AIDS prevention and care, including the secondment of staff to Ethiopia.

The World Bank considers financing the training of 20,000 community health workers within the EMSAP loan, and during visits and meetings, expressed their keen interest to participate in the Human Resource plan of the ART programme.

Several bilateral donors groups, such as HPN and HIV/AIDS donors group have been contacted by the mission. WHO-CO is secretariat to the HPN group. There is a potential for further collaboration including the possibility to mobilize financial resources.

**Entry points:**

51. Since the launch of the ART programme, in July 2003, there was a steep increase in the availability and utilization of VCT services. There is, however, a need for better links between VCT centers - particularly freestanding centers- and the health system, in view of the limited capacity to follow up the PLHA once they have been tested and counseled.

52. There is a strong TB programme with DOTS implemented in all regions. TB/HIV joint activities have been planned for in the context of a GFATM funded programme; they will be launched soon in eight sites. This will strengthen the existing links with HIV services including ART.

53. The PMTCT programme is now launched in 4 regions and there are plans to include ART services to pregnant women, their babies and spouses thus creating become a prominent opportunity for broadening access to ARV within communities.

**Major challenges for Scale up:****Equity issues in access to ART:**

54. The current cost of treatment is unaffordable to most Ethiopians. As suggested by preliminary data from the ongoing ARV programme, there is a significant drop out of enrolled patients. This is a known factor enhancing the risk of the emergence of ARV resistance.

In order to accommodate the largest need for ART and prevent the emergence of resistance, free treatment should be made available. Therefore the national policy on access to ART needs to be urgently reviewed and updated including a new set of eligibility criteria.

Specific strategies are needed to ensure equity and gender balanced access aiming at a countrywide coverage and reaching all socio-cultural groups.

**Decentralization of ARV services**

55. There is currently no provision in the national ARV policy for decentralized service delivery. ART is provided only at referral and provincial (*zonal*) hospitals. Rural hospitals and health centers are excluded from this programme. Scaling up ART services would require an extension within the health system to include more peripheral facilities. Criteria for their selection should be clearly identified. Due consideration should also be given to the private health sector.

**Human Resources:**

56. Whereas financial resources seem to be secured, there is a significant shortage of health workers of all types to serve the health needs of a rapidly expanding population of currently approximately 70 million (annual growth rate 2.9 percent)

57. This shortage is furthermore aggravated by the high turnover of health workers, especially physicians and counselors, throughout the country.

There is clearly a case for considering alternative ART service delivery models, in which roles and responsibilities are distributed across the different profiles of health workers.

58. In the first phase of the Ethiopian ART programme, the training on ART has consisted of a generic five days course common to all health workers involved in ART: physicians, nurses/counselors, pharmacists and laboratory technicians. Trainers were drawn from ENHRI, teaching hospitals, Army military medical services and WHO. Other agencies, such as CRDA, and CDC have also started their own training sessions. There is an urgent need for the development of a structured and standardized approach including specific modules and training materials. Medical schools could contribute to systematic training on ART and could also serve as training pools for –on- the-job and refresher training.

Health workforce availability, in Ethiopia by 2001:

<i>Category</i>	<i>Number</i>
Doctors (all types including health officers)	2,372
Nurses	12,838
Pharmacists	118
Pharmacy technicians	793
Laboratory technician	1,695
Radiographer	247
Health Assistant	8,149
Environmental Health Worker	971
Frontline Health Worker at community level	10,050

Ethiopia Health Sector Development Programme, Final Evaluation, March 3, 2003.

#### **Leadership and Coordination:**

59. As one of the many consequences of the major brain drain affecting the civil service, the HIV/AIDS team of the Ministry of Health, is currently understaffed and several vacancies in RHBs are not filled. This HIV/AIDS unit is evidently overwhelmed by the huge demand for technical guidance and co-ordination across the different levels of the health system (Federal-regional-woreda) and amongst the different partners.

60. This is well reflected by the limited absorptive capacity demonstrated by the health system resulting in a limited utilization of resources available and the delayed implementation of funded activities.

#### **Need to standardize and update the technical platform**

61. ARV norms and standards need to be updated to reflect the advances made in ARV delivery and the options currently available for a public health approach. Issues concerning first and second line regimens, criteria for starting, substituting, switching and stopping ARV, as well as the role of the laboratory should be urgently addressed, in order to provide comprehensive and consistent technical guidance.

#### **M & E Needs:**

62. There is an urgent need for a well-designed M & E framework able to capture clinical data, adherence data, to accommodate for patients mobility and follow up, to learn by doing and reapply the knowledge acquired.

The current system is entirely paper based and does not envisage an IT support. The capacity to collect and analyze the considerable amount of data that are collected at service delivery points remains very limited.

There is a need to ensure full coordination between the M&E framework developed by HAPCO and the ART programme. Likewise, this would have to be a complement within the Health Management Information System (HMIS).

Options for the monitoring of ARV resistance, such as enhancing the capacity of a referral laboratory, such as ENHRI, should be addressed as a pre-requisite in view of the expansion of the ART programme.

## **The way forward:**

### **Aktacha (direction)**

63. Given,

- the emergency situation in Ethiopia,
- the existing opportunities, including a favourable financial landscape and
- the commitment at all levels,

the mission tried to identify a direction for immediate action. The following steps are considered:

**I. Strengthen the HIV/AIDS unit in the Federal Ministry of Health:** This unit, composed of senior specialists will have the mandate to provide technical guidance on matters related to health sector response to HIV/AIDS, including ART and to ensure strong stewardship, management and coordination capacity: WHO and other partners could support the functions of this unit.

**II. Support the HIV/AIDS unit through the establishment of a steering committee,** which could include members of the ART and the TB/HIV working group.

**III. Clarify respective roles and responsibilities** of major stakeholders in HIV/AIDS work, namely the Ministry of Health, HAPCO, DACA, and EHNRI.

**IV. Strengthening the RHB capacity** and the coordination mechanism across the different levels of the service delivery system. RHBs need to be fully involved right from the planning stage of the ART programme.

**V. through a consensus based process, review and update:**

- **The current ARV policy-addressing issues of equity.**
- **The ARV technical platform including the development of a laboratory plan.**

**VI. Develop an IT supported Monitoring and Evaluation system with focus on:**

- Compliance, adherence and clinical outcomes,
- Establishment of a quality assurance scheme using laboratory testing, clinical studies, supervision and operational researches.

**VII. Develop a communication strategy**

**VIII. Strengthen public-private fora and create the necessary interface between the communities and services delivery** through:

- Inclusion of ART in the Health Extension Programme(HEP)
- Implementation of the HEP programme with community health workers, and treatment assistants.
- Taking steps on existing programmes, such as the HIV/TB-GF programme, to benefit from their network, catchment's area,
- Including all partners, the private sector, CBO's

**IX. Develop a roll out plan (phases, targets, human and financial resources).**

**X. Submit a proposal to the GFATM to secure the ARV programme.**

**Next steps and proposed WHO support:**

64. Over the next months, WHO (CO, RO and HQ), hopefully in collaboration with other partners joining in 3 by 5, will intensify its support to the Ministry of Health on a number of critical steps, aiming at the development of a comprehensive roll out plan.

In particular, 3 by 5 will assist in the strengthening of the HIV/AIDS unit in the MoH, and in facilitating the establishment of the ART steering committee.

Some key events of the process have been identified, with the understanding that more would be necessary to finalize the roll out plan. These steps include a consensus workshop to review and update the national ARV policy, and expert consultation to update the national ART guidelines and strategies, to be followed by the development of a national human resource plan.

65. The following tentative timeline is proposed (February-May 2004)

<b>Activity</b>	<b>Timeline</b>
Strengthening the MoH HIV/AIDS Unit	February →
Technical support to develop the GFAMT proposal	Deadline 5 April
Establishment of ART Steering Committee	February/March
Deployment of 3 by 5 technical staff	March
Identification of technical needs and provision of additional expertise (WHO and partners)	March
Consensus workshop for ARV policy review and update	March/April
Experts consultation to update ART guidelines	March/April
Development of a national ART strategy based on delivery models	April
HR and capacity building plan	End April
Development of ART roll-out plan	May
Reprogramming of GFATM and other available resources for ART	May

## **Conclusion**

64. Ethiopia faces a tremendous challenge: the 3 by 5 target brings focus to the fight against HIV to the highest possible scale. While being one of the most affected countries of the world,

Ethiopia is also one of the poorest. If adapted and correctly designed 3 by 5 could have an important impact and a leverage effect in enhancing the overall capacity of the entire health system. A strong and competent HIV/AIDS unit within the Ministry of Health would take a leading role and responsibility in planning and monitoring an extended ART programme, in line with the 3 by 5 initiative. Major coordinating efforts would be required to ensure the highest technical soundness to interventions that will receive support by various partners. The possibility to succeed of what would be a very challenging public health undertaking appears encouragingly supported by the wide range of opportunities and enabling factors identified in this report. What is urgently needed is the adoption of an emergency approach as a guiding principle.

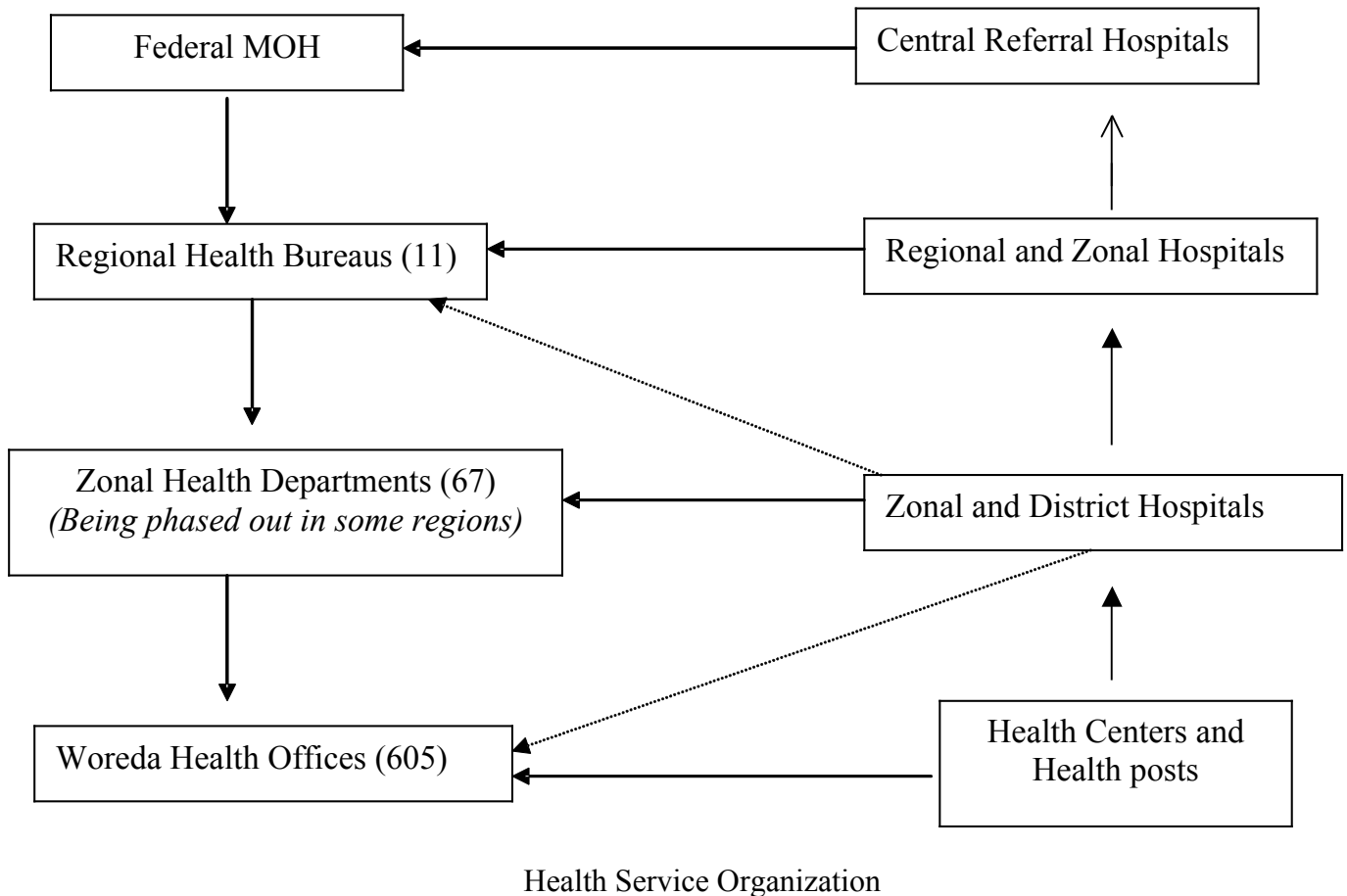
## **Annex I: Health Service Organisation and Delivery**

### **1. Health service organization and administration**

Ethiopia has initiated a process of administrative decentralization, and the health services are delivered through a four-tier system characterized by primary health units, districts –zonal-and referral /specialized hospitals.

The system includes the Federal Ministry of Health, eleven regional health bureaus, and 560 health districts. There are 67 zonal health offices within regions and districts; these are being progressively phased out as part of the decentralization process.

A total of 115 hospitals with 12,000 beds are available throughout the system at various levels. 89 belong to the public sector. There are 412 health Centers: almost one in each district.



The primary Health care unit consists of one health center with up to five satellite health posts. During the first phase of the decentralization process, regions have strengthened the referral system, mainly at regional hospital level.

## 2. HIV/AIDS response and service organization

The MOH has the responsibility to coordinate the health sector response at Federal level and to exert normative functions. The HIV/AIDS team is located in the Diseases Prevention and Control Department (DPCD). It is staffed with five programme officers (laboratory, surveillance, VCT and PMTCT). There is currently no specific position for ART, while other positions remain vacant.

The Government of Ethiopia established a National Taskforce on HIV/AIDS in 1985 and a comprehensive HIV/AIDS policy to promote a multi-sectoral approach for the control of the epidemic (August 1998).

The National Aids Council (NAC) and its secretariat was established in 2000, and the HIV/AIDS Prevention and Control Office (HAPCO) in 2002.

HAPCO:

1. Operates as an autonomous Federal Organ run by a Management Board accountable to the Prime Minister, with representatives from line ministries such as Health (Chair), Youth Sport and Culture, MOFED, PLWA, CRDA, International agencies and prominent individuals.
2. Sustains the national multi-sectoral effort against HIV/AIDS and ensures coordination, monitoring and evaluation.
3. Administers and monitors EMSAP and GFATM funds (for HIV/AIDS whereas the MOH is responsible for the TB and Malaria projects under the Global Fund)

The 3<sup>rd</sup> Joint Review Mission of the Ethiopia Health Sector Development Programme of March 2003 recommended the following:

1. MoH and HAPCO should improve their coordination in the health sector response to HIV/AIDS.  
Likewise, the multi-sectoral response to HIV/AIDS at regional and woreda level needs to strengthen its links with the health sector.
2. Federal MoH has a prime responsibility to ensure and monitor the implementation of HSDP II key activities in the areas of STIs, clinical management of OI and AIDS cases, quality assurance of VCT, blood safety, and all training efforts of these activities.

### **3. Health expenditure**

The recent Public Expenditure Review conducted with the support of the World Bank noted positive development in spending on health over the past years. It also highlighted a relatively low share of government expenditure (distribution: 40 percent government, 52 percent out-of-pocket household expenditure, 7 percent NDO preliminary figures). The largest share of paying for health care thus falls on individuals, burdening the poorest of the poor most.

	Millions Birr	Share of Total (in percent)	Birr per person	US\$ Per person
<b>Total expenditure on health</b>	1,942	100	29.79	3.50
<b>...General government expenditure on health</b>	771	40	11.77	1.38
..... Central government	299	1	4.60	0.54
..... State, regional, provincial authorities	466	24	7.16	0.84
<b>...Private expenditure on health</b>	1,171	60	18.02	2.12
..... Public enterprises	36	2	0.56	0.07
..... NGO's and non-profit institutions	135	7	2.08	0.24
..... Net out-of-pocket spending on health	1,000	52	15.38	1.81

Sources: Various sources including Min. of Health, Min. of Finance, IMF Statistics, and World Bank.

Note: Figures on government spending differ somewhat from those in later tables due to different sources and definitions.

#### 4. Human resources for health:

Human resources form the backbone of any health system and its services regardless of whether they are deployed in the public, private, or non-government sector. Without adequate numbers of staff working throughout the various types of health facilities of a health system based on Primary Health Care it is next to near impossible to reach an entire population with equitable and affordable access to needed care. The following information derived from the Health Sector Development Programme II evaluation gives an overview of the situation of the workforce availability for the nation which is approaching 70 million persons.

Issues common to most service infrastructures on the African continent also loom large: extremely low health worker/population ratio, lack of incentives, demotivation caused by poor working and remuneration conditions. Migration, both external and within country, point to the particular challenge of retention which needs attention within an imbalanced distribution of the workforce throughout the country. In 1998, Addis Ababa recorded a net loss of 2.3 percent of its health workforce. The three regions of Dire Dawa, Harari, and Somali lost 2.5 percent of the health workforce during the same period. (1) The HSDP I evaluation does, however, point out solutions to reversing these trends: Oromi region, for example, is quoted as increasing its health workforce by enhancing public sector salary scales, offering duty and tutor allowances, and implementing transparent transfer policies. Reduction in demand for the private health sector and ethical concerns of staff to return to the public sector helped to reverse the trend.

Ethiopia increased the number of health workers over the years, but to keep pace with population growth (2.9 percent in 2001) and the impact of HIV/AIDS on the demand for services, training and capacity strengthening needs pale in front of these challenges. Taking into account losses due attrition, illness, moves between sectors (public/private/NGOs with different sector development speeds), staff leaving health for another sector, migration etc. the replacement and development needs are tremendous. Further critical issues are staff losses to administrative positions in response to decentralization requirements. For Amhara region, for example, the report quotes 38 percent of trained health workers deployed at Woreda and Zonal administrative units.

#### Workforce availability, 2001

Category	Number
Doctors (all types incl. health officers)	2,372
Nurses	12,838
Pharmacists	118
Pharmacy technicians	793
Laboratory technician	1,695
Radiographer	247
Health Assistant	8,149
Environmental Health Worker	971
Frontline Health Worker (community level)	10,050

(1) Ethiopia Health Sector Development Programme, Final Evaluation, March 3, 2003.

Training capacity increased over the past decade, but output and capacity to deploy face a variety of challenges within the different levels and lines of authority of the evolving decentralized system. There is a lot of room for pressure and conflict to emerge in order to ensure the right balance between patient service access needs at community level and the distribution of decision-making authority at the various administrative levels.

However strong orientation of the system toward PHC and training of up to 30,000 Health extension workers is likely to respond positively to the need for decentralization at community level.

### **5. Workforce deployment for HIV/AIDS care**

It is in this context that the challenges to service needs caused by HIV/AIDS and the now ever increasing demands for care have to be placed with the entire additional burden this will cause to an already over-stretched workforce and service infrastructure. Currently, access to ART is provided by trained physicians (both public and private), pharmacists and counselors who are the only ones authorized to provide this kind of care. Training has so far reached around 200 physicians and around 400 nurses, and pharmacy personnel...

In order to scale up access to ART a specific HR review needs to be conducted to come up with a realistic plan for staff time needs of the various providers in the ART scheme. A number of ART sites and service delivery models have been studied recently. On the basis of an analysis of the applicability of these findings to the Ethiopian context, a more detailed plan can be established taking into account the roles and tasks needing to be assigned for diagnosis, adherence counseling, prescription, dispensing, home visit follow-up, etc.

The table below illustrates the challenges faced by the current system to integrate ART into the existing service infrastructure. Using some simplistic assumptions about service provider and ART patient encounter needs, the existing authorized ART workforce will be hard pressed to integrate the needed full time requirements into their routine daily tasks to reach the coverage goal of 150,000 patients by 2005. New skills and tasks distribution amongst the provider and community network are likely to have to be studied for rapid expansion of access.

## ART workforce needs on the basis of existing norms and standards

A crude estimate for illustration purposes: **For 150,000 patients**

<b>Category</b>	<b>Number</b>	<b>Hours/patient/year</b>	<b>FTE s Clinical needs</b>	<b>FTE including 30% patients Admin and other time</b>
<b>Doctors</b>	1.888	3,5 (7 visits@30min)	328	427
<b>Nurses</b>	12.838	3,5 (7visits@30min)	328	427
<b>Pharmacists</b>	118	3 (12visits@15min)	281	366
<b>Laboratory Technicians</b>	1.695	1,3 (4 visits@20min)	125	163

Data from HSDP II.

NB: This estimate does not include counselors, data entry clerks and other support staff.

nor possible contributions by PLHA and other volunteers from CBOs. No analysis of tasks, skills requirements and skills upgrading/re-distribution attempt.