A RIGHTS-BASED APPROACH TO HIV PREVENTION, CARE, SUPPORT AND TREATMENT: A REVIEW OF ITS IMPLEMENTATION IN ETHIOPIA

by

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ABSTRACT

Although new HIV/AIDS infections and HIV/AIDS-related morbidity and premature mortality show a declining trend globally, HIV/AIDS has continued to be a major setback to socio-economic development in several parts of the world. Countries have employed various strategies to prevent the transmission of HIV/AIDS and mitigate the impact thereof. Research from around the world and accumulated practices have disclosed that HIV prevention, care, support and treatment are essential components to a successful response to HIV/AIDS. There is also a broad global consensus on the effectiveness of using a rights-based approach as a vehicle to ensure access to HIV prevention, care, support and treatment services.

Being one of the Sub-Saharan African countries hit by the epidemic, Ethiopia has adopted laws, policies and strategies that expedite its response to HIV/AIDS. This dissertation analyses the HIV prevention, care, support and treatment-related laws, policies and strategic plans of Ethiopia through the lens of a rights-based approach. The dissertation concludes that, while Ethiopia has taken commendable measures in terms of putting human rights at the centre of the response to HIV/AIDS, there are a multitude of challenges that the country needs to overcome and a number of legal, policy and practical problems that it should rectify, if it is to conform to its HIV/AIDS-related human rights commitments.
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<thead>
<tr>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>ABC</td>
<td>Abstinence, Be Faithful and Condoms</td>
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<tr>
<td>ACHPR</td>
<td>African Charter on Human and Peoples’ Rights</td>
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<tr>
<td>ACRWC</td>
<td>African Charter on the Rights and Welfare of the Child</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>AU</td>
<td>African Union</td>
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<tr>
<td>CBO(s)</td>
<td>Community-Based Organization(s)</td>
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<tr>
<td>CDC</td>
<td>Centre for Disease Control</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
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<tr>
<td>CIS</td>
<td>Community Information System</td>
</tr>
<tr>
<td>CMW</td>
<td>International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Family</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<tr>
<td>CRDA</td>
<td>Christian Relief and Development Association</td>
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<tr>
<td>CSO(s)</td>
<td>Civil Society Organization(s)</td>
</tr>
<tr>
<td>DAG</td>
<td>Development Assistance Group</td>
</tr>
<tr>
<td>EBCA</td>
<td>Ethiopian Business Coalition against HIV/AIDS</td>
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| ECHR         | European Convention on the Protection of Human Rights and Fundamental
<table>
<thead>
<tr>
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<tr>
<td>EGLDAM</td>
<td>Ye Ethiopia Goji Limadawi Dirgitoch Aswogaji Mahiber</td>
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<tr>
<td>EHRC</td>
<td>Ethiopian Human Rights Commission</td>
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<tr>
<td>EHRCO</td>
<td>Ethiopian Human Rights Council</td>
</tr>
<tr>
<td>EIFDDA</td>
<td>Ethiopian Interfaith Faith Forum for Development, Dialogue and Action</td>
</tr>
<tr>
<td>EPHA</td>
<td>Ethiopian Public Health Association</td>
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<tr>
<td>EWDF</td>
<td>Ethiopian Women’s Development Fund</td>
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<tr>
<td>EWLA</td>
<td>Ethiopian Women Lawyers Association</td>
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<tr>
<td>FBO(s)</td>
<td>Faith-Based Organization(s)</td>
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<tr>
<td>FDRE</td>
<td>Federal Democratic Republic of Ethiopia</td>
</tr>
<tr>
<td>FGM</td>
<td>Female Genital Mutilation</td>
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<tr>
<td>FHAPCO</td>
<td>Federal HIV/AIDS Prevention and Control Office</td>
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<tr>
<td>FSW(s)</td>
<td>Female Sex Worker(s)</td>
</tr>
<tr>
<td>GHPWG</td>
<td>Global HIV Prevention Working Group</td>
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<tr>
<td>GIPA</td>
<td>Greater Involvement of People Living with HIV/AIDS</td>
</tr>
<tr>
<td>GTP</td>
<td>Growth and Transformation Plan</td>
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<tr>
<td>HAPCC(s)</td>
<td>HIV/AIDS Prevention and Control Council(s)</td>
</tr>
<tr>
<td>HAPCO(s)</td>
<td>HIV/AIDS Prevention and Control Office(s)</td>
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<tr>
<td>HCT</td>
<td>HIV Testing and Counseling</td>
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<tr>
<td>HIV</td>
<td>Human Immune Deficiency Virus</td>
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<tr>
<td>HPR</td>
<td>House of Peoples' Representatives</td>
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<tr>
<td>HTP(s)</td>
<td>Harmful Traditional Practice(s)</td>
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<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<td>Acronym</td>
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<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
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<tr>
<td>IGA</td>
<td>Income Generating Activities</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labor Organization</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<tr>
<td>MAP</td>
<td>Multi-Country HIV/AIDS Program</td>
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<tr>
<td>MARP(s)</td>
<td>Most-at-Risk Population(s)</td>
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<tr>
<td>MDG(s)</td>
<td>Millennium Development Goal(s)</td>
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<tr>
<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSM</td>
<td>Men Who Have Sex with Men</td>
</tr>
<tr>
<td>MWYCA</td>
<td>Ministry of Women, Youth and Children’s Affairs</td>
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<tr>
<td>NCWHA</td>
<td>National Coalition for Women against HIV/AIDS</td>
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<tr>
<td>NEP+</td>
<td>National Network of Networks of HIV Positives in Ethiopia</td>
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<tr>
<td>NHAPCC</td>
<td>National AIDS Prevention and Control Council</td>
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<tr>
<td>NGO(s)</td>
<td>Non-Governmental Organization(s)</td>
</tr>
<tr>
<td>NNPWE</td>
<td>National Network of Positive Women Ethiopians</td>
</tr>
<tr>
<td>NPF</td>
<td>National Partnership Forum</td>
</tr>
<tr>
<td>OAU</td>
<td>Organization of African Unity</td>
</tr>
<tr>
<td>OHCHR</td>
<td>Office of High Commissioner for Human Rights</td>
</tr>
<tr>
<td>OI(s)</td>
<td>Opportunistic Infection(s)</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PASDEP</td>
<td>Plan for Accelerated and Sustained Development to End Poverty</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PIL</td>
<td>Public Interest Litigation</td>
</tr>
<tr>
<td>PITC</td>
<td>Provider-Initiated Testing and Counseling</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>RBA</td>
<td>Rights-Based Approach</td>
</tr>
<tr>
<td>SNNP</td>
<td>Southern Nations, Nationalities and Peoples</td>
</tr>
<tr>
<td>SPM II</td>
<td>Ethiopian Strategic Plan for Intensifying Multi-sectoral HIV Response 2009-2014</td>
</tr>
<tr>
<td>STI</td>
<td>Sexual Transmitted Infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Program on HIV/AIDS</td>
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<tr>
<td>UNECA</td>
<td>United Nations Economic Commission for Africa</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Cooperation</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
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<tr>
<td>WDIP</td>
<td>Women’s Development Initiative Project</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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ACKNOWLEDGMENTS

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CHAPTER ONE

INTRODUCTION

1.1 Background

As the 2009 and 2010 UNAIDS and WHO AIDS Epidemic Update show, while significant achievement has been made in preventing new HIV infections and in reducing the annual number of AIDS-related premature deaths, the number of PLWHAs still rises, reaching an estimated 32.8 million in 2008 and 33.3 million in 2009.\(^1\) AIDS continues to be one of the top causes of premature death globally.\(^2\) It was estimated that AIDS-related illnesses cause the death of 2 million people in 2008 and 1.8 million people in 2009 globally.\(^3\)

Of all the regions, Sub-Saharan Africa remains the most seriously affected region, accounting for 71% of all new HIV infections in 2008.\(^4\) In the same year, an estimated 1.4 million AIDS-related deaths occurred and 1.9 million people became newly infected with HIV, bringing the total number of people in the region living with HIV to 22.4 million.\(^5\) As is the case in other Sub-Saharan countries, HIV/AIDS has remained among the major causes of deaths over the past two

\(^3\) Id. at 7 and UNAIDS, supra note 1, at 19.
\(^4\) See UNAIDS & WHO, supra note 2, at 2.
\(^5\) Id.
decades in Ethiopia. In 2009, more than one million people were estimated to live with HIV in Ethiopia.

The international community has recognized long ago that HIV/AIDS is one of the most terrifying challenges that undermine social and economic development throughout the world. Its negative impact on socio-economic development is, however, particularly serious in Sub-Saharan Africa where the countries are poor. Various studies make it clear that HIV/AIDS worsens the poverty situation at the individual, household and community levels as well as at the level of the national economy and vice-versa.

The negative impact of HIV/AIDS on socio-economic development is well recognized in the PASDEP, Ethiopia’s guiding strategic framework for the five-year period 2005/06-2009/10. In this document, the Ethiopian Government envisioned “to reach[ing] the level of middle-income countries in the coming 20 to 30 years where democracy and good governance are maintained through people's participation and where good will and social justice are secured.” The document states that HIV/AIDS is “a serious threat to the overall socio-economic development of the country” and is one of the prime factors that “exacerbate the poverty situation, thus

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6 Eleni Seyoum et al., ART Scale-Up in Ethiopia: Success and Challenges (2009).
7 Id.
8 See the UN, United Nations Special Session on HIV/AIDS: Declaration of Commitment on HIV/AIDS, 2001, preamble. The Declaration came out of the UNGASS in 2001. The heads of States and Governments and representatives of States and Governments assembled at the United Nations, from 25 to 27 June 2001, for this special session of the General Assembly, convened in accordance with resolution 55/13 of 3 November 2000, agreed, “as a matter of urgency, to review and address the problem of HIV/AIDS in all its aspects.”
creating the vicious cycle of aggravating the individual and community vulnerability to infections.”

Cognizant of the socio-economic crises that HIV/AIDS poses, countries of the world have committed, at various meetings, to reverse the momentum of the epidemic. At the 2000 Millennium Assembly of the United Nations, the United Nations Member States set a target to halt and reverse the spread of HIV/AIDS by 2015 as one of the MDGs. Following the Millennium Summit, in 2001, Member States made detailed time-bound targets to halt the pandemic at the 2001 UN General Assembly Special Session on HIV/AIDS. These are confirmed and expanded by the Political Declarations of the 2006 and 2011 High Level Meetings on AIDS at the General Assembly.

At the African regional level, too, member States of the AU (and its predecessor, the OAU) have committed themselves “to place the fight against HIV/AIDS at the forefront and as the highest priority issue in … [their] respective national development plans.” To that end, States, under the auspices of the AU, have put in place a number of resolutions and declarations. Ethiopia

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11 Id. at 120.
12 See UN, supra note 8.
14 Abuja Declaration, supra note 14; Framework Plan of Action for the Implementation of the Abuja Declaration on the Control of AIDS, Tuberculosis and Other Related Infectious Diseases OAS/SPS/ABUJA/3 (2001), para. 23 [hereinafter Abuja Declaration].
has also set up institutions\textsuperscript{16} and adopted various policies and strategies\textsuperscript{17} that facilitate effective response to HIV/AIDS. The policies require the mainstreaming of HIV/AIDS in every sector and ensuring that “leadership at all levels sustains HIV/AIDS as a priority development and emergency agenda.”\textsuperscript{18}

An effective response to HIV/AIDS requires integrated and comprehensive HIV prevention, care, and support and treatment programs. Put differently, “HIV Prevention, treatment, care, and support are mutually reinforcing elements and a continuum of an effective response to HIV.”\textsuperscript{19}

Since the first global AIDS strategy was developed in 1987, it has also been recognized that a rights-based approach (RBA) to HIV/AIDS prevention, care and treatment is fundamental to any effective response to HIV/AIDS.\textsuperscript{20}

A RBA demands that universally recognized human rights standards should guide policymakers and lawmakers in formulating the direction and content of HIV-related policy and form an

\textsuperscript{16} The principal institutions include: the NHAPCC established in 2000 and the FHAPCO established in July 2002 to function as the secretariat of NHAPCC.


\textsuperscript{18} See PASDEP, supra note 10, at 123.


integral part of all aspects of national and local responses to HIV. In other words, a RBA requires States to comprehensively integrate human rights principles into design and implementation of HIV/AIDS policies and strategies. By so requiring, a RBA empowers individuals to enforce provision of HIV prevention, care, support and treatment services as a right to them and an obligation of the government, not as charity. A RBA starts from the premise that human rights violations significantly contribute to the spread of HIV/AIDS and undermine attempts to protect individuals from becoming infected, and once infected, from receiving needed treatment and care. Consequently, it requires that the promotion and protection of human rights must be at the heart of any response to the epidemic.

Several years of experience in addressing the HIV epidemic has confirmed that a RBA to HIV/AIDS prevention, care, support and treatment has proved to be productive. This is evidenced from the experience of countries, such as Australia, Brazil, the Netherlands, Switzerland, Thailand, and Uganda. In such countries, the response to HIV in general and HIV policies and strategies in particular is guided by “human rights principles such as participation, non-discrimination and access to information, essential services and life-saving technologies”

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21 See UNAIDS & OHCHR, supra note 19, at para. 99. See also Andr Tun et al., The Domestic Fulfilment of Children’s Rights: Save the Children’s Experiences in the Use of the Rights-Based Approaches, in The UN Children’s Rights Convention: Theory Meets Practice 34 (Andr Alen et al., eds., 2006).
and turn out to be more successful. On the contrary, human rights violations including inequality, discrimination and denial of access and of participation rendered initial HIV/AIDS response ineffective in China, Russia and South Africa.

A RBA to HIV/AIDS has gained almost global acceptance nowadays. That is why countries, including Ethiopia, celebrates the 2009 World AIDS Day under the slogan “universal access [to HIV prevention, care, support and treatment services] and human rights.” This shows the countries’ renewed commitment to use human rights as a tool to fight HIV/AIDS. Though rhetorical recognition of the indispensability of human rights for the AIDS response continues, practical application of human rights principles is significantly lacking.

Against this background, this dissertation explores whether and to what extent a RBA to HIV prevention, care and treatment has been employed in Ethiopia to respond to HIV/AIDS. In other words, it assesses the ways in which Ethiopian national strategic plans and other core documents take into account the commitments made by it to uphold human rights in its efforts towards achieving universal access to HIV prevention, care, support and treatment.

1.2 Research Problem

The main question that is addressed in this research is: Whether and to what extent a RBA to HIV prevention, care, support and treatment has been properly applied in Ethiopia in its response

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27 See Gruskina & Tarantola, supra note 26.

to the HIV/AIDS pandemic? The study addresses this question in a broader context that requires dealing with the following issues: What is a RBA to health in general and HIV prevention, care, support and treatment in particular? Are the HIV testing and counseling policies of Ethiopia in consonant with international human rights standards? What are the specific measures that Ethiopia has taken to realize access to HIV prevention, care, and support and treatment services and to what extent do the measures taken comply with human rights norms? Is intentional or reckless transmission of HIV/AIDS criminalized in Ethiopia? If so, does it in any way contributing to curb the transmission of the virus? What are the human rights implications of such criminalization, if any? Do people living with HIV/AIDS and other stakeholders participate in formulation, execution and evaluation of HIV-related policies? Are there clear and adequate standards that are applicable to ensure accountability for violations of human rights in the context of HIV/AIDS?

1.3 Objectives of the Research

The research has the following objectives: highlighting the elements of the RBA to HIV/AIDS response; delineating the human rights principles governing HIV prevention, care, support and treatment; analyzing the institutional, legislative and policy framework designed to prevent, care and treat HIV/AIDS and exploring their actual operation and implementation in Ethiopia; scrutinizing the conformity of the policies and laws with human rights standards and outlining the specific challenges facing the implementation of a RBA to HIV/AIDS prevention, care, support and treatment in Ethiopia and proposing solutions thereto.
1.4 Significance of the Research

The researcher believes that this study is significant for the following reasons. It will raise the awareness of both HIV negative and positive individuals about their rights in the context of HIV/AIDS and about how to enforce these rights; it will give information to NGOs working on HIV/AIDS; it identifies the legislative, policy, institutional and practical gaps in the implementation of the HIV prevention, care, support and treatment policies and laws and thereby calls for the actions of the legislative, executive and judicial organs of the government and it will serve as a steppingstone for future research in related fields.

1.5 Methodology

The researcher has critically analyzed international and African human rights instruments and the relevant domestic legislation, policies and other documents to develop the conceptual aspect of the research. A reference has also been made to relevant cases and other literature. In order to gather indispensable information regarding the practical application of a RBA to the prevention, care, support and treatment of HIV/AIDS, the researcher used both primary and secondary sources of information. Primary sources include interviews of key personnel of associations of PLWHA, government, donors and civil society organizations (CSOs) and religious and community leaders; focus-group discussions with pertinent people; attend several review meetings and seminars on HIV/AIDS and analysis of judicial decisions. Reports emanating from the government and other partners, such as UNAIDS, WHO, the World Bank, Save the Children, UNICEF, EIFDDA, NEP+ and Ethiopian Business Coalition against HIV/AIDS (EBCA) and research undertaken in relation to HIV/AIDS are used as secondary sources of information.
The Addis Ababa City Administration, Amhara Region, and the SNNP Region are selected as case studies for the practical aspect of the study. These regions are selected because they have higher number of PLWHA and relatively better facilities and infrastructures that facilitate the response to HIV/AIDS in Ethiopia. The researcher believes that the identification of the strengths and weaknesses of HIV prevention, care, support and treatment in these case studies can provide lessons for other regions.

1.6 Limitations of the Study

The field research aspect of the study is conducted in selected areas and will reflect conditions only in these areas. Therefore, it cannot be used to generalize about other areas in country. However, the findings of this study may provide insights and suggest trends which are likely to exist in other parts of the country. The research also focuses on selected institutions. Consequently, it does not represent the strengths and weaknesses of other institutions.

1.7 Literature Review

There are no specific and comprehensive studies on whether and to what extent human rights norms have been used as guidelines in the drafting, formulating, implementation and evaluation of HIV policies and laws in Ethiopia. There are, nonetheless, several works on related topics with specific reference to other countries. There are also studies which give the theoretical basis of the RBA to HIV/AIDS. Some of these works are briefly summarized as follow.

The OHCHR and UNAIDS have jointly published the International Guidelines on HIV/AIDS and Human Rights. The Guidelines underline the need and the imperative to provide guidance to States on how to take concrete steps to protect human rights in the context of HIV. Citing the

29 See UNAIDS & OHCHR, supra note 19.
lessons learned from the evolution of the epidemic, the guidelines confirm that the protection of human rights in the context of HIV reduces suffering, saves lives, protects the public health, and provides for an effective response to HIV. The Guidelines also identify specific human rights that states should respect, protect and fulfill in the context of HIV/AIDS.

WHO and OHCHR\(^{30}\) have developed an important document that outlines the importance and key elements of a human rights-based approach to health. The organizations take a position that a human rights-based approach “support[s] better and more sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices…and unjust power relations which are often at the heart of development problems.”\(^{31}\)

Furthermore, a number of authors have published pieces that specifically deal with a RBA to responding to HIV/AIDS. In 2004, the Canadian HIV/AIDS Legal Network authored a document partly entitled “Programming HIV/AIDS: A Human Rights Approach.”\(^{32}\) The tool “is designed to facilitate the integration of human rights approaches into development programming on HIV/AIDS.” The document sets out four crucial principles of a human rights approach to development, and scrutinizes how these apply to HIV/AIDS programming. The author argued that the spread of HIV and its impact can only be done away with through the protection and promotion of human rights.

Sofia Gruskina and Daniel Tarantola, in an article published in a journal,\(^{33}\) have assessed the ways in which international and national strategic plans and other core documents take into


\(^{31}\) Id.


\(^{33}\) See Gruskina & Tarantola, supra note 26.
account the commitments made by countries to uphold human rights in their efforts towards achieving universal access to HIV prevention, care and treatment. They conclude that despite the rhetorical recognition of the importance of human rights for effective AIDS response, practical application is lacking in many countries.

Helen Watchirs, in an article “A Human Rights Approach to HIV/AIDS: Transforming Obligation into National Laws,” has explored the connection between the HIV/AIDS epidemic and human rights protection. She argues that “a key to reversing the spread of HIV/AIDS and reducing its devastating impact is taking a human rights approach.”

From gender perspective, Human Rights Watch, in its December 2003 Report, has pointed out that the protection of the rights of women and girls in sub-Saharan Africa is a key to turning around the continent’s AIDS crisis. The report also states that relative to the scale of the problem, however, such protection is virtually ignored as a policy tool and is certainly not viewed as a central element in ever larger national AIDS programs. It identifies many gender-based human rights abuses in Africa that fuel the epidemic and make unbearable the lives of women and girls already living with HIV/AIDS. Similarly, Amnesty International, in its 2004 Report, has urged government action through a RBA to the gender-related aspects of HIV/AIDS prevention, treatment and support. The report points to various factors that fuel women’s vulnerability to the HIV/AIDS pandemic, identifies human rights standards applicable for the prevention, care, support and treatment among women and puts forward various recommendations for effectively addressing the problem.

34 See Watchirs, supra note 22.
36 See Amnesty International, supra note 24.
This researcher will make use of these and other similar sources as a point of departure to address the research problem.

1.8 Overview of the Chapters

In order to effectively address the research question posed above, the dissertation is divided into nine chapters. Chapter one sets out the rationale of the research, identify the problem, review the available literature, discuss the limitations of the study and outline the methodology. Chapter two presents the background information on the country, such as its geographical size and population, the HIV/AIDS prevalence rate, laws and policies relevant to HIV/AIDS, a short history of AIDS in Ethiopia and a description of the institutions responsible for responding to HIV/AIDS.

After a concise discussion on the components and necessity of a RBA in chapter three, the study, in chapter four and five, explores two important areas which are critical to the success of HIV prevention, care, support and treatment programs. Accordingly, these chapters discuss the legal and policy framework regulating the multi-sectoral response and HIV testing respectively in the light of human rights standards. Then, the dissertation turns to critically examine the incorporation and implementation of a RBA to HIV prevention, in chapter six, and HIV care, support and treatment, in chapter seven.

The availability of a plethora of policies and legislation does not make sense unless these policies and laws put in place strong enforcement mechanisms in the event of their violations. Chapter eight will explore the adequacy or otherwise of mechanisms that rights-holders may avail themselves of to hold government and other actors accountable for human rights violations.
in the context of HIV/AIDS in Ethiopia. Finally, chapter nine will provide a conclusion and recommendations.
CHAPTER TWO

BACKGROUND TO THE COUNTRY

2.1 Geographical Situation, Population and Form of Government

Ethiopia is “one of the world’s oldest continuous civilizations”\(^{37}\) and the only African country that was never colonized albeit it was shortly occupied by Fascist Italy from 1936-1941. It is situated in the horn of Africa sharing borders with Kenya, Sudan, Somalia and Eritrea. It has a total surface area of 1.1 million square kilometers. The country is the home of more than 81 different ethnic groups having their own distinct languages and cultures.\(^{38}\)

Ethiopia is the second most populous country in Sub-Saharan African, next only to Nigeria. According to the 2007 Population and Housing Census Results,\(^{39}\) Ethiopia had an estimated total population of 73.9 million with an annual average growth rate of 2.6%. Of these, 50.5% and 49.5% are males and females respectively. An estimated 84% of the total population in the country resided in rural areas, while the remaining 16% lived in urban areas. In terms of regional population distribution, whereas Oromia, Amhara and SNNP regional states stood first, second and third with a population of 27, 17 and 15 million respectively, Harari Regional State stood last with 183,344 thousand of people. The major religions of the country, Orthodox Christian and Islam, consist of 43.5% and 33.9% of the total population respectively. The age


group distribution shows that the young population below the age of 15 represented 45% of the entire population.

Historically, Ethiopia used to be a unitary state. As of 1995, Ethiopia has adopted a constitutionally recognized federal form of government. The federation comprises of nine regional states and two city administrations. The designation of regions is based on ethnic and language backgrounds. The nine regional states are further divided into zones (provinces), which in turn, are divided into woredas (districts). For administrative purposes, again, the woredas are further divided into Kebeles (the smallest administrative units).

2.2 Socio-Economic Situation

Ethiopia is a low-income country with an economy largely dependent on the agriculture sector, which also provides about 85% of the employment. According to the UNDP 2010 Human Development Report, Ethiopia ranks 157th out of 169 countries with a Human Development Index of 0.328. Though Ethiopia is still a low-ranking country, the Report shows the tremendous growth Ethiopia achieved in recent years in terms of health, education, basic living standards and life expectancy. On the basis of the measurements of the developments achieved between 2005 and 2010, Ethiopia comes “at the top of the top movers of the development achievers.” The report states that, between 2000 and 2010, Ethiopia’s life expectancy at birth

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41 The nine regions are Tigray, Afar, Amhara, Oromia, Somali, Benishangul Gumuz, Gambella, Harrari, and SNNP regions and the two city administrations are Addis Ababa and Dire Dawa.
42 The full Human Development Report of 2010 is available at http://hdr.undp.org/en/ (last visited Dec. 31, 2010). The Human Development Index is published each year as of 1990 by the United Nations Development Program. HDI is meant to measure “the average achievements in a country in three basic dimensions of human development: a long and healthy life, access to knowledge and a decent standard of living.”
(56.1 years) increased by almost 5 years and Gross National Income per capita (U.S. $992) increased by 75%.

### 2.3 HIV/AIDS Prevalence Rate in Ethiopia

The first HIV infection in Ethiopia was identified in 1984 and reported in 1986. Initially, the epidemic was highly concentrated among high risk groups, such as commercial sex workers, long-distance truckers and construction workers. As time passed, the epidemic extended from the high risk groups to the general population and the country was, thereafter, regarded as a generalized epidemic where the HIV prevalence rate is more than 1% among the general population. The pandemic was rapidly expanding in the 1990s, reaching in its highest in the mid-1990s with a 17% prevalent rate. Thereafter, the epidemic showed a declining trend. For example, at the end of 2001, UNAIDS estimated that adult prevalence was 6.4%.”

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43 F.T. Lester et al., *Acquired Immunodeficiency: Seven Cases in Addis Ababa Hospital*, 26 Ethiopian Medical Journal 139, 139-45(1988).
45 Ethiopian Strategic Plan for Intensifying Multi-Sectoral Response 2004-2008 11(2004) [hereinafter SPM]. World Health Organization (WHO) and UNAIDS classify HIV epidemics into three broad categories, namely low-level, concentrated, and generalized epidemics. The basic distinction among the three is the extent to which the virus advances to the general population or is confined to a certain section of the population. In the case of generalized epidemic, more than 1% of the general population HIV is affected by the virus though the prevalence rate may be higher in certain groups than others. In this kind of epidemic, further transmission of the virus among the population may continue independent of the high-risk groups. In the case of a low-level epidemic, an HIV prevalence rate of more than 5% is not detected in any section of the society, including the so-call high-risk groups. Even the low level of the epidemic is confined to high-risk groups, such as FSWs, injecting drug users, and MSM. Networking usually exists among members of these groups and networking between these groups and other groups is too weak to entail transmission to any other sub-population. Finally, in a concentrated epidemic, while HIV prevalence in the general population is less than 1%, it exceeds 5% in one or more groups. Unlike in a low-level epidemic, there is an active networking between high-risk groups and others and this networking may cause the transmission of the virus to the general population. See UNAIDS, A Framework for Monitoring and Evaluating HIV Prevention Programs for Most-at-Risk Populations 19 (2008).
further declining tendency, the prevalence rate was around 2.1% in individuals aged 15 to 49 years in 2007.\(^{48}\)

The 2010 UNAIDS global report on HIV/AIDS disclosed that Ethiopia is one of the few African countries in which the HIV Prevalence rate declined by 25% between 2001 and 2009.\(^{49}\) The 2009 Single Point Estimate by the FHAPCO disclosed that an estimated 1.1 million PLWHA lived in Ethiopia.\(^{50}\) With this figure, Ethiopia was one of the Sub-Saharan countries highly hit by the virus.\(^{51}\) In terms of prevalence rate among the adult population, however, the situation in Ethiopia is lower than many Sub-Saharan African countries.\(^{52}\) The national HIV prevalence rate in Ethiopia was 2.3% in 2009.\(^{53}\) Though it was showing a declining trend, the prevalence rate in urban areas (7.7%) was much higher than rural areas (0.9%). The prevalence was also higher in women (2.8%) than men (1.8%). Out of 5.4 million orphans and vulnerable children in Ethiopia, around 855,750 were orphaned due to HIV/AIDS.

As elsewhere, different members of the society are not equally vulnerable to HIV/AIDS in Ethiopia. Studies made it clear that there are certain categories of people more vulnerable to the virus including women sex workers, uniformed services, long-distance trucker drivers, mobile laborers, street children, high school and university students and “indigenous populations in


\(^{49}\) See UNAIDS, supra note 1, at 59-60.


\(^{52}\) For example, South Africa, Swaziland, Kenya, Cameroon and Central African Republic have higher HIV prevalence rate than Ethiopia. See UNAIDS, supra note 13, at 28.

\(^{53}\) See FHAPCO, supra note 50, at 1.
remote foreign tourist destinations involved transactional sex.”54 The situation of the epidemic in Ethiopia also shows significant regional disparities. Amhara Region, Oromia Region, Addis Ababa City Administration and SNNP Region, with approximate number of 379,000, 287,000, 210,306 and 169,700 PLWHA, respectively, are regions with the highest number of PLWHA.55

2.4 The Impact of AIDS

It may not be an overstatement to say that the international community is well cognizant of the tragedy arising from AIDS at this point in time. Its impact is not, however, uniform across the different regions of the world. Sub-Saharan Africa is, by far, the most affected region. AIDS “has affected every aspect of life in Africa, from people’s livelihoods to the capacities of nation states.” The World Bank categorizes AIDS as one of the setbacks “preventing Africa from attaining the MDGs.”56 The problem is that there are no comprehensive studies undertaken to assess the impact of HIV/AIDS in Sub-Saharan Africa in general and Ethiopia in particular. Thus, the subsequent brief discussion is based on pieces of studies undertaken in Ethiopia and elsewhere.

AIDS has a demographic impact. Horrific premature deaths owing to AIDS have a negative impact on population growth and life expectancy. AIDS considerably alters the “age structure of the population…as [it]…reduces the proportion of the population at working ages and increases the proportions of the young and the very old.”57 A study undertaken in this regard indicated that “by the early 2000s, the mortality rate among male adults in Sub-Saharan Africa had

54 See FHAPCO, supra note 51, at 7.
55 Power point presentation by Ato Alemu Ano at the Adama Workshop entitled “The HIV/AIDS Situation and the Multi-Sectoral Response in Ethiopia”. The Adama Workshop was organized to enlighten parliamentarians, judges, executive policy makers on issues of orphans and vulnerable children at Adama City on Dec. 20-22, 2010 [hereinafter Adama Workshop]. Ato Alemu is the Director of Multi-Sectoral Coordination Directorate at the FHAPCO.
reached…four times higher that of high-income countries” and life expectancy in sub-Saharan had fallen after the late 1980s to the 1970s level due to HIV/AIDS.\(^\text{58}\) The UN Population Division indicated that despite a continuous rise of fertility rate and a declining mortality rate, Ethiopia’s population is projected to shrink up to 16% less “than it would have been in a ‘no-AIDS’ scenario” owing to, \textit{inter alia}, AIDS deaths.\(^\text{59}\) This projection may not be reflected in reality if universal access to antiretroviral treatment is fully and effectively implemented as this will have a tremendous effect in reducing HIV-related mortality.

The huge number of people infected by HIV/AIDS and the consequent premature deaths and demographic impacts tell us only a fraction of the ramifications of HIV/AIDS. Apart from its demographic ramification, the HIV/AIDS pandemic poses a great challenge to economic and social development through a host of channels. The channels, as identified by Jorge Saba Arbache, include savings and investments, health conditions, effects on children, effects on labor costs and fiscal effects.\(^\text{60}\) Each of these channels is discussed below.

HIV/AIDS seriously affects saving and investment. A person who thinks that he has a short-lived life will not be motivated to engage in long-term investment and saving. According to Jorge Saba Arbache, a “shortened expected life time horizon reduces the incentives to accumulate capital and affects economic competitiveness through lower levels of human and physical capital investments.”\(^\text{61}\) Arbache also posits that poor health conditions as a result of HIV infection


\(^{60}\) See Arbache, \textit{supra} note 58, at 66.

\(^{61}\) \textit{Id.}
“slows economic growth by increasing early mortality and reducing labor productivity.” 62 This assessment of AIDS as an impediment to investment, saving and economic growth might well work before the advent of life prolonging drugs. Thereafter, it is difficult to conclude boldly in this way. This is because PLWHA are aware of the fact that they can live long in so far as they take the life prolonging drugs. If so, there is not any disincentive to saving and long-term investment. The role that could have been played by ART is not, however, fully realized as countries are not yet able to secure universal access to HIV treatment.

Moreover, because the illness and premature death of parents leaves children helpless and more vulnerable, HIV/AIDS gravely affects children. 63 AIDS may prevent orphans from enrolling in schools and once enrolled, may compel them to drop out of school. Children’s low level of school enrollment and high level of drop out negatively affects development, as “it weakens the accumulation of human capital at the individual and national levels.” 64

HIV/AIDS affects development by increasing labor costs. In terms of age distribution, HIV particularly affects the young and adult populations which are the economically productive parts of the society. The high premature death rates and illness of these parts of the society hinder development by reducing the availability and productivity of labor and increasing training expenses. 65 Finally, Arbache identified the potential effects of AIDS on public finance and public services via escalating “demand for public services” such as provisions of antiretroviral treatment, care and support and consequent budgetary implications; decreasing “the capacity of

62 Id. at 67.
64 See Arbache, supra note 58, at 68.
65 Id.
governments (because of absenteeism by and the premature death of civil servants)" and undermining the quality and quantity of education as a consequence of early mortality and morbidity of teachers.66

UNAIDS has identified the principal facets of the impacts of HIV/AIDS.67 First of all, HIV/AIDS affects livelihoods. Drawing on specific studies conducted in Zambia, Côte d’Ivoire and Botswana, UNAIDS reports that the income of HIV-affected families is less than that of average families.68 Second, AIDS may result in the disintegration of families.69 Third, HIV/AIDS has psychological impacts. It “affect[s] relationships, the processes of decision-making, and attitudes to risk and uncertainty.”70 PLWHA make decisions that may seriously affect themselves, households and the community at large, particularly where they are subject to stigma and discrimination. Fourth, AIDS affects public sector services, such as education and health, in various ways. HIV/AIDS-related morbidity and early mortality cause the reduction of productivity and availability of skilled manpower.71 Fifth, AIDS severely affects agriculture and food security, “as illness forces people to work less, lowering the output of their subsistence farms.”72

66 Id. at 69.
70 See UNAIDS, supra note 67, at 31.
The impact of AIDS on the economy and vice-versa is of particular interest to writers. AIDS and economics are inextricably linked with each other. As the global epidemic rate itself testifies, poor countries and communities are highly hit by the virus. Conversely, AIDS negatively affects the economy. Hamoudi and Sachs comprehensively assessed the effect of HIV/AIDS on the economy. Before setting out channels through which AIDS affects the economy, they conceded that “[e]conomists, health specialists, and philosophers have not sorted out the precise economic costs of disease on a single individual, much less on a national economy.” Though one can imagine the “the financial losses that follow HIV infection”, “the complex interaction between the various consequences of these losses can be difficult to quantify.” Even so, they have generally identified seven ways through which AIDS affects the economy. AIDS affects the economy by: reducing human capital and household income; increasing “the costs of business” as a result of “creating high employee turnover, increasing search costs for new workers, reducing enterprise morale, reducing incentives for training, and reducing specialization within a firm and between firms”; undermining social capital; disrupting macroeconomic stability; raising health costs; discouraging saving and investment and affecting population growth.

As can be gathered from the proceeding discussion, HIV/AIDS has posed an enormous challenge to social and economic development. It is precisely for this reason that the intentional community, including Ethiopia, put in place policies, laws and institutions to fight the epidemic. In the following two sections, a brief discussion of the institutional, policy and legal framework that has been put in place in Ethiopia to respond to HIV/AIDS is in order.

74 See Hamoudi & Sachs, supra note 57, at 676.
75 Id.
76 Id.
2.5 An Overview of the Institutional Framework for Combating HIV/AIDS

Since the first HIV infections in Ethiopia were identified in 1984, Ethiopia has acted swiftly to control the spread of the epidemic through institutions established at various levels for this purpose. In 1985, the then government of Ethiopia set up a national Task Force that was entrusted with the task of prevention and control of HIV/AIDS. The Task Force adopted the first AIDS Control Strategy by the end of 1985. The Strategy led to the establishment of “an HIV/AIDS department within the MOH responsible for directing and coordinating implementation of the AIDS control program.”

In an attempt to consolidate the response, Ethiopia established the NHAPCC and its secretariat (HIV/AIDS prevention and Control Secretariat) in 2000. The Council was chaired by the president and was composed of members from governmental institutions, non-governmental organizations, religious bodies and civil society. The Council, through its Secretariat and seven standing Committees, supervised the implementation of the Strategic Framework for the National Response to HIV/AIDS in Ethiopia for 2000-2004, examined and approved annual plans and budgets and monitored plan performance and impact.

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81 Id.
In 2002, the Council was legally authorized to carry on its tasks by Proclamation No. 276/2002.\textsuperscript{84} The same Proclamation established the FHAPCO as the executive arm of the Council replacing the National HIV/AIDS Prevention and Control Secretariat.\textsuperscript{85} The FHAPCO was established with the objective of coordinating and directing the implementation of the country’s HIV/AIDS policies.\textsuperscript{86} The response at the Federal level is coordinated by the FHAPCO and the response at regions is coordinated by regional HAPCOs.

The fact that HAPCOs at different levels coordinate the HIV/AIDS response in Ethiopia does not mean that the response to the epidemic is exclusively their mandate. As discussed in Chapter Four, the fight against HIV/AIDS in Ethiopia adopted a multi-sectoral approach where all government institutions, donors, the private sector, faith-based organizations, community-based organizations and other civil society organizations have the obligation to engage in HIV prevention, care, support and treatment activities based on their comparative competencies. In order to harmonize their efforts, the different sectors have also established forums.

\textbf{2.6 Ethiopian AIDS Policies, Strategic Plans, Guidelines and Laws at a Glance}

\textbf{2.6.1 Policies, Strategic Plans and Guidelines}

A considerable number of policies, strategic plans and guidelines regulating and directing the HIV/AIDS prevention, care and support endeavors of the country have been adopted and put into action. While many of these policies, strategic plans and guidelines have been issued by the domestic policy makers, others are outcomes of international conferences and international

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{84} National HIV/AIDS Prevention and Control Council and the HIV/AIDS Prevention and Control Office Establishment, Proclamation No. 276/2002, \textit{Federal Negarit Gazeta}, 8\textsuperscript{th} Year, No. 23 [hereinafter Proclamation No. 276/2002].
\item \textsuperscript{85} Id. art. 8.
\item \textsuperscript{86} Id. art. 10.
\end{itemize}
\end{footnotesize}
agreements (soft laws) to which Ethiopia has subscribed. First, I will briefly discuss the policies and strategies issued by national policy makers and then I will turn to the international ones.

2.6.1.1 National policies, Strategic Plans and Guidelines

As mentioned earlier, beginning with the emergence of HIV/AIDS pandemic in Ethiopia, the Ethiopian Government responded by setting up institutions in charge of preventing and controlling the virus and by issuing policies that guide the Government’s response.\(^{87}\) Though there were several policies\(^ {88}\) that were subsequently put in place since then, the first compressive HIV/AIDS policy of Ethiopia was issued in 1998.\(^ {89}\) The 1998 Policy aims at establishing an enabling environment for effective HIV/AIDS response.\(^ {90}\) It is a document on the basis which all subsequent laws, strategic plans and guidelines have been formulated. Presently, it is under revision to ensure the incorporation of significant developments in the area of HIV prevention, care, support and treatment since its implementation.\(^ {91}\)

With the avowed purpose of intensifying the successes and adequately dealing with the gaps in the responses to the pandemic, the Ethiopian Strategic Plan for Intensifying Multi-sectoral HIV/AIDS Response for 2004-2008 was developed in 2004.\(^ {92}\) This document was meant to serve as a framework for all stakeholders involved in the HIV/AIDS response. Because it is a time bound Strategic plan, it is replaced by SPM II\(^ {93}\) which was developed after a comprehensive evaluation of the status of the epidemic, the downsides and strengths of earlier period responses.

\(^{87}\)See Garbus, supra note 77.
\(^{88}\)Examples include Short-Term Plan and the First Medium-Term plan prepared by MOH in 1987 and August 1989 Four-Point Policy Statement on AIDS Prevention drafted by MOH.
\(^{89}\)See 1998 HIV/AIDS Policy, supra note 17.
\(^{90}\)Id.
\(^{91}\)FHAPCO, Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia: Road Map 2007-2008/10 (2007).
\(^{92}\)See SPM, supra note 45.
\(^{93}\)See SPM II, supra note 17.
and the challenges faced in the implementation of past strategic policies. SPM II incorporates intensifying HIV prevention, increasing access and quality of chronic care and treatment, strengthen care and support, and enhance generation and use of strategic information as strategic issues.\(^94\) With a view to implementing Ethiopian international commitment to ensure universal access, the country adopted the Multi-sectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support in Ethiopia (2007 – 2010) in 2007.\(^95\)

Aside from the aforementioned overarching policy and strategic plans, a host of other detailed and specialized HIV/AIDS guidelines and standards have been developed and are being implemented within the framework of the 1998 National HIV/AIDS policy and strategic plans to complement and facilitate effective national response. The main documents include, but not limited to: the 2007 Guidelines for Management of Opportunistic Infections and Antiretroviral Treatment in Adolescents and Adults in Ethiopia;\(^96\) Accelerated Access to HIV/AIDS Prevention, Care and Treatment in Ethiopia: Road Map 2007-2008/10;\(^97\) the 2006 Guideline for Contrimoxazole Prophylaxis in HIV Care and Treatment;\(^98\) the 2007 Guidelines for HIV Counseling and Testing in Ethiopia;\(^99\) the 2007 Guidelines for Prevention of Mother-to-Child Transmission of HIV in Ethiopia;\(^100\) the 2008 Guidelines for Pediatric HIV/AIDS Care and Treatment in Ethiopia that address the care and treatment of HIV-exposed and infected infants

\(^{94}\) Id.\(^95\) See Universal Access Action Plan, supra note 17. This plan of action is meant to serve as a framework for the country’s plan to ensure universal access to HIV prevention, care, support and treatment for 2005-2010.\(^96\) FHAPCO & MOH, Guidelines for Management of Opportunistic Infections and Antiretroviral Treatment in Adolescents and Adults in Ethiopia (2007). These Guidelines replace the 2005 Guideline for the use of ARV drugs in Ethiopia which in turn replaced the 2002 Policy on anti-retroviral drugs supply and use.\(^97\) See FHAPCO, supra note 91, at 10. This Road Map replaces “Accelerating Access to HIV/AIDS Treatment in Ethiopia: Road Map for 2004- 2006”.\(^98\) FHAPCO & MOH, Guideline for Contrimoxazole Prophylaxis in HIV Care and Treatment (2006).\(^99\) See 2007 HCT Guidelines, supra note 17. This document replaces the 2002 National Guideline for Voluntary HIV Counseling and Testing in Ethiopia.\(^100\) See PMTCT Guidelines, supra note 17. These guidelines update the previous 2001 Guideline on the Prevention of Mother-to-Child Transmission of HIV.
and children;\(^{101}\) the 2008 Quality Management Framework for HIV/AIDS Services in Ethiopia;\(^{102}\) the 2009 Guidelines for Implementation of HIV/AIDS Case Management in Ethiopia;\(^{103}\) the 2007 Social Mobilization Implementation Guideline\(^{104}\) and the HIV/AIDS Mainstreaming Implementation Manual\(^{105}\) and the 2008 Guideline for Partnership Forums against HIV and AIDS in Ethiopia.\(^{106}\) The specific contents and the status of implementation of these and other documents are addressed in Chapter Four and the chapters that follow it.

Cognizant of the impact of AIDS on the overall development of Ethiopia, the Government gave the issue of HIV/AIDS an important place in the country’s overarching poverty reduction and development policy, PASDEP\(^{107}\) and the Growth and Transformation Plan (GTP) that replaced PASDEP.\(^{108}\) Both PASDEP and GTP recognized the need to reverse the spread of HIV/AIDS as a vital condition to boost socio-economic development and stipulated the key strategies for the effective execution of HIV/AIDS programs. Formulated in line with the 1993 National Health Policy, the Health Sector Strategic plan for the years, 2005/06 to 2009/10, (HSDP III), identified the prevention and control of HIV/AIDS as one of its top priorities.\(^{109}\)


\(^{103}\) FHAPCO & MOH, *Guidelines for Implementation of HIV/AIDS Case Management in Ethiopia* (2009). These guidelines were developed in order to establish a framework for country-wide HIV/AIDS case management services. They are intended to support the rapid scale-up of ART in Ethiopia through strengthening clients’ adherence to treatment and care. HIV/AIDS case management is a process used in chronic care situations to ensure a continuity of care for clients through the use of “trained lay persons”.


\(^{107}\) See PASDEP, supra note 10, at 122-125.


\(^{109}\) Federal Ministry of Health, Planning and Monitoring Department, *The Health Sector Strategic Plan (HSDP III) 2005/06 to 2009/10* (2005).
2.6.1.2 International Guidelines, Resolutions and Declarations

While there are no binding international agreements particularly addressing HIV/AIDS, there are quite a lot of international guidelines, resolutions and declarations that give direction to governments in their endeavors of fighting HIV/AIDS. These international instruments, though they are not issued by domestic policy makers, are pertinent to Ethiopia either because Ethiopia signed them, they were adopted by multilateral international organizations to which Ethiopia is a party, or the principles included in the policies are derived from treaties to which Ethiopia is a party.

The most important global documents include: the UN Millennium Declaration that incorporates actions and targets from which the eight MDGs are drawn including a target to halt and reverse the spread of HIV/AIDS by 2015;\textsuperscript{110} the 2001 Declaration of Commitment on HIV/AIDS in which the UN Member States set time-bound targets to halt the pandemic;\textsuperscript{111} the 2006 Political Declaration on HIV/AIDS through which the UN Member States reiterated and expanded their commitments in the 2001 Declaration of Commitment on HIV/AIDS;\textsuperscript{112} the 2011 Political commitment on HIV/AIDS in which UN Member States reaffirm their 2001 and 2006 commitments and intensify their efforts against HIV/AIDS;\textsuperscript{113} the UN Commission on Human Rights Resolution on the Protection of Human Rights in the Context of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS);\textsuperscript{114} the ILO Code of Practice on HIV/AIDS and the World of Work that has been adopted “to address the HIV/AIDS epidemic in the world of work and within the framework of the promotion of

\textsuperscript{110} The UN Millennium Declaration was adopted by 189 nations and signed by 147 Heads of States and Governments at the UN Millennium Submit that was held on 8 September 2000.
\textsuperscript{111} See UN, \textit{supra} note 8.
\textsuperscript{113} See 2011 Political Declaration on HIV/AIDS, \textit{supra} note 13, at para. 51.
decent work”;

115 the 2004 UNAIDS/WHO Policy Statement on HIV Testing

116 which is modified by the 2007 WHO/UNAIDS Guidance on Provider –Initiated HIV Testing and Counseling in the Health Facilities;

117 the World Bank 2000 Multi-Country HIV/AIDS Program (MAP) that aim at expanding the horizon of the HIV/AIDS response through a multi-sectoral approach;

118 the “Three Ones” principles adopted by representatives from donor and main international organizations in 2004 as an effective tool to harmonize and coordinate the various efforts in the HIV/AIDS response and thereby avoid duplication of efforts

119 and the 2006 Consolidated Version of the International Guidelines on HIV/AIDS and Human Rights

120 that figure out actions that states should take in their response to HIV/AIDS that are consistent with their international human rights commitments.

At the African regional level, too, a number of resolutions and declarations have been adopted and implemented under the auspices of the AU and its predecessor OAU in order to control the impetus of the HIV/AIDS epidemic in Africa. The main ones are: the 1994 Tunis Declaration on AIDS and the Child in Africa which sets forth the commitment of African Heads of States and Governments to, inter alia, put in place a “‘national policy framework’ to guide and support

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appropriate responses to the needs of affected children;"\textsuperscript{121} the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases;\textsuperscript{122} the 2003 Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases in which African leaders reiterated their commitments envisaged in the Abuja Declaration;\textsuperscript{123} the 2005 Gaborone Declaration on a Roadmap Towards Universal Access to Prevention, Treatment and Care;\textsuperscript{124} the 2006 Brazzaville Commitment on scaling up towards universal access to HIV/AIDS prevention, treatment care and support in Africa;\textsuperscript{125} and the 2006 Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010, a document adopted at a special summit convened to review the progress made in implementing the Abuja Declaration and Plan of Action and renew the commitment of African countries to halt the spread of HIV/AIDS by achieving access to universal access in 2010.\textsuperscript{126} Because many countries are unable to meet the universal access target set at the Abuja Call by 2010, the Heads of State and Government of the African Union decided to extend the Abuja Call to 2015, to coincide with the MDGs, in the Assembly of the African Union’s Fifteenth Ordinary Session held on 25 – 27 July 2010 in Kampala, Uganda.\textsuperscript{127}

\textsuperscript{121} The Tunis Declaration was adopted at the 30\textsuperscript{th} Ordinary Session of the Assembly of Heads of State and Government of the OAU held in Tunis, Tunisia, 13-15 June 1994.

\textsuperscript{122} The Abuja Declaration is the outcome of the meeting of Heads of State and Government in Abuja, Nigeria from 26-27, April 2001, “at a Special Summit devoted specifically to address the exceptional challenges of HIV/AIDS, tuberculosis and other related infectious diseases”. The Declaration is followed by an annex, Framework Plan of Action for the Implementation of the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases in Africa, that sets out detailed strategies and activities that States may use “as a guide in drawing up their respective Plans of Action and implement the activities therein”.

\textsuperscript{123} The Maputo Declaration was adopted by the AU Assembly of Heads of State and Government at its 2\textsuperscript{nd} Ordinary Session held from 10-12 July 2003 [hereinafter Maputo Declaration].

\textsuperscript{124} The Declaration was adopted at the 2\textsuperscript{nd} Ordinary Session of the Conference of African Ministers of Health in Gaborone, Botswana, 10-14 October 2005.

\textsuperscript{125} See Brazzaville Commitment, supra note 15. The Brazzaville Commitment was adopted on 8 March 8 2006 by delegates from African countries representing governments, parliaments, civil society, faith-based organizations and the private sector.

\textsuperscript{126} See Abuja Call, supra note 15.

\textsuperscript{127} See Decision on the Five (5)- Year Review of the Abuja Call, supra note 15.
2.6.2 Laws

As I have hinted earlier, there are only a few laws that explicitly address HIV/AIDS in Ethiopia. Much less are there laws exclusively devoted to HIV/AIDS. The only proclamation that is solely committed to HIV/AIDS is Proclamation No. 276/2002 that established the NHAPCC and the FHAPCO and defined their organizational structure, powers and responsibilities. Moreover, there are a couple of proclamations whose provisions explicitly address HIV/AIDS in the workplace, namely, the Labor Proclamation (Proclamation No. 377/96) and the Federal Civil Servants Proclamation (Proclamation No. 515/2007). These laws incorporate provisions that outlaw mandatory HIV testing and discrimination on the basis of HIV status in the employment setting.

The fact that other laws do not explicitly refer to HIV/AIDS should not lead us to the conclusion that they are irrelevant in the legal response to HIV/AIDS. True, a sizable number of laws were promulgated prior to the emergence of HIV/AIDS or before the issue of HIV/AIDS became at the top of national and international agenda. However, these laws can be interpreted to be applicable in the HIV/AIDS context. Laws in this category include the 1960 Civil Code, the FDRE Constitution and several international and African regional human rights treaties which Ethiopia has ratified and which are given a domestic law status under article 9(4) of the FDRE Constitution. Other laws that came into force after the emergence of HIV/AIDS failed to expressly address HIV/AIDS, perhaps, on the assumption that their provisions contains broad stipulation that can be construed in the context of HIV/AIDS. For example, the FDRE Criminal Code of 2005, without overtly mentioning HIV/AIDS, criminalizes harmful traditional practices that aggravate women’s vulnerability to HIV/AIDS and transmission of communicable human
diseases which may include HIV/AIDS. One can find such broad provisions in the federal and regional family codes.

The specific contents and the applicability of these laws are discussed in the subsequent chapters.
CHAPTER THREE

A RBA to HIV PREVENTION, CARE, SUPPORT AND TREATMENT: GENERAL CONSIDERATIONS

3.1 What Constitutes a RBA in General?

A rights-based approach (RBA), also referred to as human rights based approach or human rights approach, has attracted enormous attention from the UN agencies, international civil society organizations (CSOs) and donors since the end of the 1990s. Though the term has been widely used by these organizations since then, there have been huge disparities among them regarding its content. Each organization and agency that applies the term interprets RBA in a manner that conforms to its missions and objectives. Because their mandates vary considerably, so do the

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128 Dan Banik, Implementing Human Rights-Based Development: Some Preliminary Evidence from Malawi, Expert Seminar: Extreme Poverty and Human Rights, 2007, 1, http://www2.ohchr.org/english/issues/poverty/expert/docs/Dan_Banik.pdf (last visited Jan. 4, 2011). Some authors and organizations make subtle, blurred and even contradictory distinctions between RBA, on the one hand, and HRBA, on the other. For example, the OHCHR states that a RBA is matter of applying the rules and principles of international human rights law. For Eyben and Eide, while a HRBA focuses on the international human rights framework which states undertook to be bound, a RBA goes beyond codification and “cover[s] any kind of rights” or “incorporates a more all-encompassing reference to people’s general sense of equity, justice, entitlement and/or fairness”. See OHCHR, What is a Rights-Based Approach to Development?

definitions they give to the term. In order to foster inter-agency partnership and consistency of approaches, the UN found it imperative to put in place a common framework that guides all UN cooperation and programs. Accordingly, it issued the Human Rights Based Approach to Development Cooperation: Towards a Common Understanding among UN Agencies (Common Understanding) in 2003. Pursuant to the Common Understanding, RBA has the following three pillars.

First, all policies and programs should have the ultimate goal of advancing the protection and fulfillment of human rights as envisaged in the UDHR and other human rights documents. Put differently, national policy makers, in initiation, formulating, implementing, monitoring and evaluating of policies and programs, must be mindful of the realization of human rights as the final goal. The document makes it explicit that programs and policies “that only incidentally contribute… to the realization of human rights do… not necessarily constitute a human rights-based approach to programming.” A RBA strongly demands that policies and programs intentionally advance human rights. In this respect, the Common Understanding prescribes a stringent requirement. How is it possible to ensure that the policies and programs are set in place with the intent to realize human rights? If this fact is mentioned in the document itself, it is fine though this in itself it is not sufficient. In default of specific mention of the realization of human rights as an objective of the document, the incorporation of one or more principles of human rights and their actual implementation may serve as evidence of the intention to adopt a RBA.

and Human Rights was established in 2002 and serves as an advisory body to the UNAIDS Secretariat and Cosponsors.

130 See WHO & OHCHR, supra note 30, at 1.
Second, human rights standards laid down or derived from various human rights documents should direct the design, implementation and evaluation of all programs and policies of all sectors. This requirement seeks to test the systematic integration of human rights principles, universality and inalienability; indivisibility interdependence and interrelatedness; equality and non-discrimination; participation and inclusion and accountability and rule of law, in all phases of the programming and policy process. A RBA is concerned with the process as much as it is concerned with the outcome. This is on the basis of a valid assumption that the end may not necessarily justify the means.

Third, development cooperation should build “the capacities of ‘duty-bearers’ to meet their obligations and/or of ‘rights-holders’ to claim their rights” in terms of skills, resources, authorities and responsibilities. Under human rights law, while individuals or groups of individuals are rights-holders, states and other non-state actors are the duty bearers. Thus, the national programs and policies must contribute towards building the capacities of states and non-state actors to discharge their obligation and of individuals or groups of individuals to claim their rights. At this point, one point that deserves to be raised is that a RBA differs from the basic needs approach because the former always assumes a duty-bearer.132

3.2 A RBA to Health

A RBA is applicable in various contexts, including to a myriad of health issues.133 Drawing inspiration from the Common Understanding, the WHO and OHCHR identify the key facets of a

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RBA to health.\textsuperscript{134} Health programs, polices and strategies must have the decisive objective of promoting the realization of the right to health and other rights related to health enshrined in international and national human rights instruments. The realization of the right to health and other related rights calls for the systematic integration of human rights standards in the various stages of health strategies, policies and programs. Put succinctly, national health strategies, programs and policies should be “shaped by human rights principles.”\textsuperscript{135} The minimum principles to be integrated include: the meaningful participation of affected communities; non-discrimination in accessing health-related services; availability, accessibility, acceptability and quality of health-related services; the existence of “clear and transparent accountability mechanisms in place for decision-making, review, and redress” and the adoption of a multi-sectoral approach to responding to health crises as a requirement to enforce the principle of “interdependence and indivisibility of human rights [which] require engaging a wide range of stakeholders to promote collaboration among sectors and levels of government, external partners, and community members.”\textsuperscript{136} Finally, a RBA to health should contribute towards building the capacities of states and non-state actors to meet their obligations of protecting, respecting and fulfilling the rights to health and of rights-holders to claim the right to health and other health-related rights.

\textsuperscript{134} See WHO & OHCHR, supra note 30, at 13.


\textsuperscript{136} Sofia Gruskin et al., Rights-Based Approaches to Health Policies and Programs: Articulations, Ambiguities, and Assessment, 31 (2) Journal of Public Health Policy 129, 129 (2010).
3.3 RBA to HIV Prevention, Care, Support and Treatment: Content and Principles

As briefly touched on in first chapter, HIV prevention, care, support and treatment are indispensible for an effective response to the HIV/AIDS pandemic. There is also a mounting recognition of the importance of human rights in shaping HIV prevention, care, support and treatment-related laws, policies, strategies and programs. The UN, donors and international organizations have strongly advocated for the adoption of a RBA to HIV prevention, care, support and treatment.137 The notion of a RBA to HIV prevention, care, support and treatment, being the main theme of this dissertation, deserves an in-depth elucidation. Of course, the earlier attempts made to give content to the RBA in general and RBA to health in particular throw light on what constitutes a RBA to HIV prevention, care, support and treatment. However, in the specific context of HIV prevention, care, support and treatment, each of the three aspects of a RBA must be carefully considered.

First of all, HIV prevention, care, support and treatment-related policies, programs and strategies should ultimately aim at advancing the realization of the right to health and other related rights. This requires a prior careful evaluation of the positive or the negative impact that the policies, programs and strategies might have on the protection and promotion of human rights.138 If it is clear that the policies, programs and strategies infringe on rights of individuals, they should be modified before their implementation. This, in effect, means that HIV prevention, care, support and treatment interventions that undermine human rights should not be applied, at least in principle, even if they are deemed necessary for the realization of other competing interests.

138 See Gumedze, supra note 24, at 189.
Additionally, a RBA to HIV prevention, care, support and treatment requires using human rights principles as a framework in designing, implementing and evaluating HIV prevention, care, support and treatment-related policies, strategies and programs at national, sub-national and local levels. In other words, HIV prevention, care, support and treatment policies, strategies and programs shall be guided by and must integrate human rights principles. The core human principles that should direct HIV prevention, care, support and treatment programs, strategies and policies are: the interdependence and indivisibility of rights; participation and inclusion; non-discrimination; accountability and rule of law; and key aspects of the right to health; namely, accessibility, acceptability, availability and quality (commonly named as 3AQ).\textsuperscript{139} The content and relevance of each of these principles to HIV prevention, care, support and treatment is briefly examined in the coming sub-sections.

Finally, a RBA to HIV prevention, care, support and treatment requires HIV prevention, care, support and treatment policies to give due attention to building the capacities of providers of HIV prevention, care, support and treatment to meet their obligations and of beneficiaries of these services to assert and enforce their rights. Governments, at various levels, have the duty to ensure access to prevention, care, support and treatment services. Unless the concerned institutions and individuals do have the required goods and services and skills, they will not be in a position to ensure access of individuals to these services. It is also indispensable to building the capacities of the right-holders to assert their rights, for example, through training and awareness-raising programs. To take a specific example, unless people are educated about the importance of ART for HIV treatment and the modality of its application, they may not avail themselves of their right to access these medicines.

3.3.1 Interdependence and Indivisibility of Rights

As reiterated in the Vienna Declaration, “[a]ll human rights are universal, indivisible and interdependent and interrelated.”\(^{140}\) This principle entails two things. First, all human rights must be given the same attention.\(^{141}\) There is not any hierarchical order whatsoever between civil and political rights, on the one hand, and economic, social and cultural rights, on the other. Second, the interdependence and interrelatedness of rights entails that the protection and fulfillment of one right often depends on the protection and fulfillment of other rights. This, in turn, calls for collaboration among different sectors for fruitful implementation of national programs, strategies and policies. The human rights regime strongly supports a multi-sectoral approach to addressing problems, such as HIV/AIDS. Different sectors should join their hands in an effort to create an AIDS-free society. Due to the enormity of the problem, the health sector alone cannot manage the HIV/AIDS problem. The institutional framework for the performance of the multi-sectoral response to HIV prevention, care, support and treatment in Ethiopia is separately treated in chapter four.

3.3.2 Participation

Under a RBA, individuals are not simply recipients of goods and services. They have the right to actively, freely and meaningfully take part in all matters affecting their lives.\(^{142}\) To that end, government institutions and CSOs must be transparent and ensure access of individuals to

\(^{140}\) The Vienna Declaration and Program of Action (1993) para. 5. The Vienna Declaration was the product of the 1993 Second World Conference on Human Rights which was attended by 171 states.

\(^{141}\) Id.

\(^{142}\) This can be implied from article 25 of the International Covenant on Civil and Political Rights. The International Covenant on Civil and Political Rights was adopted and opened for signature, ratification, and accession by General Assembly resolution 2200 A (XXI) of 16 December 1966 and entered into force on 23 March 1976 [hereinafter ICCPR].
information.\textsuperscript{143} In the context of the HIV/AIDS pandemic, the participation of all sectors, with greater emphasis on the involvement of PLWHA, has been regarded as decisive for successful response to HIV/AIDS.\textsuperscript{144}

The specific rationale for a participatory approach to HIV prevention, care, support and treatment and the adequacy or otherwise of HIV prevention, care, support and treatment-related programs, strategies and policies in Ethiopia in terms of creating a space for meaningful full participation of people living with HIV/AIDS, civil societies, community-based organizations, faith-based institutions and other stakeholders is discussed in chapter four. Moreover, the extent of their actual participation is dealt with in chapters six and seven.

3.3.3 Non-Discrimination

International human rights law strongly condemns discrimination on unjustifiable grounds. The various human rights instruments guarantee the right of individuals to be free from discrimination on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. The term “other status” in the human rights instruments shows that the grounds of discrimination are not exhaustive. Other grounds, not explicitly stated, such as age, sexual orientation and disability, are also prohibited.\textsuperscript{145} The Commission on Human Rights confirmed that the catchall term “other status” in non-discrimination provisions of human rights treaties should include proscription of discrimination.


on health grounds, including HIV/AIDS.\textsuperscript{146} Thus, States should refrain from putting in place laws, policies and programs that directly or indirectly exclude people infected with and affected by HIV/AIDS.

Discrimination, apart from being wrong in itself, significantly hinders HIV prevention, care, support and treatment efforts.\textsuperscript{147} When PLWHA are discriminated against, they will be discouraged from involvement in addressing HIV/AIDS and they will be deterred from using HIV prevention and treatment services. This creates a situation for underground transmission of the virus. Furthermore, discrimination in any of the grounds listed above “creates and sustains conditions leading to societal vulnerability to infection by HIV.”\textsuperscript{148} For instance, discrimination against women in inheriting property may exacerbate their poverty. Poverty may drive them to engage in sex work that is known to be a risky business in terms of exposing them to HIV infection.

Because discrimination is counterproductive to HIV prevention, care, support and treatment interventions, relevant laws and policies should be adopted and implemented to eliminate discrimination. A detailed discussion of the anti-discrimination laws and policies is made in chapter six.

### 3.3.4 Accountability

States are the primary duty-bearers for the protection and promotion of human rights. Under a RBA approach, States should be accountable in the event of their failure to live up to their human rights obligations. Human rights law has devised a framework within which individuals

\textsuperscript{146} UN Commission on Human Rights Resolution 1996/44.
\textsuperscript{147} See Canadian HIV/AIDS Legal Network, \textit{supra} note 144, at 13.
\textsuperscript{148} See UNAIDS & OHCHR, \textit{supra} note 19, at para. 107.
can seek remedies where their rights are infringed before appropriate judicial or quasi-judicial organs according to the rules and procedures determined by law. Apart from legal redress, accountability requires effective monitoring system and transparency of actions. In the context of HIV/AIDS, transparency entails a host of obligations on States, such as ensuring the availability of information pertinent to the national response to HIV/AIDS and respecting “the rights of freedom of expression and association of civil society to review and disseminate information.”

The policies and laws that purport to put in place accountability mechanism in the context of HIV/AIDS and their status of implementation is addressed in chapter eight.

3.3.5 Ensuring the Availability, Accessibility, Acceptability and High Quality of HIV Prevention, Care, Support and Treatment Services

Though HIV/AIDS affects a rage of rights, it primarily affects the right to health. The Committee on Economic, Social and Cultural Rights has given an authoritative interpretation of the right to health in its General Comment No. 14. Building on this authoritative interpretation, the International Guidelines on HIV/AIDS and Human Rights has identified the three elements of the right to health as they apply to HIV/AIDS. The three elements are availability, accessibility, acceptability and quality of HIV prevention, care, support and treatment goods and services to be provided. The contents of the 3AQ and the condition of their implementation are addressed in an in-depth fashion in chapters five, six and seven.

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149 See Yamin, supra 143, at 49. See also Gruskin, supra note 136 and supra note 131.
150 Id.
151 See Canadian HIV/AIDS Legal Network, supra note 144, at 14 and supra note 131.
152 See Committee on Economic, Social and Cultural Rights, supra note 139, at para. 12. In the context of the right to health of the child, see also Committee on the Rights of the Child, supra note 137, at para. 22.
153 See UNAIDS & OHCHR, supra note 19, at para. 101.
3.4 History of the Recognition of a RBA to HIV/AIDS

The history of HIV/AIDS can be written from various viewpoints. In this section, an attempt will be made only from the viewpoint of its interface with human rights. The discussion is also limited only to the major episodes.

Jonathan Mann and Daniel Tarantola broadly categorized the history of the response to HIV/AIDS as consisting of four phases.\textsuperscript{154} Initially, when AIDS was officially discovered in 1981, its causes, ways of transmission and prevention methods were totally unknown. Consequently, AIDS was simply labeled as “danger”. The response during this period was primarily supplying information to the public about the “danger” (the disease) without informing them how they could prevent its transmission.\textsuperscript{155} Later in the 1980s and early 1990s, upon the discovery of its cause, AIDS was identified as individual risk that necessitated the implementation of individual risk reduction strategies by supplying HIV-related information to bring about behavioral change in reducing HIV infection and providing goods and services that help individuals reduce risk to HIV infection.\textsuperscript{156} This approach, also called the biomedical and behavioral approach, was endorsed by the first Global AIDS Strategy issued by the WHO.\textsuperscript{157}

Though the Strategy proscribed discrimination against people living with HIV/AIDS, rejection and exclusion of people infected with and affected by HIV/AIDS was one of the features of this

\textsuperscript{155} Id.
Strong pressures for compulsory testing and criminalization of those who were suspected of transmitting the virus also characterized this period.\(^{159}\)

Though the individual-centered biomedical and behavioral approach to responding to HIV/AIDS brought about limited successes, in countries such as Uganda and Thailand, it was generally unable to halt the spread of the disease.\(^{160}\) Consequently, a need arose to assess the social context in which individuals were vulnerable to the epidemic.\(^{161}\) It became obvious that HIV/AIDS highly affects people in less-industrialized countries and poor people in developed nations. It was recognized that economic, political, social and cultural factors exacerbate individual vulnerability to the virus. These structural factors of vulnerability needed to be addressed in addition to individual factors of vulnerability if the epidemic was to be successfully reversed.

The third phase of the response to HIV/AIDS was characterized by the insistent application of the biomedical and behavioral approaches of the traditional public health tools for controlling contagious diseases despite a clear evidence of the limitations of these approaches to address structural factors of HIV vulnerability.\(^{162}\) It is true that public health efforts had historically been the most effective approach in controlling infectious diseases that had afflicted societies. Public health professionals had effectively used a variety of tactics, such as provision of information, goods and services that enabled individuals to reduce risks of infection, mandatory testing,

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\(^{161}\) See Mann & Tarantola, *supra* note 154, at 6.

\(^{162}\) See Whelan, *supra* note 156, at 22.
identification and quarantine to guard against the spread of infectious disease.\footnote{163} These tools of traditional public health, however, couldn’t address the structural determinants of vulnerability to HIV/AIDS, such as poverty, gender-based violence, discrimination of vulnerable groups and other harmful traditional practices. On the contrary, some of these tools, like mandatory testing, identification, quarantine, fuelled the transmission of the epidemic.

Owing to the failure of the traditional public health approach in addressing the structural factors of HIV vulnerability, a new approach that could at least complement the public health approach was needed to achieve this purpose. Accordingly, the human rights regime received growing attention as a framework to tackle the structural factors of vulnerability.\footnote{164} The initiation and the gradually wider acceptance of a RBA in national as well as international policies and strategies was the result of relentless efforts by the CSOs, WHO and UNAIDS.\footnote{165} The necessity for a RBA was unequivocally made clear as early as 1987, in WHO first Global Strategy on AIDS.\footnote{166} The centrality of human rights in the document stems from the fact that human rights violations around the globe pertinent to HIV/AIDS, such as quarantine, compulsory testing and discrimination against PLWHA in employment, insurance and travel had hindered meaningful response to the epidemic.\footnote{167} Subsequent to the first WHO Strategy, the United Nations General Assembly, the United Nations Commission on Human Rights (now the Human Rights Council), the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities, and the World Health Assembly and other international organizations issued

\footnote{164} See Mann & Tarantola, supra note 154, at 7.
\footnote{165} Id. at 58.
\footnote{166} See WHO, supra note 157.

Nowadays, a RBA is recognized as an effective framework not only to address HIV/AIDS but also other health issues.\footnote{See Whelan, supra note 156, at 22.} Human rights violations are accepted as causes and consequences of HIV/AIDS.\footnote{Sofia Gruskin et al., \textit{Past, Present and Future: AIDS and Human Rights}, 2 (4) Health and Human Rights: An International Journal 1, 1(1998).}

\subsection*{3.5 Justifying a RBA to HIV Prevention, Care, Support and Treatment}

An appraisal of how the RBA to HIV/AIDS emerged suggests why this approach is preferred to other approaches. Writers categorize approaches employed to control the spread of HIV/AIDS into two groups; namely, the “isolationist” approach (which includes mandatory testing, breach of medical confidentiality, discrimination and criminal prosecution of those tested positive) and the “integrationist” approach (which includes voluntary testing, protection of medical confidentiality, non-discrimination and non-criminalization of those tested positive).\footnote{Mandeep Dhalwal, \textit{Testing Times, in Rights in Action Meeting Series: Meeting 5: Why the Human Rights Approach to HIV/AIDS Makes All the Difference}, 69, http://www.sarpn.org.za/documents/d0002022/7-ODI_Human-Rights_Mar2006.pdf (last visited Oct. 4, 2010).}

Public health officials and a sizable number of other people, particularly during the earlier phases of the epidemic, took a position that tools of the traditional public health (isolationist) approach of controlling contagious diseases (compulsory testing, discrimination, quarantine and criminal prosecutions) should be employed to control the transmission of HIV/AIDS. Indeed, public health efforts had historically been the most effective approach in controlling infectious diseases.
that had afflicted societies.\textsuperscript{172} Given the fact that AIDS is an infectious disease, public health officials in different countries did consider identifying AIDS patients, warning others of their existence, regulating their behavior and possibly limiting their freedoms.\textsuperscript{173} For example, in the former Soviet Union, a policy that allowed compulsory testing and identification of infected people was implemented. Foreigners who were found to be infected were subjected to deportation. Cuba was the best example to the proponents of compulsory testing. In Cuba, a policy empowered Cuban doctors to test anyone whom they thought was infected with the virus.\textsuperscript{174} Several other countries put in place laws, policies and practices that imposed travel restrictions on PLWHA and discriminated them in various settings.

In general terms, this approach, however, has proven to be unsuccessful when we come to AIDS. The question is: if this approach was historically effective in thwarting transmittable diseases, why did it fail in the case of HIV/AIDS? There are a number of reasons for this.

First, coercive measures like compulsory testing and criminal prosecution drive away people from utilizing HIV prevention, care, support and treatment services.\textsuperscript{175} It is self-evident that when people are coerced into being tested and are criminally prosecuted for being HIV positive, others might fear to go to health care services. Moreover, discrimination against PLWHA in work places and in other settings diminished their involvement in the management of the epidemic.\textsuperscript{176} All in all, the mistreatment of people infected with and affected by HIV/AIDS contributed to the underground transmission of the virus.\textsuperscript{177}

\textsuperscript{172} See Engel, supra note 163, at 35.
\textsuperscript{173} Id. at 36.
\textsuperscript{174} Id. at 94.
\textsuperscript{176} Report of the Secretary General, Second International Consultation on HIV/AIDS and Human Rights, 1996,
Second, in most cases, the coercive actions were taken against a few groups of the society, such as sex workers, discriminatorily.\footnote{See Dhaliwal, supra note 171, at 69.} The approach is inherently flawed in this regard. For instance, though sex workers are compelled to be tested, quarantined and prosecuted, this cannot bring about the intended consequences unless measures are taken to address the situation of customers of the sex workers and those hotels and bars that benefit from the sex industry. Moreover, it is extremely daunting to identify who are really the sex workers responsible for the transmission of the virus. There are others who may not be regarded as “sex workers” proper but engage in what we call transactional sex and who present even more danger than the sex workers proper. In any case, the above coercive measures cannot bring about long-lasting solutions. In the context of sex workers, for example, the more feasible solution could be to empower the sex workers to get out of activities risky to them and others.

Third, the most formidable argument against the application of traditional public health tools of infectious disease control is the special nature of HIV/AIDS, also called AIDS exceptionalism. Many writers convincingly argued that AIDS has special features that make it distinct from other epidemics.\footnote{See Kirby, supra note 159.} Reasons cited include the stigma accompanying the disclosure of HIV status, the absence of treatment, “the long latency period of the virus, and the fact that it was mostly transmitted during intimate consensual conduct between adults in private.”\footnote{Edwin Cameron, Legal and Human Rights Responses to the HIV/AIDS Epidemic, 17 Stellenbosch Law Review 37, 41(2006).}

While the latter two reasons still hold true this time, the tenability of the former two is in some way eroded. Though, initially, the disclosure of one’s positive status was extremely dangerous in

\footnote{See Gostin & Lazzarini, supra note 175, at 50-51.}

terms of exposing them to stigma, discrimination and denial.\textsuperscript{181} this situation is improved to a greater extent owing to public HIV awareness creation and availability of antiretroviral therapies which helped alter the stereotype that acquiring HIV/AIDS is a death sentence. But, it can still be argued that HIV/AIDS is special for the remaining reasons.

Testing whether a person is HIV positive or not at the earlier phases of HIV infection is not possible.\textsuperscript{182} In addition, though HIV is infectious, it is a weak pathogen which is not easily transmitted, for example, through normal body contact or breathing. Transmission from one individual to the other takes place through “sustained…exposure to infected bodily fluids.”\textsuperscript{183} The fact that the disease stays latent for quite a long period of time means that infected people can carry out their day to day businesses like any other uninfected people. This fact coupled with the fact that the disease has very few ways of transmission renders the application of the traditional public health tools of infectious diseases control, such as quarantine, unnecessary.\textsuperscript{184} Even if we assume that quarantine is productive, it may be disastrous in the HIV/AIDS context. Quarantine is a measure taken to deter the transmission of the virus from the infected to the uninfected ones and makes sense when the threat posed by the disease is short-lived, as in the case of smallpox or cholera. AIDS, however, is a permanent condition. Should people living with the virus be quarantined for life similar to those individuals who serve life sentence for commission of the most heinous crimes? Almost no one has so far answered this question

\textsuperscript{181} Id.
\textsuperscript{182} Id.
\textsuperscript{183} Id.
\textsuperscript{184} See Kirby, supra note 159, at 164.
affirmatively. Even if we agreed, it would be extremely difficult to practically execute it as the number of people to be quarantined is too many.\textsuperscript{185}

It is precisely for the reasons mentioned above that the isolationist approach has been rejected in most parts of the world these days. It is the integrationist approach which is built on human rights principles that has received an astonishing amount of recognition and implementation in international as well as national HIV prevention, care, support and treatment policies and strategies. As Kirby rightly posits, it is behavioral change, not coercion, which must be at the centre of any HIV prevention interventions.\textsuperscript{186} Kirby goes on to argue that:

\textit{The best way to promote behavioral modification, essential to prevent the spread of HIV, was to ensure that knowledge about the existence, modes of transmission and means of prevention of infection was given to all those at risk of acquiring it in circumstances that they would trust, believe and follow it.}\textsuperscript{187}

What he meant by this is fairly clear. In order to bring about genuine behavioral change, HIV prevention policies need voluntary testing rather than the compulsory testing; inclusion of PLWHA and their active involvement in HIV prevention activities to stigmatization and discrimination; and protection of the confidentiality of HIV positive status to breach of confidentiality and threat of subsequent isolation. Put differently, behavioral modification can be brought about only when the human rights of individuals and people infected with and affected by HIV/AIDS are respected, protected and fulfilled. This is expressed by OHCHR and UNAIDS powerfully as:

\textit{[T]he protection and promotion of human rights are necessary not only for the protection of the inherent dignity of persons affected by HIV but also for the}

\textsuperscript{185} \textit{ld.} For example, in Ethiopia, there are about 1.1 million PLWHA. If the country decides to quarantine all these PLWHA, one can imagine the resources that should be earmarked.

\textsuperscript{186} \textit{ld.} at 168.

\textsuperscript{187} \textit{ld.}

It may seem paradoxical to take a position that the rights of PLWHA should be respected and promoted. This is because in traditional management of infectious diseases, those who regarded as vectors of the disease used to be isolated and punished to prevent further transmission. In the context of the HIV epidemic, however, it is recognized that the protection and promotion of the rights of PLWHA is indispensible to control the epidemic. As Cameroon rightly posited, “[c]oercive measures were recognized as not merely needless[ly] punitive: they put the very public they were designed to protect at unnecessary risk of further infection.”\footnote{See Cameron, supra note 180, at 42 and Kirby, supra note 159, at 167.} If PLWHA are mistreated, they may even resort to actions that would infect the public.

Cognizant of the significance of a RBA in guiding HIV prevention, care, support and treatment interventions, the international community has showed a commitment to its implementation. This is evidenced by the affirmation of the Heads of State and Government and Representatives of States and Governments, assembled at the 2001 UN General Assembly Special Session on HIV/AIDS. The leaders commit themselves to:

\begin{quote}
[E]nact, strengthen or enforce [by 2003] as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV/AIDS and members of vulnerable groups, in particular to ensure their access to, \textit{inter alia}, education, inheritance, employment, health care, social and health services, prevention, support and treatment, information and legal
\end{quote}
protection, while respecting their privacy and confidentiality; and develop strategies to combat stigma and social exclusion connected with the epidemic.\textsuperscript{190}

They have also reiterated their commitment in the 2006 Political Declaration on HIV/AIDS.\textsuperscript{191} Underlining that an effective response to the pandemic must be anchored with principles of human rights, UNAIDS,\textsuperscript{192} WHO\textsuperscript{193} and ILO\textsuperscript{194} have likewise adopted policies and advocated for a RBA to responding to HIV/AIDS.

The effectiveness of a RBA can also be evidenced by a number of documented success stories.\textsuperscript{195} Countries that properly apply principles of a RBA, such as Australia, Brazil, the Netherlands, Switzerland, Thailand and Uganda have managed to control the epidemic.\textsuperscript{196} Other countries that followed the opposite path, including China, Russia and South Africa, on the other hand, failed in their initial response to the epidemic.\textsuperscript{197}

Though a RBA to HIV prevention, care, support and treatment is anchored in the existing human rights principles without a need to forge another framework for its implementation, it is imperative to raise the two downsides of the human rights system.

To begin with, the human rights system lacks strong enforcement mechanisms. The issues of HIV prevention, care, support and treatment call for the realization of a host of rights. However,

\textsuperscript{190} See UN, supra note 8, at para. 4.
\textsuperscript{191} See 2006 Political Declaration on HIV/AIDS, supra note 13.
\textsuperscript{192} See UNAIDS Global Reference Group on HIV/AIDS and Human Rights, supra note 128, at 1.
\textsuperscript{195} See UNAIDS Global Reference Group on HIV/AIDS and Human Rights, supra note 128, at 1.
\textsuperscript{196} See Gruskina &Tarantola, supra note 26, at 23.
\textsuperscript{197} Id.
it has more to do with the right to health. The right to health is classified among socio-economic rights. Compared to civil and political rights, they are relatively less enforced be it at international or domestic levels though they are recognized in a number of international treaties. The Optional Protocol to the ICESCR has been adopted only recently and has not yet become effective. According to the Committee on Economic, Social and Cultural Rights, it cannot entertain individual complaints. At domestic level, the adjudication of these rights is not as developed as that of civil and political rights for a number of reasons. The mechanisms of monitoring, evaluation and enforcement socio-economic rights in the context of HIV/AIDS and the status of their implementation in Ethiopia are discussed in chapter eight.

There is an additional problem that may challenge the effective implementation of a RBA approach to HIV prevention, care support and treatment. In Sub-Saharan Africa, in particular, different communities have their own customary rules that govern their behavior and regulate societal relationships. The rules are applicable formally, backed by legislation or at least condoned by the States. The application of human rights principles in respect of HIV prevention, care, support and treatment may be undermined in the face of conflicting customary rules. There are also tendencies of labeling human rights as alien to these communities. A detailed discussion

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199 Enforcement of Economic Social Rights Judgments, Analytical Report: International Symposium, May 6-7, 2010, 1, http://www.escr-net.org/usr_doc/Analytical_Report__Enforcement_of_Judgments_workshop__May_6-7__2010.pdf (last visited Feb. 2, 2011). Several myths pose challenges to the adjudication of Socio-economic rights, such as, they are too vague; they cannot be applicable by courts and hence are not judiciable; they entail issues of “public policy and resource allocation” which are not the mandates of courts; their adjudication by courts violates the principle of separation of powers and judicial remedies are not appropriate to them. For the summary of these challenges, see International NGO Coalition for the Optional Protocol to the ICESCR, Booklet 3: Why Should States Ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights?, 5-11, http://www.escr-net.org/usr_doc/Booklet_3_Jan_2011_FINAL.pdf (last visited Feb. 4, 2011).
of this problem in relation to the enforcement of the rights of women to reduce their vulnerability to HIV/AIDS is made in chapter five.

3.6 Human Rights and Public Health: Towards Complementary and Mutually Reinforcing Approaches

As highlighted in the preceding two sections, the traditional public health measures of controlling infectious diseases were taken to prevent the transmission of HIV/AIDS without success. The fundamental problem of the traditional public health approach is its failure to recognize the protection and promotion of individuals’ rights as a necessary condition for its achievement. For quite a long period of time, protection of human rights was viewed by public health practitioners as an impediment to the success of public health measures.200

True, there is a difference in focus between public health and human rights. Human rights are concerned with the right of individuals, including their protection from government infringement. Public health, on the other hand, is concerned with endeavors of states to guarantee the health of its people. Given that the preoccupation of public health is group interest, the measures to be taken may restrict rights of individuals. For example, when an epidemic erupts that can be managed through vaccination, individuals may be subject to compulsory vaccination against their will.

Lessons drawn from the successful experiences of controlling HIV/AIDS have fundamentally changed the old assumption that protection of public health and individual human rights are mutually exclusive. To the contrary, human rights provide a framework for addressing the social

200 See Gostin & Lazzarini, supra note 175, at 69.
determinants of vulnerability to HIV/AIDS. The human rights regime provides an insight to the public health approach that protection and promotion of human right is an important tool to combat HIV/AIDS apart from a catalogue of public health measures. Measures States take to realize human rights, such as provision of health-related information, goods and services, normally contribute to the achievement of public health goals. Thus, public health measures of controlling HIV/AIDS should be seen through the lens of human rights to bring about the desired goal of creating an AIDS–free society.

The above discussion leads us to the conclusion that human right and public health are principally complementary and mutually supportive approaches. Human rights and public health may not, however, necessarily be in accord with each other. In some cases, a tension may arise in the application of public health measures and the protection and promotion of individuals’ rights. The human rights regime does not turn a blind eye to this tension. It has designed a framework within which the tension can be resolved. In particular, it allows restriction of human rights in limited circumstance to preserve public health and other common goods. In order to avoid illegitimate limitations, the various instruments put in place rigorous tests.

As can be observed from the general limitation clauses and article specific limitations of various human rights instruments as well as the Siracusa Principles and the views of human rights experts, this tension can be effectively resolved.

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202 Id.
203 See Gostin & Lazzarini, supra note 175, at 44.
204 See Dhaliwal, supra note 171, at 69.
205 Under human rights regime, there are only few absolute rights which permit no qualification under any state of affairs. The classic absolute right is freedom from torture, inhuman, or degrading treatment.
206 See for example article 29 of the UDHR and article 4 of the International Covenant on Economic, Social and Cultural Rights [hereinafter the ICESCR]. ICESCR was adopted and opened for signature, ratification, and accession by General Assembly resolution 2200 A (XXI) of 16 December 1966 and entered into force on 23 March 1976.
rights monitoring bodies in interpreting these provisions, any interference with human rights should comply with five requirements: namely, legality, justification, necessity, proportionality and non-discrimination.

The legality requirement is met where the interference is prescribed by law of general application. The essence of this requirement, as indicated in the Siracusa Principles, is that limitations should have a formal legal basis and must be precisely formulated so as not to confer upon authorities wide discretionary power and must be accessible to everyone so that an individual or association will have an opportunity to know the prohibited action and consequent penalties for violating the prohibition. The requirement of legitimate justification requires that restriction to the rights not only shall have a legal basis, but also must have a legitimate aim that can justify the interference. These acceptable grounds of restriction include: national security, public order or safety, protecting the rights and freedoms of others and protecting public health and morals. In order to justify, the interference should also be necessary in a democratic society as well. It is up to the State that imposed the limitations “to demonstrate that the limitations do not impair the democratic functioning of the society.” Moreover, both the Human Rights Committee and the African Commission on Human and Peoples’ Rights have emphasized that any measures that restrict rights must be proportionate to the legitimate aim to be pursued

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207 Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, doc. E/CN.4/1985/4 (1985), para. 17 [hereinafter Siracusa Principles]. These principles were developed in 1984 by a panel of 31 international experts who met in Siracusa (Italy) to adopt a uniform set of interpretations of the limitation clauses contained in the ICCPR. While the Siracusa Principles do not have the force of law, they offer important and authoritative guidance as to the meaning of the terms contained in the Covenant, especially in areas not covered by a general comment of the Human Rights Committee.

208 See for example, Committee on Economic, Social and Cultural Rights, supra note 139, at paras. 28 and 29.

209 See Siracusa Principles, supra note, at 207.

210 Id. at para. 20.


and only imposed to the extent absolutely necessary for the advantages to be obtained. Thus, interference may be deemed to be proportional only if the means employed is actually necessary to achieve one of the legitimate purposes and is the least restrictive means among those that might achieve the desired results. Finally, even when a state is allowed to limit a right, such measures must not be discriminatory on various grounds.\textsuperscript{213} Nevertheless, not all distinctions amount to discrimination. According to the Human Rights Committee, a difference in treatment will not constitute discrimination “if the criteria for such differentiation are reasonable and objective and if the aim is to achieve a purpose which is legitimate under the Covenant.”\textsuperscript{214}

Thus, any measure of HIV prevention, care, support and treatment that poses any restriction on human rights can be justified on public health grounds only where it is stipulated by the law, absolutely necessary to safeguard public health, accepted in a democratic society, non-discriminatory and proportional. Every public health measures should be tested against these human rights standards.

### 3.7 Applicable Human Rights Instruments

As mentioned above, a RBA uses human rights standards to evaluate the success or otherwise of HIV prevention, care, support and treatment laws, policies and strategic plans. This section briefly reviews the main instruments in which States agreed on the need to use human rights standards to address HIV/AIDS and the documents in which the standards are incorporated.

At the international level, the UN Member States agreed “to integrate human rights into their national policies and gave explicit support for the integration of human rights within the UN

\textsuperscript{213} This is implied from para. 2 of General Comment No. 18 of the Human Rights Committee.

\textsuperscript{214} See Human Rights Committee, \textit{supra} note 211, at para. 13.
system” at the 2005 World Summit. It goes without saying that the national policies include HIV/AIDS policies. We can also find similar commitment at the African regional level. The Accra Agenda for Action (2008), which aims to accelerate and deepen implementation of the Paris Declaration on Aid Effectiveness, commits developing countries and donors to "ensure that their respective development policies and programs are designed and implemented in ways consistent with their agreed international commitments on gender equality, human rights, disability and environmental sustainability.” The need to use human rights as guiding principles is also incorporated in HIV/AIDS specific documents which Ethiopia has adopted, such as the 2001 Declaration on HIV/AIDS, the 2006 Political Declaration on HIV/AIDS, the 2011 Political Declaration on HIV/AIDS, the 2001 Abuja Declaration, the 2006 Brazzaville Commitment and the 2006 Abuja Call.

While the aforementioned documents have enormous significance in terms of recognizing the RBA in general and the RBA to HIV/AIDS in particular, they do not impose legal obligation on States which adopts them. The RBA to HIV prevention, care, support and treatment, however, is premised on legally binding human rights standards. It is, therefore, important to briefly mention these binding international human rights instruments. The main relevant human right treaties include, but are not limited to: the ICESCR, the ICCPR, the CEDAW, the CRC, 

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217 See UN, supra note 8.
218 See 2006 Political Declaration on HIV/AIDS, supra note 13.
220 See Abuja Declaration, supra note 14.
221 See Brazzaville Commitment, supra note 15.
222 See Abuja Call, supra note 15.
223 See ICESCR, supra note 206.
224 See ICCPR, supra note 142.
225 Adopted and opened for signature, ratification, and accession by General Assembly resolution 34/180 of 18 December 1979 and entered into force on 3 September 1981 [hereinafter CEDAW].

None of these treaties are exclusively devoted to addressing HIV/AIDS. Nor do they specifically mention HIV/AIDS. Nevertheless, their provisions are interpreted by the human rights bodies, UN agencies and scholars so as to be applicable in the HIV/AIDS context. At this point, it is imperative to mention the International Guidelines on HIV/AIDS and Human Rights that are jointly issued by the OHCHR and UNAIDS. The Guidelines are meant “to assist States in creating a positive, rights-based response to HIV that is effective in reducing the transmission and impact of HIV and AIDS and is consistent with human rights and fundamental freedoms.”

The Guidelines list specific rights in various human rights instruments that are pertinent to HIV/AIDS. The principal rights include: the right to non-discrimination; the right to life; the right to health; the right to liberty and security of person; the right to freedom of movement; the right to seek and enjoy asylum; the right to privacy; the right to freedom of opinion and expression and the right to freely receive and impart information; the right to freedom of association; the right to work; the right to marry and to found a family; the right to equal access

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226 Adopted and opened for signature, ratification, and accession by General Assembly resolution 44/25 of 20 November 1989 and entered into force on 2 September 1990 [hereinafter CRC].
227 Adopted in June 1981 and came into force in October 1986 [hereinafter ACHPR].
228 Adopted in July 1990 and came into force in November 1999 [hereinafter ACRWC].
230 The key conventions include: Discrimination (Employment and Occupation) Convention, 1958 (No. 111); Occupational Safety and Health Convention, 1981 (No. 155); Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No 159) and Occupational Health Services Convention, 1985 (No. 161). For ratification status of these ILO Conventions, see http://www.ilo.org/ilolex/english/newratframeE.htm (last visited Feb. 6, 2011).
231 Ethiopia signed, but not ratified the African Women Protocol.
232 See UNAIDS & OHCHR, supra note 19, at para. 101.
233 Id. at para. 1.
to education; the right to share in scientific advancement and its benefits and the right to participate in public and cultural life.\textsuperscript{234}

A more detailed discussion of the application of the human rights standards to specific situations is deferred for the subsequent chapters.

\section*{3.8 Status of International Human Rights Treaties in Domestic Law}

Though Ethiopia is a State Party to almost all core international human rights instruments, it did not ratify the key treaties which entitle individuals to lodge complaints before international human rights monitoring bodies and seek remedies for violations of human rights.\textsuperscript{235} Ethiopia has, however, accepted procedures of individual complaint mechanisms under the ACHPR and ACRWC. This means that individuals aggrieved of human rights infringement under these treaties can have recourse to the African Commission on Human and Peoples’ Rights and the African Committee of Experts on the Rights and Welfare of the Child.\textsuperscript{236}

No matter how many procedures for submission of communications to international human rights bodies Ethiopia has ratified, individual complaint procedures should play only a complementary role to domestic protection of human rights.\textsuperscript{237} For quite a number of reasons, domestic remedies for human rights violations are by far better than the international ones.\textsuperscript{238}

\textsuperscript{234} Id. at para. 102.
\textsuperscript{235} Ethiopia is not a party to Optional Protocol to the International Covenant on Civil and Political Rights or the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women. For ratification status of these treaties, see http://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&lang=en (last visited Feb. 6, 2011).
\textsuperscript{236} For ratification status of Ethiopia regarding ACHPR and ACRWC, see http://www.achpr.org/english/_info/index_ratifications_en.html (last visited Feb. 6, 2011).
\textsuperscript{238} Domestic remedies are “normally quicker, cheaper, and more effective than international ones”. \textit{See}, for example, the holding of the African Commission on Human and Peoples’ Rights in the Anuak Justice Council v. Ethiopia, Communication 299/2005, para. 48.
This is evidenced by the principle of exhaustion of domestic remedies before resort is made to international quasi-judicial bodies. 239 Given this fact, provisions of international human rights treaties should be domesticated by national laws so that individuals can invoke violation of human rights violations before national judicial and quasi-judicial bodies. 240

States follow a variety of approaches in domesticating and directly applying international treaties in the domestic legal system. In a few States, international law, including human rights treaties, is directly applicable before a domestic legal system without any further requirement. These countries adopted the monist theory where national law and international law are taken as part and parcel of a single legal system. 241 Consequently, international treaties are directly applicable by domestic judicial and quasi-judicial organs without a need to be domestically incorporated by parliaments. 242 In others, treaties form part and parcel of the domestic law only after they are transformed to the domestic legal system via the act of lawmakers. The practice of these countries reflects the dualist theory of the relationship between international law and municipal law. According to this theory, national law and international law are two distinct legal systems. As a result, national courts do apply international law after passing the transformation procedure via legislation. 243

A close scrutiny of the provisions of the FDRE Constitution and the practice demonstrate that Ethiopia has adopted the dualist approach. Article 9(4) of the Constitution provides that “[a]ll international agreements ratified by Ethiopia are an integral part of the law of the land.” In

239 See Committee on ICESCR, supra note 110, at para. 4.
240 Id.
243 See Shaw, supra note 242, at 129.
practice, treaties are given the status of domestic law only after they are ratified by the parliament and published in the *Federal Negarit Gazette* in the form of Proclamation. The requirement of transformation of treaties through parliamentary acts is an evidence of Ethiopian subscription to the dualist approach.

Once treaties acquire a national law status after passing the necessary procedures, it is crucial to determine their status via-a-vis other national laws. If the treaties are not given an important place or given a subordinate position against other domestic laws, their effective implementation at national level will be highly compromised particularly where they conflict with these laws. Determination of their precise status is a difficult exercise in Ethiopia owing to dearth of jurisprudence. Thus, any attempt to assess the position of human right treaties in the Ethiopian legal system is based on the pertinent constitutional provisions and views of academicians and senior judges.

The FDRE Constitution, in article 9 (1), proclaims that “[t]he Constitution is the supreme law of the land.” This supremacy clause of the Constitution unequivocally states that the Constitution is superior to all laws, including human rights treaties.

However, the supremacy of the Constitution declared under article 9(1) must be read alongside article 13 (2). Article 13(2) states that:

> The fundamental rights and freedoms specified in Chapter [chapter three-fundamental rights and freedoms-arts.13-44] shall be interpreted in a manner conforming to the principles of the Universal Declaration of Human Rights,

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international covenants on human rights and international instruments adopted in Ethiopia.

In light of this stipulation, one may reach to a conclusion that may seem contradictory to a conclusion reached by reading article 9(1) above. The fact that fundamental rights and freedoms should be construed in conformity with international human rights standards implies that, at least, chapter three of the Constitutions on fundamental rights and freedoms is subordinate to human rights treaties. Some critics who take this stance substantiate their position by making reference to article 27 (1) of the Vienna Convention on the Law of Treaties.\textsuperscript{246} Article 27 (1) of the Vienna Convention states that “[a] State party to a treaty may not invoke the provisions of its internal law as justification for its failure to perform the treaty.”\textsuperscript{247} For them, the constitutional provisions should not have precedence over human rights treaties because the later, being international obligations, should be implemented without the possibility of raising as an excuse contradictory constitutional provisions that may render implementation impossible or difficult. Others dissent from the above interpretation and take a firm position that the Constitution is superior to human rights treaties.\textsuperscript{248} They claim that article 13 (2) does not show hierarchy. It, rather, shows the possibility of interpretation of fundamental rights and freedoms provisions of the Constitution in the light of principles human rights treaties if and when interpretation is necessitated. Thus, principles of international human rights law are mere interpretative guidelines.

\textsuperscript{246} See, for example, interview with Ali Mohammed, cited in Bogale, \textit{supra} note 245, at 88. 
\textsuperscript{247} Vienna Convention on the Law of Treaties between States and International Organizations or between International Organizations, adopted on 20 March 1986. 
\textsuperscript{248} See for example, interview with Ato Menbereteshai Tadesse, Former Vice President of the Federal Supreme Court and Aysheshim Melese, Judge at the Federal High Court, cited in Bogale, \textit{supra} note 245, at 88.
It is not the mandate of this dissertation to discuss this issue at length and to give a final resolution to the controversies. It is, instead, to show how uncertainties on the status of international human rights treaties vis-a-vis the Constitution may hinder their actual implementation before domestic fora. The status of international human rights treaties against other domestic laws is not, however, as controversial as their position vis-a-vis the Constitution. Because they have to be ratified by the principal law maker, they are clearly superior to regulations (delegated legislation to be issued by the Council of Ministers)\(^ {249}\) and directives to be issued by government agencies upon delegation by the Council of Ministers.\(^ {250}\) Moreover, international human rights treaties are at least on equal footing as proclamations (primary legislation). This is due to the fact that the ratification of the former and the making of the later is the mandate of the parliament.\(^ {251}\)

\(^{249}\) Article 77(13) of the FDRE Constitution states that the Council of Ministers has the power to adopt regulations only where the power is granted to it by the parliament.

\(^{250}\) Ministries and other government departments may issue directives to govern a certain matter only where the Council of Ministers indicates to that effect in regulations.

\(^{251}\) These powers are clearly provided under article 55(1) and article 55 (12) of the FDRE Constitution.
CHAPTER FOUR

THE PLACE OF MULTI-SECTORAL APPROACH TO HIV PREVENTION, CARE, SUPPORT AND TREATMENT IN ETHIOPIA

Introduction
It is a plain fact that HIV/AIDS is cureless. After thirty years, it has become beyond the capacity of the international community to develop a vaccine or a curable drug for HIV/AIDS. So far, what we have are antiretroviral drugs that can only significantly suppress viral load and duplication without totally eradicating the virus from the body. The invention of antiretroviral drugs has, of course, helped a lot to reduce AIDS-related morbidity and mortality.

The absence of vaccine and curable drug has not frustrated the international community from combating the epidemic. Countries have effectively fought the pandemic with varying degree of success. Experience has taught that there is no a magic bullet that enables countries to effectively response to HIV/AIDS. They should design a comprehensive anti-HIV/AIDS program that combines HIV prevention, care, support and treatment. Neither of these is sufficient in its own. But, countries should implement HIV prevention, care, support and treatment programs in their own ways. Their programs should take into account local as well as cultural contexts.

No matter how States follow a myriad of approaches to craft and execute their HIV prevention, care, support and treatment strategies, their success cannot be imagined without strong leadership and involvement of stakeholders, including government institutions at different levels, civil society organizations, faith-based organizations, community-based organizations, PLWHA and
international development organizations. Multi-sectoralism is a key to the success of HIV/AIDS responses.

Against this backdrop, this chapter seeks to analyze the policy and legal framework for multi-sectoral involvement in HIV/AIDS prevention, care, support and treatment in Ethiopia.

4.1 Definition of Multi-Sectoral Response: How to Do It and Prerequisites for Its Success

At present, there is almost universal acceptance regarding the limitations of the health sector to handle the HIV response singlehandedly and the need to adopt a legal and policy framework that encourage the participation of all sectors in the HIV/AIDS response. Consequently, countries put in place a multi-sectoral approach.

Multi-sectoral approach, also called “intensified” or “expanded” approach, according to Husain and Bery, refers to “…responses to the impact of HIV/AIDS by different functional or sectoral ministries or agencies.” While it is true that multi-sectoralism requires a coordinated response by all sectors, the problem with this definition is that it seems to confine participation only to government ministries or agencies. As its very name implies, multi-sectoralism requires the involvement of all sectors and the term “sector”, though predominantly used to refer to a “country’s division of ministries”, can also be used to refer to the private sector and civil society organizations (CSOs).

A more all-inclusive definition is put forwarded by Harman. According to this author, “[m]ulti-sectorality refers to the involvement of community-based organizations, non-governmental

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organizations, line ministries and principally, the highest level of state government in shaping and leading the response to HIV/AIDS.254 True, the leadership the government should play, through its organs, is an important prerequisite to the success of a multi-cultural response. Its leadership role, contrary to what is envisaged in this definition, should, however, be exercised, not only at the ministerial level, but also at all levels including at the lowest administrative unit level.

The most comprehensive definition which this paper adopts is the one used by the Commonwealth Secretariat. According to the Commonwealth Secretariat:

A multi-sectoral response means involving all sectors of society - governments, business, civil society organizations, communities and people living with HIV/AIDS, at all levels... in addressing the causes and impact of the HIV/AIDS epidemic. Such a response requires action to engender political will, leadership and coordination, to develop and sustain new partnerships and ways of working, and to strengthen the capacity of all sectors to make an effective contribution.255

Unlike the former definition, this definition underscores the need for the participation of all stakeholders at all levels, including governments, to address root-causes and consequences of HIV/AIDS. Not only does this definition cover all stakeholders that need to be involved in the fight against HIV/AIDS, it also, in clear terms, draws the attention of these sectors to deal with the causes of HIV/AIDS (through prevention) as well as impact of HIV/AIDS (through care, support and treatment). The definition highlights what is expected of governments in this approach in that they should have the political commitment and play the leadership and coordination role in the implementation of HIV prevention, care, and support and treatment

programs. Governments should also forge partnership among stakeholders and create an enabling environment for their operation. According to this definition, it is not sufficient for governments to coordinate and lead the multi-sectoral response; more importantly, they need to build the capacity of stakeholders so that they will contribute meaningfully in the response endeavor.

As shall be discussed in detail in section three of this chapter, the multi-sectoral approach emerged with the raison d’être of intensifying the response to HIV/AIDS beyond the health sector. Given that the approach gives room for the participation of all sectors, the question is: how should these stakeholders fruitfully contribute to the response? How should multi-sectoralism be put into operation?

These above questions take us to the necessity of the notion of HIV/AIDS mainstreaming to put a multi-sectoral approach into operation. HIV/AIDS mainstreaming is defined by UNAIDS as:

A process that enables actors to address the causes and effects of AIDS as they relate to their core mandate in an effective and sustained manner, both through their usual work and within their workplace.\(^{256}\)

This definition consists of two elements that require close scrutiny. First, sectors should engage in the HIV prevention, care, support and treatment activities “as they relate to the core mandate” of the institution. This, in other words, means that HIV/AIDS mainstreaming requires sectors to use their missions, mandates and comparative advantages and ensure cost effectiveness and avoid duplication of efforts.\(^{257}\) For example, the education sector should focus on creating educational opportunity for children orphaned by HIV/AIDS. The media, on the other hand, need to concentrate on HIV/AIDS awareness-raising.

\(^{256}\) UNAIDS, Mainstreaming AIDS into Development: Why and How to Do It (2005).
The above analysis of the first element of the definition clearly shows that mainstreaming is different from mere integration. While integration involves the incorporation of HIV intervention in policies and strategies as a separate activity, mainstreaming requires the incorporation of such intervention in the usual mandates of the sector. Therefore, “through mainstreaming, HIV/AIDS becomes aligned with, and in turn influences, the core business of an institution, thus becoming more than a mere ‘add-on’.”\(^{258}\)

Second, the definition helps us identify the two dimensions of mainstreaming; namely, internal and external mainstreaming. The fact that sectors are supposed to address HIV/AIDS “within their workplace” indicates the domain of internal mainstreaming and a reference to “through their usual work” shows the external dimension of mainstreaming. Internal or workplace mainstreaming identifies and responds to factors – “individual, organizational and societal – that are likely to increase vulnerability to HIV infection for sector staffs.”\(^{259}\) In the external dimension, “HIV and AIDS interventions are undertaken in support of local or national strategic efforts based on the sector’s or organization’s mandate and capacities.”\(^{260}\)

HIV/AIDS mainstreaming may take place at different levels: at global, regional, national and sectoral(sub-national) levels.\(^{261}\) Globally and regionally, it is mainstreamed in international and regional policy documents such as the Millennium Declaration, the New Partnership for African Development, Declaration of Commitment on HIV/AIDS and the Abuja Declaration.\(^{262}\) At the national level, the mainstreaming is expressed by including HIV/AIDS issues in national overarching development laws, policies and strategies, such as poverty reduction strategies and

\(^{258}\) *Id.*  
\(^{259}\) *See* UNAIDS, *supra* note 253, at 20.  
\(^{260}\) *Id.* at 19.  
\(^{261}\) *See* UNAIDS, *supra* note 257, at 7.  
\(^{262}\) *Id.*
national HIV/AIDS policies. The national laws, policies and strategies should recognize HIV/AIDS as a cross-cutting issue. These national documents provide the framework for the practical implementation of mainstreaming at sector levels. Institutions at sector levels carry out various HIV prevention, care, support and treatment activities based on the national framework and comparative advantage.

Before winding up the discussion in this section, it is imperative to point out that it is not easy to come up with a universally applicable standard governing multi-sectoralism that will work for all countries. Yet, it possible to indicate key requirements for an effective multi-sectoral response which are, in one way or another, alluded to the above definition and collected from successful experiences. First, the success of the response is highly contingent upon effective leadership. It is the primary responsibility of governments to exercise strong leadership in the fight against HIV/AIDS. Such leadership is vital in coordinating and harmonizing the multi-sectoral response. Second, the response requires commitment of all sectors in the multi-sectoral response. Every sector should be committed to take HIV/AIDS as intrinsic to its mandate, rather than considering it as an extra-burden. Such kind of commitment is what Catherine Campbell calls “political will”. She uses the term to refer to not only “commitment of formal government groups and politicians”, but also all other actors involved in the multi-sectoral response. She emphasizes that even well-articulated HIV policies and strategies may end up in disaster without such will. Third, the success of the approach requires a huge task of capacity building and resource mobilization. Fourthly, the response should take place at all levels, from national level to local levels. Fifthly,

263 Id.
264 Id. See also UNAIDS, supra note 253, at 24.
265 See UNAIDS, supra note 253, at 9.
as mentioned above, sectors should not attempt to carry out all components of HIV prevention, care, support and treatment. They should rather identify and carry activities based on their comparative advantages.

4.2 The Human Rights Foundation of Multi-Sectoralism

Multi-sectoralism is grounded in human rights. It is basically based on the right to participation, the rights to freedom of association and the principle of interdependence and interrelatedness of rights.

In chapter three, a reference is already made to the fact that the right to participation is one of the mainstays of a rights-based approach. Under a rights-based approach, individuals should be given the opportunity to take part in all affairs that affect their interests. A number of human rights instruments protect this right, including article 21 of the UDHR, article 25 of the ICCPR, article 7 (b) and (c) of the CEDAW, article 13 of the ACHPR and article 38 (1) (a) of the FDRE Constitution.

The Human Rights Committee, an organ empowered to monitor the implementation of the ICCPR, has elaborated the content of the right to take part in processes that constitute the conduct of public affairs. According to the Committee, the conduct of public affairs is extensive enough to cover “the formulation and implementation of policy at international, national, and local levels.”

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267 Universal Declaration of Human Rights, G.A. Res. 217A, (1948) [hereinafter UDHR]. Despite the fact that the Universal Declaration of Human Rights was not meant to be a binding document, scholars argued that most of the provisions therein attained the status of customary international law. Under international law, rules of customary international law impose obligations on all states. See Dugard, supra note 242, at 315.

268 See ICCPR, supra note 142. Ethiopia is a party to this treaty. Once a treaty is ratified by Ethiopia, the current Ethiopian Constitution, under article 9 (4), provides that the treaty shall be part of the law of the land.

269 See CEDAW, supra note 225.

270 See ACHPR, supra note 227. All African Union members, including Ethiopia, are parties to this treaty.

271 See ICCPR, supra note 142, at art. 24.

272 Human Rights Committee, General Comment No. 25, Right to Participate in Public Affairs (1996) para. 2.
Therefore, the right to take part in processes that constitute the conduct of public affairs as envisaged in human rights documents and as elaborated by the Human Rights Committee entitles citizens to actively engage, directly or indirectly, as the case may be, in the initiation, formulation, implementation and evaluation of policies that affect their lives.275

The right to freedom of association, though regarded as a tool to exercise the right to participate in public affairs, is protected as distinct right in various human rights instruments. It is recognized in a number of human rights instruments.276 The UDHR, under article 20, provides that “everyone has the right to freedom of… association”, and that “no one may be compelled to belong to an association.” Using similar wording, the same right is enshrined in article 22 of the ICCPR. From trade unions’ point of view, article 8 of the ICESCR277 guarantees “the right of every one to form trade unions and join the trade union of his choice” and the “right of trade unions to function freely”. The right to freedom of association is also incorporated in other specialized human rights conventions, such as the CRC278 and the CMW279 and African regional human rights instruments, such as article 10 of the ACHPR280 and article 8 of the ACRWC.281

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274 Id. para.5.
276 Besides the human rights treaties mentioned below, the right to freedom of association is dealt in many ILO conventions.
277 See, supra note 206. Ethiopia acceded to it on 11 June 1993.
278 See CRC, supra note 226. Ethiopia acceded to it on 21 October 1991.
279 International Convention on the Protection of the rights of All Migrant Workers and Members of Their Family, art. 26 [hereinafter CMW].
280 Availing its power of monitoring the implementation of the ACHPR, the African Commission on Human and Peoples’ Rights (the African Commission) has passed two resolutions pertinent to the right to freedom of association. One of these resolutions is the Resolution on the Right to Freedom of Association. This Resolution, among other things, provides that, “in regulating the use of this right, the competent authorities should not enact provisions which would limit the exercise of this freedom.” The second resolution is the Resolution on Protection of Human Rights Defenders in Africa which is adopted by the African Commission in response to the persistent human
As can be deduced from the above international human rights documents, the right to freedom of association enables individuals to join together to pursue common interests in groups. Though the right to freedom of association is framed in different treaties as an individual right, it has been increasingly argued that the right has a hybrid character. That is, it has an aspect of both an individual and a collective right. As individual right, it encompasses the right of individuals to form and join associations freely. For this individual right to be fully enjoyed, however, the collective aspect of this right must be protected. That is, the associations formed must be able to function freely without unjustifiable governmental intrusion. In support of this, it is further argued that article 8 of the ICESCR that requires State Parties to ensure "the right of the trade union to function freely" shows an understanding that the right to “form and join” an organization may not be sufficient to enable an individual to fully realize his or her right to freedom of association.

rights violations that human rights defenders face in Africa, such as denial of freedom of association. In this Resolution, the African Commission urged State Parties to promote and give full effect to the UN Declaration on Human Rights Defenders and to take all necessary measures to ensure the protection of human rights defenders. The African Commission has also decided on a few communications pertaining to the right to freedom of association. In Civil Liberties Organization in Respect of the Nigerian Bar Association v. Nigeria (Communication No. 101/93, 1995), the African Commission held that a governmental decree establishing a governing body for a bar association by appointing the majority of nominees itself violated the freedom of association. Moreover, the African Commission has found in International Pen, Constitutional Rights Project, Interights on behalf of Ken Saro-Wiwa Jr. and Civil Liberties Organization v. Nigeria (Communications Nos. 137/94, 139/94, 154/96 and 161/97, 1998) that the right to freedom of association was violated when the state unjustly tried and convicted members of a community organization. In another communication, Interights and others v. Mauritania(Communication No., 242/2001, 2004), the African Commission found that the dissolution of the main political party by the Mauritanian Government was disproportional to the nature of the acts committed by the political party and, thus, a violation of Article 10 of the ACHPR.

281 See ACRWC, supra note 228. Ethiopia acceded to the Charter on 2 October 2002.
282 See Sepulveda, supra note 275, at 302-303.
284 See Sepulveda, supra note 275, at 302-303.
285 See Human Rights First, supra note 283, at 38.
286 Id.
Neither the Human Rights Committee nor other international treaties monitoring bodies have addressed the issue of whether and how the right to freedom of association, a right typically formulated in various conventions as an individual right, can be extended to other entities, such as CSOs.\footnote{287} The landmark decisions of the European Court of Human Rights have, however, affirmed that international law recognizes the right of individuals to form associations and that, once the associations are formed; the associations have the right to function freely.\footnote{288} Though the decisions of the European Court of Human Rights do not set precedents for other than States Parties to the ECHR, the identicalness of the wording of Article 22 of the ICCPR to the wording of Article 11 of the ECHR can serve as a basis for a strong argument that article 22 of the ICCPR should be interpreted in the same way that Article 11 of the ECHR has been interpreted.\footnote{289}

Among the Ethiopian national human rights laws, the FDRE Constitution explicitly protects the right to freedom of association in article 31 which provides that “[e]very person has the right to freedom of association for any cause or purpose.” It further provides that “[o]rganizations formed, in violation of appropriate laws, or to illegally subvert the constitutional order, or which promote such activities are prohibited.” It is apparent from article 31 that the right to freedom of association clause is applicable to everyone without regard to one’s color, race, nationality or other factors. Such formulation is different from the formulation of some other rights which are

\footnote{287}This does not include trade unions. In a number of conventions negotiated under the auspices of the International Labor Organizations (ILO), it is unambiguously affirmed that trade unions have the right to freedom of association. See Freedom of Association and Protection of the Right to Organize Convention (ILO No. 87); Right to Organize and Collective Bargaining Convention (ILO No. 98); Workers' Representatives Convention (ILO No. 135) and Labor Relations (Public Service) Convention (ILO No. 151).


guaranteed only to Ethiopian Nationals. Article 31 does not prescribe specific purposes for which associations must be established. It guarantees freedom of association regardless of the purpose for which the association is set up as long as the association is established for lawful purposes. Aside from the FDRE Constitution, the new Charities and Societies Proclamation (CSOs Proclamation) explicitly states, in its preamble, that it aims at realizing the right to freedom of association. The extent to which the Proclamation creates an enabling legal environment for the operation of CSOs in Ethiopia is dealt with later in sub-section 4.7.1.

The bottom line is that the right to freedom of association gives individuals the right to form associations and engage in lawful activities. The associations formed are also protected by the same right.

Finally, multi-sectoralism, as mentioned in chapter three, is necessitated by the interdependence and interrelatedness of rights. One of the principles of human rights unequivocally recognized in the Vienna Declaration is the interdependence and interrelatedness of rights. The principle of interdependence and interrelatedness of rights means that the realization of a right mostly depends on the realization of other right(s). Thus, for a given right to be realized, say the right to health, activities to be carried out by the health sector are not sufficient. Other sectors that work on determinants of the right heath, like the agricultural sector that work to ensure the availability of food and the education sector that works to ensure the right to education and others, must forge strong partnership to realize the right. A rights-based approach highly requires a multi-sectoral approach to addressing problems.

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290 Certain rights, such as the right to vote and to be elected (article 38) and the right to property (article 40) are enjoyed only by Ethiopian nationals.
291 Charities and Societies Proclamation, Proclamation No. 621/2009, Federal Negarit Gazeta, Year 15 No. 25 [Hereinafter CSOs Proclamation].
292 See Vienna Declaration and Program of Action, supra note 140, at para. 5.
4.3 The Rationale for Multi-Sectoral Approach

At the early age of the epidemic, responses to HIV/AIDS were shouldered by the health sector and, predominantly, the approach health sectors adopted was what Helen Epstein calls the “commodities-based approach”, such as condom social marketing, testing and counseling, education campaigns, safe blood supplies and treatment of sexually transmitted diseases and opportunistic infections. Though this approach brought about limited successes, in countries such as Uganda and Thailand, in general terms, the approach was unable to halt the spread of the disease. Consequently, a need arose to devise a new approach which can push beyond the health sector and a commodity-based approach and which would generate more participation and resource mobilization. African countries and donors, in the late 1990s, took a stance that the best candidate to meet these objectives was the multi-sectoral approach. Thus, the multi-sectoral approach has emerged primarily as a reaction to the insufficiency of the health sector to effectively respond to HIV/AIDS. Given that HIV/AIDS is an epidemic that poses an enormous challenge to every sector; each sector has the responsibility to take part in HIV prevention, care, support and treatment activities.

Catherine Campbell described the need for the adoption of a multi-sectoral approach to HIV/AIDS response eloquently as follows:

Not only is the HIV epidemic too complex to be dealt with through traditional biomedical or behavioral disease prevention, it is also too multi-faceted for any single constituency …to deal with on its own. For this reason, it is essential that HIV prevention projects build alliances with the widest possible range of relevant constituencies, to ensure that a wide range of actors pool their resources and

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293 See Epstein, supra note 160, at 258 and Ainsworth & Teokul, supra note 160, at 55-60.
294 See Epstein, supra note 160, at 258.
295 Ainsworth & Teokul, supra note 160.
creativity in working to create a new approach that is relevant to the precise manifestations of the disease in question.\textsuperscript{297}

According to Catherine Campbell, several developing countries that have been able to mobilize diverse sectors have achieved a lot in terms of controlling the spread of the epidemic from which other developing countries can draw enormous lessons. For her, even if countries like Thailand, Brazil, Senegal and Uganda have responded to the epidemic in their own ways, the fact that they were able to mobilize all sectors coupled with strong government leadership in the fight against HIV/AIDS is what they have in common.\textsuperscript{298}

Helen Epstein has described what she saw in Uganda that led to its success. She wrote that even if various interventions, such as condom promotion, AIDS education and awareness-raising, treatment of sexually transmittable disease and HIV testing and counseling contribute their part to the success, “what mattered most was something for which public health experts had no name or program. It was something like ‘collective efficacy’ - the ability of the people to join together and help one another.”\textsuperscript{299} There were hundreds of community and church based organizations that undertook HIV awareness-raising activities, dealt with special vulnerably of women, cared and supported PLWHA and children orphaned by AIDS across the country at their own expenses.\textsuperscript{300}

Thus, the multi-sectoral approach is justified not only because it is a means to realize human rights but also a key to the success of responses to HIV/AIDS.

\textsuperscript{297} See Campbell, supra note 266, at 57.
\textsuperscript{298} See Husain, supra note 252, at 11.
\textsuperscript{299} See Epstein, supra note 160, at 164.
\textsuperscript{300} Id.
4.4 International Standards Guiding Multi-Sectoralism

As mentioned above, African countries and donors, in the late 1990s, were convinced that previous approaches were inadequate to address the causes of HIV/AIDS and to mitigate its consequences. Following this, the World Bank launched a 1 Billion US Dollar Multi-Country HIV/AIDS Program (MAP) in 2000. The primary objective of MAP is to fund Sub-Saharan African countries with high HIV prevalence rate and committed to expand the horizon of the HIV/AIDS response through a multi-sectoral approach.301 MAP, in particular, attaches the following conditions for funds to be available, viz., the adoption of a national strategic plan to combat HIV/AIDS, a national coordinating body of the response, a commitment by countries to involve all sectors, including CSOs, in the fight against HIV/AIDS, and an agreement to channel 40-60% of the funds to CSOs.302 The notion of multi-sectoralism, first espoused as a policy of priority by the World Bank, has become central to the working practices of countries and international development agencies.303

Highly influenced by the tenets of World Bank MAP, heads of States and governments gathered for the 2001 UNGASS on HIV/AIDS adopted the Declaration of Commitment on HIV/AIDS. In this Declaration, the leaders have emphasized the need for strong “[l]eadership by Governments in combating HIV/AIDS” accompanied “by the full and active participation of civil society, the business community and the private sector.”304 To that end, they agreed “[t]o ensure the development and implementation of multi-sectoral national strategies…for combating HIV/AIDS by 2003.”305 Five years later, in 2006, countries confirmed and expanded their 2001

301 See World Bank, supra note 118.
302 Id.
303 See Harman, supra note 254, at 485-492.
304 See UN, supra note 8, at para. 37.
305 Id.
commitment in the 2006 Political Declaration adopted at a High Level Meeting on AIDS at the General Assembly of the United Nations.\textsuperscript{306} They, \textit{inter alia}, promised “to achieve broad multi-sectoral coverage for prevention, treatment, care and support”.\textsuperscript{307}

The leading document that sets a standard at the African level is the 2001 Abuja Declaration of Commitment on HIV/AIDS, Tuberculosis and other Related Infectious Diseases.\textsuperscript{308} This document, in which African countries agreed to place the response against HIV/AIDS as one of their priorities, sets out “a comprehensive multi-sectoral strategy which involves all appropriate development sectors of… governments as well as broad mobilization of…societies at all levels” as an important approach leading for the HIV/AIDS response in Africa.\textsuperscript{309}

The “Three Ones” principles are widely recognized as important guiding principles in national AIDS strategies, including in Ethiopian HIV/AIDS policies and strategic plans.\textsuperscript{310} The Three Ones principles were officially approved by representatives from donors and main international organizations on 25 April 2004 at a Consultation on Harmonization of International AIDS Funding in Washington, D.C.\textsuperscript{311} The Three Ones principles aim at effectively harmonizing and coordinating the various efforts in the HIV/AIDS response and thereby avoiding duplication of efforts.\textsuperscript{312} The Three Ones principles require the fulfillment of the following conditions to HIV/AIDS responses at national level. First, there should be one agreed AIDS action framework at the national level which will enable countries to harmonize and coordinate the efforts of the

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\item \textsuperscript{306} See 2006 Political Declaration on HIV/AIDS, \textit{supra} note 13.
\item \textsuperscript{307} \textit{Id.} at para. 20.
\item \textsuperscript{308} See Abuja Declaration, \textit{supra} note 14.
\item \textsuperscript{309} \textit{Id.} at para 23.
\item \textsuperscript{310} See HAPCO, \textit{supra} note 51.
\item \textsuperscript{311} See \textit{supra} note 119.
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various sectors. The preparation and evaluation of the framework should be done in a manner that allows broad-based participation from all stakeholders.\textsuperscript{313} Second, there should be one national AIDS coordinating authority with a strong commitment that coordinates the overall response.\textsuperscript{314} The coordinating authority must ensure the involvement of all sectors in the development and evaluation of the response. Third, there should be one agreed country-level monitoring and evaluation system.\textsuperscript{315}

4.5 The Legal and Policy Framework Regulating the Multi-Sectoral Response in Ethiopia

A reference has already been made to the fact that a multi-sectoral approach to HIV prevention, care, support and treatment is accepted as an effective response both by countries hit by the virus and their partners. Ethiopia is not an exception to this. The country has set up institutions and put in place laws, strategic plans and policies for the implementation of the multi-sectoral response. This section explores how multi-sectoralism is organized in Ethiopia.

Though there were specific policies that were put in place since the emergence of HIV/AIDS pandemic in Ethiopia, the first compressive HIV/AIDS policy of Ethiopia was issued in 1998.\textsuperscript{316} The adoption of this document serves as the cornerstone for the multi-sectoral response in Ethiopia. The Policy explicitly provides that one of its objectives is to “promote a broad multi-sectoral response to HIV/AIDS epidemic, coordination of activities of all sectors.”\textsuperscript{317} However, it does not incorporate in-depth provisions that set out how the multi-sectoralism should be put into

\textsuperscript{313} UNAIDS, The ‘Three Ones’ in Africa: Where We Are and Where We Go From Here 16 (2005).
\textsuperscript{314} Id. at 19.
\textsuperscript{315} Id. at 22.
\textsuperscript{316} See 1998 HIV/AIDS Policy, supra note 17.
\textsuperscript{317} Id. para. 2.2.
operation. Rather, it anticipates the issuance of other laws and guidelines for the implementation of the Policy. The Policy is still in force to date and under revision.

Subsequent to the issuance of the 1998 National HIV/AIDS Policy, NHAPCC was established in 2000. The FHAPCO, a Secretariat, accountable to the Prime Minister's Office, was also established to coordinate the national multi-sectoral response. NHAPCC and FHAPCO were given a legal backing for their operation by Proclamation No.276/2002. NHAPCC is chaired by the president of the Republic and consists of members from different walks of life. The members include: federal ministers and heads of other pertinent government agencies; the speaker of the federal parliament; regional (state presidents); heads of mass media organizations; leaders of religious institutions; employer and employee associations; a representative of the private sector; a representative of teachers association; leaders of PLWHA organizations and leaders of other NGOs and prominent personalities upon the permission of the Council. NHAPCC was established with the avowed objectives of mobilizing different sectors against AIDS; giving policy guidance and carrying out the response in an integrated manner.

As NHAPCC meets regularly every six months, it requires a secretariat that performs its day-to-day activities. That is why the FHAPCO is established by the same Proclamation. The FHAPCO, an organ accountable to the office of the Prime Minister, is in charge of coordinating HIV-related activities of federal and regional government agencies and NGOs and leading the implementation of the country’s HIV/AIDS policies and strategies. Though FHAPCO is meant

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318 Id. para .10.1.
319 See Proclamation No. 276/2002, supra note 84, at art. 4.
320 Id. art. 5.
321 Id. art.11(1).
322 Id. arts.8 and 9.
to be a government agency, CSOs represented in the HAPCC that considerably contribute to the HIV/AIDS response are represented in FHAPCO.\footnote{Apart from the Management Board, FHAPCO has the following organs: a head to be appointed by the Government and the necessary staff. \textit{See} Proclamation No. 276/2002, \textit{supra} note 84, at arts. 13 and 14.}

By including a myriad of stakeholders as members of the NHAPCC and in the Management Board of FHAPCO, the Proclamation creates an enabling environment for the multi-sectoral response in Ethiopia. The fact that top government officials, including the president of the Republic, are members of NHAPCC gives strength to the response. The Proclamation, however, does not tell us how the organization at the top level is operational at regional, zonal and local levels.

As mentioned above, since the 1998 HIV/AIDS Policy and the Proclamation contain general provisions, they need specific and detailed provisions for the implementation of the multi-sectoral response. For that purpose, in 2004, the Ethiopian Government launched the first Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response for the period 2004-2008.\footnote{\textit{See} SPM, \textit{supra} note 45, at II.} The first Strategic Plan was replaced by SPM II, which is discussed later in this section.

In 2007, the Multi-sectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support 2007–2010 was prepared by the FHAPCO assisted by donors, government ministries and civil societies.\footnote{\textit{See} Universal Access Action Plan, \textit{supra} note 17.} The purpose of this plan of action is to be used by all sectors as a framework to achieve universal access to HIV prevention, treatment, care and support.\footnote{\textit{Id.} at 1.} To achieve the overall objective, the document lists a host of HIV prevention, care, support and

\footnote{\textit{Id.} at 1.}
treatment activities that should be implemented by all sectors at different levels.\textsuperscript{327} This document highly overlaps with SPM II both in content and the objective for which it is issued.

In the same year, two other documents were also prepared and put in place: the Social Mobilization for Prevention and Control of HIV/AIDS: Implementation Guideline and the Social Mobilization for Prevention and Control of HIV/AIDS: HIV/AIDS Mainstreaming Implementation Manual. While multi-sectoralism is a tool to boost social mobilization against HIV/AIDS, mainstreaming, as mentioned previously, is an important weapon to implement multi-sectoral response and to deepen social mobilization.

The Social Mobilization for Prevention and Control of HIV/AIDS: Implementation Guideline (Social Mobilization Guideline), after defining social mobilization or public movement as “a process in which community makes use of its own assets and capacities” to reverse the transmission of HI/AIDS by integrating HIV prevention, care, support and treatment programs,\textsuperscript{328} highlights its guideline principles. Two of its guiding principles are involvement of PLWHA and population at risk including women, youth, uniformed people, commercial sex workers, truck drivers and mobile people in search of job in the HIV/AIDS response.\textsuperscript{329}

Some of the key strategies intended to mobilize the society are: utilizing existing institutions and structures of the community including kebele (local) administrations, government apparatus, FBOs and associations of women, youth, PLWHA and funeral (Idirs). The main social mobilization tasks to be done are undertaking community conversations, strengthening voluntary

\textsuperscript{327} Id. at 29-57.
\textsuperscript{328} See Social Mobilization Guideline, supra note 104.
\textsuperscript{329} Id. at 4-6. The other basic principles are public ownership and leadership; shared sense of urgency; evidence based and result oriented plan; coordinated efforts and strong partnership.
community anti-AIDS promoters and awareness-raising. Quite a lot of tasks have been carried out to implement the Social Mobilization Guideline. In 2008/09, for example, 92% of kebeles undertook community conversations, out of which 74% prepared action plans to carry out HIV-related activities. In the same budget year, the Government trained 35,097 community conversation facilitators and an equal number of agriculture development agents that would facilitate community conversations.

The social mobilization is coordinated by different organs at different levels. At the national, federal, and regional levels, HAPCOs and representatives of selected agencies coordinate the day-to-day activities of the movement. At zonal, woreda and kebele levels, zonal health desks, health offices and health extension workers respectively are primarily responsible for the coordination.

Social Mobilization for Prevention and Control of HIV/AIDS: HIV/AIDS Mainstreaming Implementation Manual (Mainstreaming Manual) was issued to strengthen social mobilization and the multi-sectoral response. The Manual covers both dimensions of mainstreaming: addressing the root causes of HIV/AIDS and its impacts on employees (internal mainstreaming) and contributing their institutional comparative advantages (external mainstreaming).

According to the Manual, HIV/AIDS mainstreaming shall take place in government institutions, including the executive, the legislative and the judiciary branches; NGOs and the private sector

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330 Id. at 6-10.
331 See FHAPCO, supra note 51, at 34.
332 Id.
333 Id. at 10-15.
334 See Mainstreaming Manual, supra note 105.
335 Id. at 4.
at federal, regional, zonal, woreda (district) and Kebele levels.\textsuperscript{336} Institutions that implement HIV/AIDS mainstreaming have the obligations, \textit{inter alia}, to assess the impact of HIV/AIDS on the institutions; to prepare and implement policies and plans to overcome the impact; to assign enough manpower and budget of up to 2\% to implement HIV/AIDS mainstreaming policy and plan; to build the capacity of the implementers of the mainstreamed activities and to monitor and evaluate the activities and submit report to the appropriate organ.\textsuperscript{337}

Compared with the Mainstreaming Manual, a more stringent assessment tool is prepared by the Federal HAPCO to assess whether federal sectors or institutions have lived up to their obligation to mainstream HIV/AIDS. The assessment yardsticks evaluate mainstreaming sectors and institutions on the basis of whether the organization or sector adopts plans, workplace policies and strategies on HIV/AIDS activities and implements the same; assigns a focal person; makes financial resources available for the implementation of the plans; works in partnership with others; shows leadership commitment; conducts employee risk assessment; establishes AIDS fund; has information, education and communication/behavioral change communication interventions; implements condom promotion and distribution programs; provides care and support services; creates linkage with health service providers; and monitors and evaluates the proper implementation of the policy, strategy and plan.\textsuperscript{338}

Those organs, discussed above, in charge of coordinating social mobilization are also in charge of coordinating HIV/AIDS mainstreaming.\textsuperscript{339}

\begin{footnotesize}
\begin{itemize}
\item\textsuperscript{336} \textit{Id.} at 5.
\item\textsuperscript{337} \textit{Id.} at 10.
\item\textsuperscript{338} Assessment Tool for HIV/AIDS Mainstreaming Stage/Scale Identification of Federal Sectors/Organizations, prepared by FHAPCO.
\item\textsuperscript{339} See Mainstreaming Manual, \textit{supra} note 105, at 11.
\end{itemize}
\end{footnotesize}
The Ethiopian Government was well aware of the limited capacity of HAPCOs to coordinate the multi-sectoral response singlehandedly and the need to broaden the space for multi-sectoral participation. Accordingly, it, in collaboration with other partners, set up the NPF against HIV and AIDS in Ethiopia in 2004. NPF is open to all networks that are committed to fight HIV/AIDS and that have nation-wide representation either in their function or structure; or “have unique voice or value addition to the forum.” The Guideline for partnership forums against HIV and AIDS in Ethiopia (Partnership Guideline) is prepared to set forth principles that are applicable for the establishment and management of partnership forums against HIV/AIDS in Ethiopia at various levels.

The Partnership Guideline states that the main reason for the establishment of the NPF is to enhance strong, participatory, accountable, transparent and effective partnership that will uphold HAPCO’s coordination of the national multi-sectoral response; create a forum for better information sharing and increase the number of partners in the fight against HIV/AIDS. The Guideline states that NPF is not meant “to duplicate existing institutional arrangements”; instead, it is meant to complement them in terms of assisting in the coordination of the multi-sectoral response by forming a better organizational structure.

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340 All regions except Afar, Gambella, Oromia and Dire Dawa have established regional partnership forums. See the Findings of the Second National Joint Integrated Supportive Supervision of 2009/2010 [Findings of Joint Supervision], presented by the Federal HIV/AIDS Prevention and Control Office Planning, Monitoring and Evaluation Directorate at the Mekelle Workshop. The Mekelle Workshop was an Annual Joint Review Meeting of the 2009/2010 National Multi-Sectoral HIV/AIDS Response organized by the FHAPCO from Oct. 28-30, 2010. The Second National Joint Integrated Supportive Supervision was conducted during August 01-11, 2010. The main aim of the joint integrated supportive supervision mission was reviewing the implementation of HIV/AIDS prevention and control programs which were jointly planned for the budget year and supporting implementers on the 2010/2011 annual planning.


342 Id.

343 Id. at 1.

344 Id. at 2.

345 Id. at 28.
NPF has four organs: the General Assembly which is co-chaired by MOH and FHAPCO, composed of sub-forums, serves as a Secretary of the NPF, and the highest decision organ of NPF; the Executive Board, composed of representatives of the General Assembly, responsible for passing decisions in operational matters and implementing the decisions of the General Assembly and the Coordination Unit. This structure of NPF is to be replicated at regional, zonal and woreda levels.

The key document that guides the multi-sectoral response for the period 2009-2014 is SPM II. Specific annual plans are expected to be issued for the implementation of this document and the different actors in multi-sectoral response are supposed to adopt and put in to operation their respective action plans consistent with this document.

SPM II is adopted with a mission of addressing both the root causes of HIV transmission and the multi-faceted impact of HIV/AIDS through ensuring the provision of HIV prevention, care, and support and treatment services and by intensifying a strong mobilization of all sectors against the epidemic. One of the key guiding principles for the achievement of the mission of SPM II is multi-sectoralism. The Strategic Plan puts forth a similar justification to the one analyzed in section three of this chapter why multi-sectoral approach is needed. What is striking in the justification given in this document is the way it articulates the myriad factors of HIV vulnerability and the need for the cooperation of all sectors to address them. It is true that a single sector, health sector, the media or the education sector, will not be able to address all the

346 Id. at 33-42.
347 Id. at 26.
348 See SPM II, supra note 17.
349 Id. at 26-27. The other guiding principles include: involvement of PLWHA; empowerment of communities and stakeholders; shared sense of urgency; gender sensitivity; customer focused; result oriented; partnership and best use of resources.
350 Id. at 26.
behavioral, social, cultural and economic drivers of the epidemic. To take the health sector as an example, setting financial constraints and lack of qualified staff aside, it may contribute to the campaign against HIV/AIDS through treatment of sexually transmittable diseases, provision of antiretroviral drugs and the like; but it will not be able to alleviate poverty that compels women to engage in formal and informal sex work that in turn put them at risk of exposure to the scourge of the epidemic. Addressing poverty has become a daunting task in many developing countries including Ethiopia. It requires the collective actions of development actors with passion and commitment.

SMP II recognized and included the principal conditions that should be fulfilled in order for the multi-sectoral response to be successful in its ambit under the name “enabling environment for the success of the multi-sectoral response”. The first is the need to build the technical as well as leadership capacity of the different multi-sectoral actors so that they can meaningfully engage in the fight against HIV/AIDS. Second, the document mentions the existence of committed leadership that coordinates the response, builds the capacity of the different actors and ensures accountability of those involved in the multi-sectoral response.\textsuperscript{351} Third, the document recognizes the need to create a strong partnership among the different stakeholders to harmonize HIV activities in the country and to effectively and sustainably address the epidemic.\textsuperscript{352} Forth, the document puts in place monitoring and evaluation mechanisms that would enable identification of the progresses and failures in the multi-sectoral HIV prevention, care, support and treatment programs.\textsuperscript{353} In accordance with the Three Ones principles, SMP II, like its predecessors, attempts to create one country-level monitoring and evaluation system of the

\textsuperscript{351} Id. at 30.
\textsuperscript{352} Id. at 32-33.
\textsuperscript{353} Id. at 72.
multi-sectoral response. The FHAPCO is in charge of coordinating the overall national monitoring and evaluation. Moreover, the FHAPCO is responsible for organizing joint review meetings and undertaking joint supportive supervision. These tasks are carried out by regional HAPCOs at regional levels. So as to enable the Federal and regional HAPCOs to effectively monitor and evaluate each sector’s performance, multi-sectoral implementers at national level and regional HAPCOs submit their reports to the FHAPCO and regional implementers and woreda HAPCOs submit their reports to regional HAPCOs. Finally, the document underscores the need for different sectors to mainstream HIV/AIDS in their core mandates.

4.6 Mainstreaming Sectors/Institutions

A reference has already been made to the impact of HIV/AIDS on all sectors. This necessitates the design of HIV/AIDS policies that create enabling environment for the participation of all sectors in the fight against the pandemic through mainstreaming of HIV/AIDS in their core mandates having regard to their comparative advantages. According to the Mainstreaming Manual, discussed above, all institutions, including government institutions of all branches, non-government organizations and the private sector at federal, regional, zonal, woreda and Kebele levels, have the obligation to implement HIV/AIDS mainstreaming.\textsuperscript{354} The Mainstreaming Manual also highlights the principles to be followed and the obligations to be discharged by all sectors that implement HIV/AIDS mainstreaming, which are reiterated by SMP II.\textsuperscript{355} SMP II imposes another obligation on mainstreaming institutions to submit plans and reports to HAPCOs at their respective levels.\textsuperscript{356}

\textsuperscript{354} See Mainstreaming Manual, supra note 105, at 5.
\textsuperscript{355} See SPM II, supra note 17, at 31.
\textsuperscript{356} Id. at 72.
The principal sectors that are involved in mainstreaming HIV/AIDS include, but are not limited to: government sectors, civil societies, donors, associations of PLWHA and the private sector. The following discussions give a glimpse of these sectors.

4.6.1 Government Sectors

Government sectors include the legislature, the judiciary and a multitude of executive offices at different levels. The Federal Service Agency has issued the Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline that regulates HIV/AIDS mainstreaming in civil service institutions. The Federal civil service institutions and their employees are supposed to undertake tasks that would help prevent and control HIV/AIDS in workplaces. To that end, the institutions should include HIV/AIDS-related activities in their plans, assign the necessary manpower and earmark the needed finances for the implementation of the plans. They should also monitor and evaluate the implementation of the plans. When institutions submit reports to the concerned offices, they are required to include a report on the tasks done relating to HIV/AIDS. Sources of finance for undertaking HIV-related tasks should come from the budget of the institutions, contributions from the employees of the institutions or donations.

The Government Sectors Sub-Forum that would have played a pivotal role to coordinate the response of the sector and serve as an experience sharing forum was established three years ago.

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358 Id. para. 2.1.
359 Id. para. 3.1.3.
360 Id. para. 4.4.
by more than 40 government institutions. It has not, however, started operation owing to financial constraints.361

As institutions owned by the government, government sectors are expected to set a standard in HIV/AIDS mainstreaming. In reality, the sectors have a weak record of mainstreaming. According to the recent 2009/2010 Annual FHAPCO Report, out of the planned 16,024 institutions, 7,887 established AIDS funds, which is only 49% of the plan.362 It is obvious that the sectors cannot undertake HIV prevention, care, support and treatment activities without having the finances. The reasons why HIV/AIDS mainstreaming has been unsatisfactory is explored in the next section.

4.6.2 CSOs

CSOs embody a host of organizations outside of government institutions and profit-motivated companies, such as international NGOs, FBOs, professional associations, trade unions, PLWHA associations and grass-root community-based organizations (CBOs).363 There are hundreds of CSOs that work on HIV/AIDS in Ethiopia.

With a view to strengthening the capacity of NGOs in fighting HIV/AIDS, facilitating information exchange among them and other partners, coordinating their tasks and consolidating partnership, the NGO Forum was set up containing members of more than 100 NGOs working on HIV/AIDS.364 The Forum is not, however, meaningfully functioning as expected.365 There are, nevertheless, other sub-forums of CSOs that play a more active role in the multi-sectoral

361 Interview with Eyob Degu, Secretary, Government Sub-Forum (Dec. 21, 2010).
362 See FHAPCO, supra note 50.
363 See Brown, supra note 296, at 37.
365 Interview with Beniam, Secretary of NGO Sub-Forum ((Dec. 21, 2010).
response. Three of these sub-forums which are also directly represented in the NPF are briefly discussed below.

4.6.2.1 EIFDDA

EIFDDA, an alliance of FBOs in Ethiopia, was set on December 22, 2002, formally registered in 2006 and reregistered in 2010 in accordance with the CSOs Proclamation. It works in the area of HIV/AIDS prevention and control, peace building and conflict resolution, good governance, dialogue and advocacy. The principal activities it implements in relation to HIV/AIDS include: care and support of PLWHA, orphans and vulnerable children through mobilization of local resources and HIV prevention through community conversation facilitated by religious leaders, media campaigns and conducting training and workshops, among others.

4.6.2.2 Associations of PLWHAs

The unique role that GIPA plays in the multi-sectoral response is widely accepted. This is clearly affirmed in the Paris Declaration in which delegates of governments who attended the meeting declared that GIPA is crucial to a successful response to the HIV/AIDS pandemic.

The UNAIDS Policy Brief on GIPA identifies three benefits of involvement of PLWHAs in the HIV/AIDS response. First, from the perspective of individual PLWHAs, “involvement can improve self-esteem and boost morale, decrease isolation and despair, and improve health through access to better information about care and prevention.” When individuals learn that they are HIV positive, they consider themselves as unworthy members of their society.

366 See CSOs Proclamation, supra note 291.
367 The list of 42 countries that signed the Paris Declaration is available at http://data.unaids.org/Governance/PCB02/pcb_09_00_04_gipaen.pdf?preview=true (last visited May 27, 2009).
369 Id.
erroneously believing that their death is imminent. Allowing them to be involved in HIV/AIDS prevention and control programs will encourage them to think that they are still an important member of the community in which they live.

Second, the involvement of PLWHA in public affairs is advantageous to minimize and eradicate society’s prejudicial attitude against PLWHA. It is not uncommon to see members of a certain community discriminating another member who has been infected by HIV/AIDS. Such outlook of discrimination once again arises from a wrong belief that PLWHA are no longer industrious parts of the community. Encouraging active participation of PLWHA in public affairs is the best way to change this prejudicial attitude.

Third, PLWHA involvement in policy processes can play a great role towards creating a better policy. As practice dictates, the involvement of people experiencing a given problem results in the best policy that purports to solve that problem. “PLWHA have directly experienced the factors that make individuals and communities vulnerable to HIV infection—and once infected, the HIV-related illnesses and strategies for managing them.” Given this fact, HIV/AIDS policies in areas of HIV prevention, treatment, care and support can only be successful, pertinent and acceptable where the policies open their rooms for proactive involvement of PLWHA.

In Ethiopia, PLWHA are actively involved in the multi-sectoral response. In order to deepen their participation, they formed a range of associations across the country. Currently, there are more than 389 associations of PLWHA, 11 regional networks, 1 women’s network (NNPWE)

370 Id.
371 Id.
and 2 national PLWHA associations. These associations and networks collectively formed NEP+ in 2004. NEP+ is set up with the objectives of influencing policy and decision-makers at all levels to protect the rights of the infected, affected and those vulnerable to HIV; ensuring the realisation of GIPA in all aspects of the national response to HIV; building and strengthening the capacity of its member organizations to effectively coordinate and implement HIV programs; supporting the implementation of programs that prevent new infections and mitigate the impact of HIV on PLWHA and engaging in resource mobilisation to effectively respond to HIV. NEP+ represents its members in the NHPCC, National FHAPCO Board, NPF and Country Coordinating Mechanism.

4.6.2.3 The National Coalition for Women Against HIV/AIDS (NCWHA)

The NCWHA, established in June 2003, is a non-governmental organization aimed at combating HIV/AIDS in the context of empowering women at all levels. NCWHA was formed by a group of committed and professional women, with the objective of creating a national movement to fight HIV/AIDS. Within this broad framework, NCWHA works to eradicate harmful traditional practices and gender-based violence and reduce poverty through community mobilization at the grassroots level, lobbying, advocacy and training. Its headquarters is located in Addis Ababa with regional coalition members in all regions of Ethiopia.

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373 The following discussion is based on a power point presentation by Yitna Abera, Program Implementation Officer of NEP+ at Mekelle Workshop.
374 NEP+ Strategic Plan (2008-2012).
375 Interviews with Mr. Alemu Shiferaw, Performer of Social Mobilization and Partnership in the Office (May 22, 2009) and Mr. Tigabe Asres, Former Executive Director of NEP+ and, Currently, Advocacy, Public Relation and Communication Advisor at NEP+ (Aug. 24, 2011 & May 22, 2009).
4.6.3 Higher Education Institutions

Cognizant of the impact of HIV/AIDS on higher education institutions and their pivotal role in HIV prevention, care, support treatment through research, consultancy and training, the Higher Education Institutions Partnership Sub-Forum was established in 2009 to coordinate their response and serve as experience sharing forum.\textsuperscript{377} The Sub-Forum has 22 public and 44 private higher education institutions as its members. It has not yet meaningfully started functioning owing to lack of cooperation from its members, financial constraints to running its affairs and absence of fulltime staff.\textsuperscript{378}

4.6.4 Donors

Donors play a central role in an effort to control and manage HIV/AIDS and support other developmental programs in Ethiopia and other developing countries. They, in particular, extend financial and technical assistance as well as build the capacities of government institutions, CSOs and the private sector. So as to foster information sharing, coordinate and harmonize their support and deepen their involvement in the HIV/AIDS response in Ethiopia, 26 donor agencies joined together to form the HIV/AIDS Donors Sub-Forum in 2003.\textsuperscript{379} The Forum represents these donors in all joint processes.\textsuperscript{380}

4.6.5 The Business Sector

The business sector, composed of profit-driven organizations, undertakes HIV prevent, care and support activities to prevent HIV/AIDS and mitigate its impact on workplaces and communities in Ethiopia. To strengthen this, the Ethiopian Business Coalition against HIV/AIDS (EBCA) was

\textsuperscript{377} Memorandum of Understanding for Higher Education Institutions Partnership Sub- Forum against HIV/AIDS in Ethiopia, June, 2010, para. 1.3.
\textsuperscript{378} Interview with Mr. Philipos Petros, Secretary of the Higher Education Sub-form (Jan .31, 2011).
established in May 2004. Currently, it has more than 70 companies as its members. The key objectives of the EBCA include: increasing the sharing of information, experience, expertise, and good practices on HIV/AIDS and social response issues in the business community; strengthening the business community’s collective response to HIV/AIDS and social responsibility in line with the national multi-sectoral response through leadership, networking and partnership; increasing the development and implementation of comprehensive HIV/AIDS workplace and social responsibility programs in local businesses, by providing targeted support to company managers clinical staff and focal persons and enhancing the understanding and capacity of individual companies to monitor and assess their HIV/AIDS and social response costs, needs and issues.

4.7 Challenges to the Multi-Sectoral Response in Ethiopia

As stated above, the Ethiopian Government has adopted laws, policies, strategic plans and guidelines that are intended to set up and regulate a multi-sectoral response to HIV/AIDS. In these documents, the Government pledges to play a leadership role in the multi-sectoral response. To that end, the HAPCC has been set up to give overall policy guidance to the response. Moreover, HAPCOs at different levels have been designated to coordinate the multi-sectoral response. In order to support the coordination tasks of HAPCOs, the NPF and sub-forums at various levels are expected to establish and start functioning.

Under the leadership of the Government, various sectors and interest groups are given a space to proactively take part in combating HIV/AIDS with the exception of the youth and some other MARPs who are not represented in the NPF. The sectors receive capacity building support from

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federal as well as regional HAPCOs. The Ethiopian Government has achieved a lot in mobilizing communities in the fight against HIV/AIDS.

While all these are successes by themselves, the writer identifies the following challenges to the multi-sectoral response.

4.7.1 Challenges Pertaining to the Legal Framework

It is true that the laws, policies and strategies give an important place for the participation of CSOs in the fight against HIV/AIDS in Ethiopia. However, the CSOs Proclamation poses a setback to the operations of CSOs. The Proclamation prohibits foreign and foreign funded CSOs from working on promotion of human rights, which may include prohibition of advocating the rights of PLWHA and human rights activism to stop gender-based violence and human rights violation which are identified as fueling the transmission of the epidemic. I would argue that such prohibition is a blatant violation of the right to freedom of association.

Depending on their place of registration, source of income, composition of members’ nationality and place of residence, the CSOs Proclamation creates three categories of charities and societies (CSOs), namely, “Ethiopian Charities” or “Ethiopian Societies”, “Ethiopian Residents Charities” or “Ethiopian Residents Societies” and “Foreign Charities”. “Ethiopian Charities” or “Ethiopian Societies” are “Charities or Societies that are formed under the laws of Ethiopia, all of whose members are Ethiopians, generate income from Ethiopia, and are wholly controlled by Ethiopians.” With respect to funding, the law envisages a strict qualification. That is, charities or societies shall be regarded as an Ethiopian charities or societies on condition that “they use not

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382 See CSOs Proclamation, supra note 291, at art. 2 (2).
more than ten percent of their funds…from foreign sources.”383 “Ethiopian Residents Charities” or “Ethiopian Residents Societies”, on the other hand, are “Charities or Societies that are formed under the laws of Ethiopia and consist of members dwelling in Ethiopia, and who receive more than 10 percent of their funds from foreign sources.”384 The third category is “Foreign Charities”. Charities that fall under this category are “those charities that are formed under the laws of foreign countries or consist of members who are foreign nationals or are controlled by foreign nationals or receive funds from foreign sources.”385 Foreign sources include “the government, agency or company of any foreign country; international agency or any person in a foreign country.”386

One of the upshots of the above classification is that only Ethiopian Charities or Societies are allowed to engage in promotion of human rights.387 Other categories of charities and societies (non-Ethiopian CSOs) are authorized to carry out only service delivery undertakings.

The issues are whether the prohibition of foreign and foreign funded NGOs from working on promotion of human rights constitutes an interference with the right to freedom of association; and if so, whether the interference is a permissible interference in light of the applicable human rights standards. For convenience, the issues will be scrutinized as follows. First, does the restriction on foreign funding of local human rights NGOs amount to an interference with their

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383 Id.
384 Id. art. 2(3).
385 Id. art.2(4).
386 Id. art. 2(15).
387 Id. art. 14 (5) cum (2). For the purpose of this article, promotion of human rights is comprised of those activities that are listed under article 14 (2) (j), (k) and (l). These activities are the advancement of human and democratic rights; promotion of equality of nations, nationalities, peoples, gender and religion and promotion of the rights of the rights of the disabled and children. Though the Proclamation treats these activities separately, the latter two can be subsumed in the former. Apart from promotion and protection of human rights, promotion of conflict resolution or reconciliation and, promotion of the efficiency of justice and law enforcement services are reserved to Ethiopian Charities and Societies.
right to freedom of association? If the answer is an affirmative, is the interference valid? Second, does the exclusion of non-Ethiopian CSOs from carrying out promotion of human rights constitute an interference with their right to freedom of association? If so, is such interference a legitimate one in the light of the appropriate human rights principles? I will address the first issue as follows.

According to article 2(2) of the CSOs Proclamation, an NGO “formed under the laws of Ethiopia” and “all of whose members are Ethiopians” is regarded as an Ethiopian NGO provided that it uses not more than ten percent of its funds received from foreign sources. If the latter requirement is not satisfied, an NGO will not be qualified as an Ethiopian NGO with a consequence that it cannot carry out promotion of human rights activities. The question worth asking is: what is the impact of restricting access of domestic human right NGOs to foreign funding on the right to freedom of association of these NGOs?

As shown in section two of this chapter, the right to freedom of association is guaranteed under the FDRE Constitution and international and African human rights treaties to which Ethiopia is a party. The right to freedom of association is not confined to guaranteeing individuals’ right to form associations for lawful purposes. It also confers up the organizations themselves the right to function effectively without unreasonable government interference. The organizations will operate effectively only when they have sufficient funds to carry out their activities. Prohibition or restriction on funding may have the effect of rendering the organization inoperative. 388 Given the indispensability of funding, it can convincingly be argued that the right to freedom of

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388 Unlike business enterprises, NGOs do not undertake income generating activities. In order to run their day to day activities, they heavily rely on contributions from their members and funding from others sources, such as donors.
association shall include the right of NGOs “to seek and secure funding from legal sources”. 389

“Legal sources should include individuals and businesses, other civil society actors and international organizations, as well as local, national, and foreign governments.” 390

In spite of the fact that the availability of sufficient funds is vital to the active functioning of NGOs, restrictions on the receipt of funding and especially on the receipt of foreign funding by human rights NGOs have grown increasingly in many countries. 391 In response to such a growing trend, various bodies of the UN have made direct statements on the right of human rights NGOs to solicit and receive funding, particularly foreign funding.

The UN Declaration on Human Rights Defenders addresses this point explicitly. Article 13 provides that “[e]veryone has the right, individually and in association with others, to solicit, receive and utilize resources for the express purpose of promoting and protecting human rights and fundamental freedoms through peaceful means.” Interpreting article 13 of the UN Declaration on Human Rights Defenders, the OHCHR, in Fact Sheet 29 392, elucidated that “the Declaration provide[s] specific protections to human rights defenders, including the right to… solicit, receive and utilize resources for the purpose of protecting human rights (including the receipt of funds from abroad).” It went on to contend that legislation banning or hindering the

390 Id.
391 For example, in the Transnistria region of Moldova, the president of the separatist government signed a decree in 2006 prohibiting foreign funding of NGOs registered in Transnistria. Specifically, NGOs were prohibited from receiving funding directly or indirectly from any international or foreign organization, foreign government, Transnistrian organization with a foreign capital share in excess of 20 %, foreign citizen or stateless person, or any anonymous source. NGO Bill was enacted in Zimbabwe in 2004 (though never signed into law) that would have prohibited local NGOs engaged in “issues of governance” from accessing foreign funds. In Eritrea, the government issued Administration Proclamation No. 145/2005 that broadly restricts the UN and bilateral agencies from funding NGOs. Egypt’s Law No. 153 of 1999, which “gives the Government control over the right of NGOs to manage their own activities, including seeking external funding.
receipt of foreign funds for human rights activities curtails human rights defenders including human rights NGOs from legitimately exercising and enjoyment of their rights, such as the right to freedom of association.\textsuperscript{393}

The Special Representative of the Secretary-General on human rights defenders, in her 2006 Report, identified “the trend in many countries to pass laws and regulations” that impose restriction on funding as a measure that stifles operations of human rights defenders.\textsuperscript{394} The Special Representative put forward that “[g]overnments must allow access by NGOs to foreign funding as a part of international cooperation, to which civil society is entitled to the same extent as Governments. The only legitimate requirements of such NGOs should be those in the interest of transparency.”\textsuperscript{395}

To sum up, restricting access of local human rights defenders to foreign funding fatally affects their operation and amounts to an interference with their right to freedom of association. The ramification of restricting access of local human rights NGO to foreign funding in Ethiopia (which includes funding from Ethiopians residing aboard) is extremely severe. Ethiopia is one of the poorest countries in the world. Given the fragile economic situation in Ethiopia, local human rights will not be able to raise the funds that are necessary to run their day to day activities from local sources. This is evident from the fact that almost all local NGOs greatly rely on financial support from foreign sources.\textsuperscript{396} Let alone the NGOs, assistance and borrowings from foreign

\textsuperscript{393} \textit{Id.} at13.
\textsuperscript{394} Hina Jilani, Promotion and Protection of Human Rights: Human Rights Defenders, Report submitted by the Special Representative of the Secretary-General on Human Rights Defenders, E/CN.4/2006/95 (2006) para. 29. This definition can also be implied from article 1 of the UN Declaration on Human Rights Defenders, paras. 50-51.
\textsuperscript{395} \textit{Id.} para. 31.
\textsuperscript{396} Ethiopia is a “country where 95% of Ethiopian NGOs currently receive more than 10% of foreign funding”. \textit{See} the Observatory for the Protection of Human Rights defenders, \textit{The Observatory for the Protection of Human Rights defenders denounces the adoption on January 6, 2008 of a law that considerably restricts the activities of NGOs in Ethiopia}, http://www.fidh.org/IMG/article_PDF/Ethiopia-Freedom-of-association-in.pdf (last visited Oct. 12, 2009).
sources cover a significant portion of the Ethiopian Government’s capital and recurrent expenditures. In brief, requiring local NGOs to cover more than ninety percent of their finances from local sources under the Proclamation would undoubtedly result in closing down or seriously weakening the operation of most of them. For example, it is in the aftermath of the coming into effect of the CSOs Proclamation and the freezing of 90% of their assets by the Government that the activities of the two notable local human rights NGOs, EWLA and Ethiopian Human Rights Council (EHRCO), have been gravely curtailed. Thus, it can be concluded that the labeling of local NGOs which receive more than ten percent of their funding from foreign sources as non-Ethiopian NGOs with the repercussion of prohibition from engaging in human right advocacy is an interference with their right to freedom of association.

The next issue to be addressed is whether the interference is a justifiable one or not. The right to freedom of association may be limited provided that certain conditions are met. As discussed in section 3.6 of chapter three, any limitation to human rights, including the right to freedom of association, should comply with five requirements; namely, legality, justification, necessity, proportionality and non-discrimination.

Definitely, the interference with the right to freedom of association has the Proclamation as its legal basis. Thus, the fulfillment of the requirement of legality is not as such controversial. The fulfillment or otherwise of the requirement of a legitimate aim that can justify the interference, however, requires a meticulous scrutiny.

The specific rationale of the Ethiopian Government for putting in place a restriction on foreign funding of local human rights NGOs cannot be traced from the preamble or provisions of the Proclamation. It can, however, be discerned from the utterances of senior Government officials and pertinent documents emanating from the Government. The Prime Minister, for example, took the position that the provision of the Proclamation against foreign funding of local NGOs is a way of protecting Ethiopia against foreign political intervention. The concern of the Government is that foreign organizations or individuals, by sponsoring local NGOs, would manipulate these NGOs and unduly influence domestic political affairs of Ethiopia. In a nutshell, restriction on foreign funding of local human rights NGOs aims at curbing foreign political intervention.

Protection of Ethiopia from foreign political interference is one of the principles which Ethiopian is guided by and, thus, one can argue that the limitation fits in with one of the legitimate ground of restricting the right to freedom of association, viz., public order. It is submitted, however, that imposing a restriction on foreign funding of local human rights NGOs and thereby muzzling their operation is highly disproportional to the nature of the threat that may arise in relation to the operation of these NGOs, namely, the local NGOs may be used by their sponsors to interfere in the political affairs of Ethiopia. Imposing foreign funding restriction on local human rights NGOs is not the only measure to avert the said danger. In fact, there are other less restrictive means which are envisaged in the Proclamation that might achieve the same aim.

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399 Promoting “mutual respect for national sovereignty and equality of States and non-interference in the internal affairs of other States” is one of the national principles and objectives of Ethiopia as set out under article 86(2) of the FDRE Constitution.
The Proclamation gives the Charities and Societies Agency (the Agency) the power to supervise and control Charities and Societies. With a view to discharging its power of supervision, the Agency has been given the power to institute inquiries and search any Charity or Society to which the Charity or Society or an officer or employee thereof shall furnish the Agency with the required documents and information. If the inquiry or search discloses that any Charity or Society has been used for illegal motives, it shall result in the cancellation of the license of the Charity or Society which may also give the Agency the power of dissolving the Charity or Society. The Agency can effectively employ this track to guarantee, on a case by case basis, that local human rights NGOs will not be used by their foreign funders to unjustifiably intervene in the domestic political affairs of Ethiopia. In view of this strong mechanism of control, restricting access of local human rights NGOs to foreign funding, unwarrantedly presuming that all local NGOs may be subject to manipulation by their foreign sponsors, does not attain any public good. It rather seriously obstructs the work of local human rights NGOs that would otherwise significantly contribute for the protection and promotion of human rights in Ethiopia.

Now, let me turn to show how the prohibition on non-Ethiopian NGOs from working on human rights fields infringes their freedom of association.

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400 The Agency is set up by article 4 of the Proclamation as an institution of the Federal Government to be accountable to the Ministry of Justice.
401 Article 2(12) read together with article 66 tells us that Sector Administrators are relevant Federal Executive organs that shall be assigned by the Ministry of Justice as Charities and Societies Sector Administrators.
402 See CSOs Proclamation, supra note 291, at arts. 6(1) (a) and 67(3).
403 Id. at art. 84 and 85.
404 Id. at art. 92 (2) (b).
405 Id. at art. 93 (1) (b).
As discussed above, the Proclamation took the position that even if an NGO has Ethiopians as its exclusive members and is established by Ethiopian laws, it is not an Ethiopian NGO (Charity or Society) if it receives more than ten percent of its funding from foreign sources. One of the consequences of such stipulation is that the NGO faces the same restrictions that would be placed on foreign NGOs under the Proclamation, including the prohibition from working on human rights fields, save that particular NGO entered a special agreement with the Ethiopian Government.\textsuperscript{406} To put in brief, the Proclamation excludes local NGOs that receive more than ten percent of their funding from abroad and foreign NGOs from carrying out activities of human rights protection and promotion. Now, let me pose this question. Does not this exclusion amount to an interference with freedom of association?

The international human rights standards highlighted in section two have made everyone a beneficiary of the right to freedom of association. In particular, article 31 of the FDRE Constitution guarantees this right “\textit{for any cause or purpose}”. (Emphasis supplied) The phrase “for any cause or purpose” implies that the right to freedom of association can be exercised to establish any association for any purpose without any restriction. Of course, the purposes for which the associations are established must be lawful. In democratic society, the whole purpose of guaranteeing the right to freedom of association is to foster societal goals through the associations. If the associations are established to pursue illegal purposes, such as commission of crimes, it will be against the raison d’être for establishment of the associations.

It is an obvious fact that promotion of human rights both at national and international spheres is a lawful activity. That is why such activity has been taken as one of the purposes of different international, regional and national institutions, such as the UN, AU and Ethiopian Human

\textsuperscript{406} Id. at art. 3(2) (b).
Rights Commission (EHRC). Given the fact that the right to freedom of association is guaranteed to everyone for any legal goal and given the fact that engagement in the promotion and protection of human rights is a lawful activity, I argue that the banning of non-Ethiopian Charities and Societies (within the meaning of the Proclamation) from engaging in human rights fiends in the proclamation is an interference with right to freedom of association.

The next question is: is this interference a permissible interference in the light of pertinent norms of human rights law?

As is the case of foreign funding restriction, the exclusion of non-Ethiopian Charities and Societies from engaging in the protection and promotion of human rights has an unequivocal legal basis which is meant to have a general application. The reason forwarded for the exclusion is also similar to the limitation on funding, that is, involvement of foreign NGOs in human rights fields in Ethiopia will open a Pandora’s Box for foreign political intrusion. Restraining foreign interference in the political affairs of Ethiopia is a legitimate ground to limit the right to freedom of association. In this particular situation, however, the outright barring of non-Ethiopian NGOs from taking part in the protection and promotion of human rights is excessively disproportional to the gravity of the concern. It is not in any way acceptable to impose a blanket prohibition on all non-Ethiopian NGOs from carrying out human rights activities contending that this may open a room for foreign interference. The consequence of such exclusion is particularly grave in countries like Ethiopia where there are no well-organized and independent governmental institutes for human rights protection and local human rights NGOS that can raise their funds from local sources.

\[ 407 \text{ See Sekaggya, supra note 398, at para. 979.} \]
The sovereignty of States that prohibits outside interference in the domestic affairs does not work with respect to the protection and promotion of human rights. The protection and promotion of human rights is not a task that is entirely reserved to States and their nationals. The UN Charter\(^{408}\) and the 1993 Vienna Declaration and Program of Action\(^{409}\) make it clear that human rights are a matter of legitimate international concern and, thus, foreign human rights activists and human NGOs have a right to interfere in the event of human rights violations in Ethiopia. They are entitled to engage in human rights activities in Ethiopia and criticize the Ethiopian Government when it infringe human rights and freedoms recognized in the FDRE Constitution and other human rights treaties to which Ethiopia is a party. This does not, however, mean that foreigners can interfere in other domestic affairs under the guise of human rights protection. In such a case, the Ethiopian Government has the power to act accordingly. This can be effectively done by applying a less restrictive supervision approach already discussed above.

The prohibition of non-Ethiopian human rights NGOs from carrying out human rights activities is not only disproportional but also discriminatory. In a manner consistent with human rights conventions, article 31 of the FDRE Constitution guarantees the right to freedom of association to everyone irrespective of one’s nationality or residence. To put in other words, the right to freedom of association can be enjoyed by Ethiopians and foreigners alike. This is self evident from the wording of article 31 itself which reads as “\emph{[e]very person has the right to freedom of association}” (Emphasis added). With particular to the enjoyment of the right to freedom of association for the purpose of promoting and protecting human rights and fundamental freedoms,

\(^{408}\) Article 55 of the UN Charter proclaimed that “the United Nations shall promote ... universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language or religion”; and pursuant to article 56 “[a]ll Members pledge themselves to take joint and separate action in co-operation with the Organization for the achievement of the purposes set forth in Article 55.”

\(^{409}\) Article 4 provides that “the promotion and protection of all human rights is a legitimate concern of the international community.”
the UN Declaration on Human Rights Defenders unequivocally affirmed that every person, be he or she a national of a given country or not, is entitled, “individually and in association with others, at the national and international levels, to form, join and participate in non-governmental organizations, associations or groups.”\footnote{\textit{UN Declaration on Human Rights Defenders, G.A. Res. 1998, A/RES/53/144 (1998) rt.5(b), http://www2.ohchr.org/english/issues/defenders/declaration.htm (last visited Dec. 24, 2009). The UN Declaration on Human Rights Defenders, as a General Assembly Resolution, is not legally binding. Significantly, however, it contains a series of principles and rights that are based on human rights standards enshrined in other international instruments and was adopted by consensus—therefore representing a strong commitment by States to its implementation.}} Since the right to freedom of association is guaranteed to every person under the FDRE Constitution, the prohibition of non-Ethiopian NGOs from engaging in human rights fields in Ethiopia amounts to differentiation on nationality and source of funding grounds. True, a differentiation may not constitute discrimination as long as the grounds of differentiation are reasonable, objective and intends to achieve a legitimate purpose. Given that the aim of banning of non-Ethiopian NGOs from engaging in human rights field is curbing foreign interference in domestic political affairs of Ethiopia and given that this aim can be achieved by the aforementioned supervisory mechanisms of the Agency and Sector Administrators stipulated in the Proclamation, the exclusion is unjustifiable discrimination.

In conclusion, the position taken by the CSOs Proclamation to prohibit foreign and foreign-funded NGOs from engaging in human rights activism, apart from being a violation of freedom of association, seriously affects the activities of NGOs that wholly or partly work on human rights advocacy to address the HIV/AIDS epidemic.

Another challenge that stems from the legal framework is the lack of policies and the limited space given to non-government actors to be proactively involved in the initiation and formulation of laws. In particular, interest groups are not entitled to initiate draft bills or set agendas of their
concern. As indicated under article 50 of the House of Peoples' Representatives (HPR) of the FDRE Rules of Procedures and Members' Code of Conduct Regulation\textsuperscript{411}, only “members of the house, committees, parliament groups, and other bodies authorized by Government shall have the power to initiate” draft laws. At the policy formulation stage, parliamentary committees invite the public to forward their views on draft bills.\textsuperscript{412} Interest groups may use this truck to take part in the parliamentary debate. The Ethiopian parliament, being highly dominated by members of the ruling party, is, however, rarely willing to incorporate views of interest groups in the final version of the legislation.

4.7.2 Implementation Challenges

4.7.2.1 Financial Constraints

Because a multi-sectoral approach to HIV prevention, care, support and treatment involves all sectors, it requires a lot of resources and manpower for its implementation. One of the huge challenges that the Ethiopian multi-sectoral response is facing is the necessary finances to run the response and make available HIV prevention, care, support and treatment services. Currently, the Government and the various sectors heavily rely on external funding though it is inadequate.\textsuperscript{413} Almost all representatives of sub-forums interviewed stated that the forums and their constituent members are not meaningfully contributing to the national response owing to budgetary problems.\textsuperscript{414}

\textsuperscript{412} Id. at art.154.
\textsuperscript{413} See Federal HAPCO 2009/2010 Report, supra note 50.
\textsuperscript{414} Interview with key informants who are kept anonymous. See also Kibret Shiferaw, The Challenge of Multi-Sectoral Responses to HIV/AIDS in Ethiopia: A Case study of Achefer Wereda (District), http://www.nuigalway.ie/dern/documents/50_kibret_shiferaw.pdf (last visited Sep.15, 2010).
Implicit in the notion of HIV/AIDS mainstreaming and social mobilization against HIV/AIDS is that sectors and communities use their own resources to combat HIV/AIDS. It seems on this assumption the Mainstreaming Manual required sectors to earmark at least 2% of their budget to implement HIV/AIDS. The 2% budget allocation requirement for AIDS-related is hardly implemented due to lack of legal framework for its enforcement.\footnote{Interview with Bekele Desalegn, Social Mobilization and Partnership Performer at Federal HAPCO, (Feb.12, 2011).} Realizing this problem, there were attempts to demand sectors to set up AIDS-fund the source of which may be contributions from employees of institutions and donations from internal sources. Much more has to be done in mobilizing local resources in the fight against HIV/AIDS. Sole reliance on foreign funding may not be sustainable particularly because of the protracted economic crises that major donors are still facing. This time, it is not unusual to watch on TV telethons organized to raise funds to support party-affiliated developmental associations, to set up health institutions for specific categories of people and so on. There is not any reason why such kinds of fund-raising are not being organized for the purpose of caring and supporting PLWHA and children orphaned by HIV/AIDS.

4.7.2.2 Lack of Incentive and Effective Enforcement for Compliance

As mentioned several times, the multi-sectoral response to HIV/AIDS is primarily implemented through sector mainstreaming. The mainstreaming Manual and SPM II require sectors to prepare specific action plans and allocate the necessary personnel and finances to execute the plan. There are, however, no incentives and effective enforcement mechanism to ensure that sectors are living up to their obligations. HAPCOs which are meant to coordinate the multi-sectoral
response have limited capacities. As a result, they lack regularity in their supervision.\textsuperscript{416} The extent of supervision is extremely limited when we come to non-public sector institutions, including CSOs and institutions of the private sector.\textsuperscript{417} Because regional HAPCOs are accountable to the regional government and the concerned regional health department, the Federal HPACO has limited power to make sure that they are discharging their obligations.\textsuperscript{418} The NPF and sub-forums were intended to supplement HAPCO’s task of coordination; yet, they are not functioning.\textsuperscript{419}

There is an urgent need to devise new initiatives that would address the enforcement problems apart from strengthening the existing mechanisms. Institutions are accountable to the concerned departments and officials for accomplishing activities falling in their mandate. One means of ensuring accountability is through reporting what they have done and what they have not done to the parliament and other concerned organs. Because mainstreaming requires HIV/AIDS-related activities to be included in their mandate, institutions should include reports on HIV/AIDS activities in their reports. On the basis of their reports, the concerned officials and departments should evaluate the failures and strengths and give directives so that institutions will strengthen positive sides and rectify weaknesses. Giving recognition to those institutions and individuals with better performance should also be used to motivate better implementation. This may include giving incentives, monetary or otherwise, promotion or salary increments. Finally, to guarantee HIV mainstreaming in the new companies, a commitment to undertake HIV/AIDS-related activities should be taken as precondition to grant investment licenses.

\textsuperscript{417} \textit{Id.} at 51.
\textsuperscript{418} \textit{Id.} at 52.
\textsuperscript{419} See Beniam, supra note 365; Degu, supra note 361 and Petros, supra note 378.
4.7.2.3 Limited Participation in the Preparation of Strategic Plans and Guidelines

Multi-sectoralism requires not only the participation of sectors in carrying out HIV prevention, care, support and treatment activities but also their participation in the development and evaluation of HIV/AIDS laws, policies, strategic plans and guidelines. Such broad-based participation is instrumental in creating a sense of ownership in the course of implementation.

An interview\(^\text{420}\) with officials of FHAPCO and former Executive Director of NEP+ and representatives of other CSOs disclosed that, sectors, including CSOs, participate in the preparation and evaluation of most HIV/AIDS policies and guidelines. However, some representatives of CSOs expressed their disappointment saying that their participation in the preparation of strategic plans and guidelines is superficial.\(^\text{421}\) The documents are prepared somewhere by the Government and presented at workshops or conferences that are convened to deliberate on strategy, guideline or policy. Feedback from stakeholders is usually disregarded. Moreover, in sensitive and major policy areas, the Government never allows the involvement of associations of PLWHA and other sectors including in the drafting HIV/AIDS law and amendment of the 1998 National HIV/AIDS Policy.\(^\text{422}\)

4.7.2.4 Sectors Focus More on Prevention Activities

Another problem which can be related to financial problem is the overriding focus of the different sectors on HIV prevention in general awareness-raising in particular with little attention

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\(^{420}\) See Shiferaw and Asres, *supra* note 375.

\(^{421}\) Interview with Dr. Habtamu Woldeyes, Global Fund Coordinator at the Ethiopian Inter-Faith Forum for Development, Dialogue and Action (EIFFDA) (Feb 2, 2011 & Aug. 29, 2011); Mekonnen Alemu, Public Relation and Advocacy Officer at Mekdim Ethiopia (May 27, 2009) and Tigabe, *supra* note 375. A survey conducted by NEP+ revealed that the involvement of PLWHA in the preparation of PLWA in the preparation of laws, policies and guidelines and programs and project affecting them is minimal. The same survey unfolded that most of PLWHA do not believe that they can affect decisions that impacts their interests. *See* NEP+, *People Living with HIV Stigma Index: Ethiopian Stigma and Discrimination Survey Report 124* (First Draft, 2010).

\(^{422}\) Id.
to care and support activities.\textsuperscript{423} It is true that HIV prevention is the mainstay of the global HIV/AIDS response. It is also true that it is less costly to involve in HIV/AIDS education than caring and supporting PLWHA. As I mentioned in chapter three, prevention, care, support and treatment are indispensable for successful response. A response that excessively relies on prevention without caring, supporting and treating PLWHA cannot, however, be fruitful. Sectors need to give the required attention to care and support. Financial problems, as stated earlier, can be resolved by working strongly on mobilization of local resources.

4.7.2.5 Limited Capacity of Sectors and HAPCOs

In the first section of this chapter, it is pointed out that the capacities of sectors involved in the HIV/AIDS response must be built so that they will meaningfully contribute their part. Though donors and HAPCOs undertook a number of capacity building activities to mainstreaming institutions financially, technically and logistically, capacity remains a chronic problem facing the multi-sectoral response. Capacity building endeavors do not give equal attention to all sectors and regions and are not implemented comprehensively.\textsuperscript{424} Other factors contributing to weak coordination by HAPCOs and implementation by sub-forms, sectors and institutions are shortage of manpower, staff turnover due to low payment, lack of adequate training and insufficient budget.\textsuperscript{425} Moreover, that fact that focal persons assigned to coordinate HIV/AIDS response activities in institutions and facilitators of social mobilization are overburdened with multiple tasks contribute to the problem.\textsuperscript{426}

\textsuperscript{423} The following discussion is based on a power point presentation by Yitna Abera, \textit{supra} 373. \textit{See} also Shiferaw, \textit{supra} note 414, at 8 and Federal HAPCO, \textit{supra} note 416, at 36-37.

\textsuperscript{424} See Federal HAPCO, \textit{supra} note 416, at 34.


\textsuperscript{426} See FHAPCO, \textit{supra} note 416, at 46-47 & 36-37 and Desalegn, \textit{supra} note 415.
Mindful of the problems, SMP II has identified a number of tasks to be accomplished to build the capacity of stakeholders and coordinating bodies.\textsuperscript{427}

### 4.7.2.6 Low Leadership and Mainstreaming Sectors’ and Institutions’ Commitment

It is mentioned earlier in this chapter that even a well-designed HIV/AIDS program may fail if the implementing institutions lack the will to implement it. The low level of commitment has contributed to weak HIV/AIDS mainstreaming in sectors.\textsuperscript{428} True, the Government has done a lot by putting in place the blueprint for the multi-sectoral response. However, it lacks the necessary courage to allocate the required finance to support institutions.\textsuperscript{429} The Government should have set the HIV/AIDS response as one of its priorities, if not the exclusive one. In sectors, the low level or lack of commitment arises mainly from viewing HIV prevention care, support activities as external to their mandates. There is still a misconception that HIV/AIDS is task of HAPCOs and health offices.\textsuperscript{430} Thus, a lot has to be done in training and raising the level of awareness of focal persons, representatives of sub-forums and other concerned officials about HIV/AIDS mainstreaming.

\begin{itemize}
  \item \textsuperscript{427} See SPM II, supra note 17, at 28.
  \item \textsuperscript{428} F HAPCO, supra note 425.
  \item \textsuperscript{429} See Shiferaw, supra note 414, at 14.
  \item \textsuperscript{430} Federal HAPCO, supra note 416, at 46-47 & 52; Desalegn, supra 415 and Shiferaw, supra note 414, at 10.
\end{itemize}
CHAPTER FIVE

HIV TESTING

Introduction

Given that an AIDS vaccine or curable drugs for HIV/AIDS are not yet developed and widely available,\(^{431}\) the only way to combat the epidemic is to exploit available HIV prevention, care, support and treatment options, such as awareness-raising to bring about behavioral modifications, use of condoms and life-prolonging medicines and supporting PLWHA. However, the successes of HIV prevention care, support and treatment programs, to a large extent, depend on the success of HIV testing programs. HIV testing is a crucial gateway to HIV prevention, care, support and treatment. If a person is not tested, he will not be able to know his status and make use of well-timed treatment, care and support services. Moreover, those who are tested late are more vulnerable to AIDS-related morbidity and premature mortality than those tested early.\(^{432}\) HIV testing is also important from a prevention point of view. It enables people to prevent HIV transmission through counseling by discouraging high-risk behavior and supporting protective behavior. Besides, individuals who are aware of their HIV status through testing will generally take steps to avoid the transmission of the virus to others.\(^{433}\)

\(^{431}\) Writers comment that the low likelihood of the development of AIDS vaccine in the near future can be attributed to two reasons. First, vaccines are not lucrative projects for the highly profit-driven big pharmaceutical corporations as the greatest demand for the vaccine is from the developing and least developing countries which will not be able to afford to use them. Second, antiretroviral treatment in developed nations has become highly rewarding for the producing firms, rendering the development of a vaccine financially unattractive.\(^{433}\)\(^{431}\) See Engel, \textit{supra} note 163, at 317.


\(^{433}\) \textit{Id.}
This chapter explores the policy and legal framework pertaining to HIV testing and the practical aspect of the implementation of the laws and policies in Ethiopia. The debate over HIV testing, human rights standards governing HIV testing and the specific human rights relevant thereto are also covered in this chapter.

5.1 Clarification of Terminologies

The terminologies regarding testing have evolved in response to changes in policies and the debates surrounding HIV testing, treatment and prevention.\footnote{Id. at 7.} The predominantly used terms are clarified as follows.

Client-initiated counseling and testing (also called opt-in testing and VCT) involves testing where individuals, not the health system, seek HIV testing and counseling services.\footnote{See WHO & UNAIDS, supra note 117.} VCT involves the following three elements (often referred to as the 3C principles): pre- and post-test counseling, informed consent and confidentiality of test results.\footnote{Id.}

According to the 2007 WHO/UNAIDS Guidance on Provider –Initiated HIV Testing and Counseling in the Health Facilities, PITC, also known as opt-out testing or routine testing, refers to HIV testing and counseling that is initiated by health care providers for persons attending health care facilities. People are tested unless they clearly opt out and refuse testing. Like VCT, PITC is voluntary and requires compliance with the 3C principles. What makes PITC different from VCT is that clients, either individually or in group, receive only essential pre-test information concerning the benefits and risks of testing, the available post-testing services, the

\footnote{Id. at 7.}
confidentiality of testing results, the need to disclose HIV status to those who are at risk of infection and the right of clients to refuse testing if they wish so.

Compulsory testing refers to “testing without a voluntary element—i.e., without informed consent, at the behest of someone or some institution other than the person tested.”437 Compulsory testing is completely different from both VCT and PITC in the sense that a person is tested without his/her consent. Compulsory testing is often confused with mandatory testing. It is true that the latter, like the former, has some involuntary element. But, mandatory testing is different from compulsory testing because a person is tested as a condition to a certain benefit. At least theoretically, the person can avoid testing in the case of mandatory testing by sacrificing the benefit attached thereto. Thus, mandatory testing can be defined as “testing that would occur as a condition for some other benefit, such as donating blood or bodily tissues, immigrating to certain countries, getting married, joining the military or as a precondition of other kinds of employment.”438

5.2 The Politics of HIV Testing

Though there is a consensus regarding the importance of HIV testing, there have been controversies on how to scale up HIV testing to maximize its benefits.

Following the development of a more specific and accurate technique of HIV testing in the late 1980s and the 1990s, the most hotly contested component of AIDS policy became whether to

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choose VCT, on the one hand, or mandatory testing or compulsory testing, on the other.\footnote{Randy Shilts, And the Band Played On: Politics, People and the AIDS the Epidemic 90 (1987). See also Edward Hooper, The River: A Journey to the Source of HIV and AIDS 113 (1999).} Historically, public health professionals had effectively used a variety of tactics, such as mandatory testing, identification, quarantine and isolation to guard against the spread of infectious disease.\footnote{Id. at 36.} Given the fact that AIDS is an infectious disease, public health professionals did consider using these tools to address HIV/AIDS.\footnote{Id. at 53.} Apart from public health professionals, a sizable number of people in affected countries supported and pushed their governments to implement the traditional public health approach to HIV/AIDS, including mandatory and compulsory testing.\footnote{Id. at 73.} Consequently, several countries adopted polices and legislation that govern the manner in which AIDS patients should be identified, quarantined, prohibited from donating blood or marked for identification.\footnote{Id. at 37.}

Despite the fact that compulsory testing and other public health approaches to responding to AIDS were supported by public health officials and many other people and adopted by specific laws and policies, their comprehensive implementation was hindered by opposition from civil rights, gay and patient activists. These groups posited that public identification of AIDS patients would undermine the enjoyment of the right to privacy and non-discrimination and could not possibly benefit the patients, particularly, due to unavailability of effective HIV treatment.\footnote{Id. at 95.} As a result, they called on governments to adopt VCT coupled with availability of support and care services for those found to be HIV positive.\footnote{Id. at 35.}
By 1987, in the U.S. in particular, the federal government and states resisted mandating testing.\textsuperscript{446} This practice was soon followed by other countries. Instead of compulsory testing, laws and policies were passed that took into account AIDS “exceptionalism” (the notion that the response to HIV/AIDS should not follow a traditional public health approach to infectious maladies, such as compulsory testing and quarantine). Consequently, the new laws required explicit consent and that an individual sign detailed informed consent documents before he or she was tested.\textsuperscript{447}

In conclusion, before ART became widely available, there was a broad international consensus for VCT.\textsuperscript{448} The fact that other modalities of testing, such as compulsory testing, mandatory testing and PITC, might lead to undesirable consequences for individuals seemed to prevail over the public health advantages of people knowing their status.\textsuperscript{449} This does not, however, mean that countries entirely desisted from applying other forms of testing. Some countries continued to apply both mandatory and compulsory testing policies to specific groups, such as immigrants, soldiers, life insurance applicants, pregnant women, sexual offenders, prisoners or pilots.

The arrival of ART in 1996 radically altered the natural progression of HIV infection in the U.S. and Europe. Statistics made it clear that ART was able to significantly reduce AIDS-related morbidity and mortality.\textsuperscript{450} In order to ensure the availability of the treatment in poor countries, WHO and the Bush Administration earmarked a large amount of money in 2003.\textsuperscript{451} The public health importance of ART and the commitment of the WHO and wealthy nations to ensure the

\textsuperscript{446} *Id.* at 184.
\textsuperscript{448} *Id.* at 323.
\textsuperscript{449} See Makhlof, *supra* note 432, at 6.
\textsuperscript{450} See Rajkumar, *supra* note 447, at 321.
\textsuperscript{451} *Id.* at 322-23.
availability of treatment shifted the debate over HIV testing.\textsuperscript{452} It was obvious that an infected person cannot benefit from ART unless he is timely tested. This situation necessitated widespread testing as a gateway to treatment. Consequently, public health officials started to advocate expanding HIV testing to make sure that people would have access to HIV treatment. They urged, in particular, PITC or routine testing, as the best way to scale up HIV testing. Some, however, continue to oppose any modality of HIV testing other than VCT.

Proponents of PITC, such as De Cock and Rahul, raised quite diverse arguments in favor of it, of which I discuss the key ones as follows.\textsuperscript{453} First, before the availability of ART, testing would not benefit the infected. To the contrary, it exposed them to stigma and discrimination. In the age of ART, persons who knew their positive HIV status would benefit much from ART. In order to make sure that people take advantage of ART and because the traditional VCT is insufficient to achieve this, we need to scale up HIV testing. For them, the best way to do this is through routine offer of HIV testing to persons attending health-care services.

Second, proponents of PITC contend that the slow uptake of VCT has impeded not only treatment endeavors but also HIV prevention efforts. Tested people generally take concrete steps to prevent transmitting the virus to other people. If they are not tested, they may engage in actions that will infect others. Third, proponents reject the notion of “AIDS exceptionalism” in the era of HIV treatment. While they accept the special features of AIDS compared to other infectious before the era of treatment, they argued that this should no longer be the case. One of the manifestations of AIDS exceptionalism is that HIV testing should be done only where the individual actively requests testing. This was justified by stigma, discrimination and lack of

\textsuperscript{452} See Makhlouf, \textit{supra} note 432, at 6.

treatment surrounding testing. A person should be tested voluntarily accepting all these circumstances. They further contend that the availability of HIV treatment has changed the special nature of AIDS, including the approach of its testing. Accordingly, routine and straightforward testing, which is a norm for most other treatable diseases, should be applicable to HIV/AIDS.

Opponents of expanded testing in general and PITC in particular, on their part, raise the following concerns to support their positions, most of which are directed against the implementation of PITC in Sub-Saharan Africa. First, they question the feasibility of routine testing in Sub-Saharan Africa given the culture of health service under-utilization. Sub-Saharan Africans in general and the poor in particular do not use health services unless they are very sick or there is a specific need. Consequently, PITC may not be able to capture the majority of individuals and, hence, it will have limited impact. They recommend that for routine testing or any other policy that focuses on health-care settings to have the maximum impact in Sub-Saharan Africa, a massive educational effort on healthcare use and removal of financial and other barriers to accessing health care is essential. While it is true that relatively Africans do not utilize health care services by Western standards, there are nowadays enormous improvements in this regard. Using their own resources and aid from rich nations and international financial institutions, Sub-Saharan African countries started to build health care institutions even in

remote parts of Africa. This has significantly improved the utilization of health care institutions in Africa. Given this reality, it is difficult for me to subscribe to the argument that PITC will have limited impact in Sub-Saharan Africa.

Second, opponents contend that though ART is available, expanding HIV testing through PITC may drive away health care users for fear that they may face discrimination and stigma. They go on to argue that if people avoid using health care institutions, the purpose for which PITC is designed, i.e. curbing the spread of HIV, cannot be successful. This argument has two underlying assumptions. First of all, it assumes that PITC is a coercive type of testing whereby people will be compelled to be tested and for this reason people may avoid using health care services. I would say that this assumption may work for mandatory and compulsory testing, but it does not work for PITC. PITC is a consensual type of HIV testing, where people can refuse testing. Given this fact, it does not seem tenable to argue that people will shy off health care services for fear of PITC. Secondly, the argument assumes that discrimination is still a challenge against expanded testing. It is true that PLWHA still face problems of stigma and discrimination. The PITC approach, however, mitigates this problem by ensuring confidentiality of testing results. Expanded testing may also play a role in minimizing stigma and discrimination. If more and more people are tested and know their positive HIV status through PITC and benefit from ART, the wrongful perception that equates HIV/AIDS infection with a death sentence will decrease. This, in turn, will lead to the decrease of stigma and discrimination.

Third, opponents are also concerned that PITC could in practice amount to mandatory testing in view of the unequal power relationship between health care workers and patients. The shifting of the onus of requesting the test from the patient to the health care worker, they argue, amounts to
a request to test rather than an offer. What is implicit in this concern is that the patient may be tested without really consenting thereto owing to undue influence by the provider. While this is a legitimate concern, it can be controlled and minimized by putting in place a detailed code of conduct that governs the activities of the providers. General AIDS education also assists in alerting the public about their rights during PITC.

Despite the arguments for and against PITC, the positions of WHO and UNAIDS and experience of countries are clearly in favor of PITC. They support PITC and adopt policies for its implementation.

5.3 RBA to HIV Testing

A rights-based approach (RBA) to HIV/AIDS response, as discussed in chapter three, is endorsed by the international community. This means that any HIV intervention, including HIV testing, should comply with human rights principles. What constitutes a RBA in terms of HIV testing has been expounded upon by UNAIDS, WHO and other human rights defenders. 456 A RBA to HIV testing imposes the following duties on States. First of all, it requires States to ensure access to HIV testing. Second, States should guarantee that the process of testing must adhere to the 3C principles, viz., informed consent, counseling and confidentiality. Third, HIV testing sites must be linked to HIV prevention, care, support and treatment services. Fourth, States need to put in place laws and policies for the protection of the rights of PLWHA and create or strengthen accountability mechanisms for the proper implementation of HIV testing

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455 See UNAIDS & WHO, supra note 116 and WHO & UNAIDS, supra note 117.
programs and the prevention of violations of human rights in the context of HIV testing. Each of these elements is briefly discussed below.

5.3.1 Availability, Accessibility and of Good Quality of HIV Testing Services

To realize adequate access of individuals to HIV testing, States should set up health facilities commensurate to the size of their population. The expansion of the health institutions providing HIV testing is not sufficient in itself. The institutions must have adequate infrastructure and trained staffs. The testing services should also be equally accessible to all without discrimination, within the physical reach of its population, affordable and of good quality.

Certain categories of people require a special setting for HIV testing. For example, HIV testing for children should be provided in “child-friendly and family-friendly manner”. This, inter alia, requires change in physical infrastructure to make it attractive to children and providing additional training on child counseling.

5.3.2 Informed Consent

The principle of informed consent is well recognized both as an ethical and human rights standard. The principle is pertinent in various circumstances, such as medical treatment, research and HIV testing. Informed consent protects the right of individuals to self-determination and privacy, which, in turn, entitle individuals to decide on their health and well-being. Moreover, from a public health perspective, informed consent coupled with counseling and confidentiality is crucial to bring about behavioral change via instilling HIV prevention information.

457 See UNAIDS Reference Group on HIV/AIDS and Human Rights, supra note 456, at 43-44.
459 Id.
460 See Human Rights Watch, supra note 456, at 17.
As the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health rightly declared, “[i]nformed consent is not mere acceptance of a medical intervention, but a voluntary and sufficiently informed decision, protecting the right of the patient to be involved in medical decision-making.” As its name implies, a decision to give informed consent can be reached only when the individual to be tested is given sufficient information before testing is carried out. As shall be discussed in the next subsection, the 2007 WHO and UNAIDS Guidance on Provider – Initiated HIV Testing and Counseling in the Health Facilities (2007 Guidance) identifies the type of information healthcare workers should provide to clients before they carry out testing. The Guidance stipulates that it is not mandatory for the informed consent to be given in writing. It provides that oral agreement is sufficient.

Due to the special situations of children, UNICEF and WHO, in 2010, jointly issued a policy on HIV testing and counseling for children. According to this policy, owing to psychological immaturity, the informed consent of children below the age of 10 should be obtained from a parent or legal guardian. Children above the age of 10 should, however, be given the opportunity to take part in the decision making process.

Like VCT, PITC is expected to be carried out in accordance with the three 3C principles. However, the 2007 Guidance introduced two features of PITC that distinguish it from VCT. PITC requires simplified pretest information in the place of pre-test counseling and consent is

462 See WHO & UNAIDS, supra note 117, at 36.
463 See WHO & UNICEF, supra note 458.
deemed secured unless the individual expressly exercises his/her right of refusal where testing is initiated.\textsuperscript{464}

Though HIV testing without consent, mandatory and compulsory testing, is considered unacceptable by international agencies working on HIV due to human rights and public health concerns, there are a few exceptional legitimate grounds on which HIV tested may be done without the consent of the individual concerned. The first exception is the case of donation of bloods, organs or tissues whereby the human product is to be tested before the donation is accepted.\textsuperscript{465} Second, compulsory HIV testing may be justified in the case of occupational exposure, the purpose being minimizing the risk of HIV transmission by applying PEP: antiretroviral drugs that can be used to minimize HIV infection.\textsuperscript{466} In order to administer PEP to the person exposed to body fluids, the source person must be tested even if he/she refuses to be tested. Thirdly, compulsory testing can be justified in sexual offense cases with the purpose of ascertaining the sero-status of the victim and administering PEP to minimize the level of risk of HIV infection and assisting the gathering of evidence for prosecuting or sentencing the sexual offender.\textsuperscript{467} Despite the fact that these are the only legitimate grounds to undertake HIV testing without informed consent, some States have adopted other unacceptable grounds in their policies, laws or practices, such as screening of immigrants and refugee persons in Canada; pre-marital testing in States such as Bahrain, Guinea, United Arab Emirates and Saudi Arabia and mandatory testing in employment settings,\textsuperscript{468} such as pilots in Ethiopia.

\begin{thebibliography}{99}

\bibitem{WHO-UNAIDS} See WHO & UNAIDS, \textit{supra} note 117, at 5 & 20.
\bibitem{UNAIDSWHO} UNAIDS/WHO, \textit{supra} note 116.
\bibitem{South-African-Criminal-Law} A good example of this is South African Criminal Law (Sexual Offences and Related Matters) Amendment Act 32 of 2007.
\end{thebibliography}
5.3.3 Counseling

The requirement of informed consent cannot be separated from the requirement of counseling. As discussed above, information to make informed decisions should be given to persons to be tested. This information is supplied in the form of counseling. Counseling should be given in two phases, namely, before testing (pre-test counseling) and after testing (post-test counseling).

Pre-test counseling should provide information that would enable the individual to given his/her informed consent. The 2007 Guidance provides that while pre-test counseling may be provided individually or in groups, consent should only be given in private. The minimum information to be provided includes: the reasons why HIV testing is initiated; the benefits and risks of testing, services available after testing results, be it positive or negative; a guarantee of confidentiality of testing results; the fact that the patient will be tested unless he exercises his right to refuse testing; the fact that the refusal to accept testing does not affect utilization of other services and encouragement of disclosure to persons at risk of infection in case of an HIV-positive result.

Post-test counseling should be done confidentially. The content of the information for HIV-negative and -positive persons is different. Post-counseling information for HIV-negative persons at a minimum encompasses: information on the window period and the need for re-testing; HIV/AIDS prevention information and provision of condoms and directions on how to use them. The 2007 Guidance contains detailed information that healthcare providers should provide and tasks they should accomplish in the case of HIV-positive testing results. To put the


469 UNAIDS/WHO, supra note 116, at 36.
470 Id. at 36.
471 Id. at 39.
472 Id. at 40.
content of post-test counseling for HIV-positive people in brief, it should concentrate on psychosocial support, the need to utilize HIV prevention and treatment services and disclosure of HIV status to sexual and injecting partners.\footnote{Id.}

\subsection*{5.3.4 Confidentiality}

Securing informed consent and providing counseling is incomplete under a RBA to HIV testing unless HIV testing results are kept confidential. Confidentiality of HIV testing results is justifiable both from human rights and public health perspectives. Keeping HIV testing results confidential is a corollary to respecting and protecting the right to privacy.\footnote{R.J. Paterson, AIDS, HIV Testing and Medical Confidentiality, 7 Otago L. Rev., 379, 385(1991).} It is also indispensable to achieving a public health goal of controlling the HIV/AIDS pandemic. A guarantee of confidentiality is essential to encourage people to undertake HIV testing and protect HIV positive people from stigma, discrimination, abandonment and abuse.\footnote{See Rajkumar, supra note 447, at 375 and Paterson, supra note 474, at 384.}

Precisely for the aforementioned reasons, disclosure of HIV testing results without the consent of the people tested is made unacceptable under international policies and guidelines.\footnote{See UN, supra note 8, at para. 58. In this Declaration, Governments pledged to protect the privacy and confidentiality of PLWHA. See also ILO, supra note 115, at para. 4(7) and UNAIDS & OHCHR, supra note 19, at para. 20(f).} Prohibition of disclosure of HIV testing results, however, allows a few exceptions where disclosure is permitted even without the consent of the person. This happens where the interests protected by confidentiality of HIV testing results is outweighed by protection of other societal benefits and interests. Instances include disclosure of HIV status in sexual offense cases.

The issue of whether partners should be notified about the HIV-positive status of their partner has been controversial. Some States and writers maintain a position that HIV positive persons are
bound to disclose their HIV status to their partners. A good example of this position is the 1998 Philippines AIDS Prevention and Control Act. Another example is provided by article 14(1) (e) of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (African Women’s Protocol). It states that women have the “the right to be informed…on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS…” Most States, however, encourage, but do not compulsorily require partner notification.\(^{477}\)

Partner notification has its own advantages and disadvantages. While notification assists the partner to take steps to prevent infection and help decrease transmission of HIV/AIDS, it also infringes the right to privacy of the partner whose status is disclosed, may expose the same to abandonment, physical and emotional abuse, stigma, discrimination and result in disruption of family relationships. Thus, it is important to ensure that the advantages of notification outweigh its disadvantages before notification. This has to be determined on a case by case basis. This is the third position taken by the International Guidelines on HIV/AIDS and Human Rights. The Guidelines recommend States to give discretion to healthcare providers to determine whether to notify the partner the HIV-positive status of his/her partner. The Guidelines also stipulate a list of factors that healthcare professionals should consider in order to decide on whether to notify.\(^{478}\)

5.3.5 Link to HIV Prevention, Care, Support and Treatment Services

HIV testing is not an end in itself. It is a means for increasing the utilization of HIV prevention, care, support and treatment services. Consequently, HIV testing intervention is regarded as fruitful only when it is linked to HIV prevention, care, support and treatment services. The 2007

\(^{478}\) See UNAIDS & OHCHR, supra note 19, at para. 20 (g).
Guidance lists a range of services that should be available for the proper implementation of PITC.479

5.3.6 Legal and Policy Framework to Guarantee the Rights of PLWHA and Ensure Accountability
An effort to scale up HIV testing should also put in place or strengthen the legal and policy environment that protect the rights of PLWHA. This is because unless the rights of PLWHA are not protected, this may negatively affect the utilization of HIV testing. Thus, the laws and the policies should guarantee PLWHA and other vulnerable groups protection against discrimination and abuse. They should also stipulate safeguards against violations of human rights in the course of HIV testing and provide redress for those whose rights are violated.480 In order to guarantee accountability of providers of HIV testing services, the 2007 Guidance requires the adoption of a code of conduct and the putting in place of a strong monitoring and evaluation system.481

5.4 Human Rights Underpinning HIV Testing
The 3C principles as well other requirements of HIV testing are not randomly selected. Rather, they are grounded in important human rights principles and meant to alert States to protect, respect and fulfill the rights of persons who undergo HIV testing. It is not possible to comprehensively deal with all specific rights that are pertinent to HIV testing. Accordingly, the following sub-sections pinpoint only the specific human rights and standards that are relevant to assess the Ethiopian laws, policies and practices in section 6 of this chapter.

479 See WHO & UNAIDS, supra note 117, at 31.
480 See WHO & UNAIDS, supra note 117, at 32-33.
481 Id. at 34.
5.4.1 The Right to Health

The right to health is guaranteed in several global human rights documents, such as article 25 (1) of the UDHR, article 12 of the ICESCR, article 24 of the CRC and articles 11 (1) (f) and 12 of the CEDAW. It is also recognized in the African Regional human rights treaties including article 16 of ACHPR, article 14 of the ACRWC and article 14 (1) (d)) of the African Women’s Protocol. On the basis of these provisions, the content of the right to health is analyzed by different human rights bodies and other UN agencies.

The International Guidelines on HIV/AIDS and Human Rights states that the obligations of States to realize the right to health in the context of HIV/AIDS include the obligation to “ensure access to voluntary and confidential testing with pre-and post-test counseling.”482 The Committee on Economic, Social and Cultural Rights, in its General Comment No.14, states that the right to health encompasses the obligation to ensure the availability of health-related goods and services that are “scientifically and medically appropriate and of good quality.”483 From the perspective of children, the Committee on the Rights of the Child posited that, in discharging their obligations under article 24 of the CRC, “States parties should ensure access to voluntary, confidential HIV counseling and testing for all children.”484 The Committee also urged States to rule out mandatory testing of children in all situations.485 The CEDAW Committee has also interpreted article 12 (1) of CEDAW to be applicable in the context of HIV testing.486

482 See UNAIDS & OHCHR, supra note 19, at para. 144.
483 See Committee on Economic, Social and Cultural Rights, supra note 139, at para. 2.
484 See also Committee on the Rights of the Child, supra note 137, at para. 22.
485 Id. at para. 23.
5.4.2 The Right to Privacy, Liberty and Security of the Person

The right to privacy is founded in article 12 of the UDHR. This provision provides that “no one shall be subjected to arbitrary interference with his privacy, family home or correspondence, nor to attacks upon his honor or reputation. Everyone has the right to the protection of the law against such interference.” The right is explicitly protected in article 17 of the ICCPR and article 10 of the ACRWC.\textsuperscript{487} The obligation of States to respect the right to privacy is construed to encompass the “obligation to seek informed consent to HIV testing and privacy of information, including the need to respect confidentiality of all information relating to a person’s HIV status.”\textsuperscript{488}

Article 9 of the ICCPR provides that “[e]veryone has the right to liberty and security of person.” The obligation to respect the right to liberty and security of a person prohibits States from undertaking HIV testing without informed consent.\textsuperscript{489}

5.4.3 The Right to Equality and Non-Discrimination

The right to equality and non-discrimination are recognized in many human rights instruments, such as the CEDAW, article 2 of the UDHR, articles 2 (1) and 26 of the ICCPR, article 2 (2) of the ICESCR, article of 2 of the CRC and article 2 of the ACHPR. Article 2 of the ACHPR, article 2 (1) of the ICCPR and article 2 (2) of the ICESCR limit the prohibition of discrimination to the enjoyment of rights recognized in these instruments. Nevertheless, article 3, the right to equality, of the ACHPR and article 26 of the ICCPR guarantee non-discrimination beyond the

\textsuperscript{487} Even if the right to privacy is not expressly protected in the African Charter on Human and Peoples’ Rights and African Women Protocol, it may be implied from other rights expressly recognized in these treaties including the right to physical integrity and the right to respect for one’s dignity. The African Commission, in its finding in Social and Economic Rights Action Centre and Another v. Nigeria (2001) AHRLR 60 (ACHPR 2001) held that the rights to housing and the right to food (though not expressly guaranteed in the Charter) are implicit in the right to property, to heath and to protection of the family.

\textsuperscript{488} See UNAIDS & OHCHR, \textit{supra} note 19, at para. 119.

\textsuperscript{489} \textit{Id.} para 135.

The various human rights treaties that protect the right to non-discrimination list specific grounds on which discrimination is prohibited. As it is difficult to list all the grounds, they include a catch-all term “other status”. In 1996, the UN Commission on Human Rights clarified that the term “other status” “should be interpreted to include health status, including HIV/AIDS.”\footnote{See UN Commission on Human Rights Resolution 1996/44, \textit{supra} 146.} The Committee on the Rights of the Child has also concluded similarly by construing article 2 of the CRC.\footnote{Committee on the Rights of the Child, General Comment No. 4, Adolescent Health and Development in the Context of the Rights of the Child (2003) para. 6.}

\subsection*{5.4.4 The Right to Marry and to Found a Family}

Article 16 (1) of the UDHR states that “[m]en and women of full age… have the right to marry and to found a family.” Taking this provision as a model, the right to marry and found a family is reiterated in binding human rights instruments to which Ethiopia is a party, such as article 23 (2) of the ICCPR and 18(1) of the ACHPR.\footnote{Article 18 (1) of the ACHPR does not explicitly mention the right to marry and found a family. However, this right is implicit in the obligation of States to protect the family.} The International Guidelines on HIV/AIDS and Human Rights have pointed out that pre-marital mandatory HIV testing is unjustifiable violation of the right to marry and to found a family.\footnote{See UNAIDS & OHCHR, \textit{supra} note 19, at para. 118.}
5.4.5 The Right to Freedom of Expression and Information

Article 19 (2) of the ICCPR protects the right of every one to seek, receive and impart information. Moreover, the right is guaranteed as an accessibility element of the right to health which is interpreted by the Committee on Economic, Social and Cultural Rights to include information accessibility. In the context of HIV/AIDS, the right to seek and receive information includes the right to seek and receive HIV-related prevention and care information.

5.4.6 The Right to Work

The right to work is recognized, inter alia, in article 23 of the UDHR, article 6 of the ICESCR and article 15 of the ACHPR. Broadly, the right to work entails the right to access to employment and protection against unjust dismissal for employment. The International Guidelines on HIV/AIDS and Human Rights state that pre-employment HIV screening and refusal of and dismissal from employment is a violation of the right to work. The Guidelines also recommend that States reasonably accommodate PLHWA to continue working in case of sickness.

5.5 An Overview of the Policy and Legal Framework in Ethiopia

5.5.1 Laws

5.5.1.1 FDRE Constitution

The FDRE Constitution, in chapter three, incorporates a host of human rights that could be applied in the context of HIV testing. It, in particular, incorporates the right to privacy, security

495 See Committee on Economic, Social and Cultural Rights, supra note 139, at para. 12(b).
496 See UNAIDS & OHCHR, supra note 19, at para. 138.
497 See Sepulveda et al., supra 275, at 259.
498 See UNAIDS & OHCHR, supra note 19, at para. 149.
499 Id.
and liberty;\textsuperscript{500} the right to non-discrimination;\textsuperscript{501} marital and family rights\textsuperscript{502} and the right to freedom of information.\textsuperscript{503} Moreover, the Constitution has recognized socio-economic rights, including the right to health and work, both in the substantive part of its provisions and in the National Policy Principles and Objectives. Though it is poorly formulated, article 41 (3) guarantees the right of Ethiopian citizens to have “equal access to publicly funded social services.” Sub-article 4 of the same article gives a non-exhaustive list of social services including health. The fact that socio-economic rights in article 41 are only framed in the form of entitlements to services ignores the freedom aspects of the right to health. Ensuring access of Ethiopians to health is also mentioned as one of the National Policy Principles and Objectives.\textsuperscript{504} Furthermore, the right to work is incorporated in a bill of rights provisions.\textsuperscript{505}

As mentioned in chapter three, there is no a well developed constitutional jurisprudence that elaborates the content of these rights in relation to HIV testing in particular and HIV/AIDS in general. Given this fact, it is imperative to use provisions of human rights and interpretations of their monitoring bodies, UN agencies and writers discussed above. The FDRE Constitution itself requires the interpretation of human rights recognized in the Constitution in the light of international human rights standards.\textsuperscript{506}

\textbf{5.5.1.2 The Civil Code and the Employment Laws}

Though some of its provisions are repealed and replaced by other pieces of legislation, most of the provisions of the Civil Code are still enforce. True, the Civil Code was enacted far before the

\textsuperscript{500} See FDRE Constitution, \textit{supra} note 40, at arts. 26 and 14.
\textsuperscript{501} \textit{Id.} at art. 25.
\textsuperscript{502} \textit{Id.} at art. 34.
\textsuperscript{503} \textit{Id.} at art. 29.
\textsuperscript{504} \textit{Id.} at art. 90.
\textsuperscript{505} \textit{Id.} at art. 42(2) cum 41(6) & (7).
\textsuperscript{506} \textit{Id.} at art. 13 (2).
emergence of the AIDS crisis. However, it contains provisions that may be interpreted in the HIV/AIDS context. One of these provisions entitles individuals to reject “medical- or surgical examination or treatment.” The term “medical examination” is broad enough to capture HIV testing. Thus, individuals have a legal ground to say no to HIV testing without their willingness unless testing is authorized by laws or regulations to safeguard public interest. As I shall discuss in the subsequent sub-sections, there are laws and policies in Ethiopia that allow compulsory testing and mandatory testing on exceptional grounds. The Civil Code also provides that where a person refuses to undergo medical examination in situations where this is authorized by law in the interest of the public, “the court may consider as established the facts which the examination had the object of ascertaining.”

Unlike the Civil Code, the major employment laws of the country, the Federal Civil Servants Proclamation and Labor Proclamation, expressly make a reference to HIV testing. Both proclamations prohibit HIV testing of employees in their areas of regulation. The Civil Service Proclamation takes a commendable position in forbidding HIV screening of job applicants. It states that job seekers are not bound to produce a medical certificate showing HIV testing results. The Proclamation also forbids discrimination among job applicants on the basis of HIV status. The Labor Proclamation, however, does not incorporate similar provisions. As shall be discussed shortly, this does not mean that employers at for-profit organizations have a

507 Civil Code of 1960, art. 20(1).
508 Id. at art.20(2).
509 Id. at art. 22.
512 See Civil Servants Proclamation, supra note 510, at art. 63 (1) and Labor Proclamation, supra note 511, at art. 14 (2) (d).
513 See Civil Servants Proclamation, supra note 510, at art. 17.
514 Id. at art.13(1).
free license to test job applicants. The HIV testing policies prohibit mandatory testing in employment settings. The problem, nevertheless, is that persons who may be coerced to be tested cannot invoke these policies before courts to seek a remedy. They can only resort to administrative remedies.

The Civil Code contains another important provision which can be invoked by individuals who sustain material or moral damage to claim civil damage owing to the failure of healthcare providers to live up to their professional obligations.515

5.5.1.3 The Criminal Code

The Criminal Code punishes anyone who restrains the free exercise of civil rights of others with simple imprisonment not exceeding three years or fine.516 The provision can be used by victims of human rights violations in the context of HIV testing. There are also other more specific provisions which make HIV testing providers criminally accountable for failure to comply with their obligations. Article 399 provides for punishment of imprisonment or fine for disclosure of information by doctors, nurses, auxiliary medical personnel and other professionals “which has come to their knowledge in the course of their professional duties.” It is, however, made clear that disclosure of information is not criminally punishable where it is ordered by law, court and other competent authorities.517 Furthermore, it is punishable to deprive the freedom of others to make a decision.518 This provision can be construed to punish those who may undertake HIV testing without consent of the person tested.

515 See Civil Code, supra note 507, at art. 2031.
517 Id. at art.400.
518 Id. at art.583.
5.5.1.4 The Criminal Procedure Code

The Criminal Procedure Code authorizes an investigating police officer to order the physical examination of a suspected offender, including testing of blood, where the nature of the crime demands so.\(^{519}\) As shall be discussed below, this provision has been used as a legal backing both by the police and courts for the compulsory HIV testing of sexual offenders.

5.5.2 Policies

5.5.2.1 The 1998 Policy on HIV/AIDS

The 1998 Policy on HIV/AIDS specifically addresses HIV testing. In principle, the Policy promotes voluntary testing and counseling.\(^{520}\) It allows, however, two exceptions to the principle of voluntary HIV testing, namely, where mandatory HIV screening is justified by the nature of the job “(pilots - civil aviation and air force)”\(^{521}\) and in screening of blood for donation purposes.\(^{522}\) The tenability or otherwise of these two exceptions is analyzed in section six below.

The Policy reiterates the right of individuals to confidentiality of HIV testing results.\(^{523}\) It, however, encourages PLWHA to disclose their HIV status to “others (spouse, friends, and family).”\(^{524}\) Where the sero-positive partner rejects notification of his/her partner after receiving counseling, the partner at risk of being infected “has the right to directly access the information regarding the sero-status of the partner.”\(^{525}\) This, in other words, means that the result of HIV status will be disclosed to the other partner despite the unwillingness of the HIV positive partner to disclose it.

\(^{519}\) Article 34 of the 1961 Criminal Procedure Code of Ethiopia.

\(^{520}\) See 1998 HIV/AIDS Policy, supra note 17, at para 3(2).

\(^{521}\) Id. at para 3(3).

\(^{522}\) Id. at paras. 3(5) and 3(6).

\(^{523}\) Id. at para. 8(1).

\(^{524}\) Id. at para. 5 (5).

\(^{525}\) Id. at para. 5 (6).
5.5.2.2 Guidelines for HCT in Ethiopia

The 2007 Guidelines for HCT (2007 HCT Guidelines)\(^{526}\) is a document exclusively devoted to HIV testing. These Guidelines have replaced the 2002 VCT Guidelines and the main reason for the adoption of the Guidelines is to ensure that HIV testing is “promoted and made widely available, affordable and accessible to all individuals and communities” “as a crucial intervention component of the HIV/AIDS prevention, care and support program.”\(^{527}\) Two mechanisms are given particular emphasis to scale up HIV testing. First, apart from VCT model of HIV testing, the Guidelines introduced PITC. Second, the Guidelines expanded the settings in which HIV testing should be provided. HIV testing services can be provided in public, non-governmental organizations and private health institutions; in stand-alone counseling and testing services sites outside health facilities; in outreach and mobile services for special populations such as people in remote rural areas, pastoralists, refugees and prisoners and in workplaces by trained personnel.\(^{528}\)

The Guidelines recognize three types of testing, namely, VCT, PITC and mandatory and set out requirements that healthcare providers should follow regarding consent, counseling and confidentiality in VCT and PITC.

The Guidelines state that consent is a prerequisite for all types of testing save mandatory testing.\(^{529}\) Informed consent is deemed to be given only where “clients adequately understand benefits, implications and consequences of testing” and healthcare providers “recognize the right

\(^{526}\) See 2007 HCT Guidelines, supra note 17.
\(^{527}\) Id. at para. 1.1.
\(^{528}\) Id. at para. 2.2.
\(^{529}\) Id. at para. 1.1.
of clients to withdraw consent at any time, even after blood has been taken for HIV testing."\footnote{Id. at para. 3(2)(2).} Individuals aged 15 and above are deemed to be capable of giving informed consent.\footnote{Id. at para. 1(4).} For children below the age of 15, consent of their parents and guardians must be obtained and the testing should only be done to promote the best interest of the child.\footnote{Id. at para. 1(4)(1).} Nevertheless, children between the ages of 13 and 15 and "who are married, pregnant, commercial sex workers, street children, heads of families, or sexually active are regarded as ‘mature minors’" for the purpose of giving consent for HIV testing.\footnote{Id. at para. 1.4.} If a person is not in a position to give consent owing to critical illness and HIV testing is believed to be crucial to lesson his/her sickness, the decision whether he/she should be tested may be taken by the healthcare provider or his/her relative.\footnote{Id. at para. 3.4.8.}

The Guidelines require consent to be accompanied by pre-test and post-test counseling.\footnote{Id. at para. 1(1) read together with para. 3.2.} In PITC, pre-test counseling should be provided in the form of education or information, either in group or in private informing clients about the advantages of testing and services available both for HIV positive and negative testing results.\footnote{Id. at para. 3(2) (1).} In contrast to pre-test counseling, providers of HIV testing are bound to give post-test counseling in private. The contents of post-testing counseling vary depending on whether the testing result is negative or positive. Where the result of the test is positive, the counseling should concentrate on support, care and treatment of the sero-positive persons.\footnote{Id. at para. 3.2.4.} Then, the HIV positive persons will be referred to sites where care, support and treatment services are available.\footnote{Id. at para. 2.3.6.}
The Guidelines impose an obligation on providers of HIV testing to respect confidentiality of testing results.\textsuperscript{539} To that end, it warns not to give testing results in public places or to couples.\textsuperscript{540} The Guidelines recognize two exceptional circumstances under which confidentiality of testing results may not be maintained. The first situation is where testing is carried out under the order of the court.\textsuperscript{541} The Guidelines do not, however, mention the specific grounds on which courts may order HIV testing. The second situation is where the HIV positive partner rejects to notifying his/her endangered partner. In this case, the officials may decide to notify the partner at risk of infection.\textsuperscript{542} Disclosure of HIV positive status without consent is a last resort measure because it may entail stigma, discrimination, abandonment and disruption of family relationship. In order to prevent this from happening, the Guidelines encourage couples to be tested, counseled and receive testing results together.\textsuperscript{543} The Guidelines allow mandatory testing where it is ordered by the court and before transfusion of blood and transplantation of body tissues and organs.\textsuperscript{544}

Any effort to scale up HIV testing should not ignore the quality aspect of the service. In order to provide quality HIV testing and counseling, the Guidelines require the fulfillment of minimum requirements in all sites of HIV testing in terms of staff, space, equipment and supplies.\textsuperscript{545} With respect to staffing, each testing site should have adequate staff who took the necessary training.\textsuperscript{546} The training to all counselors, including non-health professional counselors should, \textit{inter alia}, provide information about HIV/AIDS; available HIV prevention, care, support and

\begin{itemize}
\item \textsuperscript{539} \textit{Id.} at para. 1(1).
\item \textsuperscript{540} \textit{Id.} at para. 3(2) (3).
\item \textsuperscript{541} \textit{Id.} at para. 3(2) (7).
\item \textsuperscript{542} \textit{Id.} at paras. 1(6) and 3(2) (8).
\item \textsuperscript{543} \textit{Id.} at para. 1.2.
\item \textsuperscript{544} \textit{Id.} at paras. 1 (1) and 2 (1) (3).
\item \textsuperscript{545} \textit{Id.} at para. 2.3
\item \textsuperscript{546} \textit{Id.} at para. 2.3
\end{itemize}
treatment services; principles of HIV counseling, couple and child counseling and PITC.547 In 2010, two manuals have been prepared that facilitate the implementation of PITC: National Training Package, Provider-Initiated HIV Testing and Counseling: Trainer’s Manual548 and National Training Package, Provider-Initiated HIV Testing and Counseling: Participant’s Manual.549 The Guidelines do also require testing sites to include rooms and facilities to ensure confidentiality.550 Moreover, they require testing sites to ensure the availability of the necessary testing tools.551 In order to check whether the quality standards are met, the Guidelines put in place a periodic quality assurance mechanism. Supervisors trained for this purpose determine whether HIV testing quality standards are being observed. 552

5.5.2.3 The 2007 Guidelines for PMTCT of HIV in Ethiopia

Mother-to-child transmission is the second largest way of HIV infection in Sub-Saharan Arica, next only to heterosexual transmission. Thus, any effort to curb the transmission of HIV/AIDS should address mother-to-child transmission of HIV. Recognizing this, the Government of Ethiopia adopted the Guidelines for PMTCT of HIV in Ethiopia (PMTCT Guidelines) in 2007553 replacing the 2001 Guideline on the PMTCT with a view to regulating PMTCT in the country. Declaring the upholding of human rights as one of the guiding principles of the PMTCT,554 the Guidelines identify PITC as one of the strategies to scale up PMTCT services.555 The Guidelines, similar to the 2007 HIV Testing Guidelines, prescribe requirements with regard to the

547 Id. at para. 4.4
550 See 2007 HCT Guidelines, supra note 17, at para. 2.3.2.
551 Id. at para. 2.3.3.
552 Id. at para. 3.2.9.
553 See PMTCT Guidelines, supra note 17.
554 Id. at para. 1.2.
555 Id. at para. 5.3.2.

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requirements of consent, counseling, confidentiality and referral to prevention, care, support and treatment services.

5.5.2.4 Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline
The Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline aims at controlling HIV/AIDS at civil service institutions.\textsuperscript{556} Two of the guiding principles to be followed in preventing and controlling HIV/AIDS in workplaces are combating stigma and discrimination against PLWHA and care, support and treatment of PLWHA.\textsuperscript{557} The Guideline provide that if PLWHA are unable to carry out the tasks they are assigned to perform, they, upon their consent, should be transferred to other tasks of the same status and if transfer is not possible in the same rank, they may be transferred to lower ranks without affecting their salaries.\textsuperscript{558} Institutions are duty bound to establish AIDS funds that will be used for care, support and treatment PLWHA.\textsuperscript{559} Institutions are also under a duty to promote VCT of employees without, however, undertaking mandatory testing of job applicants or employees. The Guideline states that any action or in action that undermines rights of PLWHA constitutes a serious disciplinary offence and it stipulates procedures for lodging complaints.\textsuperscript{560}

5.5.2.5 Quality Management Framework for HIV/AIDS Services in Ethiopia
Cognizant of the lack of comprehensive quality assurance mechanisms in the delivery of HIV-related services, the FHAPCO, in 2008, issued the Quality Management Framework for HIV/AIDS Services.\textsuperscript{561} The document is developed so as to be used by all actors that should

\textsuperscript{556} See Civil Service HIV/AIDS Guideline, \textit{supra} 357, at para. 1.4.2.
\textsuperscript{557} Id. at para. 1.4.8.
\textsuperscript{558} Id. at paras. 1.4.8, 2.4 and 5.3.
\textsuperscript{559} Id. at para. 2.4.
\textsuperscript{560} Id. at para. 6
\textsuperscript{561} See FHAPCO, \textit{supra} note 102, at 3.
implement quality management, such as health care providers, non-governmental organizations, faith-based organizations, governmental organizations and other actors that take part in delivery of HIV-related services. The Framework identifies three features of quality that should be monitored for improvement. These are the technical competence of providers to provide quality service, the availability of adequate facilities (infrastructure, equipment, supplies and drugs) and the interpersonal aspects of care provision. The specific types of HIV/AIDS services that will be monitored for improvement include: VCT, PITC, ongoing counseling and referral to care, support and treatment sites. The concerned institutions are required to implement the quality framework and it is the responsibility of the FHAPCO to coordinate, monitor and evaluate the implementation of the framework.

5.5.2.6 Strategic Framework for Referral and Linkages between HCT and Chronic HIV Care Services in Ethiopia

Research undertaken by the FHAPCO in 2008 disclosed that there is a weak linkage between HIV testing centers and sites rendering HIV prevention, care, support and treatment services. According to the study, there were a sizable number people who were tested HIV positive but had not benefited from care, support and treatment services. The main reasons for the huge gap between uptake of HIV testing and care, support and treatment services encompass: fear of stigma and discrimination, lack of trained healthcare providers, lack of adequate care and support, inadequate post-test counseling and misunderstandings related to ART. This weak level of linkage led the MOH to issue, in 2009, the Strategic Framework for Referral and

562 Id. at 3.
563 Id. at 12.
564 Id. at 16.
565 Id. at 23, 36 & 40.
566 The study is referred in MOH, Strategic Framework for Referral and Linkages between HIV Counseling and Testing and Chronic HIV Care Services in Ethiopia (2009) 2.
Linkages between HCT and Chronic HIV Care Services with the aim of rectifying the problems and thereby reinforcing the referral system. The strategies are supposed to be implemented in all the public, private and NGO health sites.

5.6 A Rights-Based Appraisal of the HIV Testing Policies, Laws and Practices

In the preceding section, an attempt is made to discuss the human right standards governing HIV testing and the laws and policies of Ethiopia regulating HIV testing. Below, the researcher explores the laws, policies and practices in the light of human rights principles apposite to HIV testing. Areas examined include availability and acceptability of HIV testing services; quality of HIV testing; informed consent; counseling; confidentiality of testing results; linkage between HIV testing and HIV prevention, care, support and treatment services and the adequacy of the policy and legal framework for protecting the rights of PLWHA and ensuring accountability.

5.6.1 Availability and Accessibility of HIV Testing Services

I have already referred that the right to health, which is recognized in the FDRE Constitution and human rights treaties which Ethiopia has ratified, requires the availability and accessibility of HIV testing services to everyone in need. This is reiterated by the 2007 HCT Guidelines that were issued with the aim of scaling up HIV testing services. Making HIV testing services available and accessible, inter alia, calls for expanding the sites where the services will be provided, fulfilling the necessary infrastructure and staff. The 2007 HCT Guidelines, as discussed above, urge testing centers to meet minimum requirements in terms of staff, space, equipment and supplies.

567 Id. at 3.
568 Id. at 4.
The Ethiopian Government has worked a lot to scale up the institutions providing HIV testing. As a result, the number of testing sites in the country has increased remarkably. Compared with 658 health facilities providing HIV testing services in 2005, there were 2,184 health facilities in 2010.\textsuperscript{569} This is a great achievement. Relative to the number of its population, however, the country need to set up more health institutions that will offer HCT services. In doing so, it is important to give greater attention to expanding the testing sites in rural and remote areas. The existing limited practice of setting up mobile VCT sites need to be intensified to solve the scarcity of testing sites in rural and remote parts of the country. Moreover, within the available resources, the Government should establish child and youth-friendly testing centers that encourage young people to know their sero-status.

The success or otherwise of efforts to make HIV testing available and accessible should be measured by the extent to which people are utilizing the services. According to the 2004-2008 HIV Strategic Plan for the Multi-sectoral Response Evaluation Report, about 70\% of young people between 15-24 years of age, 86\% of uneducated people, 91\% of poor women of reproductive age, and 85.9\% of rural women in reproductive age were not tested.\textsuperscript{570} According to the 2010 national report by FHAPCO, only 9.4 million people were tested in 2010 nationally.\textsuperscript{571} This figure shows only the number of testing undertaken even if there are people tested more than once. Thus, the data does not give us the accurate number of people tested.

\textsuperscript{569} See HAPCO, \textit{supra} note 51.
\textsuperscript{570} See FHAPCO, \textit{supra} note 416, at 28.
\textsuperscript{571} See FHAPCO, \textit{supra} note 50, at 14.
What is clear from the above figures is the low uptake of HIV testing services in Ethiopia. With this figure, Ethiopia is one of the African countries with a low rate of HIV testing. The fact that poor and rural women have low records of utilizing the service is a clear indication of problem of accessibility of the service. Because the testing centers are predominantly concentrated in urban areas, this makes economically as well as physically inaccessible to rural women. Even for women residing in urban areas and other sections of the population, studies have indicated that there are other several reasons that contributed to the low uptake of HIV testing in Ethiopia. According to a study conducted under the sponsorship of the World Bank, the problems, include, but are not limited to: scarcity of test kits and laboratory materials, lack of HIV testing sites that are tailored to youth and lack of focus on couple testing and counseling. Another reason worth mentioning that affects uptake of HIV testing negatively is the unaffordability of the service to the poor, particularly in private health centers. An individual is required to pay up to 100 Birr (an equivalent of U.S. $5.9) for a single test. This is too much for citizens in a country where approximately 39% of its population live below the international poverty line of U.S. $ 1.25 per day. Currently, the Government is in the process of developing guidelines that aim at standardizing fees required for HIV testing.

The problem of testing equipment was highlighted in a recent workshop organized by the FHAPCO to evaluate the annual multi-sectoral performance. Participants of the Workshop emphatically raised this problem. According to the participants, there is a huge discrepancy

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573 See Berhane et al., *supra* note 46, at 30-40.
575 Interview with Negash Tesfu, HIV/AIDS Focal Person at the Amhara National Regional State Health Bureau, (Jun. 24, 2011).
576 The workshop was organized at Martyr Memorial Hall of Bahir Dar City on Feb. 24-26, 2011 for the Bi-Annual Review Meeting of the National Multi-Sectoral Response against HIV/AIDS [hereinafter Bahir Dar Workshop].
between supply and demand. According to Ato Betiru Tekle, Director General of the FHAPCO, the problem of lack of testing kits and other equipment is not due to lack of finance. The problem is inefficient utilization of funds by regional states. Regions do not submit programmatic as well as audit reports on time and even when they submit reports on time, their reports are usually defective. Another problem is utilization of funds for other purposes than indicated in the agreements or action plans. These problems seriously affect the release of funds by donors.

Officials of the Pharmaceuticals Fund and Supply Agency, the Government organ responsible for procurement and distribution HIV/AIDS Pharmaceuticals, pointed out that the fact that the distribution of HIV test kits follows a long chain has also contributed to the shortage of the kits. Test kits and other medicines reach health facilities from the centre of Pharmaceuticals Fund and Supply Agency only after passing through regional health bureaus, zonal health departments and woreda (district) health offices. According to the officials, this long process of distributions of testing kits does not add any value. To the contrary, it acutely impedes the timely availability of the equipment and causes wastage of resources.

Couple testing and counseling is highly encouraged in the 2007 HCT Guidelines. Couple testing and counseling is necessitated to minimize blame, abandonment and disruption of family relationships in the event of discordant testing results. Couples, particularly women, who would otherwise decide to avoid testing owing to fear of its negative consequences, may accept testing if their partners are willing to be tested together. Several empirical research findings in Addis Ababa and Amhara and SNNP regions and areas indicate that women are highly encouraged to

577 Taken from presentation by experts of the Pharmaceuticals Fund and Supply Agency entitled “HIV/AIDS Pharmaceuticals Procurement and Distribution in 2009/2010 and Future Plan” at the Mekelle Workshop.
be tested when their husbands support their decisions.\textsuperscript{578} The studies also disclose that fear of learning positive results; stigma and discrimination attached to TB and HIV; lack of good knowledge on HIV transmission, prevention and benefits of testing and lack of affordability of the services are the main barriers to uptake of VCT and acceptance of PITC.\textsuperscript{579}

In order to lessen challenges pertaining to availability and accessibility of HIV testing, the Government of Ethiopia has put in place several strategies that are expected to be implemented over five years (2010-2014). The strategies, as incorporated in SPM II, are HIV education and awareness-raising to achieve universal testing; mobilization of communities using health extension workers, religious leaders and local community leaders to increase uptake of HIV testing; increasing the number of health facilities providing HIV testing and ensuring sustainable supply of testing equipment.\textsuperscript{580} While the SPM II has taken a commendable step in designing specific strategies to solve some of the challenges, it has failed to indicate clear strategies to solve the rest of the problems. It does not mention how to address barriers to couple testing and counseling and stigma and discrimination with a view to scaling up the demand of HIV testing. Furthermore, it does not put in place strategies to consolidate youth and children-friendly testing facilities.


\textsuperscript{580} See SPM II, supra note 17, at 38.
5.6.2 Quality of the Services

As has been mentioned earlier, quality of health-related services, including HCT services, is an important element of the right to health. Cognizant of this, the 2007 HCT Guidelines and the Quality Management Framework for HIV/AIDS Services, highlighted above, requires all actors to be involved in the delivery of HIV testing services to comply with certain quality standards in respect of technical competence of HIV testing providers and facilities providing the services. These documents have also put in place quality assurance mechanisms to be applied by all stakeholders.

There are very few studies that have been undertaken to assess the quality of HIV testing on the ground and the status of implementation of quality assurance mechanisms. These studies measured quality of HIV testing on the basis of client satisfaction. All the three studies came to the conclusion that most clients of HIV testing in Addis Ababa are satisfied with the services.\(^{581}\) Comparatively speaking, the study undertaken by Fasika Desalegn revealed that clients who received the services in public institutions are more satisfied than those served by the private ones.\(^{582}\) He used the existence of comfortable and private counseling room, status of maintaining confidentiality and counseling skills as parameters to compare the private and public health facilities.\(^{583}\) This study also showed that in the testing health centers covered in the study, with the exception of one, all counselors had formal training.\(^{584}\) In the research undertaken by Hussien

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582 See Desalegn, supra note 581, at 67-68.

583 Id.

584 Id.
Ismail, the researcher found that though clients were generally satisfied with the services, the people he interviewed disclosed that the counseling was too brief, rudimentary and lacked depth and coverage.\textsuperscript{585} Consequently, a quarter of people interviewed were unable to understand why they were offered testing.\textsuperscript{586}

Even though there is an adequate policy framework designed to ensure compliance with quality standards, it has weak implementation status.\textsuperscript{587} The supervisory bodies do not regularly supervise the effective implementation of the policies.\textsuperscript{588} The concerned officials the researcher contacted pointed out that lack of sufficient supervisors and high staff turnover immensely hinder the effective implementation of quality assurance mechanisms.\textsuperscript{589}

### 5.6.3 Informed Consent

At the heart of the 3C principles that are taken to be important components of a RBA to HIV testing is informed consent. The 1998 HIV Policy, the 2007 HCT Guidelines, the PMTCT Guidelines, the employment policies and laws explicitly mention that HIV testing, in principle, should be undertaken only where the individual consents thereto. In the case of VCT, as it is the client who initiated testing, testing without consent is not as such a concern. Given the fact that PITC is carried out upon the request of the provider, there are fears of misuse of the policy to conduct testing without informed consent. There are evidences to that effect in Ethiopia. In studies conducted at 10 selected health centers in Addis Ababa, one researcher observed that out of 66 pre-test and post-test counseling sessions observed, the mothers were not given the chance

\textsuperscript{585} See Ismail, supra note 581, at 55-56.
\textsuperscript{586} Id.
\textsuperscript{587} See Berhane, supra note 46, at 39-40.
\textsuperscript{588} See Desalegn, supra note 581, at 67-68.
\textsuperscript{589} See Tesfu, supra note 575; Azeb Feleke, Curative and Rehabilitation Services Coordination Officer at the SNNP Region Health Bureau (Jun. 16, 2011) and Dr. Mahlet Kifle, Officer of HIV/AIDS Prevention and Control Directorate at Ministry of Health (Jul. 7, 2011).
to freely consent or refuse blood tests in 25.5% of the sessions. The existence of these problems was also witnessed by some of the participants of a Bahir Dar Workshop convened to evaluate the multi-sectoral response against HIV/AIDS.

The policies allow testing without consent (mandatory and compulsory testing) in certain defined circumstances. To start with mandatory testing, as discussed above, the 1998 HIV/AIDS Policy permits mandatory testing where it is justified by the nature of the job “(pilots - civil aviation and air force)” and before donations of blood, tissues or organs. The 2007 HCT Guidelines also allow mandatory testing where it is ordered by court and before transfusion of blood and transplantation of body tissues and organs. Testing of body products before donations has a legitimate public health justification under international human rights standards. It aims at protecting the recipient of the body parts from HIV infection. There is no any other way than screening of the body parts before donation to avoid further infections.

It is, however, difficult to find acceptable public health justification for allowing mandatory testing where the nature of the job allows doing so “(pilots - civil aviation and air force)” . It is not clear whether the Policy allows mandatory testing in all employment settings as long as the nature of the job demands or is confined to the testing of pilots. In practice, evidence of pre-employment mandatory testing is available for pilots. There are no judicial decisions in Ethiopia on the appropriateness or otherwise of pre-employment HIV screening of pilots. There are, however, groundbreaking cases that denounce HIV testing as a requirement for a job in certain employment settings, such as the aviation industry and the military. To give examples, the court in South Africa, in the Hoffman case, held that HIV status alone cannot be taken to

590 See Ismail, supra note 581, at 55-56.
591 See Bahir Dar Workshop, supra note 576.
592 Interview with Dr. Saba Teklu, a Medical Examiner at the Ethiopian Airlines (June 30, 2011).
evaluate whether a person is fit for the job.\textsuperscript{593} Similar reasoning was followed by the Labor Court of Namibia in \textit{N. v. Minister of Defense} Case.\textsuperscript{594} In another employment case, the High Court of Judicature of Bombay in India rejected the contention that employing HIV positive person imposes considerable financial and administrative costs.\textsuperscript{595}

As elsewhere, the two possible reasons that might motivate the policy makers to allow mandatory pre-employment testing of pilots in Ethiopia are the nature of the job justification and financial reasons. Nevertheless, these justifications are unacceptable from human rights perspective. Put differently, as pointed out in the aforementioned judicial decisions, the two reasons are not legitimate grounds for restricting human rights that informed consent seeks to safeguard. The “nature of the job” justification assumes that PLWHA are too weak both physically and mentally to serve as pilots. This arises from a false belief that all PLWHA are sick persons. This is not true, however. HIV positive people are healthy and can carry out their day to day activities like any HIV negative people until and unless they are affected by HIV-related morbidity. Given this fact, it does not make sense to discriminate against PLWHA in employment solely on the basis of their HIV status. In this era of ART where HIV morbidity and early mortality are significantly reduced, it is ridiculous to assume that PLWHA are too weak to be pilots. The financial justification presumes that PLWHA live shorter lives compared to their HIV negative counterparts. It further presumes that if this is the case, the staff turnover and costs involved to train these people will seriously affect the employers financially. This again does not hold water these days where ART has drastically reduced AIDS-related morbidity and enabled PLWHA to live longer.

\textsuperscript{593} Hoffmann \textit{v. South African Airways}, Case CCT 17/00 (2000); 2001 (1) SA 1 (CC); 2000 (11) BCLR 1235 (CC).
\textsuperscript{594} \textit{N v Ministry of Defense} (2000) ILJ 1999 (Labor Court of Namibia, Case No.: LC 24/98).
\textsuperscript{595} MX \textit{v. ZY}, AIR 1997 Bom 406 (High Court of Judicature, 1997) para 56.
Aside from the reasons mentioned above, HIV screening for employment purposes is unacceptable for it is not in the interest of the public to do so. Non-discrimination, care and support of PLWHA are part of the strategy to prevent transmission of HIV/AIDS. As discussed in chapter three, it is only where we care and support PLWHA and avoid discrimination against them that we can effectively manage further infections.

The 2007 HCT Guidelines allow mandatory HIV testing where a court orders to that end. The Guidelines do not specify the grounds on which the court may order mandatory testing. In default of limitations to the power of the court, it means that the court has unfettered discretion to order HIV testing. This, in turn, may lead to abuses of human rights of individuals who will be subjected to mandatory testing.

Regardless of whether the HIV policies that allow mandatory testing are based on strong grounds, they are technically defective from a human rights standards perspective. As briefly discussed in section 3.6 of chapter three, it is a common requirement of all human rights treaties that any restriction on human rights must be prescribed by a law of general application. One of the reasons for this requirement, I believe, is to prevent arbitrary limitations of human rights by policies to be adopted by the executive. Restrictions on human rights should come from the law maker that represents the people after thorough deliberations. In Ethiopia, mandatory testing for employment purposes or through court order is authorized by policies of the executive and, hence, does not comply with one the most important requirements for any restriction on human rights.
Neither the 1998 HIV/AIDS Policy nor the 2007 HCT Guidelines allow compulsory HIV testing. However, article 34 of the 1961 Criminal Procedure Code of Ethiopia which authorizes an investigating police officer to order the physical examination of a suspected offender, including testing of blood, is used in practice for compulsory testing of suspected sexual offenders.\textsuperscript{596} Though from the view point of criminal procedure, the purpose of this testing is to gather evidence for the purpose of prosecution and subsequent conviction, it is equally necessary to apply PEP for the victim of the sexual violence so as to reduce the transmission of the virus from the offender to the victim.

Because compulsory HIV testing of suspected sexual offenders is conducted without the consent of the individual, it infringes human rights which serve as a basis for informed consent, such as the right to privacy and bodily integrity. Punishing offenders is one way of protecting the society from criminal activities. Thus, compulsory testing of suspected sexual offenders, though it infringes human rights, is justified by the protection of public order. Furthermore, the need to apply PEP to the victim of criminal act necessities the detection of the HIV status of the suspected criminal.

In practice, though article 34 of the Criminal Procedure Code clearly refers to the power of the police officer to order physical examination including blood test, the same provision is cited by courts to order the compulsory HIV testing of sexual rape offenders.\textsuperscript{597} The practice, at least in federal courts, reveals that the sole purpose of compulsory HIV testing of rapist is to gather evidence to prosecute and penalize the criminal. The victim of the rape is simply advised by doctors to take the PEP where there is evidence showing he is HIV positive without waiting for

\textsuperscript{596} Interview with Wosenyelesh Admasu, Women and Children Team Coordinator, Lideta Office, Ministry of Justice (Jul. 1, 2011).

\textsuperscript{597} Interview with Tsehai Menkir, Judge at Federal First Instance Court, Lideta Bench (Jun. 29, 2011).
his test results. Given the enormous side effect of PEP “such as, nausea, diarrhea, headaches, tiredness and a rash,” it is, however, highly advisable to apply PEP to the victim after ensuring the positive HIV status of the rapist through HIV testing.

There are cases entertained by Ethiopian courts involving compulsory HIV testing, some of which are still pending. In Public Prosecutor v. Abdulkadir Yasin Case, the offender was convicted of intentional transmission of HIV/AIDS. In the facts of the case, it is indicated that the criminal paid a sum of money to Mulu Gobu to have sex with him. Though they agreed to have sex with a condom, the victim testified and other evidence showed that he tore the end of the condom two times with the intent to infect the women with the virus. To ascertain whether he is HIV positive, he was ordered by the police and the court to undergo HIV testing. Moreover, in other rape case, Public Prosecutor v Alemu Degefa, the criminal was ordered to undergo HIV testing to determine whether the offender attempted to transmit or transmitted the virus to the victim.

5.6.4 Counseling

If the behavioral change that enables individuals to avoid risky behavior is to be achieved, consent must be accompanied by pre-test and post-test counseling. Counseling is also an end in itself in terms of realizing the right to freedom of information and the right to health. The official position in Ethiopia, as incorporated in the 1998 HIV Policy, the 2007 HCT Guidelines and the PMTCT Guidelines discussed above, is that HIV testing cannot be carried out without

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598 See Admasu, supra note 596.
counseling. However, the exceptions where testing is allowed without consent are equally applicable to counseling.

PITC poses a special concern from a human rights perspective. The 2007 PITC Guidelines require counselors to provide pre-test information as opposed to extensive pre-test counseling. This is not a problem in its own rights. The problem comes from the failure of the guidelines to incorporate the essential minimum set of information that counselors should communicate to the clients before testing is carried out. The Guidelines do not explicitly require, for instance, counselors to inform clients about the fact that testing results will be treated confidentially, the fact that refusal to take HIV testing does not affect the right of the client to have access to other treatment services and encouraging the client to disclose the testing results to those who are at risk of exposure. If this and other relevant information is not clearly communicated to the client, it is really difficult to say that he/she really gives informed consent. This concern is confirmed by empirical research findings. In a study conducted in 10 health centers in Addis Ababa, one researcher observed that pre-test discussions “were unusually too brief, rudimentary and lacking depth and coverage. Nearly a quarter of the exit clients didn’t understand why they were offered HTC particularly during their pregnancy time.”

5.6.5 Confidentiality of Testing Results

Confidentiality of HIV testing results is not only a corollary to the right to privacy and health but also a requisite to the success of the HIV/AIDS response. Realizing this, it is protected in the 2007 HCT Guidelines, the 1998 Policy on HIV/AIDS, the PMTCT Guidelines and other

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602 See Ismail, supra note 581, at 55-56.
documents discussed above. The exceptional grounds on which testing may be carried out without informed consent are applicable to confidentiality of testing results, too.

As discussed above, different jurisdictions follow different approaches with respect to partner notification. The approach which is adopted by majority of States, including Ethiopia, is encouraging partners to give notice of their HIV status to their partners at risk of infection. The 1998 HIV/AIDS Policy and the 2007 HIV Testing Guidelines give the endangered partner the right to have access to the HIV testing results of his/her partner if the latter, after repeated counseling, refuses to disclose his/her status. Though the right to health, privacy and security are restricted as a result of mandatory disclosure of HIV status, this is tolerable under international human rights law for it is done to protect the right of others. The conditions attached to mandatory disclosure of HIV status show that the action is a measure of last resort. The best way is to encourage couple testing and counseling and to persuade the individual to voluntarily share his/her status particularly in case of discordant statuses.

It may happen that one of the partners may be HIV positive and the other negative. For example, a study conducted among premarital couples undergoing VCT in Bahir Dar city of Ethiopia disclosed a 3.6% prevalence of sero-discordance. Though it is a less prevalent phenomenon, policies need to address the problem. In particular, the policies need to tackle the setbacks that hinder voluntary partner notification. In two separate studies undertaken in Hawassa Referral Hospital and Zewuditu Hospital of Addis Ababa, more than 15% of the respondents did not

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603 Gizachew Tadele, Assessment of HIV Sero-discordance, Sexual Behavior and Practice of Preventive Behavior against HIV among Premarital Couples Attending VCT in Bahir Dar, Northwest Ethiopia, in Extract N0.8, EPHA Sponsored Master’s Theses Extracts on HIV/AIDS 72 (2009).

604 Taye Gari, HIV Positive Status Disclosure among Women PLWHA at Hawassa Referral Hospital, in Extract N0.8, EPHA Sponsored Master’s Theses Extracts on HIV/AIDS 25 (2009).
disclose their HIV status to their partners. Barriers to disclosure include: low income and fear of abandonment, break-up in relationship and stigma.

5.6.6 Linkages Between HIV Testing and Prevention, Care, Support and Treatment Services
As briefly discussed in the previous section, studies by the Government have demonstrated that there is a weak referral system from testing centers to sites where HIV prevention, care, support and treatment are available. A similar study sponsored by the World Bank reached on a similar conclusion.\(^{606}\) In order to tackle the problem, the Government of Ethiopia, in 2009, put in place the Strategic Framework for Referral and Linkages between HIV Testing and Counseling and Chronic HIV Care Services. An interview with the concerned officials revealed that stigma and discrimination, weak counseling, lack of trained healthcare providers, lack of adequate care and support and healthcare workers overburden with multiple responsibilities are still the main challenges that weaken the linkage between HIV testing and HIV care, support and treatment services.\(^{607}\)

5.6.7 Legal and Policy Framework to Guarantee the Rights of PLWHA and Ensure Accountability
Provisions of the FDRE Constitution and human rights treaties to which Ethiopia is a party which are also reiterated in other policies, such as the 1998 HIV/AIDS Policy, discussed above, give an important framework for the protection of PLWHA against discrimination and for caring, supporting and treating them. In practice, studies have showed that discrimination against PLWHA creates a barrier to the acceptance of PITC and voluntary notification. A more detailed

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\(^{606}\) See Berhane, supra note 46, at 39-40.

\(^{607}\) See Tesfu, supra note 575; Feleke, supra note 589; Kifle, supra note 589 and Interview with Abebe Fekade, Monitoring and Evaluation Officer at Amhara HAPCO (Jun. 16, 2011) and Desalegn Fantaye, Planning, Monitoring and Evaluation Officer at SNNP Region Health Bureau (Feb. 25, 2011).
discussion of the non-discrimination and HIV support, care, support and treatment related laws, policies, strategies and the status of their implementation is deferred for chapters six and seven. Moreover, the legal and policy framework for ensuring accountability in the overall HIV-related activities is separately treated in chapter eight.
CHAPTER SIX
HIV PREVENTION

Introduction

Member States of the UN have made a number of commitments to strengthen their response to HIV/AIDS. One of these commitments is the extraordinary undertaking in the 2006 Political Declaration on HIV/AIDS to attain universal access to HIV prevention, treatment, care and support services to all those in need by 2010. Many States have made a remarkable progress in terms of increasing access to these services and reversing the momentum of HIV/AIDS. However, much more needs to be done to reach a point where there is a zero discrimination, zero new HIV infections, and zero AIDS-related deaths by implementing the universal access commitment.608 Many counties, including Ethiopia, did not meet the universal access commitment by 2010. It is precisely for this reason that UN and AU Member States agreed to extend the universal access cut-off date to 2015.609

This chapter assesses the laws, policies, specific strategies and practices designed to prevent the spread of HIV/AIDS in Ethiopia. After briefly exploring the means of and factors fuelling transmission of HIV/AIDS, strategies for effectively preventing HIV/AIDS and the human rights basis of access to HIV prevention goods and services in section one, two and three respectively,

608 See UNAIDS, supra note 1.
609 The Heads of States and Governments of the African Union decided to extend the Abuja Call for Accelerated Action Towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa to 2015 to coincide with the Millennium Development Goals, in the Assembly of the African Union Fifteenth Ordinary Session, held on 25 – 27 July 2010 in Kampala, Uganda. See Decision on the Five (5)- Year Review of the Abuja Call, supra note 15. Moreover, in the June 2011, Member States of the UN reached on similar agreement. See 2011 Political Declaration on HIV/AIDS, supra note 13, at para. 51.
the rest of the sections explore HIV prevention-related laws, policies and strategies of Ethiopia and the extent of their implementation in the light of a rights-based approach (RBA) to HIV prevention.

6.1 Ways of and Factors Aggravating HIV Transmission At Glance

Any effort to prevent the spread of HIV/AIDS should first identify causes of HIV transmission. The Global HIV Prevention Working Group (GHPWG) has recognized three broad ways of HIV transmission, namely, sexual transmission, parenteral (blood-borne) transmission and mother-to-child transmission.610

According to the 2010 UNAIDS Global Report on HIV/AIDS, the overwhelming majority of new HIV infections in Sub-Saharan Africa are caused by unprotected heterosexual intercourse.611 There are a host of factors that fuel the transmission of HIV through unprotected sexual intercourse. These factors explain why HIV prevalence is high in certain countries and sub-populations but not in others. The UNAIDS Global Reference Group on HIV/AIDS identified three set of factors that aggravate sexual transmission of the virus, viz., social, biological or behavioral factors.612 The social factors that influence transmission include the subordinate position of women in a society, the prevalence of violence against women, poverty, vast illiteracy, weak health conditions, stigma, discrimination and HTPs, such as dry sex, widow cleansing, female genital mutilation, widow inheritance and early marriage.613 The biological factors encompass high viral load; high prevalence and low treatment of sexual transmittable

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611 See UNAIDS, supra note 1, at 30.
613 Id. at 1. See also Epstein, supra 160, at 51-52; Michael Kirby, in Mark Heywood and Dennis Altman, Confronting AIDS: Human rights, Law and Social Transformation, 5(1) Health Human Rights: An International Journal 149, 149-79 (2000) and Engel, supra note 163, at 231.
diseases, such as syphilis, gonorrhea or Chlamydia; low male circumcision rate that explains, for example, why HIV/AIDS prevalence is higher in Southern Africa than West and North Africa and high rate of TB, parasite infections and malnutrition.\(^{614}\)

Behavioral factors of influence include greater numbers of sexual partners, high rate of partner change, sharing of needles and syringes and intoxication arising from various substances, such as drugs or alcohol.\(^{615}\) The degree of risk among individuals who have sexual relationships with many partners is not identical. Concurrent relationships, simultaneous relationship with more than one partner for a relatively long period of time, is more dangerous than “serial monogamy, because they link people up in a giant web of sexual relationship that serves as superhighway for the rapid spread of HIV.”\(^{616}\) Relatively speaking, short-term sexual relationships are less dangerous than concurrent relationships “because they involve less exposure and are also more likely to be protected with condoms.”\(^{617}\)

Blood-borne transmission refers to a type of HIV infection through the bloodstream. It may arise from sharing of needles among injection drug users and unsafe blood transfusions and body organs transplants.\(^{618}\) Mother-to-child transmission is a mode of HIV transmission from the mother to child during pregnancy, labor, delivery or breastfeeding.\(^{619}\) It is also called vertical transmission.

The fact that ways of transmission of HIV/AIDS and other determinants of vulnerability to HIV/AIDS are several in number does not necessarily mean that all of them or even most of

\(^{614}\) Id. at 1. See also Engel, supra note 163, at 220-221 and Epstein, supra 160, at 52 & 263-64.
\(^{615}\) Id. at 1.
\(^{616}\) See Epstein, supra 160, at 55.
\(^{617}\) Id. at 59.
\(^{618}\) See Global HIV Prevention Working Group, supra note 610, at 15.
\(^{619}\) Id. at 17.
them equally drive the epidemic everywhere. The ways of infection and factors of aggravating vulnerability vary considerably from place to place. To take one simple example, HIV prevalence is relatively high in the United States among the gay community and injected drug users. The causes of transmission among these people are unprotected anal sex and sharing of needles and syringes. These are not, however, the primary ways HIV is transmitted in Sub-Saharan Africa. In Sub-Saharan Africa, the predominant means of transmission is heterosexual sexual intercourse fueled by other behavioral, biological and social risk factors, such as high concurrent partner relationships, low male circumcision rate and high prevalence of violence against women.

6.2 HIV Prevention Strategies

What should be the effective strategy that should be put in place to control the transmission of HIV/AIDS has been debated for several years. Drawing from successful experiences, the UNAIDS, in 2005, came up with the principles of effective HIV prevention. At the heart of these principles is the need to adopt evidence-based comprehensive HIV prevention strategies that are grounded in human rights and tailored to local contexts.620

In chapter three, it has been extensively discussed that strategies intended to respond to HIV/AIDS, including HIV prevention strategies, should be guided by human rights standards. This, in other words, means that HIV prevention strategies must be designed to promote, protect and respect rights of individuals. A RBA to HIV prevention entitles individuals to have access to HIV prevention goods and services that enable them to circumvent infection and have access to life prolonging drugs if infected, protect marginalized groups in the community and empower

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women and other vulnerable groups. As the Secretary General of the UN rightly stated on the 2009 World AIDS Day, the goal of universal access to HIV prevention, care, support and treatment “can be achieved only if we shine the full light of human rights on HIV.”

HIV prevention programs not only should be grounded in human rights, but also be comprehensive. The need to adopt comprehensive HIV prevention strategies can be justified on two grounds. First of all, because the ways of transmission and risk aggravating factors are several, it is a must to adopt several specific strategies that deal with them. There is no single “magic bullet” that can be applied to prevent HIV in all means of transmission. Second, alternative strategies to prevent HIV transmission in a certain way must be available. Individuals should be given the opportunity to choose among these alternatives that suit their preferences. An equally important guiding principle is the need to make sure that the different HIV prevention strategies be evidence-based. That is, strategies must be proven to be effective.

Now the question is: what are the components of a RBA and comprehensive strategy for HIV prevention? In Ethiopia and elsewhere, abstinence, be faithful and condoms (ABC) slogan was taken as an effective strategy to prevent HIV transmission. However, the ABC slogan is subject to sever criticisms. In particular, it does not work for non-sexual HIV transmission: blood-borne transmission and mother-to-child transmission. Even in case of sexual transmission, the ABC approach has its own limitations. It fails to address the social aspects of vulnerability to

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621 See UNAIDS, supra note 1, at 122.
HIV/AIDS. Even if an individual picks one of the strategies from the ABC list of options, he/she may not be able to protect himself/herself from HIV infection. The social determinants of vulnerability, such as violence against women, polygamy and poverty render the choices infective, difficult or even impossible.\textsuperscript{626}

The downsides of the ABC approach called for more comprehensive HIV prevention strategies that can deal with the biological, behavioral as well as social factors of HIV vulnerability. The GHPWG has identified the various evidence and rights-based strategies that need to be adopted in order to effectively prevent HIV transmission. It categorized the strategies on the basis of ways of HIV transmission and factors that aggravate vulnerability.\textsuperscript{627} The strategies to be applied to prevent sexual transmission of HIV/AIDS include: behavioral change strategies to avoid risky behaviors, condom use, HIV testing, treatment of sexually transmittable diseases and adult male circumcision. Strategies to prevent blood-borne transmission, among other things, are comprised of: ensuring the availability of clean syringes and needles to injection drug users, guaranteeing the safety of the blood supply and prevention of exposure at health institutions. The interventions recommended to prevent mother-to-child transmission encompass: primary HIV prevention for women of childbearing age, antiretroviral drugs, prevention of unintended pregnancy in HIV positive women, breast feeding alternatives and caesarean delivery. Finally, social strategies to prevent HIV transmission should include: HIV awareness-raising and education; measures to reduce stigma, gender equality and women’s empowerment; involvement of PLWHA and other affected people; provision of antiretroviral therapy (ART) to PLWHA and legal and policy

\textsuperscript{626} Id.
\textsuperscript{627} Global HIV Prevention Working Group, Bringing HIV Prevention to Scale: An Urgent Global Priority 7 (2007). A similar approach is followed to classify various HIV prevention strategies by Condon & Sinha, supra note 73, at 304.
reform to create an enabling environment for HIV prevention, such as decriminalization of sex workers, gays and injection drug users and outlawing discrimination.

The fact that there are several HIV prevention strategies does not mean that countries should adopt all these strategies. National authorities must choose from the menu and prioritize those strategies guided by national and local circumstances. Countries must understand the local particulars of the pandemic and act according to the principle of “know your epidemic, know your response.”

6.3 International Human Rights Standards Governing HIV Prevention

The comprehensive and evidence-based HIV prevention strategies listed above are based on pertinent human rights principles. This section briefly discusses the declarations and resolutions in which States and other actors recognize the importance of realization of human rights to the success of HIV prevention programs. Then, it reviews the specific human rights upon which a RBA to HIV prevention is based.

6.3.1 Declarations and Resolutions

This sub-section is not intended to comprehensively canvass all the declarations and resolutions that recognize the role of the human rights framework in HIV prevention. It is mainly intended to show how the crucial importance of human rights to prevent transmission of HIV/AIDS is recognized by selecting the principal documents.

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One of these important declarations in which Member States of the UN explicitly affirmed the need to use human rights as a tool to prevent HIV transmission is the 2001 Declaration of Commitment on HIV/AIDS. In the Declaration, Member States noted that stigma, silence, discrimination and denial hinder HIV prevention endeavors and hence committed to eradicate them. Furthermore, States underscored that “gender equality and the empowerment of women are fundamental elements in the reduction of the vulnerability of women and girls to HIV/AIDS.” The affirmations and commitments in the 2001 Declaration on HIV/AIDS are reiterated in the 2006 Political Declaration on HIV/AIDS and the 2011 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS. In these declarations, Heads of State and Governments similarly stressed that “the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV/AIDS pandemic, including in the areas of prevention…” Realizing the setbacks that discrimination placed on the success of HIV prevention, the United Nations Commission on Human Rights, on its part, adopted a resolution on discrimination. The resolution clarifies that discrimination on the basis of HIV status is outlawed under human rights law. The Resolution, in particular, affirms that the term “other status” in different human rights conventions must be interpreted in such a way that discrimination on the ground of HIV/AIDS is prohibited.

At the African regional level, Member States have also pledged to implement various strands of a RBA to HIV prevention. In the Abuja Declaration, AU Member States, inter alia, agreed to address gender inequalities, protect the social and reproductive rights of women and ensure

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629 See UN, supra note 8, at para. 16.
630 Id. at para. 13.
631 Id. at para. 14.
632 See 2006 Political Declaration on HIV/AIDS, supra note 13, at para. 11. See also 2011 Political Declaration on HIV/AIDS, supra note 13, at para. 39.
633 See UN Commission on Human Rights Resolution 1996/44, supra note 146.
These commitments are reiterated and expanded in the 2006 Abuja Call wherein States pledged, among other things, to consolidate their efforts of creating an “enabling policy, legal and social environment that promotes human rights particularly for women, youth and children and ensure the protection of people infected with and affected by HIV and AIDS.”

### 6.3.2 Human Rights Foundations of the Right to Have Access to HIV Prevention Services

Though there are several human rights that may serve as a foundation for HIV prevention, the right to health is the most relevant one. Several HIV prevention strategies are designed to realize the right to health. As mentioned in chapter five, the right to health is recognized in various human rights treaties. The authoritative interpretation of the right both in terms of normative content and obligations of Member States is given in General Comment No.14 of the Committee on Economic, Social and Cultural Rights. The Committee expounded the right to health as having four inter-woven elements; namely, availability, accessibility, acceptability and quality. Availability requires the availability of sufficient HIV prevention goods, services and health facilities. The accessibility component of the right to health, inter alia, requires States to ensure that health facilities, goods and services are affordable; within the physical reach of the beneficiaries and accessible to all without discrimination. Acceptability requires that the health facilities, goods and services are in conformity with medical ethics and cultures of the population. The quality element requires HIV prevention goods and services to be “scientifically and medically appropriate and of good quality.”

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634 See Framework Plan of Action for Abuja Declaration, supra note 15.
635 See Abuja Call, supra note 15.
637 See UNAIDS & OHCHR, supra note 19, at para. 144.
The right to education, recognized in several human rights instruments, such as article 26 of the UDHR, article 13 of the ICESCR and article 10 of the CEDAW, is also relevant to HIV prevention. The International Guidelines on HIV/AIDS and Human Rights elaborated how the right to education can be construed in the context of HIV/AIDS. First, the right enables PLWHA to have access to education without discrimination. Second, it gives individuals the right to receive HIV education and imposes obligations on States to ensure HIV prevention education is included in educational curricula and programs.

Moreover, the right to freedom of expression and information in general and the right to seek, receive and impart information in particular, guaranteed under article 19 of the ICCPR and other human rights treaties, gives everyone the right to receive HIV prevention-related information. The right to enjoy the benefits of scientific progress and its applications recognized in article 15 of the ICESCR is also relevant in terms of ensuring access to new scientific developments in the area of HIV prevention as well as care and support. The non-discrimination and the right to equality provisions of various human rights documents, discussed in chapter five, are relevant to HIV prevention as well. The appropriate implementation of the right to non-discrimination on the basis of HIV status and other grounds promotes HIV prevention efforts by decreasing vulnerability to HIV/AIDS and encouraging behavioral change.

It has become increasing clear that women are disproportionally affected by HIV/AIDS partly due to gender-based discrimination, sexual violence and violations of their reproductive rights. Protecting, respecting and fulfilling the social, sexual and reproductive rights of women are important strategies to prevent HIV infection among women. In particular, it is indispensible to

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638 Id. at paras. 136-137.
639 Id. at para. 138.
640 Id. at para. 107.
realize the sexual and reproductive rights of women, eliminate discrimination against women and work hard towards their empowerment. The sexual and reproductive rights of women which are derived from existing rights and which States should realize include the right of women to: control over and decide freely on matters of sexuality; have access to sexual and reproductive healthcare services and have access to information pertaining to sexuality and sexual education.\footnote{WHO, \textit{Official Definitions of Sexual and Reproductive Health and Rights}, 2002, http://www.choiceforyouth.org/information/sexual-and-reproductive-health-and-rights/official-definitions-of-sexual-and-reproductiv (last visited Mar. 14, 2011).} Regarding discrimination against women, CEDAW requires States Parties to abolish discrimination against women in all its forms and to “[t]o take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.”\footnote{See CEDAW, \textit{supra} note 225, at art. 2 (f).} In order to rectify the historical legacy of discrimination against women, it is also equally important to empower women in all aspects of life. From the perspective of HIV prevention, empowerment enables women to keep away from and terminate any relationship or employment that may endanger them with HIV transmission.\footnote{See UNAIDS & OHCHR, \textit{supra} note 19, at para. 113.}

\textbf{6.4 Strategies Applicable to All HIV Prevention Interventions}

While the HIV prevention strategies discussed in the next sections are specifically designed to deal with specific ways of HIV transmission and factors of HIV vulnerability, strategies reviewed in this section are prerequisites to the success of all HIV prevention interventions.

\textbf{6.4.1 Behavioral Change Strategies}

Behavioral factors significantly contribute to HIV infections. As a result, HIV prevention programs must devise behavioral change strategies in the form of awareness-raising and HIV/AIDS basic education. Awareness-raising and HIV/AIDS education are not only important
HIV prevention instruments but also crucial to the success of other HIV interventions. In countries where there is a success in terms of slowing or reversing the momentum of the epidemic, behavioral change strategies played a central role. A recent study conducted in Zimbabwe showed that HIV prevention strategies that combine “mass media and church-based, workplace-based, and other interpersonal communication activities” have brought about behavioral changes, such as reduction of concurrent partnerships and extramarital, commercial and causal sexual relationships that would enable individuals to avoid exposure to HIV/AIDS. Behavioral change strategies that promote safe sex practices can be conducted through a host of channels: the mass media, posters, billboards, brochures, pamphlets, leaflets, workshops, conferences, videos, dramas etc.

Quite a number of laws and policies require Ethiopia to disseminate HIV prevention education as a means of fighting HIV/AIDS. As I have showed above, the obligations of States to ensure HIV prevention education is a corollary to the right to health, education and freedom of information. These rights are also recognized in the FDRE Constitution. Building on these human rights guarantees, States, including Ethiopia, have made a specific commitment to disseminate HIV prevention information, education and communication in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS.

Moreover, the need to disseminate HIV information to the public is stipulated in various HIV/AIDS-related national policies. The 1998 Policy on HIV/AIDS provides that HIV

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645 See Global HIV Prevention Working Group, supra note 623, at 8.
647 See UN, supra note 8, at paras. 52 &53 and 2006 Political Declaration on HIV/AIDS, supra note 13, at para. 22.
information and education via the media and other channels to the public in general and MARPs in particular should be broadened as one strategy of HIV prevention.\textsuperscript{648} Though the new Higher Education Proclamation does not make a specific reference to HIV/AIDS,\textsuperscript{649} the FDRE Constitution and human rights treaties has been adopted by the Ministry of Education to manage and lead the overall response of the education sector. The Policy, envisioned to create AIDS-free education sector and applicable to all private and public learning institutions, has incorporated prevention, mitigation, care and support, mainstreaming HIV/AIDS in the education system and research as its strategic themes.\textsuperscript{650} The HIV prevention methodologies recommended in the Policy are life-skills education and peer learning, establishing and strengthening HIV/AIDS clubs and integrating HIV/AIDS issues in all extracurricular activities.\textsuperscript{651} The Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline incorporates various strategies to prevent HIV/AIDS at workplace including: avoiding stigma and discrimination, offering HIV/AIDS education, adopting and implementing gender sensitive approaches and care, supporting and treating PLWHA.\textsuperscript{652} It does not, however, set out specific behavioral change strategies.

The FHAPCO and MOH have put in place various specific guidelines that can be used by various sectors for social mobilization. One of these guidelines is the Community Conversation Implementation Manual adopted in 2007.\textsuperscript{653} The Manual is meant to ignite and manage community conversations across all localities in the country. The other two guidelines, also

\begin{footnotesize}
\begin{enumerate}
\item See 1998 HIV/AIDS Policy, \textit{supra} note 17.
\item Higher Education Proclamation, Proclamation No. 650/2009, \textit{Federal Negarit Gazeta}, 15\textsuperscript{th} Year No.64.
\item \textit{Id.} at 19.
\item See Civil Service HIV/AIDS Guideline, \textit{supra} note 357.
\end{enumerate}
\end{footnotesize}
adopted in 2007, are the Voluntary Community Anti-HIV/AIDS Promoters Implementation and Training Manual\textsuperscript{654} and HIV Mainstreaming Manual.\textsuperscript{655}

The laws and policies, briefly discussed above, are useless unless they are implemented and bring about the intended outcomes. The success of laws and policies that are intended to change behaviors regarding vulnerability to HIV/AIDS should ultimately be measured against the extent to which people who receive behavioral change information and education have the knowledge to avoid risky behavior. However, there are limited studies that have assessed to what extent HIV prevention information and education have achieved behavioral changes in Ethiopia. It is true that HIV prevalence in Ethiopia has significantly decreased over the past few years. Though it is difficult to create a link between this decline and HIV information and education, one cannot ignore the contribution of behavioral changes strategies. This should not, however, leads us to complacency. A few studies suggest that knowledge on ways of HIV transmission and prevention is still low in different areas and populations in the country. For example, a certain study undertaken by the Global Fund to Fight AIDS, Tuberculosis and Malaria showed that comprehensive knowledge about HIV prevention and transmission is low among women in general and poor, married, rural and uneducated women, in particular.\textsuperscript{656} A recent study conducted in the Negele town of Oromia Region disclosed that, in general, the knowledge of the residents of the town about HIV transmission and prevention means is very low.\textsuperscript{657}

\textsuperscript{655} See Mainstreaming Manual, supra note 105.
\textsuperscript{656} See FHAPCO, supra note 416, at 22.
HIV information and education is a strategy that is implemented by all actors, including governmental organizations, NGOs, community-based organizations (CBOs) and FBOs. In fact, this is the only strategy that is extensively used by all sectors. The various sectors employ a myriad of channels to provide HIV prevention information and education, such as the mass media, posters, billboards, brochures, pamphlets, leaflets, workshops, conferences, social gatherings, youth centers, market places, videos and dramas. It is not possible to review the activities of all sectors and the means used in this section in the interest of time and space. Accordingly, the following sub-sections assess the major devices used by different sectors to provide HIV prevention information and education.

6.4.1.1 The Mass Media

The mass media, including broadcast and print media, is indispensable to providing HIV prevention information and education. The media is the most economical means of conveying HIV prevention message to a larger number of people, especially to those who cannot be or are difficult to be reached through outreach and other ways.658

In Ethiopia, there are three government owned television stations that broadcast in several languages. Moreover, there are at least two radio stations with national coverage and more than 11 FM radio stations. The television and radio stations play a crucial role in disseminating HIV information to the public in areas of stigma and discrimination, use of VCT, PMTCT and ART services and experience sharing among individuals.659 The stations earmark a program or programs of some time in a week. In terms of coverage, only the national radio stations have

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658 See Global HIV Prevention Working Group, supra note 627, at 22.
659 See HAPCO, supra note 51, at 38.
national coverage. The television stations and FM radio have limited coverage, particularly in rural areas.

In addition to the electronic media, the print media is also used in Ethiopia to convey HIV information. There are more than 80 newspapers and magazines that circulate in Ethiopia. Few magazines and newspapers allocate pages or columns to HIV/AIDS matters. Most of them, however, give an event-oriented coverage. There are also certain newspapers exclusively devoted to HIV/AIDS and related matters. Studies indicate that radio transmissions are more effective than television programs and the print media. Like the electronic media or even less, the circulation of the print media is very low in rural areas. As mentioned above, the problem with the print media, also true for the electronic media, is the fact that coverage of HIV/AIDS issues is event-oriented, such as on World AIDS Day and conferences and workshops organized by the Government or “spot news types which had no breadth of coverage.” Moreover, the coverage concentrates on “officials rather than on issues concentrating on analysis and educative type.” Limited access to official documents and lack of guidelines on media coverage of HIV/AIDS-related issues can be added to the problem. Television and radio advertisements on HIV/AIDS prevention almost exclusively concentrate on male condom use without giving equal

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661 *Id.* at 10.
662 *Id.* at 24.
663 One can take Lambadina as an example. It is a newsletter published on a monthly basis both in Amharic and English by the Ethiopian Volunteer Media Professionals Association. The newspaper primarily covers matters pertaining to the HIV/AIDS, STI and youth reproductive health.
665 *Id.* at 24.
666 *Id.* at 25. Certain radios, such as Fana FM and FM 97.1, have regular analytic programs on issues of particular concern pertaining to HIV/AIDS. See interview with Solomon Guangule, HIV/AIDS Program Coordinator at Fana FM (Sep. 14, 2011).
667 *Id.* at 27.
weight to abstinence and faithfulness. This type of advertisement may send a wrong message to the audiences and viewers that they should not even consider abstinence and faithfulness.

6.4.1.2 AIDS Resource Centers

AIDS resource centers at national and regional levels are other ways through which HIV prevention information is transmitted. The main beneficiaries of the services of the AIDS resource centers are the youth, high school and university students, public servants, teachers, institutions, researchers, media professionals, advocacy groups, civil society organizations and development partners. One of the ways through which the centers disseminate HIV Prevention information is through their libraries. Their libraries contain foreign and locally published materials that give diversified information starting from the basic information to complicated issues on HIV/AIDS, sexual transmitted infections (STI), reproductive health and others. The libraries also provide internet services and audiovisual materials to the beneficiaries.

The second way through which AIDS resource centers disseminate HIV information is by using hotlines. The telephone talk lines are available to anyone for free. Beneficiaries can ask questions pertaining to HIV/AIDS to which expert answers are given. For example the National AIDS Resource Center situated in Addis Ababa has two talk lines. Wegen AIDS Talk line provides HIV/AIDS information and counseling for the public. According to the FHAPCO report, 2.4 million calls were received from the public requesting information and counseling on issues of HIV/AIDS, STI and TB in 2009/2010 alone. Fitun Warm-line is dedicated to provide technical assistance to healthcare providers on ART. More than 500 health care workers received

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668 See FHAPCO, supra note 51, at 39; Amhara HPACO, Services of the AIDS Resource Centre, 3(2) Akil: A Biannual Bulletin 21, 21 (2010) and interview with Tsehai Lemma, Behavioral Change and Communication Officer at S/N/N/P/ Health Bureau AIDS Resource Centre (Jun. 9, 2011).
669 See FHAPCO, supra note 51, at 39.
technical advice from this line in 2009/2010 alone.\textsuperscript{670} Aside from their library and talk line services, AIDS resource centers, in partnership with other partners disseminate HIV prevention information using posters and brochures.\textsuperscript{671}

Because AIDS resource centers are concentrated in major urban areas, an overwhelming majority of the people in Ethiopia cannot utilize their services. In SNNP Region, for example, there is only one resource centre at Hawassa (the capital of the Region) and 118 resource centers at High Schools.\textsuperscript{672} This means individuals outside the capital and other people in other rural and urban areas who cannot use the centers at high schools cannot benefit from the services of the resource centers. In Amhara Region, there are only three AIDS Resource Centers located in Bahir Dar, Dessie and Gondar.\textsuperscript{673} Even where AIDS resource centers are available, they may not provide all the services they are meant to provide.\textsuperscript{674}

\textbf{6.4.1.3 Other Behavioral Change Strategies}

Behavior change strategies that can benefit people who otherwise cannot benefit from the services of mass media and AIDS resource centers or at least complement their roles are also designed and implemented in Ethiopia. The main ones are discussed below.

\textbf{a. In-School HIV Information and Education}

Schools are preferable areas for children and adolescents in terms of protecting them from HIV infection.\textsuperscript{675} Children and adolescents who do not attend basic education are more than two times

\textsuperscript{670}Id.
\textsuperscript{671}See FHAPCO, supra note 50, at 10.
\textsuperscript{672}See Lemma, supra note 668.
\textsuperscript{673}See Fekade, supra note 607.
\textsuperscript{674}See Lemma, supra note 668.
\textsuperscript{675}Mohini Venkatesh, Indicators for Education Sector HIV Response Programs: A Review of Existing Resources 10 (2009).
vulnerable to HIV infection. In addition to increasing the psychological maturity of students, education in schools in general and HIV education in particular assists them to protect themselves from HIV infection.

The education sector in Ethiopia is a sector where 24% of the country’s population is contained. According to data emanating the Ministry of Education, the education sector has 17,413,176 students, 314,524 teachers and more than 80,000 supporting staff. Given these large figures in the education sector, any strategy that does not address HIV prevention in schools cannot bring about the required goal of reducing HIV prevalence in Ethiopia. Cognizant of this fact, the Ethiopian Government devised specific strategies for prevention of HIV/AIDS in schools. The behavioral change HIV prevention strategies adopted and implemented are composed of: curricular and non-curricular peer and life-skills education, school community conversation, providing pre-service and in-service training to teachers on how to control HIV/AIDS in schools, anti-AIDS clubs, media clubs and dramas.

The Education Sector Policy and Strategy on HIV and AIDS requires schools at different levels to mainstream HIV/AIDS information, knowledge, skills, and attitudes into the school curricula, educational materials and research. To that end, the Policy requires learning institutions to review, adapt, develop and integrate HIV and AIDS-related information into formal school curricula and programs. It also requires the training of educators and students on the implementation of curriculum-based HIV/AIDS education. Though not clearly provided in the Policy, it is understandable that the curricula should be prepared or revised taking into account

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676 Donald Bundy et al., Accelerating the Education Sector Response to HIV: Five Years of Experience from Sub-Saharan Africa 1 (2010).
677 See Ministry of Education, supra note 650, at 3.
678 See SPM II, supra note 17, at 38.
grade and age levels.\textsuperscript{679} The HIV prevention methodologies recommended in the Policy are life-skills education and peer learning for which the Policy requires schools to prepare guidelines.\textsuperscript{680}

In practice, a study conducted in higher education institutions in 2008 found that higher education institutions have not incorporated HIV and AIDS issues in their curricula and research priorities with the exception of faculties of health and medicine. The research attributed the failure to the chronic problem of centralization of curriculum development and the “slow process of revision of curricula to make them relevant.”\textsuperscript{681} The problems identified in this study are also reiterated by a report presented by the Ministry of Education at the Mekelle Workshop and in an interview with a key informant in the Ministry of Education.\textsuperscript{682} Contrary to the situation in higher education institutions, mainstreaming of HIV/AIDS is done better in primary and high schools’ curricula primarily in science, biology, civics and ethical education courses.\textsuperscript{683}

Various reports and studies have confirmed that a lot of tasks have been undertaken to provide HIV information and education in schools outside of the formal curriculum. School community conversations and peer education have been undertaken in all regions; anti-AIDS clubs have been established and strengthened in Amhara, Oromia, Somali, SNNP, Harari regions and Dire Dawa City Administration; awareness-raising trainings have been provided to freshman students in different universities; weekly talk show programs and dialogues among students on HIV-

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\textsuperscript{679} See Venkatesh, \textit{supra} note 675, at 27.
\textsuperscript{680} See Ministry of Education, \textit{supra} note 650, at 19.
\textsuperscript{682} Taken from presentation by experts of the Ministry of Education entitled “HIV Response in the Education Sector with Particular Emphasis on Higher Education” at the Mekelle Workshop [hereinafter Presentation by Experts of Ministry of Education].
\textsuperscript{683} Interview with Damena Lemma, HIV/AIDS Mainstreaming Senior Expert at Ministry of Education (Jul. 21, 2011) and Tesfaye Sahle, HIV Mainstreaming Core Process Owner at SNNP Region Education Bureau (Jun. 17, 2011).
related issues have been organized and billboards have been prepared and displayed on certain universities.\textsuperscript{684} According to the 2009/2010 Government Report, a total of 957,164 students and teachers were trained on life skills education; more than 90\% of the schools undertook school community conversations and training to members of anti-AIDS clubs on life skill were offered.\textsuperscript{685} Another study emanating from non-government sources indicate that anti-AIDS clubs sponsored by certain NGOs are the “focal points for spearheading piecemeal HIV/AIDS activities.”\textsuperscript{686} However, anti-AIDS clubs are unable to fully utilize their potentials due to “lack of management attention to the units, limited leadership capacities owing to absence of training, inadequate training and allocation of financial resources and facilities.”\textsuperscript{687} The limited extra-curricular HIV prevention activities are carried out by government educational institutions. Private educational institutions have paid no attention to HIV/AIDS issues and there are no monitoring and evaluation mechanisms to oversee what they are doing and what they are not.\textsuperscript{688}

b. Voluntary Community Anti-HIV/AIDS Promoters and Health Extension Workers

In developing countries like Ethiopia, not all people have access to the media. Consequently, innovative strategies need to be designed to provide HIV information and education at the community and grass-root levels. Of these strategies, utilization of voluntary community anti-HIV/AIDS promoters and health extension workers and conducting community conversations are the main ones.

\textsuperscript{684} See Findings of Joint Supervision, supra note 340 and Presentation by Experts of Ministry of Education, supra note 682.

\textsuperscript{685} See FHAPCO, supra note 50, at 8.

\textsuperscript{686} See Hialegebril, supra note 681, at 3.

\textsuperscript{687} Id.

\textsuperscript{688} See Lemma, supra note 683.
Voluntary community anti-HIV/AIDS promoters are individuals selected and trained, among other things, to provide door-to-door anti-HIV education to their families, neighbors and community about HIV/AIDS without payment.689 More specifically, voluntary community anti-HIV/AIDS promoters are expected to educate about how to prevent HIV/AIDS, the need to abolish HTPs that exacerbate HIV infection, the unwanted ramifications of stigma and discrimination, HIV treatment adherence and the importance of HIV testing. They are also expected to manage care and support activities to PLWHA, work in close collaboration with extension workers and set up AIDS resource centers.690 Voluntary community anti-HIV/AIDS promoters are selected from members of the communities who are also elected as models in implementing health extension programs and based on proximity of houses in the village.691

Unlike voluntary community anti-HIV/AIDS promoters, health extension workers are government employees assigned by the government to each locality. According to a report from the MOH, currently, there are 34,382 health extension workers working in all rural and urban areas. The health extension workers are in charge of the implementation of 16 packages of health extension programs. The specific activities they are mandated to carry out include: data collection; provision of education on HIV/AIDS, other related diseases, HTPs and family planning to PLWHA; encouragement of women to utilize health facilities for delivery; advise mothers on infant feeding options and provision of support and care services to those directly or indirectly affected by HIV/AIDS.692 Since health extension workers are overloaded with 16

689 See FHAPCO & MOH, supra note 654, at para. 2.1.
690 Id. at para 5.2.
691 Id. at para. 6.2.2.
692 Taken from presentation by experts of the Ministry of Health entitled “[t]he Role of Health Extension Workers in the Implementation of HIV Services” at the Mekelle Workshop.
health extension packages, there are concerns that they may not give sufficient attention to HIV/AIDS prevention education.\footnote{This concern was raised at the Mekelle Workshop, supra note 340.}

c. Community Conversations

According to the Community Conversation Implementation Manual, community conversation is a “process in which the community uses its own resources, knowledge and helpful practices to prevent and control HIV/AIDS and curve the social crises imposed as a result of the epidemic.”\footnote{FHAPCO & WHO, supra note 653, at para. 2.1.} Put differently, it is a process through which members of the community come together and discuss HIV/AIDS issues and then respond accordingly. Because community conversations engage local communities, they are important tools to eliminate societal prejudices and HTPs that exacerbate vulnerability to HIV/AIDS. Community conversations may take place in various settings including villages, schools, workplaces and correctional settings. They are managed using the existing institutions and structures, such as \textit{kebele} (local) administrations, government institutions, FBOs, women and youth associations, \textit{Idirs} (funeral associations) and associations of PLWHA.\footnote{See Social Mobilization Guideline, supra note 104, at para. 3.1 (2007).} Community Conversations are facilitated by health extension workers, agriculture extension workers, school teachers and others who are selected from the community.\footnote{\textit{Id.} at para. 6.2.}

The 2009/2010 report of the FHAPCO shows that community conversation was conducted in 89.3\% of the \textit{Kebeles} across the country. According to the report, Amhara Region and Addis Ababa City administration are among the regions that were able to conduct community
conversations in all Kebeles. Studies, nevertheless, cast a shadow on the continuity of community conversation pointing out that the facilitators are overburdened by other responsibilities and the program is fraught with problems of insufficient training of facilitators and inadequate supportive supervision.

A study conducted by researchers from Bahir Dar University in mid 2010 in all zones of Amhara Region has identified the strengths and weaknesses of community conversations. According to the study, community conversation has resulted in increasing people’s knowledge and attitude towards HIV and its transmission; reducing many of the traditional practices such as milk teeth removal, sharing needles and blades and concurrent and informal sexual partners; enhancing a culture of openness among members of the community about HIV-related issues; reducing stigmatization and discrimination against HIV patients and increasing voluntarism for HIV testing and use of condoms. The weaknesses identified include: lack of regular supervision and refresher training for facilitators; lack of continuity in the activities of community members after they graduated and lack of ownership and synergy among various NGOs and governmental organizations that work on community conversation.

6.4.2 Strengthening Surveillance Systems and Research

As discussed above, ways of HIV transmission and drivers of the epidemic are not the same everywhere. Consequently, countries need to implement HIV prevention strategies that are specifically designed to address the various means of HIV transmission and factors of

697 See FHAPCO, supra note 50, at 7.
698 See FHAPCO, supra note 656, at 38.
699 Taken from presentation by Molla Gedefaw et al., A Research Team from Bahir Dar University, entitled “Implementation Process and Outcomes of Community Conversation in Amhara National Regional State”, Presented at the Bahir Dar Workshop, supra note 576.
vulnerability.\textsuperscript{700} Doing so, however, requires the availability of reliable data for policy makers and program designers concerning the rate of infection of MARPs and the general population and the factors that fuel the epidemic.\textsuperscript{701} The main sources of information are research, surveillance and reports.\textsuperscript{702}

Realizing the crucial importance of information for effective HIV prevention, the 1998 Policy on HIV/AIDS provides for scaling up of the HIV/AIDS surveillance system.\textsuperscript{703} Moreover, the Policy intends to promote research on HIV prevention and other related issues.\textsuperscript{704} As part of monitoring and evaluation of the multi-sectoral response, SPM II requires sectors to report their performance in response to HIV/AIDS.\textsuperscript{705} Thus, at the policy level, the major ways through which HIV-related information should be gathered are included. In practice, lack of reliable, quality and up-to-date data on HIV/AIDS is a critical problem in Ethiopia.\textsuperscript{706} Most of the data included are based on studies and surveillance conducted many years ago. There is also little attention paid to research on HIV/AIDS.\textsuperscript{707} The challenges pertaining to the weak information system include: lack of trained and experienced staff, lack of a more advanced HIV information system and the insufficiency of the monitoring and evaluation system outside of health facilities.\textsuperscript{708}

\textsuperscript{700} See SPM II, supra note 17, at 35.
\textsuperscript{703} See 1998 HIV/AIDS Policy, supra note 17, at para. 5.4.
\textsuperscript{704} Id. at para. 7.1.
\textsuperscript{705} See FHAPCO, supra note 17, at 72.
\textsuperscript{706} Closing speech by Betiru Tekle, Bahir Dar Workshop, supra note 576 and Fekade, supra note 607.
\textsuperscript{707} See Berhane et al., supra note 46, at 50.
\textsuperscript{708} See FHAPCO, supra note 17, at 25.
To rectify reporting problems in the non-clinical aspect of the response to HIV/AIDS, the FHAPCO in collaboration with partners has developed the Community Information System (CIS) Guideline which is currently in the pilot phase of implementation in 20 districts in the country.\footnote{Interview with Netsanet Haniko, Monitoring and Evaluation Performer at FHAPCO (Jul. 25, 2011).} The CIS Guidelines seek to: standardize the reporting system at all levels and among partners; simplify the procedures for reporting HIV/AIDS activities by providing new reporting tools and a reference guideline; guide users on the correct way of filling out the reporting formats, registry, and tally sheets and alleviate the coordination problem at the woreda (district) level.\footnote{Taken from presentation by experts of FHAPCO entitled “HIV/AIDS Community Information System for Non-Clinical Multi-Sectoral Response: An Overview” at the Adama Workshop, \textit{supra} note 55.} The Guidelines also exhaustively outline where the report of each organization operating at different levels and interventions should be submitted.\footnote{\textit{Id.}}

6.4.3 Strengthening Health Systems

One of the defining features of developing countries is the existence of weak health systems. Weak health systems affect HIV prevention in a number of ways, such as by undermining HIV testing, STI treatment and provision of diverse HIV prevention goods and service; increasing the occurrence of occupational exposure to HIV in health care centers and compelling health care workers to reuse injecting syringes.\footnote{See Global HIV Prevention Working Group, \textit{supra} note 627, at 16.} To the contrary, a strong health system facilitates HIV prevention efforts.

In Ethiopia, a lot of tasks have been undertaken to expand the coverage of health centers and to build their capacities. More specifically, the number of health centers have been expanded and equipped and training of healthcare workers have been undertaken.\footnote{See FHAPCO, \textit{supra} note 416, at 31-34 and FHAPCO, \textit{supra} note 17, at 22.} However, the health
system in Ethiopia is still fraught with several problems including lack of trained health workers
due to high staff turnover and shortages of drugs and medical equipment for both OIs and
STIs.714 In order to solve these problems, SPM II plans to improve the medical equipment and
drug supplies of health centres, equip health facilities with trained health professionals and build
the overall capacity of health centers.715

6.5 Strategies to Prevent Sexual Transmission of HIV/AIDS

6.5.1 Prevention, Early Diagnosis and Treatment of STIs

Little is known about the prevalence of STIs in Ethiopia except for syphilis whose adult
prevalence is estimated to be 1.8 %.716 It is well documented that STIs increase HIV risk by at
least two to five times.717 STIs aggravate vulnerability to HIV infection by “increas[ing] HIV
shedding in the genital tract”…and “recruit[ing] HIV susceptible inflammatory cells to the
genital tract and disrupt[ing] mucosal barriers to infection”.718 That is why the GHPWG
recommends that countries incorporate and implement STI prevention, early diagnosis and
treatment as one of the HIV prevention strategies.719 The National HIV/AIDS Policy of Ethiopia
has recognized prevention and control of STIs as one of the strategies that should be
implemented to prevent and control HIV/AIDS. The Policy states that the measures to be taken
to manage and control STIs are risk reduction education and counseling of patients, condom
instruction, providing quality and effective STI services and development and promotion of

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714 See FHAPCO, supra note 416, at 34.
715 See FHAPCO, supra note 17, at 47.
716 Taken from presentation of experts of MOH entitled “TB/HIV, STI and PITC Implementation Status in Ethiopia”
at the Bahir Dar Workshop, supra note 576 [hereinafter MOH Presentation].
717 See Global HIV Prevention Working Group, supra note 610, at 10. See also Albertus Voetberg, The Evolution of
HIV/AIDS Programs: Recent and Ongoing Developments in Selected Areas, in The Changing HIV/AIDS
Landscape: Selected Papers for the World Bank’s Agenda for Action in Africa, 2007-2011 33 (Elizabeth L. Lule et
al., eds., 2009).
718 Sevgi O. Aral & Thomas A. Peterman, STD Diagnosis and Treatment as an HIV Prevention Strategy, in Beyond
719 See Global HIV Prevention Working Group, supra note 610, at 10.

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standardized treatment guidelines.\textsuperscript{720} In 2001, MOH has prepared a National Guideline for the Management of Sexually Transmitted Infections.\textsuperscript{721}

Controlling and managing STIs is one of the components of HIV prevention that is poorly implemented in Ethiopia. Admitting that the provision of STI services is inadequate, the 2009/2010 Government report indicated that a total of 86,648 people were diagnosed and benefited from STI treatment.\textsuperscript{722} Research done by the Centre for Disease Control (CDC) and the EPHA named several challenges to the management and control of STIs including insufficiency of STI guidelines, poor facilities for diagnosis and treatment, lack of adequate training of health workers, fear of stigma, breach of confidentiality and long waiting times.\textsuperscript{723} A 2010 study also confirmed that provision of STI services remains a challenge in all regions to date.\textsuperscript{724} A report of the MOH on the implementation status of STI management and control identified high turnover of trained staff, inadequate and irregular drug supply, problems with partner notification and management, a preference for alternative health care service- usually with poor quality, reluctance to follow safe sex practices, the social stigma often attached to STIs, failure to take full prescribed course of treatment, lack of supervision, weak monitoring and evaluation system, understatement of STIs statistics and the failure of the current guideline to address effective management of STIs in specific risk groups like commercial women sex workers. The solutions suggested to overcome the problems are promoting syndromic management of STIs, regular and adequate supply of STI drugs, condoms and other supplies, onsite trainings on syndromic STI management, improving monitoring and evaluation systems, encouraging standardized STI

\begin{footnotes}
\item[720] See 1998 HIV/AIDS Policy, \textit{supra} note 17, at paras. 2.1-2.3.
\item[722] See FHAPCO, \textit{supra} note 50, at 13. See also FHAPCO, \textit{supra} note 51, at 62.
\item[723] CDC & EPHA, Targeted Evaluation of Barriers to STI Partner Management in Ethiopia (March 2006).
\item[724] See Findings of Joint Supervision, \textit{supra} note 340.
\end{footnotes}
service delivery by the private and informal sectors, providing special services for people at high risk and revising the STI national guideline.\textsuperscript{725}

6.5.2 Provision of Essential HIV Prevention Commodities

There are certain commodities whose proper application may significantly reduce HIV transmission. Some of these commodities serve as physical barriers against exposure (male and female condoms) while others reduce HIV transmission through chemical reaction (microbicides).

Studies disclosed that the proper and consistent use of male condoms prevents HIV transmission by approximately by 85%.\textsuperscript{726} Thus, ensuring the wide availability and accessibility of quality and affordable condoms to the general population in general and MARPs in particular is one of the strategies to be implemented. Female condoms give extra-protection to women in all situations where negotiating of male condoms is difficult.\textsuperscript{727} Microbicides are chemical substances that may be applied to the vagina or rectum to prevent HIV infection through chemical reaction.\textsuperscript{728} The ways in which microbicides reduce HIV and STI infection is not uniform: they may “kill or inactivate the virus, inhibit viral entry, or reduce viral replication.”\textsuperscript{729} A new generation of microbicide gels, namely, vaginal gel is proved to reduce HIV infection by 39%.\textsuperscript{730}

\textsuperscript{725} See MOH Presentation, supra note 716.
\textsuperscript{726} S. D. Pinkerton & P.R. Abramson, Effectiveness of Condoms in Preventing HIV Transmission, 44 (9) Social Science & Medicine 1303, 1303-1312 (1997). See also Gable et al., supra note 477, at 34.
\textsuperscript{727} See Voetberg, supra note 717, at 38.
The 1998 Policy on HIV/AIDS mentions practicing safe sex practices in general and condom use in particular as one way of preventing and controlling HIV/AIDS. The Policy, however, does not mention microbicides. Moreover, reports of performance of the Ethiopian Government and other stakeholders only highlight what has been done regarding male condom distribution.

A 2009/2010 Government report showed that an overall 127 million condoms were distributed in the country and the report mentioned that condom distribution is showing a mounting trend. The problem with this report is that it does not tell us to what extent the distributed condoms are actually used. There is no comprehensive study conducted in this area. According to the 2010 UNAIDS Global HIV/AIDS Report, condom use in Ethiopia is one of the lowest in the world with the rate of not more than 20%. Several reasons can be raised for the low consumption of condoms in Ethiopia. One study showed that one of the reasons for low condom use is cultural and religious taboos attached to condom promotion and use. Another study conducted in Ethiopia among government employees in Addis Ababa indicated that low educational status, substance use and trust in the partner are among the barriers to condom use. There are no reports and studies in Ethiopia regarding the distribution and utilization of microbicides. Though the female condom is the preferable way of preventing HIV infection among women in certain situations, it is not available in the market in Ethiopia. Key informants told to the researcher that lack of demand and advertisement, the fact that it is too expensive, cultural problems and

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732 See FHAPCO, supra note 50, at 12.
733 See UNAIDS, supra note 1, at 70.
734 See Findings of Joint Supervision, supra note 340.
736 See Tesfu, supra note 575 and Endeshaw W/Senbet, Behavior Change and Communication Senior Expert at FHAPCO (Jul.13, 2011).
complications in its application are the challenges that hinder the availability and utilization of female condoms.\textsuperscript{737}

6.5.3 Male Circumcision

Male circumcision, removal of the foreskin of the penis, has been practiced for more than thousands of years on cultural and religious grounds. Quite recently, studies have revealed that there is a low rate of HIV/AIDS prevalence in countries where male circumcision rate is high. Several studies proved that male circumcision carried out by trained healthcare professionals significantly reduce vulnerability to HIV infection.\textsuperscript{738} Male circumcision lessens risk to HIV infection “because the mucosal surface of the foreskin of the penis contains Langerhans cells that are highly susceptible to HIV infection” and the removal of the foreskin reduces this susceptibility.\textsuperscript{739}

No mention was made about male circumcision as a prevention strategy in the 1998 Policy on HIV/AIDS of Ethiopia. It is, nevertheless, incorporated in the SPM II. SPM II mentions that, with the exception of Gambella and SNNP regions, male circumcision is universal in most parts of Ethiopia and it goes on to state that there is a plan to speed up the practice in areas where rate of circumcision is low.\textsuperscript{740} It, in particular, plans to provide training to health workers on male circumcision, ensure the availability of circumcision kits and provide safe circumcision.\textsuperscript{741}

\textsuperscript{737} \textit{Id.}
\textsuperscript{738} \textit{See Gable et al., supra note 477, at 38.}
\textsuperscript{739} \textit{See Global HIV Prevention Working Group, supra 728, at 8.}
\textsuperscript{740} \textit{See FHAPCO, supra note 17, at 39.}
\textsuperscript{741} \textit{Id. at 62.}
6.5.4 Criminalization of HIV Transmission and Sexual Violence

The criminal law is meant to safeguard the public from dangerous conduct that threatens life, health, property etc. It does so by preventing the commission of crimes and punishing criminals. One of the purposes of criminal punishment is to deter the commission of further crimes. Because intentional transmission of communicable diseases affects the life and health of the victims, the act is a crime in almost all countries.\footnote{See Gable et al., \textit{supra} note 477, at 38.} Being a communicable disease and due to the disproportionate morbidity and premature mortality in the aftermath of HIV infection compared to other communicable diseases, some jurisdictions have adopted specific legislation for criminalization of HIV transmission.\footnote{\textit{Id}.} UNAIDS is against the adoption of specific legislation to criminalize HIV transmission and calls for the application of the general criminal law.\footnote{UNAIDS, \textit{Policy Brief: Criminalization of HIV Transmission}, 2008, 1, http://data.unaids.org/pub/basedocument/2008/20080731_jc1513_policy_criminalization_en.pdf (last visited Apr. 21, 2011).} UNAIDS claims that specific criminal laws that criminalize intentional exposure may negatively affect the uptake of HIV testing and, in so doing, create a setback to the overall HIV prevention endeavors.\footnote{\textit{Id}.} Moreover, UNAIDS recommends that States confine themselves to criminalizing only intentional HIV transmission “i.e. where a person knows his or her HIV positive status, acts with the intention to transmit HIV, and does in fact transmit it.”\footnote{\textit{Id}.} UNAIDS takes a position that punishing HIV transmission in the absence of criminal intent opens a door for judges to take in to account irrelevant factors, such as prejudices against marginalized groups, to determine whether the crime is committed recklessly.\footnote{Rudolf V. Van Puymbroeck, \textit{Beyond Sex: Legal Reform for HIV/AIDS and Poverty Reduction}, 15 Georgetown Journal on Poverty Law and Policy 781, 798 (2008).} It will be difficult for me to subscribe to the latter position. First of all, while it is true that judges may be influenced by irrelevant factors, it is also true that there are other factors that should be taken into account when determining whether a crime has been committed. Therefore, I believe that the position taken by UNAIDS is the more prudent one.
factors in passing judgments, it is unacceptable to attribute this to all judges. Second, in cases where judges abuse their power and decide contrary to what the law says, there are review mechanisms to correct mistakes committed by judges. For these reasons, I would say that negligent transmission of HIV transmission should be criminalized as well.

The need to criminalize intentional HIV exposure as a prevention strategy is not incorporated in the 1998 Policy on HIV/AIDS in Ethiopia. Nor is it given a place in the HIV/AIDS multi-sectoral strategic plans. This does not, however, mean that there is no law that is applicable to criminalize transmission of HIV. Article 514 of the 2005 Criminal Code of Ethiopia which criminalizes spreading of human diseases is relevant. Sub-article (1) of this provision provides that “[w]hoever intentionally spreads or transmits a communicable human disease, is punishable with rigorous imprisonment not exceeding ten years.” The punishment is harsher where the offender spread a disease that can cause grave injury or death or where the criminal commit an offence that can “cause grave injury or death, out of hatred or envy, with malice or with a base motive.” Intentional conduct is inferred from the situation of commission of the crime. The Criminal Code also penalizes negligent transmission of communicable disease even if the penalty is less harsh. This, in effect, means that both intentional and negligent transmissions of HIV/AIDS are punishable.

The crime of spreading HIV/AIDS, predominately committed in sexual relationships, may arise from consensual or non-consensual relationships. In cases where transmission of HIV/AIDS happens in non-consensual sexual relationships, the offender is punished for the sexual violence offences on top of transmitting HIV/AIDS. The Criminal Code, in article 620, penalizes rape

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748 See Criminal Code, supra note 516, at art. 514 (2).
749 See Admasu, supra note 596.
750 See Criminal Code, supra note 516, at art. 514(3).
“with rigorous imprisonment from five years to fifteen years.” The punishment increases depending on age, the relationship between the offender and the victim, the dangerous disposition of the offender and other aggravating grounds.751 One of defining element for the act to constitute rape is its occurrence outside marriage. From this, it must be clear that the criminal law of Ethiopia does not sanction marital rape. The issue of marital rape is discussed as a gap in the legal framework in section eight of this dissertation.

Since rape is a serious sexual offence as well as one of the causes of HIV infection among women, it has received a special attention from the Government of Ethiopia. Accordingly, the Ministry of Justice has established special units for the investigation and prosecution of rape at all its branches.752 These kinds of special units are not, however, set up in Amhara and SNNP regions.753 In these regions, the investigation and prosecution of rape is carried out by the existing regular prosecution offices.

There are several cases that have been entertained by Ethiopian courts involving rape and intentional transmission of HIV, most of which are still pending. I have reviewed two of these cases due to their higher educational value. In the Public Prosecutor v. Getye Betru, a case decided by Bhair Dar City District Court in Amhara Region,754 the defendant was initially charged with the crime of raping his domestic servant, namely, Yeshimebet Mekuria. Following the admission of the accused of his positive HIV status, the prosecutor amended his charge and

751 Id. at 620.
753 Interview with Nuru Mohammed, HIV/AIDS Focal Person at Amhara Region Women, Children and Youth Affairs (Jun. 16, 2011) and Zewedu Lemma, Advocates and Civil Associations Licensing, Registration and Supervision Prosecutor at S/N/N/P/ Region Justice Bureau (Jun. 8, 2011).
indicted the offender for rape and intentional transmission of HIV. The District Court, after examining the facts and evidence produced on both sides, convicted and sentenced the defendant on both counts for the overall 15 years of rigorous imprisonment.

There are two points worth commenting on about the decision of this Court. First, in holding that the accused had committed the crime of transmitting HIV to the victim, the Court argued that, though medical evidence confirmed that she was HIV positive owing to the window period, there is not any reason why the virus would not be transmitted to the victim in the aftermath of rape. The Court’s argument implies that in all cases where rape is perpetrated, the victim of the crime will be infected with HIV/AIDS. This is a flawed argument, however. It is erroneous to say that the victims of rape are also victims of crime of intentional transmission of HIV/AIDS in the absence of clear medical evidence confirming the virus is actually transmitted. It is precisely for this reason the Western Gojam High Court reversed the decision of the lower court. Though sexual intercourse is a major way of transmission of HIV/AIDS in Ethiopia, this does not necessarily mean every sexual contact would result in transmission of the virus from the man to the woman. The risk of HIV transmission reduces where sexual intercourse takes place in situations where the man has low viral load, is not infected with STIs, is circumcised or adheres to ART.755

Second, even in the presence of medical evidence showing the virus is transmitted to the victim, it is difficult to conclude that the accused committed the crime intentionally. This is something even the appellate court failed to scrutinize. The fact that the offender knows his positive HIV

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status and he raped the woman is not sufficient in itself to conclude that he intended to transmit the virus. The Prosecutor must prove, beyond a reasonable doubt, that the offender has a specific intent to transmit the virus. In the absence of this, the defendant would be responsible for negligent commission of the crime given that there is medical evidence showing that the virus was actually transmitted to the victim.

There are cases where the intention to transmit the virus is clear. In Public Prosecutor v. Abdulkadir Yasin Case, the offender was convicted of intentional transmission of HIV/AIDS. In the facts of the case, it is indicated that the criminal paid a sum of money to Mulu Gobu to have sex with him. Though they agreed to have sex with a condom, the victim testified and other evidences showed that he tore the end of the condom two times. This act is a clear indication of the intention of the offender to transmit the virus to the victim.

6.5.5 Paying Special Attention to MARPs

There are some behaviors and factors that may put individuals at greatest risk of infection, such as unsafe sexual relationship including concurrent or multiple sexual relationships; use of contaminated needles and syringes; individual problems pertaining to lack of awareness on how to avoid infection; problems relating to lack of availability, accessibility or quality of HIV prevention goods and services and structural factors, such as poverty, discrimination, cultural and religious factors. Whether it is due to individual risky behavior or other factors that exacerbate vulnerability, there are certain categories of people who are more at risk of HIV infection. These categories of people are also referred to MARPs. UNAIDS and studies in

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756 See Public Prosecutor v. Abdulkadir Yasin, supra note 600.
757 See UNAIDS, supra note 702, at 4.
several countries identify FSWs, clients of FSWs, injecting drug users (IDUs), and MSM as MARPs for the reasons mentioned above.\textsuperscript{758}

In generalized epidemics, in particular, MARPs have a great potential to infect the general population. Consequently, any HIV intervention should give special attention to MARPs. As the UNAIDS pointed out, this calls for States to identify MARPs, designate specific HIV prevention interventions that are tailored towards each MARP and effectively implement the identified HIV intervention programs for each MARP.\textsuperscript{759}

There are no up-to-date studies conducted to identify MARPs in Ethiopia. Some past studies and reports showed that commercial FSWs, long-distance truck drivers, mobile merchants, mobile agricultural workers and construction workers, college and university students, residents in tourist destination areas, members of uniformed services and MSM are MARPs in the country.\textsuperscript{760}

The problem of high vulnerability of students is attributed to transactional sex, stimulant (\textit{khat} and \textit{shisha}) and alcohol use, violence against female students by teachers and students, lack of strict campus rules and recreational centers in the university campuses.\textsuperscript{761} The lack of stipends as well as dormitory services for technical and vocational colleges students attending education centers outside their hometown have also contributed to more vulnerability. Owing to financial problems, these students have been compelled to rent and live in small houses in groups of 10-15 female and male students.\textsuperscript{762} FSWs include not only those engaged in commercial sex work in brothels but also those who are street-based as well as those who are involved in transactional

\textsuperscript{758} See UNAIDS, supra note 45, at 19.
\textsuperscript{759} See UNAIDS, supra note 702, at 4.
\textsuperscript{760} Amhara HAPCO et al., \textit{Most-at-Risk Population and Prevention Strategies, in Akiit}: Biannual Bulletin 57 (Amhara HAPCO, 2009); FHAPCO, supra note 416 and FHAPCO, supra note 51, at 14.
\textsuperscript{761} See FHAPCO, supra note 416, at 23 and Bahir Dar Workshop, supra note 576.
\textsuperscript{762} See FHAPCO, supra note 416, at 25.
sex. The main reasons for sex work in Ethiopia and elsewhere are violence, trafficking and poverty. Clients of sex workers come from different sectors of the society which encompass truck and long-range bus drivers, traders, civil servants, daily laborers and the unemployed. Mobile agricultural workers and construction workers including daily laborers are more vulnerable to HIV infection due to expansion of sex work around big industrial and construction sites. Because the workers are not living with their wives and partners, they opt for visiting commercial sex workers around the project areas.

So far, the legal and policy framework in Ethiopia is inadequate to address HIV among MARPs for the following reasons. First of all, none of these MARPs listed above are represented either in the NHAPCC or NPF. This greatly hinders them from realizing their right to participation in matters affecting their lives. More specifically, the lack of representation in these organs excludes MARPs from taking part in the preparation and evaluation of policies and plans on HIV/AIDS. Second, same sex sexual relationships are crimes in the Criminal Code punishable with simple imprisonment. Criminalization of homosexuality, apart from being discrimination based on sexual orientation, makes it impossible to designate HIV prevention to these target groups. Third, though decriminalization and regulation of sex work is one step to prevent HIV among commercial sex workers and their clients, there are no rules that regulate the licensing and operation of commercial sex workers in Ethiopia. To the contrary, though not implemented in practice, “prostitution” is a petty offence punishable with fine or arrest not exceeding a month.

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763 See UNAIDS, supra note 45, at 20.
764 See FHAPCO, supra note 51, at 16-17.
765 See Criminal Code, supra note 516, at art. 629.
766 See UNAIDS & OHCHR, supra note 19, at para. 21(c).
where the act “is a nuisance to the occupants of the dwelling or the inhabitants of the neighborhood.”

Even if the National Policy on HIV/AIDS requires implementers of the policy to give priority to MARPs, such as sex workers and their clients, long distance truck drivers, street children and military personnel, it does not set forth strategies to combat HIV/AIDS among these groups. Though college and university students and mobile workers are identified as MARP, neither the Education Sector Policy and Strategy on HIV/AIDS nor the Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline provide for specific HIV prevention strategies for these groups.

The predecessor of SPM II, the Ethiopian Strategic Plan for Intensifying Multi-sectoral HIV/AIDS Response for 2004-2008, incorporated special attention to MARP as one the strategic issues. However, it did not specify prevention strategies that take in to account their factors of vulnerability. It simply lists a bunch of strategies lumped together without indicating which strategy targets which MPRP. SPM II, pinpointing the need to develop HIV prevention strategies taking into account the specific situation of each MARP, leaves the details for regional states. So far, it is the 2009 study undertaken jointly by Amhara Region HAPCO, Amhara Region Health Bureau, EPHA and CDC-Ethiopia that identified specific prevention strategies for each MARP. While the study is groundbreaking in terms of recommending comprehensive

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767 See Criminal Code, supra note 516, at art. 846. Apart from the “prostitutes” themselves, anyone who benefits from the prostitution and let others use their brothel for prostitution is punishable under art. 634 of the Criminal Code.
768 SPM, supra note 45, at 11.
769 Id. at 16.
770 See FHAPCO, supra note 17, at 36.
771 See Amhara HAPCO, Supra note 760, at 59-65.
HIV prevention packages for each MARP, its recommendations are not adopted and incorporated in strategic plans including SPM II.

The absence of a comprehensive policy that provides for a package of HIV prevention for MARPs gives some clue on the weak status of intervention in this area. Even if a lot has been done to prevent HIV among the general population, targeted interventions to MARPs are too little.\footnote{See FHAPCO, \textit{supra} note 416, at 22, 29 & 55; Save Your Generation Ethiopia, The Addis Ababa City Taxi Community HIV/AIDS Interventions Project Implementation Report 2004-2009 (December 2009) and FHAPCO, \textit{supra} note 51, at 62. The lack of specific strategies geared towards MARPS, especially sex workers and, young women was also raised as a concern by Committee on the Elimination of Discrimination against Women. \textit{See} 2011 CEDAW Concluding Observations, \textit{supra} note 397, at para. 34.} The tasks undertaken by the government, NGOs, FBOs, CBOs and others in terms of establishing and strengthening school anti-AIDS clubs and out of school anti-AIDS clubs, youth and recreational centers, providing life skills and vocational training, setting up youth-friendly health facilities, condom distribution and training and support of vulnerable women and commercial sex workers have a limited coverage.\footnote{See \textit{supra} note 416, at 42, 55, 56 & 57; L. Van Blerk, \textit{AIDS, Mobility and Commercial Sex in Ethiopia: Implications for policy}, 19 (1) AIDS Care 79, 79-86 (2007) and Alula Pankhurst et al., \textit{Social Responses to HIV/AIDS in Addis Ababa, Ethiopia, With Reference to Commercial Sex Workers, People Living with HIV/AIDS and Community-Based Funeral Associations in Addis Ababa}, in \textit{The HIV/AIDS Challenge in Africa, An Impact and Response Assessment: The Case of Ethiopia} 250 (Organization for Social Science Research in Eastern and Southern Africa, 2008).} Cognizant of the exiting gaps, FHAPCO is in the process of developing a MARPs strategy.\footnote{See W/Senbet, \textit{supra} note 736.}

6.6 Strategies to Prevent Blood-Borne Transmission

Transmission of HIV through blood accounts for only a fraction of the total actual HIV infections in Sub-Saharan Africa in general and Ethiopia in particular. Blood-borne transmission of HIV can be prevented by ensuring safe supply of blood and other body organs, guaranteeing the accessibility of clean syringes to injection drug users and strengthening infection control in
health care settings in terms of injection safety, universal precautions and administering PEP in the event of HIV infection.

6.6.1 Safe Blood Supplies

In order to avoid HIV infection in the blood supply industry, all donations of blood, tissues and organs need to be effectively screened before donations and only those that are found out be negative should be donated. In Ethiopia, both the 1998 Policy on HIV/AIDS and the 2007 HCT Guidelines require the prior screening of all blood donations. The Ethiopian Red Cross Society Blood Bank, with its 12 blood banks in regional states, has a monopoly of blood screening for donation purposes. According to the 2009/2010 FHAPCO report, all the 3,6741 units of blood collected from the various blood banks were screened, of which a total of 815 blood units were found to be HIV positive and removed.

6.6.2 PEP for Occupational Exposure

HIV infection via blood contamination in health centers is a source of infection to health care workers while they are on duty. Occupational exposure in health care settings may result from “percutaneous needle injury” and “contact of mucous membrane or non-intact skin”. A point to note is that inasmuch as HIV infection may occur from the patient to the health worker, it may also happen from the healthcare worker to the patient and from patient to patient. Patient to patient HIV infection can result from sharing of unsterilized injecting syringes. Though it is the primary way of occupational exposure, infection of healthcare workers is not the only case of

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775 See 1998 HIV/AIDS Policy, supra note 17, at paras. 3(5) and 3(6) and 2007 HCT Guidelines, supra note 17, at paras. 1.1 and 2.1.3.
776 See FHAPCO, supra note 50, at 18.
777 Id.
778 See PMTCT Guidelines, supra note 17.
occupational exposure. Occupational exposure may also happen to other workers, such as firefighters and police officers.

Exposure to HIV in health and other settings can be controlled by ensuring safe injections, universal health precautions and administering PEP. PEP is an antiretroviral drug that can be used to minimize HIV infection after occupational exposure and among victims of rape. PEP has proven to be effective when it is taken immediately after exposure to HIV (within 72 hours after exposure). PEP as HIV prevention strategy is recognized in the strategic plan, not in the overarching 1998 HIV/AIDS Policy. SPM II stipulates that PEP will be available at health facilities as well as to rape victims. The fact that SPM II provides for ensuring the availability of PEP at health centers indicates that it will be applied to other occupational exposure scenarios. SPM II is superficial in the sense that it does not address complicated issues surrounding the use of PEP as HIV prevention strategy. In other jurisdictions, there are two alternative approaches to PEP. One of the approaches is that the laws and the policies provide for the use of PEP for the exposed person after the “source person” (the person to whose bodily fluids someone has been exposed) is first tested. HIV testing of the source person has been made a prior requirement for the application of testing due to the serious side effects of PEP. Thus, if the source person is HIV negative, application of PEP to the expose person will be avoided. The problem with this approach is that the source person may not be willing to be tested. In some jurisdictions, the source will be subject to compulsory HIV testing. Because compulsory HIV testing, as

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779 See FHAPCO, supra note 17, at 38 & 39. See also 1998 HIV/AIDS Policy, supra note 17, at para.4.3
780 Id. at 62.
781 See Gable et al., supra note 477, at 31-32.
782 Examples include laws of provinces of Canada, such as Ontario, Alberta, Nova Scotia, and Saskatchewan. See Canadian HIV/AIDS Legal Network, supra note 456.
discussed in chapter five, restricts human rights, their policies and laws have taken a position that PEP is universally accessible to all potentially exposed persons.783

SPM II is silent regarding which of the two approaches is adopted in Ethiopia. In chapter five of this paper, I have argued that compulsory HIV testing of sexual offenders is a justifiable limitation on human rights for dual purpose of prosecution and sentencing of the offender and prescription of PEP to the victim of the crime. Thus, at least for exposure in the aftermath of rape, it is possible to invoke article 34 of the Criminal Procedure Code to compel the source person to be tested in order to determine whether the victim of the crime should take PEP. As discussed in chapter five, the practice, however, is that the victim of the rape is simply advised by doctors to take PEP where there is evidence showing that the suspected criminal is HIV positive without even waiting his test results. It is highly disproportional to order compulsory testing of the source person in other situations of occupational exposure. Nor are there policies and laws that explicitly authorize compulsory HIV testing in these circumstances. Thus, it would be more appropriate to make PEP available to all potentially exposed individuals. It is this position that is adopted in practice in Ethiopia. Persons suspected of having been potentially exposed to the virus are given PEP.784

6.7 Strategies to PMTCT

If no prevention measure is taken, a child born to or breastfed by HIV positive mother has an approximately one-third chance of being infected by HIV/AIDS during labor, delivery or

783 See Gable et al., supra note 477, at 31-32.
784 See Kifle, supra note 589.
784 See Ismail, supra note 581, at 55-56.
breastfeeding.\textsuperscript{785} It is estimated that more than 90\% of HIV infection among children arise from mother-to-child transmission.\textsuperscript{786}

As mother-to-child transmission of HIV/AIDS is one major cause of HIV infection, it has gotten a lot of attention both at the international and national levels. At the international level, Members States of the UN at the 2001 UN Special Session on HIV/AIDS meeting pledged to “reduce the proportion of infants infected with HIV by 20 percent” by 2005, “and by 50 percent by 2010” through ensuring the availability of PMTCT Services.\textsuperscript{787} With a view to meeting its international commitment, Ethiopia adopted the November 2001 Guidelines on the PMTCT of HIV which are updated and replaced by the 2007 PMTCT. The implementation of the PMTCT program in the 2007 PMTCT Guidelines is guided by the principles of equality (access of PMTCT services to all in need without discrimination), promotion and protection of human rights, confidentiality of HIV testing results and community participation in the PMTCT program.\textsuperscript{788}

Consistent with the recommendations of the UNAIDS, WHO and other international human rights bodies, the 2007 Ethiopian PMTCT Guidelines adopted four comprehensive strategies for an effective PMTCT of HIV/AIDS. The four strategies encompass: the primary prevention of HIV infection among women of childbearing age; the prevention of unintended pregnancies in HIV-infected women; the prevention of HIV transmission from HIV-infected women to their infants and the provision of care, treatment and support to HIV-infected women, their infants and

\textsuperscript{787} See UN, supra note 8, at para. 54.
\textsuperscript{788} See PMTCT Guidelines, supra note 17, at para. 1.2.
families. With respect to the first strategy, primary prevention of HIV infection among women of childbearing age, it is a prevention strategy that aims at curbing HIV infection among parents and would be parents. If parents are not infected, children also will not be infected through vertical means of transmission. The specific interventions that need to be adopted and implemented to prevent HIV among parents and prospective parents are the behavioral, biomedical and structural interventions discussed in this chapter. To prevent unintended pregnancies among women living with HIV/AIDS, the second strategy to PMTCT, it is vital first for these women to undergo HIV testing. This is because once they learn their status, they will be in a position to take all the necessary measures to avoid unplanned pregnancies and, if they get pregnant, to utilize PMTCT services to reduce transmission of the virus to the child. In order to increase the uptake of HIV testing, the 2007 HCT Guidelines and the 2007 PMTCT Guidelines require routine testing of all pregnant women visiting health facilities for antenatal care, labor and delivery and post partum follow-up. A more detailed discussion on routine HIV testing or PICT is found in chapter five. After being informed of their HIV positive status, pregnant HIV positive women should be given family planning services including contraceptives. The 2007 PMTCT Guidelines urge the integration of family planning and counseling into all PMTCT and VCT service sites.

If the first two strategies do not work for one reason or another, the third strategy to be applied is prevention of the transmission of the virus from the infected mother to her child. This strategy requires the following measures to be taken. One of these measures is providing ART during

789 Id. para. 1.3. see also Committee on the Rights of the Child, supra note 137, at para. 25; WHO, supra note 701, at 85; Inter-Agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and Their Children, Guidance on Global Scale-up of the Prevention of Mother to Child Transmission of HIV: Towards Universal Access for Women, Infants and Young Children and Eliminating HIV and AIDS among Children, 5 (2007) and UNAIDS, supra note 1, at 219.

790 See PMTCT Guidelines, supra note 17, at para. 5.3.2.

791 Id. at para. 1.3.
pregnancy and delivery and after birth.\textsuperscript{792} The second measure is following appropriate infant feeding set by the WHO.\textsuperscript{793} The third measure is ensuring safe delivery practices which require, \textit{inter alia}, a skilled birth attendant at every birth and “use of standard precautions at every delivery, covering umbilical cord with gauze before cutting, safe handling and disposal of placenta and soiled materials, proper processing of used instruments.”\textsuperscript{794}

If it is not possible to prevent transmission of the virus to the child by applying the above three strategies, the next strategy is to ensure the provision of appropriate treatment, care and support to mothers living with HIV and their children and families. HIV care, support and treatment including among children and their positive mothers is elaborately discussed in chapter seven.

The fact that there is a comprehensive policy on PMTCT in Ethiopia does not guarantee effective implementation. The fruitful application of a good policy may be challenged by a complex of factors on the ground. To start with the progress that has been in Ethiopia in this regard, available data shows that the number of health centers providing PMTCT services has increased in Ethiopia. For example, the numbers of health facilities providing PMTCT services have increased from 32 in 2003/2004 to 1,352 in 2009/2010.\textsuperscript{795} However, PMTCT programs are one of the HIV prevention interventions poorly implemented in the country.\textsuperscript{796} According to the report of FHAPCO, though the number of health facilities providing PMTCT services has grown over the past years, the service is given in less than 50 % of health facilities that can potentially provide the service.\textsuperscript{797} Compared to the estimated 84,149 positive mothers who need PMTCT

\begin{footnotes}
\item[792] See also Gable et al., supra note 477, at 7-8.
\item[793] See WHO, supra note 785, at 11.
\item[794] See PMTCT Guidelines, supra note 17, at para. 4.4.
\item[795] See FHAPCO, supra note 50, at 16.
\item[796] Taken from presentation by experts from the Monitoring and Evaluation Directorate of the FHAPCO at the Bahir Dar Workshop, supra note 576.
\item[797] See FHAPCO, supra note 50, at 16.
\end{footnotes}
services in 2009, only 6,990 (8%) were able to access it. The same report pointed out that out of 653,065 pregnant women who were testing for HIV in 2009/2010, only 13,257 were found HIV positive and only 6,990 (53%) have taken ART. The coverage of skilled birth attendance is roughly 18%.

The figures highlighted above clearly indicate the availability, accessibility and consumption of various components of PMTCT services, including health facilities providing PMTCT services, HIV testing service among pregnant women, provision of ART and coverage of skilled birth attendants is unacceptably low in Ethiopia. Participants of the Mekelle and Adama Workshops as well as key informants the researcher interviewed pointed out that low coverage and uptake of PMTCT services is attributable to low acceptance of testing by mothers, inability of women to attend antenatal care without men’s permission, inaccessibility of the services in rural areas, shortage of trained health care workers providing the service, lack of awareness of the service by the society, belief in traditional birth attendants rather than health extension workers and problems of equipment, HIV test kits, adherence to ART and logistics.

In order to overcome the challenges pertaining to the implementation PMTCT intervention, the various sectors working in this area have planned in SPM II to: intensify the integration of PMTCT with Maternal, Newborn and Child Health (MNCH) in all health facilities, deepen health extension service programs, design strategies that encourage the participation of men in the program, improve the participation of private health facilities in the provision of PMTCT

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798 Id. at 18.
799 Id. at 16.
800 Taken from presentation by experts of MOH entitled “[t]he Role of Health Extension Workers in the Implementation of HIV services” at the Mekelle Workshop, supra note 340.
801 See Adama Workshop, supra note 55; Mekelle Workshop, supra note 340; Tesfu, supra note 575 and Fekade, supra note 607.
services, improve the coverage of antenatal care, offer HIV testing to all pregnant women seeking antenatal care and increase community mobilization through safe motherhood campaigns coordinated by different women structures, outreach programs by health extension workers, women health development army (using model women to educate others) and mother support groups (using positive mothers to teach others).  

6.8 Addressing the Structural Determinants of Vulnerability to HIV/AIDS

Undeniably, the behavioral and bio-medical strategies discussed above are vital to prevent HIV transmission. However, these strategies have to be supplemented by strategies that address the economic, social, cultural, legal and other factors that exacerbate exposure to HIV/AIDS. These factors of vulnerability include gender inequities, stigma and discrimination against PLWHA and MARPs, poverty and economic dependency, legal and policy barriers, socio-cultural beliefs and practices that affect women.

6.8.1 Addressing Stigma and Discrimination

Stigma is defined as “a dynamic process of devaluation that significantly discredits an individual in the eyes of others.” The materialization of stigma entails discrimination. In other words, the manifestation of stigma in the form of actions or omissions that hurts the stigmatized or excludes them from rights and interests is discrimination. PLWHA and other marginalized groups, such as FSWs, injecting drug users and MSM are stigmatized and discriminated against in different

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802 See FHAPCO, supra note 17, at 38-39; and interview with Habtamu Beyene, Curative and Rehabilitation Services Core Process Owner at S/N/N/P/ Region Health Bureau (Jun. 9, 2011).
805 Id. at 5.
parts of the world, among other reasons, due to lack of knowledge and wrongful perceptions concerning means of HIV transmission.\textsuperscript{806} These groups face stigma and discrimination at the individual, family, community, institutional, legal and policy levels.\textsuperscript{807} Stigma and discrimination result in abandonment, social exclusion, loss of job and property, exclusion from school, denial of health-related services, violence and lack of care and support.

It is well documented that stigma and discrimination have posed a setback to the success of HIV prevention as well as care, support and treatment programs. In particular, it undermines HIV prevention efforts by discouraging individuals to have HIV tests, and if tested, to disclose HIV status, negatively affecting the utilization of other HIV prevention services, lowering the involvement of PLWHA in HIV prevention and causing PLWHA to resort to risky sexual practices.\textsuperscript{808} Thus, any HIV prevention program should devise mechanisms to deal with stigma and discrimination. In Ethiopia, the problem of stigma and discrimination is mainly associated with PLWHA and hence the discussions below focus on the laws, policies and practices in respect to combating stigma and discrimination among PLWHA.

Discrimination is outlawed both in international law and national laws. As discussed in chapter five, the right to equality and non-discrimination is recognized in many human rights instruments to which Ethiopia is State Party, such as article 2 of the UDHR, article 2 (1) of the ICCPR, article 2 (2) of the ICESCR, article of 2 of the CRC and article 2 of the ACHPR. The various human rights treaties that protect the right to non-discrimination list specific grounds on which


\textsuperscript{808} \textit{Id.} at 82. \textit{See} also UNAIDS, \textit{supra} note 620, at 37 and Gable et al., \textit{supra} note 477, at 82.
discrimination is prohibited. As it is difficult to list all the grounds, they include a catch-all term “other status”. In 1996, the UN Commission on Human Rights clarified that the term “other status” “should be interpreted to include health status, including HIV/AIDS.” 809 The Committee on the Rights of the Child has also concluded similarly by construing article 2 of the CRC. 810

With a view to discharging their international obligations, States, in the 2001 UNGASS on HIV/AIDS, have explicitly pledged to “enact, strengthen or enforce, as appropriate, legislation, regulations and other measures to eliminate all forms of discrimination against…people living with HIV/AIDS.” 811 A similar type of agreement has been reached at African level where Member States of the AU vowed to amend laws taking in to account discrimination against PLWHA and ratify international conventions on discrimination. 812

Non-discrimination in general and non-discrimination against PLWHA in particular is a prevention strategy that is highly discussed in national laws and policies of Ethiopia. The FDRE Constitution incorporated a non-discrimination clause that can be applied to PLWHA. 813 The Federal Civil Servants Proclamation forbids discrimination among job applicants on the basis of HIV status. 814 The Labor Proclamation, however, does not incorporate similar type of provision. It only contains a general provision that outlaws discrimination among workers which can also be interpreted to include prohibition of discrimination against PLWHA in workplaces. 815

809 See UN Commission on Human Rights Resolution 1996/44, supra note 146.
810 See Committee on the Rights of the Child, supra note 492, at para. 6.
811 See UN, supra note 8, at para. 58.
812 See Abuja Call, supra note 15.
813 See FDRE Constitution, supra note 40, at art. 25.
814 See Civil Servants Proclamation, supra note 510, at art. 13 (2).
815 Labor Proclamation, supra note 511, at art. 14(1) (f).
five year Growth and Transformation Plan (GTP) of Ethiopia has also mentioned that Government is committed to ensure the realization of the rights of PLWHA.\textsuperscript{816}

The 1998 Policy on HIV/AIDS stipulates that one of the objectives of the Policy is to combat discrimination against PLWHA.\textsuperscript{817} The Education Sector Policy and Strategy on HIV and AIDS explicitly states that “teaching and non-teaching staffs should not be denied employment or their employment terminated on actual or perceived HIV status.”\textsuperscript{818} It also prohibits “denial of students’ admission to the institution on HIV status.”\textsuperscript{819} The Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline incorporates various strategies to prevent HIV/AIDS at the workplace including avoiding stigma and discrimination.\textsuperscript{820} It sets forth measures to be taken to avoid discrimination against PLWHA during employment, placement, promotion and transfer.\textsuperscript{821}

The laws and the policies on non-discrimination require awareness-raising as an important strategy to reduce stigma and discrimination. Awareness-raising and education on HIV-related issues including non-discrimination is undertaken by all sectors involved in the HIV/AIDS multi-sectoral response. In order to make targeted interventions, it is, however, crucial to identify places where stigma and discrimination take place and make sense of the magnitude of the problem.\textsuperscript{822}

\textsuperscript{816} See GTP, supra 108, at para. 7.2.3.
\textsuperscript{817} See 1998 HIV/AIDS Policy, supra note 17, at para. 2.5.
\textsuperscript{818} See Ministry of Education, supra note 650, at 11.
\textsuperscript{819} Id. at 10.
\textsuperscript{820} See Civil Service HIV/AIDS Guideline, supra 357, at section 2.
\textsuperscript{821} Id. at Section 5.
\textsuperscript{822} See UNAIDS, supra note 200, at 17.
Similar to other areas, there is not any comprehensive and updated study in Ethiopia that shows the prevalence of stigma and discrimination and the extent of the problem. There are, however, limited studies that give a clue to the prevalence of the problem and its negative impact on various HIV prevention efforts. An Evaluation Report of the country’s Strategic Plan for Multi-Sectoral Response for 2004-2008 disclosed that stigma and discrimination impede the uptake of HIV services and disclosure of positive HIV status.\textsuperscript{823} Similarly, several studies sponsored by the EPHA confirmed that stigma and discrimination associated with HIV/AIDS have created barriers to the uptake of VCT and PITC.\textsuperscript{824} Two other studies conducted in 2006 in Bahir Dar, Addis Ababa, Hawassa and other areas revealed that PLWHA are stigmatized and discriminated against their neighbors, private housing renting landlords and the community and in social institutions such as \textit{edirs} (funeral associations) and \textit{equibs} (saving associations), employment institutions, \textit{kebele} (local) administration and health facilities.\textsuperscript{825}

In June 2011, NEP+ released a new report on stigma and discrimination in Ethiopia though the report is still in the drafting stage.\textsuperscript{826} The study surveyed the prevalence and magnitude of stigma and discrimination across the country. The study disclosed that, in general, the level of stigma and discrimination is showing a declining trend with the exception of some regional states, such as Somali, Benishangul-Gumuz and Gambela where stigma is still a serious concern. Identifying gossip as a common form of stigmatizing PLWHA, the study found out that PLWHA and their families face stigma and discrimination at social gatherings; in house renting process,

\textsuperscript{823} See FHAPCO, supra note 416, at 29.
\textsuperscript{824} See Tilahun, supra note 578; Tasew, supra note 578; Kabato, supra note 579; Hiruy, supra note 579 and Demissie, supra note 579.
\textsuperscript{826} NEP+, supra note 421.
particularly in the form of denial of house renting, unreasonable increment of fee for house rent and eviction; at employment settings manifested in the form of denial of promotion, refusal of employment opportunity and dismissal; in enrolling HIV positive children and children of HIV positive parents at schools and in health facilities in the form of refusal by health care workers to carry out surgery on pregnant women living with HIV/AIDS who wish to go through caesarean section upon their delivery.

6.8.2 Addressing Economic Factors of Vulnerability to HIV/AIDS

Poverty is one of the drivers of the HIV epidemic in Sub-Saharan Africa, particularly among women. Poverty exacerbates vulnerability to HIV/AIDS in a host of channels. First, poverty deprives individuals of access to HIV prevention, information, goods and services. Second, malnutrition as a result of poverty “increases vulnerability to infectious and parasitic diseases generally and it increases HIV viral load and viral shedding, thereby increasing sexual and vertical transmission of HIV.” Third, economic dependency among women seriously affects their ability to negotiate safe sex and compels them to live in abusive relationships. Various studies conducted in Botswana, Uganda and Swaziland confirmed food insecurity as a cause of inconsistent condom use even in cases of irregular sexual relationships. Fourth, poverty drives women to risky sexual relationships, such as cross-generational sex, sex trade and transactional sex. Fifth, poverty forces people to migrate in order to look for employment, food and money.

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829 See UNAIDS, supra note 1, at 17 and FHAPCO, supra note 17, at 17.

830 See UNAIDS, supra note 1, at 76. See also Linda K. Fuller, African Women's Unique Vulnerabilities to HIV/AIDS: Communication Perspectives and Promises 101 (2008); WHO, Integrating Gender into HIV/AIDS
Migration, in turn, muddles family relationships and subjects people to more danger of HIV infection.\textsuperscript{831}

Thus, any HIV prevention intervention may not bring about the desired outcome unless poverty reduction and economic empowerment policies and strategies are fruitfully implemented. Being one of the poorest countries on earth, Ethiopia adopted poverty reduction programs and implemented the same for the last two decades though the level of poverty is not reduced as expected. Comparatively, Ethiopia is a country where women are more highly impoverished than their male counterparts. Due to the patriarchal nature of Ethiopian society and a centuries-old history of gender-based discrimination, women have played a minimal role in economic, political and social affairs.

Ensuring gender equality in all spheres is an important step to economic empower of women. Gender equality in all areas, such as employment, political decision making and other social fields is recognized in article 35 the FDRE Constitution. Recognizing the \textit{de jure} equality of women and men in the Constitution and other laws is not, however, enough to rectify a centuries-old legacy of discrimination against women. It is exactly for this reason the FDRE Constitution, in article 35(3), gives women the right to affirmative measures in economic, social and political fields both at governmental and non-governmental institutions. Affirmative action plays a crucial role in accelerating \textit{de facto} equality of men and women. Gender equality and affirmative action in the form of positive action, preferential treatment or the quota system, having a constitutional

\textsuperscript{831} See WHO, supra note 830, at 18 and FHAPCO, supra note 416, at 26.
basis, are incorporated in several pieces of legislation and other policy documents. The implementation of these laws and policies has benefited a lot of women in accessing higher education and employment. Ethiopia has also committed to ensuring equality of women by ratifying major international treaties and signing other international documents on the rights of women, such as CEDAW, the 1993 Declaration on the Elimination of Violence Against Women, the 1995 Beijing Platform for Action and the Millennium Declaration (MDG number 3).

The principal HIV/AIDS policy of Ethiopia, the 1998 Policy on HIV/AIDS, does not include addressing poverty as one of the HIV prevention strategies. The Policy seems to be highly focused on the behavioral and biomedical aspect of HIV prevention intervention without devoting similar attention to structural factors of vulnerability. However, SPM II incorporated economic empowerment programs to reduce women’s vulnerability to HIV/AIDS, including provision of vocational training for livelihood development and seed money support to poor women to enable them take part in income generating activities; integration of safety net programs for HIV/AIDS; inclusion of special attention to girls’ education and consolidation of other measures that ensure equality of men and women. The economic empowerment programs for women included in SPM II are reflected in the country’s overarching development policy, the GTP. The specific strategies incorporated in the GTP to alleviate economic problems of women include ensuring the involvement of women in economic development programs; encouraging them to associate in furtherance of their benefits; assisting women to become involved in income generating activities; ensuring the utilization of saving and credit services by

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832 See Ethiopian Combined Sixth and Seventh Periodic Report to the CEDAW Committee, supra note 752, para. 27. Examples of these laws and policy documents include: the Civil Servants Proclamation, the Labor Proclamation, the Family Law, the Criminal Law, the 1993 National Policy on Ethiopian Women and the 2006 Ethiopian Women Development and Change Package.

833 See FHAPCO, supra note 17, at 38.
women; enhancing the education opportunity of women and raising their decision making power.\textsuperscript{834}

In addition to putting in place the necessary laws and policies, the Ethiopian Government has set up the basic institutional framework with a view to enforcing the rights of women. Formerly, an Office of Women’s Affairs was operating in the Prime Minister’s office. In 2005, the Government established a separate ministry, namely Ministry of Women Affairs, and currently due to the reshuffling of Ministries by the Government, the Ministry is named as Ministry of Women, Youth and Children’s Affairs (MWYCA) and is given the mandate of overseeing women, youth and children’s affairs. Regional Governments have also set up Women, Youth and Children’s Affairs Bureaus for similar purposes. The Ministry and regional bureaus play coordination, planning and gap filling roles, offer training to sectors on women empowerment and prepare guidelines and policies.\textsuperscript{835} Women’s Affairs is not single-handedly managed by the MWYCA and its regional counterparts. It is a multi-sector responsibility. As a result, each government institution is under a duty to incorporate gender issues in its annual plans and to assign a gender focal person.\textsuperscript{836} The National Women, Youth and Children’s Forum, composed of government ministries and agencies, has been established to deepen gender mainstreaming in all sectors and to serve as an experience sharing and joint evaluation forum.\textsuperscript{837} While all these efforts are commendable, the Committee on the Elimination of All Forms of Discrimination Against women, in its recent concluding observations, expressed its concern that the institutional machinery is not yet strong enough in terms of effectively implementing laws and policies

\textsuperscript{834} See GTP, supra 108, at para. 71-72.
\textsuperscript{835} Interview with Tesfayenesh Lemma, Women and Youth Mainstreaming Directorate Director at the MWCYA (Jul. 25, 2011) and Biruk Assefa, Women and Youth Mainstreaming Expert at Ministry of Women, Children and Youth Affairs (Jul. 25, 2011).
\textsuperscript{836} Ministry of Finance and Economic Cooperation, 2010 MDGs Reports: Trends and Prospects for Meeting MDGs by 2015 17 (2010).
\textsuperscript{837} See Lemma and Assefa, supra note 835.
pertaining to the rights of women, ensuring gender mainstreaming and effective monitoring and evaluation of tasks undertaken. \(^{838}\) To remedy this problem, the committee recommended that Ethiopia build up the institutional framework “by providing it with adequate human, technical and financial resources.”\(^{839}\)

Aside from the institutional, legal and policy reforms, the Ethiopian Government, in partnership with others, has taken several measures to improve the economic situations of poor women. The establishment of the Ethiopian Women’s Development Fund (EWDF) and the launching of the Women’s Development Initiative Project (WDIP) in 2001 are two of the most remarkable actions. \(^{840}\) The EWDF was set up with aim of supervising various grass-roots women’s projects. \(^{841}\) The WDIP, coordinated by the EWDF, provides credit services, technical support and capacity-strengthening trainings to disadvantaged women with a view to enabling them to undertake income-generating activities. \(^{842}\) The Government through the Federal Micro and Small Enterprises Development Agency and its regional equivalents and in collaboration with international partners, also provides favorable credit services, land, technical and vocational training, technical assistance on management of business as well as facilitates access to raw materials and markets for the sale of their products for those who form micro and small enterprises. \(^{843}\) Moreover, the Government has designed an integrated housing scheme whereby at least 20-30% of the houses built under the program should be earmarked for women. \(^{844}\) Equally

\(^{838}\) See 2011 CEDAW Concluding Observations, supra note 397, at 16.

\(^{839}\) Id. at para. 27 (a).


\(^{841}\) Id.

\(^{842}\) See Ethiopian Combined Sixth and Seventh Periodic Report to the CEDAW Committee, supra note 752, at para. 161.

\(^{843}\) Id. at para. 158.

\(^{844}\) Id. at para. 162.
important is the implementation of the productive safety net program (a kind of social security program) that has benefited poor rural women through the payment of a certain amount of money in return for public services they perform or freely for those who cannot take part in public services. Though these initiatives have contributed a lot in terms of improving the living conditions of a sizable number of poor women, the situation on the ground revealed that millions of Ethiopian women still live with poverty. In particular, most women living in rural areas are economically dependent on men. This situation calls for increased efforts to pull women out of the trap of poverty.

6.8.3 Dealing with Socio-Cultural Factors of Vulnerability to HIV/AIDS

6.8.3.1 Prevailing HTPs in Ethiopia

There are several gender-based cultural practices that abuse the rights of women and significantly increase their vulnerability to HIV/AIDS. In fact, these cultural practices partly explain why Sub-Saharan African women are more vulnerable to HIV/AIDS than men. The main HTPs that are practiced in Ethiopia are early marriage, polygamy, widow inheritance, marriage by abduction and FGM.

Early marriage of women, marriage before the age of 18, is prevalent in many countries. Though the reasons for early marriage may vary from one place to another, studies disclose that parents opt for the early marriage of their children hoping “that the marriage will benefit them both financially and socially, while also relieving financial burdens on the family.” Early marriage may, however, aggravate their vulnerability to HIV infection. Married girls will not be in a position to implement mechanisms of HIV/AIDS control. It will be difficult for them to apply

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845 Id. at para. 170.
846 See 2011 CEDAW Concluding Observations, supra note 397, at para. 36.
“abstinence, partner change or reduction, condom use (which is not possible for married girls seeking pregnancy) and having mutually monogamous sex with an uninfected partner whose HIV status has been discerned.”848 Consequently, in developing countries in particular, “married adolescents tend to have higher rates of HIV infection than their peers.”849 In Ethiopia, 19% of girls are married at the age of 15 and in some regions, such as Amhara Region, the proportion goes as high as 50%.850

Polygamy is a practice that allowed a man to marry more than one wife. It remains a practice in many countries, particularly in Africa.851 It has been practiced for thousands of years. It was purportedly justified by “sexual abstinence during pregnancy in societies where sexual intercourse” was a “taboo during periods of pregnancy, menses, lactation, mourning, and ritual ceremony periods”852 and giving “security to childless women”.853 According to proponents, it served as an instrument of sexual abstinence during the said times as the husband would have sex with one of his other wives. It also gave sterile women some sort of security because the husband can marry an additional wife instead of divorcing the sterile one.854 Polygamous marriages are less acceptable these days. This is partly because, as compared to monogamous marriages, they are more risky from HIV/AIDS transmission perspective. Women are more subservient in such kind of marriage than in monogamous marriage.855 Since the husband may have several wives,

851 See UNICEF, supra note 847, at 18.
853 Id.
854 Id. at 39.
he can divorce one of them in case of refusal to blindly obey him. The inferior position of the women in this relationship will decrease her bargaining power over when and how to have sex.\textsuperscript{856} It is estimated that roughly 14\% of all married Ethiopian women are members of polygamous marriages.\textsuperscript{857}

Another tradition, the practice of widow inheritance, commonly requires a woman to marry her husband's brother or another family member after he dies.\textsuperscript{858} In the past, the practice was justified as taking care of the widow and the children of the deceased.\textsuperscript{859} However, “this practice exposes women both to greater violence and to a greater chance of being infected with HIV/AIDS.”\textsuperscript{860} Owing to economic necessities, the widow may be forced to remarry several men who may be HIV positive.\textsuperscript{861} Though its rate is decreasing, widow inheritance is still practiced in some areas in Ethiopia.\textsuperscript{862} Historically, the practice used to be done without any consent. But nowadays, there is a move towards requiring consent of the women.\textsuperscript{863} According to research done in Arsi zone, Oromia Regional State, widow inheritance is a key factor on spreading HIV/AIDS.\textsuperscript{864} As the practice is performed without due regard to the HIV status of the “parties involved and the principles of safe sex”, it contributes to the transmission of HIV.\textsuperscript{865}

\textsuperscript{857} See Garbus, supra note 77, at 8.
\textsuperscript{858} See Human Rights Watch, supra note 855, at 34.
\textsuperscript{859} Id.
\textsuperscript{860} Id.
\textsuperscript{861} Id.
\textsuperscript{863} Id. at 38.
\textsuperscript{864} Id. at 39.
\textsuperscript{865} Id.
Marriage by abduction is widely practiced in Ethiopia. It is practiced in approximately 70 percent of the country. According to the 2007 survey conducted by Ye Ethiopia Goji Limadawi Dirgitoch Aswogaji Mahiber (EGLDAM), the Former National Committee for Traditional Practices in Ethiopia, marriage by abduction is still a major concern in Amhara, Oromia and SNNP regions. While marriage abduction is currently widely practiced for economic reasons, “the root causes are still enshrined in the patriarchal attitudes of the community, emphasized by the inferiority of women.” As marriage by abduction involves violence and sexual intercourse in a situation where the girl does not know the HIV status of a man with whom she will be forced to have sex, it exposes her to a higher risk of HIV infection.

FGM is “an umbrella term for a number of culturally motivated practices that involve partial or complete cutting of female genitals, usually performed in childhood or adolescence.” The 2005 Ethiopian Demographic and Health Survey indicated that 74% of girls and women nationwide were subjected to FGM. The 2007 Follow up Survey undertaken by EGLDAM showed that the prevalence of FGM in Ethiopia decreased to 57%. The Survey also revealed that the decreasing trend applies to all regions with the exception of Somali and Afar. Apart

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868 Id.
869 See United Nations Children’s Fund, supra note 867.
872 See EGLDAM, supra note 867, at 133.
873 Id.
from causing physical and psychological injuries to the women undergoing FGM, “the use of unsterilized instruments, unhealed or open wounds or other complications arising in the process facilitates entry of the HIV virus into the body.”

6.8.3.2 Laws, Policies and Practices

To begin with the FDRE Constitution, though it incorporates several rights of women, article 35(4) is exceedingly pertinent from the perspective of protecting women from gender-based customs that expose them to HIV/AIDS, such as polygamy, FGM, early marriage, widow inheritance and marriage by abduction. It states that “[t]he State shall enforce the right of women to eliminate the influences of harmful customs.” Thus, this article guarantees women’s rights to be free from customs that are prejudicial to their health and life and imposes obligation on the part of Ethiopia to work to that end. Being a constitutional provision, this article does not, however, specify those harmful customs against women and the particular measures the country should take to abolish the same.

Among the laws that are put in place in order to give effect to the aforementioned constitutional provisions, one can take the Family Law and the Criminal Law as examples. Echoing article 34 (2) of the FDRE Constitution, article 6 of the Federal Revised Family Code denounces marriage concluded without the free and full consent of the prospective spouses and thereby rejects marriage by abduction. Moreover, the Family Code prohibits conclusion of marriage: as long as the man is bound by bonds of a preceding marriage, without the attainment of the full

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876 Id. at art.11.
age of eighteen for both sexes (at least in principle)\textsuperscript{877} and between a woman and the brother of her husband.\textsuperscript{878} By so doing, the Revised Family Code outlaws polygamy, early marriage and widow inheritance respectively. The violation of these legal prohibitions entails civil sanction in the form of dissolution of the marriage\textsuperscript{879} and criminal sanctions in the relevant provisions of the Criminal Code (with the exception of widow inheritance which is not criminally punishable). Perpetrators of HTPs, participators and instigators are criminalized and made punishable in article 567, 569 and 570 respectively with fine or simple imprisonment that may extend to one year. If the commission of the harmful traditional practices resulted in the transmission of communicable diseases, such as HIV/AIDS, the Criminal Code imposes a more serious penalty that may extend from six months of imprisonment to death penalty, depending on the dangerous disposition of the offender and/or the manner in which the crime is committed.\textsuperscript{880} Specific types of HTPs, such as abduction, FGM, early marriage and bigamy are criminalized and made punishable with varying length of imprisonment ranging from three months to twenty-five years under articles 587-590, 565-566, 648 and 650 respectively. Bigamy is not, however, an offence where it “is committed in conformity with religious or traditional practices recognized by law.”\textsuperscript{881} This is so where one of the regional family codes legalizes bigamy or polygamy. For example, the Family Code of Hareri Region exceptionally permits polygamous marriages where they are authorized by religious rules.\textsuperscript{882}

Women’s rights to be free from harmful customs that aggravate their vulnerability to HIV/AIDS are also given due recognition in human rights treaties which Ethiopia has ratified including the

\begin{itemize}
  \item \textsuperscript{877} \textit{Id.} at art.7(1).
  \item \textsuperscript{878} \textit{Id.} at art. 9(2).
  \item \textsuperscript{879} \textit{Id.} at arts. 31-39.
  \item \textsuperscript{880} See Criminal Code, \textit{supra} note 516, at art. 568 read together with art. 514.
  \item \textsuperscript{881} \textit{Id.} at art.651.
  \item \textsuperscript{882} Hareri Region Family Code, Proclamation No. 80/2000, \textit{Hareri People Regional Government Negaret Gezetta, 13th Year}, Special Publication No.1/2000, art.11(2).
\end{itemize}
ICCPR, ICESCR, CEDAW, ACHPR, CRC and ACRWC. Article 5 (a) of CEDAW obliges State Parties “to modify the social and cultural patterns of conduct of men and women”, with the purpose of eliminating customary practices that are hurtful to women. Likewise, the CRC and ACRWC oblige member States, which include Ethiopia, to take effective measures to abolish traditional practices that are prejudicial to the health and life of the girl child.\textsuperscript{883} The measures that States are supposed to take could be legislative, judicial, administrative or other measures as long as they are effective in terms of eliminating the customary practices that are injurious to women including, polygamy, FGM, early marriage, marriage by abduction and widow inheritance. Apart from requiring States to eliminate harmful traditional practices in more general terms, the treaties make explicit reference to certain customary practices, such as the case of article 35 of the CRC that requires states to “take all appropriate measures to prevent the abduction of children for any purposes;” article 23 of the ICCPR that requires free and full consent of parties intending to enter marriage thereby rejects marriage by abduction and article 16 of CEDAW that protects the girl child from child marriage.

In addition to the laws discussed above, the commitment of the Ethiopian Government to eradicate HTPs can be discerned from the various policies it has adopted. To start with the overarching national development policy of the country, the GTP, sets forth “empowerment of women by abolishing harmful traditional practices” as one of the priority objectives that the Government wants to attain.\textsuperscript{884} The 1998 HIV/AIDS Policy on HIV/AIDS and SPM II incorporate stopping HTPs as one of the strategies to control HIV/AIDS.\textsuperscript{885} Other policies that aim at abolishing HTPs include: the 1997 National Cultural Policy, the 1993 Health Policy, the

\textsuperscript{883} See article 24(3) of the CRC, \textit{supra} note 226 and article 21 of the ACRWC, \textit{supra} note 228.

\textsuperscript{884} See GTP, \textit{supra} 108, at paras. 8.1.2 & 8.5.3.

\textsuperscript{885} See 1998 HIV/AIDS Policy, \textit{supra} note 17, at para. 4.5 and FHAPCO, \textit{supra} note 17, at 38.

Fully aware of the lack of capacity of existing institutions to aggressively work on eradicating HTP, the Government set up the National Committee for Traditional Practices in Ethiopia, now EGLDAM, in 1987 and gave it the mandate of identifying HTPs and working towards their eradication.\textsuperscript{886} EGLDAM, in partnership with MOH, HTP-eliminating committees at all levels and more than 80 different governmental and NGOs, has carried out encouraging activities against HTPs.\textsuperscript{887} The main activities performed to abolish HTPs include: awareness-raising through diverse devises, advocacy for policy and legal change, alternative sources of income for those who rely on HTPs for their livelihood, legal, economic, medical and psychological support to victims of HTPs, capacity building of officials and other actors, research and publication.\textsuperscript{888} Challenges to the success of HTP interventions include: lack of follow-up and continuity, the clandestine undertaking of HTPs, resistance of the community against eradication of HTPs, hurdles to bring offenders to justice, lack of cooperation from community elders, resource and financial constraints, problems of synergy among different actors and facilitators and recurrent turnover of facilitators.\textsuperscript{889}

The legislative and policy reforms as well as the efforts of various institutions to eradicate HTPs have borne fruits. The 2007 Follow up Survey witnessed the decreasing trend in the prevalence of HTP and increasing awareness about HTPs overall in the country.\textsuperscript{890} As briefly discussed in the previous sub-section, however, HTPs are still widely practiced in Ethiopia. Reiterating its

\textsuperscript{886} Ethiopian Combined Sixth and Seventh Periodic Report to the CEDAW Committee, supra note 752, at para. 14.

\textsuperscript{887} See EGLDAM, supra note 867, at 265.

\textsuperscript{888} Id. at 267-278.

\textsuperscript{889} Id. at 266-267. See also Mohammed, supra note 753.

\textsuperscript{890} Id. at 97-98.
concern regarding the “persistence of adverse cultural norms, practices and traditions” including HTP, the Committee on CEDAW, in its recent concluding observations, concluded that the “State party [Ethiopia] has not taken sufficient sustained and systematic action to modify or eliminate stereotypes and negative cultural values and harmful practices.”891 As a consequence, efforts to abolish HTPs must be strengthened to save Ethiopian women from HTPs and HIV infection.

6.8.4 Addressing the Legal Barriers to HIV Prevention

One of the measures States should take to effectively prevent HIV/AIDS is legislative measures. They should adopt new laws or amend the existing ones in a manner that facilitates HIV prevention efforts. The various laws and policies of Ethiopia that are pertinent to HIV prevention have been analyzed in various sections covered above. In this section, I will explore the legal barriers that need to be rectified from an HIV prevention point of view.

6.8.4.1 Outlawing Polygamy

Ethiopia is a home for more than 80 nations, nationalities and peoples with distinct cultures. Article 39 (1) of the FDRE Constitution is an important provision recognizing the rights to self-determination of ethnic groups (nations, nationalities and peoples). Sub-article two of article 39, in particular, entitles each ethnic group “the right to speak, to write and to develop its own language; to express, to develop and to promote its culture; and to preserve its history.” As an aspect of the right to develop their cultures, the Constitution permits “the adjudication of disputes relating to the personal and family laws in accordance with religious or customary laws, with the consent of the parties to the dispute.”892 The Constitution also allows the federal and

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891 See 2011 CEDAW Concluding Observations, supra note 397, at para. 18.
892 See FDRE Constitution, supra note 40, at art.34 (5).
regional parliaments to “establish or give official recognition to religious and customary courts” which adjudicate cases on the basis of religious and customary laws in personal and family matters.\textsuperscript{893} The Constitution, not only recognizes the application of customary law, but also gives the power of enacting family laws and other personal laws to regional states.\textsuperscript{894} That is why regional states have put in place different family laws which, to some extent, reflect the cultures of ethnic groups inhabiting them.

While several regions have restrained from recognizing polygamy in their family laws, others allow the conclusion of polygamous marriages on a religious or cultural grounds. For example, the Hareri Region Family Code allows the conclusion of bigamous marriage on religious rationale. In line with the position of the regional family laws that permit polygamy when concluded as a manifestation of freedom of religion or the right to practice culture, the Criminal Code provides that polygamy is not punishable where it “is committed in conformity with religious or traditional practices recognized by law.”\textsuperscript{895} As mentioned earlier, polygamy erodes women’s rights to equality and puts them at higher risk of HIV infection. The FDRE Constitution, under article 9(1), declares that any law, including regional constitutions and laws, that contravene the Constitution shall be invalid. This, in other words, means that in the event of conflict between human rights standards recognized in the Constitution and regional laws, the former has precedence. Article 35 of the FDRE Constitution is unequivocal in terms of guaranteeing the equality of women with men and non-discrimination against women. Thus, article 9(1) of the FDRE Constitution sends a message that regional laws can give effect to cultures of the different ethnic groups in so far as they do not offend individual or collective

\begin{thebibliography}{9}
\bibitem{893} Id. art. 78(5).
\bibitem{894} Id. art. 55 (6).
\bibitem{895} See Criminal Code, \textit{supra} note 516, at art. 651.
\end{thebibliography}
human rights that are recognized in the Constitution. Because the recognition of polygamy in regional family laws goes against the rights of women, the recognition is unconstitutional and, hence, should be repealed.

6.8.4.2 Decriminalization of Homosexual Conduct

The Ethiopian Criminal Code criminalizes consensual homosexual act with simple imprisonment (from tens day to three years).\textsuperscript{896} The Criminal Code stipulates more grave penalties where the criminal takes unfair advantage of the situation of the victim, the act is committed against minors, or involves coercion, fraud or intimidation.\textsuperscript{897}

In the section dealing with MARPs, I have already mentioned that men having sex with men are emerging as one of the MARPs in Ethiopia. It means that we need to make a targeted intervention to prevent HIV transmission among members of this group. Such intervention, however, requires a legal reform that allows the group to receive HIV prevention information, goods and services without fear of stigma and condemnation. If the act of homosexuality is criminalized, the group, for fear of criminal sanction, stigma and discrimination, may not be willing to proactively take part in the HIV prevention among members of this group. Moreover, without benefiting from HIV prevention information, goods and services, homosexuals may infect other people in a heterosexual relationship. Thus, the Ethiopian Government should consider decriminalization of homosexuality.

\textsuperscript{896} Id. art. 629 read in conjunction with art. 106 (1).
\textsuperscript{897} Id. arts. 630-631.
6.8.4.3 Criminalizing Marital Rape

Marriage may aggravate women’s exposure to HIV/AIDS in communities where heterosexual relationship are responsible for the majority of HIV infection and customary rules encourage, or at least, tolerate male promiscuity.\(^{898}\) Ethiopia is a country where HIV/AIDS is overwhelmingly transmitted through heterosexual intercourse and practices that support male promiscuity, such as polygamy and extra-marital affairs, are widely practiced. In these settings, men may engage in several unprotected sexual activities. Even when the wife comes to know her husband is infected with HIV/AIDS, she may not be in a position to protect herself. Her husband may coerce her to have sex with him. One way of protecting the wife from forced sex and the consequential HIV infection is by penalizing marital rape. This protection is not available in the Criminal Law of Ethiopia. The Criminal Law penalizes rape only where it is committed outside of wedlock.\(^{899}\)

According to Mehari Redae, a professor at Addis Ababa University Faculty of Law and who wrote a commentary on the Federal Family Code, the legislature did not opt for criminalizing marital rape because it is was not an issue of a major concern for Ethiopian women at the time of drafting the Family Law.\(^{900}\) The Family Code was revised in 2000, when the HIV/AIDS epidemic was increasing at alarming rate. It is, thus, difficult to accept the position that marital rape was not a pressing issue in Ethiopia. Recently, in responding to questions and issues raised by the Committee on CEDAW while considering Ethiopian report, Ethiopia responded that “criminalizing spousal rape may in the future be considered.”\(^{901}\)

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898 See also Gable et al., supra note 477, at 139.
899 See Criminal Code, supra note 516, at art. 620.
900 Mehari Redae, Points Helpful to Understand the Revised Family Law 59 (2003).
6.8.4.4 Outlawing Widow Inheritance

A reference has already been made to the fact that widow inheritance, the practice that requires a widow to marry the brother of her husband or any of his relatives, increases women’s vulnerability to HIV/AIDS. While the widow has the right to say no to the marriage, she may not be able to exercise this right due to other social factors. Thus, it is better to outlaw the practice altogether whether it is done consensually or not. The Federal Revised Family Code partly prohibits widow inheritance by rendering illegal marriage concluded between a women and a brother of her husband.902 In the context of HIV/AIDS, it is vital to broaden this prohibition so as to deprive of legal recognition any marriage concluded between a widow and the relatives of her deceased husband and to attach a specific criminal sanction for the violation of the prohibition.

6.8.4.5 Adoption of Comprehensive HIV/AIDS Law

As has been discussed in different chapters of this dissertation, the response to HIV/AIDS in Ethiopia is largely governed by a plethora of guidelines, manuals and strategies, with the exception of some recent laws that make superficial reference to HIV/AIDS and existing laws whose provisions can be construed to be applied in the context of HIV/AIDS. This in itself has a negative impact in the effectiveness of the response. Due to the lack of specific legislation that imposes obligations on private enterprises or even government institutions to mainstream HIV/AIDS in their activities, as discussed in chapter four, mainstreaming of HIV/AIDS in various sectors is not satisfactory. Moreover, the lack of specific laws that entitle PLWHA and other marginalized groups to claim HIV prevention and treatment services as of rights place the provision of these services at the discretion of the government. In general, because HIV/AIDS is still a huge concern to socio-economic development and continues to claim the lives of many

902 See Revised Family Code, supra note 875, at art. 9(2).
people, law should have a place in fighting HIV/AIDS. It is, thus, imperative to adopt HIV/AIDS-specific legislation that incorporates the different areas of interventions, entitlements of PLWHA and enforcement mechanisms. Realizing this, a draft HIV/AIDS bill was prepared by the Ministry of Justice even though the finalization of the draft and its submission to the Council of Ministers has been discontinued for unknown reasons.\textsuperscript{903} It would be appropriate to complete the adoption of this law for the reasons mentioned above.

\textsuperscript{903} Interview with Hibret Abahoy, Coordinator of Women, Children and Women’s Affairs at the Ministry of Justice (Jun. 20, 2011).
CHAPTER SEVEN
HIV CARE, SUPPORT AND TREATMENT

Introduction

One of the MDGs that governments strive to achieve is halting HIV/AIDS by 2015. The achievement of this goal, otherwise called MDG 6, is buttressed and elaborated by a host of time-bound targets both in the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. In the 2006 Political Declaration on HIV/AIDS, in particular, governments pledged to achieve universal access to HIV prevention, care, support and treatment services by 2010. The Declaration clearly pointed out that HIV prevention, care, support and treatment are mutually reinforcing and crucial elements for an effective response to HIV/AIDS. Because the universal access commitment is unlikely to be met by 2010 by a lot of States, Member States of the UN and AU have already agreed to extend the deadline to 2015.904

Ethiopia is among the countries that had committed to achieve the universal access target by 2010. Despite considerable progress, the country did not meet the universal access target by 2010. A review of the universal access achievement in Ethiopia by civil society organizations (CSOs) working on HIV/AIDS highlighted that “Ethiopia has only reached around 40% of the Universal Access target.”905 This is a clear indication of the fact that much more needs to be

904 See 2011 Political Declaration on HIV/AIDS, supra note 13, at para. 51 and Decision on the Five (5)- Year Review of the Abuja Call, supra note 15.
done in terms of HIV prevention, care, support and treatment to achieve the universal access target.

In chapter six, I have reviewed the laws and policies adopted in Ethiopia to regulate HIV prevention and the extent of their implementation. In this chapter, I will, primarily, assess the laws and policies that pertain to HIV care, support and treatment and the extent to which they are implemented. The analysis of the laws and policies is preceded by a brief discussion on the public health justification of the need to care, support and treat PLWHA and those affected by HIV/AIDS; human rights foundations of HIV care, support and treatment; international commitments to ensure access to HIV care, support and treatment and components of comprehensive HIV care, support and treatment.

7.1 The Public Health Rational for HIV Care, Support and Treatment

Apart from being an end in itself, ensuring care, support and treatment of those infected with and affected by HIV/AIDS is a means to an end. As shall be discussed in the coming section, it is an end in itself because caring, supporting and treating PLWHA and HIV affected communities is realizing the human rights of these individuals recognized in binding international as well as national human rights documents. It is also a means because HIV care, support and treatment significantly contribute towards the public health goals of controlling HIV/AIDS and mitigating its effects.

Several studies have demonstrated that extending care and support to people affected and infected by HIV/AIDS creates a supportive environment to disclose their positive HIV status, encourages them to utilize HIV prevention goods and services, actively take part in HIV
prevention activities and avoid unsafe sexual practices.\textsuperscript{906} It has also become clear that HIV care and treatment lessen the socio-economic impact of HIV/AIDS and increase the length and quality of life of PLWHA.\textsuperscript{907}

Proper implementation of an antiretroviral therapy (ART) program has proven to be successful in terms of significantly reducing the viral load and thereby reducing the risk of HIV transmission. The role of ART on HIV prevention was initially recognized in the context of preventing the vertical transmission of HIV from the mother to the child.\textsuperscript{908} Recent evidences, nevertheless, showed the impact of ART beyond vertical transmission. According to a study by the United States National Institutes of Health, “if an HIV-positive person adheres to an effective antiretroviral therapy regimen, the risk of transmitting the virus to their uninfected sexual partner can be reduced by 96%.”\textsuperscript{909} Furthermore, ART has proven to increase the uptake of HIV testing and encourage disclosure of HIV status. It also significantly contributes to reducing stigma and discrimination compounding HIV infection.\textsuperscript{910}

\textsuperscript{906} See UNAIDS, supra note 620, at 25. See also UNAIDS, supra note 807.


\textsuperscript{909} UNAIDS, supra note 755.

\textsuperscript{910} Id.
7.2 Access to HIV Care, Support and Treatment Services as Human Right

Ensuring access to HIV care, support and treatment to PLWHA is an obligation which States are duty bound to fulfill and rights which individuals can legitimately claim. While a number of rights require States to realize PLWHA’s access to HIV care, support and treatment, the most relevant one is the right to health. As discussed in the previous chapters, the right to health is recognized both in human rights treaties to which Ethiopia is a party and in the FDRE Constitution.

The pioneer binding global human rights treaty on socio-economic rights, the ICESCR, provides, under article 12(2), that, in order to realize the right to health, States shall take the necessary measures, inter alia, to ensure “[t]he prevention, treatment and control of epidemic… diseases” and “[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness.”\(^{911}\) More specifically, article 12(2) enjoins States to guarantee “equal and timely access to basic preventive, curative, rehabilitative health services…, appropriate treatment of prevalent diseases, illnesses… and …essential drugs.”\(^{912}\) From HIV/AIDS perspective, the obligation of States to ensure essential drugs includes the duty to guarantee the availability, accessibility and good quality of antiretroviral drugs and other medicines necessary for the treatment of OIs.\(^{913}\) The right of everyone to have access to curative and rehabilitative health services can also be interpreted so as to encompass PLWHA’s access to care and support services that are necessary for healthy life.

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\(^{911}\) See ICESCR, supra note 206, arts. 12 (2) (c) & (d).

\(^{912}\) See Committee on Economic, Social and Cultural Rights, supra note 139, at para. 17.

In relation to the rights of children in the context of HIV/AIDS, the Committee on the Rights of the Child has expounded the provisions of the CRC in its General Comment 3 entitled “HIV/AIDS and Rights of the Child”.\footnote{914} The Committee noted that the duties of the States shall include the provision of comprehensive HIV care and treatment.\footnote{915} The Committee goes on to elaborate that:

\[\text{[C]omprehensive treatment and care includes anti-retroviral and other drugs, diagnostics and related technologies for the care of HIV/AIDS, related opportunistic infections and other conditions, good nutrition, and social, spiritual and psychological support, as well as family, community and home-based care.}\footnote{916}

Moreover, the Committee urges States to pay particular consideration to AIDS orphans and other children whose families are affected by HIV/AIDS, including child-headed households, in terms of ensuring the provision of legal, economic and social support and other necessary services.\footnote{917}

Similarly, the Committee on CEDAW has elaborated the normative content of the right to health care as incorporated in article 12 of the CEDAW and the obligations of states to realize the same. Noting that HIV/AIDS is a serious health problem to women, the Committee urges Member States to take all the necessary measures to prevent and treat HIV/AIDS.\footnote{918}

\textbf{7.3 Commitment of States to Realize Access to HIV Care, Support and Treatment Services}

With a view to achieving the public health goal of controlling the spread of HIV/AIDS and discharging their obligation to protect and fulfill the human rights of those infected with and

\footnote{914} See Committee on the Rights of the Child, supra note 137.  
\footnote{915} Id. at para. 28.  
\footnote{916} Id.  
\footnote{917} Id. at para. 31.  
\footnote{918} See Committee on the Elimination of All Forms of Discrimination against Women, supra note 486, at para. 18 & 31(b).
affected by HIV/AIDS, governments pledged to ensure access to HIV care, support and treatment in several declarations. The most notable ones are highlighted below.

One of the MDGs Member States of the UN agreed to achieve at the 2000 Millennium Summit is halting the spread of HIV/AIDS by 2015.\footnote{The Millennium Development Goals can retrieved from http://www.alliance2015.org/fileadmin/user_upload/MDGs.pdf (last visited Aug. 22, 2011).} A year later, in the 2001 Declaration of Commitment on HIV/AIDS, UN Member States set time-bound targets to halt the pandemic. They, in particular, pledged to progressively realize HIV treatment which includes treatment of opportunistic infections and provision of antiretroviral drugs.\footnote{See UN, supra note 8, at para. 55.} They also promised to deepen family and community-based care, strengthen health facilities to ensure HIV treatment, support individuals, families and communities affected by HIV/AIDS and strengthen referral systems to facilitate the provision of various care, support and treatment services.\footnote{Id. at para. 56.} Moreover, States agreed to develop and implement national strategies on the provision of psychosocial care to those infected with and affected by HIV/AIDS and to invigorate the capability of the government, families and communities to extend support for orphans and children infected by HIV/AIDS.\footnote{Id. at para. 57& 65.}

The 2006 Political Declaration on HIV/AIDS is a document in which the UN Member States reiterated and expanded their commitments in the 2001 Declaration of Commitment on HIV/AIDS. In this document, States undertook to take all necessary efforts to achieve universal access to comprehensive HIV care, support and treatment.\footnote{See 2006 Political Declaration on HIV/AIDS, supra note 13, at para. 20.} To that end, they agreed to “overcome any legal, regulatory, trade and other barriers that block access to prevention,
Moreover, by giving special attention to children, the States vowed to render support and treatment to children infected with and affected by HIV/AIDS. Reiterating their commitments to the implementation of the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS, Member States of the UN stressed the “urgent need to scale up significantly [their] efforts towards the goal of universal access to comprehensive prevention programs, treatment, care and support” in the 2011 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS.

Aside from the above global commitments, African States adopted several declarations and resolutions on HIV care, support and treatment. In the 2001 Abuja Declaration on HIV/AIDS, TB and other Infectious Diseases, African Heads of States and governments agreed to allocate the necessary resources to care and support PLWHA. In the 2005 Gaborone Declaration on a Roadmap towards Universal Access to Prevention, Treatment and Care, Member States of the AU reiterate their commitment to realize the MDGs, the 2001 Declaration of Commitment on HIV/AIDS and the Abuja Declaration and vow to realize universal access to prevention, care and treatment services that are instrumental to halt Malaria, Tuberculosis and other communicable diseases by 2015. In the 2006 Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by 2010, African countries renewed their commitment to halt the spread of HIV/AIDS by achieving access to universal access in 2010. Recently, because many African countries are not in a position to meet the 2010 universal access

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924 *Id.* at para. 15.
925 *Id.* at para. 32.
928 Gaborone Declaration on a Roadmap towards Universal Access to Prevention, Care and Treatment, para. 2. The Declaration was adopted at the 2 nd Ordinary Session of the Conference of African Ministers of Health in Gaborone, Botswana, 10-14 October 2005.
929 See Abuja Call, *supra* note 15.
target, the Heads of State and Government of the African Union have decided to extend the
deadline to 2015 to coincide with the time limit for the attainment of the MDGs.\textsuperscript{930}

\textbf{7.4 Components of Comprehensive HIV Care, Support and Treatment}

In the absence of appropriate care, support and treatment, HIV infection results in serious
morbidity. Needless to say, sickness prevents individuals from continuing their day-to-day
productive activities. This, in turn, entails lack of income to cover costs of living. Even in the
absence of bad health, PLWHA need care, support and treatment services to avoid sickness and
depression that may come after they are informed of their HIV positive status. In general,
PLWHA as well as their families require a lot of care, support and treatment services which may,
of course, differ based on sex, age, level of responsibility in the family, treatment regimens,
economic situation and other factors.\textsuperscript{931}

According to WHO, comprehensive HIV care, support and treatment should cover clinical care
and treatment, psychological and socioeconomic support, participation of PLWHA and their
families and provision of legal assistance.\textsuperscript{932} Clinical (medical and nursing) care and treatment
services include, but are not limited to, VCT, prevention, diagnosis and treatment of OIs and
controlling HIV/AIDS progression using ART and PEP. The socio-economic and psychological
support that should be provided to PLWHA and their families include material and social
support, such as nutritional support, housing and clothing, home-based care and counseling
services that enables them to cope up depression. PLWHA and their families must also be given

\textsuperscript{930} See Decision on the Five (5)-Year Review of the Abuja Call, \textit{supra} note 15.
\textsuperscript{931} Horizons Program, \textit{Strengthening Care and Support Services in the Era of Treatment: Symposium Report}, 2006,
\textsuperscript{932} See WHO, \textit{supra} note 907, at 5-6. See also Joia Mukherjee, \textit{HIV/AIDS Care: The Minimum Package and Scaling
Up, in Public Health Aspects of HIV/AIDS in Low and Middle Income Countries: Epidemiology, Prevention and
Care} 73 (David D. Celentano & Chris Beyrer eds., 2008) and UNAIDS & OHCHR, \textit{supra} note 19, at para. 26.
the opportunity to take part in the planning, monitoring and evaluation of HIV intervention programs. Finally, realizing human rights and ensuring their access to justice through the provision of legal aid services is an element to a package of care, support and treatment services that PLWHA are entitled to.

The care, support and treatment services are, in most cases, difficult to be fulfilled by PLWHA themselves and/or their families. Let alone PLWHA and their families, a good number of States have faced difficulties in realizing these services singlehandedly. In these States, ART and other treatment services are donor-funded. In the same manner as HIV prevention, HIV care, support and treatment require the massive involvement of community-based organizations (CBOs), CSOs, FBOs, government institutions, business organizations, health facilities and donors.933 To maximize their efforts, all sectors should be involved on the basis of their comparative advantages.

While the status of PLWHA participation has already been covered in chapter four and the realization of human rights in the context of HIV/AIDS is a theme that this dissertation generally grapples with, the laws, policies and practices that address the remaining strands of a comprehensive HIV care, support and treatment in Ethiopia are explored from sections five to ten.

7.5 An Overview of National Laws, Policies and Strategies

In section two of this chapter, it is pointed out that the right to health is basically the human rights foundation of PLWHA’s rights to have access to HIV care, support and treatment services. A reference has also already been made in chapters five and six to the recognition of the right to

933 See Horizons Program, supra note 931, at 2.
health in various global and African regional human rights instruments to which Ethiopia is a State party. The FDRE Constitution gives treaties ratified by Ethiopia a status of domestic (national laws).\textsuperscript{934} Furthermore, the right to health is recognized in the FDRE Constitution both in the bill of rights provisions and National Policy Principles and Objectives.\textsuperscript{935} There is, however, neither specific law nor judicial decision in Ethiopia that elucidate the applicability of the right to health to HIV care, support and treatment.

Though there are no specific laws that guarantee the various HIV care, support and treatment services that PLWHA should have access, there are a plethora of non-binding policy guidelines in this area. To begin with the overarching development strategic plan of the Ethiopia, the Growth and Transformation Plan (GTP), makes reference to PLWHA’s right to have access to HIV care, support and treatment services, albeit superficially. In the document, the Government is committed to guarantee that “victims of the disease [HIV/AIDS] get the appropriate service in a manner that respects their human rights.”\textsuperscript{936}

The 1998 National Policy on HIV/AIDS underscores the need to provide care and support to PLWHA and their affected families.\textsuperscript{937} The Policy goes on to state some specific care, support and treatment services like counseling services, creating an enabling environment where PLWHA can generate their income, access to health care for those who cannot afford to pay and ensuring the availability of drugs for the treatment of OIs.\textsuperscript{938} Provision of ART is not at all mentioned in the Policy apparently due to the unavailability of the drugs in Ethiopia then. With

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{934} See FDRE Constitution, supra note 40, at art. 9 (4).
\item \textsuperscript{935} Id. at arts. 41 (3) & (4) & art. 90.
\item \textsuperscript{936} See GTP, supra 108, at 6.Though I have access only to the draft plan, it is now final after being approved by the federal parliament.
\item \textsuperscript{937} See 1998 HIV/AIDS Policy, supra note 17.
\item \textsuperscript{938} Id. at paras. 4 & 6.
\end{itemize}
\end{footnotesize}
the assumption that the Government has resource constraints to provide all these services, the document requires the mobilization of various sectors and communities.\textsuperscript{939}

The Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline requires institutions to reasonably accommodate PLWHA.\textsuperscript{940} This, in other words, means that if PLWHA are unable to carry out the tasks they are assigned to perform, they, upon their consent, should be given the opportunity to be transferred to other tasks of the same status and if transfer is not possible in the same rank, they may be transferred to lower ranks without affecting their salaries.\textsuperscript{941} The Guideline also requires each institution to establish an AIDS fund for the care, support and treatment of PLWHA.\textsuperscript{942} At this juncture, it is important to be cautious in that this Guideline is applicable only to civil service institutions. There are no other particular guidelines that guide HIV care and support service delivery in other public sector institutions and all private enterprises. The sole exception to this is the Education Sector Policy and Strategy on HIV and AIDS that regulates the HIV/AIDS response in the education sector. This document requires education institutions to provide care and support to learners, education personnel living with HIV/AIDS and OVC.\textsuperscript{943}

Due to their special vulnerability and with a view to intensifying and improving care and support activities to OVC, the Ethiopian Government issued the Standard Service Delivery Guidelines for OVC’s Care and Support Program in February 2010. The Guidelines are prepared with the aims of standardizing service delivery among different actors, avoiding duplication of efforts and thereby augmenting the efficient utilization of resources and improving the wellbeing

\textsuperscript{939} \textit{Id.} at para. 6.
\textsuperscript{940} \textit{See} Civil Service HIV/AIDS Guideline, \textit{supra} note 357.
\textsuperscript{941} \textit{Id.} at paras. 2.4 & 5.3.
\textsuperscript{942} \textit{Id.} at para. 2.4.
\textsuperscript{943} \textit{See} Ministry of Education, \textit{supra} note 650, at para. 9 (2).
of OVC.\textsuperscript{944} In order to function as a regulatory instrument for childcare systems and, in so doing, improving the quality of services to OVC, the Government, in June 2009, also developed the Alternative Childcare Guidelines by revising the 2001 Guidelines.\textsuperscript{945}

Ensuring the provision of ART is indispensible to improving the duration and quality of life of PLWHA. In Ethiopia, ART was begun in 2003 and the provision of free ART was commenced in 2005. In 2003, the Government issued the guidelines regulating ART which were revised in 2005 and further updated in 2007. The Guidelines for Implementation of the ART Program were issued to guide program managers and service providers at all levels as well as for planning and implementation of ART programs.\textsuperscript{946} Under the coordination of the MOH and regional health bureaus, health facilities are responsible for providing ART, supporting adherence and giving psychosocial support.\textsuperscript{947} ART plays a significant role in terms of improving the life of PLWHA only if they are properly taken in accordance with the prescription of healthcare workers. The 2009 Guidelines for Implementation of HIV/AIDS Case Management in Ethiopia were developed, \textit{inter alia}, for the purpose of forging a mechanism to engender adherence to treatment and trace those who drop out of treatment.\textsuperscript{948}

Apart from ART, treatment of OIs is critical to reducing HIV-related morbidity and mortality. Treatment of OIs is nowadays regulated in Ethiopia by the 2007 Guidelines for Management of Opportunistic Infections.\textsuperscript{949} The objectives for which these Guidelines are prepared include standardizing the management and prevention of OIs, expanding “evidence-based, safe and

\textsuperscript{945} Ministry of Women’s Affairs, \textit{Alternative Childcare Guidelines on Community-Based Childcare, Reunification and Reintegration Program, Foster Care, Adoption and Institutional Care Service}, 3 & 6 (2009).
\textsuperscript{946} FHAPCO & MOH, \textit{Guidelines for Implementation of Antiretroviral Therapy Program in Ethiopia}, 1 (2007).
\textsuperscript{947} \textit{Id.} at 3 & 10.
\textsuperscript{948} See FHAPCO & MOH, \textit{supra} note 103, at 10.
\textsuperscript{949} See FHAPCO & MOH, \textit{supra} note 96.
rational use of OI drugs,” describing the prevention and treatment of OIs from the perspective of ART and serving as a guideline to healthcare workers and PLWHA.\footnote{Id. at para. 2.1.} As mentioned above, comprehensive HIV care, support and treatment include provision of nutritional support to PLWHA. In 2008, the Ethiopian Government prepared the National Nutrition and HIV/AIDS Implementation Reference Manual that is intended to recognize and implement nutritional support to PLWHA as part and parcel of a package of care and support services.\footnote{MOH, National Nutrition and HIV/AIDS Implementation Reference Manual, 8 (2008).}

Deeply concerned with the unsatisfactory implementation of care and treatment for children living with HIV/AIDS in Ethiopia, the Government paid special attention to improving the situation.\footnote{See FHAPCO & MOH, supra note 101, at 14.} The priority given to care and treatment of children living with HIV/AIDS was partly reflected through the issuance of separate Guidelines for Pediatric HIV/AIDS Care and Treatment in July 2008. The Guidelines concentrate, among other things, on early detection of HIV infection among infants and children through provider-initiated testing and counseling, provision of ART, management of OIs and nutritional support.\footnote{Id. at 13.}

As stipulated in SPM II, care, support and treatment are among the priority areas of intervention that the Government seeks to fast-track. Within this period, the Government plans to increase the coverage of ART to 100\% through, among other things, establishing additional ART sites, integrating TB-HIV and PMTCT/maternal, newborn and child health Maternal, Newborn and Child Health (MNCH) services, strengthening laboratory and referral system, ensuring the availability of OI and ART drugs and augmenting treatment literacy and adherence
The Government also plans to raise care and support to PLWHA and OVC and set targets to be achieved by 2014 by way of intensifying the participation of communities in care and support programs, rejuvenating the role of institutions in providing care and support and enhancing income generating activities by PLWHA.

7.6 Provision of ART

The right to health in general and the right to access to ART, as discussed earlier, is recognized in the FDRE Constitution, major human rights treaties to which Ethiopia is a State party, international declarations on HIV/AIDS and other specific policy documents pertaining to HIV/AIDS. The Government of Ethiopia has taken various measures to realize PLWHA’s access to ART. It launched payment-based ART in 2003 and free ART as of January 2005. Thus, as matter of policy, ART is available for eligible PLWHA without any payment. Free ART is entirely funded by foreign funders, such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria, PEPFAR and the Clinton Foundation.

As part of an effort to realize access to ART and thereby meet the country’s universal access to HIV/AIDS treatment commitment, the Ethiopian Government has undertaken a lot of tasks to expand the sites where ART can be provided. Reports emanating from the Government show that health facilities providing ART has grown from 3 hospitals in 2004/2005 to 550 in 2009/2010. A more recent interview with key informants discloses that the number of health

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954 See SPM II, supra note 17, at 40-42.
955 Id. at 43.
956 The fact that a person is living with HIV/AIDS does not necessarily mean that he/she is eligible to take antiretroviral drugs. PLWHA are eligible for ART only where their CD4 cells drop below a certain level or they show clinical AIDS symptoms. See John A. Bartlett & John F. Shao, Successes, Challenges, and Limitations of Current Antiretroviral Therapy in Low-Income and Middle-Income Countries, 9 Lancet Infect Diseases, 637, 637–49 (2009).
facilities where ART service is available has risen to 690. Though initially ART was available only in public hospitals, nowadays, there are attempts to decentralize both at the health centers and private health facilities.

Parallel to the increment of health facilities providing ART, the uptake of ART has increased tremendously in Ethiopia over the past few years. Compared to 8,278 PLWHA taking ART at the end of 2004/2005, the collective number of PLWHA who commenced taking ART has grown to 268,934 with 207,733 PLWHA actively benefiting from ART at the end of 2010. Of all PLWHA who started to benefit ART, 52%, 5.2% and 42.8% are women, children and men respectively.

While the measures taken in Ethiopia to ensure PLWHA’s access to ART services is commendable, there are still gaps that need to be filled if the universal access to treatment is to be met and access to ART is to be fully realized. Health facilities providing ART services, though having grown in number, are not adequate to be accessible to all PLWHA in rural areas and many small towns. The problem of concentration of the services in urban areas has negatively affected the uptake of the service. The 2009/2010 FHAPCO report revealed that more than 39% of PLWHA were not benefiting from ART at the end of 2010. Another report originating from the same institution disclosed that more than 52% of children in need of ART have not benefited from the service.

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958 See Kifle, supra note 589.
959 See Berhane et al., supra note 46, at 42.
960 See FHAPCO, supra note 50, at 10.
961 Id. at 21.
962 See Kifle, supra note 589.
963 See FHAPCO, supra note 50, at 20.
964 See HAPCO, supra note 51, at 52.
Aside from the limited ART sites, there are other factors that hinder the provision of ART in Ethiopia. These factors include lack of awareness which, in turn, is imputable to insufficient awareness-raising about the services; shortage of CD4 machines, laboratory agents and trained staff; low uptake of HIV testing; weak way of tracking patients and patients dropping out of ART in search of alternative treatments, such as holy water treatment. The problem of lack of trained healthcare workers arises mainly from the migration of workers from government health facilities to other areas in search of better salaries and other benefits. A successful ART program, not only maximizes the number of PLWHA who start ART, but also retains them throughout their life. Ensuring treatment retention or adherence of PLWHA to ART is crucial in terms of reducing “both the progression to AIDS and the development of ARV resistance.” However, studies undertaken in various parts of Ethiopia has shown that several factors are impeding adherence to ART treatment, including lack of efficient follow-up mechanisms, lack of adequate food, stigma and discrimination, patients dropping out of ART and opting for other alternative treatments, economic constraints, panic about the side effects of the drugs, poor patient handling and delay in the initiation of ART.

966 See USAID, supra note 965, at 21.
967 Sofia Gruskin, et al., Beyond the Numbers: Using Rights-Based Perspectives to Enhance Antiretroviral Treatment Scale-up, 21 AIDS 13, 16 (2007).
968 See Mukherjee, supra note 932, at 74.
969 See FHAPCO, supra note 103, at para. 2; FHAPCO, supra note 416, at 97; Esmael Wabela, Abstract-7: Assessment of Factors Influencing Adherence to Antiretroviral Therapy among in Addis Ababa, in Abstract Book: Maternal and Newborn Health in Ethiopia 87 (EPHA, 2010); Addis Akalu, Thesis 6: Reasons for Defaulting from Antiretroviral Treatment Programs in Public ART Sites in Addis Ababa, in ExtractNo.13: Extracts from EPHA-Sponsored Master’s Theses on HIV/AIDS 88 (EPHA, 2010); Taye T. Balcha et al., Barriers to Antiretroviral Treatment in Ethiopia: A Qualitative Study, Abstract, http://www.google.com.et/#q=hiv+care,+support+and+treatment+in+ethiopia&hl=en&prmd=ivns&ei=jizvTeP4LNK1hAeCpcSrCQ&start=10&sa=N&jsa=1&fp=8e7c3b2a2a327167&biw=1016&bih=488 (last visited Jan. 12, 2011); Yibeltal Assefa et al., Outcomes of Antiretroviral Treatment Program in Ethiopia: Retention of Patients in Care is a
7.7 Treatment of OIs

HIV results in gradual exhaustion of the CD4 T cells and the weakening of these cells creates room for OIs which cause more than 90% of AIDS-related premature deaths and sicknesses. There are a range of IOs including malaria, TB, diarrhea, STIs, skin disorders and OIs that affect the central nervous system. Of all OIs, TB is the most prevalent and the greatest source of mortality and morbidity among PLWHA in Sub-Saharan Africa. Prevention, early diagnosis and treatment of OIs are central to reducing AIDS-related morbidity and early mortality.

Similar to ART, OI treatment used to be free in Ethiopia and the only thing PLWHA were expected to do was prove their positive HIV status. This was applicable both at federal and regional levels. However, key informants revealed to the researcher that the Government has changed the policy of free OI treatment on the ground that it became too expensive. According to these informants, this change of position has left many PLWHA without OI treatment due to lack of money and, thus, has resulted in the increment of AIDS-related morbidity and premature mortality.

Appreciating the necessity of prevention, early diagnosis and treatment of OIs in respect of enhancing the length and quality of life of PLWHA, the Ethiopian Government has issued the Guidelines for Management of Opportunistic Infections in 2002 and updated and revised it in

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See FHAPCO and MOH, supra note 96, at 1.
Id. See WHO, supra note 26.
Id. See Kifle, supra note 589.
Id. See Interview with Fatuma Jemale, Director, South Nations, Nationalities and Peoples’ Region PLWHA Network (Jun. 15, 2011) and Asres, supra note 375. According to these informants, the change of policy come after the Ministry of Health distributed a circular to that end.
Id.
As indicated in the 2007 Guidelines for Management of Opportunistic Infections, the Guidelines aim at laying out a blueprint for a standardized and simplified program for prevention and management of OIs. The Guidelines set forth detailed directions that healthcare providers, program managers, and PLWHA should follow with respect to prevention, early diagnosis and treatment of each OI.

It is not possible to find detailed data on the percentage of PLWHA who are also affected by OIs and the extent of prevention, diagnosis and treatment activities undertaken. Being the commonest OI, the only data available is on the measures taken to manage TB-HIV co-infection. A notable task that has been accomplished is the launching of the “TB/ HIV collaborative work” in 2004 in few health facilities and later intensified in more than 330 health facilities. This initiative has contributed a lot to facilitating provision of HCT among TB patients, referral of TB/HIV patients to ART and OI treatment, screening beneficiaries of ART for TB and referral to TB treatment provided that they are positive. The TB-HIV collaboration and the referral system between TB clinics and HIV clinics is not, however, as strong as expected for a number of reasons including “lack of integration of TB case detection in all out patient departments,” problems of laboratory equipment; shortage of trained health workers and inefficient TB/HIV monitoring and evaluation as well supportive supervision. Aside from the specific challenges pertaining to management of TB among HIV positive people, reports, studies and interviews with relevant persons reveal the researcher that inadequacy of OI drugs, shortage of STIs drugs,

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976 See FHAPCO and MOH, supra note 96, at 1.
977 Id. para 2.1.
978 See Berhane et al., supra note 46, at 43 and SPM II, supra note 17, at 53.
979 SPM II, supra note 17, at 54; PEPFAR, supra note 965, at 60 and Berhane et al., supra note 46, at 43.
financial constraints and transportation problems are the major problems that hamper OIs treatment in Ethiopia. 

7.8 Socio-Economic and Psychological Support

A key element of a comprehensive HIV care and support program, recognized in human rights treaties, HIV/AIDS-related international policy documents and laws and policies of Ethiopia discussed above, is provision of socio-economic and psychological support to PLWHA. No matter how States may be able to meet the treatment demands of PLWHA, this in itself is insufficient to realize the right to health of these people without also meeting their needs of socio-economic and psychological support. In fact, lack of socio-economic and psychological support immensely hinders HIV prevention and treatment endeavors. Shortage of food negatively affects adherence to ART and accelerates “progression to AIDS-related illnesses”. Moreover, because HIV/AIDS patients have increased demands of energy compared to their HIV negative counterparts, weight loss as a result of HIV progression is in itself the cause of AIDS-related deaths and several life-prolonging HIV/AIDS drugs and OIs should not be taken without food, fulfilling the nutritional requirements of PLWHA is a necessary condition to enable PLWHA to live a healthy life. Progression of HIV/AIDS affects the productivity of PLWHA. Consequently, they may not be in a position to meet their basic needs. Thus, it is critical to extend other material and social support, such as housing and clothing and home-based care (cooking, keeping personal and environmental hygiene etc.). It is also vital to design self-supporting programs, such as creating job opportunities and income generating activities for

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980 See Berhane et al., supra note 46, at 43; FHAPCO, supra note 416, at 97; Tesfu, supra note 575 and presentation by the FHAPCO Planning, Monitoring and Evaluation Directorate and Abera, supra note 373.
982 Id.
those PLWHA who can work. In addition to material and other social support, it is equally imperative to ensure that PLWHA receive psychosocial support (counseling) that is instrumental to bringing about behavior change; reducing self-stigmatization, anguish, panic, resentment and depression and promoting treatment adherence.\(^{983}\) While psychological support from relatives, close friends and religious leaders are the basis of healthy life for PLWHA, it is also appropriate to strengthen a system where PLWHA can benefit from “more formal psychological support” in critical situations.\(^{984}\)

Though many institutions take part in providing care and support to PLWHA in Ethiopia, the demand is hardly met. According to the most recent FHAPCO report, out of an estimated more than half a million PLWHA who need support, only 104,399, 47,370 and 54,942 received food and shelter, training on IGA and seed money for IGA support respectively in 2009/2010 budget year.\(^{985}\) These figures clearly show the extent to which the coverage of socio-economic support remains extremely low. It is true that the Government is trying to mobilize communities and a range of sectors to increase support to PLWHA. In general, however, support provided to PLWHA by home-based voluntary care-givers, CSOs, PLWHA associations and government institutions is not at all commensurate to the enormous demand.\(^{986}\) The poor performance of socio-economic support can be attributed primarily to lack of capacity on the part of the Government to effectively and massively mobilize various sectors, donors and communities in this area. As I have concluded in chapter four, the lack of effective enforcement mechanisms, limited capacities of FHAPCO and regional HPACOs to coordinate the multi-sectoral response and the Government’s preoccupation with other “priority issues” are primarily responsible for

\(^{983}\) See WHO, supra note 26, at 8.
\(^{984}\) Id.
\(^{985}\) See FHAPCO, supra note 50, at 23. For similar data, see also SPM II, supra note 17, at 49.
\(^{986}\) See Berhane et al., supra note 46, at 43.
inadequate involvement of sectors in socio-economic support. Relatively speaking, psychological support is given much less attention than other issues. This is evident from lack of a specific plan in SPM II on what should be done and from a report from FHAPCO on what has been done in terms of providing psychological counseling to PLWHA. Key informants the researcher interviewed stated that, though limited in coverage, psychological support is given by volunteer home-based care givers who received training for that purpose and if PLWHA are highly depressed, they are referred to religious fathers and health institutions for more psychological counseling.987

Interviews and focus-group discussions with relevant officials disclosed that other factors that present challenges to providing socio-economic support are financial constraints, problems of double/multiple beneficiaries, irregularities in selection of beneficiaries, development of a dependency syndrome, reluctance of microfinance institutions to lend money to PLWHA and inadequate and poor quality support.988 The problem of double/multiple beneficiaries affects equitable care and support. This is because some PLWHA receive support from various organizations while others do not receive it at all. Lack of strong alignment among institutions providing support contributes to this problem. To avoid double beneficiaries, PLWHA associations, primarily responsible for selection of beneficiaries, have started to require PLWHA to produce a clearance letter when they apply to join a new association or seek support from supporting organizations. Because irregularity in the selection of beneficiaries creates a system where those who do not deserve selection are selected and those who do deserve it are not

987 Interview with Melaku Amalede, Monitoring and Evaluation Officer at the Network of HIV Positive Associations in Amhara (Jun. 16, 2011) and Asres, supra note 375.
988 The problems are pointed out by participants (home-based caregivers, health extension workers and other government officials) in a half-day workshop organized by the Ethiopian Red Cross in Addis Ababa at Hotel Difaqrie on June 9, 2011 to share experiences on HIV care and support. See also Amalede, supra note 987 and Jemale, supra note 974.
selected, it also creates an artificial shortage of provision of support. Furthermore, some beneficiaries develop a dependency syndrome in the sense that they want to receive support despite the fact that opportunities are arranged for them to engage in IGA. They tend to consume the seed money rather than using it to run income generating activities. Even when they are in a position to work after the necessary care and support, they do not want to do that.

More often than not, financial constraints are raised as an excuse by the Government officials at various levels for lack of or poor implementation of various HIV interventions. As I have pointed out in chapter five, part of the problem pertaining to financial constraints arises from weak performance of the Government institutions themselves. Quite a range of donors promised and poured a large sum of money into the Government’s pocket for the undertaking of HIV/AIDS-related activities. The donors require the timely submission of performance and audit reports from implementers of HIV/AIDS programs to ensure that the money is properly utilized and as a condition to release the subsequent installments. Owing to non-reporting, delay in reporting and poor reporting, the donors will be hesitant to release all the money they promised to donate. Another bad practice that causes financial constraints is utilization of AIDS funds for purposes other than that for which the money is destined. According to the report of the Federal Auditor General to the federal parliament on financial utilization of federal government institutions for 2010/2011 budget year, out of the total money allocated for HIV prevention and control, more than 200 million Birr and 1.6 million dollars was utilized for other purposes.\footnote{Ethiopian Television News on June 9, 2011, Amharic News at 8 pm local time, also available at http://www.ertagov.com/am/2011-04-27-14-03-55/891-32003.html (last visited Jun. 15, 2011).} It is absolutely paradoxical to talk about financial constraints for HIV-related activities, on the one hand, and misuse HIV funds for other purposes, on the other.
7.9 Meeting the Legal Needs of PLWHA

According to a recent study undertaken by NEP+, PLWHA still face human rights violations in Ethiopia in the form of discrimination, violence, dispossession of property, etc. The study also pointed out that most of PLWHA whose rights are violated do not initiate legal action. This is because, first, many of them feel that legal suit does not produce adequate remedy and are afraid of retaliatory measures. Second, lack of financial means to initiate and pursue the case inhibits them from bringing legal action. As I mentioned above, HIV progression decreases the productivity of PLWHA and thereby impoverishes them. They may not have the means to survive let alone a sum of money needed to hire a lawyer. Human rights violations like dismissal from employment and dispossession of property may also contribute to the indigence of PLWHA.

While fulfilling the legal needs of PLWHA is an element of a package of services to which they should have access, access to justice is a right in its own which should be guaranteed for the affluent and the needy alike. Even if the rich have no problem of resources to seek legal remedies in the event of violation of human rights, financial constraint is a major problem for the poor to realize access to justice. Legal aid is an important way through which the legal needs of the poor can be met. However, PLWHA and other disadvantaged people have not benefited from legal aid schemes as required in Ethiopia. In fact, it is possible to say that the need to provide legal aid to PLWHA is given almost no attention from the Government and other partners. This can be deduced from the lack of any reference to it in the HIV/AIDS national policies, strategic plans as well as reports on the performance of the multi-sectoral response.

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990 NEP+, supra note 421.
991 See Amalede, supra note 987.
The notion of multi-sectoralism came into the scene with a view to providing each sector an opportunity to contribute to the response to HIV/AIDS. The justice-related sector, comprising bar associations, law schools and the like, can contribute in the fight against HIV/AIDS, among other ways, through the provision of legal aid to PLWHA. In Ethiopia, the potential of this sector in providing legal aid is not yet adequately utilized. Indeed, the Federal Court Advocates’ Code of Conduct Regulation mandatorily requires each advocate to provide “at least 50 hours of legal services, in a year, free of charge or upon minimum payment.”992 There are similar regulations in regions as well. However, the obligation of the advocates to provide pro bono legal service is almost not implemented so far.993 According to the Ethiopian Bar Association, two of the main problems that hinder the implementation of pro bono legal service are lack of effective enforcement mechanisms and lack of specific guidelines on the implementation of the service.994 In order to curb the enforcement problem, some regional justice bureaus have started to require the provision of pro bono legal service as a condition to the renewal of licenses.995 It means that the license of an advocate cannot be renewed unless he/she adduces evidence showing that he/she has rendered the threshold legally stipulated pro bono legal service. At the federal level, the Ministry of Justice is in the process of preparation of a proposal for the amendment of the Advocates Licensing and Registration Proclamation. The amended draft proclamation is expected to incorporate enforcement mechanisms for pro bono legal service and provisions that allow senior law students to represent indigents before federal courts.996

994 Id.
995 See Lemma, supra note 753 and Mesfin Leulseged, Civil Litigation Prosecutor at Amhara Region Justice Bureau (Jun. 16, 2011).
996 See Abahoy, supra note 903.
Currently, the limited legal aid that exists is provided by some CSOs and legal aid centers set up by law schools. Under the new LL.B curriculum, applicable in law schools across the country, a number of clinical courses are incorporated, one of which is an HIV/AIDS Legal Clinic. In the clinics, law students learn the skill aspect of the law while at the same time provide legal aid to the needy. The ERC has started to financially support the operation of legal clinics. Despite these initiatives, it is difficult to say that the legal needs of PLWHA are met. Because the services are not well promoted, PLWHA do not know the availability of the services. Furthermore, since the services are concentrated in Addis and other major urban areas, PLWHA in other areas have no access to the services.

7.10 OVC Care and Support

Children bear a double burden of HIV/AIDS. They themselves are infected with the virus and suffer from AIDS-related morbidity and premature mortality. At the same time, they are affected by HIV/AIDS via the sickness and/or premature death of their parents, guardians and members of the communities in which they live. Care and support services should be provided not only to children living with the virus but also children orphans by HIV/AIDS even if they are HIV-negative. The care and support of Children infected with and affected by HIV/AIDS are usually addressed within the broader category of OVC.997

Though there are a number of international documents that deal with service delivery to OVC and elucidate the content of the rights of children from the view point of OVC care and support, the most relevant document to date is “[t]he Framework for the Protection, Care and Support of

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997 The term orphan is understood in Ethiopia to mean any child who does not attain 18 years of age and lost one of his/her parents regardless of the cause of the loss. The term vulnerable child is also taken to mean any child who has not attained 18 years of age and “whose survival, care, protection or development might have been jeopardized due to a particular condition, and who is found in a situation that precludes the fulfillment of his or her rights.” See these definitions in Ministry of Women’s Affairs and FHAPCO, supra note, 944, at 3.
Orphans and Vulnerable Children Living in a World with HIV and AIDS” published in 2004.\textsuperscript{998} The Framework, adopted by more than 40 international organizations, is the result of consultative process among international organizations working on the rights of children since 2000 and intended to provide guidelines to governments and other partners addressing the needs of OVC. The five key strategies recognized in the document to address the needs of OVC are: building the capacity of households to care and support OVC; strengthening community care and support; guaranteeing the provision of OVC care and support services; increasing the role of governments in extending OVC care and support through creating conducive legal and policy frameworks and earmarking resources for their implementation and intensifying public awareness-raising on the need to care and support OVC.\textsuperscript{999}

In spite of the fact that Ethiopia is a party to major global and African regional human rights treaties guaranteeing rights of children, such as the ACRWC and recognizes the rights of children in the FDRE Constitution,\textsuperscript{1000} there were no guidelines until recently on the various services to which OVC should have access. In the absence of these guidelines, the quality and the type of services was left largely to the judgment of each institution providing the service. In February 2010, the Government, in consultation with other stakeholders, prepared the Standard Service Delivery Guidelines for Orphans and Vulnerable Children’s Care and Support Program. These Guidelines seek to provide quality services to OVC by standardizing the same and

\textsuperscript{999} \textit{Id.} at 14.
\textsuperscript{1000} \textit{See} FDRE Constitution, \textit{supra} note 40, at art. 36.
minimizing duplication of efforts.\footnote{1001}{See Ministry of Women’s Affairs and FHAPCO, \textit{supra} note 944, at 1.} The sad news is that the Guidelines have not yet been put into effect and are still waiting validation.\footnote{1002}{Interview with Solomon Kidane, OVC Officer at Ministry of Women, Children and Youth Affairs (Jul.25, 2011).}

The Alternative Childcare Guidelines, developed in June 2009, by revising the 2001 Guidelines, is also pertinent in terms of improving care and support services that should be provided for PLWHA.\footnote{1003}{See Ministry of Women’s Affairs, \textit{supra} note 945, at 3 & 6.} The Guidelines reiterate the obligation of the Government to provide alternative child care for children who are deprived of family care. The Guidelines also incorporated a code of ethics childcare organizations should observe, prescribe the requirements for the establishment of alternative childcare organizations and lay down monitoring and evaluation mechanisms.

The number of orphans in Ethiopia is estimated to be 5.4 million, of which 855,720 are believed to be AIDS orphans.\footnote{1004}{See FHAPCO, \textit{supra} note 50, at 22. It is worth noting that these figures are not based on updated situational analysis of OVC in Ethiopia. Because there is no recent data on the number of OVC and their situations in Ethiopia, the researcher is forced to rely on old statistics.} Under the coordination of the former Ministry of Women Affairs, now the Ministry of Women, Youth and Children’s Affairs (MWYCA) and its regional counterparts, the OVC care and support program is an area of intervention in which a lot of governmental institutions, CSOs, CBOs, FBOs, the business community, UN agencies and other donors take part. Compared to the governmental institutions, CSOs are the prime providers of OVC care and support in Ethiopia.\footnote{1005}{See Berhane et al, \textit{supra} note 46, at 42.} In spite of the involvement of several organizations on the provision of OVC care and support, it is one of the HIV programs that are poorly implemented.\footnote{1006}{See USAID, \textit{supra} note 965, at 22.} The Committee on the Elimination of All Forms of Discrimination Against Women, in its recent concluding observations, expressed its concern about the “lack of care and support for orphans

\begin{footnotes}
\item[1001]See Ministry of Women’s Affairs and FHAPCO, \textit{supra} note 944, at 1.
\item[1002]Interview with Solomon Kidane, OVC Officer at Ministry of Women, Children and Youth Affairs (Jul.25, 2011).
\item[1003]See Ministry of Women’s Affairs, \textit{supra} note 945, at 3 & 6.
\item[1004]See FHAPCO, \textit{supra} note 50, at 22. It is worth noting that these figures are not based on updated situational analysis of OVC in Ethiopia. Because there is no recent data on the number of OVC and their situations in Ethiopia, the researcher is forced to rely on old statistics.
\item[1005]See Berhane et al, \textit{supra} note 46, at 42.
\item[1006]See USAID, \textit{supra} note 965, at 22.
\end{footnotes}
and vulnerable girls and boys affected by HIV/AIDS.\textsuperscript{1007} The unsatisfactory performance of OVC care and support programs can also be seen from data emanating from the Government. According to the 2009/2011 national multi-sectoral performance of FHAPCO, out of the total number of OVC indicated above, only 325,201, 229,287, 40,872 and 43,843 OVC were provided with the school material support, food and shelter, IGA training and IGA startup capital support respectively.\textsuperscript{1008} As with any area of HIV intervention, the frequent reasons cited for poor performance for OVC care and support is resource constraints. Unquestionably, resource-related problems continue to challenge global efforts to put the HIV/AIDS epidemic under control.\textsuperscript{1009} The demand for HIV care, support and treatment services continue to surpass the supply. It is, however, proper to question whether the Ethiopian Government has done its best and given the required attention to OVC. Key informants the researcher contacted believe that resource problems for OVC care and support are partly the result of the failure the Government to employ effective resource mobilization strategies from local sources.\textsuperscript{1010} Though an OVC Taskforce, composed of members from the MWYCA and other stakeholders, was established with a view to strengthening OVC care and support, its role has been minimal due to lack of similar arrangements at regional and grassroots levels.\textsuperscript{1011} The existing OVC care and support programs are largely dependent on foreign funding for their operation.

\textsuperscript{1007} 2011 CEDAW Concluding Observations, \textit{supra} note 397, at para. 34.
\textsuperscript{1008} See FHAPCO, \textit{supra} note 50, at 48.
\textsuperscript{1009} See 20110, \textit{supra} note 1, at 5.
\textsuperscript{1010} See Woldeyes, \textit{supra} note 421. EIFDDA is a local CSO that aggressively works on OVC care and support. EIFDDA is one of the direct receipts of the Global Fund along with NEP+ and FHAPCO.
\textsuperscript{1011} \textit{Id.}
CHAPTER EIGHT
ACCOUNTABILITY

Introduction

In chapter three, I have ventured to show that accountability is one of the pillars of the rights-based approach (RBA). In fact, the raison d’être for the emergence of the RBA is accountability.\textsuperscript{1012} Without accountability, the commitment of States and other actors to mainstream human rights in their policies, strategies and actions would be inefficient. Accountability under a rights-based approach (RBA) requires duty-bearers (states and non-state actors) to be responsible where they fail to meet their human rights obligations, rights-holders to have effective redresses where their rights are violated, an efficient monitoring and evaluation system and transparency of actions.\textsuperscript{1013} Accountability is central to the improvement of the availability, accessibility and quality of HIV prevention, care, support and treatment services, too.\textsuperscript{1014} Global as well as national commitments to ensure access to HIV prevention, care, support and treatment services “may be of little value if there are no effective mechanisms with which to hold government accountable for poor performance in the response.”\textsuperscript{1015}

\begin{footnotes}
\item Chris Collinsa et al., Accountability in the Global Response to HIV: Measuring Progress, Driving Change, 22 AIDS 105, 105 (2008).
\item Per Strand, Making Accountability Work for the AIDS Response, 4(1) Global Health Governance 1, 2 (2010).
\end{footnotes}
improves the response to HIV/AIDS both by prescribing liability for unacceptable performance and through constructive feedback for better implementation.\textsuperscript{1016}

This chapter canvasses the laws, policies and practices pertinent to accountability in the implementation of HIV prevention, care, support and treatment interventions in Ethiopia. Section one gives a brief account of the meaning and dimensions of accountability. Section two explores the recognition given to accountability as a mainstay to effective HIV/AIDS response in international AIDS-related commitment documents. Then, section three succinctly reviews the legal and policy framework of Ethiopia relating to accountability in the context of the response to HIV/AIDS. The remaining sections discuss the various facets of accountability, the laws and other policy documents governing them and their status of implementation in Ethiopia.

8.1 Definition and Dimensions of Accountability

Different people give different definitions for the term “accountability”.\textsuperscript{1017} Black’s Law Dictionary takes accountability to mean responsibility or answerability.\textsuperscript{1018} Godwin \textit{et al} similarly define the term to mean answerability and explain what the notion of answerability is all about.\textsuperscript{1019} For them, answerability requires “someone…to provide information and explanations for action and inaction, and be liable to sanctions for failure to deliver.”\textsuperscript{1020} Cook contends that the notion of accountability is broader than “liability for a breach of the law” and,

\begin{footnotesize}
\begin{enumerate}
\item See Chris Collinsa \textit{et al.}, \textit{supra} note 1014, at 105-106.
\item For the various meanings of accountability, see, for example, Helen Potts, \textit{Accountability and the Right to the Highest Attainable Standard of Health}, http://www2.warwick.ac.uk/fac/soc/csgr/events/conferences/2007/hivaidspapers 21 (last visited Aug. 29, 2011) and Andreas Schedler \textit{et al.}, \textit{The Self-Restraining State: Power and Accountability in New Democracies} (1999). This section is not intended to give the details of the various definitions. It only aims at laying a background for subsequent discussions.
\item Black’s Law Dictionary 55 (8th ed. 2004).
\item \textit{Id}.
\end{enumerate}
\end{footnotesize}
thus, it “requires a state to explain an apparent violation and to offer an exculpatory explanation if it can.” Drawing components of accountability from these definitions and adapting them to the RBA, the concept of accountability is used in this dissertation to refer to a process through which States and non-state actors are held responsible for violation of human rights in the response to HIV/AIDS, bound to provide information regarding their actions and decisions, to have effective remedies for victims of human rights violations and to put in place an effective monitoring and evaluation framework.  

There are important elements of accountability worth noting in this definition. First of all, accountability necessitates the continuous monitoring and evaluation of HIV programs at all levels by governments and other stakeholders. The purpose of monitoring and evaluation is to identify weaknesses and strengths in program implementation, intensify best practices and rectify poor performances. Monitoring and evaluation is also instrumental to finding out who should be responsible for weak or non-performance or encouraged for better performance. Second, accountability requires government officials and other actors to be transparent in their actions and decisions. In the context of HIV/AIDS, transparency entails a host of obligations on States, such as ensuring the availability and accessibility of reliable information pertinent to the national response to HIV/AIDS and respecting “the rights of freedom of expression and association of civil society to review and disseminate information.” Third, accountability requires the meaningful and active involvement of the infected and affected communities in the planning,

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1022 The elements of this definition are also recognized by different authors. See Yamin, *supra* 143, at 49; Gruskin, *supra* note 136 and Mubangizi & Twinomugisha, *supra* note 1013, at 12.

1023 See Canadian HIV/AIDS Legal Network, *supra* note 144, at 14. In Ethiopia, information pertaining to the response to HIV/AIDS is widely available in the websites of the AIDS resource centers and HAPCOs. The extent to which the right to freedom of association of CSOs is guaranteed is discussed in chapter four.
implementation, monitoring and evaluation of various HIV prevention, care, support and treatment programs. Last, but not least, accountability demands States to put in place accessible and effective remedies for victims of human rights violations.

From the perspective of institutions that play a crucial role in ensuring accountability, accountability mechanisms can be broadly grouped into five categories. These are judicial accountability through which courts review actions and decisions of administrative bodies and order remedies to those who suffer loss; quasi-judicial accountability through, inter alia, national human rights institutions, regional and international human rights treaty bodies and ombudsmen; administrative accountability; political accountability by means of, for example, legislative control and electorate disapproval during election and social accountability through, for example, the involvement of civil society and the media.1024

8.2 Recognition of Accountability as a Component to an Effective Response to HIV/AIDS

In the 2001 UNGASS on HIV/AIDS, Head of States and Government of Member States of the UN have adopted the Declaration of Commitment on HIV/AIDS. The Declaration specifies time-bound targets they want to achieve to prevent HIV infection and mitigate its impacts. The Declaration also sets down the various measures States should take to realize the targets. Though accountability is not mentioned by name, its different dimensions are recognized among the measures States should take for an effective response to HIV/AIDS. The Document underscores the need to organize regular national reviews that allow the participation of all stakeholders, including PLWHA, with a view to assessing the developments in terms of implementing the Declaration of Commitment and spelling out strengths and weaknesses for improved

1024 See Potts, supra note 1017.
implementation. It also enjoins States to put in place a workable monitoring and evaluation system to track and evaluate the results achieved.

In contrast to the 2001 Declaration of Commitment on HIV/AIDS, the 2006 Political Declaration on HIV/AIDS explicitly mentions accountability as one of the guiding principles to achieve universal access to HIV prevention, care, support and treatment services. In the Declaration, States vow to implement national HIV/AIDS strategies “with transparency, accountability and effectiveness, in line with national priorities” and to urge other actors to “work closely together to achieve the targets set out… and to ensure accountability and transparency through participatory reviews of responses to HIV/AIDS.”

In the recent 2011 Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, Member States of the UN reiterate their commitment to achieve the universal access commitment by 2015 “through decisive, inclusive and accountable leadership” and “effective evidence-based operational monitoring and evaluation and mutual accountability mechanisms between all stakeholders.”

Being leaders of a continent highly hit by the epidemic, Head of States and Governments of Members of the AU have also adopted a number of commitment documents to prevent and manage HIV/AIDS in Africa. Consistent with the global commitments, the leaders have endorsed realizing universal access to HIV prevention, care, support and treatment services as sine qua non to prevent new HIV infections and mitigate its impacts. The leaders have also recognized monitoring and evaluation and strong partnership with relevant stakeholders as a

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1025 See UN, supra note 8, at para.94.
1026 Id. at para. 95 & 96.
1027 See 2006 Political Declaration on HIV/AIDS, supra note 13, at paras. 38 & 51.
1028 See 2011 Political Declaration on HIV/AIDS, supra note 13, at paras. 50 &102.
perquisite to successful and accountable HIV prevention, care, support and treatment programs.¹⁰²⁹

As highlighted in chapter four, the “Three Ones” principles are widely applied as a blueprint to national AIDS strategies, including in Ethiopia.¹⁰³⁰ The Three Ones principles, adopted by the donor community and international organizations in 2004, aim at effectively harmonizing and coordinating the various efforts in the HIV/AIDS response and thereby avoiding duplication of efforts.¹⁰³¹ The Three Ones principles recognized to achieve this purpose are: one agreed national AIDS action framework, one national AIDS coordinating authority and one agreed country-level monitoring and evaluation system. The recognition of these principles in general and a common national monitoring and evaluation system in particular helps facilitate accountability of the different actors by effectively utilizing monitoring and evaluation devices. The very notion of one national AIDS coordinating body evolves out of the necessity of aligning activities of all stakeholders and effectively holding the various actors taking part in HIV prevention, care, support and treatment activities accountable.

8.3 The Ethiopian Legal and Policy Framework on Accountability

The FDRE Constitution lays a foundation for accountable government. It provides that “[a]ny public official or an elected representative is accountable for any failure in official duties.”¹⁰³² This constitutional provision sends a message to public officials that they should discharge their obligation within the accepted standards. If they fail short of these accepted standards, they will be liable for their failures. The liabilities, stipulated in various primary and secondary legislation

¹⁰²⁹ See Abuja Call, supra note 15, at para. 10.
¹⁰³⁰ See HAPCO, supra note 51.
¹⁰³¹ See UNAIDS, supra note 312.
¹⁰³² See FDRE Constitution, supra note 40, at art. 12 (2).
as well as other government documents, may involve disciplinary penalties ranging from simple warnings to grave ones, including dismissal from employment as well as criminal and civil sanctions. With respect to unacceptable performance of elected public officials, the Constitution gives the electorate the power to remove from office. As one of the devices to hold government officials accountable, the Constitution also enjoins public officials to carry out their tasks transparently. This stipulation is also pertinent to guarantee individuals’ access to information. Illegal actions and inactions by government officials generally victimize individuals and negatively affect public interest. Victims of the misconduct of government officials must be redressed on top of the penalties the official must face. For this reason, the FDRE Constitution gives victims the right to take their cases to judicial and quasi-judicial bodies to seek judgment on their side.

Ethiopia has ratified multiple international and regional human rights treaties. By doing so, the country obliges itself to protect and promote human rights under its jurisdiction including in the context of HIV/AIDS. The FDRE Constitution gives the ratified treaties the status of domestic or national law. This means that national institutions, directly or indirectly working on the protection and promotion of human rights, such as courts, civil society organizations (CSOs), the Ethiopian Human Rights Commission (EHRC) and Institution of Ombudsman, can utilize human rights standards incorporated in the treaties and works of treaty bodies to monitor and evaluate the conduct of the government and thereby hold it accountable if it fails to live up to its obligations. As richly dealt with in the previous chapters, human right treaties contain entitlements that are also relevant to protect, respect, promote and fulfill human rights in the

\[1033\] Id. at art. 12(3).
\[1034\] Id. at art. 12 (1).
\[1035\] Id. at art. 37 (1).
context of HIV/AIDS. The relevant and specific rights have been identified and their normative content has been elucidated by treaty bodies, such as the Committee on Economic, Social and Cultural Rights, the CEDAW Committee and the Committee on the Rights of the Child and other UN bodies and specialized agencies, such as the UN Commission on Human Rights (now the Human Rights Council), the OHCHR, the UNAIDS and the ILO.

The Growth and Transformation Plan (GTP) is of paramount importance in terms of putting forth the blueprint for accountable government in Ethiopia. The GTP aims at fast-tracking rapid socio-economic development in the country. To achieve this lofty objective, the document stipulates seven pillar strategies, one of which is “building capacity and deepening good governance.” The GTP unambiguously recognizes that boosting socio-economic development is unthinkable without equally strengthening good governance and capacity of institutions. The document has incorporated several strategies to build the capacity of institutions and consolidate good governance which include enhancing public participation, guaranteeing access to information, strengthening complaint handling mechanisms, providing effective system of solving disputes, improving the role of CSOs and guaranteeing transparency and accountability of public institutions as well as the independence of the judiciary.

Coming to HIV/AIDS specific laws, policies, strategies and guidelines, it is appropriate first to consult what the 1998 compressive National Policy on HIV/AIDS says on accountability. Though the Policy specifies a range of prevention, care, support and treatment measures and lays down the framework for multi-sectoral involvement to take these measures, it fails to provide the

1036 See GTP, supra 108, at para. 8. The other six pillar strategies are: sustaining faster and equitable economic growth; maintaining agriculture as a major source of economic growth; creating favorable conditions for the industry to play a key role in the economy; enhancing quality of infrastructure and social development and promoting women and youth empowerment and equitable benefit.

1037 Id. at 57-70.
structure on how institutions and individuals should be accountable. It is quite strange to see that this important document does not even mention accountability which is accepted as a key instrument of ensuring the effective implementation of HIV prevention, care, support and treatment programs. From the view point of accountability, Proclamation No.276/2002 is better than the 1998 Policy in the sense that it lays a foundation for the establishment of the principal organs that do play a crucial role in HIV/AIDS governance. It sets up the NHAPCC and the FHAPCO. NHAPCC is chaired by the president of the Republic, consists of members from government institutions, CSOs, PLWHA associations and private sector and is responsible for giving policy guidance and overseeing the overall national response to HIV/AIDS. At least on paper, NHAPCC is a good forum to ensure accountability at the highest level. Since major sectors are represented at NHAPCC, NHAPCC meetings give the different actors the opportunity to jointly evaluate what has been done and what has not been done. The FHAPCO has, however, the real power to hold sectors accountable in respect of implementing HIV/AIDS programs. Established to serve as a secretariat to the NHAPCC and accountable to the prime minister, FHAPCO coordinates HIV-related activities of federal and regional government agencies, donors and CSOs. The coordination power of FHAPCO gives it the power to control what sectors are doing relative to what they expected to do. As stated in the Guideline for Partnership forums against HIV and AIDS in Ethiopia, the NPF was set up in 2004 to supplement the coordination role of the FHAPCO. NPF is composed of members representing different sectors (sub-forums). Each sub-forum is responsible for monitoring, evaluating and coordinating the different sectors and institutions thereunder. At the NPF meetings, the sub-forms share experiences and jointly evaluate programs implemented.

1038 See Proclamation No. 276/2002, supra note 84, at arts. 4 and 5.
1039 Id. arts. 8, 9 & 11(1).
Like its predecessors, SPM II is a common framework for various institutions involving in HIV prevention, care, support and treatment. SPM II lays down the processes, devices and structures of accountability for the multi-sectoral response. It does so, first, by assigning institutions that are responsible for leading a specific area of HIV intervention. Second, SPM II seeks to ensure accountability by providing the coordination role of the multi-sectoral response to HAPCOs at different levels. Third, SPM II intends to ensure accountability through monitoring and evaluation of the multi-sectoral response. The principal mechanisms of monitoring and evaluation are routine reporting, program evaluations, surveillances, surveys and studies. HAPCOs at different levels are responsible for receiving reports for implementing institutions and the FHAPCO and regional HAPCOs are in charge of coordinating the multi-sector monitoring and evaluation, organizing annual and bi-annual joint review meetings and coordinating the quarterly joint supportive supervision of the different institutions involved in the implementation of HIV/AIDS programs. Apart from SPM II, a myriad of specific guidelines adopted to guide the different aspects of HIV prevention, care, support and treatment devote chapter(s) or section(s) to institutional arrangement and process for coordination as well as monitoring and evaluation. As shall be discussed below, there are also other laws that could be applicable to accountability in implementing HIV prevention, care, support and treatment programs.

1041 See SPM II, supra note 17, at 47-70.
1042 Id. at 71.
1043 Id. at 72.
1044 Id.
1045 Id.
1046 See, for example, FHAPCO & MOH, supra note 654; Social Mobilization Guideline, supra note 104; FHAPCO & WHO, supra note 653; PMTCT Guidelines, supra note 17; 2007 HCT Guidelines, supra note 17 and Ministry of Women’s Affairs & FHAPCO, supra note 944.
8.4 Monitoring and Evaluation

As noted earlier, monitoring and evaluation is one element of accountability. Monitoring and evaluation helps identify weaknesses and strengths of program implementation and whether the program is realizing the purpose for which it is designed. In so doing, it gives the inputs necessary to improve program implementation.\textsuperscript{1047} Even if the term “monitoring” and the term “evaluation” are seldom taken as synonymous, the two terms are often used differently. Monitoring is the day-to-day course of action of following inputs (the financial, material and human resources utilized to run the programs), processes, such as the types of activities the program renders and outputs, for example, the number of people benefit from services.\textsuperscript{1048} Evaluation, on the other hand, assesses the overall impact or outcome of a program over a given longer period of time.\textsuperscript{1049} For example, it measures the extent to which the various HIV prevention, care, support and treatment programs changed the trajectory of HIV/AIDS.

As a consequence of the country’s subscription to the “Three Ones” principles, Ethiopia has one national monitoring and evaluation framework for HIV prevention, care, support and treatment programs enshrined in the national strategic plan. Monitoring and evaluation is undertaken by multiple stakeholders. The principal mechanisms of monitoring and evaluation are routine reporting, program evaluations, surveillances, surveys and studies.\textsuperscript{1050} In order to facilitate monitoring and evaluation, SPM II outlines different areas of interventions, their goals, objectives, indicators, expected results and leading bodies. HAPCOs at different levels are


\textsuperscript{1048} See WHO, supra note 907, at 9-11.

\textsuperscript{1049} \textit{Id.} at 9.

\textsuperscript{1050} See SPM II, supra note 17, at 72.
responsible to receiving reports for implementing institutions and the FHAPCO and regional HAPCOs are in charge of coordinating the multi-sector monitoring and evaluation, organizing annual and bi-annual joint review meetings and coordinating the quarterly joint supportive supervision of the different institutions involved in the implementation of HIV/AIDS programs.\textsuperscript{1051} The NPF and the different sub-forums are established to back HAPCOs in their coordination efforts.\textsuperscript{1052} As the highest organ responsible for overseeing the response to HIV/AIDS, the NHAPCC is empowered to evaluate the overall execution of the various HIV prevention, care, support and treatment programs in its regular meeting.\textsuperscript{1053}

Despite the fact that the SPM II and its predecessors as well as other guidelines lay down the institutions, procedures and principles of monitoring and evaluation of HIV prevention, care, support and treatment programs, the implementation of monitoring and evaluation is fraught with enormous challenges in Ethiopia. The principal challenges are highlighted below.

First, the limited capacity of HAPCOs to coordinate monitoring and evaluation and the lack of effective mechanism to ensure sectors’ compliance with implementation standards is one reason for not having an efficient monitoring and evaluation system.\textsuperscript{1054} True, for those sectors and programs that FHAPCO earmark the necessary finance for their operation, HAPCOs have better authority to evaluate and monitor their performance.\textsuperscript{1055} This is not, however, the case for all sectors. FHAPCO does not have the means to finance the majority of the sectors that take part in the response to HIV/AIDS, in which case there is no effective means of controlling their activities. The main reasons responsible for weak coordination capacities of HAPCOs are

\begin{flushright}
\textsuperscript{1051} \textit{Id.} \\
\textsuperscript{1052} See Partnerships Guideline, \textit{supra} note 106. \\
\textsuperscript{1053} See Proclamation No. 276/2002, \textit{supra} note 84, at art. 6 (3). \\
\textsuperscript{1054} See FHAPCO, \textit{supra} note 416, at 51. \\
\textsuperscript{1055} See Fekade, \textit{supra} note 607; Kidane, \textit{supra} note 1002 and Haniko, \textit{supra} note 709.
\end{flushright}
problems of lack of skilled personnel that process data for monitoring and evaluation, poor infrastructure and logistics. These problems obstruct flow of reports from sites and cause delay in regular monitoring and evaluation contrary to what is stipulated in the strategic plan.

Second, the NPF and sub-forums that would have played an important role in supporting HAPCOs coordination role of monitoring and evaluation are not functioning as expected. The major reason for this, they say, is a budgetary problem. Aside from the problem of resources, I would say, there is an equally pressing challenge that cripples their operation. Because forum and sub-forums staffs are not full-time staffs, they have little time to devote to forum-related activities.

Third, there is lack of regularity and delay in conducting bi-annual and annual review meetings of the various actors taking part in different HIV interventions, joint supportive supervision by the same, sessions of NPF and bi-annual meetings of HAPCC. High level review meetings are delayed, inter alia, because political leaders are often preoccupied by other “pressing issues”. The ramifications of irregularities and delay in conducting joint supervision of HIV-related activities of various sectors and review meetings of stakeholders, HAPCOs and NHAPCC to evaluate the performance of the different actors is understandable. That is, the strengths and weaknesses of sectors in the implementation of HIV prevention, care, support and treatment programs are barely assessed.

1056 See Fekade, supra note 607; Kate Stillman et al., The System Wide Effects of the Global Fund in Ethiopia: Final Study Report, 31 (2006) and HAPCO, supra note 51, at 57.
1057 See for example, interview with Tadesse Tekalign, Executive Director, Ethiopian Business Coalition against HIV/AIDS (Dec. 20, 2010); Petros, supra note 378 and Yitna Adera, Program Implementation Officer of NEP+ (Oct. 29, 2010). See also Shiferaw, supra note 414.
1058 See Fekade, supra note 607 and FHAPCO, supra note 416, at 52.
1059 Id.
Fourth, part of the problem of ineffectiveness in ensuring the accountability of sectors in their HIV-related activities is that the highest body to oversee the response to HIV/AIDS, NHAPCC, does not have the muscle to secure compliance. The NHAPCC is chaired by the office of the president of the country who does not have the political power and machinery to ensure that sectors discharge their obligations. Under the existing constitutional power arrangement, the president of the republic is a non-executive body with limited power. It would have been much better had NHAPCC been headed by the prime minister, head of the executive branch.

8.5 Accountability through Treaty Bodies

A RBA to HIV/AIDS is widely accepted, in part, due to the belief that human rights violations fuel the epidemic. It is precisely for this reason Member States of the UN and AU agree to place protection and promotion of human rights at the centre of their response to HIV/AIDS. Aside from national institutions responsible for overseeing the protection and promotion of human rights in the context of HIV/AIDS, there are international mechanisms of holding States accountable for the implementation of human rights treaties. Broadly, the two international human rights mechanisms of controlling States’ compliance with human rights standards are the treaty-based and charter-based mechanisms. The treaty-based mechanisms are established in the binding human rights treaties. The mechanisms of supervision include: reporting, inter-state complaint, individual complaint, inquiries and other procedures. The organs in charge of monitoring the implementation of human rights conventions under a treaty-based mechanism are often referred to as treaty bodies.\textsuperscript{1060} The charter-based supervising mechanisms, on the other hand, do not rely on binding human rights conventions. They are mandated either by the

\footnote{1060 Examples include the Human Rights Committee, the Committee on the Rights of the Child, the Committee on the Elimination of All Forms of Discrimination Against Women, the African Commission on Human and Peoples’ Rights, the African Court on Human and Peoples’ Rights, the European Court of Human Rights and the Inter-American Court and Commission of Human Rights.}
constituent document of the intergovernmental organization or a resolution of the general assembly or a representative body of the same.

State reporting is the principal and standardized way of monitoring the implementation of HIV/AIDS-related human rights by States. With respect to Ethiopia, in particular, because it has not accepted all the UN individual complaint mechanisms and due to the lack of concrete cases in African human rights system where Ethiopia has accepted the individual complaints procedures, it is imperative to assess to what extent Ethiopia complies with its reporting obligations.

By ratifying treaties, States undertake the duty to submit initial and periodic reports to treaty bodies highlighting the measures taken to implement treaties. After evaluating information obtained from State reports, shadow reports from CSOs, UN agencies and others and dialogue with States’ delegates, treaty bodies issue concluding observations which incorporate the positive sides of implementation, areas of concern and recommendations to the State. Since HIV/AIDS has become a human rights issue, State reports and concomitant concluding observations of treaty bodies refer to HIV/AIDS. According to a survey conducted by the Danish Institute for Human Rights, HIV/AIDS was referred to in 127 concluding observations for 89 States between

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1061 Ethiopia is not a party to the Optional Protocol to the International Covenant on Civil and Political Rights or Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women. For ratification status of these treaties, see http://treaties.un.org/Pages/Treaties.aspx?id=4&subid=A&lang=en (last visited Feb. 6, 2011). For ratification status of Ethiopia regarding ACHPR and ACRWC, see http://www.achpr.org/english/_info/index_ratifications_en.html (last visited Feb. 6, 2011). The limited communications submitted to the African Commission against Ethiopia were rejected (made inadmissible) on grounds of non-exhaustion of domestic remedies and that Ethiopia was not a party to the ACHPR at the time of submission of the communications See International Lawyers Committee for Family Reunification v. Ethiopia, Communication No. 9/88; Getachew Abebe v. Ethiopia, Communication No. 10/88; Dr. Abd Eldayem Ae Sanussi v. Ethiopia, Communication No. 14/88; International Pen v. Malawi, Ethiopia, Cameroon and Kenya, Communication No. 19/88; Centre Haitien Des Libertes Pubmiques v. Ethiopia, Communication No. 21/88; Association Internationale Des Jurists Democrates v. Ethiopia, Communication No. 28/89; Commission Francaise Justice Et Paix v. Ethiopia, Communication No. 29/89 and Anuak Justice Council/ Ethiopia, Communication No. 299/05.
2005 and 2010. Out of the total concluding observations, 95 (75%) of them were issued by the Committee on the Rights of the Child and the Committee on CEDAW.\footnote{Danish Institute for Human Rights in Collaboration with Aidsnet – the Danish Network of AIDS NGOs, \textit{HIV/AIDS and the International Human Rights Treaty Bodies, 2005-2010} (2010).}

Ethiopia has ratified/acceded to the major global and African regional human rights treaties, such as the ICESCR, the ICCPR, the CEDAW, the CRC, the ACHPR and the ACRWC. The country has also submitted several reports to the treaty bodies. In the reports and the consequent concluding observations issued by the treaty bodies, measures taken to realize access to HIV prevention, care, support and treatment, challenges faced, areas of concern and recommendations have been noted.

Generally, however, Ethiopia has a weak reporting record to treaty bodies. With the exception of fair reporting to the Committee on the CRC\footnote{Ethiopia ratified the CRC in 1991. Under the CRC, Ethiopia submitted its initial report in 1995 for which the concluding observations were issued in 1997, second periodic report in 1998 for which the concluding observations came in 2001 and third period report in 2005 for which the Committee issued concluding observations in 2006. Its fourth and fifth combined reports will be due in December 2011.} and relatively better reporting status to the Committee on CEDAW,\footnote{Ethiopia ratified CEDAW in 1981. Ethiopia submitted the initial, second and third combined reports in 1995 for which the Committee on CEDAW issued concluding observations in 1996. \textit{See} Committee on the Elimination of Discrimination against Women, Consideration of Reports Submitted by States Parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women, combined initial, second and third periodic reports of States parties: Ethiopia, Oct. 1995 and CEDAW, Report of the Committee on the Elimination of Discrimination against Women (Fifteenth session) General Assembly Official Records, Fifty-first Session Supplement No. 38 (A/51/38), 1996. Ethiopia submitted its fourth and fifth combined reports in 2002 for which the concluding observations were issued in 2004. \textit{See} Committee on the Elimination of Discrimination against Women, \textit{supra} note 840 and Report of the Committee on the Elimination of Discrimination against Women, Thirtieth session (12-30 January 2004) and Thirty-first session (6-23 July 2004). Moreover, it submitted its six and seventh combined reports in 2009 for which the Committee issued concluding observations on July 2011. \textit{See} Ethiopian Combined Sixth and Seventh Periodic Report to the CEDAW Committee, \textit{supra} note 752 and 2011 CEDAW Concluding Observations, \textit{supra} note 397, at para. 34.} the country is notorious for non-reporting and delay in reporting to other treaty bodies. On most occasions, the country submitted combined reports so as to reduce reporting backlogs. It would suffice to see the following statistics to have a sense of the magnitude of the problem. Ethiopia ratified the ACHPR in 1998. It was, nonetheless, after ten...
years, in 2008, that it submitted its combined initial, second, third and fourth periodic reports due from 2000-2007.\textsuperscript{1065} The Government attributed the delay to financial constraints.\textsuperscript{1066} Ethiopia ratified the ACRWC in 2002. The due date for submission of the initial report was on October 2, 2004, but the country has not reported to date. Whereas Ethiopia ratified the ICCPR and the ICESCR in 1993, the country submitted its initial and combined reports to the respective Committees in 2009.\textsuperscript{1067}

Notwithstanding the inherent problems of reporting as one way of ensuring States’ accountability for the implementation of HIV/AIDS-related human rights, delay in or non-reporting adds to the problem. In case of total failure to report, the treaty bodies cannot have the opportunity to know what the State is actually doing in terms of implementing human rights. The lack of knowledge inhibits treaty bodies from commending the State for encouraging measures it took; raising its concerns in areas where there was poor implementation and recommending remedial measures to rectify the problems. In case of delay in reporting, treaty bodies cannot have the opportunity to receive up-to-date information. This, in turn, disables them from exercising meaningful supervision on State Parties.


\textsuperscript{1066} See the 2008 Ethiopian Report to the African Commission, supra note 1065, at para. 3.

8.6 Mutual Accountability between the Government and Donor Agencies

Donor agencies play irreplaceable roles in the fight against HIV/AIDS in Ethiopia. In fact, it is possible to reach to a conclusion that, without donor agencies, the response to HIV/AIDS would have been futile. Donor agencies are involved in the implementation of HIV prevention, care, support and treatment programs in various ways. They finance care and support to PLWHA and OVC, the ART program and other prevention programs. They also take part in building the capacity of different stakeholders through training and technical assistance. While there are many donor agencies and initiatives operating in Ethiopia, the notable ones in the area of HIV/AIDS are the Global Fund, the World Bank, PEPFAR, UNAIDS, UNICEF and other UN agencies.

As long as these agencies operate in Ethiopia, they have to be answerable to the Ethiopian Government for what they are doing. It is not only the Government that controls donor agencies. Donor agencies, too, control the Government to the extent of the funds or assistance they extend to the Government. Because these agencies pour a lot of resources into running HIV prevention, care, support and treatment programs, recipients of the fund, the Government and CSOs, should be accountable to them. The Government and donors use various ways of controlling donors and the Government respectively. When donors intend to work in Ethiopia and the Government seeks assistance from them, they should enter into an agreement. The agreement is a point of reference for mutual accountability. 1068 The donors are also represented and participate in forums, such as NPF, NHAPCC, multi-sectoral review meetings and joint planning, that aim at ensuring mutual accountability.

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1068 See Haniko, supra note 709.
accountability among the different actors, including the government and donor agencies.1069

Other mechanisms of control of donors by the Government and vice-versa are joint supportive supervision, visits to the place of job and appraisal of proposals and annual plans.1070

Donor agencies demand the submission of periodic operational and audit reports from the Government and other fund recipients. The interval within which the reports should be submitted is something to be determined in the project agreement. For example, Member States of the UN collectively agreed to submit performance reports to UNAIDS every two years.1071 As highlighted in chapter five and seven of this dissertation, there is generally a chronic problem of submitting timely reports to donor agencies in Ethiopia. Delay in reporting has affected the effective utilization of funds. This is because donor agencies have been unwilling to disburse funds without the prior submission of performance and audit reports for previously utilized funds.

8.7 Legislative Accountability Mechanisms

The legislature can generally play two important roles in terms of ensuring government institutions and stakeholders are accountable in their efforts to realize access to HIV prevention, care, support and treatment services. It can stipulate legislative standards of accountability and evaluate the activities of other branches of the government periodically.

1069 Interview with Shimeles Esatu, Multi-Sectoral Coordination and Leadership Officer at S/N/N/P/ Region Health Bureau (Jun. 15, 2011). See also interview with See Fekade, supra note 607; Kidane, supra note 1002 and Haniko, supra note 709.
1070 Id.
With the sole exception of the Proclamation that established the National NHAPCC and FHAPCO, there is not any comprehensive law that has been put in place by the parliament on HIV/AIDS in Ethiopia. As discussed in chapter six, the legislature makes only superficial reference to HIV/AIDS in a few recent laws. Though a draft HIV/AIDS bill was prepared by the Ministry of Justice in 2009, the finalization of the draft and its submission to the Council of Ministers was discontinued for unknown reasons.\textsuperscript{1072} Due to the absence of comprehensive law on HIV/AIDS, the response to HIV/AIDS is overwhelmingly regulated by a bunch of policy documents, strategic plans and guidelines. But, these documents do not impose legal obligation on the part of the Government. They merely entail political obligation. A legally binding law which, \textit{inter alia}, specifies standards of performance, review mechanisms, monitoring and evaluation frameworks and penalties for intolerable performance could have remedied the enforcement problem. As discussed in chapter six, the absence of a specific and comprehensive binding HIV/AIDS law has left HIV prevention, care, support and treatment fundamentally at the discretion of sectors with no effective sanction for underperformance or non-performance.

Another way the lawmaker holds government institutions accountable concerning the implementation of HIV prevention, care, support and treatment programs is by requiring them to submit annual reports. In Ethiopia, the parliament, the House of Peoples' Representatives (HPR), is constitutionally empowered to evaluate whether executive offices discharge their obligations.\textsuperscript{1073} In practice, ministries and other equivalent government agencies as well as the judiciary submit annual performance reports, present the same before the House and answer any question that could be raised by members of the House. Logically, the performance report should include what institutions have done in respect of HIV prevention, care, support and treatment on

\textsuperscript{1072} See Abahoy, \textit{supra} note 903.

\textsuperscript{1073} See FDRE Constitution, \textit{supra} not 40, at art. 55 (17).
top of other performances in their core mandates. This is because the multi-sectoral approach to HIV prevention, care, support and treatment implemented in Ethiopia requires including HIV/AIDS-related activities in their core mandates based on their comparative advantages. Nonetheless, except for the FHAPCO and regional HAPCOs that are responsible for coordinating the response to HIV/AIDS, it is not customary to see institutions brief the parliament on their HIV/AIDS-related activities. Quite recently, however, the federal parliament has started to ask reporting institutions to explain their accomplishments with respect to HIV/AIDS prevention, care, support and treatment.¹⁰⁷⁴

As a matter of law, if the HPR believes that a certain office fails to discharge its responsibilities, it has the power to take any measure it deems necessary.¹⁰⁷⁵ It is unusual, however, to hear serious measures taken or serious criticisms raised by the parliament against government offices for poor or non-performance. Ethiopia follows parliamentary form of government in accordance with which ministers, in majority of cases, are also members of the parliament.¹⁰⁷⁶ This lack of separation of power/persons between the legislature and the executive organ weakens checks and balances in general and parliamentary control over the executive in particular. The fact that an overwhelming number of members of the parliament are from the ruling party also contributes to poor parliamentary oversight over the executive branch.¹⁰⁷⁷

¹⁰⁷⁴ Haniko, supra note 709.
¹⁰⁷⁵ See FDRE Constitution, supra not 40, at art 55 (18). In case of judges, it approves their removal when a decision is made by the Judicial Administration Council to that end. See FDRE Constitution, supra not 40, at art. 79(4).
¹⁰⁷⁶ Id. art. 74.
¹⁰⁷⁷ Currently, with the exception of one member from one of the opposition parties and another private member, the other members of the parliament are members of the ruling party (Ethiopia Peoples’ Revolutionary Democratic Front) and closely allied parties.
8.8 Role of CSOs in Ensuring Accountability

The Government has diversified ways through which it controls the activities of CSOs. In Ethiopia, the institutions as well as mechanisms of holding CSOs accountable to the Government are specifically provided in the CSOs Proclamation. CSOs also have a role to play in holding government accountable. Of course, CSOs do not have the power to change or render government policies inapplicable by themselves. Rather, they engage in activism “either to shame the government into realizing it is in the government’s own political interest to improve the response, or to mobilize sufficient political pressure to trigger vertical or horizontal accountability of the formal kind.”

Advocacy, PIL, monitoring and evaluation are the principal strategies CSOs employ to boost government accountability.

There are thousands of FBOs, community-based organizations (CBOs) and other CSOs working directly or in directly on HIV/AIDS across the country. Out of these CSOs, more than 400 are associations of PLWHA and their networks. CSOs are represented and participate in forums, such as NPF, NHAPCC, multi-sectoral review meetings, joint supervision and joint planning that aim at ensuring mutual accountability among the different actors. Representatives of CSOs, however, expressed their disappointment saying that their participation in the preparation of strategic plans and guidelines is superficial. The documents are prepared somewhere by the Government and presented at workshops or conferences that are convened to deliberate on strategy, guideline or policy. Feedback from stakeholders is usually disregarded.

1078 See Strand, supra note 1015, at 5.
1079 See Esatu, supra note 1069; Fekade, supra note 607; and Haniko, supra note 709.
1080 See Woldeyes, supra note 421; Shiferaw, supra note 375; Tigabe Asres, supra 375 and Alemu, supra 42. A survey conducted by NEP+ revealed that the involvement of PLWHA in the preparation of laws, policies and guidelines and programs and projects affecting them is minimal. The same survey found that most PLWHA do not believe that they can affect decisions that impact their interests. See NEP+, supra note 421, at 124.
As extensively discussed in chapter four, the CSOs Proclamation has seriously threatened human rights advocacy by CSOs. The Proclamation prohibits foreign and foreign-funded NGOs from working on promotion of human rights, which may include prohibition of advocating the rights of PLWHA and human rights activism to stop gender-based violence and human rights violations which are identified as fueling the transmission of the epidemic. These NGOs are authorized to carry out only service delivery undertakings and other “developmental” activities. The position taken by the CSOs Proclamation to prohibit foreign and foreign-funded NGOs from engaging in human rights activism, apart from being a violation of freedom of association and other human rights, seriously affects the activities of NGOs that wholly or partly work on human rights advocacy, including PLWHA associations and their networks, to address the HIV/AIDS epidemic.\(^\text{1081}\)

PIL is an important mechanism by which CSOs hold government accountable. PIL is vital in the context of HIV/AIDS as PLWHA and other vulnerable groups may not have the means and knowledge to pursue legal action where their rights are violated. PIL enables CSOs to challenge the laws, policies and actions of the government that violate human rights before courts or other quasi-judicial bodies. Unfortunately, there is not a favorable legal framework for PIL in Ethiopia. As shall be discussed in last section of this chapter, except for specific purposes and before certain fora, PIL is not permitted in Ethiopia.

\(^{1081}\) See Asres, supra note 375. The Committee on the Elimination of Discrimination against Women has expressed its concern to the Ethiopian Government saying that the Proclamation “has obstructed the capacity of local women’s rights organizations to provide legal aid and other support to women victims of human rights violations.” Similarly, the African Commission on Human and Peoples’ Rights states that the Proclamation “has the potential to violate the rights of freedom of expression as specified by the African Charter, especially the provision that requires NGOs not to raise more than ten percent of their funding outside of Ethiopia.” See 2011 CEDAW Concluding Observations, supra note 397, at para. 28 and African Commission Concluding Observations, supra note 1065, at para, 45.
8.9 The EHRC and Institution of Ombudsman

National human rights institutions, such as human rights commissions and ombudspersons, have an important place in holding government and other actors accountable for implementation of HIV-related rights. Especially, they function as a guardian of human rights through supervising the conformity of national HIV-related laws, policies, practices and programs with human rights principles; resolving HIV/AIDS-related complaints; paying visits to PLWHA and scrutinizing whether they receive the services necessary for a healthy life and tracking the implementation of concluding observations of treaty bodies and recommendation of other human rights supervisory bodies.\(^\text{1082}\) National human rights institutions can effectively carry out these tasks only where they are independent and have the necessary legal mandate, budgets and human power.

The two relevant institutions in this regard in Ethiopia are the EHRC and the Institution of the Ombudsman established by law as autonomous organs in 2000.\(^\text{1083}\) As its name hints, the EHRC has been established to serve as one of the institutions that would take the responsibility to enforce human rights and freedoms.\(^\text{1084}\) Within this broader mandate, the Commission has the power and duty, among other things, to monitor the conformity of laws and policies to human rights standards, disseminate human rights education and investigate human rights violations both on its own initiative and upon receiving complaints.\(^\text{1085}\) With the overall mandate of combating maladministration, the Institution of Ombudsman, on the other hand, is responsible, *inter alia*, for monitoring directives issued and decisions passed by the executive as well as

\(^{1082}\) *See* Danish Institute for Human Rights, *supra* note 1062.

\(^{1083}\) Ethiopian Human Rights Commission Establishment Proclamation, Proclamation No. 210/2000, *Federal Negarit Gazeta*, 6th Year No. 40 [hereinafter EHRC Proclamation] and Institution of the Ombudsman Establishment Proclamation, Proclamation No. 211/2000, *Federal Negarit Gazeta*, 6th Year No. 41 [hereinafter Ombudsman Proclamation]. The fact that these institutions are autonomous only implies that they are immune from the interference of the executive in pursuing their mandates. Otherwise, they are accountable to the parliament. *See* art. 3 of both EHRC Proclamation and Ombudsman Proclamation.

\(^{1084}\) *See* EHRC Proclamation, *supra* note 1083, at art.5.

\(^{1085}\) *Id.* at art. 6.
ensuring that its practices do not violate human rights and the law, investigating maladministration both in its own initiative or upon receiving complaints and paying visits to executive offices to ensure that the offices perform their tasks in conformity with the law.  

What is clear from the power vested on these institutions is that EHRC has broader power than the Institution of Ombudsman. Whereas the EHRC has the power of supervising the implementation of human rights in all government institutions, the power of the Ombudsman is limited only to the executive institutions. It is worth noting, however, that both institutions have a role to play in terms of supervising the implementation of human rights. This overleaping jurisdiction has already been foreseen and resolved by the enabling laws of these institutions. Accordingly, where a case arises over which both have jurisdiction, which of the two may handle the case can be decided by the agreement of the two, and, in the absence of agreement, by having regard to which institution started the investigation first.  

One of the powers given to the EHRC and the Institution of Ombudsman that merits elucidation is the power to receive and investigate complaints of human rights infringements. With respect to standing requirements to lodge complaints, the enabling legislation of the two institutions give victims of human rights violations, their spouse, family members, representative or a third party the right to lodge complaints. Compared to ordinary courts, standing requirements before these institutions is exceptionally liberal. They allow a number of people, including third parties, to lodge complaints without a need to show that they themselves suffer from human rights

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1086 See Ombudsman Proclamation, supra note 1083, at the preamble and art.6. The Proclamation, under article 2(5), defines the term "maladministration" to mean "acts committed, or decisions given, by executive government organs, in contravention of administrative laws, the labor law or other laws relating to administration."

1087 See art. 29 of both the EHRC Proclamation, supra note 1083 and Ombudsman Proclamation, supra note 1083.

1088 Id. art. 22.
violations or have a special interest in the case.\textsuperscript{1089} Moreover, the institutions also have the power to “receive anonymous complaints” where they believe that the violation of human rights is of grave nature.\textsuperscript{1090} Essentially, the two institutions commence investigations when complaints are submitted to them; however, they have the authority to investigate on their own initiatives where they deem it necessary.\textsuperscript{1091}

Upon the completion of investigation, the institutions communicate their findings along with their views to the head of government institutions against which a grievance was lodged and to the complainant in writing. Their recommendations should unequivocally state that an act or omission that violated human rights should be terminated, a directive that contravenes human rights be canceled, appropriate remedy to the victims provided or “any other appropriate measure be taken.”\textsuperscript{1092}

From their enabling laws, it is thus clear that the EHRC and the Institution of Ombudsman are given important power of national human rights institutions; namely investigation of complaints of human rights violations and monitoring of the consistency of laws, policies and practices with human rights standards. In practice, however, the institutions are primarily discharging their promotional mandates, such as awareness-raising and training, rather than their investigation and

\textsuperscript{1089} According to article 2(9) of the EHRC Proclamation, \textit{supra} note 1083, the term “third party” shall include “a deputy, an association or an NGO representing an individual or a group.”

\textsuperscript{1090} \textit{See} art. 22 of both the EHRC Proclamation, \textit{supra} note 1083 and Ombudsman Proclamation, \textit{supra} note 1083.

\textsuperscript{1091} \textit{See} art. 24 of both the EHRC Proclamation, \textit{supra} note 1083 and Ombudsman Proclamation, \textit{supra} note 1083. Institutions are legally bound to cooperate in the course of investigation. \textit{See} art. 25 of both the EHRC Proclamation, \textit{supra} note 1083 and Ombudsman Proclamation, \textit{supra} note 1083. In reality, many institutions do not cooperate. For example, the Institution of Ombudsman reported that six government institutions were not willing to cooperate with it during its investigation in 2009. \textit{See} Institute of Ombudsman, \textit{Report Submitted to the Legal and Administrative Committee of the House of Peoples’ Representative}, 5 (2010).

\textsuperscript{1092} \textit{See} art. 26 of both the EHRC Proclamation, \textit{supra} note 1083 and Ombudsman Proclamation, \textit{supra} note 1083.
monitoring responsibilities. There are limited complaints received and investigated on their own initiatives by the institutions and even much less HIV-related complaints. This is the reflection of the general situation of poor human rights litigation in Ethiopia. Lack of public awareness and poverty are among the factors that negatively affect human rights litigation in Ethiopia. An aggressive human rights education by these institutions, CSOs and other Government institutions may contribute towards creating a human rights conscious society. It may be argued that since submission of complaints at EHRC and the Institution of Ombudsman is free, financial problems are not an issue. While this contention is partly true, it can still be argued that lack of means to pursue cases before these institutions is a barrier to have access thereto. This is because there are huge costs involved to cover transportation and accommodation in order to submit complaints to the office of these institutions for those individuals who live far from these offices. The Institution of Ombudsman has only one office in Addis Ababa with a plan to open regional offices. The EHRC has recently opened six regional branches in Bahir Dar, Mekele, Jimma, Hawassa, Gambella and Jigjiga apart from its headquarter in Addis Ababa. It has also a plan to open seven other branches in regions. One may wonder: what are the reasons for not having enough offices in different parts of the country? One obvious reason for this is resource constraints on the part of the Government. The other problem is shortage of skilled human power. However, this is not to say that there are no qualified experts on the market in Ethiopia. The problem is lack of adequate incentives to attract qualified experts. Experts

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1094 Interview with Muluye Welelaw, Director of Correction of Violation of Human Rights Directorate at the Ethiopian Human Rights Commission (Sep. 14, 2011) and Petros Woldesenbet, Director of the Maladministration Investigation and Correction Directorate at the Ethiopian Institute of Ombudsman (Sep. 14, 2011).
1095 Id. See also the 2008 Ethiopian Report to the African Commission, *supra* note 1065, at para. 70.
1096 Id.
generally tend to avoid employment in government institutions and favor employment in CSOs, private institutions and international organizations that offer better remuneration.

The EHRC and Institution of Ombudsman, as briefly mentioned above, do not have the kind of power ordinary courts have. Their findings are in the form of recommendations to which the institutions the recommendation are forwarded should cooperate in the execution.\textsuperscript{1097} Though the majority of government institutions are willing to cooperate for the execution of their recommendations, a few others are not.\textsuperscript{1098} In case of refusal, the EHRC and Institution of Ombudsman do not have an effective enforcement mechanism. They only endeavor to name and shame by publicizing the situation of defiant institutions in their reports.

\section{Remedies for Violations of HIV-Related Human Rights}

As stated earlier, providing effective redress to victims of violations of human rights is one of the elements of accountability in the RBA. The right to an effective remedy is a right in its own recognized in several human rights instruments. The UDHR, under article 8, provides that “[e]veryone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted by the constitution or by law.” Having stipulated this right under article 2(3) more generally, the ICCPR incorporates specific redresses including on the right to apply for pardon, amnesty and commutation of the death sentence under article 6(4); the right to \textit{habeas corpus} and judicial review under article 9(3) and (4) and the right not to be illegally expelled under article 13. Other human right instruments that recognize the general right to effective remedy and its particular strands include, but are not limited to, articles 2 and 3 of

\textsuperscript{1097} Id.
the ICESCR, articles 2 and 3 of the CEDAW, articles 2, 3, 4, 19, 20, 32 and 37(d) of the CRC and articles 7, 21 and 26 of the ACHPR.

Treaty bodies and other international supervisory bodies play a supplementary role in terms of ensuring remedies to victims of human rights violations. This is evidenced by the principle of exhaustion of domestic remedies before resort is made to international quasi-judicial bodies.\textsuperscript{1099} Thus, States have the principal obligation to guarantee accessible and effective remedies for human right violations. For quite a number of reasons, domestic remedies for human rights violations are by far better than the international ones.\textsuperscript{1100} Courts, national human rights institutions and administrative bodies are the main government institutions providing remedies. Remedies for violation of human rights may take different forms including “cessation of an ongoing violation” and reparation to victims of human rights violations.\textsuperscript{1101} The Human Rights Committee explained that reparation may include “restitution, rehabilitation and measures of satisfaction, such as public apologies, public memorials, guarantees of non-repetition and changes in relevant laws and practices, as well as bringing to justice the perpetrators of human rights violations.”\textsuperscript{1102} Since the responsibilities of the EHRC and the Institution of Ombudsman with respect to holding government accountable for implementation of human rights in general and remedying violations in particular is discussed above, only administrative and judicial remedies are discussed below.

\textsuperscript{1099} See Committee on ICESCR, \textit{supra} 237, at para. 4.

\textsuperscript{1100} Domestic remedies are “normally quicker, cheaper, and more effective than international ones”. \textit{See}, for example, the holding of the African Commission on Human and Peoples’ Rights in the Anuak Justice Council \textit{v.} Ethiopia, \textit{supra} note 238, at para 48.

\textsuperscript{1101} \textit{See} Human Rights Committee, \textit{supra} note 211, at paras. 15 and 16.

\textsuperscript{1102} \textit{Id}.
8.10.1 Administrative Remedies

The Committee on Economic, Social and Cultural Rights opined that effective remedies are not only restricted to judicial remedies but also “accessible, affordable, timely and effective” administrative remedies.\footnote{1103} It has also mentioned that if individuals are dissatisfied with the decision of administrative bodies, it is imperative to guarantee the right to appeal to courts.\footnote{1104} Administrative remedies are normally preferable to judicial remedies in terms of effectiveness and the time and resources necessary to pursue the case. It is exactly for these reasons various laws of Ethiopia and practices demand exhaustion of administrative remedies prior to seeking remedies before judicial and quasi-judicial bodies. For example, the CSOs Proclamation requires CSOs to exhaust administrative remedies before they appeal to the Director General and the Board of the Charities and Societies Agency and the Federal High Court.\footnote{1105} Likewise, the Institution of the Ombudsman Establishment Proclamation urges any person to lodge his/her complaints to the pertinent institutions before coming to the Institution of Ombudsman.\footnote{1106} Though the requirement of exhaustion of administration of remedies is not provided in the EHRC Establishment Proclamation, in practice, the EHRC refer cases to appropriate organs before it embarks on investigation.\footnote{1107}

As highlighted in different chapters, there are a number of rights States are duty bound to respect, protect and fulfill in the context of HIV prevention, care, support and treatment. The question worth asking at this juncture is: what are the administrative remedies available to

\footnote{1103} See Committee on ICESCR, supra note 237, at para. 9.  
\footnote{1104} Id.  
\footnote{1105} See CSOs Proclamation, supra note 291, at art. 104.  
\footnote{1106} See Ombudsman Proclamation, supra note 1083, at art. 22 (3).  
individuals whose rights are violated, such as individuals compelled to undergo HIV testing without their consent, persons whose HIV testing results are disclosed to others without their approval, PLWHA discriminated against solely on the basis of their HIV status and individuals whose access to HIV treatment is not realized? The precise answer to this question is that there is not any comprehensive and specific law or policy that enshrines the various remedies available to individuals who sustained HIV-related human rights violations. The range of HIV specific policy documents, in most cases, only narrate what the government and other stakeholders should do to realize the various elements of the right to have access to HIV prevention, care, support and treatment without addressing the issue of how individuals whose rights are violated can claim administrative remedies. There are, however, few HIV-specific and other policy and legal documents that are relevant in terms of expressly guaranteeing access to administrative remedies for human right violations in the context of HIV/AIDS. The primary ones are discussed below.

The health sector and health professionals play a central role, though not an exclusive one, in the implementation of HIV prevention, care, support and treatment programs. Particularly, healthcare workers carry out HIV testing activities, treatment of STIs and OIs and provide psychological counseling. In performing these and other activities, it is proper to ensure that they do not violate individuals’ rights, and, in the event of violation, guarantee redress to the victims. The Government of Ethiopia has issued the Ethiopian Health Professionals Council Establishment Regulation which, among other things, identifies the organs responsible for handling disciplinary cases and the disciplinary penalties that members of the health profession
should face for violations of ethical standards. The Regulation establishes the Ethiopian Health Professionals Council and defines its powers and responsibilities. The Council is composed of representatives of the MOH, regional health bureaus, health professional associations, the Drug Administration and Control Authority and Ministry of Education. The Council has an Executive Committee and several sub-committees that share powers and responsibilities.

One of the powers of the Council is to ensure the observance of professional ethics by health professionals. The Professional Ethics Sub-Committee of the Council is given a specific mandate of investigating complaints regarding violations of professional ethics and, if evidence adduced thereto show that the professional breached ethical rules, submitting its findings together with proposed punishment to the Executive Committee. The Executive Committee, after thorough examination, submits the proposed punishment to the MOH who may approve the proposed punishment or may come up with a different decision. Because the Regulation is not detailed enough regarding the professional ethics that health professionals need to abide by, the MOH is currently in the process of drafting a health professionals’ code of conduct that will be submitted to the Council of Ministers to be issued in the form of regulation. The Council of Ministers is mandated to issue this Regulation by the Food, Medicine and Health Care Administration and Control Proclamation No. 661/2009.

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1109 Id. art. 5.
1110 Id. art. 4 (3).
1111 Id. art. 16.
1112 Id. art. 24.
1113 Interview with Edget Tilahun, Vice Director, Legal Affairs Directorate at Ministry of Health (Jul. 7, 2011).
1114 Food, Medicine and Health Care Administration and Control Proclamation, Proclamation No. 661/2009, 16th Year No. 9, Federal Negarit Gazeta , art. 35.
As the ethical standards are not specified in the Ethiopian Health Professionals Council Establishment Regulation, it is possible to argue that the Professional Ethics Sub-Committee can interpret human rights violations as violation of ethical standards. In reality, complaints on violations of health professional ethics are uncommon in Ethiopia due to problem of physical accessibility of the Health Professionals Council and the lack of awareness on the part of the public.\footnote{See Tilahun, supra note 1113.}

The Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline is the most important and elaborative document in terms of guaranteeing remedies for violation of HIV-related human rights in workplaces.\footnote{See Civil Service HIV/AIDS Guideline, supra note 357.} The Guideline, in no uncertain terms, provides that any civil servant or civil service official who intentionally or negligently violates the rights of PLWHA, intentionally or negligently transmits HIV at workplaces, engages in any discriminatory act or commits any HIV/AIDS–related offenses faces serious disciplinary penalties similar to individuals who commit grave serious disciplinary offences under article 68 of the Federal Civil Servants Proclamation.\footnote{Id. at para. 6.1.} Article 68 of the Federal Civil Servants Proclamation provides a long list of serious disciplinary offences that may entail grave disciplinary penalties, such as mistreatment of clients, deliberately obstructing work, unjustifiable repeated absenteeism, initiating physical violence at the place of work, committing an act of theft or breach of trust and abuse of power.\footnote{See Civil Servants Proclamation, supra note 510.} The Proclamation categorizes fine up to three month’s salary, down-grading up to the period of two years and dismissal as grave disciplinary penalties.\footnote{Id. at art. 67(2).}

\footnote{See Tilahun, supra note 1113.} \footnote{See Civil Service HIV/AIDS Guideline, supra note 357.} \footnote{Id. at para. 6.1.} \footnote{See Civil Servants Proclamation, supra note 510.} \footnote{Id. at art. 67(2).}
According to the Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline, any civil servant against whom an HIV-related disciplinary offence is committed has the right to lodge his/her complaint to the head of the institution and receive the final decision. The head of the institution who receives a complaint is obliged to refer the same to the appropriate body so that the latter will institute disciplinary charges to the disciplinary committee of the institution in accordance with the pertinent provisions of the Civil Servants Proclamation. The disciplinary committee then investigates whether the offence has been committed and submits its findings to the head of the institution. A complainant dissatisfied by the decision of the head of the government institution has the right to appeal to the Civil Service Administrative Tribunal whose decision may also be appealable to the Federal Supreme Court on the ground of error of law.

With a view to exploring the practice, my attempt to find cases decided by government institutions and the Civil Service Administrative Tribunal has been futile. From the lack of cases, I have logically concluded that, despite the well-articulated Guideline, the practice of lodging human rights violations at workplaces is not developed. The absence of any indication regarding what has been done in terms guaranteeing redress to violations of HIV-related human rights in the reports of the multi-sectoral performance strengths this conclusion. As we shall discuss below, litigation of human rights even before courts of law is extremely poor in Ethiopia.

Though the Federal Civil Service Institutions and Employees Workplace HIV/AIDS Prevention and Control Guideline and the Civil Servants Proclamation are important documents from the

1121 Id.
1122 See Civil Servants Proclamation, supra note 510, at art. 69 (1).
1123 Id. at arts.74-77.
perspective of putting in place mechanisms of remedying HIV-related human rights violations, they have limited scope of application. They are applicable only to civil service institutions. Employees of private enterprises and public enterprises, judges, prosecutors, members of the armed forces and the police are beyond their reach. There are no specific guidelines governing HIV prevention, care, support and treatment, let alone mechanisms of redress in these settings. This should not, however, lead us to conclude that employees that suffer human right violations outside of civil service institutions have no administrative remedy whatsoever. I would rather argue that the ethical standards regulating the employees in these settings should be liberally interpreted and applied to the violations of HIV-related human rights. As has been addressed in chapter four, each sector is supposed to mainstream HIV prevention, care, support and treatment activities in its core mandates having regard to its comparative advantage. Needless to say, misconduct that hinders the institutions from realizing their core mandates are regarded as disciplinary offences that entail disciplinary penalties. Given that HIV-related activities are among the mandates of the institutions as a corollary to mainstreaming, any action or omission that obstructs HIV prevention, care, support and treatment activities should be penalized as any other disciplinary offence. In reality, nonetheless, there are no practices that buttress such a liberal stance.

The Education Sector Policy and Strategy on HIV/AIDS, applicable to all private and public learning institutions, is another document relevant to our discussion on administrative remedies to victims of human rights violations in the context of HIV/AIDS. This document sets forth that one of the activities to be carried out to protect PLWHA against discrimination is to take disciplinary measures against those who violate the rights of PLWHA.\footnote{See Ministry of Education, \textit{supra} note 650, at para. 10.2.3.} While the position
taken by this document in terms of explicitly recognizing the need to take disciplinary action where the rights of PLWHA are infringed is commendable, it confines human rights violations only to stigma and discrimination. Moreover, the document does not give us a clue on how and to whom complaints of violations of human rights are to be lodged. This might have been left unaddressed on the assumption that disciplinary matters may perhaps be handled on the basis of the existing disciplinary handling mechanisms and rules, such as the Civil Servants Proclamation and senate legislation of higher education institutions.

A common problem that characterizes the laws and guidelines that guarantee remedies for violations of HIV-related human rights is that they fail to incorporate various types of remedies. They almost exclusively prescribe penalties for perpetrators of the offences and, by inference, stoppage of the unlawful activity, without leaving a room for other types of remedies, such as restitution and rehabilitation.

**8.10.2 Judicial Remedies**

Courts are the main institutions through which governments are held accountable and individuals obtain redress for human rights violations. They have exercised their judicial power to realize human rights in the context of HIV/AIDS in several countries.\(^{1125}\) Courts have various options to apply international human rights standards “including direct applicability of the Covenant[s], application of comparable constitutional or other provisions of law, or the interpretive effect of the Covenant[s] in the application of national law.”\(^{1126}\)

\(^{1125}\) On cases concerning PLWHA, see UNAIDS, Courting Rights: Case Studies in Litigating the Human Rights of People Living with HIV (2006).

\(^{1126}\) See Human Rights Committee, *supra* note 211, at para. 15.
As in other jurisdictions, judicial power is given to courts in Ethiopia. This authorization of courts is a clear indication of the fact that courts can directly use the human rights provisions of the Constitution to adjudicate cases based on human rights standards. Ethiopian courts are not, however, confined to the constitutional avenue of human rights enforcement. They can also directly apply global and African regional human rights treaties. This can be safely deduced from article 9(4) of the FDRE Constitution which gives treaties ratified by Ethiopia the status of national law. Article 9(4) sends an unambiguous message that, where appropriate, courts can directly use provisions of international treaties to adjudicate cases. Apart from their direct applicability, international human rights instruments to which Ethiopia subscribes to can be utilized as interpretative tool for human rights provisions of the FDRE Constitution. Finally, Ethiopian courts could realize human rights indirectly through the effective enforcement of other ordinary laws, such as the criminal law, the civil law, labor law and other procedural laws. These laws, inter alia, aim at safeguarding the rights of different classes of persons and attach specific remedies in the event of their violations.

In practice, the direct application of human rights standards, enshrined in the FDRE Constitution and human rights treaties which Ethiopia has ratified, to adjudicate cases by courts is uncommon in Ethiopia. Several studies conducted in this area unanimously demonstrate that there is generally a poor record of direct application of human rights by courts in Ethiopia. To the

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1127 See FDRE Constitution, supra not 40, at art. 79 (1).
1128 Id. at art. 13(1).
1129 Id. at art. 13(2).
1130 See, for example, Alemayehu, supra note 1098, at 286; Bogale, supra 245 and Tesfaye, supra 245. There are, however, certain cases in which courts refer to human rights provisions of the FDRE Constitution or human rights treaties to which Ethiopia is a party in their decisions. See, for example, W/rt Tseadale Demissie v. Ato Kiflie Demissie, Federal Supreme Court, Cassation Division, C/F/No. 23632, decided on Oct. 2008. In this case, a dispute arose between the father of the child, who played no role in the upbringing of the child, and the maternal aunt of the
best of my knowledge, there are no cases at all wherein courts directly apply human rights in the context of HIV/AIDS. As analyzed in chapter five and six, court cases are available only in relation to transmission of HIV/AIDS decided by criminal benches. There are a host of legal and practical challenges that hamper the direct application of human rights by Ethiopian courts. The key problems are concisely identified below.

First, courts generally show a hesitant position on adjudication of disputes based on the bill of rights of the Constitution.1131 This position arises basically from article 83 of the FDRE Constitution which provides that “[a]ll constitutional disputes shall be decided by the House of the Federation” upon the recommendation of the Council of Constitutional Inquiry.1132 Article 83 is understood by many as prohibiting courts from applying the Constitution. However, a close scrutiny of the pertinent provisions of the Constitution and other relevant laws reveals that courts are not precluded from applying the Constitution. In particular, it is possible to conclude from the reading of article 84 of the Constitution, articles 6, 17 and 21 of the Council of Constitutional Inquiry Proclamation and article 4, 5 and 6 of the Consolidation of the House of the Federation and the Definition of Its Powers and Responsibilities Proclamation1133 that “constitutional disputes” are disputes where the constitutionality of laws or decisions are challenged and which require constitutional interpretation to ascertain the constitutionality or otherwise of the same.

1132 The House of the Federation is a political organ established as the second chamber of the parliament, but not with lawmaking mandates. The Constitutional Inquiry Council is destined to serve as an advisor body to the House of Federation in its mandate of constitutional interpretation. For more on these organs, See arts. 53, 62-68 & 83-84 of the FDRE Constitution, supra not 40.
Thus, the House of Federation is empowered to decide cases only where constitutional interpretation is necessary. In all other cases, courts can apply the Constitution including settling disputes on the basis of human rights provisions of the Constitution. This position is warranted having regard to article 13 (1) of the FDRE Constitution that requires courts to enforce bill of rights of the Constitution and article 3(1) of the Federal Courts Proclamation which provides that “[f]ederal courts shall have jurisdiction over cases arising under the Constitution, federal laws and international treaties.”

Second, the non-publication of texts of human rights treaties in the official gazette translated into the working language of the Federal Government and other local vernaculars also partly contributes to the limited human rights litigation in Ethiopia. In practice, the parliament ratifies international treaties by passing a certain proclamation in which the name of the treaty ratified is indicated. The pertinent provisions of the FDRE Constitution are not unambiguous on this issue. Being silent on the requirement of publication, article 9(4) of the FDRE Constitution provides that treaties ratified by the parliament shall be part of the national law. Another pertinent provision, article 71(2), states that the president of the republic shall proclaim treaties ratified by the parliament in the Federal Negarit Gazette without explicitly addressing whether the full text of the treaty should be published. Unquestionably, the publication of the translated version of the treaty helps improve human rights litigation by making the treaties accessible to judges and the general public in the language they understand, though it is unacceptable to argue that publication of the whole text is a precondition for judicial application of human rights treaties. It is for this reason the Committee on the Elimination of Discrimination against Women and the African Commission on Human and Peoples’ Rights have recommended that the Ethiopian

1134 See FDRE Constitution, supra not 40, at art. 62 (1).
Government officially translate the treaties and publish the entire content of the treaties in the 
Federal Negarit Gazeta.\textsuperscript{1136}

Third, there is limited legal basis for PIL (actio-popularis) before judicial and quasi-judicial 
bodies in Ethiopia. There is a mounting recognition of PIL as an instrument of influencing socio-
economic policies, enforcing the rights of the poor and the marginalized and holding 
governments accountable in a number of countries.\textsuperscript{1137} PIL gives CSOs the opportunity to litigate 
human rights on behalf of the poor and those who do not have the knowhow about the 
technicalities of the human rights litigation, such as PLWHA. In Ethiopia, with the exception of 
the Environmental Pollution Control Proclamation,\textsuperscript{1138} the Federal Courts Advocates Licensing 
and Registration Proclamation,\textsuperscript{1139} the EHRC Establishment Proclamation and the Institution of 
the Ombudsman Establishment Proclamation discussed in section 8.9 above, there is no legal 
support for PIL to challenge human rights violations.\textsuperscript{1140} In the aftermath of the coming into

\begin{footnotesize}
\begin{enumerate}
\item[1138] Environmental Pollution Control Proclamation, Proclamation No. 300/2002, \textit{Federal Negarit Gazeta}, 9th Year No. 12, No. art. 11. Article 11 authorizes anyone, without proving vested interest, to lodge complaints to federal and regional environmental agencies and courts. In one case, Action Professionals Association for the People (APAP) v. Environmental Protection Authority, though the Federal First Instance Court turned down the case on other grounds which was also affirmed by both the Federal High Court and Supreme Court, the Court did not question the status of APAP: a local CSO that brought the case on behalf of the population affected by pollution. \textit{See} Action Professionals Association for the people (APAP) v. Environmental Protection Authority, Federal First Instance Court, Arada Bench, F/No. 64902, 21, decided in 1992.
\item[1139] The Federal Courts Advocates Licensing and Registration Proclamation, Proclamation No. 199/2000. \textit{Federal Negarit Gazeta}, 6\textsuperscript{th} Year No. 27. Art. 10 (1) of this Proclamation states that “[a]ny Ethiopian who defends the general interests and rights of the society and who fulfills the requirements specified [under article 10] shall be issued with a federal court special advocacy license.”
\item[1140] Courts apply the traditional standing requirement provided in the 1965 Civil Procedure Code despite the fact that article 37 (1) of the FDRE Constitution seems to imply that anyone has the right to take justiciable matters to courts and other quasi-judicial organs without showing special interest in the case. According to article 33 of the Civil Procedure, a party who seeks to initiate civil action should have vested interest in the case. Even in case of constitutional litigation, article 84(2) of the FDRE Constitution and article 23 of the Constitutional Inquiry Proclamation restrict access to the Constitutional Inquiry Council and the House of Federation only to interested parties. \textit{See} Council of Constitutional Inquiry Proclamation, Proclamation No. 250/2001, \textit{Federal Negarit Gazeta}, 7\textsuperscript{th} Year No. 40. For detailed discussions on standing requirement to bring actions on the basis of constitutional
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effect of the CSOs, the limited space available to public interest litigators is further restricted. This is because the Proclamation reserves the task of promotion and protection of human rights including through PIL to Ethiopian CSOs.\footnote{See CSOs Proclamation, supra note 291, at art. 14 (5).} This stipulation automatically excludes foreign and foreign-funded NGOs from involving in PIL.

Fourth, the divided position of judges on justiciability of socio-economic rights has an impact on judicial enforcement of these rights. Studies conducted recently revealed that a sizable number of judges in Ethiopia believe that adjudication of socio-economic rights is not the mandate of the judiciary raising all the outdated grounds of objection against justiciability of socio-economic rights.\footnote{See Bogale, supra note 245 and Tesfaye, supra note 245.} There was considerable debate among academicians and practitioners on the justiciability of socio-economic rights in many parts of the world.\footnote{Opponents of justiciability of socio-economic rights argue that socio-economic rights are not justiciable because they entail issues of “public policy and resource allocation” which is are not the mandates of courts; their adjudication by courts violates the principle of separation of powers; and judicial remedies are not appropriate to them. For summary of these arguments, see International NGO Coalition for the Optional Protocol to the ICESCR, supra note 199, at 5-11.} Nowadays, it has become a less tenable position to say that courts are not competent to adjudicate socio-economic disputes. Courts in several jurisdictions have passed groundbreaking decisions involving socio-economic rights. For example, the South African Constitutional Court in the \textit{Treatment Action Campaign} case has successfully ordered the government to ensure the availability of nevirapine to all pregnant women to PMTCT of HIV.\footnote{South African Minister of Health v. Treatment Action Campaign (No. 2), 2002 (5) SA 721.} There is not any reason why Ethiopian courts should not make these kinds of decisions. The justiciability of socio-economic rights in Ethiopia stems from the recognition of the rights in the FDRE Constitution and other domestic laws including human rights treaties Ethiopia has ratified and are given a domestic laws status; the responsibilities of

courts to enforce the human rights treaties of the FDRE Constitution as provided under article 13(1) of the same and individuals’ right to take any justiciable matter to courts to get redress as guaranteed under article 37(1) of the FDRE Constitution.

Fifth, ouster clauses in several laws have excluded courts from overseeing decisions of administrative bodies and tribunals. A number of laws have incorporated provisions (ouster clauses) that make decisions of administrative bodies and tribunals final with no possibility of appeal to regular courts. Essentially, these laws make decisions of administrative heads or tribunals appealable to regular courts on questions of law but not on questions of fact. The CSOs Proclamation takes, however, an exceptional position in the sense that it allows appeal from the decision the Charities and Societies Board to the Federal High Court only to Ethiopian Charities. According to this Proclamation, Ethiopian Charities are CSOs that receive not more than ten percent of their funds from abroad. This in effect means that foreign and foreign-funded CSOs cannot appeal to regular courts no matter how they are dissatisfied with the decision of the Board. As I have argued in relation to prohibition of these CSOs from involving in human rights fields in section 4.7.1 of chapter four, the ouster clause in the CSOs Proclamation is unjustifiably discriminatory against foreign and foreign-funded CSOs on nationality and sources of income grounds.

Ouster clauses generally takeaway the judicial power of courts including that of overseeing human rights violations by the executive. It is true that the administrative bodies and tribunals have the technical knowledge and are believed to discharge their powers responsibly; yet, it is

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1145 See, for example, CSOs Proclamation, supra note 291, at art. 104; Civil Servants Proclamation, supra note 510, at arts. 74-78; Labor Proclamation, supra note 511, at arts. 144-156; Income Tax Proclamation, Proclamation No. 286/2002, Federal Negarit Gazeta, 8th Year No. 34, arts.104- 117 and Defense Forces Proclamation, Proclamation No. 27/96, Federal Negarit Gazeta, 2nd Year No. 15, arts. 25-36.
1146 See CSOs Proclamation, supra note 291, at art. 104(3).
1147 Id. art. 2(2).
not possible to rule out bias and unfairness as they belong to and are answerable to the executive. Despite this and surprisingly, courts have never challenged the status of ouster clauses. Quite to the contrary, they pass decisions that legitimatize the tendency of snatching power from them.¹¹⁴⁸

Sixth, the judiciary is the weakest branch of the government in Ethiopia.¹¹⁴⁹ There is also a wide public perception that the judiciary in Ethiopia is the hands of the executive.¹¹⁵⁰ This has a direct impact on the level of human rights protection by the judiciary. The Government, particularly, the executive branch, is frequently accused of violations of human rights. When the judiciary is weak and allied with the executive, it cannot rule against the executive by holding in clear terms that it has infringed human rights. In situations where the judiciary does not send a clear message that it will not tolerate violation of human rights by the executive, the public or CSOs lose the confidence in courts as guardians of human rights. This may partly explain why we rarely have human rights litigation in Ethiopia.

Seventh, there are no adequate domestic laws that give detailed content particularly to socio-economic rights.¹¹⁵¹ The ICESR and other human rights treaties enjoin Member States to adopt legislative measures in order to effectively implement the treaties under their jurisdictions.¹¹⁵²

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¹¹⁴⁸ One can see the following cases decided by the Cassation Division of the Federal Supreme Court in which it held, by reversing the decisions of lower courts, that the decisions of the administrative tribunals are final and thus immune from judicial review. Government Houses Renting Agency v. Ato Mersie Menerbu’s Successors, Federal Supreme Court, Cassation division, F/No. 31906, decided on Oct. 2008; Gedera Hotel PLC v. Commercial Bank of Ethiopia, Federal Supreme Court, Cassation division, F/No. 33552, decided on Jul. 24, 2008 and Mahberawi Wastina Belesiltan v. Ato Bahiru Hiruy and Ato Kebede G/Mariam Federal Supreme Court, Cassation division, F/No. 18342, decided on Dec. 17, 2005.


¹¹⁵¹ There are only a few laws that are relevant in terms of giving details to some of the socio-economic rights, such as the Condominium Proclamation, Proclamation No. 370/2003, Federal Negarit Gazeta, 9th Year No.95; the Public Health Proclamation, Proclamation No.200/2002, Federal Negarit Gazeta, 6th Year No. 28; Proclamation No. 276/2002, supra note 84; Labor Proclamation, supra note 511 and Civil Servants Proclamation, supra note 510.

¹¹⁵² See ICESCR, supra note 206, at art. 2(1); ICCPR, supra note 142, at art. 2(2) and CRC, supra note 226, at art. 3(2). See also Committee on Economic, Social and Cultural Rights, General Comment No. 3, The Nature of State Parties’ Obligation (1990) para. 3.
The FDRE Constitution is of no help in this regard as its provisions on socio-economic rights are too general. Thus, Ethiopia should adopt specific laws that elaborate the provisions of the Constitution and human rights treaties and clearly delineate the obligation of government organs and institutions. Needless to say, specific legislation could improve the justiciability of socio-economic rights and alleviate the language barriers in applying the human rights treaties.
CHAPTER NINE

CONCLUSION AND RECOMMENDATIONS

9.1 Conclusion

HIV/AIDS is one of the most monstrous challenges that mankind has ever faced. Since it was officially discovered thirty years ago, it has claimed the lives of millions of people in the various parts of the world. It has had a huge negative impact on economic and social development through its various manifestations. The prevalence and ramifications of the epidemic are not, however, uniform around the world. Of all the regions, Sub-Saharan Africa is the region that has been disproportionally hit by the epidemic.

From the time when the epidemic started to erupt, the international community has taken several measures to overcome the spread of the epidemic and mitigate its impacts. In the 2000 Millennium Summit, Member States of the UN declared halting the spreading of HIV/AIDS as one of the millennium development goals that Members States should achieve by 2015. States reiterated their commitment to achieving this millennium development goal by setting time-bound targets to be met by them in the 2001 Declaration of Commitment on HIV/AIDS. In 2006, UN Member States adopted a landmark declaration in which States pledged to ensure universal access to HIV prevention, care, support and treatment by 2010. In this Declaration, Member States also agreed to use the human rights framework to address HIV/AIDS. Aside from the Global commitments, Members States of the AU have passed similar declarations and resolutions that guide the response to HIV/AIDS at the African regional level.
The 2010 universal access commitment, reset to be met by 2015 in the 2011 United Nations General Assembly Special Session, is evidence of the importance of guaranteeing HIV prevention, care, support and treatment services for those in need to effectively reverse the momentum of HIV/AIDS. Best practices of countries unambiguously have taught that there is not a magic bullet that enables countries to effectively respond to HIV/AIDS. In the face of lack of a vaccine or a curable drug for HIV/AIDS, States should design a comprehensive anti-HIV/AIDS program that combines HIV prevention, care, support and treatment. Success stories from countries that have been victorious in combating HIV/AIDS also reaffirm the centrality of the protection and promotion of human rights in dealing with HIV/AIDS. It is precisely for this reason a rights-based approach (RBA) to HIV prevention, care, support and treatment is widely recognized in international and national HIV-related policies and strategic plans.

The importance of a RBA to HIV prevention, care, support and treatment became evident when other coercive approaches in the early years of the epidemic, such as mandatory HIV testing, quarantine and discrimination against PLWHA, resulted in fueling the spread of HIV/AIDS and undermining attempts to care, support and treat the HIV infected people. A RBA, *inter alia*, requires human rights principles to guide and to be integrated in the adoption, implementation and evaluation of HIV prevention, care, support and treatment-related laws, policies and strategic plans at national, sub-national and local levels. The core human rights principles that should direct and be integrated in HIV prevention, care, support and treatment programs, strategic plans, policies and laws are: the interdependence and indivisibility of rights, participation, non-discrimination, accountability and the key aspects of the right to health; namely, accessibility, acceptability, availability and quality.
The principle of interdependence and indivisibility of rights entails collaboration among different sectors for fruitful implementation of national programs, strategies and policies. In the context of HIV/AIDS, participation requires the involvement of all sectors in general and PLWHA in particular in the formulation, execution and evaluation of HIV/AIDS-related programs, strategic plans, policies and laws. Non-discrimination enjoins States not to put in place laws, policies and programs that directly or indirectly exclude people infected with and affected by HIV/AIDS and other marginalized groups. From the perspective of HIV/AIDS, the three interwoven elements of the right to health are the availability, accessibility, acceptability and quality of HIV prevention, care, support and treatment goods and services. The principle of accountability under a RBA requires States to be responsible for violations of human rights in the response to HIV/AIDS, to have effective remedies for victims of human rights violations and to put in place effective monitoring and evaluation mechanisms.

Ethiopia is one the Sub-Saharan countries highly affected by HIV/AIDS. Since the first HIV infection in Ethiopia was identified in 1984, the Ethiopia Government has taken various measures which it believes are necessary to bring the epidemic under control. The government’s response is regulated by a multitude of policies, strategic plans, guidelines and laws. This dissertation assesses the extent to which the Ethiopian response to HIV/AIDS conforms to the principles of a RBA through an evaluation of the country’s HIV/AIDS-related laws, policies, strategic plans and practices.

Multi-sectoralism is critical to the success of HIV prevention, care, support and treatment programs. Owing to the enormity of the problem, the health sector alone cannot successfully respond to the HIV epidemic. It is for this reason many countries adopt the multi-sectoral
approach. The multi-sectoral approach offers all stakeholders the opportunity to take part in HIV prevention, care, support and treatment activities based on their comparative advantages. It is also one way through which freedom of association and the right to participation of individuals in matters that affect their lives are realized. Ethiopia has set up institutions and put in place laws, strategic plans and policies for the implementation of the multi-sectoral approach. As indicated in the 1998 National Policy on HIV/AIDS and SPM II, multi-sectoralism is one of the principles that guide the response to HIV/AIDS in Ethiopia. Proclamation No.276/2002 establishes NHAPCC, an organ responsible for overseeing the overall national response, and FHAPCO, an organ responsible for coordinating the multi-sector response, and provides for the representation of a myriad of stakeholders in NHAPCC and the Management Board of FHAPCO. Moreover, the country has put in place several specific guidelines that require government institutions, the business community, civil society organizations (CSOs), community-based organizations (CBOs) and FBOs to take part in combating HIV/AIDS.

However, the multi-sectoral approach is fraught with a multitude of challenges in Ethiopia as a consequence of which it is hardly implemented. Just to mention the main ones, first, there is a problem of lack of a binding law that requires sectors to mainstream HIV/AIDS. This has created a setback in ensuring the compliance of sectors with their HIV/AIDS mainstreaming responsibilities. There are no sanctions for failure to discharge HIV/AIDS-related activities. In brief, the implementation of HIV prevention, care, support and treatment has been left to the discretion of the sectors. Second, the prohibition of foreign and foreign-funded NGOs from engaging in human rights activism, in the CSOs Proclamation, apart from being a violation of freedom of association, seriously affects the activities of NGOs that wholly or partly work on human rights advocacy to address the HIV/AIDS epidemic. Third, there is a limited space, both
in law and practice, for the meaningful participation of CSOs including PLWHA in the preparation of HIV/AIDS-related laws, strategic plans and guidelines. Fourth, financial constraints hinder the operations of institutions and partnership sub-forums. The overall response to HIV/AIDS in Ethiopia heavily relies on foreign funding sources with limited efforts to mobilize funds from local sources. Fifth, MARPs are not at all represented either in the NHAPCC or NPF.

Apart from multi-sectoralism, the successes of HIV prevention care, support and treatment programs, to a large extent, depend on the success of HIV testing programs. HIV testing is a crucial gateway to HIV prevention, care, support and treatment. To bring about a fruitful outcome, HIV testing policies should comply with human rights standards. A RBA to HIV testing requires States to ensure access to HIV testing; guarantee that the process of testing must adhere to the 3C principles, viz., informed consent, counseling and confidentiality; link HIV testing sites to HIV prevention, care, support and treatment services; put in place laws and policies for the protection of the rights of PLWHA and create or strengthen accountability mechanisms for the proper implementation of HIV testing programs and the prevention of violations of human rights in the context of HIV testing. These requirements are grounded in several human rights and are meant to alert States to protect, respect and fulfill the rights of persons who undergo HIV testing.

There are several policy documents regulating HIV testing in Ethiopia including the 1998 Policy on HIV/AIDS, the 2007 HCT Guidelines and PMTCT Guidelines. The FDRE Constitution, the Civil Code, employment laws, the Criminal Code and Criminal Procedure Code also contain provisions applicable to HIV testing. The laws and policies generally incorporate the RBA
requirements for HIV testing. The country has also done a lot in terms of expanding institutions providing HIV testing and strengthening HIV testing quality assurance mechanisms. There are, however, certain legal, policy and practical barriers that negatively affect individuals’ access to HIV testing and human rights. As a result of these problems, an overwhelming majority of the Ethiopian people has never been tested and known their HIV status.

While, in principle, HIV testing is carried out upon the consent of the individuals, the 1998 HIV policy and the 2007 HCT Guideline allow mandatory testing for pilots and where there is a court order to that effect. Mandatory testing unjustifiably violates human rights of individuals that informed consent seeks to safeguard. It is unacceptable to give discretionary power to courts to order mandatory testing without clearly specifying the grounds. This unfettered discretion may create room for abuses of human rights of individuals who will be subjected to mandatory testing. There are also practices whereby HIV testing is offered to clients attending health sectors without giving them the chance to freely consent or refuse blood tests. Other problems relating to HIV testing include, but are not limited to, the inadequacy of HIV testing centers in rural and remote areas, the economic inaccessibility of these services in urban areas, stigma and discrimination, lack of good knowledge on benefits of testing, shortage of testing equipment, lack of regular supervision to ensure compliance with HIV testing principles and weak linkage between HIV testing centers and sites where HIV care, support and treatment services are provided due to weak counseling, lack of trained healthcare providers, lack of adequate care and support and overburdening of healthcare workers with multiple responsibilities.

Ethiopia has generally put in place the legal and policy framework to prevent the transmission of HIV/AIDS. The country has also undertaken several measures to implement the laws and
policies. These efforts have borne fruits in terms of reducing new HIV infections over the past few years. There are, however, enormous challenges that hinder HIV prevention efforts. To begin with, lack of reliable, quality and up-to-date data and little attention paid to research on HIV/AIDS have seriously affected targeted and evidence-based HIV prevention interventions. Regarding behavioral change strategies, the major problems include the failure of the media to focus on analysis and educative type programs rather than event-oriented ones; the concentration of AIDS resource centers only in major urban areas; the failure of higher education institutions to mainstream HIV/AIDS in their curricula and research; the weak performance of anti-AIDS club and lack of continuity of community conversations. While there are several factors that create a setback to the implementation of strategies to prevent sexual transmission of HIV/AIDS, the main ones are poor facilities for diagnosis and treatment of STIs; low consumption of male condoms due to cultural, religious taboos and substance use; unavailability of female condoms; lack of rules that regulate the licensing and operation of commercial sex worker and absence of specific strategies designed for MARPs. The main factors that contribute to the limited coverage of PMTCT services include inaccessibility of PMTCT services in rural areas, shortage of trained healthcare workers providing the service, lack of awareness of the service by the society, belief in traditional birth attendants rather than health extension workers and shortage of equipment, HIV test kits and logistics. Finally, the structural barriers to HIV prevention are poverty, the prevalence of HTPs, legalization of polygamy in some regions, criminalization of consensual homosexual relationships, non-criminalization of marital rape and the lack of specific laws that entitle PLWHA and other marginalized groups to claim HIV prevention and treatment services as their rights.
Accumulated experiences and studies have revealed that realizing the access of PLWHA and other affected communities to HIV care, support and treatment services not only mitigate the impact of HIV/AIDS but also contribute towards prevention efforts. Though there are no specific laws that guarantee the various HIV care, support and treatment services that PLWHA should have access in Ethiopia, there are a plethora of non-binding policy guidelines in this area. However, there are a lot of gaps in the implementation of these guidelines. First, the health facilities providing ART services are still inadequate to be accessible to all PLWHA in rural areas and many small towns. Second, other factors, such as lack of awareness which, in turn, is imputable to insufficient awareness-raising about the services; shortage of CD4 machines, laboratory agents and trained staff; low uptake of HIV testing; weak ways of tracking patients and patients dropping out of antiretroviral therapy (ART) in search of alternative treatments, such as holy water treatment hinder the uptake of HIV treatment. Third, inadequacy of OI drugs, shortage of STIs drugs and financial constraints have seriously affected OIs treatment. Fourth, poor performance of socio-economic support to PLWHA and OVC attributed primarily to financial constraints as a result of the Government’s and sectors’ inability to mobilize funds from local sources and problems of misuse of AIDS funds for other purposes and weak utilization of foreign funds due to non-reporting, delay in reporting and poor reporting to donor agencies. Fifth, no attention is paid to meeting the legal service needs of PLWHA.

The commitments of States and non-State actors to ensure access to HIV prevention, care, support and treatment services cannot bear fruits without effective accountability mechanisms. Accountability is a mechanism through which States and non-state actors are held responsible for unacceptable performance and violations of human rights in the response to HIV/AIDS and victims of HIV-related human rights violation can get effective remedies. Though Ethiopia has
put in place laws, policies and guidelines and established institutions to ensure accountability in its response to HIV/AIDS, its implementation is fraught with multiple problems. The monitoring and evaluation mechanisms of the multi-sector response is seriously constrained, among other things, by the limited capacity of HAPCOs to coordinate monitoring and evaluation; lack of effective mechanisms to ensure sectors’ compliance with implementation standards; the non-functioning of sub-forums owing to budgetary problems as well as lack of permanent staff who run their day-to-day tasks and lack of regularity and delay in conducting bi-annual and annual review meetings and joint supportive supervision. The role that treaty bodies would have played in terms of holding government accountable for implementation of HIV-related human rights is hindered by the Ethiopian poor record of reporting to treaty bodies. The legislature has hardly discharged its mandate of evaluating government institutions’ performance in respect of HIV prevention, care, support and treatment. The role of CSOs in holding government accountable is obstructed by the prohibition of human rights advocacy in the CSOs Proclamation and by the lack of a legal framework that supports public interest litigation. Even though the Ethiopian Human Rights Commission (EHRC) and the Institution of Ombudsman are given the power of investigation of complaints of human rights violations and monitoring of the consistency of laws, policies and practices with human rights standards, in practice, the institutions are primarily discharging their promotional mandates, such as awareness-raising and training, rather than their investigation and monitoring responsibilities. Most of the HIV specific policy documents do not put in place administrative procedures and institutions so that individuals whose rights are violated can claim administrative remedies. The limited laws and guidelines that guarantee administrative remedies for violations of HIV-related human rights almost exclusively prescribe penalties for perpetrators of the offences and, by inference, stoppage of the unlawful activity,
without leaving a room for other types of remedies such as restitution and rehabilitation. Except in criminal matters, judicial remedies to violations of HIV-related rights are uncommon in Ethiopia. The limited roles of courts in applying human rights arise mainly from the constitutional uncertainty of their role in enforcing the bill of rights of the Constitution; the inaccessibility of treaty texts to judges and the public in the languages they understand, limited legal support for PIL, the divided position of judges on justiciability of socio-economic rights, ouster clauses that excluded courts from overseeing decisions of administrative bodies and tribunals, the weak authority of the judiciary to control the executive and lack of adequate domestic laws that give detailed content particularly to socio-economic rights.

9.2 Recommendations

To achieve the goal of universal access to HIV prevention, care, support and treatment services and to deepen compliance with principles of RBA in the furtherance of this goal in Ethiopia, the researcher makes the following recommendations.

To strengthen mainstreaming of HIV/AIDS in the mandates of sectors and institutions:

- The Ethiopian Government should adopt a law that imposes an obligation on government institutions, business organizations and CSOs to mainstream HIV/AIDS in their core mandates.
- Government institutions should include in their reports to the parliament and other concerned organs what they have done in terms of mainstreaming of HIV/AIDS.
- The Government should put place sanctions for weak performance and incentives for better performance.
• The Government should allow the meaningful participation of CSOs including PLWHA in the preparation of HIV/AIDS-related laws, strategic plans and guidelines.

• Mainstreaming sectors and HIV-sub-forms should raise funds from local sources to solve their financial constraints that hinder their operations.

In order to maximize individuals’ access to HIV testing services consistent with human rights norms:

• The Government should expand the testing sites in all rural and remote areas and equip them with the necessary manpower and testing equipment.

• The Government should scale up HIV education and awareness-raising programs to encourage persons to come forward for testing.

• The Government should put in place strategies to consolidate youth and children-friendly HIV testing facilities.

• The policy makers should delete parts of the 1998 HIV Policy and the 2007 HCT Guideline that allow mandatory testing for pilots and where there is a court order to that effect.

• Health centers should avoid the practice of offering HIV testing to clients attending health sectors without giving them the chance to freely consent thereto.

• The Government should standardize the price of HIV testing in private health institutions to make it economically accessible.

• The Ministry of Health and regional health bureaus should consolidate regular supervision to ensure compliance with HIV testing principles.

• The Government should strengthen the link between HIV testing sites and sites where HIV care, support and treatment services are provided.
To expedite HIV prevention efforts:

- The media should focus on analysis and educative type programs rather than event-oriented ones.
- The Government should expand AIDS resource centers outside of the major urban areas.
- The Ministry of Education and regional education bureaus should work to mainstream HIV/AIDS in the curricula of higher education institutions and to strengthen the performance of anti-AIDS clubs.
- HAPCOs should ensure the continuity of community conversations.
- The Government should encourage and support research on the various aspects of HIV/AIDS.
- The Ministry of Health and regional health bureaus should give the necessary attention to the diagnosis and treatment of STIs.
- The Government should ensure the availability and accessibility of female condoms.
- The Government should put in place rules that regulate the licensing and operation of commercial sex workers and specific strategies designed to each MARP.
- The Government should scale up the coverage of PMTCT services by making the services accessible in rural areas, assigning trained health care workers providing the service, furnishing the health centers with the necessary equipment, improving the participation of private health facilities in the provision of the services, improving the coverage of antenatal care, offering HIV testing to all pregnant women seeking antenatal care and strengthening community mobilization programs.
- The Government should scale up its efforts of poverty reduction and combating HTPs.
The legislature should legalize consensual homosexual relationships, criminalize marital rape, adopt a comprehensive anti-HIV/AIDS law that specifically entitles PLWHA and other marginalized groups to claim HIV prevention, care, support and treatment services as their rights, and stipulates administrative procedures through which individuals whose HIV-rights are violated can claim the various administrative remedies.

To augment the provisions of HIV care, support and treatment services:

- PLWHA associations and HAPCOs should harmonize their plans and require beneficiaries of socio-economic support to bring clearance from their previous associations or supporting institutions to reduce the level of double/multiple beneficiaries.

- PLWHA associations and HAPCOs should set precise guidelines on selection of beneficiaries.

- Microfinance institutions should design special and favorable credit schemes for PLWHA and OVC.

- The Government should adopt guidelines on the type and quality of socio-economic support that PLWHA should receive.

- The Ministry of Health and regional health bureaus should expand health centers providing ART services in all rural areas and small towns.

- The Government should scale up awareness-raising programs on the benefits of ART and anti-stigma and discrimination endeavors.

- The Ministry of Health and regional health bureaus should equip health centers with adequate CD4 machines, laboratory agents, OI and STIs drugs and trained staff.
• The Ministry of Health and regional health bureaus should effectively implement ways of tracking patients dropping out of ART.

• The Government should continue to make OIs treatment free for PLWHA.

• The Government should rectify the poor performance of socio-economic support to PLWHA and OVC through, *inter alia*, the mobilization of funds from local sources and supervising the effective utilization of foreign AIDS funds for their intended purposes.

• The justice sector should contribute to the response to HIV/AIDS through the provision of legal services to PLWHA and other affected communities.

In order to consolidate the effectiveness of accountability mechanisms for the implementation of HIV prevention, care, support and treatment-related laws, policies and strategic plans:

• The legislature should adopt a legally binding law which, *inter alia*, specifies standards of performance for the different actors involved in the response to HIV/AIDS, review mechanisms, monitoring and evaluation frameworks and penalties for intolerable performance.

• HAPCOs should strengthen the monitoring and evaluation mechanisms of the multi-sector response by building their technical and material coordination capacity, supporting HIV/AIDS sub-forums, organizing regular bi-annual and annual review meetings and joint supportive supervisions.

• The Government should discharge its reporting obligation to treaty bodies.

• The legislature should require government institutions to include what they have done in areas of HIV prevention, care, support and treatment in their annual reports to the parliament.
• The House of Peoples’ Representative should delete provisions of the CSOs Proclamation that prohibit CSOs from involvement in human rights advocacy.

• The legislature should adopt legislation that creates an enabling environment for PIL.

• The EHRC and the Institution of Ombudsman should aggressively work on investigation of violations of HIV-related human rights and monitoring the extent to which sectors are discharging their HIV/AIDS mainstreaming responsibilities.

• The Government should create an enabling environment for the judicial enforcement of HIV-related human rights by making treaty texts accessible to judges and the public in the languages they understand, putting in place a legal framework for PIL and guaranteeing the independence of the judiciary.

• The legislature should delete clauses of the various proclamations that exclude courts from overseeing decisions of administrative bodies and tribunals and adopt adequate domestic laws that give detailed content particularly to socio-economic rights.

• The judiciary should organize an awareness-raising training on the role of courts in enforcing the bill of rights of the constitution and other human rights treaties in general and the justiciability of socio-economic rights in particular.
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APPENDICES

Appendix I-List of Interviewees

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<td>1. Abebe Fekade</td>
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<td>Zewudu Lemma</td>
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Appendix II-Interview Guide to HAPCOs and ARCs

1. Are there studies on HIV/AIDS-behavioral Change in Ethiopia?
2. What are the problems that hinder the availability of data on HIV/AIDS and what are the strategies designed to solve the problem?
3. Did the Community Management Information System that is designed to capture non-clinical data from all implementing partners start functioning? If so, how does it resolve the existing problem of data in Ethiopia?
4. Do all ARCs have libraries, telephone call lines and other services?
5. How many and how are ARCs distributed in regions?
6. How are HIV education and information disseminated at workplaces both in private and public institutions?
7. What are the barriers for male condom use?
8. Is female condom available and accessible in Ethiopia?
9. What are the practices regarding the distribution and utilization of microbicides and PEP?
10. Are there specific policies and strategic plans that specifically address MARPs and their status of implementation?
11. What are the particulars of the draft revised HIV Policy and when is it going to be effective?
12. What is the extent of psychological support to PLWHA by relatives, friends, traditional healers and those of religious faith and formal psychological counselors?
13. What are the challenges to scale up the coverage of care and support of PLWHA and OVC in terms of food and other social supports such as, schooling, job creation, income generating activities and assistance with shelter?
14. Who selects beneficiaries of HIV care and support and what are the criteria of selection?
15. What are the mechanisms through which governmental hold donors and other stakeholders accountable for their HIV/AIDS related activities?
16. What are the capacity building activities that FHAPCO and regional HAPCOs provide to build the capacities of mainstreaming agencies?
17. What are the challenges and proposed remedial strategies to mainstreaming of HIV/AIDS in public and private sectors?
18. Do HAPCOs actually control institutions other than government agencies?
Appendix III- Interview Guide to Ministry of Health and Health Bureaus

1. What are the strategies designed to alleviate the problem of mother-to-child transmission of HIV/AIDS?
2. To what extent do private health centers participate in PMTCT?
3. Are antiretroviral drugs prescribed to patients in accordance with the WHO updated standards?
4. Are health facilities providing various HIV/AIDS-related services accessible to all including people in rural areas? What is the reason behind why only few private health centers provide ART?
5. What are the barriers to reach 100% coverage of ART and universal HCT in Ethiopia? What are the strategies to solve the problems?
6. What are the challenges to monitoring adherence to ART and drug resistance in practice?
7. What are mechanisms of tracing of defaulters of ART?
8. What are the measures taken to alleviate problem of laboratory supplies, test kits and other related equipments?
9. Is treatment of OI given equal attention as ART? What are the problems and strategies to solve the problems?
10. Are the quality assurance mechanisms of ART, HCT and other HIV prevention, care, support and treatment services effectively working?
11. Do patients really exercise their right to refuse testing in PITC?
12. What are the barriers to couple testing and partner notification?
13. What are the measure taken to get rid of problems pertaining to the linkage between HIV testing and other services?
Appendix IV- Interview Guide to NPF and HIV/AIDS Sub-Forums

1. Why do we need NPF and sub-forums against HIV/AIDS in Ethiopia given multi-sectoral representation in the NHAPCC and Management Board of HAPCO?
2. What are the different sub-forums that are actually organized and start operation?
3. When is the sub-forum established?
4. What are the specific purposes for which the sub-forum is established?
5. Do the forum and its members meaningfully participate in the preparation, evaluation and implementation of HIV/AIDS policies and strategic plans?
6. What are that actual tasks it accomplished so far?
7. What are the member institutions under this sub-forum?
8. Do institutions under the sub-forum specialize on the basis of their comparative advantage?
9. What are the problems the institutions face in actual implementation of HIV/AIDS related tasks?
10. How does the sub-forum monitor and evaluate the activities of institutions under it?
11. What are the sanctions or incentives for non-compliance and compliance respectively? What is the enforcement mechanism?
12. What are the capacity building activities that your sub-forum received from FHAPCO?
13. What are the institutions with best and worst practices under the sub-forum?
14. Where does the fund for the operation of the sub-forum and the institutions come from? Does the sub-forum or institutions thereunder mobilize resources from communities and the private sector?
Appendix V- Interview Guide to HIV/AIDS Mainstreaming Sectors

1. How do stakeholders evaluate and monitor the Government’s response to HIV/AIDS?
2. What are the HIV-related tasks that your institution is supposed to carry out?
3. How is the 2% AIDS fund contributed? Is it from the budget of the institution or contribution of staffs? Is the fund meant to serve to fight HIV/AIDS only in the institution?
4. What are the administrative remedies for people whose HIV/AIDS-rights are violated? Are there practical cases?
5. What roles Institution of Ombudsman and EHRC do play to ensure accountability in HIV/AIDS context?
6. How is the issue of HIV integrated in schools ‘curricula? What are the success and challenges in this regard?
7. Do private schools implement curricular and extra-curricular HIV Education?
8. What are the successes and challenges in terms of conducting in-schools community conversations and ensuring the operation of anti-AIDS clubs and mini-medias?
9. What are the measures taken to integrate HIV/AIDS into the pre-service and in-service teachers training curricula and continuous professional development programs?
10. How are HIV education and information disseminated at workplaces both in private and public institutions?
11. How are intentional or negligence transmissions of HIV prosecuted and punished?
12. What are the measures taken and strategies adopted to reduce Ethiopian women’s more vulnerability to HIV/AIDS?
13. What is the reason for the discontinuance of the finalization of the draft HIV/AIDS law?
14. What are the legal aid supports available to PLWHA where their property and personal rights are violated?
15. Is the Ethiopian Airline still undertaking pre-employment testing?
16. What are those settings in which HIV testing is carried out without consent?
17. How and when is compulsory testing of rapist allowed?
18. In case of occupational exposure other than rape victims, do courts compel the source person to be tested?