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EQUITY AND ACCESS TO ART IN ETHIOPIA: ACTIVITY REPORT

JUNE 2010

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EXECUTIVE SUMMARY

This document presents a brief overview of a study conducted by the Health Policy Initiative, Task Order 1, to identify the barriers to equitable access to antiretroviral treatment (ART) in Ethiopia. A full report on the findings, *Equity and Access to ART in Ethiopia*, is available online. The report provides the Ethiopia HIV/AIDS Prevention and Control Office, program implementers, and ART providers with useful information to ensure the equitable scale-up of and increased access to ART provision in Ethiopia. The Health Policy Initiative also prepared a report on the study methodology, *Equity and Access to ART in Ethiopia: Study Protocol*.¹

Thus far, the Ethiopian government has approached ART provision within the context of universal access for all and has emphasized an explicit policy of equity in delivering services. The country is in a good position to achieve universal access given a prevalence rate that should not overload the health system and a policy of free ART for all. However, many people living with HIV are not accessing ART through the system. The Health Policy Initiative explored the barriers to accessing ART in Ethiopia to gain a better understanding of those people both currently undergoing ART, as well as those who need ART but are not accessing it.

¹ The full report and study methodology can be accessed at www.healthpolicyinitiative.com.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ART	antiretroviral treatment
ARV	antiretroviral
HAPCO	HIV/AIDS Prevention and Control Office
HIV	human immunodeficiency virus
MOH	Ministry of Health
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
USAID	United States Agency for International Development

BACKGROUND

Ethiopia is the second most populous country in Africa next to Nigeria, with a population estimated at 77 million in mid-2008.² In Ethiopia, the HIV epidemic has remained a major public health problem, largely affecting people of productive and reproductive age. At the end of 2005, an estimated 1.3 million people were living with HIV.³ HIV prevalence in the general population is estimated at 2.1 percent.⁴ The epidemic is well established in the urban areas, with prevalence as high as 5.5 percent in 2005. In the same year, only 0.7 percent of the rural population was estimated to be HIV positive.⁵

In striving to achieve universal access to ART and further improve the lives of people living with HIV (PLHIV), the Ethiopian government, through the Ministry of Health (MOH), endorsed a policy on the supply and provision of antiretroviral drugs in 2002.⁶ The policy emphasized the government's commitment in several areas: mobilizing all stakeholders, allowing the importation of antiretroviral (ARV) drugs free from tax, lowering the price of ARV drugs through negotiation, encouraging international initiatives on ART in the country, and promoting research on ART. In February 2003, the MOH issued guidelines for the provision of ART.⁷ These guidelines aimed to provide a simple and standardized approach to ART; training in the care of PLHIV for physicians, other health workers, and program managers; and a basis for advocacy for PLHIV. In January 2005, the government launched a free-of-charge ART program, underlining its commitment to the global "3 by 5" initiative. This was backed up by the first road map for accelerating access to HIV treatment for 2005–06, issued by the MOH. This provides clear targets for the rollout of ART for all actors concerned, with a detailed plan covering each month through to December 2006. Immediately after the close-up of the 1st road map, the 2nd strategy, "Road Map II," was issued; it emphasizes service quality and reaching universal access to ART.

Since the advent of the ART program, more than 200,000 people have started on treatment in about 500 facilities throughout the country. ART service expansion has been recent and fast from only four facilities in 2003 to 517 in 2009. Parallel with this, the number of people who have accessed ART has also increased substantially from 900 in 2003 to 211,000 in 2009. The impact of the program on the survival and quality of life of patients has also been demonstrated.⁸ A recent population-based study revealed significant decline in adult AIDS mortality as a result of the scale-up of ART in Addis Ababa.⁹ But despite the recent gains, universal access to ART is still far from being achieved. The number of patients ever started on ART represents only 54 percent of the population needing ART in the country.¹⁰ Although ART is being provided free-of-charge, with a rapid expansion of facilities providing the service, population access to treatment cannot be deemed equitable and universal due to a number of deterrents that operate at individual, community, and facility levels.

Ethiopia's policy and guidelines on the provision of ART show a strong commitment to equitable access to ART. The documents touch on roles for all levels of the health service provision program, as well as

² Berhane, Y., Y. Mekonnen, E. Seyoum, L. Gelmon, and D. Wilson. 2008. *HIV/AIDS in Ethiopia: An Epidemiological Synthesis*. Washington, DC: World Bank Global AIDS Program.

³ Ministry of Health (MOH). 2006. *AIDS in Ethiopia 6th Report*. Addis Ababa: MOH/HAPCO.

⁴ Agreement on a point prevalence of 2.1 percent was reached in April 2007.

⁵ Central Statistical Authority (CSA) and ORC Macro. 2006. *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: CSA and ORC Macro.

⁶ Federal Democratic Republic of Ethiopia (FDRE). 2002. *Policy on ARV Drug Supply and Use of the Federal Democratic Republic of Ethiopia*. Addis Ababa: FDRE.

⁷ MOH/HAPCO and DACA. 2003. *Guideline for Use of ARV Drugs in Ethiopia*. Addis Ababa: MOH.

⁸ MOH/HAPCO. 2008. *Effectiveness of ART Program in Ethiopia*. Addis Ababa: unpublished.

⁹ Reniers, G., T. Araya, and G. Davey. 2009. "Steep Decline in Population-level AIDS Mortality Following the Introduction of Antiretroviral Therapy in Addis Ababa, Ethiopia." *AIDS* 23: 511–518.

¹⁰ MOH. *AIDS in Ethiopia 2006. 6th Report*. Addis Ababa: MOH/HAPCO.

communities and the private sector—with the intent that different segments of the population will be served by different sectors—all with the end goal of providing an equitable ART program. The country also envisages achieving universal access to ART by the end of 2010 (Road Map II). Thus, equity is certainly among the most important aspects of Ethiopia’s policy agenda on ART scale-up.

This research aims to inform policy on and improve equitable access to ART by identifying barriers to treatment and how these barriers impact groups differently. With this information, the government and other actors can design policy solutions that will help diminish barriers, bring more people into facilities for ART, and ensure adherence once treatment is initiated.

STUDY OBJECTIVES AND RESEARCH QUESTIONS

The study objectives were as follows:

1. Increase knowledge of how Ethiopia’s ART delivery system impacts different client groups and determine whether ART access is equitable.
2. Identify the barriers to equitable access to ART at individual, household, community, and health systems levels.
3. Identify the factors for lack of adherence to treatment and the reasons that patients become lost to follow-up.¹¹
4. Provide evidence-based recommendations on how to reduce barriers to accessing ART.

The key research questions include the following:

- How does ART use vary between different population groups (gender, age, geographical location, socioeconomic groups, ethnicity)?
- How have patterns of ART use changed over time? Is the ART scale-up (free ART) benefiting only some types of target groups or improving equity of access?
- What are the individual/household factors that inhibit ART use?
- What are the community/contextual factors that inhibit ART use?
- What are the key facility-related (health system) factors that inhibit ART use? And how do these factors vary by type of health facility?
- What are the barriers to treatment adherence? And how do these barriers work across gender, age, and socioeconomic groups?
- What are the reasons that patients become lost to follow-up from treatment, and how do the reasons compare across gender, age, and socioeconomic groups?

STUDY METHODOLOGY

The study protocols are documented in *Equity and Access to ART in Ethiopia: Study Protocol*. This report details the study methodology and provides an overview on the sites and respondents, focus group discussion guides, in-depth health worker interviews, key-informant interviews, and document review. Secondary and qualitative data analysis is also discussed, as well as ethical considerations.

¹¹ ART patients’ outcomes encompass the following broader categories: patients who (1) are alive and still on treatment, (2) stopped treatment, (3) transferred to another facility, and (4) were lost to follow-up. A patient who misses appointments for one to three months is considered lost to follow-up.

SUMMARY OF FINDINGS

This section highlights some of the major findings of the study. For a detailed report of the results, analysis, and recommendations, refer to *Equity and Access to ART in Ethiopia*.

Progress Toward Equity in Access to ART

- In 2005, disproportionately more men than women were accessing ART despite a higher infection rate among women. The study findings indicate that women's access is improving, with more females than males now accessing treatment in 2006. A gender gap remains, however, as the infection rate is still higher among women.
- Expanding provision of ART to health centers located closer to the communities has improved access to ART for vulnerable groups such as women, non-working adults, and children.
- ART access is still urban-biased. While the prevalence rate in rural areas is significantly lower than in urban areas, 40 percent of those needing ART in Ethiopia live in rural regions.¹² Universal access will require that ART is expanded to rural areas through satellite facilities and outreach programs.

Barriers to ART Use

Individual-level barriers

Reasons reported by individuals for not taking or continuing ART included reluctance to commit to ART for life; knowledge that ART prolongs life but is not a cure; fear of side effects; reluctance to quit addictions such as *khat*, cigarettes, and alcohol; and belief that life is in God's hands or that disease progression can be slowed by other means (such as by treatment with Holy water or treatment with traditional medicines).

Social/Community-level barriers

Reasons identified as social/community-level barriers include the following:

- Stigma affecting PLHIV's ability and willingness to access ART and disclose their status for fear of social or work-related discrimination.
- Community-level stigma keeps PLHIV from accessing treatment close to home, driving them to further, less accessible facilities.
- Widespread misconception that Holy water can cure HIV keeps people from treatment. The practice of combining Holy water and ART, endorsed by the Ethiopian Orthodox Church, leads to confusion related to which treatment improved patient's health.
- Belief that traditional medicine is an appropriate substitute for ART.

Health system barriers to ART

Reasons for barriers to ART in health systems include the following:

- High indirect costs related to treatment such as transport fees to travel to and from facilities and laboratory fees and drug costs associated with opportunistic infections and medical care costs for children.
- Long queues and waiting time at hospitals in big towns. This is partially due to the fact that many rural residents come to city facilities to avoid stigma they may encounter closer to home.
- Overloaded health workers who show signs of fatigue and impatience with their work due to inadequate staffing for the high patient loads.
- High turnover of health staff was a problem noted by facilities and health workers, as well as by patients who were angered by new providers always asking them to repeat their history.

¹² Authors calculations, based on: MOH/HAPCO. 2008. *Single Point HIV Prevalence Estimate*. Addis Ababa: MOH/HAPCO.

- Lack of incentives for healthcare workers, such as overtime, duty exemptions, and risk allowance.
- Problems with supplies and equipment, especially CD4 machines.
- Inconvenient ART wards that are separated from other services, making them easily identifiable and contributing to stigmatization of patients.
- Required permanent address and ID card for pre-ART registration and ART services. This barrier affects homeless PLHIV, residents without ID cards, and those people renting homes.

Discontinuing ART

The nine health facilities in the study reported that 10.6 percent of individuals discontinued ART over the last 12 months—a proportion that is lower than previously reported. The following are key findings associated with discontinuation of treatment:

- Men, youth (ages 15–24), and non-working individuals are most likely to discontinue ART.
- Discontinuation rates are significantly higher at health centers than at hospitals; although, transfers were not always recorded at either set of facilities and thus would not be reflected in these results.
- Reasons for discontinuing treatment:
 - Lack of food
 - Side effects
 - Perceived and actual stigma
 - Improved health leading to loss of patient commitment to continue ART
 - Treatment fatigue and loss of hope
 - Lack of money to pay for transportation
 - Change of residence
 - Discontinuation during fasting season, especially among Muslim patients
 - Relapse of *Khat* and alcohol habits
 - Incarceration (ART services are not easily accessible for inmates)

RECOMMENDATIONS AND NEXT STEPS

Actions at the policy, community, and facility levels are recommended to reduce the barriers identified in this study.

At the policy level, it is recommended that Ethiopia clearly define potentially underserved populations for ART-related services and develop equity monitoring indicators at the national level to evaluate progress toward equity in access to treatment for these groups. These could be monitored using information currently being collected but not analyzed in this manner. Because food support programs were shown to be crucial to recruiting and maintaining ART users, mapping food support programs available for PLHIV on ART and evaluating program efficiency, sustainability, impact, and pitfalls are recommended.

At the community level, working to educate communities about HIV and ART will facilitate an enabling environment in which PLHIV will be more comfortable disclosing their status and accessing the services they need. In addition, working with churches, PLHIV associations, and communities to address the prevailing confusion between simultaneous use of ART and Holy water and vigorously promoting ART as the single most effective treatment option for HIV will help clients to adhere to ART. Partnerships with Islamic faith groups can also benefit PLHIV by helping patients adhere to ART during fasting seasons.

Facilities need to meet treatment demand by strengthening their physical assets (equipment, supplies, and integrated service delivery areas) as well as improving conditions for healthcare workers to reduce turnover and maintain an experienced cadre of ART providers. They should also solicit viable options to reduce or eliminate the costs for PLHIV associated with diagnosis, treatment, and drugs for opportunistic infections and other health problems and expand access to ART by the rural population through initiatives that bring services closer to the community.

Because this study had limited geographic coverage and a small facility sample, further research is recommended. Studying the barriers to accessing ART in emerging regions and private facilities may provide additional dimensions and improve our understanding of contextual and institutional barriers.

As noted, the Health Policy Initiative prepared two additional materials on this activity: *Study Design Protocol: Equity and Access to ART in Ethiopia*, detailing the study methodology, and *Equity and Access to ART in Ethiopia*, detailing the study results. A poster summarizing the study will be presented at the 2010 International HIV/AIDS Conference. The Ethiopia HIV/AIDS Prevention and Control Office, USAID/Ethiopia, and the U.S. President's Emergency Plan for AIDS Relief have all expressed interest in the findings, and it is the project's hope that the findings will be used to reduce identified barriers and increase equitable access to ART.

Other countries desiring to undertake a similar study can build on this work by adapting the questionnaires and data collection tools, using a similar data analysis plan, comparing their results with the findings in Ethiopia, and continuing to build the evidence base regarding equitable access to ART. These efforts will help countries improve their care and treatment program and continue to expand access to life-saving care.

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