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PERMANENT MISSION OF THE FEDERAL
DEMOCRATIC REPUBLIC OF ETHIOPIA
TO THE UNITED NATIONS

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STATEMENT

BY

H.E. DR. TEDROS ADHANOM GHEBREYESUS
MINISTER OF HEALTH
OF THE
FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA

AT

The High Level Meeting and Comprehensive Review of the Progress Achieved in Realizing the Targets set out in the Declaration of Commitments on HIV/AIDS

United Nations
2 June 2006

Mr. President,

Respected delegates

Ladies and Gentlemen

On behalf of the Government of the Federal Democratic Republic of Ethiopia, I would like to express my gratitude for the opportunity to address this august Assembly on the progress made in our country since the Declaration of commitment on HIV/AIDS in 2001.

The 2005 antenatal care survey indicates adult prevalence of 3.5 compared to a prevalence of 7.3 in 2001. A population survey that was conducted for the first time in 2005 indicated an adult prevalence of 1.6. HIV prevalence is declining especially in urban areas.

Our multi-sectoral response to HIV/AIDS over the past 5 years, after the 2001 declaration, has shown positive development in all three pillars: prevention, treatment and care and support.

To intensify prevention we are using an innovative community based approach called health extension program and based on the recently revised strategic plan, a total of 30,000 health extension workers will be trained and deployed by 2008 to achieve blanket coverage. So far around 10,000 health extension workers were deployed which covers a third of the total villages in Ethiopia. These health extension workers reach out each and every household and ensure transfer of ownership of HIV/AIDS prevention to the communities they serve. While the health post in each village serves as a formal institution to coordinate the program, FBOs, NGOs, CSOs and village leaders are active players of the campaign.

An average of 103,000 PLHA and OVC are being supported annually and the target for 2010 is to support 1 million. In order to achieve the set target, care and support is being integrated into the social mobilization efforts for prevention outlined above.

The idea is to tap domestic resources for care and support during the household and community based interventions.

Prior to the initiation of an accelerated free ART treatment in 2005, the number of People on free ART were 900 and in May 2006 we were able to enroll a total of 34,000 on free treatment. The total target for the end of 2006 is 100,000 and universal access by 2010. The number of sites providing ART increased from 8 in 2003 to 77 in 2006. In order to achieve the 100,000 target by the end of 2006 (around 40 to 50% of those who need ART) more than 50 facilities are being readied to provide free ART. We will treat 210,000 by 2008 and we will achieve Universal access by 2010.

The signing in January 2006 of a Memorandum of Understanding with Global Fund and PEPFAR in line with the one national program and harmonization principles is creating synergy and contributed greatly to accelerate the implementation of major activities.

Although encouraging results have been registered, the challenges ahead of us are more than what we have done so far. I would like to reiterate Ethiopia's full commitment to achieving Universal Access by 2010 in the major targets outlined above under the three pillars.

To accelerate the targets under the three pillars, the main strategic issues we are following are: capacity building, social mobilization, integration with health programs, leadership and mainstreaming, coordination (harmonization) and focus on the most vulnerable.

Finally, I would like to use this opportunity to thank the Global Fund, PEPFAR, the World Bank, UNAIDS and all other partners for all the support provided.

I thank you