# NATIONAL HIV PREVENTION ROAD MAP

## 2023 -2027

**Ministry of Health**

**June 2023**

**Addis Ababa, Ethiopia**

# Foreword

The Federal Democratic Republic of Ethiopia has committed to reduce new adult HIV infections and AIDS-related deaths to less than 1 per 10, 000 population by 2027 at the national, sub-national and sub-population groups. This reduction is essential to attain and sustain HIV epidemic control at national and subnational levels and in population groups by 2027, and to achieve the third United Nations Sustainable Development Goal (SDG-3) to end the epidemic of HIV/AIDS by 2030.

As stated in the National HIV/AIDS Strategic Plan 2023-2027, Ethiopia aims to reach 95 percent of key and priority populations, including adolescent girls and young women, with combination HIV prevention interventions. The progress towards the 95-95-95 targets will be accelerated to ensure that Ethiopia's prevention and treatment goals are attained and sustained at national and subnational levels and in population groups.

The first National HIV Prevention Road Map 2018–2020 successfully defined the geographic and population priorities for HIV prevention and a set of high-impact combination HIV prevention interventions. During its operational period, the first Road Map contributed to a reduction of new infections. However, the COVID-19 pandemic and armed conflict in various regions of the country have negatively impacted the HIV response. The country fell short of attaining by 2020 the planned 75 per cent reduction in the number of new HIV infections from the 2016 baseline.

The second National HIV Prevention Road Map 2023-2027 is based on a comprehensive analysis of the epidemic and its response context, as well as a wider consultation of national and regional stakeholders to address challenges in the HIV prevention programme. The Road Map 2023-2027 will ensure that the HIV programme responds to the impact of both COVID-19 and conflict, and that it removes the barriers to HIV services and inequalities among geographic localities and population groups.

The Road Map 2023-2027 is aligned with the National HIV/AIDS Strategic Plan 2023-2027, the Health Sector Transformation Plan, the Global AIDS Strategy 2021-2026 and the Global HIV Prevention Road Map 2025.

Implementation of the National HIV Prevention Road Map 2023-2027 calls for leadership commitment across all levels. It requires a strong focus of donors and implementers on prevention interventions targeting geographic and population priorities. There should also be a strong tracking of progress and accountability to end inequalities and to end AIDS.

Finally, I would like to thank national task force members UNAIDS, UNFPA, AHF and Project Hope for the technical and financial support provided for the development of this Road Map.

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# Acronyms

| | |
|---|---|
| AGYW | Adolescent Girls and Young Women |
| ASK-US | National Association of HIV Positive Children, Adolescents and Youth |
| CCC | Community Care Coalition |
| CSA | Central Statistical Agency |
| CSE | Comprehensive Sexuality Education |
| DHIS | District Health Information Software |
| DSDM | Differentiated Service Delivery Model |
| EPHA | Ethiopia Public Health Association |
| EPHIA | Ethiopia Population-based HIV Impact Assessment |
| EPHI | Ethiopia Public Health Institute |
| EPSS | Ethiopia Pharmaceutical Supplies Services |
| FBO | Faith-Based Organization |
| FHAPCO | Federal HIV/AIDS Prevention and Control Office |
| FSW | Female Sex Workers |
| HIVST | HIV Self-Test |
| HTS | HIV Testing Services |
| IBBS | Integrated Behavioural and Biological Survey |
| ICT | Index Case Testing |
| KPs | Key Populations |
| KPPs | Key and Priority Populations |
| MSM | Men who have Sex with Men |
| MSR | Maternal Surveillance and Response |
| MRIS | Multisectoral Response Information System |
| MTCT | Mother-to-Child Transmission of HIV |
| NAPWE | National Association of Positive Women Ethiopians |
| NEP+ | Network of Networks of HIV-Positives in Ethiopia |
| NSF | National Strategic Framework |
| OST | Opioid Substitution Therapy |
| PEP | Post-Exposure Prophylaxis |
| PrEP | Pre-Exposure Prophylaxis |
| PWID | People Who Inject Drugs |
| SBCC | Social Behavioral Change Communication |
| SOP | Standard Operating Procedure |
| SRH | Sexual and Reproductive Health |
| STIs | Sexually Transmitted Infections |
| U=U | Undetectable = Untransmittable |
| VL | Viral Load |
| YFHS | Youth-Friendly Health Services |

# Chapter 1

# INTRODUCTION

## 1.1 Background

Ethiopia has made remarkable progress in the prevention and control of the HIV and AIDS epidemic. HIV prevalence among the adult population (aged 15-49) has declined from 1.26 per cent in 2010 to 0.8 per cent in 2022 (EPHI 2023). In 2022, the national HIV incidence rate among the adult population was estimated at 0.008 per cent, with an estimated 8,300 new infections per year (4,000 females aged 15 years and above, 2,300 males aged 15 years and above, and 2,000 children under 15 years).

Nonetheless, with an estimated 610,000 people living with HIV (PLHIV), of whom 37,000 are under 15 years of age, HIV is a heavy burden on the country. The predominant drivers of this epidemic reside among key and priority populations (KPPs) and children infected through vertical transmission.

In 2022, among women and men aged 15-49 in Ethiopia, 0.8 per cent were living with HIV. However, there is wide variation by sex, age, geographic localities, and population groups. HIV prevalence was higher among women (1%) than men (0.6%) One-third (34%) of new infections occurred among adolescent girls and young women (AGYW) aged 15-29 years. A quarter of new infections occurred in the age group of 0-4 years (EPHI 2023).

There is wide regional geographical variation in HIV prevalence and concentration. HIV prevalence is seven times higher in urban areas than in rural areas (2.9% and 0.4%). Among the regions, Gambella has the highest adult HIV prevalence (3.7%), followed by Addis Ababa (3.2%), Diredawa (2.7%) and Harari (2.5%). Southern Nations, Nationalities and Peoples (SNNP) and Somali regions have the lowest HIV prevalence (0.4% and 0.2%) (EPHI 2023).

Key population groups are disproportionately affected by HIV, with HIV prevalence ranging from 4 per cent to 39 per cent among these groups. HIV prevalence was reported to be 18.3 per cent among female sex workers (FSW) in 2021 (EPHI, FHAPCO, 2021), 4.2 per cent among prisoners (UNODC and Federal Prison Administration, 2014), and an average of 6 per cent among people who inject drugs (PwID), with much higher prevalence at 31 per cent among female PWID and lower at 5 per cent among male PWID in Addis Ababa (EPHI, UNODC 2015).

Among priority populations, HIV prevalence ranges from 1.3 per cent to 11 per cent. The EDHS 2016 reported an HIV prevalence of 11.5 per cent among widowed women and 3.5 per cent

among divorced women (CSA, ICF 2018); 4.9 per cent among long-distance derivers (EPHA, CDC, EPHI, FHAPCO 2014) and 1.3 per cent among mobile workers (MOH 2021).

HIV prevalence is low (0.4%) among adolescent girls and young women (CSA, ICF 2018). However, 34 per cent of new infections occurred among AGYW aged 15-24 years in 2022 (EPHI 2023). In many urban areas, high-risk AGYWs engage in transactional sex (FHAPCO 2020).

The decline in new HIV infections and AIDS-related deaths in the past decade is the result of the comprehensive HIV prevention, care and treatment programme implemented in the country. Combination HIV prevention services included behavioral, biomedical and structural interventions. In 2022, a total of 21,684 eligible populations (19,670 female sex workers and 2,014 discordant couples) were on Pre-Exposure Prophylaxis (PrEP) across the country. About 25,000 voluntary medical male circumcisions (VMMC) were performed annually in Gambella Region.

However, only 80 million of the 250 million condoms needed were procured and distributed. Only one-fifth of the estimated STI cases were treated at health facilities. The HIV programme for PWID was limited (MOH 2023a).

The country has made good progress in linking HIV-positive people to antiretroviral therapy (ART) and in overall viral suppression. In 2022, 84 per cent of the estimated PLHIV knew their status. Among them, 98 per cent were on ART, and 98 per cent of those on ART had suppressed viral load (<1000 copies/ml) (MOH 2023).

In recent years, the COVID-19 pandemic and conflict in different parts of the country have posed serious threats to the national HIV prevention and control programme and to people living with HIV, as they are more vulnerable to infection, serious morbidity and mortality.

COVID-19 placed an unprecedented strain on the human, physical and financial resources of the health sector, including the HIV prevention, care and treatment programmes. To reduce the number of HIV-related visits to health centers during the crisis, the MOH spaced the schedules of enhanced appointments and increased the size of take-home supplies of ARVs.

The conflict in Tigray, Amhara, Afar and other regions destroyed health facilities and interrupted HIV prevention, care and treatment services. Hundreds of thousands of people were displaced in the affected regions, increasing their vulnerabilities to HIV and AIDS. The MOH and its partners provided ART services for PLHIV displaced from their residences

through emergency transfers to nearby health facilities. Most HIV services and health facilities destroyed by the conflict in the northern part of the country have since been restored. (MOH 2021).

## 1.2 The National HIV/AIDS Strategic Plan 2023-2027

The National HIV/AIDS Strategic Plan (NSP) 2023-2027 aims to achieve epidemic control by 2027, reducing new HIV infections and AIDS-related deaths to less than 1 per 10,000 population at national and subnational levels and in population groups.

The NSP aims to reach 95 per cent of key and priority populations with combination HIV prevention. It also aims to achieve the 95-95-95 goal, namely, that 95 per cent of PLHIV know their status, 95 per cent of these are on ART, and 95 per cent of those on ART attain viral suppression, among different age, sex and population groups. Another goal is to achieve the triple elimination of vertical transmission of HIV, syphilis and hepatitis by 2027 (MOH 2023b).

The NSP is built on geographic and population prioritization. Ethiopia has more than one thousand woredas or geographic localities. Regarding HIV, the MOH classifies woredas in three priority levels (high, medium and low HIV incidence) according to the estimated HIV incidence among people aged 15-49 years: high (≥0.03%), medium (0.01-0.029%) and low-incidence (<0.01%) (FHAPCO, MOH 2023b).

- **High-incidence:** 265 woredas
- **Medium-incidence**: 326 woredas
- **Low-incidence**: 485 woredas

Recently, 35 conflict-affected woredas were added to this category, making a total of 300 high- priority woredas.

The HIV prevention programme targets both key and priority populations (KPPs). For the period 2023-2027, Ethiopia has defined **three key populations** (female sex workers, prisoners, and people who inject drugs) and **seven priority populations** (high-risk adolescent girls and young women, widowed and divorced men and women, long-distance drivers, workers in hotspot areas, negative partners of PLHIV, high-risk uniformed men and women, people in humanitarian emergency settings). Based on available data, it is estimated there were about 2.7 million KPP in the country in 2022 (MOH 2023b)

**Table 1.1: Estimated size of key and priority populations in priority woredas**

| Key and priority populations | 2022 | 2027 |
|---|---|---|
| Female Sex Workers[1] | 210,000 | 240,000 |
| Prisoners | 110,000 | 110,000 |
| People who inject drugs | 11,000 | 9,000 |
| Widowed/divorced men and women | 956,475 | 1,114,931 |
| Long-distance drivers | 65,000 | 85,000 |
| Workers in hotspot areas | 840,000 | 1,050,000 |
| Seronegative partners of PLHIV | 206,841 | 234,599 |
| High-risk adolescent girls and young women | 338,341 | 378,134 |
| People in humanitarian emergency settings | TBD | TBD |
| High-risk uniformed people | TBD | TBD |

The NSP 2023-2027 sets clear prevention goals, defines population and geographic priorities, and outlines strategic prevention interventions. The second National HIV Prevention Road Map 2023-2027 is the tool to materialize the NSP during its five-year strategic period. The second Road Map addresses the disruptions caused by COVID-19, conflict and displacement to both the delivery of HIV services and the dynamics of the HIV epidemic. Furthermore, the National HIV Prevention Road Map 2023-2027 responds to changes in the HIV coordination structure and the new lead role for MOH.

The National HIV Prevention Road Map 2023-2027 will facilitate the realization of the prevention goals of the NSP 2023-2027 by defining substantial granular details of HIV prevention interventions, service delivery models, indicators, leadership, accountability and the monitoring framework.

## 1.3 The First National HIV Prevention Road Map 2018 -2020

The first National HIV Prevention Road Map 2018-2020 was aligned with the global HIV Prevention Road Map (UNAIDS) and was built around six central pillars: combination HIV prevention for KPPs, combination HIV prevention for AGYW, condom programmes, PrEP, VMMC, and STI control and prevention (FHAPCO 2018).

[1] Technical Report on Size Estimates. HIV and other STIs prevalence among FSWs in Ethiopia: National HIV and STIs Bio-behavioral Survey Round II EPHI, FHPACO 2021

Based on global UNAIDS guidance, the first National HIV Prevention Road Map 2018-2020 defined two key populations (FSWs and prisoners) and five priority populations (adolescent girls and young women, long-distance drivers, widowed and divorced women and men, workers in hotspot areas, and HIV-negative partners of PLHIV). Defining KPPs enabled the HIV prevention programmes to focus on the most affected groups (FHAPCO 2020).

Goals of the first National HIV Prevention Road Map 2018-2020 included:

- To reduce adult new HIV infections by 50 per cent by 2020, from the 2016 baseline of 9,800 to 4,900
- To reach 90 per cent of KKP and AGYW with combination HIV prevention
- To ensure that 25 per cent of HIV funding is allocated to HIV prevention
- To achieve the target of annual distribution of 200 million condoms by 2020 (FHAPCO 2018)

Though the first Road Map was not evaluated, the programme review of the NSP 2015-2020 showed remarkable progress in HIV prevention by 2020. According to EPHI 2022 spectrum estimates, the number of new HIV infections reduced from 16,442 in 2016 to 11,702 in 2020.

However, according to FHAPCO, only 69 per cent of FSWs had been reached with combination HIV prevention by 2020. Even fewer AGYW and widowed and divorced women accessed combination HIV prevention. Given the vast population of tens of millions of AGYW in Ethiopia, priority was given to the smaller high-risk FSW group. The allocation of 25 per cent of HIV funding to prevention by 2020 fell short.

## 1.4 Global HIV Prevention Targets and HIV Prevention Road Map 2023-2026

According to UNAIDS, inequalities are the key reason why the 2020 global targets were missed. Inequalities underpin stigma, discrimination and HIV-related criminalization, which increase people's vulnerability to acquire HIV and die of AIDS-related illnesses. Most people disproportionately affected by the epidemic live in vulnerable contexts, where inadequate political will, funding, policies and social norms block their access to health care. Most people newly infected with HIV and who are not accessing life-saving HIV services are from the key population groups. Globally, key populations and their sexual partners account for an estimated 62% of new infections (UNAIDS 2020).

The **Global AIDS Strategy 2021–2026** seeks to eliminate the inequalities that drive the AIDS epidemic and to put people at the center of the response, with the ultimate goal of ending

AIDS as a public health threat by 2030 (UNAIDS 2020).

The **Global AIDS Strategy 2021-2026** builds on three interlinked strategic priorities:

- Strategic Priority 1: Maximize equitable and equal access to HIV services and solutions.
- Strategic Priority 2: Break down barriers to achieving HIV outcomes.
- Strategic Priority 3: Fully resource and sustain efficient HIV responses integrated into systems for health, social protection, humanitarian settings and pandemic responses (UNAIDS 2020).

The Global Strategy encouraged countries to set granular targets for population and geographic localities. Goals of the Strategy include reaching 95 per cent of people at risk of HIV infection with combination HIV prevention interventions, reaching the 95–95–95 testing, treatment and viral suppression targets across all demographics, populations and geographic settings, and eliminating new HIV infections in children.

The Strategy recognizes the need to implement combination HIV prevention, including the Undetectable=Untransmittable (U=U) approach, and access to affordable medicines, diagnostics, vaccines and health technologies. Social and legal barriers to HIV services must be addressed. Community-led service delivery and monitoring with greater involvement of PLHIV is critical, as is the integration of HIV services in health, social and economic services. The Strategy emphasized the need to fully fund the HIV response and set a target to invest US$ 29 billion annually in low- and middle-income countries, including at least US$ 3.1 billion for societal enablers (see table 12.1).

The **Global HIV Prevention Coalition** works to accelerate progress on HIV prevention with a focus on the countries with the highest numbers of new HIV infections or where new infections are rising. Created in 2017, the Coalition seeks to build commitment, momentum, investment and accountability across governments, civil society, donors and the private sector to implement large-scale, high-coverage, equitable and good quality prevention programmes. Ethiopia is one of the 28 countries of the Coalition (UNAIDS 2022).

The **Global HIV Prevention 2025 Road Map** offers guidance to all stakeholders who seek to reduce new HIV infections. All countries—whether they participated in the Global HIV Prevention Coalition in the past or not —are expected to intensify their HIV prevention efforts to end the AIDS epidemic. The 28 focus countries of the Coalition together accounted for almost three quarters of annual new HIV infections globally in 2020. Exceptional international

and national efforts are needed in these countries (UNAIDS 2022).

The **Global HIV Prevention 2025 Road Map** charts a way forward for countries to achieve an ambitious set of HIV prevention targets by 2025. These targets emerge from the 2021 Political Declaration on HIV and AIDS, which the United Nations General Assembly adopted in June 2021, and are underpinned by the Global AIDS Strategy 2021–2026.

In the 2021 Political Declaration on HIV and AIDS, Member States agreed to prioritize HIV prevention and reduce global new HIV infections to fewer than 370,000 per year by 2025. The commitments are anchored in the 2025 Global AIDS Strategy targets, namely, the 95–95–95 targets for access to HIV services; the 10–10–10 targets for removing social and legal impediments to accessing or using HIV services; and the use of integrated approaches to link at least 95 per cent of people who are at heightened risk of HIV infection to the services they need for their overall health and well-being (UNAIDS 2022).

The **Global HIV Prevention 2025 Road Map** focuses on scaling up primary prevention of HIV infections and on introducing policy, legal and societal enablers that can prevent people from acquiring HIV infection. It also highlights the considerable complementarity and interaction between primary HIV prevention, testing, treatment and the prevention of vertical transmission of HIV.

The **Global HIV Prevention 2025 Road Map** responds to the need for stronger action against the inequalities that hold back progress. It takes account of an evolving context that is marked by persistent inequalities, overlapping pandemics, economic challenges, shrinking space for civil society activities, and the erosion of human rights (UNAIDS 2022).

The **Global HIV Prevention 2025 Road Map** prioritizes reaching key populations everywhere and adolescent girls and young women and their male partners in sub-Saharan Africa, while addressing the inequalities that fuel new HIV infections and strengthening the roles of communities in HIV prevention. The 2025 Road Map guides the use of scarce resources to achieve maximum impact and to prepare for wider availability and use of innovative HIV prevention tools (such as long-acting formulations for PrEP methods) and approaches (such as telemedicine and other virtual services). (UNAIDS 2022).

The **Global HIV Prevention 2025 Road Map** identified ten action points for countries to adopt during the development of country-specific HIV Prevention Road Maps.

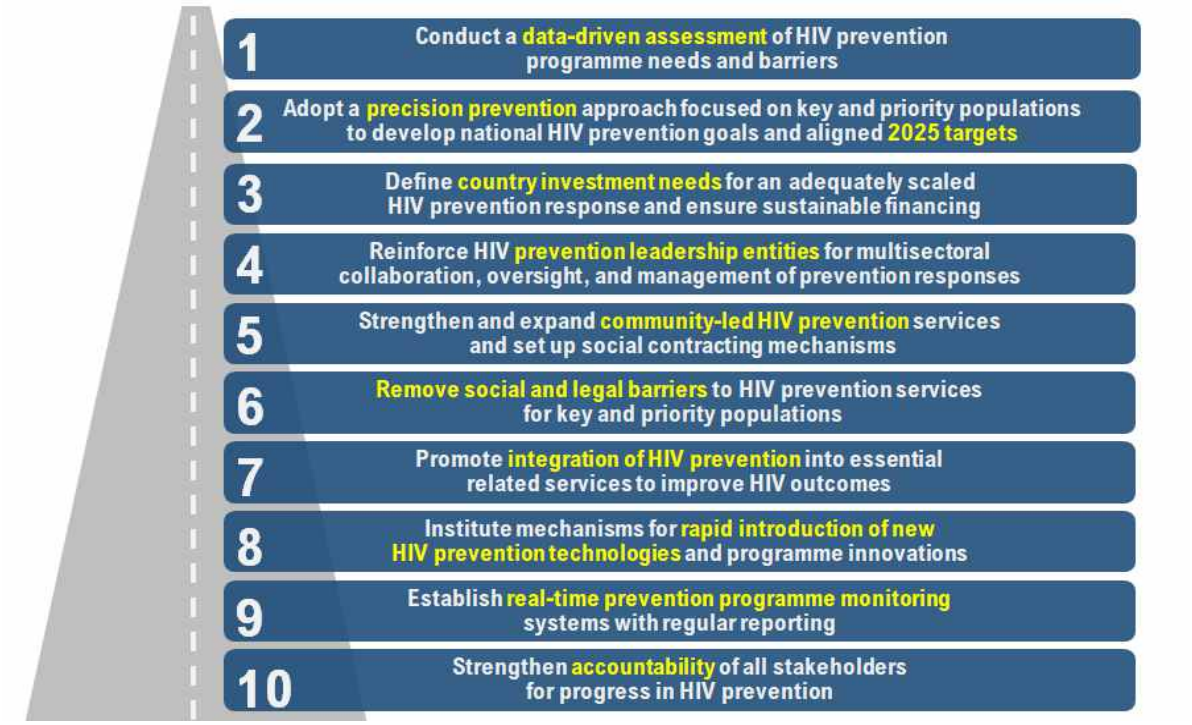


**Figure 1.1 The Global HIV Prevention 2025 Road Map: Ten-Point Plan (UNAIDS 2022)**

The **Global HIV Prevention Road Map** 2023-2026 identified five pillars for HIV prevention programmes in Coalition countries:

- Pilar 1. Combination prevention targeting key populations
- Pillar 2. Combination HIV prevention targeting AGYW in high-incidence settings
- Pillar 3. Combination prevention targeting adolescent boys and men (ABYM) in high-incidence settings
- Pillar 4. Condom programming
- Pillar 5. ARV-based prevention (UNAIDS 2022)

*See the Global Road Map Figure 12.1 in Annex.*

The pillars on AGYW and ABYM refer to settings with high HIV incidence defined as ≥ 1% (UNAIDS 2022). UNAIDS recommends that, in addition to district level HIV incidence, programming targeting AGYW and ABYM should also use behavioral Indicators. AGYW and ABYM are defined as high-risk when they are sexually active with at least one non-regular sexual partner (non-cohabiting, non-marital) or two or more partners (of any type). AGYW who exchanged sex for cash, gift, or other material benefits in the past 12 months are also considered high-risk. UNAIDS recommended that AGYW and ABYM in high-risk districts and high-risk AGYW and ABYM in all settings should be priorities in prevention programmes.

## 1.5 National HIV Prevention Road Map 2023-2027

The development process of the National HIV Prevention Road Map 2.0 2023-2027 was led by a national task force chaired by the MOH. Members include UN agencies, development partners and civil society organizations such as NEP+, NEPWE and ASK-US. The Road Map drafts were reviewed and enriched in several multi-stakeholder workshops.

The Road Map 2023-2027 is based on a data-driven assessment of HIV programme needs and barriers, and an in-depth analysis of the HIV epidemic context and response. The analysis involved a desk review of global and national strategies, policy and legal documents, programme reports, surveys, assessments and surveillance reports. In addition, key informant interviews were conducted with the government, donors, development partners and civil society organizations (CSOs). The following are the key findings and recommendations in the programme needs assessment.

**Table 1.2: The HIV epidemic and response analysis: findings and recommendations**

| Key Findings | Recommendations |
|---|---|
| Alignment of National Strategic Plan with Global AIDS Strategy<br>• NSP treatment cascade 95-95-95 targets are aligned to the Global AIDS Strategy.<br>• NSP targets set for HIV prevention in children need alignment with Global AIDS Strategy.<br>• HIV prevention target aims to reach 90% of KPP versus 95% target in the Global AIDS Strategy.<br>• The NSP does not have targets aligned to the global 10-10-10 targets for stigma, discrimination, punitive laws and policies, gender inequality and GBV<br>• The NSP does not have clear targets aligned with the global 30-60-80 targets on community-led service delivery and monitoring.<br>• Ethiopia recognized only three of the five global key populations – FSWs, PWID and prisoners. Some KPPs are either illegal or socially unaccepted in Ethiopia. | Set contextualized targets aligned with Global AIDS Strategy<br>• Align targets for combination HIV prevention intervention targeting KPP to Global AIDS Strategy (increase NSP target from 90% to 95%)<br>• Set a clear national target for HIV prevention in children aligned with the global targets.<br>• Set targets for stigma, discrimination, punitive laws and policies, gender inequality and GBV aligned with the global 10-10-10 targets.<br>• Set targets for community-led service delivery and monitoring aligned with global 30-60-80 targets |

| Populations and geographic areas most affected by the epidemic (concentrations) | Ending inequalities must focus on places and people most affected |
|---|---|
| • HIV epidemic is concentrated in urban areas and women are the most affected by HIV.<br>• A significant proportion of new HIV infection is among adolescent girls and young women<br>• Population groups highly affected by the epidemic are FSWs, PWID, divorced and widowed persons, long-distance drivers, high-risk AGYW, HIV-negative partners of PLHIV.<br>• Gambella, Addis Ababa, Diredawa and Harari regions have high HIV prevalence.<br>• 265 woredas are high priority but there is concern about the accuracy of woreda HIV incidence estimate (Naomi Methods). Hotspot towns not in high-incidence woredas are included in the NSP. | Geographic and population prioritization is key.<br>Focus on populations most affected, including AGYW and KPP.<br>Focus on urban areas. Reconsider the NSP list of 265 high-incidence woredas with Regional Health Bureaus list of hotspots woredas/towns based on programme data and behavioral indicators. |
| HIV risks and vulnerabilities | Address risks and vulnerabilities |
| • Comprehensive HIV knowledge is low among adults and young people (>40%).<br>• Few adults report sex with casual partners but condom use is low in such sexual encounters.<br>• A majority of FSWs use condoms with paying clients but report low condom use with non-paying clients.<br>• One-third of PWID share needles.<br>• About 4% of adults and a higher percentage of FSWs reported STIs symptoms but care-seeking is low.<br>• One-third of married women face intimate partner violence, in a context of high gender inequality.<br>• AGYW engage in transactional sex for economic reasons. | • Educate young people and adults on HIV transmission and prevention and address misconceptions.<br>• Promote safe sex and condom use, especially among non-paying clients.<br>• Provide syringes and needles for PWID.<br>• Integrate STIs screening, diagnosis and treatment in HIV prevention programmes.<br>• Address gender inequalities, prevent and mitigate GBV .<br>• Integrate economic empowerment and HIV |

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|---|---|
| | prevention programmes for AGYW. |
| Legal and social barriers to services<br>• High external and self-stigma and discrimination among PLHIV, including at health-care centers.<br>• Lack of a solid legal framework or penal and civil code laws to fight stigma and discrimination.<br>• The HIV Policy is old and unresponsive to changing contexts and emerging needs.<br>• Legal barriers to HIV services for key populations. KPs are not socially accepted. HIV-positive KPs are likely to face more stigma and discrimination than other PLHIV. | Address legal and social barriers<br>• Set clear targets for stigma and discrimination.<br>• Advocate for and create a legal framework to mitigate stigma and discrimination.<br>• Implement a comprehensive stigma and discrimination reduction at community and health facility level.<br>• Revise the HIV policy to address emerging needs.<br>• Conduct policy advocacy and reform legal barriers so PWID and FSWs can access HIV services. |
| COVID-19 and armed conflict<br>• Increased HIV vulnerability and risk in conflict-affected zones due to influx of armed men, internal displacement of people, reduced adherence for HIV treatment, and GBV.<br>• Disruption of HIV services and reduced service uptake. Health centers were destroyed. ART clients were lost to follow-up. Displacement increased vulnerability.<br>• Competition for resources and leadership attention.<br>• The pandemic disrupted the global logistics system and delayed commodity procurement.<br>• No comprehensive strategy was in place for HIV response in a humanitarian emergency context. | Address the impact of conflict on the epidemic dynamics and HIV response<br>• Develop a strategy for HIV response in humanitarian emergency contexts.<br>• Consider conflict-affected zones as priority for HIV and GBV prevention and response<br>• Advocate for the HIV epidemic to regain leadership attention.<br>• Mitigate impact of the pandemic on procurement of HIV commodities. |
| Delayed implementation of NSP combination HIV prevention | Enhance accelerated implementation of NSP |

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|---|---|
| • Weak leadership delayed preparation, planning and orientation of grassroot implementers of NSP.<br>• Delayed development of guidelines, training packages and standard operating procedures (SOP) to implement the NSP.<br>• Lack of granular details on how to map, identify and reach KPP (PWID, high-risk AGYW, divorced and widowed persons) and implement the NSP new initiatives (harm reduction, scale up DICS, condom programme, and PrEP)<br>• Lack of capacity among programme staff and service providers on new NSP initiatives (harm reduction and opioid substitution therapy) | • Regain the leadership commitment.<br>• Provide granular details in Road Map 2023-2027 on how to map, identify and reach KPP and implement NSP initiatives.<br>• Conduct orientations and training on the NSP and Road Map 2023-2027.<br>• Develop guidelines, training packages and SOPs to implement the NSP.<br>• Train programme staff and service providers on the new NSP initiatives |
| Combination HIV Prevention: Condom Programme<br>• Ethiopia uses the Total Market Approach for condoms. The national condom strategy and guideline define the national condom programme but is not adequately implemented.<br>• The national condom programme lacks a governance and coordination structure to bring all actors (free condoms, social marketing and commercial) on one platform.<br>• Flaws in procurement of condoms for free distribution resulted in poor quality condoms from least-cost bids. Shortages of condoms happen. | Strengthen the National Condom Programme<br>• Adopt the condom strategy and national condom guideline to the HIV Prevention Road Map.<br>• Create a strong condom governance structure.<br>• Resolve condom procurement issues by balancing least cost and quality considerations.<br>• Implement the national condom guideline.<br>• Target free condoms to KPP. |
| Combination HIV Prevention: PrEP<br>• PrEP was scaled up in all ART sites in the country targeting FSWs and discordant couples.<br>• However, uptake and retention in PrEP is low. | Scale up PrEP and improve uptake and retention<br>• Include PWID in the target for PrEP, in addition to FSWs and |

| | |
|---|---|
| • Little creative promotion and communication to improve uptake and retention.<br>• Delays in adoption of innovations like the vaginal ring.<br>• Though recognized in the NSP, PWID were not targeted with PrEP | discordant couples.<br>• Promote creative communication using digital and social media.<br>• Adopt new technologies, like the vaginal ring and injectables for PrEP |
| Combination HIV Prevention: Harm reduction & opioid substitution therapy (OST) for PWID<br>• PWID are recognized as KP in the NSP to receive combination HIV prevention, including harm reduction<br>• Little advocacy to remove legal and policy barriers to implement the NSP for PWID.<br>• Lack of experience, guidelines and tools to implement harm reduction and OST. | Address the barriers and implement harm reduction & OST for PWID<br>• Advocate for policies to address the legal barriers.<br>• Develop guidelines, SOPs and tools.<br>• Train providers and programme staff and engage experienced partners. |
| Combination HIV Prevention: Undetectable = Untransmittable (U=U)<br>• U=U was not adopted in the NSP but it is part of the National guideline for HIV prevention, care and treatment.<br>• Electronic and print media-based education and training on U=U provided for PLHIV and providers<br>• Concerns about potential misunderstanding of U=U among PLHIV | Contextualize the concept of U=U to improve adherence to ART<br>• Contextualize, standardize and monitor the communication around U=U |
| STIs screening, diagnosis and treatment<br>• High STIs prevalence and low care-seeking among adults and FSWs<br>• STIs has been part of HIV prevention programme.<br>• However, there was fragmented and weak SBCC, many missed opportunities for screening, diagnosis and treatment at health facilities, shortage of STI treatment kits, poor partner notification, weak surveillance and drug resistance monitoring. | Strengthen STIs screening, diagnosis and treatment<br>• Ensure that KPP have STIs screening, diagnosis and treatment integrated at all health service outlets.<br>• Supply STIs treatment kits.<br>• Strengthen STIs, SBCC, partner notification and surveillance. |

| | |
|---|---|
| Social behavioral change communication and integration of HIV in social and economic sectors<br>• Better integration of HIV prevention and testing in other health programmes (STIs, TB, SRH, FP, MNH and outpatient medical services).<br>• Integration of HIV services in health services of prisons, universities, colleges, and some workplace health programmes.<br>• Weak integration of HIV education in intra- and extracurricular activities of schools and universities.<br>• Weak integration of HIV prevention and social and economic services. | Strengthen SBCC and integration of HIV prevention<br>• Strengthen integration of HIV and other health services.<br>• Strengthen HIV and health services integration at workplaces, prisons and schools.<br>• Enhance integration of HIV in intra- and extracurricular activities<br>• Strengthen integration of HIV services in social and economic sectors. |
| Rapid adoption of new technologies and innovation<br>• The country does not have a strong structure or mechanism to continuously monitor for new technology and innovation.<br>• However, efforts were made to adopt technology and innovation (PrEP, DSDM, social media and digital technologies) | Ensure rapid adoption of new technologies and innovation<br>• Create a national task force or working group for evaluation and adoption of new technologies and innovation.<br>• Identify, evaluate, and quickly adopt new technologies and innovation. |
| Community-led service delivery and monitoring<br>• PLHIV have been engaged in HIV service delivery and programme leadership in Ethiopia.<br>• KPP are less organized and less engaged in leadership, delivery and monitoring HIV services.<br>• The legal and policy environment does not encourage organizations of KPP and social contracting arrangements to finance KPP-led services.<br>• Community-led monitoring was piloted in KP clinics led by partners. However, funding, capacity, guidelines and tools are lacking. | Strengthen community-led service delivery and monitoring<br>• Conduct policy advocacy and support KPP organized in formal and informal groups<br>• Develop guidelines and tools for community-led monitoring.<br>• Support KPP led organizations initiatives through social contracting arrangements.<br>• Capacity building to strengthen community-led services and monitoring. |

| | |
|---|---|
| Leadership and accountability: continued decline in political commitment and accountability<br>• The National and Regional AIDS Councils (NAC and RAC), which ensured multisectoral accountability and political commitment, were not functional for a long time.<br>• FHAPCO is dissolved and its mandate transferred to MOH. The HIV response will be coordinated by an office in MOH that manages multisectoral and biomedical interventions. This will create synergy between prevention and treatment interventions under one plan. However, there are concerns about weakening the multisectoral response and resource mobilization.<br>• Regional structures vary and need to follow the federal restructuring for better coordination.<br>• Infrequent meetings of the National HIV prevention advisory group and weak technical working groups (TWG).<br>• HIV mainstreaming in strategic sectors is weakening. Downsizing of mainstreaming structure, budget and interventions. | Strengthen leadership and accountability<br>• Revitalize NAC and RACs or replace them with appropriate mechanisms for multisectoral accountability.<br>• MOH needs to emphasize the MSR and resource mobilization.<br>• Regions to align with the federal HIV response coordination structure for better synergy and communication.<br>• Strengthen HIV prevention National Coalition /Advisory Group (NHPAG) and TWGs<br>• Strengthen HIV mainstreaming in the ten strategic sectors with legal framework, advocacy, building capacity, and ensuring commitment of sectors with assignment of staff, workplan and budget. |
| Real-time HIV prevention programme monitoring<br>• The HIV programme is monitored through two separate systems, MRIS and DHIS2.<br>• DHIS2 monitors biomedical interventions and has standardized register, electronic reporting platform and designated personnel for routine reporting.<br>• MRIS monitors multisectoral and community level HIV prevention, but it was weak and produced inconsistent and incomplete data.<br>• Poor IBBS data on KPP, except for FSWs | Ensure real-time HIV monitoring<br>• Integrate MRIS in DHIS2.<br>• Conduct IBBS for KPPs.<br>• Improve the utilization of data for decision- making. |

| Scale up resource needs estimation and mobilization for HIV prevention | Update resource needs estimation and expedite resource mobilization |
| --- | --- |
| • The HIV programme is estimated to cost about $260 million, of which 70% is donor-funded and 30% from domestic sources.<br>• A domestic resource mobilization strategy (DRMS) was developed but its implementation was delayed.<br>• Inflation affects resource need estimations for the HIV programme | • Expedite the implementation of DRMS.<br>• Strengthen mobilization and utilization of external funding.<br>• Update the resource needs estimates of HIV prevention programme. |

# Chapter 2

# Purpose, Objectives and Guiding Principles of the National HIV Prevention Road Map 2023-2027

## 2.1 Purpose

The purpose of the National HIV Prevention Road Map 2023 -2027 is to guide the implementation of the HIV prevention programme to adequately respond to the changing epidemic context and to address the social and legal barriers to accessing HIV services. The Road Map supports community-led and integrated service provision to attain clearly defined milestones and targets aligned with global HIV strategies. The Road Map 2023-2027 aims to:

- Ensure that the HIV prevention programme goals, targets and strategies are aligned with current global HIV prevention programme targets and strategies.
- Provide granular details to implementers on the combination HIV prevention strategies, interventions and service delivery models defined in the NSP.
- Provide detailed guidance and milestones to scale up provision of combination HIV prevention through a community-led integrated approach.
- Identify and adequately respond to the changing epidemic context and address social and legal barriers.
- Facilitate rapid adoption of new technologies and innovations.
- Reinforce HIV prevention leadership and accountability.
- Ensure real-time monitoring and data quality.
- Accurately define HIV prevention resource needs and strengthen resource mobilization and efficient utilization.

### 2.1.1 Guiding principles

The following are the guiding principles of the National HIV Prevention Road Map 2023-2027:

- **Multisectoral approach:** The multisectoral approach and partnership model considers HIV a shared responsibility of all sectors and constituencies.
- **Ending inequalities**: Inequalities in health outcomes will be addressed through rights-based programming and through improving the understanding of, and response to legal, social, human rights and gender-related barriers to accessing services. The Road Map's primary focus is on key and priority populations that have disproportionately higher risks and burden of HIV, and frequently face persecution and stigma.
- **Inclusiveness**: The inclusive and people-centered approach recognizes different

prevention options that individuals may choose at different stages of their lives.

- **Community-led** programme leadership, service delivery and monitoring: Supporting KPP communities to lead, deliver and monitor HIV prevention services will improve acceptance of and retention in HIV prevention, care and treatment services.
- **Gender responsiveness:** The gender-sensitive approach caters for the different needs of women, girls, men and boys in accessing HIV information and related services.
- **Value for money:** Maximize and sustain equitable and quality health outputs, outcomes and impacts in the current constrained economic and financial environment. The Road Map applies principles of economy, whereby HIV prevention programmes minimize inputs costs for service delivery while achieving acceptable levels of quality. The Road Map ensures effectiveness, allocative and technical efficiency in the design, implementation, monitoring and evaluation of HIV prevention programmes.
- **Sustainability:** The Road Map builds a sustainable programme based on reliance on domestic resources, strategic partnerships with external funders, community ownership and leadership commitment.

## 2.2 Goals, objectives and targets of the National HIV Prevention Programme

### 2.2.1 Goals

The goal of the National HIV prevention programme is to attain epidemic control by 2027. This goal entails a reduction in the number of new HIV infections and AIDS-related deaths to below 1 per 10,000 population per year at national and subnational levels and subpopulation groups by 2027.

### 2.2.2 Objectives and targets

The strategic objectives and targets of the National HIV Prevention Road Map 2023-2027 are:

- Reduce new infections in all age groups to below 4,800 by 2027.
- Reach 95 per cent of KPP with combination HIV prevention by 2027.
- Ensure that 15 per cent of FSWs, 5 per cent of PWID, 5 per cent of high-risk PBFW, and 75 per cent of serodiscordant couples (not attaining viral suppression), will receive oral PrEP at least once during the last 12 months by 2027.
- Raise the percentage of eligible PWID who receive OST from zero to 30 per cent

by 2027.

- Increase the percentage of people 15-49 years with STIs treated from 17 per cent to 75 per cent by 2027.
- Increase the percentage of FSWs with STIs treated from 64 per cent to 95 per cent by 2027.
- Expand the VMMC programme to reach 90 per cent in Gambella region by 2027.
- Reduce stigma and discrimination towards PLHIV, including HIV-positive KPP, to below 10 per cent by 2027.
- Reduce GBV to less than 10 er cent by 2027.
- Ensure that significant proportion of HIV testing, social enablers and HIV prevention services targeting key and priority population at community level in the 300 priority woredas are delivered and monitored by CLOs/CSOs
- Put in place a legal and policy framework that supports KPP access to HIV prevention services.

# Chapter 3

# HIV Prevention Road Map: Priorities and Pillars

## 3.1 Population and Geographic Prioritization

### 3.1.1 Population prioritization

#### Defining key and priority populations (KPPs)

The following population groups are defined as Key and Priority Populations, taking into consideration local epidemiology, HIV prevalence, high-risk behaviors, increased morbidity and mortality, and higher vulnerabilities (MOH 2023b).

**KEY POPULATIONS**

- Female sex workers (FSW)
- Prisoners
- People who inject drugs (PWID)

**PRIORITY POPULATIONS**

- Long-distance drivers
- Widowed and divorced men and women
- Workers in hotspot workplaces
- High-risk adolescent girls and young women (HRAGYW)
- PLHIV and their HIV-negative partners
- High-risk uniformed people
- People in humanitarian emergency settings

**Key Populations** are groups that have a high-risk and disproportionate burden of HIV in all epidemic settings. They frequently face legal and social challenges that increase their vulnerability to HIV, including barriers to accessing HIV prevention, treatment and other health and social services. The following are groups defined as key populations in Ethiopia:

**Female Sex Workers** are defined as women who regularly or occasionally exchange sex for money in drinking establishments, night clubs, local drink houses, "khat" and ''shisha'' houses, on the streets, around military and refugee camps, construction sites, trade routes, red-light districts, mining areas, at their homes, and other places. Their paying and non-paying clients are included within this population. A sex worker can be self-identified, or non-self-identifying but who is identified by others as being a sex worker (FHAPCO & MOH 2023b).

FSW can be categorized by where they work:

- *Venue-based:* FSW stationed in hotels and bars.
- *Street-based:* FSW who are mobile or work on the streets.
- *Home-based:* FSW who work at home, or in *areque*, *tella*, *khat* and *shisha* houses.
- *Phone/SMS/social media-based:* FSW who can be contacted and accept sexual appointments through telephone calls and social media.

**Prisoners** are all people, including adult and juvenile males and females, detained in a criminal justice and prison facility during the investigation of a crime, while awaiting trial, after conviction, before sentencing and after sentencing (MOH 2023b).

**People who inject drugs** are men and women whose use of illegal injectable substances puts them at high risk of acquiring HIV. They require special arrangements to access HIV services and harm reduction and rehabilitation interventions (MOH 2023b).

**Priority Populations** are groups of people who are vulnerable to HIV infection. The following are the vulnerable populations defined as priority in the Ethiopian context:

### Long-distance drivers

Long-distance drivers who regularly travel for more than 24 hours on the road, with overnight stays out of their homes. This group includes drivers of heavy trucks, buses, Isuzus, and tour cars (MOH 2023b).

### Widowed and divorced men and women

Widowed men and women are those whose spouse has died and who have not remarried. Divorced men and women are those who have legally dissolved or terminated a marriage under the rule of law of the country and have not remarried. High-risk widows are those who are sexually active, have multiple sexual partners, are involved in petty trade or sell local drinks (MOH 2023b).

### Workers in hotspot areas

Workers in hotspot areas are employed in large sites with more than 500 employees, in localities that have a high HIV burden (>3% if data is available), and poor access to HIV and other health services. They may work in large construction projects, industrial parks, factories, industries, commercial farms, sugar plantations, dry ports, mega-projects like electricity dams, mines, and other infrastructure development projects.

Workers in these sites are likely to be migrant labourers with some disposable income. Thus, the sites attract many female sex workers, resulting in potential risk behaviors associated with the acquisition and spread of HIV. Surveys will collect data to inform HIV programming in these workplaces (MOH 2023b).

**PLHIV and their partners** are defined in the NSP as follows:

- *PLHIV:* People who tested positive for HIV.
- *PLHIV Partners:* People who have sexual relationships with PLHIVs.
- *Discordant couples*: Those where one sexual partner is HIV-positive and the other one is HIV-negative (MOH 2023b)

**High-risk adolescent girls and young women (AGYWs)** are females aged between 10-24 years, who are sexually active (defined as having had sex at least once in the past 12 months), and who meet one or more of the following characteristics in the past 12 months:

- Have multiple sexual partners or sex with a non-regular partner.
- Are involved in transactional sex or are victims of sexual exploitation (irregular exchange of sex for money or goods).
- Are involved in substance abuse (heavy use of alcohol or illicit drugs).
- Have a history of STIs, unintended pregnancy or abortion.

AGYW are found in higher learning institutions, high schools or night schools. They may work as waitresses, coffee sellers, petty traders or domestic workers, may be out of school and/or unemployed, or living on the streets (MOH 2023b).

**People in humanitarian emergency settings** live in areas ravaged by drought, conflict and post-conflict, and natural and human-made disasters. They may be internally displaced people (IDPS), refugees and returnees. IDPs are individuals or groups of people who have been forced to flee or to leave their homes or places of habitual residence, due to armed conflict, natural disasters, and other factors. Refugees are people who have been forced to flee their country because of persecution, war or violence. Returnees are people who, having fled or having been displaced, go back to their places of residence in large numbers, either from abroad or internally (MOH 2023b).

### High-risk uniformed men and women

High-risk uniformed men and women are those on active or frontline duty, and new military and police recruits. A 2018 Department of Defense (DOD) study found an HIV prevalence of 1.2 per cent among them. In addition, the case-based surveillance results show that 13.73 per cent of the newly identified HIV-positive men and women in uniform had recent infections. The conflicts in Ethiopia have resulted in a huge influx of youth into the uniformed services, which generally don't have strong HIV prevention services (MOH 2023b).

### Population with special needs

**People with disabilities** (PwD), especially adolescent girls, young women and youth (YwD), have specific vulnerabilities to HIV and GBV. They are often excluded from HIV prevention information and services and have unaddressed SRH needs. The NSP prioritizes making HIV and SRH services more accessible for PwD.

**Street children, adolescents and youth** are those unable to live in a safe environment with a relative and who have no other safe alternative living arrangement. They usually live on the streets in urban areas. Previously, the HIV response has not given sufficient attention to youth in street situations, although they are vulnerable to HIV/STI infection and GBV. Illicit substances and drug use is common among street children, adolescents and youth. Because national surveys and surveillances have missed this group, there is little accurate data to understand the size of this population, their HIV burden and access to HIV/SRH services.

### 3.1.2 Geographic prioritization

The UNAIDS Guidance classifies districts according to their HIV incidence rate in four categories: very high (≥3%), high (1-2.9%), medium (0.3-0.9%) and low (<0.3%). Ethiopia's national HIV incidence is categorized as low (<0.3%) by UNAIDS. In 2020, none of the 1,076 woredas (districts) fell in the UNAIDS high or very high incidence (≥1%) category. Just five woredas met the medium incidence threshold (0.3-0.9%), with the remaining 1,071woredas in the low incidence category (<0.3%) (EPHI 2020).

Therefore, Ethiopia has adopted its own criterion to categorize districts into high, medium and low incidence woredas that align with the geographic priorities of the national HIV prevention programme. However, incidence estimates at woreda level have low precision and should consider additional risk criteria to improve accuracy. Based on the HIV incidence estimate (Annex 11.4), Ethiopia classifies woredas in the following categories :

- **High-incidence: 265 woredas** with HIV incidence of ≥0.03% among people aged 15-49
- **Medium-incidence: 326 woredas** with HIV incidence of 0.01- 0.029% among people aged 15-49
- **Low-incidence: 485 woredas** with HIV incidence of < 0.01% among people aged 15-49

An additional 35 woredas affected by conflict in Afar, Amhara, Benishangul Gumuz, Oromia, and Tigray regions are considered high-priority woredas to be supported by donors. These woredas present heightened risk factors for new HIV infections:

- High number of IDPs, refugees and returnees.
- Widespread disruption of livelihoods leaving women at greater risk of transactional sex as a means of survival.

- High incidence of sexual gender-based violence during conflict.

The criteria for selection of the 35 additional conflict-affected priority woredas from the regions of Afar, Amhara, Benishangul Gumuz, Oromia, and Tigray regions will be applied stepwise as follows:

- First, woredas affected by conflict that had medium HIV incidence based on the 2020 Naomi estimate will be selected.
- Second, woredas with incidence rates close to higher incidence (0.02% -0.029%) will be selected.
- Third, woredas with the highest estimated PLHIV and IDP populations, and with longer duration of conflict, will be selected.

This makes a total of 300 high-priority woredas to be reached with comprehensive HIV prevention interventions targeting KPPs. Woredas with a low HIV burden will be implement integrated and sustainable HIV prevention interventions mainstreamed in the health and non-health sector programmes and through media and community initiatives. Medium-burden woredas will have the same services listed for low-burden areas, and additional HIV services for KPP integrated into sustainable service delivery models. Based on evidence, woredas may shift categories and the response will be tailored accordingly.

## 3.2 Pillars of the HIV Prevention Road Map 2023-2027

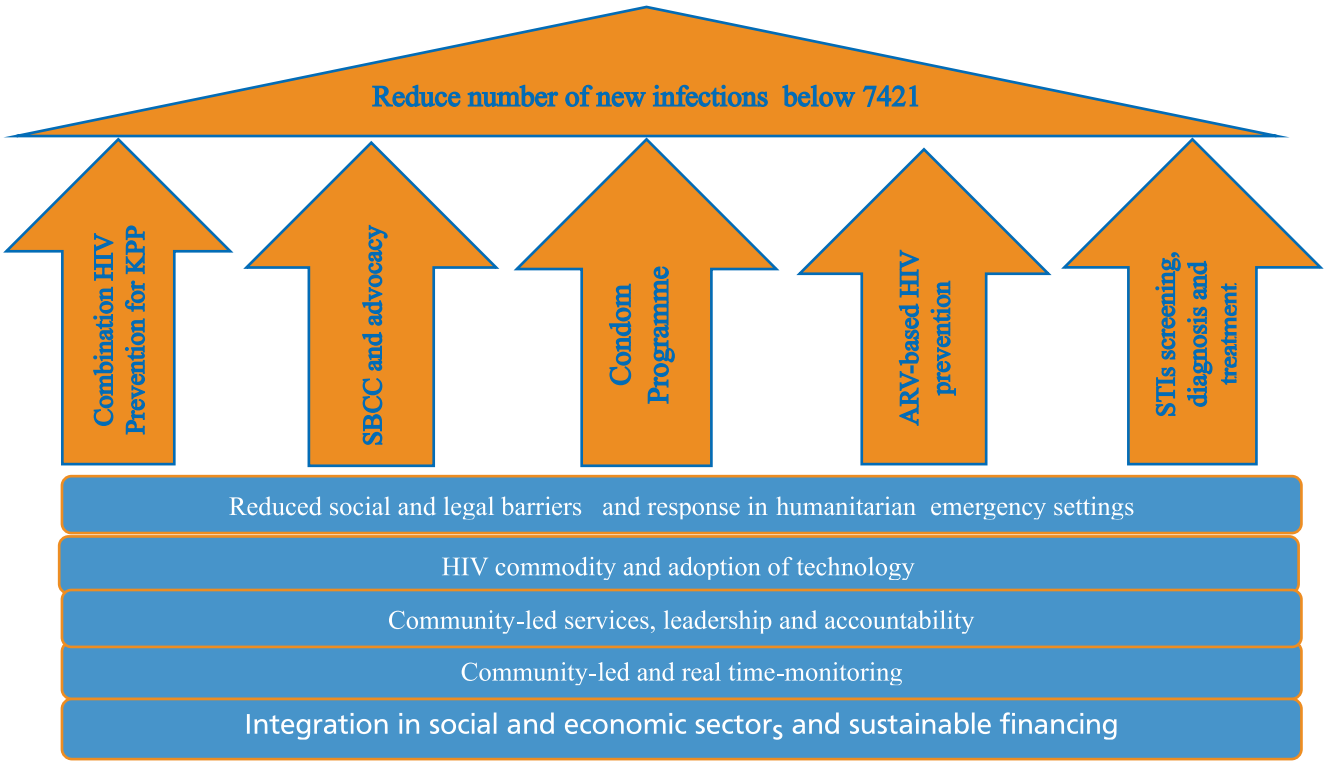
The Road Map 2023-2027 has five pillars and five enablers to attain the goal of reducing new HIV infections to 4,800 by 2027 (see Figure 4.1).

In the first pillar, one of the five priority populations are AGYW with high-risk behavior. To identify AGYW, Ethiopia uses a combination of incidence rates and behavioral risk.

In an evidence-informed addition, Ethiopia introduced two pillars, namely, social behavioral change communication (SBCC), and STIs diagnosis and treatment. Surveys have found low comprehensive knowledge about methods of HIV transmission and prevention among the general population, young people and KPP. Similarly, there is high STIs prevalence and low care-seeking among the general population and KPP.

Voluntary male medical circumcision was one of the five pillars in the first HIV Prevention Road Map 2018-2022. VMMC is no longer a national prevention pillar, although it is part of combination HIV prevention interventions, because circumcision is universal in Ethiopia except in the Gambella region, which has relatively Low Male Circumcision And Higher HIV Prevalence.

Figure 4.1. National HIV Prevention Road Map pillars adapted from the Global HIV




Prevention Road Map 2023-2026

# Chapter 4

# Scaling up Combination HIV Prevention Interventions

| **WHO**: KPP groups | **WHAT**: Integrated service package | **HOW**: Venue/service delivery platform | **WHERE** |
|---|---|---|---|
| Female sex workers (FSW) | • SBCC, including peer-based and small group learning<br>• Condom promotion and distribution, including lubricant.<br>• Pre-exposure Prophylaxis (PrEP)<br>• Post-exposure Prophylaxis (PEP)<br>• Screening and treatment of STIs<br>• SRH services<br>• HIV testing -Provider Initiated Testing and Counseling (PIHTC), Index Case Testing (ICT), Social Network Services (SNS), HIV self-test (HIVST)<br>• Screening/management for hepatitis B and C<br>• GBV services<br>• ART<br>• U=U messaging<br>• Viral Load (VL) testing<br>• Economic empowerment | • Drop-in Centers (DICS)<br>• KP-friendly clinics<br>• Targeted outreach to streets, bars, hotels, brothel and FSWs group homes, including moonlight outreaches<br>• Peer service providers (trained FSWs)<br>• FP/SRH clinics for SRH, STIs, PrEP and PEP services<br>• ART clinics<br>• PMTCT clinics<br>• Virtual safe spaces | 300 high-incidence woredas<br><br>Hotspots: bars, hotels, streets, brothels, FSWs homes, virtual spaces like online dating sites |
| People who inject drugs (PWID) | • Medically assisted treatment (MAT) including opioid substitution therapy (OST)<br>• Drug overdose treatment<br>• Needles and syringes through private pharmacies and social marketing<br>• SBCC, including peer-based and small-group learning<br>• Condom promotion and distribution | • Drop-in Centers<br>• CSO-led MAT clinics.<br>• Public and private health facilities, mental health units, addiction rehabilitation services<br>• Peer service providers (trained | Addis Ababa and four hotspot towns<br><br>Hotspots: drug distribution places, nightclubs and private pharmacies |

| | | | |
|---|---|---|---|
| | • Pre-exposure Prophylaxis (PrEP)<br>• Post-exposure Prophylaxis (PEP)<br>• Screening and treatment of STIs<br>• SRH services<br>• Screening and treatment of mental health services<br>• SRH services<br>• HIV testing (PIHTC, ICT, HIVST)<br>• Screening/management for hepatitis B and C<br>• GBV services<br>• ART<br>• U=U messaging<br>• VL testing | PWIDs)<br>• KP-friendly clinics<br>• FP/SRH clinics for SRH, STIs, PrEP and PEP services<br>• ART clinics<br>• PMTCT clinics<br>• Virtual safe spaces | |
| Prisoners | • SBCC, including peer-based and small group learning<br>• HIV testing<br>• Screening and treatment of STIs<br>• Screening/management for Hepatitis B and C<br>• TB screening<br>• Screening and treatment of mental illness<br>• Referral for ART<br>• Condoms on release from prison | • Prison clinics HIV referrals to health facility HIV services<br>• Public health facility – SRH, STIs, HIV testing, PMTCT, and ART services<br>• Peer service providers (trained prisoners) | Correctional facilities across the country |
| High-risk AGYW | • SBCC, including peer-based and small group learning<br>• Condom promotion and distribution<br>• Post-exposure Prophylaxis (PEP)<br>• Screening and treatment of STIs<br>• SRH services<br>• HIV testing (PIHTC, ICT, HIVST)<br>• Screening/management for | • Adolescent-friendly clinics/spaces in public health facilities<br>• Drop-in Centers<br>• KP-friendly clinics<br>• Targeted outreach to streets, hotels, cafes, broker | 300 high-incidence woredas<br><br>Hotspots: higher learning institutions, cafes, hotels, |

| | | | |
|---|---|---|---|
| | hepatitis B and C<br>• GBV services<br>• ART<br>• U=U messaging<br>• VL testing<br>• Economic empowerment | houses, night schools, etc<br>• Peer service providers (trained HRAGYW)<br>• Mentor services at community and HLI<br>• FP/SRH clinics for SRH, STIs, PrEP and PEP services<br>• University clinics HIV services<br>• ART clinics<br>• PMTCT clinics | broker houses, schools, streets, shisha houses, etc. |
| Sero discordant partners | • SBCC, including one-to-one counselling and group education<br>• Condoms<br>• Pre-exposure Prophylaxis (PrEP)<br>• Post-exposure Prophylaxis (PEP) | • Public health facility – SRH, STIs, HIV testing, PMTCT, and ART services<br>• PLHIV association peer services | Nationwide programme Places: ART clinics and PLHIV associations |
| Widowed, and divorced women and men | • SBCC, peer-based, small group learning<br>• Condom promotion and distribution, including lubricants<br>• Post-exposure Prophylaxis (PEP)<br>• Screening and treatment of STIs<br>• SRH services<br>• HIV testing (PIHTC, ICT, HIVST)<br>• Screening/management for Hepatitis B and C<br>• ART (either on site or through referral)<br>• U=U messaging<br>• VL testing | • Public health facility – SRH, STIs, HIV testing, PMTCT, and ART services<br>• Community outreach by community health workers<br>• Peer service providers<br>• Saving associations and groups | 300 high-incidence woredas. Places: communities, brothel houses, petty trade places, etc. |

| | | | |
|---|---|---|---|
| | • Economic empowerment | | |
| Long-distance drivers | • SBCC, peer based, small group learning<br>• Condom promotion and distribution<br>• Post-exposure Prophylaxis (PEP)<br>• Screening and treatment of STIs<br>• HIV testing (PIHTC, ICT, HIVST)<br>• Screening/management for hepatitis B and C<br>• ART (on site or through referral)<br>• U=U messaging | • Public health facilities – SRH, STIs, HIV testing, and ART services<br>• Outreach/mobile clinics at truck stops run by CSOs | The Ethio-Djibuti, Metema-Sudan, Addis-Mombassa, Ethiopia-Somalia Republic road corridors |
| Workers in hotspot areas | • SBCC, including peer-based small group learning<br>• Condom promotion and distribution<br>• Screening and treatment of STIs<br>• HIV testing (PIHTC, ICT, HIVST)<br>• Post-exposure Prophylaxis (PEP)<br>• ART<br>• PMTCT<br>• GBV services<br>• Screening/management for hepatitis B and C | • Public health facilities – SRH, STIs, HIV testing, and ART services<br>• Workplace clinics HIV services<br>• Outreach HIV services at hotspot workplaces<br>• Peer service providers (trained workers to serve as peer providers) | 300 high-incidence woredas |
| People in humanitarian settings | • SBCC, group education and print media<br>• Condom promotion and distribution<br>• HIV testing (PIHTC, ICT, HIVST)<br>• Post-exposure Prophylaxis (PEP)<br>• Screening and treatment of STIs<br>• GBV services | • Refugee and IDP camp clinics HIV services<br>• Public health facility – SRH, STIs, HIV testing, PMTCT, and ART services<br>• Targeted outreach | 35 woredas affected by armed conflict |

| | | | |
|---|---|---|---|
| | • Mental health screening and treatment<br>• Screening/management for hepatitis B and C<br>• ART<br>• PMTCT | to humanitarian settings<br>• Mobile clinics at humanitarian settings<br>• Community health workers and peer service providers | |
| High-risk uniformed persons | • SBCC<br>• Condom promotion and distribution<br>• Voluntary medical male circumcision<br>• Screening and treatment of STIs<br>• HIV testing (PIHTC, ICT, HIVST)<br>• Post-exposure Prophylaxis (PEP)<br>• Screening/management for Hepatitis B and C<br>• GBV services<br>• ART | • Ethiopian Defence Force Services Federal/Regional police camps, clinics/ hospitals HIV services<br>• Public health facility – SRH, STIs, HIV testing, PMTCT, and ART services<br>• Peer providers in training camps and on mission (trained uniformed people) | Uniformed people training centers and active-duty camps, |
| HIV negative High-risk pregnant & breast-feeding women (PBFW) (in addition to PMTCT service package) | • SBCC, including one-to-one risk reduction counselling and group education<br>• HIV retesting based on risk during pregnancy<br>• Post-exposure Prophylaxis (PEP)<br>• Condoms | • Public health facilities MNCH services<br>• Community outreach, house-to-house services by HEWs<br>• Community services by mother support groups | Across the country |

## 4.1 HIV prevention interventions by population and geographic priorities

Between 2023-2027, a package of combination HIV prevention will be delivered through differentiated service delivery platforms to the different key and priority populations.

### Table 4.1: Combination HIV prevention packages by population groups

The following combination HIV prevention interventions will be scaled-up mainly at the high-incidence woredas and targeting KPP. HIV prevention interventions tailored for all three incidence levels will be implemented targeting KPP and the general population.

### Table 4.2: Service delivery models in high-incidence woredas

| **Prevention interventions** to reduce the risk of and protect against HIV infection include: | **Service delivery models:** approaches, platforms and points of delivery of HIV services and interventions include: |
|---|---|
| • Intensive social behavioral change communication and demand creation<br>• HIV education through print and electronic mass and social media<br>• Condom promotion and distribution, including lubricants<br>• Pre-exposure Prophylaxis (PrEP)<br>• Post-exposure Prophylaxis (PEP)<br>• Undetectable = Untransmittable (U=U)<br>• VMMC in selected geographic areas of high HIV prevalence and low circumcision rates<br>• Harm reduction interventions for PWID including opioid substitution therapy<br>• STIs screening and treatment<br>• Blood safety and infection prevention practices at health facilities | • KPP-friendly clinics<br>• Friendly services at the general HIV services<br>• Peer service providers<br>• Mentor-based HIV services for AGYW<br>• Drop-in Centers<br>• Integrated HIV prevention services (VMMC, , prisons, workplaces, HLI, clinics)<br>• Integrated into other health services (mental health, SRH, TB, hepatitis, cervical cancer, STIs and others)<br>• Integrated services in the social and economic sector<br>• Targeted outreach |

| | |
|---|---|
| • Prevention and management of GBV<br>• Economic empowerment of women, especially HRAGYW<br>• Empowerment of communities, especially KPPs<br>• Intra- and extracurricular HIV education programmes at schools and higher learning institutions (HLI) | • Social marketing, private sector and CSO service delivery outlets<br>• Health extension programme |

**Table 4.3: Service delivery models in medium-incidence woredas**

| Prevention interventions | Service delivery models |
|---|---|
| • SBCC and demand creation<br>• HIV education through print and electronic mass and social media<br>• Condom promotion and distribution, targeting KPPs and general population<br>• Pre-exposure Prophylaxis (PrEP)<br>• Post-exposure Prophylaxis (PEP)<br>• Undetectable = Untransmittable (U=U)<br>• Screening and treatment of sexually transmitted infections<br>• Blood safety and infection prevention practices at health facilities<br>• Economic empowerment of women, especially HRAGYW<br>• Intra- and extracurricular HIV education programmes at schools and HLI | • Friendly services at the general HIV services<br>• Integrated HIV prevention services (VMMC, prisons, workplaces, and HLI clinics)<br>• Integrated into other health services (mental health, TB, hepatitis, SRH, cervical cancer, STIs and others)<br>• Integrated services in the social and economic sector<br>• Social marketing, private sector and CSO service delivery outlets<br>• Health extension programmes |

**Table 4.4: Service delivery models in low-incidence woredas**

| Prevention interventions | Service delivery models |
|---|---|
| • Demand creation SBCC through HEP and CCC<br>• SBCC through mass and social media<br>• Condom promotion and distribution<br>• Pre-exposure Prophylaxis (PrEP)<br>• Post-exposure Prophylaxis (PEP)<br>• Undetectable = Untransmittable (U=U)<br>• Screening and treatment of sexually transmitted infections<br>• Blood safety and infection prevention practices at health facilities<br>• Economic empowerment of women, especially high-risk AGYW<br>• Intra- and extracurricular HIV education programmes at schools and HLI | • Integrated HIV prevention services (prison, workplace, and HLI clinics)<br>• Integrated into other health services (mental health, TB, hepatitis, SRH, cervical cancer, STIs and others)<br>• Social marketing, private sector and CSO service delivery outlets<br>• Integrated services in the social and economic sector<br>• Health extension programme |

## 4.2 Scale up of combination HIV prevention interventions

### 4.2.1 Social behavioral change communication

Intensive SBCC interventions will address key and priority populations in high-incidence woredas. Peer and life skills education will be delivered through either one-to-one or group learning formats, and will follow the national peer education manual. The education component will be linked with condom promotion, HIV testing including self-test, STIs screening and treatment and other HIV services. CSO and community organizations will be encouraged to deliver and monitor the quality of peer and life skills education targeting KPP. The goal is to reach 95 per cent of KPP in the priority woredas with intensive, tailored SBCC at least once by 2027.

Integration of HIV into the school curriculum will be implemented nationally. In-school AGYW and ABYM will learn about HIV and safe sexual practices through peer and life skills education integrated in the school curriculum and in extracurricular activities such as mini-media and

clubs. A peer learning guide will be developed for high-risk in-school AGYW, who will be identified through risk screening tools. Colleges and universities will implement a credited course on HIV, SRH, life skills and gender as part of the first semester of the first-year academic programme.

Tailored demand creation communication will reach KPPs and the general population (mainly youth) through mass media (radio and television), mini-media, print media (leaflets, posters, magazines and newspapers), social media and interactive digital applications. These interventions will raise awareness and create demand for HIV prevention, HIV testing, including self-test, care and treatment, consolidated through integration and community implementation.

Social media and interactive digital applications will be optimized to reach large group of KPPs and general population (mainly youth) to create demand and raise awareness about HIV/SRH prevention, HIV testing, care and treatment, consolidated through integration and strengthening of community level implementers.

Disability friendly HIV education messages will be developed and distributed through various communication modalities including the mass media, electronic, print and social media platforms.

Street-based children, adolescents and youth will be reached through CSOs with tailored and standardized HIV messages and educations.

### 4.2.2 Condom programme

The condom programme includes needs assessment, planning and coordination; forecasting and procurement; storage and maintaining the distribution pipeline; expanding outlets, promotion, and distribution; condom skill-building and advocacy; monitoring quality and performance, among others.

The goal of the condom programme is that 95 per cent of key and priority populations will use condoms at high-risk sex (sex with a non-regular or commercial sexual partner, with inconsistent or incorrect condom use, or without a condom) by 2027.

The condom programme will use the total market approach (TMA). The TMA business model

entails three modalities of condom supply: free distribution by government, subsidized through social marketing, and sold commercially. In 2018/2019, the market share of social market, free condoms and commercial was 58 per cent, 41 per cent and 1 per cent respectively. To ensure sustainability, commercial and social marketing must progressively grow to meet more condom needs.

In the meantime, free condoms will be distributed to targeted KPP groups who can't afford to buy them. Condom-compatible lubricants will be available to FSW through free distribution by CSOs, through social marketing or commercially. Social marketing and the commercial sector will meet the condom needs of the general population and KPP in all woredas.

The national condom programme has been weakened by the lack of a strong coordination platform. The three sources of condoms – free, social marketing and commercial – are not coordinated in terms of planning, product selection, procurement and distribution.

Consequently, the MOH, with the backing of the national condom and HIV commodity Technical Working Group, should take on the responsibility of coordinating the three condom sources, particularly in planning, quantification of universal condom needs, and monitoring and evaluation (M&E). The Ethiopia Pharmaceutical Supplies Services (EPSS) will be responsible for procurement of free condoms. The Ethiopian Food and Drug Authority (EFDA) will lead the quality assurance for all condoms in the country.

The MOH, in collaboration with legal, regulatory and other stakeholders, will identify and address policy, regulatory and market barriers that impede the growth of commercial and social marketing. In addition, the supply of free condoms will strictly target KPP and groups that cannot afford to buy, in order to maintain a competitive market environment for social marketing and commercial sources.

The procurement of free condoms has been beset by the controversy between accepting the least cost bidder versus meeting quality and user preferences. Procurement of free condoms is based on product specification that meets the WHO minimum quality specification. But selection of the product (condoms) has mostly failed to consider users' preferences. In the new strategic period, product selection and procurement specification will also consider user preferences for quality, as well as national regulatory body requirements and WHO minimum quality standards.

Another issue has been the return of condom consignments due to poor quality. WHO pre-qualified bidders that fulfill ISO standards for certifying Good Manufacturing Practice are invited to bid in a competitive process. This process has a long lead time between order and arrival in country. Some consignments of condoms supposedly meeting WHO minimum quality requirements have failed quality tests upon delivery to Ethiopia and have been returned.

One solution to avert the risk of rejection is for EFDA to set up pre-shipment inspection and quality testing in the countries of frequent bulk procurement. Testing will be outsourced to an independent and trusted private or international agency accredited to perform condom quality inspection and testing. In addition, post-market quality surveillance will be conducted by EPSS and EPHI to monitor the quality of condoms distributed in-country.

Currently, the procurement of condoms for free distribution and condoms for family planning and HIV prevention is handled separately, which duplicates efforts and wastes time and financial resources. To streamline the process, the funds for condom procurement for both programmes will be pooled, and EPSS will lead a unified procurement process, managed under a single supply chain.

To avoid the long lead time, procurement of condoms for free distribution will have the additional options of buying through procurement agents and from international agencies, if needed, by decision of EPSS and MOH.

Social marketing and commercial marketing will use the procurement modalities that best suit their organizational regulations and needs, while meeting all condom quality requirements specified by the regulatory authority. MOH, EFDA and other government entities will facilitate and support actors working in commercial and social marketing through the process of procurement and local manufacturing of quality condoms.

The national condom strategy and guideline will be widely disseminated and translated into action to ensure effective demand creation, distribution, and skills building. All three condom marketing approaches will adhere to the national condom guideline standards for quality, procurement, transportation, storage and distribution.

Condom demand creation will be a central theme in all SBCC interventions targeting KPPs as

well as the general population. The NSP aims to reach 95 per cent of KPPs with peer education. One of the six sessions of peer education will clear misconceptions about condoms and teach consistent and correct condom use. Printed materials (posters, information kits and leaflets) with information and step-by-step demonstration of correct condom use will be produced and distributed to KPPs.

Correct and consistent condom use will be promoted through several channels. Condom use is one of the key messages and skills component of curricular and extracurricular activities at schools and HLI. Mass media, social media, and the interactive digital apps with SRH information for youth will feature information and edutainment on correct and consistent condom use.

Free condom distribution to KPPs will be conducted through DICS, peer service providers, door-to-door distributions, workplaces in hotspot areas, health workers outreach programmes, hotels, bars, and truck stops. CSOs will distribute condoms through non-traditional outlets. Condoms will be available through static outlets of health facilities, drop-in centers, hotels, bars, workplaces and other outlets.

The HIV prevention messaging for FSWs, through SBCC products, peer-to-peer learning and life skills education, will emphasize the benefits of using condoms with both paying and non-paying sexual partners, correct and consistent condom use, and ARV-based HIV prevention.

### 4.2.3 ARV-based HIV prevention

#### Pre-exposure Prophylaxis (PrEP)

Pre-exposure Prophylaxis is the use of antiretroviral drugs by HIV-negative people before potential exposure to prevent the acquisition of HIV.

PrEP will be provided to people at substantial risk of acquiring HIV (FSWs, sexual partners of PLHIV, PBFW and PWID) according to the National Guideline for comprehensive HIV prevention, care and treatment (MOH 2022). Additional eligibility criteria and target population for PrEP will be defined in the service delivery guidelines and can be updated as appropriate.

PrEP will be scaled up in all ART facilities across the country, and integrated in ART, MNCH/PMTCT, FP, DICs and KPP-friendly clinics. Community-based PrEP initiation and refill will be introduced as per the WHO simplified guidelines for PrEP.

Repackaging of oral PrEP will be done either through the suppliers or in country to minimize stigma and discrimination due to the similarity of PrEP and ART bottles. In addition to oral PrEP, other PrEP options such as long-acting PrEP will be offered as they become available and are registered in the country.

National programme data reports suboptimal PrEP uptake and retention among the eligible FSWs and HIV-negative partners of PLHIV. Consequently, MOH, partners, media and community-led organizations will creatively generate demand and reinforce retention in care using peer-based SBCC, mainstream media (TV and radio), print media (leaflets and posters), social media, and digital applications.

Training and refresher sessions for health workers will ensure effective counseling practices to drive awareness and interest of KPPs in using PrEP during their risk period.

### Post-exposure Prophylaxis (PEP)

PEP will be offered and initiated for people with medical and non-medical accidental exposure and for victims of rape. Non-medical exposures include condom breakage, condomless sex, exposure to body fluids with a person of known HIV-positive or unknown HIV status. The detailed eligibility criteria for PEP will be described in the National HIV prevention, care and treatment guideline.

### Undetectable = Untransmittable (U=U)

Undetectable=Untransmittable (U=U) or the Amharic equivalent "የማይታይ መጠን = የተገታ መተላለፍ (የ=የ) refers to the scientific consensus about the prevention benefits of antiretroviral therapy in reducing HIV transmission risk. This means that an HIV-positive person who is on antiretroviral therapy and whose viral load becomes undetectable (<50 copies/ml) during at least six months cannot transmit the virus to their sexual partners.

As a public health campaign, U=U/"የ=የ"/ brings a powerful motivation for PLHIV to adhere to ART and maintain an undetectable viral load to protect their sexual partners. In society at large, U=U messages help to reduce HIV stigma and discrimination by sharing the robust scientific evidence that PLHIV with durably undetectable viral loads minimizes the risk of HIV transmission

However, there is a potential risk that U=U/"የ=የ"/ could be misinterpreted as a complete cure for HIV or delinked from adherence to ART. Such misunderstanding could reverse the gains of

promotion of condom use and safer sex among PLHIV. Furthermore, the unequal availability and inconsistent use of regular viral load testing poses another concern for an indiscriminate promotion of U=U/"Ꝑ=Ꝑ"/ among PLHIV.

Implementation of the U=U/"Ꝑ=Ꝑ"/ campaign will be based on a national communication strategy and messages developed and monitored by MOH and RHBs. A standardized communication campaign on U=U/"Ꝑ=Ꝑ"/ will reach PLHIV through mainstream media (TV and radio), print media (leaflets and posters), social media and digital applications and at health centers and community-based HIV services, especially ART clinics.

It's essential to foster conversations about U=U ("Ꝑ=Ꝑ") in a safe space at clinical settings because patients see their health-care providers as a trusted source of reliable information. In turn, health-care staff can enhance their clients' understanding of the U=U concept.

The conversations are a great opportunity to encourage adherence to ART, regular clinical monitoring, and viral load testing, and to promote complementary services for sexual and reproductive health. Health workers at ART clinics should counsel PLHIV on U=U/"Ꝑ=Ꝑ"/ considering their adherence to ART, viral load (<50 copies/ml) and access to regular viral load testing.

All U=U/"Ꝑ=Ꝑ"/ communication and counseling will continue to emphasize safe sexual practices among PLHIV and their sexual partners, such as using a condom to protect from STIs and unintended pregnancy

Health workers, journalists, community leaders and PHIV associations will receive orientation, both virtually and in person, on the U=U campaign, complemented with guidelines and communication kits.

The impact of U=U/"Ꝑ=Ꝑ"/ communication on PLHIV adherence to ART, viral load levels and condom use will be monitored through periodic assessments and operational research conducted by academic institutions and EPHI, in collaboration with NEP+ and partners.

### 4.2.4 Harm reduction and opioid substitution therapy

For the first time in Ethiopia, the NSP 2021-2025 recognized people who inject drugs (PWID) as a key population. On the other hand, as of 2022 the National Programme had no national guidelines or tools, nor experience, to implement the harm reduction and opioid substitution therapy (OST) for PWID.

MOH will coordinate a multisectoral task force to plan comprehensive harm reduction and OST programmes for PWID and people using illicit drugs. The Ministry of Justice will chair the task force, with the Ministry of Health serving as the secretary. The task force will include EFDA, EPSA, the Federal Police, stakeholders from various other sectors and implementing partners. Through extensive consultations, the task force will develop a comprehensive multisectoral policy and legal framework to effectively control narcotic drug trafficking, while finding ways to reduce harm and rehabilitate PWID within Ethiopia's legal framework.

The MOH will develop the national guideline and SOP for harm reduction and OST that will guide programme implementation at all levels. Health workers, programme managers and PWID peer providers will be trained on the national guideline and SOPs.

The harm reduction and OST services will be delivered at DICS, KPP-friendly clinics, outreach programmes, and mental health services at public and private facilities. One-stop-shops for harm-reduction services, including OST, will operate in mental health services of selected public and private health facilities. At community level, male and female PWIDs will be recruited, trained, and deployed as peer service providers to deliver harm reduction services tailored to male and female PWID. A package of harm reduction services, including SRH/GBV for male and female PWID, will be available at DICS.

In Ethiopia, needles and syringes can be acquired in private pharmacies without a prescription. PWID will continue obtaining needles and syringes from private pharmacies, as well as through social marketing by CSOs and distribution by PWID peer service providers.

PWID will be offered intensive BCC through peer and life skills education that covers sexual and drug-related risks. HIV testing, including self-test, as well as screening for hepatitis B and C, will be available to PWID through a combination of outreach and static services of health facilities and CSO/NGO services.

Selected health facilities will renovate one ward for PWID rehabilitation. Health-care providers in these facilities will undergo standard training on OST and comprehensive rehabilitation of PWID. PWID who have been through intensive BCC, and have used needle and syringe exchange and other services, will be referred to health facilities for rehabilitation services.

### 4.2.5 Voluntary male medical circumcision (VMMC)

Voluntary medical male circumcision will be integrated in primary health care facilities in settings of high HIV prevalence and low circumcision. Health workers will be trained on VMMC.

Minor surgical procedure rooms will be equipped as needed to routinely perform quality VMMC. Outreach VMMC services will be organized by the health facilities in collaboration with partners.

Community dialogues to address social and cultural barriers to male circumcision will be coordinated by CSOs, RHB and partners. A survey will determine VMMC unmet needs.

### 4.2.6 STIs screening, diagnosis and treatment

In line with the national guidelines, every health-care facility will adopt a syndromic approach for the diagnosis and treatment of individuals with an STI. In addition, facilities with the necessary capabilities will conduct etiologic diagnoses. Health workers will be trained in the national STIs treatment guideline, which will be distributed to all health facilities.

Active screening and treatment of STIs will be available in youth-friendly health facilities, drop-in centers and outreach services. For KPPs, subsidized or free of charge STI diagnosis, treatment and management is recommended.

STIs awareness will be part of the behavioral change communication, peer learning and life skills education for KPPs. In schools, STI information will be shared in both intra- and extracurricular activities. For the general population, the STI programme will utilize broadcast and print media (TV, radio, leaflets and posters), social media and digital applications.

The MOH will coordinate the STIs programme with a technical working group consisting of agencies, CSOs and other partners.

### 4.2.7 Prevention and management of gender-based violence

Medical, legal and social services will be readily available to prevent and mitigate GBV through a multisectoral response. Health facilities will offer comprehensive medical services to survivors of GBV, with strong referrals to other sectors and to community actors that provide legal and social services.

The programme will enhance the capacity of law enforcement personnel and communities to provide legal and social services in the safe houses and one-stop centres for GBV survivors. Community dialogues on prevention and management of GBV will be organized, in collaboration with the Ministry of Women's and Social Affairs, law enforcement institutions and the health extension programme (HEP).

Community scorecards will monitor levels of GBV. In addition, in collaboration with MOH and RHBs, community scorecards will assess confidentiality and quality at KPP-friendly health services.

Community elders, and tribal and religious leaders will be engaged to set up platforms for dialogues, especially through the Community Care Coalitions, to advocate for change in gender-related social norms and to prevent GBV.

## 4.3 Mapping, identification and reaching KPPS

### 4.3.1 Service delivery models

#### KPP-friendly clinics

Many public health facilities have one-stop-shops of HIV/SRH services for KPPs. Similarly, each of the 300 high-priority woredas will have at least one KPP-friendly clinic with specially trained health staff. Serving FSWs, AGYW and other KPP groups, these clinics will have extended opening hours. As per the national guidelines, services available will include SBCC, counseling, condom, HIV testing, PrEP, PEP, STIs screening and treatment, family planning, PMTCT, and referral linkages for ART, among others. The KPP-friendly clinic will link with peer service providers and community mobilizers, who in turn create demand and engage clients to visit the clinic. Communities and KPP-friendly clinics will have a mutual referral system.

Community-led monitoring of quality of services at the KPP-friendly clinic is vital. A team of five to 10 trained peer navigators and clients will conduct quarterly, semi-structured quality assessments using a standardized tool. The team will collaborate with the KPP-friendly clinic staff, the Woreda Health Office and partnering organizations to create a quality improvement plan. Implementation of the plan will be jointly reviewed during the quarter following its execution.

#### Drop-in centers

Drop-in centers (DICs) are safe spaces that provide social, behavioral and clinical services to FSWs and other KPPs. Located near the hotspots where many KPP groups live or work, managed by CSOs or KPP communities, and staffed by friendly providers, DICS are popular among KPPs. On the other hand, DICS in Ethiopia are costly, donor-driven, and face sustainability issues. In the past, when donor funding ended and DICS closed, FSWs on ART

were lost to follow-up. Tracking them was a challenge.

Furthermore, the need for facility infrastructure and human resources is considerably higher when DICS offer ART services, which increase their operational costs. One solution is to have DICS provide comprehensive HIV services except ART. This will reduce operational costs, improve sustainability and avoid losing clients on ART to follow-up when DICS phase out (FHAPCO 2021). The NSP had proposed that DICS should be government-led with support of CSOs and communities, but lack of space and commitment hindered this plan. Based on previous experience, it is recommended that new DICS are established as non-ART services led by CSOs, government and community partners, as appropriate.

DICS will be established in selected large towns of high-incidence woredas. The DICS will be run by CSOs and community groups funded by donors or the government through social contracting arrangements. Provision of services will follow national guidelines. MOH, RHBs and Woreda Health Offices will support and supervise DICS by facilitating licensing and providing supplies and drugs procured through the Global Fund and other donors.

DICs will conduct outreach services for KPPs through nurses, social workers and peer service providers. Strong referral links among DICS, KPP-friendly clinics and health facilities will increase uptake of ART and other HIV services. Quarterly meetings will facilitate referral and joint outreach services.

Community-led monitoring of the quality of services offered at DICS is crucial for retention and sustainability. Community-led monitoring that is mainly led by clients and CSOs will conduct quarterly, semi-structured quality assessments using a standardized tool. The team will collaborate with DIC staff, the Woreda Health Office, and partnering organizations to make a quality improvement plan. The plan's implementation will be jointly reviewed during the quarter following its execution.

### HIV services at health facilities

At least one health facility in each of the 300 priority woredas and the 326 medium-incidence woredas will have KPP-friendly services delivered through the general HIV service delivery outlets. Specialized training of health-care staff will enable them to respond to the unique needs of KPPs attending general services.

Health facilities will use risk screening tools at all outpatient and inpatient outlets to identify

KPPs and link them to combination HIV prevention services. Referral linkages with peer service providers, community-level services, and KPP-friendly clinics will be strengthened. A Zero Stigma policy will be implemented in health facilities providing general HIV service delivery.

### Peer service providers (PSP)

Each high-incidence woreda will have 30 trained peer service providers (PSP) working full time with a monthly standard incentive package. Selected from among KPPs and adequately trained, PSP will deliver to their peers (KPPs) a standard package of services (SBBC, peer education, condom, self-testing, information and referral for PrEP , and referral for other HIV prevention and treatment services)

PSPs will be linked with KPP-friendly clinics, DICS and other service delivery models. PSPs will create demand and mobilize KPPs to use the different service delivery outlets, support adherence to ART and trace clients lost to follow up. The PSP programme will be managed and led by the regional and Woreda Health Offices, in collaboration with CSOs and partners.

### Mentor-based services for high risk AGYW and divorced and widowed women

A mentor-based prevention programme for high-risk AGYW and high risk divorced and widowed women in 300 high-incidence towns and in public and private higher learning institutions (HLI) will be implemented by CSOs. The programme will produce a comprehensive service package, manual, and guidelines to facilitate the delivery of one-to-one and small group education, counseling, life skills, and services including condom, PEP, HIVST, STIs, FP/SRH and referral linkages.

### Targeted outreach to hotspots

KPP-friendly clinics and DICS will have at least quarterly outreach programmes to reach KPPs at nearby hotspots in high-incidence woredas. A health worker will lead the outreach, along with peer service providers and community groups, while CSO and partners will mobilize KPPs to attend.

Targeted outreach services should deliver comprehensive HIV clinical services, including condoms and lubricant, HIV testing including self-test, STIs screening and treatment, family planning, emergency contraception screening, and GBV services, as well as linking KPPs to KP-friendly clinics and DICS. The outreach will leverage peer-based learning and mass communication to promote safe behaviors, PrEP, HIV testing, condoms and other HIV services.

### Virtual safe spaces

Introducing virtual safe spaces will generate demand and link KPPs to health services. The programme will develop a training package for the management of virtual safe spaces, train 150 KPP champions (FSWs, high-risk AGYW, PWID and AYLHIV) as moderators, and provide financial and technical support for their work.

### Integrated services in other health programmes

### Integrated HIV services for prisoners

Health facilities in prisons and juvenile correctional centers will be strengthened to deliver integrated HIV prevention services, including general medical examination, HIV counseling and testing, treatment referral, TB screening, STI screening and treatment, viral hepatitis screening, diagnosis and treatment, hepatitis B vaccination for HIV-positive prisoners, and screening of other communicable and non-communicable diseases. Condoms will be supplied upon release from prison.

Other planned activities include:

- Assess the HIV service delivery capacity of prison facilities and advocate for improvement with regional Health Office, prison administration, and CSOs.
- Develop national health service delivery standards for prisons.
- Train prison administration focal persons on health service delivery standards.
- Train service providers from federal and regional prisons on comprehensive HIV prevention, care and treatment.
- Supply communication and demand creation materials for federal and regional prisons.

### Integrated HIV services at hotspot workplaces

A national assessment will map hotspot workplaces across the country. All hotspot workplaces with a total of 500 or more employees shall have at least one clinic, run by the employer, that provides integrated health and HIV services. The package of services includes SBCC (peer-based and mini-media, in multiple languages), condoms, GBV prevention, HIV counselling and testing, STI screening and treatment, TB screening, hepatitis screening and diagnosis, referral & treatment and SRH services. This is a great opportunity to build upon the experiences of

the malaria programme and expand prevention and screening services for both TB and HIV in seasonal hotspots that attract lots of migrant workers.

Workplaces and projects will finance and manage the integrated HIV and health services at hotspot workplaces, with support from CSOs, RHB, Woreda Health Offices and development partners. Advocacy with relevant sectors, including private employers, will take place, and an accountability policy framework will be put in place. The programme will assess the capacity of workplaces to deliver HIV/SRH services, develop standards for such health services, and update the policy for workplace HIV programmes that requires employers to provide comprehensive HIV prevention services.

### Integrated HIV services for uniformed people

Uniformed people in the Ethiopian National Defense Forces and federal and regional police will receive HIV services integrated with their health-care facilities. The HIV prevention services include SBCC, condoms, HIV and hepatitis counseling and testing, VMMC, STI screening, diagnosis and treatment, PEP, HIV, and hepatitis diagnosis and treatment. MOH will provide technical support, HIV/AIDS logistics, commodities and supplies for the health-care services of National Defense Forces and the Federal Police, with technical and financial support from partners and donors. The Uniformed Services HIV programme will focus on high-risk groups such as new recruits and those deployed away from home. HIV/AIDS, gender, human rights and health education will be part of the training curriculum for uniformed people.

### Integrated HIV services in humanitarian emergency settings

People in humanitarian emergency settings are generally located in areas affected by drought, war, conflict, and other natural and human-made disasters.

Leadership and coordination of the HIV response for people in humanitarian emergency settings will be strengthened with the development of a policy framework, guidelines, training packages, SOPs and job aids on HIV/GBV/VH prevention, care, support, and treatment.

The MOH will be represented in the national emergency taskforces at EPHI and other emergency coordination structures. HIV will be mainstreamed in the national emergency preparedness and response plan. Emergency preparedness and response teams will be trained in HIV response across regions and humanitarian settings.

The impact of conflict on the HIV programmes in the affected areas will be assessed. In

collaboration with local partners, the MOH will develop a rapid response plan to expand and restore HIV services in conflict-affected areas. Health facilities in or near humanitarian setting, such as in IDP camps, will be reinforced with staff, training, equipment, supplies, and drugs for comprehensive HIV/SRH/GBV services. Programmes for community outreach and peer service providers will be strengthened, and the emergency response platforms will be used to deliver HIV/SRH/SGBV services.

### Integrated HIV services in higher learning institutions

Health services at private and public higher learning institutions (HLI) will be assisted to deliver combination HIV prevention services for young people, particularly high-risk AGYW. An assessment will map HIV services and curricular activities in public and private HLI. Its findings will inform high-level advocacy workshops with the leadership of public and private HLI.

Planned activities at HLI:

- Integrate a 2-credit hour HIV/SRH/life skills course for freshman students.
- Develop and implement a mentor-based high-risk AGYW programme, where three mentors (female fresh university graduates) per HLI will be trained and assigned to identify high-risk AGYW, and deliver a package of services linked with the student clinics in public and private HLI.
- Set up condom distribution outlets and condom depots.
- Strengthen and deliver combination HIV prevention and sexual and reproductive health services in the HLI student clinics

### HIV services integrated with social and economic sectors (HIV mainstreaming)

MOH will identify strategic sectors for mainstreaming HIV, develop a mainstreaming directive. In addition, MOH will conduct capacity assessment and high-level advocacy with strategic sectors, develop a mainstreaming service package and implementation guideline, and build the capacity of strategic sectors to implement HIV mainstreaming.

The strategic sectors will allocate budget, as well as staff and facilities, to implementing HIV prevention programmes directed to both KPPs and the general population. The HIV prevention interventions include SBCC, condom and HIV testing service. The strategic sectors can work with CSO and the private sector through social contracting arrangements.

Economic empowerment projects (job creation, vocational skills training and income-

generating schemes) will be implemented by microfinance, the Agency for small- to medium-size enterprises, technical and vocational skill training colleges and other economic programmes. These projects, conceived as structural HIV prevention, will focus on disadvantaged women, especially AGYW in high-incidence woredas.

### Integration of HIV at facility and community-level health services

The programme will develop an implementation guideline for the integration of HIV services at health facility and community level, train programme people on the integration guideline, orientate providers at service delivery outlets, and monitor implementation of service integration. Planned activities include:

- Strengthen integration of HIV risk screening, HIV testing, PrEP, PEP, hepatitis, STIs, and GBV diagnosis and treatment in FP/MCH clinics.
- Strengthen integration of HIV risk screening, HIV testing, STIs, and GBV diagnosis and treatment in outpatient and inpatient services.
- Strengthen integration of HIV risk screening, HIV testing, PrEP, PEP, hepatitis, STIs, and GBV diagnosis and treatment in adolescents and youth SRH clinics.
- Strengthen integration of FP, cervical cancer, PrEP, PEP, hepatitis, STIs, mental health and GBV diagnosis and treatment in the ART clinic
- Strengthen integration of HIV testing, PrEP, PEP, hepatitis, STIs, mental health and GBV diagnosis and treatment, FP and SRH in outreach and community services for KPPs.

### Social marketing and private sector services delivery

Condoms for the general population will be available through social marketing and private sector outlets (pharmacies, shops, hotels, bars, peer service providers) in all woredas. Lubricants will be available through pharmacies and private facilities.

## 4.3.2 Mapping, identification and size estimation of KPPs

Mapping, identification and size estimation of KPP will be conducted in each of the 300 high-incidence woredas. The objective of the mapping is to identify the areas where KPPs live and work, estimate the size of KPP population, and assess the HIV services available in the woreda.

In collaboration with partners, the MOH will develop SOPs for and tools for the mapping exercise, and will train regional and woreda programme staff on their use.

The mapping team will be led by the local Woreda Health Office, along with peer service

providers (from KPPs), health workers (KPP-friendly clinic and DIC), community members (bar owners, job brokers, and women and youth representatives), kebele administration and community police. The data collected will inform the HIV prevention, care and treatment programme planning and implementation of community and facility-based interventions.

**FSW**. Mapping of FSWs should locate the bars, hotels, nightclubs, local drink houses, streets and houses of FSW, streets where FSWs concentrate, and estimate the number of FSWs in the area. Online platforms that connect clients and FSW in big cities should also be identified.

**PWID**. Mapping and size estimation of PWID will be conducted by woreda health officials in collaboration with CSOs and peer educators. Using the SOP, the mapping exercise will employ a chain referral method to identify areas where PWID concentrate and health services available.

**Prisoners**. The Woreda Health Office, in collaboration with CSOs, and prison administration, will map prisons and police stations. The Woreda Health Office will estimate the average number of prisoners in each correction facility, disaggregated by gender. The mapping will assess the availability of combination HIV prevention interventions in each setting.

**HRAGYW.** High-risk adolescent girls and young women aged 10-24 years who are sexually active (had sex in preceding 12 months) and have at least one of the following risk signs– multiple sexual partners, sex with non-regular partner, or any sign of an STI in the past 12 months. This mapping will focus on high-risk domestic workers, waitresses and cleaners at café and hotels and girls engaged in street petty trade or living on streets. Mapping of these groups should focus on areas where transactional sex takes place.

The mapping team is led by the Woreda Health Office, in collaboration with the woreda Education Office, Women Development Army, health extension workers, community police and job brokers. Night schools should identify and screen high-risk domestic workers using the risk screening tool (HRAGYW criterion). The team will map broker houses, night schools, and streets where AGYW live or do petty trade.

The woreda Education Office should map high schools, TVET colleges and universities, which will identify HRAGYW using the risk screening tool, in collaboration with the schoolgirls' clubs, peer educators and teachers. The mapping should have lists of girls by school and classroom for future interventions.

MOH, in collaboration with partners, will develop and validate an android-based digital self-risk screening tool for AGYW that will score risk and link the young women to HIV services.

**Widows and divorced women**. The Woreda Health Office, in collaboration with Women Development Army and health extension workers, will map households where high-risk widowed and divorced women live, focusing on those who are sexually active, have multiple sexual partners, engage in petty trade and sell local drinks. The mapping should have clusters of houses by small geographic localities such as 'gotte', villages and kebeles.

**Hotspot workplaces**. The Woreda Health Office, in collaboration with the woreda administration, will map local hotspot workplaces – housing, road, dam or other construction projects, big farms (coffee, sugar, fruit, sesame, etc.), industry parks and other megaprojects - that employ large numbers of young workers (>5000 staff), where FSWs operate close to the camps or workplaces, and where HIV prevalence exceeds 3% (>3%) based on service records. The Woreda Health Office should estimate the number of high-risk young workers while the Health Office will map the availability of combination HIV prevention in each workplace.

**Long-distance drivers**. The Regional Health Bureau should identify and map high-risk transport corridors and hotspot relay towns and hotels where long-distance drivers stay overnight. Woreda Health Offices, in collaboration with RHBs and partners, will design interventions based on mapping and size estimation.

**PLHIV**. Woreda Health Offices will work with ART clinics and PLHIV associations to identify and estimate the numbers of PLHIV and their partners. Periodic surveys should be conducted for comprehensive KPPs size estimation and mapping.

# Chapter 5

# Addressing Social and Legal Barriers and Responding to Emergencies

## 5.1 Fighting stigma and discrimination

Despite more than a decade of effective programmes and successful treatment for HIV and AIDS in Ethiopia, the levels of stigma and discrimination, both internalized and externalized, remain high in multiple settings, namely, among communities, at health facilities, and at both private and government institutions. There are limited legal instruments in Ethiopia to prevent stigma and discrimination against PLHIV and to mitigate their negative impact.

The Road Map 2023-2027 aims to reduce stigma and discrimination towards PLHIV and key populations to less than 10 per cent by 2027. To achieve this objective, the HIV response will engage in policy advocacy, establish a robust legal framework, empower PLHIV and their associations and networks, conduct media advocacy and provide public education. The strategies include:

- Educate, advocate and communicate with the public to shift negative attitudes towards PLHIV and KPP.
- Engage religious and community leaders and address stigma and discrimination in intra- and extracurricular education at schools.
- Engage the media in communication and advocacy to improve public attitudes towards PLHIV and KPP.
- Empower PLHIV and their associations with advocacy and communication skills to address both internalized and externalized stigma.
- Educate PLHIV through mainstream, social and print media about ways to fight internal and external stigma and discrimination.
- Ministry of Health and Ministry of Education will develop a Zero Tolerance policy for stigma and discrimination at health-care facilities and schools, monitor its implementation, and orient health workers and teachers on the new non-discriminatory policy .
- Enhance health providers' counseling skills to address HIV-positive test results, internalized self-stigma and discrimination among PLHIV, particularly women, young people and KPP.
- Provide legal services for PLHIV and KPPs
- Formulate and enforce anti-discriminatory laws and regulations.
- Conduct stigma index surveys and take action based on the findings.
- Integrate community dialogues to reduce stigma and discrimination into the regular

programmes of HEP, Women Development Army and CCC.

## 5.2 Addressing legal barriers

The HIV policy was issued in 1998 and has not been revised since to address new issues and new thinking, among them, the emerging epidemic context, service delivery models, new HIV testing options, new treatment modalities, age of consent for HIV testing services (HTS), partner notification, school HIV programmes, social network services, workplace HIV testing, HIV mainstreaming, and key and priority populations. Hence, an update to the HIV policy is required.

In Ethiopia, female sex workers, people who inject drugs and prisoners are recognized as key populations but legal barriers impede effective programming and empowerment of KPs. Narcotic and psychotropic drug use is a crime in Ethiopia. Article 525 of the 2004 FDRE Penal code states that producing, making, trafficking in or using poisonous. or narcotic and psychotropic substances is punishable with rigorous imprisonment for not less than five years, and a fine not exceeding one hundred thousand Birr (FDRE 2004 p178). Similarly, Articles 846c and 635 of the 2004 Penal Code identify prostitution as immoral (FDRE 2004 p. 276). Therefore, the legal context limits the KPPs access to services.

In addition to the policy and legal barriers, there are widespread social barriers to the provision of combination HIV prevention services for key populations. A priority for the HIV response is to advocate for a legal and social environment that supports HIV prevention programming for key populations. This will enable key POPULATIONS, especially PWID and FSW, to gain access to the tools, information and health care that meet their needs.

The goal is to remove key policy and legal barriers by 2027. The strategies are as follows:

- Conduct national advocacy meetings involving key stakeholders such as the Ministry of Justice, police, religious and community leaders, CSOs and development partners to influence the policy and legal environment that undermines HIV prevention and empowerment of PWID and FSWs.
- Educate, advocate and communicate with the public through media, religious and community leaders on the human rights and HIV prevention needs of key and priority populations.
- Empower and engage PWID and FSWs through leadership training, organization in formal and informal groups, and social contracting for HIV prevention interventions,

including advocacy.

- Advocate for the amendment of the legal and policy frameworks that hinder HIV prevention and empowerment of PWID and FSWs.

## 5.3 Responding to humanitarian emergency context

In the past three years, armed conflict and the COVID 19 epidemic seriously affected the HIV prevention programme. The humanitarian emergency context increased people's vulnerability to HIV and HIV- related morbidity; reduced access to and utilization of HIV services; delayed the global logistics supply pipeline for HIV commodities and competed for resources and leadership attention. The country did not have an HIV prevention, care and response plan for emergency and humanitarian contexts.

Hence, the Road Map 2023-2027 proposes to create a national task force, guidelines, a plan and a mechanism to ensure comprehensive HIV prevention, care, and treatment interventions in a humanitarian emergency context, resulting from both human-made and natural disasters. The strategy involves:

- The MOH will set up a national task force, chaired by the National Disaster Prevention and Response Commission, with MOH as secretary. Task force members include sector ministries, donors, UN agencies, partners and CSOs working on HIV and humanitarian emergencies. The task force will meet quarterly and frequently on an as-needed basis.
- The national task force will develop a national guideline for HIV prevention, care and treatment in humanitarian emergencies, including emergency transfers, multi-month dispensing of ART, and HIV prevention service delivery at emergency settings such as IDP camps.
- The national task force will predict, plan and timely implement comprehensive HIV prevention, care and treatment services that are appropriate for a humanitarian emergency setting.
- The national task force will assess the impact of the humanitarian emergency on the HIV epidemic dynamics, as well as the impact on the health services, in order to plan the restoration of HIV services in the affected regions.
- The national task force will mobilize resources for HIV prevention and review the performance of the HIV prevention, care and treatment response in humanitarian emergency settings.

# Chapter 6

# Community-led HIV Service Delivery and Monitoring

## 6.1 Organizing KPPs, building capacity and social contracting

Civil society organizations (CSOs) and community-led organizations (CLOs) are a highly effective way of reaching people living with HIV and key populations. These organizations mostly operate at community levels and deliver friendly differentiated HIV services.

In Ethiopia, regional and national networks and associations of PLHIV have been an integral part of the HIV prevention leadership, implementation, review and monitoring of programmes. But key and priority populations were neither organized nor strongly engaged in HIV service delivery beyond working as peer service providers and peer navigators who provide education, condoms HIV self-test kits. The legal and policy environment does not support formal organizations of KPPs.

To strengthen KPP involvement in the HIV response, the Road Map 2023-2027 outlines the following strategies:

- Key and priority populations will be empowered and supported to become organized in clubs, support groups and associations, based on the country's legal context, and engage meaningfully in service delivery and monitoring.
- PLHIVs and PLHIV networks and peer support groups will be involved in programme advocacy and communication activities, community-led monitoring, and economic empowerment initiatives.
- MOH, donors, development partners and CSOs will build the capacity of KPP and PLHIV clubs, support groups and associations. Areas of support include training in leadership and organizational management skills, HIV programme and financial management skills, as well as provision of office space, materials, and funding to implement HIV services and community-based monitoring.
- CSO will support KPPs and vulnerable groups with a basket of targeted interventions aimed at building capacity for potential social contracting arrangements.
- CBOs, FBOs, and communities will participate in awareness creation campaigns to reduce stigma, discrimination and GBV, promote use of HIV services, and provide care for orphans and vulnerable children, PLHIVs, destitute women, people with disabilities and the elderly, among other groups.

## 6.2 Community-led service delivery

The Road Map aims to have, by 2027, a significant proportion of HIV testing, social enablers and HIV prevention services for KPP delivered by CLOs and groups led by PLHIV and KPPs.

MOH, donors and development partners will support and fund CLOs to implement HIV prevention, community-based HIV testing, and socio-economic empowerment services for PLHIV and KPPs.

MOH will develop a guidance on social contracting arrangements for RHBs to provide funding, HIV commodities, and logistics to community-led organizations to implement HIV prevention, community-based HIV testing and socio-economic empowerment for PLHIV and KPPs.

MOH and RHBs will monitor performance on social contracting arrangements and donor funding to support community-led service delivery as a proportion of all services delivered.

## 6.3 Community-led monitoring

Community-led monitoring (CLM) has proved to be effective in improving the quality of HIV services and HIV programme performance. In Ethiopia, community-led monitoring of quality of services was piloted at selected KPP-friendly clinics. However, the lack of national guideline and coordination structure, coupled with limited capacity and funding, impeded the expansion of CLM.

In the strategic period 2023-2027, community-led monitoring will be scaled up across the country, under the leadership of CSOs including PLHIV associations and with support from MOH, donors and development partners. The following activities will be implemented to scale up CLM:

Establish a CLM task force at national and regional levels, to be chaired by national and regional PLHIV networks, with KPP associations and groups, MOH, donors and development partners as members.

- With technical and financial support from MOH, donors and development partners, NEP+ will develop the national CLM guideline and monitoring tools.
- The leadership of national and regional PLHIV associations, KPP associations and groups, their networks and CSOs will be trained on the national CLM guidelines and tools.
- National and regional PLHIV associations, KPP associations and groups, their networks and

CSOs will implement CLM, with technical and financial support from MOH, donors and development partners.

- The national and regional task forces will conduct bi-annual reviews on the performance and impact of CLM on service quality and access, in collaboration with national and regional PLHIV associations, KPP associations and groups, their networks and CSOs.

# Chapter 7

# HIV Prevention Commodities and Adoption of Technology and Innovation

## 7.1 HIV prevention commodities

An effective supply chain for HIV prevention commodities plays a pivotal role in achieving the objectives of the national HIV prevention programme. The HIV commodities supply chain encompasses several stakeholders and is coordinated nationwide by the Ethiopia Pharmaceutical Supplies Service (EPSS).

Lately, the HIV supply chain has encountered several challenges, including:

- Inadequate coordination of supply chain actors to pull resources together and ensure the commodity flow is smoothly managed end to end.
- Long procurement process.
- Weak quality assurance process for condoms, as indicated in the Condom strategy. Pre-shipment and post-market testing are needed.
- Disparities in distribution of HIV commodities throughout the country.
- Inadequate cross-checking of stock consumption with service-related data.
- Poor fleet management causes delays in deliveries.
- Limited access to HIV/AIDS medicines and related health technologies in the private sector.
- Shortage of trained staff at ART pharmacies.
- Poor recording and reporting at ART pharmacies.
- Weak system in place for pharmacovigilance.
- The price of condoms through social marketing is becoming unaffordable.

The Road Map 2023-2027 plans to streamline the national HIV prevention commodities supply chain by reinforcing the national system quantification, procurement, inventory management, distribution and monitoring of HIV commodities. The following actions will be pursued:

- Strengthen the national technical working group (TWG) for HIV commodities, including condoms. The TWG will be chaired by MOH, with EPSS serving as the secretary. Its members include EFDA, EPHI, Public Procurement and Property Administration (PPA), DKT, private sector, development partners and donors. The TWG will meet at least monthly and frequently on an as-needed basis to identify and address challenges in the supply chain. The TWG should be cascaded at all levels.
- The TWG will redefine the rules governing procurement of condoms and HIV commodities

to allow acquisition of quality condoms that meet user preferences.

- EPSS, with support from the TWG, will conduct operational studies to refine quantification assumptions and increase forecast accuracy.
- EPSS, with support from the TWG, will improve distribution of condoms and HIV commodities by ensuring data visibility across all levels of the supply chain; strengthen the web-based interface between health facilities and EPSS; create an interface between DAGU2 and HCMIS; reinforce performance monitoring teams at health facilities; provide more technical assistance to facility warehouse managers and dispensing units, and strengthen paper-based Integrated Pharmaceutical Logistics System (IPLS) for quality essential logistics data and regular reporting.
- EPSS and EFDA, with support from the TWG, will update the national list of HIV prevention commodity to include drugs for opioid substitution therapy (methadone) and lubricants.
- EPSS will pool the resources for procurement of condoms for both family planning and HIV programme and unify condom quantification, procurement, inventory management, distribution and monitoring across the country.
- EPSS will improve fleet management to avoid delays in HIV commodities deliveries.
- EFDA, with support from MOH, donors and development partners, will obtain the necessary accreditation to conduct quick and efficient quality assurance procedures and eliminate any bottlenecks that delay market authorization for HIV commodities.

## 7.2 Adoption of technology and innovation

The national HIV prevention and control programme has a history of early adoption of new technologies and innovations such as PrEP and differentiated service delivery models to improve uptake and adherence to ART. The national programme pioneered the use of social media platforms and digital applications to reach youth and key populations with HIV information and behavioral change communication.

One limitation is the absence of a clearly designated body in the national programme to promptly identify and adopt new technologies. Likewise, innovations and opportunities in the realm of social media, web-based platforms and digital applications were underutilized.

The national condoms and HIV commodities TWG will monitor innovations in HIV prevention, care and treatment, evaluate contextual benefits and facilitate adoption and scale up of new technologies. The TWG will discuss and review adoption of technology and innovation at least

on a quarterly basis.

MOH, with support from donors and development partners, will promote the rapid adoption of innovative technologies such as long-acting PrEP. Another priority is to expand the use of social media, web-based platforms and digital applications for meetings, training, individual and group education, and behavioral change communication.

# Chapter 8

# Leadership and Accountability Framework

## 8.1 HIV Prevention coordination structure at federal, regional and woreda levels

The current HIV/AIDS Strategic Plan 2023-2027 and the National HIV Prevention Road Map 2023-2027 are the guiding framework for coordinating Ethiopia's multisectoral HIV response.

The coordination is guided by the Three Ones Principle - one plan, one coordination mechanism, and one monitoring and evaluation system. All HIV prevention interventions (biomedical, behavioral and structural) delivered at health facilities, as well as through the community and sectoral response are an integral part of the woreda-based plan. The HIV prevention programme will be routinely monitored using DHIS2. There will be quarterly, bi-annual and annual reviews at national, regional and woreda level, led by the health sector, in collaboration with other sectors, development partners, CSO, private sector and communities.

The key actors supporting and coordinating the national HIV prevention programme are:

The **Ministry of Health** is responsible for the overall coordination of the HIV response in Ethiopia, and coordination of the national HIV prevention programme at federal level. MOH oversees the coordination of the HIV Prevention Road Map 2023-2027, its implementation, M&E, and translation into costed annual plans. MOH is tasked with the following specific roles and responsibilities:

- Provide guidance and facilitate translation of the Prevention Road Map into a detailed, costed annual plan of action in all regional states and city administrations.
- Coordinate the implementation of the Prevention Road Map at all levels.
- Plan, implement, monitor and evaluate HIV prevention services.
- Scale up HIV service delivery models for KPPs at health facilities and at community level.
- Provide HIV prevention services, including HCT, HIV self-test, STIs, VMMC, PrEP, blood safety and condoms.
- Coordinate the non-health sector HIV prevention interventions, including BCC, community mobilization, advocacy, and HIV mainstreaming.
- Support community-led service delivery and monitoring.
- Ensure rapid adoption of technology and availability of HIV prevention commodity.
- Guide HIV mainstreaming in both government and private sector and ensure accountability.
- Lead and coordinate NAC, NaHPAG, national task forces, technical working groups,

partnership forums and subforums, and oversee the mapping of partners working at all levels.

- Ensure engagement of CSO, FBO and CBOs in the HIV prevention response.
- Support and coordinate the non-health sector HIV prevention interventions, including HIV mainstreaming in both government and private sectors.
- Coordinate resource mobilization, including domestic resources.
- Support effective and efficient utilization of resources for HIV prevention interventions.
- Lead and coordinate regular joint supportive supervision and review meetings.
- Coordinate DHIS, MRIS and generation of strategic information.
- Document and disseminate lessons learned and good/best practices on HIV prevention.

### Ethiopia Pharmaceutical Supplies Services (EPSS)

*Tasks and responsibilities*

- Lead forecasting and quantification of HIV prevention commodity, including condoms.
- Lead the procurement, warehousing and distribution of HIV prevention commodity, including condoms.
- Guarantee procurement of quality prevention products and condoms, with adequate shelf life and sourced from reliable suppliers, in accordance with national specifications.
- Ensure proper storage, distribution, availability and accessibility of quality prevention commodity at facility level in a sustainable manner.
- Manage inventory effectively, guided by data captured consistently in the national health LMIS in a standardized way.
- Collect, validate, analyze, and utilize data captured in LMIS to optimize the uninterrupted supply of quality HIV prevention commodity, including condoms, and prevent the occurrence of expired products.

### Ethiopia Food and Drugs Authority (EFDA)

*Tasks and responsibilities*

- Create a conducive environment for product diversification, such as implementing a fast-track registration process and timely revision of the lists of HIV prevention commodity and condom suppliers.
- Review existing licensing, registration and clearance standards to facilitate the involvement

of all sectors in HIV prevention commodity and condom supply.

- Develop standardized quality assurance tools that can be used by all sectors of HIV prevention commodities and condom importers.
- Ensure the quality of HIV commodities and condoms imported for HIV/STI prevention.
- Conduct follow-up inspection to check proper handling and storage.
- Perform post-market surveillance to cross-check the quality of products and condoms.
- Develop and revise the policy to encourage private sector involvement in HIV prevention commodity and condom marketing.
- Conduct pre-shipment quality assurance tests of imported HIV prevention commodities and condoms.

### Ethiopian Public Health Institute (EPHI)

*Tasks and responsibilities*

- Conduct surveys and surveillances to monitor HIV prevention response in the country.
- Conduct routine country level estimates for HIV prevalence and incidence as well as programme indicators.
- Develop and disseminate policy briefs to programme people and policy-makers to ensure data informs their decision-making.
- Reinforce national capacity to generate and use accurate and timely strategic information.

Mobilize resources to support the generation of better strategic information.

### National AIDS Council (NAC)

The National AIDS Council is chaired by the President of Ethiopia, and MOH serves as its secretary. NAC members are ministers of key sector ministries, regional presidents and Regional Health Bureaus, religious and community leaders, private sector, media, CSOs, UN, development partners and donors. The NAC, which convenes annually, is the platform to address and coordinate all policy, strategic, legal and regulatory issues of the HIV prevention programme.

### National HIV Prevention Coalition

The Coalition will be established to provide policy advice, advocate for HIV prevention, mobilize resources, foster multisectoral collaboration, and oversee the implementation of the Road Map. The Coalition will be chaired by MOH. Its members comprise the leadership of the ten strategic sectors, development partners, CSOs, media and private sector. The National HIV

Prevention Advisory Group (NaHPAG) will provide technical support to the Coalition.

### National HIV Prevention Advisory Group (NaHPAG)

NaHPAG will be chaired by MOH and UNAIDS is the secretary. Members include the ten key sector ministries, UN agencies, U.S. government partners, development partners, CSOs including NEP+ and NEPWE, ASKUS, NaHPAG will meet every other month to provide technical guidance and coordinate all HIV prevention federal actors. As the technical arm of NAC, NaHPAG will execute decisions and coordinate multisectoral actors on the HIV programme at federal level.

### National Task Force for HIV Response in Humanitarian Emergency Context (NEmHTF)

NEmHTF will be chaired by the National Disaster Prevention and Response Commission, with MOH serving as secretary. Task force members include UN agencies working on HIV and humanitarian emergency (UNAIDS, UNFPA, UNHCR, WFP and IOM), USAID, donors, development partners and CSOs. The task force will meet quarterly and frequently on a demand basis. The Task Force will predict, plan, coordinate and monitor the HIV response in humanitarian emergency contexts, while also mobilizing resources to maintain and restore the affected health facilities and HIV services.

### National Task Force for Community-led Service Delivery and Monitoring (NCLMTF)

NCLMTF will be chaired by MOH and NEP+ will be the secretary. Task force members include UN agencies working on HIV, development partners, donors, community-led organizations and CSOs. The task force will meet quarterly and frequently on a demand basis. The task force will guide the planning, coordination, implementation and resource mobilization for community-led service delivery and monitoring.

### National Condom and HIV Prevention Technical Working Group (CHCTWG)

CHPCTWG will be the platform for all technical work of the national HIV commodity and condom programme under NaHPAG. CHPCTWG will meet monthly. Its responsibilities include:

- Coordinate national forecasting and quantification for condoms and HIV prevention commodities maintain the supply pipeline, storage and distribution.
- Monitor programme quality and performance.
- Identify and advocate for matters related with programming, market approach, policy,

strategic, legal and regulatory issues.

- Monitor, identify, evaluate and facilitate rapid adoption of technology and innovation.

The **National STIs Technical Working Group** will be chaired by MOH, with development partners and CSOs as members. It will meet quarterly.

The **National ARV-based Prophylaxis Technical Working Group** will be chaired by MOH and consists of donors, development partners and CSOs. It will meet quarterly to plan, review and provide guidance and technical support to MOH on PrEP, PEP and U=U.

The **National SBCC, Advocacy and Mainstreaming Technical Working Group** will be chaired by MOH and have sectors, media, development partners and CSOs as members. It will meet quarterly.

The **National Domestic Resource Mobilization Technical Working Group** will be chaired by MOH. Its members include strategic sectors, media, development partners, private sector and CSOs. It will meet quarterly.

### Regional Health Bureau and Regional HIV Prevention and Control Office

Coordination of the regional HIV prevention program will be the responsibility of the Regional HAPCO or the Regional Health Bureau where there is no HAPCO structure. Regional governments will be encouraged to align their HIV response structure with the federal level to promote communication and accountability between federal and regional levels. Regional coordination includes the following:

- Provide guidance and facilitate translation of the Road Map 2023-2027 into a costed plan of action in the region or city administration.
- Coordinate the implementation of the Road Map at regional and woreda levels by all implementing actors.
- Lead the development of policies, strategies, technical and programme guidelines, manuals and SOPS.
- Scale up HIV service delivery models for KPPs at health facility and community level.
- Provide HIV prevention services including VMMC, PEP, PrEP, U=U, blood safety and condoms services, HCT, STIs.
- Coordinate the non-health sector HIV prevention interventions, including SBCC,

community mobilization, advocacy, and HIV mainstreaming.

- Support community-led service delivery and monitoring.
- Ensure rapid adoption of technology and availability of HIV prevention commodities.
- Lead and coordinate RAC, RaHPAG, regional task forces, technical working groups, partnership forums and subforums, including mapping of partners at regional and woreda levels.
- Support and ensure engagement of CSOs, CBOs and faith-based organizations (FBO) in the HIV prevention response.
- Coordinate resource mobilization efforts, including domestic resources.
- Support effective and efficient utilization of resources for HIV prevention interventions.
- Lead and coordinate regular joint supportive supervision and review meetings.
- Coordinate DHIS and MRIS data flow, analysis and reporting.
- Document and disseminate lessons learned and good/best practices on HIV prevention.

### Regional AIDS Council (RAC)

The Regional AIDS Council will be chaired by the Regional President or City Mayor, with RHBs serving as the secretary. It will meet bi-annually. RAC will be the platform to address and coordinate all regional level HIV programme policy, strategic, legal and regulatory issues. The RHB will present condom programme policy, legal and regulatory issues to the RAC and follow up on its decisions.

### Regional HIV Prevention Coalition

The Regional Coalition will be established to provide policy advice, advocate for HIV prevention, mobilize resources, foster multisectoral collaboration, and oversee the implementation of the Road Map. The Regional Coalition will be chaired by RHB. Its members comprise the leadership of the ten strategic sectors, development partners, CSOs, media and private sector. The Regional HIV Prevention Advisory group will provide technical support to the Coalition.

### Regional HIV Prevention Advisory Group (RHPAG)

This platform will provide technical guidance and coordinate the regional strategic sectors, CSOs, and partners operating locally. The RHPAG will meet every other month. As the technical arm of RAC, RHPAG will implement its decisions and coordinate multisectoral actors on the

HIV prevention programme at regional level.

### Regional Condom and HIV Commodities Technical Working Group (CHCTWG)

The Regional CHCTWG is the platform for all technical work Condom and HIV prevention commodity under RHPAG. The Regional CHCTWG will be responsible for coordinating regional condom and HIV commodity forecast and quantification, maintaining the supply pipeline, storage, distribution and quality, and monitoring programme performance.

### Regional Task Force for HIV Response in Humanitarian Emergency Context (RTFHE)

The RTFHE will be chaired by the Regional Disaster Prevention and Response Commission and RHB will be its secretary. Its members include UN agencies working on HIV and humanitarian emergency, development partners and CSOs. The task force will meet quarterly and more frequently if needed, on a demand basis. The task force will predict, plan, coordinate and monitor HIV response, in the humanitarian emergency context, while also mobilizing resources to maintain and restore the affected health facilities and HIV services.

### Regional Task Force for Community-led Service Delivery and Monitoring (RCLMTF)

The RCLMTF will be chaired by MOH and the regional PLHIV network will serve as its secretary. Task force members include UN agencies, development partners, donors, development partners, community-led organizations and CSOs. RCLMTF will meet quarterly and more frequently on a demand basis. RCLMTF will guide the planning, coordination, implementation and resource mobilization for community-led monitoring.

**Woreda Health Offices** coordinate the woreda HIV response. Among their responsibilities:

- Provide guidance and facilitate translation of the prevention Road Map into a costed plan of action at the woreda level.
- Coordinate the implementation of the prevention Road Map at woreda levels by all implementing actors.
- Plan, implement, monitor, and evaluate HIV prevention services.
- Scale up HIV service delivery models for key and priority populations at health facilities and community level.
- Provide HIV prevention services, including SBCC, VMMC, PEP, PrEP, U=U, STIs, blood safety, condoms, and voluntary counselling and testing.

- Coordinate the non-health sector HIV prevention interventions, including SBCC, community mobilization, advocacy, and HIV mainstreaming.
- Support community-led service delivery and monitoring.
- Support and ensure engagement of CSOs, CBOs and FBOs in the HIV prevention response.
- Coordinate resource mobilization efforts, including domestic resources.
- Support effective utilization of resources for HIV prevention.
- Lead and coordinate regular joint supportive supervision and review meetings.
- Coordinate DHIS and MRIS data flow, analysis and reporting.
- Document and disseminate lessons learned and good/best practices on HIV prevention.

### Woreda HIV Prevention Advisory Group (WHPAG)

Chaired by the Woreda Health Office, WHPAG coordinates the HIV prevention programmes of health facilities, CSOs, and community-led organizations such as CCC. The WHPAG will meet quarterly.

### Government and Private Sectors

The strategic sectors at federal, regional and woreda levels will be responsible for mainstreaming HIV prevention and control activities. They will identify key population groups, prepare plans, allocate budgets, implement, monitor and evaluate HIV prevention interventions with a focus on KPP in their mandate and high-risk staff in their organizations. All government offices and the private sector are expected to contribute to the AIDS Fund and other domestic resource mobilization initiatives with the goal of expanding HIV services in the country. Government offices and the private sector are encouraged to educate their staff about HIV prevention and provide condoms at the workplace.

### Donors and Development Partners

The financial and technical support of international and local development partners is critical to the success of the HIV Prevention Road Map 2023-2027. Here are specific roles and responsibilities of donors and development partners:

- Provide technical support in the planning, implementation, monitoring and evaluation of the Road Map.
- Provide capacity building support to key actors at federal, regional and woreda levels.

- Provide financial support (mobilize resources for primary prevention).
- Introduce and promote innovative HIV prevention interventions for KPP groups.
- Participate in and support partnership and coordination efforts among the different actors.
- Support generation and dissemination of strategic information.
- Support documentation and dissemination of lessons learned and good/best practices on HIV prevention.

### Community-led Organizations and Civil Society Organizations

Community and civil society organizations will lead, coordinate and implement HIV prevention interventions at grassroots level. Community-led organizations will deliver HIV testing, HIV prevention, and social enabler services targeting KPP and PLHIV. They will organize, train and equip KPP and PLHIV to meaningfully participate in the HIV prevention response. The following are specific roles and responsibilities of community-led and civil society organizations:

- Organize KPP and PLHIV, build their capacity, and mobilize them for action.
- Advocate to influence policy and remove legal barriers to HIV services.
- Plan, implement, monitor and evaluate HIV prevention interventions targeting AGYW and KPP groups.
- Support local resource mobilization and effective utilization of available funds.
- Collaborate with medium, small and micro-enterprises to facilitate job opportunities and training on vocational skills for vulnerable adolescent girls and young women.
- Collecting and reporting MRIS data to respective government offices,
- Participate in joint supportive supervision and review meetings.
- Document and disseminate lessons learned and good/best practices on HIV prevention.

### The Media

Media houses will mainstream HIV prevention activities in their newsrooms. As part of their corporate social responsibility, the media can provide accurate HIV prevention information, raise awareness, educate the public, create a sense of responsibility and mobilize people into action.

## 8.2 Capacity building of the National HIV Prevention Programme

Building the capacity of the health and other strategic sectors, as well as the media, CSOs and communities at national, regional and woreda level, is crucial to achieve epidemic control by 2027. A multiplicity of channels and approaches are needed for these diverse actors: staff assignment in adequate numbers and mix, resource distribution, training, supervision, mentorship, and experience-sharing are all valuable tools.

Importantly, the MOH will print and distribute adequate numbers of the key HIV-related plans, strategies, guidelines, service delivery and programming guidelines, manuals and SOPs, among others, with strong engagement of community-led organizations and development partners in nationwide distribution to end users. (see list of documents below)

The MOH, RBs and Woreda Health Offices will have adequate number of staff with the skill mix required to coordinate the multisectoral behavioural, biomedical and structural interventions.

Planned capacity-building activities:

- Train HIV/AIDS programme staff at health and strategic sectors at federal, regional and woreda levels on the National Strategic Plan 2023-2027 and the National HIV Prevention Road Map 2023-2027.
- Training on the National comprehensive HIV prevention, care and treatment guideline.
- Training on the Minimum HIV prevention service packages and SOP for mapping, identification and targeting KPP with HIV prevention interventions. The package will be aligned with the NSP and Road Map 2023-2027.
- Training on the National Condom Strategy and guideline.
- Training on the National guideline for HIV response in the humanitarian context.
- Training on the National guideline on community-led service delivery and monitoring.
- MOH will develop a U=U communication strategy, standardized messages and communication materials. RHBs will adapt the communication strategy and tools to regional contexts.
- MOH will develop the national guideline for harm reduction and OST and train service providers and programme people.
- MOH will train its staff on grants management to ensure efficient grant making, fund absorption and reporting.

## 8.3 Accountability framework

### Table 8.1: The accountability framework and milestones

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| ***Scale up of combination HIV prevention*** | | | | | | |
| Scale up of combination HIV prevention interventions | Scale up intensive behavioural change communication targeting KPPs (peer and life skill education) | X | X | X | X | MOH, RHBs & CSO |
| | Integrate HIV education in school curricular and extracurricular activities, especially in colleges and universities – a credited HIV/SRH/Life skills course | X | X | X | X | MoE, RBE, MOH, colleges, universities & partners |
| | Train media and programme people and scale up the use of mainstream, social media and digital applications for HIV behavioural change communication targeting youth and KPP | X | X | X | X | MOH and Media |
| | Scale up biomedical HIV prevention interventions (condoms, PrEP, PEP, U=U, VMMC, STIs treatment, IP and blood screaming) | X | X | X | X | MOH |
| | Develop national guideline on harm reduction and opioid substitution therapy, train providers and programme people, engage experienced partners | X | X | X | X | MOH, RHBs, hospitals, partners and CSOs |

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| | to implement needle & syringe social marketing. Introduce OST, overdose treatment and PWID rehabilitation in mental health programmes at health facilities. | | | | | |
| | Develop U=U communication strategy, standard messages and materials, and adapt to regional contexts | X | | | | MOH, RHBs, media and partners |
| | Conduct promotion and creative communication through mainstream, print and social media on PrEP, U=U and HIV prevention | X | X | X | X | MOH, RHBs, media and partners |
| | Strengthen the STIs programme with training of providers, better availability of treatment kits and partner notification | X | X | X | X | |
| Expand HIV service delivery models and integration | Expand KPP-friendly clinics to all the high-incidence woredas | X | X | X | X | MOH, RHB/Woreda Health Office (HO), development partners, CSOs |
| | Expand Non-ART DICs in 50 hotspot towns among 265 high-incidence woredas | X | X | X | X | MOH, RHB/Woreda HO, development partners, CSOs |

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| | Make the general HIV services friendly to KPPS and PLHIV | X | X | X | X | MOH, RHB/Woreda HO |
| | Establish standard peer service providers in all the 265-high-incidence woredas | X | X | X | X | MOH, RHB/Woreda HO, development partners, CSOs |
| | Train, deploy and support mentors to deliver combination HIV prevention services for high risk AGYW and divorced and widowed women | X | X | X | X | CSOs, universities, MoE, MOH , RHBs and Woreda HO |
| | Integrate HIV behavioural and biomedical services in health programmes of hotspot workplaces, uniformed people training camps, humanitarian emergency settings, schools, universities and prisons. | X | X | | | MOH/RHBs, MoE, universities/colleges, workplaces, prison administration |
| | Mainstream HIV prevention in the ten strategic sectors core functions and mandates (assign staff, budget, implement and monitor HIV prevention) | X | X | X | X | MOH/RHBs and the ten strategic sectors |
| | Integrate HIV in social and economic sectors, particularly micro-finance schemes, Small and Medium Enterprises Agency (SMEA) | X | X | X | X | MOH, RHB, SMEA, microfinance |

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| Mapping and identification of KPPs | Develop the national mapping and identification of KPPs | X | | | | MOH, development partners |
| | Train providers and programme people on KPP mapping, identification and targeting | X | X | | | MOH, RHBs, development partners |
| | Conduct the mapping of KPPs at woreda level | | X | X | X | Woreda Health Office , woreda sectors and CSOs |
| | Document and expand best practices and lessons on mapping, identification and targeting of KPPs | X | X | X | X | MOH, RHBs, CSOs, development partners |
| ***Addressing the social and legal barriers*** | | | | | | |
| Fighting stigma and discrimination | Conduct policy advocacy and prepare a solid legal framework to mitigate stigma and discrimination | X | | | | NEP+ and MOH |
| | Conduct community education and advocacy through religious and community leaders, electronic media (radio-TV), print media and social media to reduce stigma and discrimination | X | X | X | X | NEP+, regional networks/ associations, partners, CSOs, CBOs, FBOs |
| | Issue a health facility and schools Zero Tolerance | X | X | X | X | MOH, MoE, RHBs, |

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| | policy, train health workers and teachers and monitor implementation of the policy in all health facilities and schools | | | | | NEP+, PLHIV associations, health facilities |
| Addressing legal and policy barriers | Revise the HIV/AIDS policy, disseminate the revised policy, and orientate programme staff | X | | | | MOH and partners |
| | Conduct policy advocacy to address the legal and policy barriers to HIV prevention services for key populations (PWID and FSWs) | X | | | | MOH, MoJ and CSOs |
| | Revise legal and policy frameworks that hinder access of KPs to HIV services | | X | | | MOH, MoJ and CSOs |
| | Support familiarization and implementation of revised legal and policy frameworks | | X | X | X | MOH, MoJ, RHBs, development partners, CSOs |
| Strengthen HIV response in humanitarian emergency context | Establish national and regional task forces for HIV response in humanitarian emergency context | X | | | | MOH and national task force |
| | Develop a national guideline for HIV response in humanitarian emergency context | X | | | | MOH & national task force |
| | Mobilize and implement HIV response in humanitarian emergency context | X | X | X | X | MOH, RHBs, Woreda HO, development partners |

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| ***Community-led services delivery and monitoring*** | | | | | | |
| Organizing communities | Support KPPs to get organized in both informal support groups and formal associations (provide finance, material, office and technical support) | X | X | | | MOH, RHBs, WHO, partners and CSOs |
| | Train PLHIV and KPP support groups and associations on leadership, organizational management, and HIV prevention | X | X | | | MOH, RHBs, partners and CSOs |
| Community-led service delivery | Fund HIV prevention services delivered by PLHIV and KPPs-led organizations through social contracting arrangements | X | X | X | X | MOH/RHBs and donors |
| | Audit and monitor proportion of community-led HIV testing, HIV prevention and social enablers services | X | X | X | X | MOH and RHBs |
| Community-led monitoring | Establish national and regional task force for Community-led monitoring | X | | | | MOH, RHBs, NEP+ and regional PLHIV networks |
| | Develop the national guideline and tools for community-led monitoring | X | | | | MOH, NEP+ CSOs & development partners |
| | Implement community-led monitoring of community and facility-based HIV service performance and quality | X | X | X | X | MOH, NEP+ CSOs & development partners |
| | | | | | | |

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| ***HIV prevention commodities and adoption of innovation and technology*** | | | | | | |
| Ensure the supply of HIV commodities, including condoms | Establish a technical working group for condoms and HIV commodities | | | | | MOH/RHBs |
| | Train programme people on the national condom strategy and guidelines | X | X | | | MOH, RHBs and partners |
| | Ensure continued quality supply of condoms and HIV commodities at all levels | X | X | X | X | MOH, EPSA, EFDA and donors |
| Ensure timely adoption of technology and innovation | The national technical working group for condoms and HIV commodities will continuously monitor, evaluate and adopt new technologies and innovations on HIV prevention | X | X | X | X | MOH |
| | Expand the use of social media and digital applications for HIV prevention training, education and communication | X | X | X | X | MOH/RHBs and development partners |

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| ***Leadership and accountability*** | | | | | | |
| Strengthen HIV prevention leadership and coordination | National and regional HIV prevention coalition, advisory group, task forces and technical working groups | X | | | | MOH and RHBs |
| | Ensure an adequate number and skill mix of staff at the MOH, RHBs, Woreda Health Offices, strategic sectors, EPSA & EFDA | X | X | X | X | MOH, RHBs, Woreda HO, EPSA, EFDA and strategic sectors |
| | Develop, print and distribute national policy, strategy, service delivery guidelines and SOPs | X | X | | | MOH and development partners |
| | Train programme staff and service providers on the National HIV Policy, HIV Strategy 2023-2027, HIV Prevention Road Map 2023-2027, Condom Strategy and guideline, service delivery and programme guidelines, and SOPs | X | X | X | X | MOH, RHBs, development partners |
| | | | | | | |

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| ***Real-time monitoring*** | | | | | | |
| ***Ensure real-time monitoring*** | Merge MRIS in DHIS2 (Select MRIS indicators, create registers and forms for community and sectors HIV response, integrate indicators in DHIS2 e-platforms) | X | | | | MOH and RHBs |
| | Train and orient Woreda Health Office and health posts on collection and reporting of data on community and sectors HIV response | X | | | | MOH and RHBs |
| | Conduct annual JSS and ARM at national level | X | X | X | X | MOH |
| | Conduct biannual regional JSS and review meting | X | X | X | X | RHBs |
| | Conduct quarterly woreda JSS and review meeting | X | X | X | X | Woreda Health Office |
| | Conduct IBBS for KPPs | | | X | X | EPHI |
| | Conduct annual national and sub-national HIV prevalence and incidence estimates | X | X | X | X | EPHI |
| | Conduct case-based HIV surveillance | X | X | X | X | EPHI |
| | Conduct ART & drug resistance surveillance | X | X | X | X | EPHI |
| | Conduct STIs surveillance | X | X | X | X | EPHI |
| | Manage and produce annual Laboratory Management Information System reports | X | X | X | X | EPHI |
| | Manage and produce annual Logistics Management Information System reports | X | X | X | X | EPSA |
| | | | | | | |

| Action Area | Intervention | 2023/24 | 2024/25 | 2025/26 | 2026/27 | Responsible stakeholder |
|---|---|---|---|---|---|---|
| ***Sustainable HIV financing*** | | | | | | |
| Ensure that HIV prevention is fully funded | Assign adequate staff with appropriate skill mix at MOH for Global Fund and domestic resource mobilization (Equity and Resilience Health Fund) | X | X | X | X | MOH |
| | Endorse domestic resource strategy (Equity and Resilience Health Fund) and Proclamation by MOH and HPR | | X | | | MOH and HPR |
| | Build capacity of MOH and RHBs staff on grant making and domestic resource mobilization strategy (Equity and Resilience Health Fund) | X | X | X | | MOH, RHBs and partners |
| | Implement the domestic strategy (Equity and Resilience Health Fund) | | X | X | X | MOH, RHBs, government and private sector |
| | Ensure effective grant-making, utilization and reporting on donor funds. | X | X | X | X | MOH and RHBs |

# Chapter 9

# Resource Needs and Resource Mobilization

## 9.1 Resource mobilization

### 9.1.1 External resource mobilization

From the beginning, the HIV programme in Ethiopia has largely relied on donor funding, mainly from the Global Fund, PEPFAR and UN agencies, along with bilateral donors. Although domestic financing for HIV continues to grow, it is anticipated that in the near future donor funding will continue to be the primary source of external financial support.

In the current re-structuring process, with FHAPCO dissolved and the MOH assuming responsibility for external funding management, MOH will appoint and train a specialized team to efficiently oversee grant administration, funds allocation, tracking and reporting. They will work closely with all donors and partners to efficiently plan, implement and monitor HIV prevention, care and treatment programmes.

The MOH and RHBs will utilize the costed National Strategic Plan 2023-2027 and the HIV Prevention Road Map 2023-2027 as the guiding framework for implementing HIV programmes.

MOH and RHBs will closely work with PEPFAR, U.S. government partners and UN agencies, to effectively plan and implement HIV prevention, care and treatment programmes.

Furthermore, MOH will map global resources and funding opportunities for HIV, disburse grants, and mobilize additional resources for HIV prevention focused on KPP.

### 9.1.2 Domestic resource mobilization

Recognizing the need to build sustainable financing for health, Ethiopia developed the Equity and Resilience Health Fund. Further strategies to mobilize domestic funding include:

- Increase allocation of general government revenue to health, and specifically HIV, at federal and regional levels.
- Expand participation, management and pooling of the AIDS Fund for public and private sector employees.
- Introduce a “sin tax” levied on products such as liquor and tobacco.
- Require a mandatory health fund contribution from large public and private enterprises.

## 9.2 Resource need estimates for the HIV Prevention Programme

### Table 9.1: HIV Prevention Programme resource needs estimate

| | | 3 years | | | |
|---|---|---|---|---|---|
| **Cost Items by Programme Areas (in USD)** | **2023/24** | **2024/25** | **2025/26** | **2026/27** | **Total (in USD)** |
| **Scale up combination HIV prevention interventions** | | | | | |
| Scale up KPP-friendly clinics in the 265 high-incidence woredas | 1,515,495 | 916,655 | 914,631 | 914,631 | 4,261,411 |
| Scale up DICs in 50 high-incidence woredas | 1,169,126 | 848,659 | 848,659 | 848,659 | 3,715,102 |
| Scale up outreach services in 265 high-incidence woredas | 865,615 | 714,460 | 714,460 | 714,460 | 3,008,993 |
| Scale up peer service providers programme in the high-incidence woredas | 5,964,819 | 5,138,264 | 5,138,264 | 5,138,264 | 21,379,611 |
| Integrate HIV prevention in prison health programmes | 765,466 | 623,950 | 623,950 | 623,950 | 2,637,315 |
| Integrate HIV in health programmes at hotspot workplaces | 733,332 | 429,680 | 429,680 | 429,680 | 2,022,371 |
| Strengthen HIV mainstreaming in the ten strategic sectors | 506,364 | 411,310 | 25,437 | 25,437 | 968,549 |
| Strengthen HIV prevention delivered through health extension workers | 727,841 | 1,222,789 | 1,222,789 | 1,222,789 | 4,396,208 |
| Scale up intensive behavioral change interventions (peer education for KPP) | 8,822,131 | 8,765,092 | 8,822,131 | 8,822,131 | 35,231,486 |
| Integrate HIV education in school | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| intra- and extracurricular activities | 2,362,423 | 1,696,186 | 1,696,186 | 1,696,186 | 7,450,980 |
| SBCC through mainstream, social media and digital applications | 965,131 | 931,609 | 931,609 | 931,609 | 3,759,960 |
| Condom programming | 9,762,270 | 10,611,983 | 10,147,694 | 10,147,694 | 40,669,641 |
| Scale up ARV-based HIV prevention (PrEP, PEP and U=U) | 1,798,232 | 1,967,730 | 2,447,730 | 2,447,730 | 8,661,420 |
| Scale up harm reduction and opioid substitution therapy for PWID | 1,831,658 | 1,128,239 | 1,128,239 | 1,128,239 | 5,216,375 |
| Scale Up VMMC in Gambella, including social mobilization | 544,916 | 332,161 | 389,923 | 389,923 | 1,656,923 |
| STIs prevention and treatment | 1,440,463 | 1,344,513 | 1,412,516 | 1,412,516 | 5,610,008 |
| Scale up gender empowerment and GBV prevention and mitigation interventions | 1,585,073 | 1,429,718 | 1,429,718 | 1,429,718 | 5,874,226 |
| **Sub total** | **41,360,354** | **38,512,996** | **38,323,614** | **38,323,614** | **156,520,578** |
| **Addressing social and legal barriers and responding to emergencies** | | | | | - |
| Addressing social and legal barriers | 1944552.14 | 1669233.96 | 1669233.96 | 1669233.96 | 6,952,254 |
| HIV response in humanitarian and emergency contexts | 169956.84 | 96967.39 | 96967.39 | 96967.39 | 460,859 |
| **Sub total** | **2,114,509** | **1,766,201** | **1,766,201** | **1,766,201** | **7,413,113** |
| **Community-led service provision and monitoring** | | | | | - |

| | | | | | |
|---|---|---|---|---|---|
| Support establishment and build capacity of community-led organizations and CSOs to deliver HIV services | 3,723,453 | 3,144,025 | 3,144,025 | 3,144,025 | 13,155,528 |
| Community-led monitoring | 1,136,454 | 638,795 | 638,795 | 638,795 | 3,052,840 |
| **Sub total** | **4,859,906** | **3,782,821** | **3,782,821** | **3,782,821** | **16,208,368** |
| **Leadership and accountability** | | | | | - |
| Staffing of MOH and RHBs HIV prevention programme | 7,374,577 | 7,374,577 | 7,374,577 | 7,374,577 | 29,498,309 |
| Building capacity of staff at MOH/RH and Woreda Health Offices | 585,103 | 198,170 | 198,170 | 198,170 | 1,179,613 |
| Joint planning | 1,655,633 | 1,655,633 | 1,655,633 | 1,655,633 | 6,622,531 |
| **Sub total** | **9,615,313** | **9,228,380** | **9,228,380** | **9,228,380** | **37,300,453** |
| **Strategic Information** | | | | | - |
| Joint supportive supervision and review meetings | 2,940,862 | 2,940,862 | 2,940,862 | 2,940,862 | 11,763,448 |
| Strengthen coverage and quality of DHIS2 routine data collection, analysis and reporting | 1,061,424 | 1,061,424 | 1,061,424 | 1,061,424 | 4,245,698 |
| Survey and surveillance | 190,132 | 2,212,283 | 1,306,037 | | 3,708,451 |
| **Sub-Total** | **4,192,419** | **6,214,569** | **5,308,323** | **4,002,286** | **19,717,597** |

| | | | | | |
|---|---|---|---|---|---|
| **Resource Mobilization** | | | | | - |
| Advocacy policy and legal framework | 193,593 | 42,057 | 193,593 | 193,593 | 622,835 |
| Increase government budget allocation to HIV | 23,196 | 19,393 | 19,393 | 19,393 | 81,377 |
| Strengthen and scale up AIDS Fund | 33,027 | 30,231 | 30,231 | 30,231 | 123,721 |
| Strengthen and expand Community Care Coalitions | 85,296 | 618,785 | 7,986 | 7,986 | 720,052 |
| Establish earmarked Tax (Mandatory contribution of large private companies | - | - | 28,575 | 28,575 | 57,150 |
| Strengthen HIV service delivery in private sectors | 203,441 | - | - | - | 203,441 |
| Explore potential integration of HIV in Health Insurance Schemes | - | - | 100,984 | | 100,984 |
| Enhance efficiency, transparency and accountability | 135,305 | - | - | - | 135,305 |
| Sub Total | **673,859** | **710,467** | **380,761** | **279,778** | **2,044,864** |
| **Total (in USD)** | **62,816,360** | **60,215,433** | **58,790,100** | **57,383,080** | **239,204,974** |

# Chapter 10

# Monitoring and Results Framework

## 10.1 Monitoring and evaluation framework

The Ministry of Health will provide the overall leadership, coordination and reporting of routine HIV prevention, care and treatment programme performance through DHIS2, as well as through annual and semi-annual joint supportive supervision and review meetings.

The Ethiopian Public Health Institute (EPHI) will oversee the **Laboratory Management Information System (LaMIS)** and the HIV-related surveys and surveillance, with support from MOH and partners. The Ethiopia Pharmaceutical Supplies Agency (EPSA) will manage the **Logistics Management Information System (LMIS)**.

The health sector biomedical interventions have been monitored under MOH through the **District Health Information System (DHIS2).** The DHIS 2 has standard registers and forms, an electronic platform and structure, and designated staff to collect and report data from health post to ministry level. However, it has limited HIV indicators, and many are not disaggregated by KPP groups and age categories. There have been concerns about the quality and scope of data reporting using the e-platform.

The HIV multisectoral response at community level and by strategic sectors was monitored under FHAPCO through the **Multisectoral Response Information System (MRIS).** However, MRIS lacks standard reporting forms, a register, and a designated structure and staff to collect and report data at community level. MRIS data was incomplete and inconsistent.

**DHIS 2** will now be the platform to collect all HIV prevention, care and treatment routine data from health facilities, strategic sectors, and at community levels. MOH will identify key indicators for community, sectoral and health HIV programme interventions, as well as key HIV indicators disaggregated by KPP, sex and age. The selected MRIS indicators will be integrated into the DHIS2 forms, registers and e-platform.

Health posts, health centers and Woreda Health Offices will be responsible for collecting and reporting on the community and sectors HIV response through the DHIS2 platform. MOH and RHBs will train and assign staff and monitor the integration of MRIS in the DHIS2.

MOH will conduct regular joint supportive supervision to regions, in collaboration with development partners, to observe HIV prevention, care and treatment programmes at community,

strategic sectors and health facilities. There will be regular national meetings to review the HIV response and other 'health programmes, with a special session to review comprehensive HIV prevention care and treatment implemented at community, sector and health facility levels.

Regional Health Bureaus will conduct regular joint supportive supervision and review meetings with Woreda Health Offices and partners. In turn, Woreda Health Offices will conduct regular supportive supervision and review meetings involving community actors, sectors and health facilities.

**EPHI** will ensure that the Laboratory Management Information System generates timely, comprehensive and accurate data to guide HIV planning and monitoring. EPHI will produce estimates of HIV prevalence and incidence, of service coverage and programme performance and prepare annual reports. With support from MOH and partners, EPHI will conduct the following surveys and surveillances:

- HIV prevalence and incidence estimate for national and subnational levels
- Integrated Biological and Behavioural Surveillance (IBBS) for PWID, prisoners, long-distance drivers, high-risk AGYW and workers in hotspot areas
- Case-based HIV surveillance
- STIs surveillance

**EPSA** will manage the Logistics Management Information System to produce timely, comprehensive and accurate data on HIV prevention, care and treatment commodity, including condoms, to guide HIV programme planning and monitoring.

## 10.2 HIV prevention results framework

### Table 10.1: HIV Prevention Results Framework

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| Impact | Number of new HIV infections | All age and sex | 8,300 | Spectrum Estimates | 7300 | 6500 | 5600 | 4800 |
| | | Female 15+ Years | 4,100 | " | 3700 | 3400 | 3000 | 2700 |
| | | Male 15+ Years | 2200 | " | 1,900 | 1,700 | 1,500 | 1,300 |
| | | Children 0-14 Years | 2000 | " | 1700 | 1400 | 1100 | 800 |
| | | **Number of new infections by region (all ages)** | | | | | | |
| | | Amhara | 500 | '' | 325 | 300 | 250 | 200 |
| | | Oromia | 500 | '' | 325 | 275 | 250 | 200 |
| | | SNNP | 1,500 | '' | 1300 | 1200 | 1050 | 1000 |
| | | Tigray | 100 | '' | 70 | 65 | 60 | 50 |
| | | Addis Ababa | 500 | '' | 325 | 300 | 250 | 200 |
| | | Afar | 500 | '' | 325 | 300 | 250 | 200 |
| | | Gambella | 100 | '' | 70 | 65 | 60 | 50 |
| | | Dire Dawa | 1,600 | '' | 1350 | 1200 | 1100 | 1050 |
| | | Sidama | 870 | | 700 | 650 | 600 | 550 |
| | | Somali | 500 | '' | 325 | 300 | 250 | 200 |
| | | Benis Gumz | 200 | '' | 160 | 145 | 130 | 100 |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | | Harari | 500 | '' | 325 | 300 | 250 | 200 |
| | Percentage of people living with HIV (Prevalence) | Disaggregated by age, gender, location and KPs (FSW, PWID) | 0.8 (2022) Adults 15-49 | Spectrum Estimates | 0.71 | 0.65 | 0.6 | 0.55 |
| | | FSW | 18.7% | IBBS 2020 | 18% | 17% | 16% | 15% |
| | Number of AIDS-related deaths | All | 11,000 | Spectrum Estimates | 10,500 | 10,000 | 9,300 | 8,500 |
| | | Male | 4,400 | Spectrum Estimates | 4300 | 4200 | 3900 | 3500 |
| | | Female | 5,100 | " | 4800 | 4500 | 4200 | 4000 |
| | | Children (0-14) | 1,500 | " | 1400 | 1300 | 1200 | 1000 |
| Outcome | Percentage of women and men aged 15-49 who correctly identify ways of preventing sexual transmission of HIV and who reject major | Adults (15 – 49):Make | 38% | DHS 2016 | 45% | 50% | 55% | 60% |
| | | Adults (15 – 49): Female | 20% | DHS 2016 | 25% | 30% | 40% | 50% |
| | | Young People (15 – 24): Male | 39% | DHS 2016 | 45% | 50% | 55% | 60% |
| | | Young People (15 – 24): Female | 24% | DHS 2016 | 25% | 30% | 40% | 50% |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | misconceptions about HIV transmission | | | | | | | |
| Outcome | % of youth aged 15-24 who have sex before age 15 | Males | 1% | DHS 2016 | 0.75% | 0.65% | 0.50% | 0.50% |
| | | Females | 9% | DHS 2016 | 7% | 6% | 5% | 4% |
| Coverage | % youth aged 15 – 24 reached with HIV prevention programmes during the last 12 months (school and out-of-school peer or life skills education ) | All | 23% | MOH 2014 EFY annual report | 40% | 50% | 60% | 70% |
| Coverage | Number of adolescents and youth reached with school and out-of-school prevention programmes | All | 5.1M | MOH2014 EFY annual Report | 9M | 11.5M | 14M | 16.5M |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | (millions) | | | | | | | |
| Coverage | % of males aged 15-49 circumcised in Gambella | Young men 15 – 29 | 72% | DHS 2016 | 83% | 85% | 90% | 90% |
| | | Adult men 15-49 | 72% | DHS 2016 | 80% | 85% | 90% | 90% |
| | Number of medically circumcised men 10+ years | 10+ Years | 10+ Years | 26,737 | MOH2014 EFY annual report | 14,300 | 15,000 | 16,000 |
| Outcome | % of people who used condoms during their last high-risk sex act in last 12 months[3] | Adults (15-49): Females | 20% | DHS 2016 | 35% | 45% | 50% | 50% |
| | | Adults (15-49): Male | 51% | DHS 2016 | 60% | 65% | 70% | 70% |
| Coverage | Number of male and female condoms distributed annually | Male condoms | 80.6 M | MOH2014 EFY annual report | 250 M | 279.7 M | 318M | 362.7 M |
| | | Female condoms | DNA | | 2M | 2M | 2M | 2M |
| Coverage | % of eligible | All | 11% | MOH 2021 | 9% | 11% | 13% | 15% |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | people who initiated oral PrEP during the reporting period | | (21, 684) | Report | (26,764) | (32,036) | (37,571) | (44,178) |
| Coverage | % and number of eligible people who received oral PrEP at least once during the last 12 months | Discordant couple % Number | 19% (2,014) | Calculated from MOH2014 EFY annual report | 30% (3,436) | 45% (5,339) | 60% (7,363) | 75% (9,511) |
| | | FSWs % Number | 11% (19,670) | Programme Data | 12% (22,435) | 13% (24,944) | 14% (27,552) | 15% (30,258) |
| | | High-risk pregnant and breastfeeding women | 0% | Programme data | 1% (802) | 2% (1,604) | 3% (2,406) | 5% (4,010) |
| | | PWID % Number | 0% | Programme data | 1% (90) | 2% (173) | 3% (250) | 5% (400) |
| Coverage | % KPP members reached with a defined packages of HIV prevention services | FSW [Denominators: 228,000 in 2023 and 246,000 in 2027] | 70% | IBBS 2020 | 75% | 80% | 90% | 95% |
| | | | | | 171,000 | 187,200 | 216,000 | 233,700 |
| | | Prisoners *(Prison Administration) | 58% | Person Survey | 90% | 70% | 80% | 90% |
| | | | | | 77850 | 60550 | 69200 | 77850 |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | | PWID [Denominators: 10,000 in 2023 and 8850 in 2027, 0.13% of adults in Spectrum pop. projection] | N/A | | 20% | 40% | 60% | 70% |
| | | | | | 2000 | 3850 | 5500 | 6200 |
| | | Widowed and divorced men and women [Denominators: 1,046,000 in 2023 and 1,14180,0 by 2027] | 28% | DHS 15-49 both sex | 40% | 60% | 80% | 95% |
| | | | | | 418,400 | 645,600 | 891,945 | 1,084,706 |
| | | Long-distance drivers [Denominators: 77000 in 2020; 89,000 in 2027] | 55% | IBBS 2013 | 60% | 75% | 90% | 95% |
| | | | | | 46,200 | 60,750 | 76,500 | 84,550 |
| | | Workers in hotspot areas [Estimated at 840,000 in 2020 and 1,088,000 in 2027] | N/A | | 40% | 60% | 80% | 95% |
| | | | NA | | 384,800 | 601,200 | 840,000 | 1,033,600 |
| | | High-risk adolescent girls and young women [Denominators: 358550 in 2023 and 371,500 by 2027] | 24% | DHS 2016 | 40% | 60% | 80% | 95% |
| | | | | " | 143,417 | 218,967 | 297,036 | 353,000 |
| Outcome | Percentage of key populations | FSW condom use at last sex with paying and non-paying clients | Paying clients: | IBBS | 99% | 99% | 99% | 99% |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | reporting use of a condom with their most recent partner | | 95% | | | | | |
| | | | Non-Paying 26% | IBBS | 55% | 70% | 90% | 95% |
| | | LDD condom use at last sex with non-regular partner | 84% | IBBS | 90% | 93% | 95% | 95% |
| | | Widowed and divorced men and women condom use at last sex (15-49) | 31% | DHS | 40% | 50% | 60% | 70% |
| | | Workers at hotspot areas condom use at last sex with non-regular partner (15-24 men and women) | 41% | DHS | 45% | 50% | 60% | 70% |
| | | High-risk adolescents and young women condom use at last sex with non-regular partner | 24% | DHS | 40% | 50% | 60% | 70% |
| Coverage | % Eligible PWID receiving Opioid Substitution Therapy | PWID | 0% | " | 0% | 10% | 20% | 30% |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | Number of PWID receiving OPIOID Substitution Therapy | | 0 | " | 0 | 960 | 1840 | 2660 |
| Coverage | Percentage of Key and Priority populations reached with SBCC | KPP | 40% | DHIS2 | 40% | 60% | 80% | 95% |
| Coverage | Percentage of people 15-49 years with STIs treated | Adults 15-49 | 17% | Programme Report 2022 (MOH 2014 EFY) | 30% | 45% | 60% | 75% |
| | Percent of FSWs with STIs treated | Female sex workers | 64% | IBBS 2020 | 75% | 80% | 90% | 95% |
| Outcome | Percentage in-country utilization of disbursed funds (e.g., in-country disbursement utilization) | Disaggregated by source of funding and implementer type (public or community) | Less than 70% | NHA/ Programme Report | 85% | 90% | 95% | 98% |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| Coverage | Completeness of facility reporting: Percentage of expected facility monthly reports (for the reporting period) that are actually received | All | | DHIS2 | 85% | 90% | 90% | 95% |
| Coverage | Percentage of health facilities timely submitting reports within DHIS2 | All | | (DHIS2) | 95% | 95% | 95% | 9% |
| Coverage | Percentage of planned surveys and surveillances conducted, and reports released on time (within 3 months of | All | <80% | Programme report | 90% | 95% | 98% | 100% |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | finalization) | | | | | | | |
| Coverage | Percentage of Woredas that produce periodic analytical report(s) as per nationally agreed plan and reporting format during the reporting period | High Burden, Medium Burden, Low Burden | | Programme reports; DHIS2 | 85% | 90% | 92% | 95% |
| Coverage | Percentage of facilities which record and submit data using the electronic information system | All | 89% | DHIS2 | 95% | 98% | 98% | 98% |
| Outcome | % of PLHIV, HIV-positive key and priority population | PLHIV | 24% | Stigma Index survey 2020 | 20% | 15% | 10% | <10% |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | members who faced stigma and discrimination in the community setting | | | | | | | |
| Outcome | Percentage of people living with HIV who report experiencing stigma and discrimination in the health facility in the last 12 months | PLHIV | 40% | Stigma Index survey 2020 | 30% | 20% | 15% | <10% |
| Outcome | Proportion of women aged 15-49 who reported experiencing physical or sexual violence from a male intimate | Adult Females (15-49) | 19.8% | Gender link GBV Indicator - UN 2019 | 18% | 15% | 12% | 10% |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | partner in the past 12 months | | | | | | | |
| Coverage | AGYW economic and other empowerment programmes | % | < 1% | Programme Reports | 3% | 4% | 5% | 5% |
| | | Number | 88,076 | " | 350,000 | 470,000 | 590,000 | 590,000 |
| Coverage | Percentage of HIV funding from domestic sources | All | 11% | NASA / NHA | 13% | 14% | 15% | 16% |
| | Number of priority woredas with at least one community-led formal organization of informal support group | Woreda (At least 1 per highest incidence Woreda) | NA | Programme Reports | 150 | 200 | 250 | 300 |
| Coverage | % of HIV prevention services | In the 265 high-incidence woredas | NA | Programme Report | 10% | 20% | 30% | 40% |

| Level | Indicator | Disaggregation | Baseline (2022) | Source | 2023/24 | 2024/25 | 2025/26 | 2026/27 |
|---|---|---|---|---|---|---|---|---|
| | delivered by community-led organizations in 300 priority woredas | | | | | | | |
| | Number of priority woredas implementing community-led monitoring (CLM) | Woreda (At least 1 per highest incidence Woreda) | NA | Programme Reports | 150 | 200 | 265 | 300 |
| Coverage | Number of restrictive policy and legal frameworks revised | Legal and policy documents revised (cumulative) | NA | Programme Reports | 1 | 2 | 3 | 4 |

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# Annexes

## Annex 1: Global AIDS Strategy 2021-2025, Targets and Commitments

### Table 12.1: The 2025 Global Targets and Commitments

| | |
|---|---|
| • Ending inequalities: Take urgent and transformative action to end the social, economic, racial and gender inequalities that perpetuate the HIV pandemic.<br>• Equitable outcomes and granular targets: Achieve HIV combination prevention, testing and treatment targets across relevant demographics, populations and geographic settings.<br>• Prioritized combination HIV prevention: Prioritize comprehensive packages of HIV prevention services and ensure they are available and used by 95% of people at risk of HIV infection.<br>• Key populations: Act on the recognition that key populations—including gay men and other men who have sex with men, people who inject drugs, sex workers, transgender people, and people in prisons and other closed settings—are at high-risk of HIV infection.<br>• New HIV cascade: Reach the new 95–95–95 testing, treatment and viral suppression targets across all demographics, populations and geographic settings.<br>• Undetectable=Untransmittable (U=U): | • Fully fund the HIV response: Invest US$ 29 billion annually in low- and middle-income countries, including at least US$ 3.1 billion for societal enablers.<br>• 10–10–10 targets for societal enablers: Reduce to less than 10% the number of women, girls and people living with, at risk of and affected by HIV who experience gender-based inequalities and sexual and gender-based violence.<br>• Ensure that less than 10% of countries have restrictive legal and policy environments that lead to the denial or limitation of access to HIV services. Ensure that less than 10% of people living with, at risk of and affected by HIV experience stigma and discrimination.<br>• Sexual and reproductive health: Ensure that 95% of women and girls of reproductive age have their HIV and sexual and reproductive health-care service needs met.<br>• Access to affordable medicines, diagnostics, vaccines and health technologies: Ensure the global accessibility, availability and affordability |

| | |
|---|---|
| Recognize that viral suppression through antiretroviral therapy is a powerful component of combination HIV prevention (since people living with HIV who have undetectable viral loads cannot transmit the infection to others).<br>• Elimination of new HIV infections in children: Ensure that 95% of pregnant and breastfeeding women have access to combination HIV prevention, antenatal testing and retesting; 95% of women living with HIV achieve and sustain viral suppression before delivery and during breastfeeding; and 95% of HIV-exposed children are tested within two months of birth and, if HIV-positive, receive optimized treatment. | of safe, effective and quality-assured medicines and other health technologies for preventing, diagnosing and treating HIV infection and its coinfections and comorbidities.<br>• Service integration: Invest in health and social protection systems to provide 90% of people living with, at risk of and affected by HIV with people-centered and context-specific integrated services.<br>• Community leadership, service delivery and monitoring: Increase the proportion of community-led HIV services to achieve 30-60-80 targets and ensure relevant networks and organizations are sustainably financed, participate in decision-making and can generate data through community monitoring and research.<br>• GIPA: Uphold the Greater Involvement of People Living with or affected by HIV principle. |

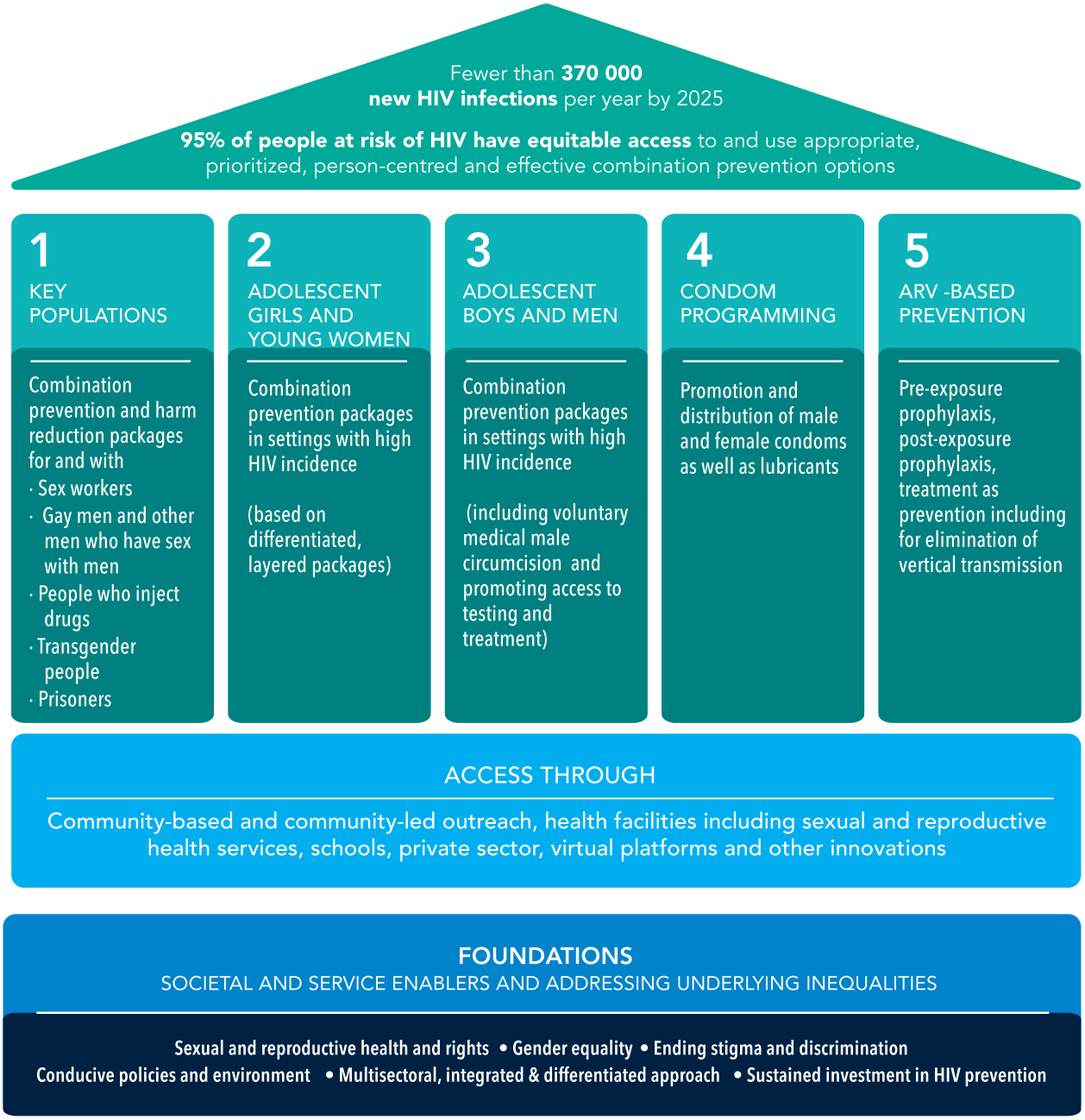



**Figure 12.1 The five prevention pillars for 2025 (UNAIDS 2022)**

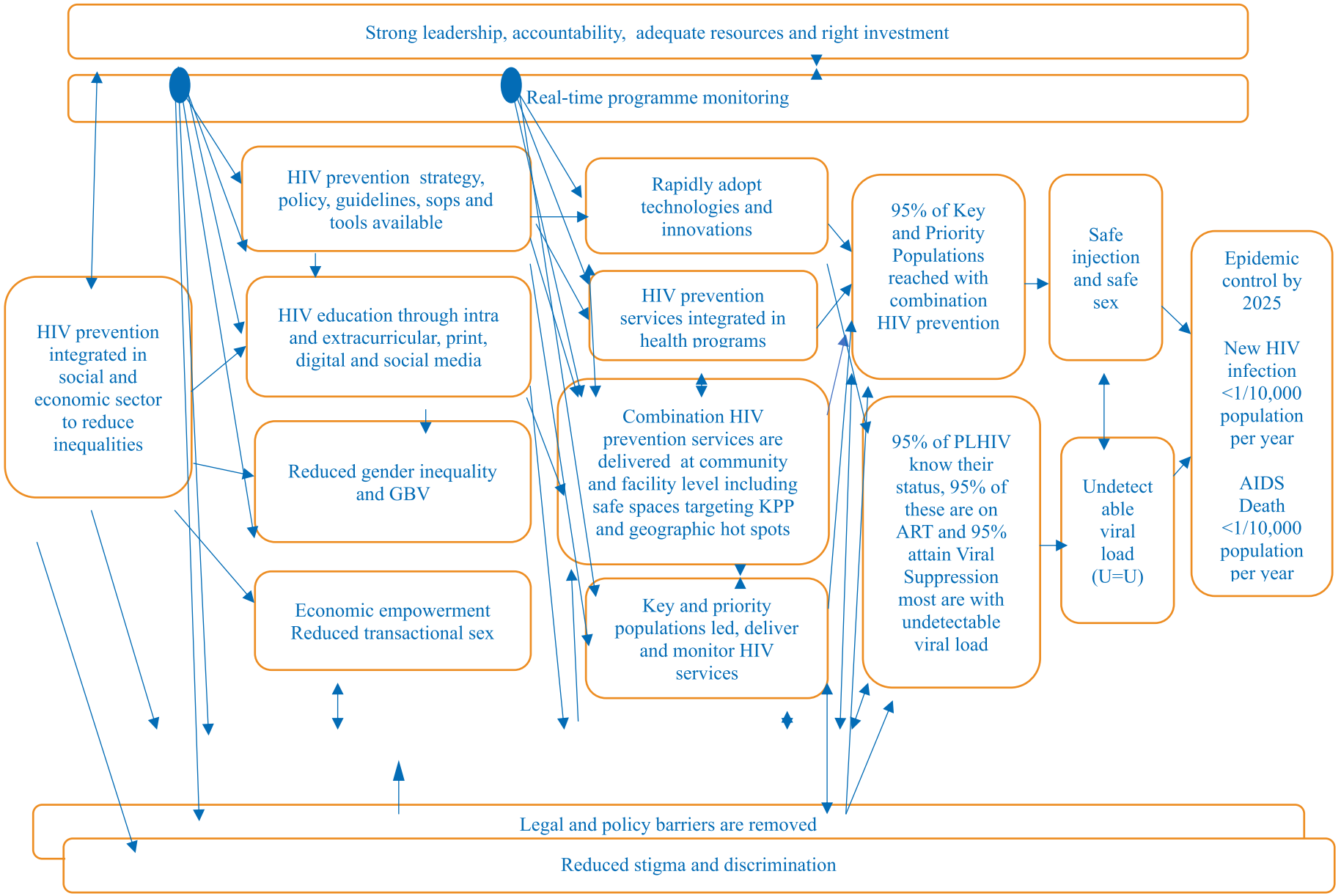
## Annex 2: List of HIV Programme Resources

- Policies and Strategies:
  - ✓ Federal Democratic Republic of Ethiopia, 1993. Health Policy of the transitional government of Ethiopia (Old and under revision)
  - ✓ Federal Democratic Republic of Ethiopia Ministry of Health, 2021b. Reproductive Health Strategic Plan 2021-2025.
  - ✓ Federal Democratic Republic of Ethiopia Ministry of Health, National Adolescent and Youth Health Strategy 2021-2025.
  - ✓ Federal Democratic Republic of Ethiopia Ministry of Health, Health System Transformation Plan II 2020/21- 2024/25.
  - ✓ Federal Democratic Republic of Ethiopia Ministry of Health, 2015c. National guidelines for the management of sexually transmitted infections using syndromic approach.
  - ✓ Federal Democratic Republic of Ethiopia Ministry of Health, 1998. Policy on HIV/AIDS (Old and needs revision)
  - ✓ Federal HIV/AIDS Prevention and Control Office, 2021. HIV/AIDS National strategic plan for Ethiopia 2021-2025
  - ✓ Federal HIV/AIDS Prevention and Control Office, 2018. HIV Prevention in Ethiopia National Road Map 2018-2020.
  - ✓ National School Health and Nutrition Strategy, 2019
  - ✓ National Policy for Women, 1998
  - ✓ National Social Protection Strategy, 2016
  - ✓ National Social Protection Policy of Ethiopia, 2012
  - ✓ Food and Nutrition Policy,2018
  - ✓ Food and Nutrition Strategy, 2020
  - ✓ National Occupational Health and Safety Policy,2012/13
  - ✓ Education and Training Policy,1994
  - ✓ National Youth Policy, 2004
  - ✓ National Health Promotion Strategic Plan, 2021/22-2025/26
  - ✓ Employee Relations Policy, 2014

- ✓ National Disability Strategy, 2021
- ✓ Ethiopian National Condom Strategy, 2018

- Guidelines
  - ✓ National strengthening vulnerable population guideline
  - ✓ Health communication materials development guideline, 2016-2020
  - ✓ Orphan and vulnerable children implementation guideline, 20
  - ✓ National guideline for condom programming in Ethiopia, 2022
  - ✓ National guideline for prevention of mother to child transmission of HIV, syphilis and hepatitis B virus,2021
  - ✓ Federal Democratic Republic of Ethiopia Ministry of Health, 2022. National guidelines for comprehensive HIV prevention, care and treatment
- Training Manuals
  - ✓ Condom programming training manual, 2022
  - ✓ Peer learning manual for FSWs, 2020
  - ✓ Peer learning manuals for workers at hotspot area,2020
  - ✓ HIV AIDS mainstreaming training manual, 2010
  - ✓ HIV AIDS mainstreaming implementation manual,2022
  - ✓ Undetectable=Untransmittable training manual for health-care providers,2021
  - ✓ Peer learning manual for people with disability, 2022 (ready for print)
- SOPs and Job Aids
  - ✓ SOP for Non-ART DIC
  - ✓ SOP for KPP friendly clinics
  - ✓ SOP for targeted outreach
  - ✓ SOP for needle syringe social marketing
  - ✓ Optimizing HIV testing algorithm toolkit, 2021

## Annex 3: HIV Prevention Programme: the Theory of Change



## Annex 4: HIV Incidence Estimates by Woreda

**High-incidence woredas:** HIV incidence ≥0.03%

**Medium-incidence woredas:** 0.01-0.029%

**Low-incidence woredas:** < 0.01 %

### Table 12.2: HIV Incidence Estimates by Woreda, 2020 (EPHI 2020)

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 1 | Sodo Town | Wolayita | SNNPR | 43 | 40 | 8934 | 0.4824% |
| 2 | Debre Markos Town | East Gojam | Amhara | 85 | 628 | 20379 | 0.4305% |
| 3 | Mengesh | Mejenger | Gambella | 46 | 1594 | 14977 | 0.3471% |
| 4 | Raya Azebo | South Tigray | Tigray | 64 | 443 | 19072 | 0.3415% |
| 5 | Metema | West Gondar | Amhara | 37 | 268 | 12516 | 0.3024% |
| 6 | Gidan | North Wolo | Amhara | 57 | 1460 | 20675 | 0.2965% |
| 7 | Habru | North Wolo | Amhara | 47 | 900 | 19192 | 0.2582% |
| 8 | Gog | Angewak | Gambella | 20 | 408 | 8520 | 0.2508% |
| 9 | Semen | Mekele Special Zone | Tigray | 50 | 1361 | 23405 | 0.2279% |
| 10 | Makuey | Nuwer | Gambella | 37 | 472 | 17135 | 0.2210% |
| 11 | Bole Woreda 3 | Bole | Addis Ababa | 9 | 214 | 4367 | 0.2199% |
| 12 | Abobo | Angewak | Gambella | 34 | 767 | 16224 | 0.2187% |
| 13 | Kewet | North Shewa (Amhara) | Amhara | 28 | 55 | 12801 | 0.2161% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 14 | Lideta Woreda 3 | Lideta | Addis Ababa | 7 | 1214 | 4932 | 0.2009% |
| 15 | Gambella | Gambella Town | Gambella | 59 | 1715 | 31257 | 0.1992% |
| 16 | Shire Endasilasie Town | North Western Tigray | Tigray | 38 | 334 | 19959 | 0.1924% |
| 17 | Tepi Town | Sheka | SNNPR | 33 | 91 | 17500 | 0.1876% |
| 18 | Hosaena Town | Hadiya | SNNPR | 43 | 65 | 23621 | 0.1827% |
| 19 | Golina | Fanti (Zone 4) | Afar | 59 | 207 | 33862 | 0.1760% |
| 20 | Ebinat | South Gondar | Amhara | 28 | 169 | 17009 | 0.1687% |
| 21 | Kirkos Woreda 7 | Kirkos | Addis Ababa | 19 | 2049 | 13386 | 0.1672% |
| 22 | Nefas Silk-Lafto Woreda 3 | Nefas Silk-Lafto | Addis Ababa | 18 | 274 | 11376 | 0.1616% |
| 23 | Kolfe Keraniyo Woreda 1 | Kolfe Keraniyo | Addis Ababa | 44 | 270 | 27799 | 0.1612% |
| 24 | Lare | Nuwer | Gambella | 21 | 112 | 13226 | 0.1596% |
| 25 | Gode Town | Shebele (Gode) | Somali | 14 | 21 | 9097 | 0.1586% |
| 26 | Dabat | North Gondar | Amhara | 38 | 871 | 26008 | 0.1511% |
| 27 | Tarma Ber | North Shewa (Amhara) | Amhara | 16 | 420 | 10988 | 0.1481% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 28 | Gambella Zurya | Angewak | Gambella | 11 | 1 | 7322 | 0.1478% |
| 29 | Etang | Etang Spe. Woreda | Gambella | 36 | 1140 | 26339 | 0.1434% |
| 30 | Dubti | Awsi (Zone 1) | Afar | 26 | 27 | 17995 | 0.1421% |
| 31 | Aneded | East Gojam | Amhara | 14 | 1053 | 10941 | 0.1419% |
| 32 | Sebeta Hawas | Finfinne Special Zone | Oromia | 23 | 1167 | 17838 | 0.1396% |
| 33 | Miyu | Borena | Oromia | 25 | 19 | 17878 | 0.1387% |
| 34 | Akobo | Nuwer | Gambella | 17 | 2 | 12347 | 0.1358% |
| 35 | Segen Zuria | Konso | SNNPR | 8 | 284 | 6511 | 0.1339% |
| 36 | Jabi Tehnan | West Gojam | Amhara | 32 | 553 | 24505 | 0.1336% |
| 37 | Woldiya Town | North Wolo | Amhara | 59 | 2590 | 47375 | 0.1310% |
| 38 | Alamata Town | South Tigray | Tigray | 45 | 2926 | 37581 | 0.1297% |
| 39 | Ayder | Mekele Special Zone | Tigray | 22 | 258 | 17552 | 0.1269% |
| 40 | Yeka Woreda 12 | Yeka | Addis Ababa | 7 | 1393 | 7016 | 0.1226% |
| 41 | Addis Ketema Woreda 1 | Addis Ketema | Addis Ababa | 5 | 1056 | 5493 | 0.1215% |
| 42 | Yeka Woreda 4 | Yeka | Addis Ababa | 12 | 668 | 10978 | 0.1208% |
| 43 | Bole Woreda 13 | Bole | Addis Ababa | 5 | 482 | 4347 | 0.1202% |
| 44 | Muhor Na Aklil | Gurage | SNNPR | 11 | 339 | 9330 | 0.1181% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 45 | Awash Town | Gabi (Zone 3) | Afar | 16 | 2 | 13503 | 0.1174% |
| 46 | Gulo Meheda | Eastern Tigray | Tigray | 16 | 552 | 14477 | 0.1154% |
| 47 | Alge Sachi | Ilu Aba Bora | Oromia | 43 | 365 | 37547 | 0.1147% |
| 48 | Godere | Mejenger | Gambella | 37 | 1254 | 33301 | 0.1141% |
| 49 | Odo Shakiso | Guji | Oromia | 25 | 16 | 22284 | 0.1139% |
| 50 | Dengila Town | Awi | Amhara | 32 | 89 | 28108 | 0.1134% |
| 51 | Akaki Kality Woreda 2 | Akaki Kality | Addis Ababa | 6 | 577 | 5615 | 0.1129% |
| 52 | Abala | Kilbati (Zone 2) | Afar | 30 | 314 | 26990 | 0.1128% |
| 53 | Kuyu | North Shewa (Oromia) | Oromia | 33 | 573 | 29579 | 0.1127% |
| 54 | Nefas Silk-Lafto Woreda 5 | Nefas Silk-Lafto | Addis Ababa | 8 | 68 | 7074 | 0.1119% |
| 55 | East Dembia | Central Gondar | Amhara | 39 | 1257 | 36861 | 0.1099% |
| 56 | Mandura | Metekel | Benishangul-Gumuz | 12 | 575 | 11192 | 0.1093% |
| 57 | Wegidi | South Wolo | Amhara | 17 | 25 | 15359 | 0.1089% |
| 58 | Gulele Woreda 9 | Gulele | Addis Ababa | 12 | 719 | 11918 | 0.1078% |
| 59 | Mile | Awsi (Zone 1) | Afar | 37 | 488 | 34905 | 0.1068% |
| 60 | Birbirsa Kojowa | West Guji | Oromia | 11 | 145 | 10022 | 0.1066% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 61 | Dima (Gambella) | Angewak | Gambella | 14 | 1274 | 14367 | 0.1060% |
| 62 | Addis Ketema Woreda 4 | Addis Ketema | Addis Ababa | 7 | 796 | 7421 | 0.1054% |
| 63 | Kobo Town | North Wolo | Amhara | 42 | 92 | 40494 | 0.1038% |
| 64 | Dewe | Harri (Zone 5) | Afar | 26 | 138 | 26262 | 0.1008% |
| 65 | Addis Ketema Woreda 3 | Addis Ketema | Addis Ababa | 8 | 540 | 8643 | 0.0980% |
| 66 | Kemisie Town | Oromiya Zone | Amhara | 22 | 468 | 23323 | 0.0978% |
| 67 | Mekane Selam Town | South Wolo | Amhara | 1 | 106 | 734 | 0.0963% |
| 68 | Bule Hora | West Guji | Oromia | 34 | 55 | 35604 | 0.0954% |
| 69 | Chifra | Awsi (Zone 1) | Afar | 15 | 309 | 16397 | 0.0952% |
| 70 | Kombolcha Town | South Wolo | Amhara | 97 | 388 | 103684 | 0.0937% |
| 71 | Kafta Humera | Western Tigray | Tigray | 23 | 1234 | 26278 | 0.0936% |
| 72 | Kedamay Weyane | Mekele Special Zone | Tigray | 27 | 266 | 29280 | 0.0924% |
| 73 | Dehena | Wag Himra | Amhara | 24 | 979 | 27295 | 0.0923% |
| 74 | Yilma Na Densa | West Gojam | Amhara | 15 | 255 | 16896 | 0.0921% |
| 75 | Mizan Aman Town | Bench Sheko | SNNPR | 44 | 227 | 47687 | 0.0917% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 76 | Goba Town | Bale | Oromia | 22 | 10 | 23572 | 0.0917% |
| 77 | Chagni Town | Awi | Amhara | 23 | 347 | 25485 | 0.0903% |
| 78 | Dire Dawa Town | Dire Dawa Town | Dire Dawa | 228 | 7775 | 262368 | 0.0896% |
| 79 | Adet Town | West Gojam | Amhara | 21 | 359 | 23883 | 0.0886% |
| 80 | Misrak Belesa | Central Gondar | Amhara | 27 | 12 | 30412 | 0.0877% |
| 81 | Arbaminch Town | Gamo | SNNPR | 38 | 1470 | 44942 | 0.0870% |
| 82 | Quiha | Mekele Special Zone | Tigray | 5 | 319 | 6442 | 0.0856% |
| 83 | Sawla Town | Goffa | SNNPR | 41 | 2756 | 50230 | 0.0856% |
| 84 | Gezegofa | Goffa | SNNPR | 18 | 151 | 21714 | 0.0847% |
| 85 | Gemches | West Hararge | Oromia | 83 | 178 | 98850 | 0.0846% |
| 86 | Nefas Silk-Lafto Woreda 6 | Nefas Silk-Lafto | Addis Ababa | 8 | 443 | 10215 | 0.0842% |
| 87 | Harar | Harari | Harari | 114 | 4046 | 139166 | 0.0842% |
| 88 | Lideta Woreda 9 | Lideta | Addis Ababa | 10 | 746 | 13173 | 0.0842% |
| 89 | Simada | South Gondar | Amhara | 57 | 343 | 68878 | 0.0838% |
| 90 | Adami Tulu Jido Kombolcha | East Shewa | Oromia | 8 | 1557 | 11296 | 0.0834% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 91 | Semera Logia Town | Awsi (Zone 1) | Afar | 12 | 379 | 15110 | 0.0808% |
| 92 | Gulele Woreda 1 | Gulele | Addis Ababa | 15 | 309 | 19098 | 0.0808% |
| 93 | Angolala Tera | North Shewa (Amhara) | Amhara | 11 | 247 | 13589 | 0.0807% |
| 94 | Lideta Woreda 10 | Lideta | Addis Ababa | 6 | 960 | 9043 | 0.0795% |
| 95 | Kamashi | Kemashi | Benishangul-Gumuz | 13 | 3 | 16754 | 0.0793% |
| 96 | Debre Tabor Town | South Gondar | Amhara | 51 | 672 | 68012 | 0.0759% |
| 97 | Dese Town | Dese Town | Amhara | 97 | 5745 | 134026 | 0.0754% |
| 98 | Amibara | Gabi (Zone 3) | Afar | 12 | 378 | 16903 | 0.0746% |
| 99 | Assosa Town | Assosa Town | Benishangul-Gumuz | 0 | 11 | 398 | 0.0746% |
| 100 | Bahir Dar Liyu | Bahir Dar Sp. Zone | Amhara | 160 | 9062 | 228060 | 0.0728% |
| 101 | Sululta | Finfinne Special Zone | Oromia | 46 | 543 | 64346 | 0.0722% |
| 102 | Akaki Kality Woreda 6 | Akaki Kality | Addis Ababa | 7 | 695 | 10364 | 0.0708% |
| 103 | Haro Maya Town | East Hararge | Oromia | 9 | 165 | 13447 | 0.0708% |
| 104 | Gedeb | Gedeo | SNNPR | 13 | 227 | 18973 | 0.0708% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 105 | Raya Kobo | North Wolo | Amhara | 32 | 892 | 46416 | 0.0705% |
| 106 | Shakiso Town | Guji | Oromia | 16 | 47 | 22208 | 0.0705% |
| 107 | Addis Zemen Town | South Gondar | Amhara | 13 | 358 | 19714 | 0.0685% |
| 108 | Debre Birhan Town | North Shewa (Amhara) | Amhara | 54 | 409 | 80163 | 0.0673% |
| 109 | Afdera | Kilbati (Zone 2) | Afar | 13 | 9 | 19810 | 0.0671% |
| 110 | Bole Woreda 7 | Bole | Addis Ababa | 3 | 70 | 4367 | 0.0671% |
| 111 | Belo Jegenfoy | Kemashi | Benishangul-Gumuz | 6 | 4 | 9596 | 0.0670% |
| 112 | Bambasi | Assosa | Benishangul-Gumuz | 13 | 2 | 19437 | 0.0667% |
| 113 | Dire | Borena | Oromia | 3 | 65 | 3861 | 0.0666% |
| 114 | Hintalo Wajirat | South Eastern Tigray | Tigray | 45 | 1786 | 69661 | 0.0665% |
| 115 | Minjar Shenkora | North Shewa (Amhara) | Amhara | 41 | 275 | 63696 | 0.0652% |
| 116 | Yeka Woreda 3 | Yeka | Addis Ababa | 5 | 396 | 7600 | 0.0649% |
| 117 | Limu Kosa | Jimma | Oromia | 41 | 547 | 64501 | 0.0646% |
| 118 | Lay Armcho | Central Gondar | Amhara | 33 | 1592 | 52778 | 0.0638% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 119 | Arada Woreda 10 | Arada | Addis Ababa | 5 | 89 | 7368 | 0.0638% |
| 120 | Bero | West Omo | SNNPR | 12 | 50 | 18459 | 0.0637% |
| 121 | Bole Woreda 14 | Bole | Addis Ababa | 2 | 35 | 3240 | 0.0627% |
| 122 | Adigrat Town | Eastern Tigray | Tigray | 31 | 654 | 49470 | 0.0625% |
| 123 | Lay Gayint | South Gondar | Amhara | 15 | 11 | 24006 | 0.0621% |
| 124 | Aykel Town | Central Gondar | Amhara | 12 | 518 | 19587 | 0.0611% |
| 125 | Goncha Siso Enese | East Gojam | Amhara | 20 | 292 | 32918 | 0.0610% |
| 126 | Pawe | Metekel | Benishangul-Gumuz | 25 | 948 | 41917 | 0.0610% |
| 127 | Nefas Silk-Lafto Woreda 11 | Nefas Silk-Lafto | Addis Ababa | 7 | 266 | 11376 | 0.0608% |
| 128 | Addis Ketema Woreda 7 | Addis Ketema | Addis Ababa | 11 | 511 | 17911 | 0.0606% |
| 129 | Yeka Woreda 8 | Yeka | Addis Ababa | 6 | 494 | 11140 | 0.0601% |
| 130 | Tehuledere | South Wolo | Amhara | 13 | 83 | 21966 | 0.0596% |
| 131 | Mida Woremo | North Shewa (Amhara) | Amhara | 18 | 288 | 30903 | 0.0592% |
| 132 | Wegera | Central Gondar | Amhara | 28 | 414 | 48264 | 0.0591% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 133 | Kolfe Keraniyo Woreda 14 | Kolfe Keraniyo | Addis Ababa | 7 | 274 | 12565 | 0.0587% |
| 134 | Yeka Woreda 5 | Yeka | Addis Ababa | 14 | 620 | 25449 | 0.0579% |
| 135 | Janamora | North Gondar | Amhara | 21 | 622 | 36900 | 0.0576% |
| 136 | Hadinet | Mekele Special Zone | Tigray | 15 | 1114 | 27069 | 0.0574% |
| 137 | Kirkos Woreda 2 | Kirkos | Addis Ababa | 4 | 112 | 6519 | 0.0572% |
| 138 | Legambo | South Wolo | Amhara | 54 | 378 | 94210 | 0.0570% |
| 139 | Denbi Dollo Town | Kelem Welega | Oromia | 21 | 50 | 37621 | 0.0567% |
| 140 | SekotaTown | Wag Himra | Amhara | 20 | 342 | 35514 | 0.0565% |
| 141 | Ada Berga | West Shewa | Oromia | 36 | 182 | 65449 | 0.0558% |
| 142 | Yalo | Fanti (Zone 4) | Afar | 13 | 4 | 22842 | 0.0554% |
| 143 | Ahiferom | Central Tigray | Tigray | 37 | 87 | 66219 | 0.0553% |
| 144 | Abey Chomen | Horo Gudru Welega | Oromia | 17 | 208 | 31347 | 0.0545% |
| 145 | Emba Alage | South Tigray | Tigray | 14 | 504 | 26499 | 0.0537% |
| 146 | Gondar Zuria | Central Gondar | Amhara | 48 | 842 | 90777 | 0.0534% |
| 147 | Awash Fentale | Gabi (Zone 3) | Afar | 9 | 1 | 17888 | 0.0523% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 148 | Ale (Oromia) | Ilu Aba Bora | Oromia | 8 | 335 | 15666 | 0.0518% |
| 149 | Gida Ayana | East Welega | Oromia | 25 | 331 | 48794 | 0.0516% |
| 150 | Lideta Woreda 4 | Lideta | Addis Ababa | 11 | 669 | 21279 | 0.0516% |
| 151 | Chencha Town | Gamo | SNNPR | 3 | 4 | 6678 | 0.0514% |
| 152 | Gondar Town | Gondar Town | Amhara | 95 | 5158 | 190392 | 0.0511% |
| 153 | Didu | Ilu Aba Bora | Oromia | 6 | 9 | 11704 | 0.0507% |
| 154 | Dolo Mena | Bale | Oromia | 10 | 361 | 19961 | 0.0497% |
| 155 | Adwa Town | Central Tigray | Tigray | 30 | 127 | 61597 | 0.0495% |
| 156 | Lideta Woreda 5 | Lideta | Addis Ababa | 6 | 1234 | 12914 | 0.0493% |
| 157 | Shebedino | Sidama | SNNPR | 25 | 7 | 50201 | 0.0490% |
| 158 | Enebse Sar Midir | East Gojam | Amhara | 27 | 895 | 57057 | 0.0489% |
| 159 | Dawa Chefa | Oromiya Zone | Amhara | 12 | 842 | 26651 | 0.0482% |
| 160 | Chora | Buno Bedele | Oromia | 10 | 225 | 20334 | 0.0475% |
| 161 | Wondo Genet Town | Sidama | SNNPR | 17 | 10 | 35081 | 0.0473% |
| 162 | Kalu | South Wolo | Amhara | 50 | 684 | 107886 | 0.0467% |
| 163 | Kolfe Keraniyo Woreda 9 | Kolfe Keraniyo | Addis Ababa | 9 | 310 | 19630 | 0.0466% |
| 164 | Abuna Gendeberet | West Shewa | Oromia | 17 | 7 | 37535 | 0.0463% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 165 | Ankober | North Shewa (Amhara) | Amhara | 19 | 161 | 40708 | 0.0459% |
| 166 | Mojana Waderea | North Shewa (Amhara) | Amhara | 11 | 784 | 24464 | 0.0459% |
| 167 | Enjibara Town | Awi | Amhara | 25 | 483 | 53941 | 0.0459% |
| 168 | Lideta Woreda 8 | Lideta | Addis Ababa | 8 | 473 | 18548 | 0.0458% |
| 169 | Robe | Arsi | Oromia | 20 | 212 | 44968 | 0.0456% |
| 170 | Arada Woreda 3 | Arada | Addis Ababa | 3 | 294 | 6004 | 0.0454% |
| 171 | Guba | Metekel | Benishangul-Gumuz | 15 | 283 | 33693 | 0.0453% |
| 172 | Shiraro Town | North Western Tigray | Tigray | 19 | 375 | 41478 | 0.0452% |
| 173 | Lega Tafo Town | Lega Tafo Town | Oromia | 0 | 4 | 125 | 0.0451% |
| 174 | Bole Woreda 1 | Bole | Addis Ababa | 5 | 79 | 11530 | 0.0450% |
| 175 | Limu | East Welega | Oromia | 24 | 124 | 53699 | 0.0449% |
| 176 | Kofele | West Arsi | Oromia | 41 | 56 | 90817 | 0.0447% |
| 177 | Guagusa Shikudad | Awi | Amhara | 25 | 641 | 56397 | 0.0444% |
| 178 | Jima Genete | Horo Gudru Welega | Oromia | 7 | 274 | 16128 | 0.0439% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 179 | Wukro Town | Eastern Tigray | Tigray | 21 | 266 | 48563 | 0.0438% |
| 180 | Nefas Silk-Lafto Woreda 7 | Nefas Silk-Lafto | Addis Ababa | 3 | 211 | 6564 | 0.0436% |
| 181 | Bati Town | Oromiya Zone | Amhara | 23 | 884 | 54847 | 0.0435% |
| 182 | Kacha Bira | Kembata Timbaro | SNNPR | 11 | 149 | 25758 | 0.0433% |
| 183 | Tanqua Abergele | Central Tigray | Tigray | 8 | 122 | 18116 | 0.0432% |
| 184 | Kirkos Woreda 8 | Kirkos | Addis Ababa | 6 | 438 | 14609 | 0.0429% |
| 185 | Lideta Woreda 1 | Lideta | Addis Ababa | 4 | 468 | 10129 | 0.0421% |
| 186 | Berhile | Kilbati (Zone 2) | Afar | 13 | 10 | 31908 | 0.0419% |
| 187 | Saesi Tsadamba | Eastern Tigray | Tigray | 24 | 820 | 59146 | 0.0419% |
| 188 | Geladin | Dollo (Warder) | Somali | 5 | 99 | 12916 | 0.0415% |
| 189 | Awabel | East Gojam | Amhara | 34 | 336 | 82013 | 0.0414% |
| 190 | Cheliya | West Shewa | Oromia | 23 | 31 | 55401 | 0.0413% |
| 191 | Jama | South Wolo | Amhara | 19 | 13 | 46092 | 0.0412% |
| 192 | Mota Town | East Gojam | Amhara | 25 | 709 | 60834 | 0.0409% |
| 193 | Meket | North Wolo | Amhara | 27 | 81 | 66068 | 0.0407% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 194 | Arada Woreda 8 | Arada | Addis Ababa | 5 | 556 | 12634 | 0.0407% |
| 195 | Goro (Bale) | Bale | Oromia | 12 | 466 | 28995 | 0.0405% |
| 196 | Bure (Amhara) | West Gojam | Amhara | 36 | 787 | 88941 | 0.0405% |
| 197 | Sadi Chanka | Kelem Welega | Oromia | 16 | 109 | 38759 | 0.0404% |
| 198 | Mojo Town | Mojo Town | Oromia | 0 | 40 | 1129 | 0.0403% |
| 199 | Arada Woreda 1 | Arada | Addis Ababa | 5 | 997 | 14034 | 0.0401% |
| 200 | Kirkos Woreda 11 | Kirkos | Addis Ababa | 3 | 216 | 8925 | 0.0401% |
| 201 | Tenta | South Wolo | Amhara | 20 | 557 | 50472 | 0.0401% |
| 202 | Arada Woreda 5 | Arada | Addis Ababa | 4 | 503 | 11618 | 0.0400% |
| 203 | Jijiga Town | Fafen (Jijiga) | Somali | 4 | 2 | 10790 | 0.0398% |
| 204 | Filtu | Liben | Somali | 3 | 73 | 6965 | 0.0396% |
| 205 | Arada Woreda 6 | Arada | Addis Ababa | 9 | 497 | 22794 | 0.0395% |
| 206 | Homosha | Assosa | Benishangul-Gumuz | 23 | 556 | 60164 | 0.0394% |
| 207 | Dukem Town | Dukem Town | Oromia | 0 | 15 | 513 | 0.0391% |
| 208 | Debay Tilatgen | East Gojam | Amhara | 23 | 319 | 60334 | 0.0389% |
| 209 | Bugna | North Wolo | Amhara | 15 | 2148 | 41486 | 0.0387% |
| 210 | Humera Town | Western Tigray | Tigray | 28 | 1017 | 75292 | 0.0383% |
| 211 | Sululta Town | Sululta Town | Oromia | 0 | 9 | 378 | 0.0381% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 212 | Asela Town | Asela Town | Oromia | 12 | 1238 | 33112 | 0.0380% |
| 213 | Yeka Woreda 9 | Yeka | Addis Ababa | 12 | 123 | 30845 | 0.0379% |
| 214 | Melekoza | Goffa | SNNPR | 31 | 37 | 81171 | 0.0377% |
| 215 | Wuchale | North Shewa (Oromia) | Oromia | 13 | 204 | 33929 | 0.0374% |
| 216 | Raya Alamata | South Tigray | Tigray | 25 | 483 | 66897 | 0.0373% |
| 217 | Yirga Alem Town | Sidama | SNNPR | 28 | 44 | 75233 | 0.0372% |
| 218 | Arada Woreda 4 | Arada | Addis Ababa | 4 | 334 | 12143 | 0.0372% |
| 219 | Akaki Kality Woreda 5 | Akaki Kality | Addis Ababa | 4 | 308 | 11841 | 0.0371% |
| 220 | Dale | Sidama | SNNPR | 6 | 6 | 16805 | 0.0370% |
| 221 | Bako Tibe | West Shewa | Oromia | 17 | 242 | 47711 | 0.0368% |
| 222 | Warder | Dollo (Warder) | Somali | 3 | 27 | 8997 | 0.0358% |
| 223 | Enarj Enawga | East Gojam | Amhara | 31 | 320 | 86216 | 0.0358% |
| 224 | Dawo | South West Shewa | Oromia | 11 | 969 | 31819 | 0.0358% |
| 225 | Nejo Town | West Welega | Oromia | 13 | 301 | 36782 | 0.0357% |
| 226 | Woreta Town | South Gondar | Amhara | 24 | 1253 | 69168 | 0.0356% |
| 227 | Bole Woreda 6 | Bole | Addis Ababa | 6 | 251 | 18503 | 0.0353% |
| 228 | Tsagibji | Wag Himra | Amhara | 9 | 1197 | 27333 | 0.0352% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 229 | Gulele Woreda 8 | Gulele | Addis Ababa | 4 | 277 | 12397 | 0.0352% |
| 230 | Mekaneyesus Town | South Gondar | Amhara | 8 | 2254 | 25967 | 0.0349% |
| 231 | Gulele Woreda 7 | Gulele | Addis Ababa | 7 | 1556 | 21803 | 0.0346% |
| 232 | Bure Town | West Gojam | Amhara | 25 | 12 | 72961 | 0.0345% |
| 233 | Yabelo Town | Borena | Oromia | 5 | 95 | 14371 | 0.0344% |
| 234 | Bishoftu Town | Bishoftu Town | Oromia | 28 | 2915 | 83865 | 0.0344% |
| 235 | Lideta Woreda 7 | Lideta | Addis Ababa | 8 | 897 | 23536 | 0.0341% |
| 236 | Were Ilu | South Wolo | Amhara | 26 | 377 | 75286 | 0.0341% |
| 237 | Bedele Town | Buno Bedele | Oromia | 17 | 25 | 50456 | 0.0339% |
| 238 | Meda Welabu | Bale | Oromia | 12 | 419 | 34495 | 0.0338% |
| 239 | Akaki Kality Woreda 1 | Akaki Kality | Addis Ababa | 4 | 132 | 11362 | 0.0337% |
| 240 | Enemay | East Gojam | Amhara | 18 | 3261 | 58178 | 0.0336% |
| 241 | Jeldu | West Shewa | Oromia | 14 | 827 | 42381 | 0.0335% |
| 242 | Durame Town | Kembata Timbaro | SNNPR | 7 | 209 | 20635 | 0.0335% |
| 243 | Agarfa | Bale | Oromia | 17 | 490 | 54466 | 0.0323% |
| 244 | Nefas Silk-Lafto Woreda 13 | Nefas Silk-Lafto | Addis Ababa | 3 | 1759 | 10233 | 0.0320% |
| 245 | Addis Ketema Woreda 5 | Addis Ketema | Addis Ababa | 5 | 170 | 17308 | 0.0319% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 246 | Menz Keya Gebreal | North Shewa (Amhara) | Amhara | 4 | 1046 | 14306 | 0.0319% |
| 247 | Bonga Town | Kefa | SNNPR | 15 | 251 | 47010 | 0.0318% |
| 248 | Ambasel | South Wolo | Amhara | 25 | 950 | 79967 | 0.0318% |
| 249 | Basona Werana | North Shewa (Amhara) | Amhara | 14 | 2037 | 45702 | 0.0317% |
| 250 | Shashemene Town | Shashemene Town | Oromia | 28 | 1521 | 90527 | 0.0317% |
| 251 | Akaki Kality Woreda 7 | Akaki Kality | Addis Ababa | 6 | 89 | 19473 | 0.0316% |
| 252 | Bokoji Town | Arsi | Oromia | 6 | 193 | 18288 | 0.0314% |
| 253 | Ayira | West Welega | Oromia | 10 | 21 | 31583 | 0.0310% |
| 254 | Akaki Kality Woreda 4 | Akaki Kality | Addis Ababa | 1 | 86 | 4305 | 0.0309% |
| 255 | Degua Temben | South Eastern Tigray | Tigray | 25 | 977 | 81092 | 0.0308% |
| 256 | Hawzen | Eastern Tigray | Tigray | 20 | 360 | 65978 | 0.0307% |
| 257 | Wadla | North Wolo | Amhara | 16 | 2669 | 54916 | 0.0304% |
| 258 | Nekemte Town | Nekemte Town | Oromia | 15 | 1322 | 49520 | 0.0304% |
| 259 | Merab Belsa | Central Gondar | Amhara | 20 | 197 | 67515 | 0.0303% |
| 260 | Chiro Town | West Hararge | Oromia | 8 | 4 | 27760 | 0.0303% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 261 | Adama Town | Adama Town | Oromia | 63 | 5127 | 213550 | 0.0302% |
| 262 | Becho | South West Shewa | Oromia | 14 | 432 | 47330 | 0.0302% |
| 263 | Kolfe Keraniyo Woreda 3 | Kolfe Keraniyo | Addis Ababa | 3 | 775 | 10451 | 0.0302% |
| 264 | Woliso | South West Shewa | Oromia | 17 | 312 | 56641 | 0.0301% |
| 265 | Kolfe Keraniyo Woreda 13 | Kolfe Keraniyo | Addis Ababa | 8 | 287 | 28251 | 0.0300% |
| 266 | Ejere | West Shewa | Oromia | 15 | 289 | 50779 | 0.0299% |
| 267 | Takusa | Central Gondar | Amhara | 36 | 1530 | 121310 | 0.0299% |
| 268 | Bore | Guji | Oromia | 7 | 926 | 25749 | 0.0297% |
| 269 | Yeka Woreda 7 | Yeka | Addis Ababa | 9 | 352 | 29317 | 0.0297% |
| 270 | Deramalo | Gamo | SNNPR | 10 | 12 | 32733 | 0.0294% |
| 271 | Hagere Mariam Kesem | North Shewa (Amhara) | Amhara | 6 | 1570 | 21602 | 0.0293% |
| 272 | Jijiga Galbeed (Shabeley) | Fafen (Jijiga) | Somali | 13 | 452 | 46665 | 0.0292% |
| 273 | Karat Town | Konso | SNNPR | 2 | 65 | 6638 | 0.0290% |
| 274 | Semen Mecha | West Gojam | Amhara | 7 | 213 | 26091 | 0.0290% |
| 275 | Awra | Fanti (Zone 4) | Afar | 12 | 991 | 43830 | 0.0289% |
| 276 | Alem Ketema Town | North Shewa (Amhara) | Amhara | 9 | 651 | 31469 | 0.0288% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 277 | Semu robi | Harri (Zone 5) | Afar | 7 | 16 | 23834 | 0.0288% |
| 278 | Addis Ketema Woreda 9 | Addis Ketema | Addis Ababa | 5 | 700 | 18398 | 0.0288% |
| 279 | Shewa Robit Town | North Shewa (Amhara) | Amhara | 17 | 125 | 59758 | 0.0288% |
| 280 | Mereb Lehe | Central Tigray | Tigray | 17 | 103 | 57556 | 0.0287% |
| 281 | Maychew Town | South Tigray | Tigray | 25 | 2067 | 87779 | 0.0287% |
| 282 | Kilte Awlalo | Eastern Tigray | Tigray | 9 | 188 | 31028 | 0.0287% |
| 283 | Burayu Town | Burayu Town | Oromia | 19 | 1181 | 69944 | 0.0283% |
| 284 | Dera (Oromia) | North Shewa (Oromia) | Oromia | 13 | 437 | 45142 | 0.0281% |
| 285 | Finote Selam Town | West Gojam | Amhara | 35 | 752 | 126209 | 0.0280% |
| 286 | Bole Woreda 2 | Bole | Addis Ababa | 4 | 853 | 15018 | 0.0280% |
| 287 | Debub Achefer | West Gojam | Amhara | 22 | 405 | 78719 | 0.0279% |
| 288 | Kolfe Keraniyo Woreda 2 | Kolfe Keraniyo | Addis Ababa | 4 | 415 | 14452 | 0.0277% |
| 289 | Gesha Deka | Kefa | SNNPR | 6 | 128 | 20767 | 0.0277% |
| 290 | Holeta Town | Holota Town | Oromia | 5 | 447 | 20323 | 0.0277% |
| 291 | Dendi | West Shewa | Oromia | 17 | 851 | 62100 | 0.0275% |
| 292 | Axum Town | Central Tigray | Tigray | 31 | 308 | 113081 | 0.0275% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 293 | Babile (Oromia) | East Hararge | Oromia | 13 | 231 | 49126 | 0.0274% |
| 294 | Tselemti | North Western Tigray | Tigray | 20 | 62 | 73020 | 0.0274% |
| 295 | Gulele Woreda 10 | Gulele | Addis Ababa | 3 | 540 | 11551 | 0.0273% |
| 296 | Cheha | Gurage | SNNPR | 17 | 167 | 62372 | 0.0273% |
| 297 | Ginde Beret | West Shewa | Oromia | 13 | 154 | 47956 | 0.0271% |
| 298 | Boset | East Shewa | Oromia | 32 | 141 | 117901 | 0.0270% |
| 299 | Baso Liben | East Gojam | Amhara | 18 | 682 | 67038 | 0.0268% |
| 300 | Efrata Gidim | North Shewa (Amhara) | Amhara | 21 | 223 | 77502 | 0.0267% |
| 301 | Kersana Malima | South West Shewa | Oromia | 22 | 631 | 83890 | 0.0266% |
| 302 | Lideta Woreda 6 | Lideta | Addis Ababa | 4 | 222 | 15397 | 0.0266% |
| 303 | Arsi Negele | West Arsi | Oromia | 7 | 10 | 24745 | 0.0266% |
| 304 | Habro | West Hararge | Oromia | 26 | 1014 | 99638 | 0.0265% |
| 305 | Lude Hitosa | Arsi | Oromia | 30 | 208 | 114192 | 0.0265% |
| 306 | Kirkos Woreda 10 | Kirkos | Addis Ababa | 2 | 154 | 9267 | 0.0265% |
| 307 | Were Jarso | North Shewa (Oromia) | Oromia | 10 | 1484 | 37935 | 0.0264% |
| 308 | Guraferda | Bench Sheko | SNNPR | 8 | 73 | 31351 | 0.0264% |
| 309 | Adola Town | Guji | Oromia | 15 | 63 | 58307 | 0.0262% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 310 | Tulo (Oromia) | West Hararge | Oromia | 15 | 23 | 55527 | 0.0261% |
| 311 | Werebabu | South Wolo | Amhara | 23 | 1046 | 90193 | 0.0260% |
| 312 | Hitosa | Arsi | Oromia | 13 | 18 | 49509 | 0.0260% |
| 313 | Butajira Town | Gurage | SNNPR | 12 | 267 | 48043 | 0.0257% |
| 314 | Gubalafto | North Wolo | Amhara | 21 | 939 | 81281 | 0.0257% |
| 315 | Fentale | East Shewa | Oromia | 12 | 621 | 48939 | 0.0257% |
| 316 | Aga Wayu | Guji | Oromia | 9 | 315 | 34142 | 0.0255% |
| 317 | Tercha Town | Dawuro | SNNPR | 7 | 3 | 28475 | 0.0255% |
| 318 | Legahida | South Wolo | Amhara | 15 | 2052 | 62789 | 0.0252% |
| 319 | Bole Woreda 4 | Bole | Addis Ababa | 6 | 270 | 23658 | 0.0252% |
| 320 | Lasta | North Wolo | Amhara | 7 | 555 | 29605 | 0.0250% |
| 321 | Alefa | Central Gondar | Amhara | 34 | 1185 | 139508 | 0.0249% |
| 322 | Dodota | Arsi | Oromia | 12 | 119 | 49562 | 0.0248% |
| 323 | Lalibela Town | North Wolo | Amhara | 20 | 331 | 80232 | 0.0248% |
| 324 | Jawi | Awi | Amhara | 16 | 1024 | 63943 | 0.0246% |
| 325 | Jima Rare | Horo Gudru Welega | Oromia | 7 | 209 | 27869 | 0.0246% |
| 326 | Bule Hora Town | West Guji | Oromia | 16 | 15 | 66745 | 0.0246% |
| 327 | Metu Town | Ilu Aba Bora | Oromia | 9 | 69 | 35410 | 0.0244% |
| 328 | Goro Dola | Guji | Oromia | 8 | 371 | 32236 | 0.0244% |
| 329 | Woliso Town | Woliso Town | Oromia | 7 | 518 | 28588 | 0.0243% |
| 330 | Guto Gida | East Welega | Oromia | 9 | 472 | 37595 | 0.0243% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 331 | Kirkos Woreda 1 | Kirkos | Addis Ababa | 4 | 261 | 17127 | 0.0240% |
| 332 | Moyale (Somali) | Dawo | Somali | 5 | 31 | 19519 | 0.0240% |
| 333 | Sekota Zuria | Wag Himra | Amhara | 7 | 659 | 29824 | 0.0238% |
| 334 | Saba Boru | Guji | Oromia | 8 | 307 | 35835 | 0.0237% |
| 335 | Megale | Kilbati (Zone 2) | Afar | 5 | 3 | 19977 | 0.0237% |
| 336 | Lalo Asabi | West Welega | Oromia | 8 | 93 | 35596 | 0.0236% |
| 337 | Seka Chekorsa | Jimma | Oromia | 7 | 38 | 30583 | 0.0236% |
| 338 | Dera (Amhara) | South Gondar | Amhara | 28 | 333 | 118740 | 0.0235% |
| 339 | Gelan Town | Gelan Town | Oromia | 0 | 10 | 944 | 0.0234% |
| 340 | Antsokiya Gemza | North Shewa (Amhara) | Amhara | 10 | 159 | 41445 | 0.0234% |
| 341 | Kolfe Keraniyo Woreda 11 | Kolfe Keraniyo | Addis Ababa | 4 | 4106 | 23346 | 0.0233% |
| 342 | Tahtay Adyabo | North Western Tigray | Tigray | 13 | 428 | 57833 | 0.0233% |
| 343 | Bole Woreda 11 | Bole | Addis Ababa | 2 | 552 | 10401 | 0.0233% |
| 344 | Nefas Silk-Lafto Woreda 4 | Nefas Silk-Lafto | Addis Ababa | 2 | 271 | 9554 | 0.0232% |
| 345 | Batu (Ziway) Town | Batu Town | Oromia | 6 | 417 | 24602 | 0.0231% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 346 | Jimma Town | Jimma Town | Oromia | 23 | 2027 | 101306 | 0.0231% |
| 347 | Kochere | Gedeo | SNNPR | 17 | 120 | 74234 | 0.0231% |
| 348 | Jarso (West Welega) | West Welega | Oromia | 3 | 111 | 15035 | 0.0231% |
| 349 | Beyeda | North Gondar | Amhara | 15 | 1585 | 66713 | 0.0230% |
| 350 | Sebeta Town | Sebeta Town | Oromia | 3 | 183 | 13520 | 0.0228% |
| 351 | Elidar | Awsi (Zone 1) | Afar | 11 | 1 | 47828 | 0.0228% |
| 352 | Jinka Town | South Omo | SNNPR | 8 | 116 | 36129 | 0.0228% |
| 353 | Gololcha (Bale) | Bale | Oromia | 10 | 5 | 45744 | 0.0226% |
| 354 | Dangur | Metekel | Benishangul-Gumuz | 7 | 440 | 31488 | 0.0225% |
| 355 | Yeka Woreda 11 | Yeka | Addis Ababa | 4 | 1128 | 18029 | 0.0225% |
| 356 | Meta Robi | West Shewa | Oromia | 16 | 72 | 69850 | 0.0224% |
| 357 | Ferfer | Shebele (Gode) | Somali | 1 | 18 | 6662 | 0.0223% |
| 358 | Kolfe Keraniyo Woreda 7 | Kolfe Keraniyo | Addis Ababa | 3 | 5 | 14069 | 0.0221% |
| 359 | Debub Ari | South Omo | SNNPR | 29 | 19 | 132217 | 0.0221% |
| 360 | Hawilti | Mekele Special Zone | Tigray | 6 | 2550 | 31273 | 0.0219% |
| 361 | Bole Woreda 5 | Bole | Addis Ababa | 3 | 58 | 12360 | 0.0219% |
| 362 | Adama | East Shewa | Oromia | 25 | 380 | 114857 | 0.0217% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 363 | Kiltu Kara | West Welega | Oromia | 9 | 5 | 42088 | 0.0216% |
| 364 | Adaba | West Arsi | Oromia | 24 | 122 | 112585 | 0.0216% |
| 365 | Akaki Kality Woreda 11 | Akaki Kality | Addis Ababa | 3 | 621 | 14756 | 0.0215% |
| 366 | Mekdela | South Wolo | Amhara | 14 | 3965 | 67289 | 0.0215% |
| 367 | Guna Begemeder | South Gondar | Amhara | 14 | 584 | 65783 | 0.0214% |
| 368 | Gulele Woreda 3 | Gulele | Addis Ababa | 5 | 1238 | 25867 | 0.0214% |
| 369 | Ginir Town | Bale | Oromia | 12 | 6 | 56706 | 0.0213% |
| 370 | Arada Woreda 2 | Arada | Addis Ababa | 3 | 525 | 14590 | 0.0210% |
| 371 | Kolfe Keraniyo Woreda 4 | Kolfe Keraniyo | Addis Ababa | 3 | 667 | 15063 | 0.0206% |
| 372 | Hula | Sidama | SNNPR | 7 | 11 | 31878 | 0.0206% |
| 373 | Gishe | North Shewa (Amhara) | Amhara | 7 | 308 | 36369 | 0.0205% |
| 374 | Addis Ketema Woreda 2 | Addis Ketema | Addis Ababa | 2 | 548 | 11333 | 0.0205% |
| 375 | Bole Woreda 12 | Bole | Addis Ababa | 5 | 188 | 24651 | 0.0205% |
| 376 | Dugda | East Shewa | Oromia | 14 | 370 | 69420 | 0.0205% |
| 377 | NegeleTown | Guji | Oromia | 15 | 85 | 73061 | 0.0204% |
| 378 | Korem Town | South Tigray | Tigray | 10 | 643 | 52130 | 0.0204% |
| 379 | Ilu | South West Shewa | Oromia | 13 | 125 | 63182 | 0.0203% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 380 | Dibate | Metekel | Benishangul-Gumuz | 7 | 241 | 37026 | 0.0203% |
| 381 | Arada Woreda 7 | Arada | Addis Ababa | 3 | 364 | 16251 | 0.0202% |
| 382 | Yeka Woreda 1 | Yeka | Addis Ababa | 4 | 368 | 18356 | 0.0202% |
| 383 | Dila Town | Gedeo | SNNPR | 20 | 361 | 100143 | 0.0201% |
| 384 | Wantawo | Nuwer | Gambella | 5 | 831 | 25499 | 0.0201% |
| 385 | Artuma Fursi | Oromiya Zone | Amhara | 17 | 57 | 84428 | 0.0200% |
| 386 | Dedesa | Buno Bedele | Oromia | 5 | 839 | 26818 | 0.0200% |
| 387 | Kersa (Jimma) | Jimma | Oromia | 6 | 229 | 31716 | 0.0199% |
| 388 | Kolfe Keraniyo Woreda 10 | Kolfe Keraniyo | Addis Ababa | 3 | 833 | 16916 | 0.0199% |
| 389 | Tach Gayint | South Gondar | Amhara | 15 | 365 | 77697 | 0.0197% |
| 390 | Yeka Woreda 6 | Yeka | Addis Ababa | 5 | 453 | 26350 | 0.0197% |
| 391 | Dega | Buno Bedele | Oromia | 6 | 255 | 28451 | 0.0197% |
| 392 | Nifas Mewcha Town | South Gondar | Amhara | 24 | 2532 | 124455 | 0.0196% |
| 393 | Girawa | East Hararge | Oromia | 11 | 63 | 55031 | 0.0195% |
| 394 | Kirkos Woreda 3 | Kirkos | Addis Ababa | 1 | 658 | 7968 | 0.0194% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 395 | Bishan Guracha Town | Bishan Guracha Town | Oromia | 1 | 83 | 6929 | 0.0194% |
| 396 | Ofla | South Tigray | Tigray | 10 | 1132 | 50875 | 0.0194% |
| 397 | Genida Wuha Town | West Gondar | Amhara | 5 | 282 | 26127 | 0.0193% |
| 398 | Robe Town | Robe Town | Oromia | 6 | 172 | 32686 | 0.0192% |
| 399 | Arsi Negele Town | West Arsi | Oromia | 14 | 9 | 73526 | 0.0192% |
| 400 | West Dembia | Central Gondar | Amhara | 19 | 841 | 100297 | 0.0191% |
| 401 | Tocha | Dawuro | SNNPR | 4 | 47 | 23142 | 0.0190% |
| 402 | Gimbi Town | West Welega | Oromia | 16 | 351 | 83294 | 0.0188% |
| 403 | Hadele Ele | Harri (Zone 5) | Afar | 5 | 66 | 28489 | 0.0187% |
| 404 | Gazgibla | Wag Himra | Amhara | 13 | 232 | 71828 | 0.0187% |
| 405 | Dale Wabera | Kelem Welega | Oromia | 6 | 621 | 35394 | 0.0186% |
| 406 | Basketo | Basketo Sp. Woreda | SNNPR | 7 | 356 | 39724 | 0.0186% |
| 407 | Wolmera | Finfinne Special Zone | Oromia | 23 | 1201 | 123632 | 0.0185% |
| 408 | Hawassa Town | Hawassa Town | SNNPR | 43 | 6 | 233196 | 0.0184% |
| 409 | Eijersa Lafo | West Shewa | Oromia | 13 | 741 | 73521 | 0.0184% |
| 410 | Kelela | South Wolo | Amhara | 23 | 819 | 128497 | 0.0184% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 411 | Sayint | South Wolo | Amhara | 16 | 221 | 84809 | 0.0183% |
| 412 | Degehabur Town | Jerer (Degahabur) | Somali | 3 | 24 | 16946 | 0.0183% |
| 413 | Hamero | Erer | Somali | 2 | 15 | 8591 | 0.0183% |
| 414 | Mao Komo Sp. Woreda | Mao Komo Sp. Woreda | Benishangul-Gumuz | 6 | 142 | 33749 | 0.0183% |
| 415 | Jima Arjo | East Welega | Oromia | 8 | 68 | 41994 | 0.0182% |
| 416 | Gasera | Bale | Oromia | 13 | 149 | 70042 | 0.0182% |
| 417 | Welkite Town | Gurage | SNNPR | 13 | 757 | 71742 | 0.0181% |
| 418 | Aleta Wondo Town | Sidama | SNNPR | 14 | 3 | 75233 | 0.0181% |
| 419 | Dara | Sidama | SNNPR | 10 | 7 | 56210 | 0.0181% |
| 420 | Maji | West Omo | SNNPR | 3 | 22 | 19025 | 0.0179% |
| 421 | Meta | East Hararge | Oromia | 17 | 56 | 96972 | 0.0179% |
| 422 | Wonchi | South West Shewa | Oromia | 8 | 733 | 43095 | 0.0179% |
| 423 | Ameya | South West Shewa | Oromia | 10 | 809 | 57745 | 0.0178% |
| 424 | Ankasha Guagusa | Awi | Amhara | 15 | 939 | 84177 | 0.0177% |
| 425 | Mersa Town | North Wolo | Amhara | 20 | 722 | 111755 | 0.0177% |
| 426 | Girja | Guji | Oromia | 10 | 3 | 57530 | 0.0176% |
| 427 | Asayita | Awsi (Zone 1) | Afar | 10 | 1172 | 56246 | 0.0176% |
| 428 | Ambo Town | Ambo Town | Oromia | 7 | 340 | 37366 | 0.0176% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 429 | Wenbera | Metekel | Benishangul-Gumuz | 6 | 191 | 36524 | 0.0175% |
| 430 | Gololcha (Arsi) | Arsi | Oromia | 13 | 143 | 74783 | 0.0174% |
| 431 | Kebridehar Town | Korahe (Keberidehar) | Somali | 2 | 1 | 9551 | 0.0174% |
| 432 | Sedan (Sirba Abay) | Kemashi | Benishangul-Gumuz | 4 | 121 | 22188 | 0.0174% |
| 433 | Nefas Silk-Lafto Woreda 2 | Nefas Silk-Lafto | Addis Ababa | 5 | 181 | 30990 | 0.0172% |
| 434 | Hababo Gudru | Horo Gudru Welega | Oromia | 4 | 359 | 23908 | 0.0172% |
| 435 | Kirkos Woreda 6 | Kirkos | Addis Ababa | 3 | 314 | 17217 | 0.0172% |
| 436 | Tegede | Central Gondar | Amhara | 19 | 2135 | 113414 | 0.0170% |
| 437 | Boloso Sore | Wolayita | SNNPR | 12 | 497 | 70870 | 0.0170% |
| 438 | Kimbibit | North Shewa (Oromia) | Oromia | 9 | 324 | 51930 | 0.0169% |
| 439 | Yeka Woreda 2 | Yeka | Addis Ababa | 4 | 1207 | 25487 | 0.0168% |
| 440 | Mubarek | Dawo | Somali | 1 | 11 | 6902 | 0.0168% |
| 441 | Anfilo | Kelem Welega | Oromia | 10 | 149 | 60355 | 0.0168% |
| 442 | Merti | Arsi | Oromia | 10 | 327 | 57796 | 0.0167% |
| 443 | Hadigala | Siti (Shinile) | Somali | 2 | 2 | 10944 | 0.0167% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 444 | Atsbi Wonberta | Eastern Tigray | Tigray | 14 | 862 | 82865 | 0.0165% |
| 445 | Gimbo | Kefa | SNNPR | 10 | 35 | 58780 | 0.0164% |
| 446 | Wonberima | West Gojam | Amhara | 21 | 160 | 129205 | 0.0164% |
| 447 | Sheko | Bench Sheko | SNNPR | 6 | 34 | 38810 | 0.0163% |
| 448 | Gulele Woreda 2 | Gulele | Addis Ababa | 4 | 437 | 23112 | 0.0160% |
| 449 | Fagita Lekoma | Awi | Amhara | 12 | 77 | 73308 | 0.0159% |
| 450 | Dara Otilcho | Sidama | SNNPR | 6 | 72 | 35081 | 0.0159% |
| 451 | Jile Timuga | Oromiya Zone | Amhara | 9 | 206 | 56260 | 0.0159% |
| 452 | Nefas Silk-Lafto Woreda 9 | Nefas Silk-Lafto | Addis Ababa | 5 | 769 | 29305 | 0.0158% |
| 453 | Merab Armacho | West Gondar | Amhara | 10 | 1989 | 66168 | 0.0158% |
| 454 | Sekela | West Gojam | Amhara | 13 | 909 | 84468 | 0.0156% |
| 455 | Kulito Town | Alaba Sp. Woreda | SNNPR | 6 | 36 | 40191 | 0.0155% |
| 456 | Nefas Silk-Lafto Woreda 12 | Nefas Silk-Lafto | Addis Ababa | 3 | 342 | 22827 | 0.0155% |
| 457 | Akaki Kality Woreda 10 | Akaki Kality | Addis Ababa | 1 | 128 | 8272 | 0.0155% |
| 458 | Dale Sadi | Kelem Welega | Oromia | 6 | 135 | 35922 | 0.0155% |
| 459 | Toke Kutayu | West Shewa | Oromia | 9 | 1784 | 59649 | 0.0153% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 460 | Laelay Adyabo | North Western Tigray | Tigray | 8 | 1532 | 55367 | 0.0153% |
| 461 | Mendi Town | West Welega | Oromia | 8 | 37 | 49927 | 0.0152% |
| 462 | Shishoende | Kefa | SNNPR | 7 | 178 | 45565 | 0.0152% |
| 463 | Dolobay | Afder | Somali | 2 | 64 | 16067 | 0.0151% |
| 464 | Arero | Borena | Oromia | 3 | 913 | 17977 | 0.0151% |
| 465 | Endamehoni | South Tigray | Tigray | 11 | 1140 | 73720 | 0.0151% |
| 466 | Bure (Oromia) | Ilu Aba Bora | Oromia | 3 | 138 | 21804 | 0.0150% |
| 467 | Gewane | Gabi (Zone 3) | Afar | 3 | 126 | 21051 | 0.0149% |
| 468 | Mulo | Finfinne Special Zone | Oromia | 11 | 2377 | 73062 | 0.0149% |
| 469 | Moretna Jiru | North Shewa (Amhara) | Amhara | 11 | 337 | 75303 | 0.0148% |
| 470 | Hidabu Abote | North Shewa (Oromia) | Oromia | 5 | 367 | 37381 | 0.0147% |
| 471 | Kirkos Woreda 5 | Kirkos | Addis Ababa | 2 | 396 | 13978 | 0.0147% |
| 472 | Hargele | Afder | Somali | 3 | 43 | 23188 | 0.0145% |
| 473 | Adi Arkay | North Gondar | Amhara | 15 | 608 | 103346 | 0.0145% |
| 474 | Were Lehe | Central Tigray | Tigray | 8 | 621 | 57639 | 0.0144% |
| 475 | Dengila | Awi | Amhara | 12 | 213 | 84920 | 0.0141% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 476 | Akaki Kality Woreda 3 | Akaki Kality | Addis Ababa | 1 | 212 | 6454 | 0.0141% |
| 477 | Dhass | Borena | Oromia | 1 | 0 | 3861 | 0.0141% |
| 478 | Male | South Omo | SNNPR | 1 | 1101 | 11447 | 0.0141% |
| 479 | Shebel Berenta | East Gojam | Amhara | 16 | 309 | 117053 | 0.0140% |
| 480 | Menz Mama Midir | North Shewa (Amhara) | Amhara | 8 | 1 | 57918 | 0.0140% |
| 481 | Kolfe Keraniyo Woreda 5 | Kolfe Keraniyo | Addis Ababa | 3 | 296 | 24346 | 0.0139% |
| 482 | Tula | Hawassa Town | SNNPR | 0 | 0 | 855 | 0.0139% |
| 483 | Digluna Tijo | Arsi | Oromia | 7 | 694 | 50785 | 0.0139% |
| 484 | Danot | Dollo (Warder) | Somali | 1 | 27 | 8997 | 0.0139% |
| 485 | Berbere | Bale | Oromia | 9 | 10 | 64533 | 0.0138% |
| 486 | Anderacha | Sheka | SNNPR | 1 | 60 | 9834 | 0.0138% |
| 487 | Burji | Burji Sp. Zone | SNNPR | 5 | 164 | 33451 | 0.0137% |
| 488 | Goncha Kolola | West Gojam | Amhara | 10 | 301 | 73074 | 0.0137% |
| 489 | Debub Bench | Bench Sheko | SNNPR | 5 | 297 | 34753 | 0.0136% |
| 490 | Bahir Dar Zuria | West Gojam | Amhara | 4 | 472 | 33118 | 0.0136% |
| 491 | Shambu Town | Horo Gudru Welega | Oromia | 5 | 3 | 34741 | 0.0136% |
| 492 | Tulo (SNNPR) | Kefa | SNNPR | 4 | 208 | 26166 | 0.0135% |
| 493 | Abergele | Wag Himra | Amhara | 2 | 18 | 14970 | 0.0135% |
| 494 | Gedeb Asasa | West Arsi | Oromia | 7 | 245 | 51415 | 0.0135% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 495 | Metu Zuria | Ilu Aba Bora | Oromia | 4 | 1803 | 29687 | 0.0134% |
| 496 | Gerese | Gamo | SNNPR | 4 | 12 | 33538 | 0.0134% |
| 497 | Fogera | South Gondar | Amhara | 11 | 1228 | 80704 | 0.0134% |
| 498 | Saya Debirna Wayu | North Shewa (Amhara) | Amhara | 8 | 688 | 57669 | 0.0133% |
| 499 | Bichena Town | East Gojam | Amhara | 13 | 942 | 101874 | 0.0133% |
| 500 | Debark Town | North Gondar | Amhara | 15 | 625 | 111196 | 0.0132% |
| 501 | Mehal Meda Town | North Shewa (Amhara) | Amhara | 7 | 412 | 55638 | 0.0131% |
| 502 | Bora | East Shewa | Oromia | 8 | 362 | 58246 | 0.0131% |
| 503 | Guna Gado | Jerer (Degahabur) | Somali | 3 | 94 | 22961 | 0.0130% |
| 504 | Guliso | West Welega | Oromia | 3 | 326 | 26941 | 0.0130% |
| 505 | Sankura | Silti | SNNPR | 2 | 10 | 13709 | 0.0130% |
| 506 | Boji Dirmej | West Welega | Oromia | 6 | 118 | 46971 | 0.0129% |
| 507 | Agaro Town | Jimma | Oromia | 13 | 35 | 97120 | 0.0129% |
| 508 | Jeju | Arsi | Oromia | 4 | 438 | 32030 | 0.0129% |
| 509 | Telalak | Harri (Zone 5) | Afar | 3 | 107 | 25454 | 0.0129% |
| 510 | Tsegede | Western Tigray | Tigray | 12 | 516 | 92927 | 0.0129% |
| 511 | Merab Azernet | Silti | SNNPR | 8 | 126 | 59874 | 0.0129% |
| 512 | Gera | Jimma | Oromia | 5 | 709 | 42942 | 0.0128% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 513 | Tach Armacho | Central Gondar | Amhara | 9 | 906 | 73606 | 0.0128% |
| 514 | Gununo Hamus Town | Wolayita | SNNPR | 1 | 3 | 8757 | 0.0128% |
| 515 | Bole Woreda 10 | Bole | Addis Ababa | 1 | 434 | 7033 | 0.0128% |
| 516 | Wenago | Gedeo | SNNPR | 9 | 89 | 70921 | 0.0128% |
| 517 | Delanta | South Wolo | Amhara | 5 | 960 | 43353 | 0.0127% |
| 518 | Ataye Town | North Shewa (Amhara) | Amhara | 7 | 32 | 51191 | 0.0127% |
| 519 | Ambo Zuria | West Shewa | Oromia | 6 | 855 | 47484 | 0.0126% |
| 520 | Adaa | East Shewa | Oromia | 7 | 275 | 58894 | 0.0126% |
| 521 | Gechi | Buno Bedele | Oromia | 5 | 469 | 36852 | 0.0126% |
| 522 | Seharti Samre | South Eastern Tigray | Tigray | 9 | 472 | 73434 | 0.0125% |
| 523 | Kirkos Woreda 9 | Kirkos | Addis Ababa | 3 | 334 | 25049 | 0.0125% |
| 524 | Gulele Woreda 5 | Gulele | Addis Ababa | 3 | 119 | 21965 | 0.0124% |
| 525 | Tole | South West Shewa | Oromia | 5 | 66 | 44337 | 0.0124% |
| 526 | Decha | Kefa | SNNPR | 5 | 351 | 37046 | 0.0123% |
| 527 | Mieso (Oromia) | West Hararge | Oromia | 5 | 47 | 38031 | 0.0121% |
| 528 | Gazo | North Wolo | Amhara | 12 | 693 | 101859 | 0.0121% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 529 | Asegede Tsimbila | North Western Tigray | Tigray | 11 | 755 | 88400 | 0.0120% |
| 530 | Assosa | Assosa | Benishangul-Gumuz | 2 | 37 | 17201 | 0.0120% |
| 531 | Bita | Kefa | SNNPR | 5 | 4 | 40781 | 0.0120% |
| 532 | Ayehu Guagusa | Awi | Amhara | 8 | 496 | 70661 | 0.0120% |
| 533 | Gulele Woreda 6 | Gulele | Addis Ababa | 1 | 373 | 11801 | 0.0120% |
| 534 | Enderta | South Eastern Tigray | Tigray | 12 | 362 | 100454 | 0.0119% |
| 535 | Mari mansa | Dawuro | SNNPR | 3 | 115 | 26067 | 0.0119% |
| 536 | Fiche Town | North Shewa (Oromia) | Oromia | 15 | 142 | 124759 | 0.0119% |
| 537 | Semen Achefer | West Gojam | Amhara | 11 | 1270 | 95766 | 0.0119% |
| 538 | Begi | West Welega | Oromia | 8 | 124 | 65660 | 0.0119% |
| 539 | Damot Woyide | Wolayita | SNNPR | 3 | 266 | 25168 | 0.0118% |
| 540 | Menge | Assosa | Benishangul-Gumuz | 2 | 49 | 13124 | 0.0118% |
| 541 | Enemor Ener | Gurage | SNNPR | 7 | 408 | 56485 | 0.0118% |
| 542 | Welkayit | Western Tigray | Tigray | 8 | 356 | 70136 | 0.0118% |
| 543 | Amaro | Amaro Sp. Zone | SNNPR | 12 | 450 | 102809 | 0.0117% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 544 | Birqod | Jerer (Degahabur) | Somali | 1 | 98 | 9529 | 0.0117% |
| 545 | Abe Dongoro | Horo Gudru Welega | Oromia | 5 | 122 | 45952 | 0.0116% |
| 546 | Akaki Kality Woreda 8 | Akaki Kality | Addis Ababa | 2 | 384 | 18508 | 0.0115% |
| 547 | Bati | Oromiya Zone | Amhara | 5 | 637 | 48166 | 0.0115% |
| 548 | Kutaber | South Wolo | Amhara | 9 | 777 | 83190 | 0.0115% |
| 549 | Fik | Erer | Somali | 3 | 85 | 22434 | 0.0115% |
| 550 | Medebay Zana | North Western Tigray | Tigray | 9 | 811 | 81169 | 0.0115% |
| 551 | Meta Walkite | West Shewa | Oromia | 5 | 634 | 43798 | 0.0115% |
| 552 | Babile Town (Oromia) | East Hararge | Oromia | 2 | 5 | 14651 | 0.0114% |
| 553 | Quarit | West Gojam | Amhara | 11 | 1155 | 94140 | 0.0114% |
| 554 | Chomen Guduru | Horo Gudru Welega | Oromia | 5 | 242 | 40761 | 0.0114% |
| 555 | Gomma | Jimma | Oromia | 16 | 15 | 143206 | 0.0113% |
| 556 | Kiremu | East Welega | Oromia | 7 | 1308 | 66214 | 0.0113% |
| 557 | Goro Gutu | East Hararge | Oromia | 18 | 49 | 157554 | 0.0113% |
| 558 | Konta | Konta Sp. Woreda | SNNPR | 7 | 323 | 65737 | 0.0112% |
| 559 | Chena | Kefa | SNNPR | 6 | 541 | 53878 | 0.0111% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 560 | Amuru | Horo Gudru Welega | Oromia | 4 | 237 | 37269 | 0.0110% |
| 561 | Nole Kaba | West Welega | Oromia | 6 | 213 | 54763 | 0.0109% |
| 562 | Sasiga | East Welega | Oromia | 4 | 35 | 35696 | 0.0108% |
| 563 | Kersa (East Hararge) | East Hararge | Oromia | 10 | 312 | 95479 | 0.0108% |
| 564 | Sinan | East Gojam | Amhara | 9 | 538 | 81765 | 0.0108% |
| 565 | Adadle | Shebele (Gode) | Somali | 1 | 44 | 9097 | 0.0108% |
| 566 | Goro Bekeksa | Liben | Somali | 1 | 9 | 9412 | 0.0108% |
| 567 | Genji | West Welega | Oromia | 2 | 279 | 20390 | 0.0107% |
| 568 | Diga | East Welega | Oromia | 6 | 384 | 59365 | 0.0107% |
| 569 | Boditi Town | Wolayita | SNNPR | 6 | 169 | 59900 | 0.0107% |
| 570 | Aseko | Arsi | Oromia | 6 | 4 | 58286 | 0.0107% |
| 571 | Dereashe | Dereashe Sp. Zone | SNNPR | 4 | 177 | 39717 | 0.0107% |
| 572 | Marawi Town | West Gojam | Amhara | 11 | 402 | 104730 | 0.0107% |
| 573 | Sibu Sire | East Welega | Oromia | 7 | 400 | 64798 | 0.0106% |
| 574 | Bulen | Metekel | Benishangul-Gumuz | 5 | 266 | 47611 | 0.0106% |
| 575 | East Meskan | Gurage | SNNPR | 4 | 11 | 33369 | 0.0106% |
| 576 | Dese Zuria | South Wolo | Amhara | 9 | 628 | 87541 | 0.0106% |
| 577 | Abichu Gnaa | North Shewa (Oromia) | Oromia | 7 | 571 | 68011 | 0.0106% |
| 578 | Hayik Town | South Wolo | Amhara | 10 | 534 | 98971 | 0.0106% |
| 579 | Ziquala | Wag Himra | Amhara | 5 | 99 | 44776 | 0.0106% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 580 | Kirkos Woreda 4 | Kirkos | Addis Ababa | 1 | 377 | 10192 | 0.0105% |
| 581 | Dekisis | Arsi | Oromia | 4 | 312 | 40272 | 0.0105% |
| 582 | Abi Adi Town | Central Tigray | Tigray | 5 | 293 | 50194 | 0.0104% |
| 583 | Hadero Town | Kembata Timbaro | SNNPR | 4 | 140 | 35352 | 0.0103% |
| 584 | Boh | Dollo (Warder) | Somali | 6 | 172 | 54595 | 0.0103% |
| 585 | Ganta Afeshum | Eastern Tigray | Tigray | 7 | 995 | 64812 | 0.0102% |
| 586 | Liben (East Shewa) | East Shewa | Oromia | 13 | 397 | 124374 | 0.0102% |
| 587 | Sedie | East Gojam | Amhara | 9 | 1180 | 86169 | 0.0102% |
| 588 | Ale (SNNPR) | Ale (SNNPR) Sp. Zone | SNNPR | 6 | 233 | 60322 | 0.0102% |
| 589 | Merab Este | South Gondar | Amhara | 12 | 1065 | 120002 | 0.0101% |
| 590 | Albuko | South Wolo | Amhara | 9 | 427 | 92545 | 0.0100% |
| 591 | Goba | Bale | Oromia | 3 | 5 | 27366 | 0.0100% |
| 592 | Sire | Arsi | Oromia | 5 | 237 | 55599 | 0.0099% |
| 593 | Sedi Muja | South Gondar | Amhara | 8 | 657 | 77239 | 0.0099% |
| 594 | Adi Haki | Mekele Special Zone | Tigray | 5 | 756 | 52700 | 0.0098% |
| 595 | Boricha | Sidama | SNNPR | 4 | 14 | 43106 | 0.0097% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 596 | Degem | North Shewa (Oromia) | Oromia | 6 | 6 | 58250 | 0.0097% |
| 597 | Misrak Este | South Gondar | Amhara | 8 | 1056 | 81633 | 0.0096% |
| 598 | Deder Town | East Hararge | Oromia | 7 | 446 | 76931 | 0.0096% |
| 599 | Lanfuro | Silti | SNNPR | 4 | 25 | 42034 | 0.0096% |
| 600 | Malga | Sidama | SNNPR | 5 | 426 | 55588 | 0.0095% |
| 601 | Kercha Town | West Guji | Oromia | 6 | 127 | 63028 | 0.0095% |
| 602 | Gimbi | West Welega | Oromia | 3 | 559 | 33252 | 0.0094% |
| 603 | Kolfe Keraniyo Woreda 12 | Kolfe Keraniyo | Addis Ababa | 3 | 75 | 31949 | 0.0094% |
| 604 | Quara | West Gondar | Amhara | 5 | 206 | 56163 | 0.0094% |
| 605 | Adagn Ager Chako | West Gondar | Amhara | 4 | 544 | 41338 | 0.0094% |
| 606 | Shebe Senbo | Jimma | Oromia | 9 | 273 | 101578 | 0.0092% |
| 607 | Yayu | Ilu Aba Bora | Oromia | 5 | 52 | 53003 | 0.0092% |
| 608 | Endegagn | Gurage | SNNPR | 1 | 157 | 10018 | 0.0091% |
| 609 | Banja Shekudad | Awi | Amhara | 5 | 1015 | 57737 | 0.0091% |
| 610 | Areka Town | Wolayita | SNNPR | 4 | 13 | 44913 | 0.0090% |
| 611 | Debre Elias | East Gojam | Amhara | 8 | 763 | 93766 | 0.0089% |
| 612 | Gibe (Konteb) | Hadiya | SNNPR | 1 | 8 | 12941 | 0.0089% |
| 613 | Dugida Dawa | West Guji | Oromia | 4 | 169 | 46274 | 0.0089% |
| 614 | Legehida (Somali) | Erer | Somali | 0 | 7 | 5248 | 0.0089% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 615 | Akaki | Finfinne Special Zone | Oromia | 3 | 440 | 33026 | 0.0088% |
| 616 | Tibaro | Kembata Timbaro | SNNPR | 5 | 64 | 61852 | 0.0088% |
| 617 | Ofa | Wolayita | SNNPR | 1 | 3 | 7759 | 0.0087% |
| 618 | Chinaksan | East Hararge | Oromia | 4 | 24 | 51003 | 0.0087% |
| 619 | Dejen Town | East Gojam | Amhara | 8 | 206 | 87884 | 0.0087% |
| 620 | Wachile | Borena | Oromia | 2 | 93 | 20557 | 0.0087% |
| 621 | Kore | West Arsi | Oromia | 6 | 526 | 64864 | 0.0086% |
| 622 | Erob | Eastern Tigray | Tigray | 5 | 1242 | 54984 | 0.0086% |
| 623 | Limuna Bilbilo | Arsi | Oromia | 9 | 260 | 106888 | 0.0086% |
| 624 | Segeg | Nogob | Somali | 0 | 3 | 4174 | 0.0086% |
| 625 | Machakel | East Gojam | Amhara | 8 | 169 | 94395 | 0.0086% |
| 626 | Gozamin | East Gojam | Amhara | 8 | 165 | 98455 | 0.0085% |
| 627 | Lideta Woreda 2 | Lideta | Addis Ababa | 2 | 867 | 23456 | 0.0085% |
| 628 | Gimbichu | East Shewa | Oromia | 6 | 692 | 67644 | 0.0084% |
| 629 | Hurumu | Ilu Aba Bora | Oromia | 2 | 28 | 19635 | 0.0084% |
| 630 | Akaki Kality Woreda 9 | Akaki Kality | Addis Ababa | 1 | 434 | 10589 | 0.0084% |
| 631 | Gidami | Kelem Welega | Oromia | 4 | 47 | 44911 | 0.0084% |
| 632 | Weeraa | Alaba Sp. Woreda | SNNPR | 4 | 4 | 45382 | 0.0083% |
| 633 | Dihun | Nogob | Somali | 0 | 3 | 4174 | 0.0083% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 634 | Nono | West Shewa | Oromia | 3 | 4 | 33360 | 0.0083% |
| 635 | Aleltu | North Shewa (Oromia) | Oromia | 8 | 673 | 99112 | 0.0082% |
| 636 | Shirka | Arsi | Oromia | 4 | 89 | 48752 | 0.0082% |
| 637 | Fedis | East Hararge | Oromia | 5 | 2 | 61068 | 0.0082% |
| 638 | Hawa Gelan | Kelem Welega | Oromia | 4 | 847 | 55362 | 0.0081% |
| 639 | Lome | East Shewa | Oromia | 8 | 607 | 97166 | 0.0080% |
| 640 | Degahmedo | Jerer (Degahabur) | Somali | 1 | 24 | 9529 | 0.0080% |
| 641 | Melku Soda | West Guji | Oromia | 5 | 184 | 68475 | 0.0080% |
| 642 | Haro Limu | East Welega | Oromia | 2 | 145 | 31628 | 0.0079% |
| 643 | Siraro | West Arsi | Oromia | 7 | 257 | 92524 | 0.0079% |
| 644 | Wayu Tuka | East Welega | Oromia | 3 | 32 | 35389 | 0.0078% |
| 645 | Loko Abeya | Sidama | SNNPR | 5 | 153 | 63276 | 0.0078% |
| 646 | Dejen | East Gojam | Amhara | 5 | 516 | 70114 | 0.0077% |
| 647 | Ezha | Gurage | SNNPR | 4 | 793 | 57062 | 0.0077% |
| 648 | Dewe Harewa | Oromiya Zone | Amhara | 2 | 335 | 20068 | 0.0077% |
| 649 | Kola Temben | Central Tigray | Tigray | 3 | 1378 | 45532 | 0.0077% |
| 650 | Kondala | West Welega | Oromia | 3 | 77 | 34262 | 0.0076% |
| 651 | Oda Buldigilu | Assosa | Benishangul-Gumuz | 2 | 56 | 31339 | 0.0076% |
| 652 | Mareka | Dawuro | SNNPR | 3 | 81 | 43564 | 0.0076% |
| 653 | Sora | Guji | Oromia | 2 | 29 | 24900 | 0.0075% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 654 | Gudru | Horo Gudru Welega | Oromia | 3 | 350 | 45837 | 0.0075% |
| 655 | Qubi | Erer | Somali | 1 | 15 | 11838 | 0.0075% |
| 656 | Sendafa Town | Finfinne Special Zone | Oromia | 9 | 148 | 115615 | 0.0074% |
| 657 | Dembecha | West Gojam | Amhara | 7 | 1288 | 97412 | 0.0074% |
| 658 | Darimu | Ilu Aba Bora | Oromia | 1 | 48 | 16929 | 0.0073% |
| 659 | Nefas Silk-Lafto Woreda 10 | Nefas Silk-Lafto | Addis Ababa | 2 | 520 | 25668 | 0.0073% |
| 660 | Gulele Woreda 4 | Gulele | Addis Ababa | 1 | 140 | 16085 | 0.0073% |
| 661 | Arbaminch Zuriya | Gamo | SNNPR | 4 | 127 | 51757 | 0.0073% |
| 662 | Nefas Silk-Lafto Woreda 1 | Nefas Silk-Lafto | Addis Ababa | 3 | 807 | 39335 | 0.0073% |
| 663 | Mareko | Gurage | SNNPR | 4 | 70 | 60995 | 0.0072% |
| 664 | Bona Zuria | Sidama | SNNPR | 10 | 7 | 139740 | 0.0072% |
| 665 | Midakegn | West Shewa | Oromia | 4 | 203 | 51836 | 0.0072% |
| 666 | Yirgachefe Town | Gedeo | SNNPR | 6 | 683 | 79956 | 0.0072% |
| 667 | Kechi | Dawuro | SNNPR | 3 | 4 | 47216 | 0.0071% |
| 668 | Tena | Arsi | Oromia | 4 | 418 | 63786 | 0.0070% |
| 669 | Munesa | Arsi | Oromia | 8 | 151 | 110121 | 0.0069% |
| 670 | Deder | East Hararge | Oromia | 5 | 591 | 74902 | 0.0069% |
| 671 | Lehel-Yucub | Dollo (Warder) | Somali | 1 | 38 | 12783 | 0.0069% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 672 | Loma | Dawuro | SNNPR | 2 | 46 | 26491 | 0.0068% |
| 673 | Dasenech | South Omo | SNNPR | 1 | 18 | 19088 | 0.0068% |
| 674 | Ziway Dugda | Arsi | Oromia | 6 | 443 | 82335 | 0.0068% |
| 675 | Elkere | Afder | Somali | 2 | 89 | 24674 | 0.0067% |
| 676 | Ayida | Goffa | SNNPR | 2 | 34 | 33412 | 0.0067% |
| 677 | Addis Ketema Woreda 6 | Addis Ketema | Addis Ababa | 2 | 222 | 26290 | 0.0066% |
| 678 | Gerbo | Nogob | Somali | 1 | 3 | 9922 | 0.0066% |
| 679 | Merhabete | North Shewa (Amhara) | Amhara | 4 | 594 | 63999 | 0.0066% |
| 680 | Buee Town | Gurage | SNNPR | 3 | 56 | 38531 | 0.0066% |
| 681 | Jerdga Jerte | Horo Gudru Welega | Oromia | 2 | 82 | 36218 | 0.0065% |
| 682 | Danan | Shebele (Gode) | Somali | 0 | 18 | 7663 | 0.0065% |
| 683 | Beranod | Shebele (Gode) | Somali | 1 | 34 | 22845 | 0.0065% |
| 684 | Doyo Gena | Kembata Timbaro | SNNPR | 4 | 428 | 59406 | 0.0065% |
| 685 | Bena Tsemay | South Omo | SNNPR | 2 | 89 | 36129 | 0.0065% |
| 686 | Sude | Arsi | Oromia | 4 | 189 | 54204 | 0.0065% |
| 687 | Addis Ketema Woreda 8 | Addis Ketema | Addis Ababa | 2 | 36 | 26187 | 0.0065% |
| 688 | Meyu Muluka | Erer | Somali | 0 | 11 | 5248 | 0.0065% |
| 689 | Borecha | Buno Bedele | Oromia | 4 | 179 | 57377 | 0.0064% |
| 690 | Lata Sibu | West Welega | Oromia | 3 | 217 | 51800 | 0.0064% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 691 | Zigem | Awi | Amhara | 2 | 609 | 30038 | 0.0063% |
| 692 | Nefas Silk-Lafto Woreda 8 | Nefas Silk-Lafto | Addis Ababa | 1 | 662 | 11568 | 0.0063% |
| 693 | Tahtay Maychew | Central Tigray | Tigray | 6 | 220 | 93378 | 0.0063% |
| 694 | Sinana | Bale | Oromia | 4 | 111 | 59262 | 0.0062% |
| 695 | Omonada | Jimma | Oromia | 7 | 18 | 113752 | 0.0062% |
| 696 | Dega Damot | West Gojam | Amhara | 8 | 271 | 134896 | 0.0062% |
| 697 | Gelana | West Guji | Oromia | 5 | 4 | 76226 | 0.0061% |
| 698 | Dodola Town | West Arsi | Oromia | 6 | 206 | 96051 | 0.0061% |
| 699 | Midga Tola | East Hararge | Oromia | 0 | 118 | 7971 | 0.0061% |
| 700 | Libokemkem | South Gondar | Amhara | 8 | 468 | 133312 | 0.0061% |
| 701 | Bedesa Town | West Hararge | Oromia | 2 | 17 | 34565 | 0.0061% |
| 702 | Alicho Werero | Silti | SNNPR | 4 | 159 | 62999 | 0.0061% |
| 703 | Jibat | West Shewa | Oromia | 4 | 682 | 67083 | 0.0061% |
| 704 | Chole | Arsi | Oromia | 6 | 22 | 95728 | 0.0060% |
| 705 | Merab Abaya | Gamo | SNNPR | 3 | 62 | 55192 | 0.0059% |
| 706 | Yeka Woreda 10 | Yeka | Addis Ababa | 1 | 833 | 18268 | 0.0059% |
| 707 | Yeka Woreda 13 | Yeka | Addis Ababa | 1 | 99 | 22034 | 0.0058% |
| 708 | Deberelibanos | North Shewa (Oromia) | Oromia | 3 | 153 | 54594 | 0.0058% |
| 709 | Mana | Jimma | Oromia | 5 | 226 | 90871 | 0.0057% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 710 | Werabe Town | Silti | SNNPR | 3 | 167 | 53004 | 0.0057% |
| 711 | Hulet Ej Enese | East Gojam | Amhara | 4 | 1296 | 78575 | 0.0057% |
| 712 | Afdem | Siti (Shinile) | Somali | 3 | 2 | 55265 | 0.0057% |
| 713 | Adwa | Central Tigray | Tigray | 2 | 1146 | 41921 | 0.0057% |
| 714 | Masha Town | Sheka | SNNPR | 2 | 2 | 35973 | 0.0056% |
| 715 | Bare | Afder | Somali | 3 | 31 | 48535 | 0.0055% |
| 716 | Gobu Seyo | East Welega | Oromia | 2 | 130 | 27363 | 0.0055% |
| 717 | Hamer | South Omo | SNNPR | 3 | 24 | 55702 | 0.0055% |
| 718 | Haro Walebu | Guji | Oromia | 1 | 270 | 23554 | 0.0055% |
| 719 | Shilabo | Korahe (Keberidehar) | Somali | 1 | 2 | 9551 | 0.0054% |
| 720 | Bele Gasegar | Arsi | Oromia | 6 | 195 | 112907 | 0.0054% |
| 721 | Gursum (Oromia) | East Hararge | Oromia | 5 | 86 | 92443 | 0.0053% |
| 722 | Farta | South Gondar | Amhara | 4 | 529 | 73587 | 0.0052% |
| 723 | Horo Bulluq | Horo Gudru Welega | Oromia | 2 | 176 | 30700 | 0.0052% |
| 724 | Sokoru | Jimma | Oromia | 5 | 42 | 100708 | 0.0052% |
| 725 | Bibugn | East Gojam | Amhara | 4 | 332 | 83026 | 0.0052% |
| 726 | Ensaro | North Shewa (Amhara) | Amhara | 3 | 367 | 64362 | 0.0052% |
| 727 | Qohol | Afder | Somali | 1 | 3 | 22486 | 0.0051% |
| 728 | Kokir Gedabano | Gurage | SNNPR | 3 | 54 | 53421 | 0.0051% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 729 | Yaya Gulele | North Shewa (Oromia) | Oromia | 4 | 396 | 89234 | 0.0051% |
| 730 | Elfata | West Shewa | Oromia | 4 | 656 | 83545 | 0.0050% |
| 731 | Dembecha Town | West Gojam | Amhara | 6 | 765 | 120655 | 0.0049% |
| 732 | Jida | North Shewa (Oromia) | Oromia | 3 | 247 | 68948 | 0.0049% |
| 733 | Mesekan | Gurage | SNNPR | 5 | 218 | 112159 | 0.0049% |
| 734 | Yem | Yem Sp. Woreda | SNNPR | 3 | 102 | 58975 | 0.0049% |
| 735 | Wondo Genet | Sidama | SNNPR | 3 | 58 | 53896 | 0.0049% |
| 736 | Bilate Zuria | Sidama | SNNPR | 2 | 6 | 40620 | 0.0049% |
| 737 | Bule | Gedeo | SNNPR | 3 | 529 | 62328 | 0.0049% |
| 738 | Doba | West Hararge | Oromia | 5 | 563 | 108731 | 0.0048% |
| 739 | Karat Zuria | Konso | SNNPR | 2 | 78 | 47623 | 0.0048% |
| 740 | Central Armacho | Central Gondar | Amhara | 4 | 1451 | 94340 | 0.0048% |
| 741 | Debark | North Gondar | Amhara | 4 | 177 | 89186 | 0.0048% |
| 742 | Hambela Wamena | West Guji | Oromia | 2 | 1049 | 38766 | 0.0047% |
| 743 | Gewata | Kefa | SNNPR | 3 | 2 | 61521 | 0.0047% |
| 744 | Dubuluk | Borena | Oromia | 2 | 181 | 40398 | 0.0047% |
| 745 | Abeshge | Gurage | SNNPR | 2 | 8 | 45994 | 0.0047% |
| 746 | Sodo Zuria | Wolayita | SNNPR | 4 | 28 | 80415 | 0.0046% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 747 | Isara | Dawuro | SNNPR | 2 | 86 | 38344 | 0.0046% |
| 748 | Yirgachefe | Gedeo | SNNPR | 4 | 155 | 85179 | 0.0046% |
| 749 | Dillo | Borena | Oromia | 1 | 69 | 14265 | 0.0046% |
| 750 | Tiro Afeta | Jimma | Oromia | 2 | 79 | 39726 | 0.0046% |
| 751 | Jajura Town | Hadiya | SNNPR | 0 | 31 | 9608 | 0.0046% |
| 752 | Daroor | Jerer (Degahabur) | Somali | 0 | 43 | 9529 | 0.0045% |
| 753 | Yoale | Jerer (Degahabur) | Somali | 1 | 39 | 27506 | 0.0045% |
| 754 | Gashamo | Jerer (Degahabur) | Somali | 3 | 35 | 55675 | 0.0045% |
| 755 | Aware | Jerer (Degahabur) | Somali | 1 | 12 | 30547 | 0.0045% |
| 756 | Ararso | Jerer (Degahabur) | Somali | 1 | 5 | 16714 | 0.0045% |
| 757 | Goro Muti | East Hararge | Oromia | 7 | 170 | 158034 | 0.0044% |
| 758 | Wama Hagelo | East Welega | Oromia | 2 | 202 | 54056 | 0.0044% |
| 759 | God God | Afder | Somali | 1 | 71 | 28170 | 0.0044% |
| 760 | Laelay Maychew | Central Tigray | Tigray | 3 | 196 | 63338 | 0.0043% |
| 761 | Seyo | Kelem Welega | Oromia | 3 | 177 | 78838 | 0.0043% |
| 762 | Arada Woreda 9 | Arada | Addis Ababa | 1 | 591 | 18864 | 0.0043% |
| 763 | West Emey | Afder | Somali | 1 | 37 | 32957 | 0.0043% |
| 764 | Yabelo | Borena | Oromia | 0 | 20 | 10220 | 0.0043% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 765 | Nader Adet | Central Tigray | Tigray | 3 | 1169 | 77544 | 0.0042% |
| 766 | Guma | Jimma | Oromia | 3 | 8 | 79565 | 0.0042% |
| 767 | Gursum (Somali) | Fafen (Jijiga) | Somali | 1 | 0 | 28477 | 0.0041% |
| 768 | Dila Zuria | Gedeo | SNNPR | 2 | 800 | 54724 | 0.0041% |
| 769 | Lalo Kile | Kelem Welega | Oromia | 3 | 221 | 67147 | 0.0041% |
| 770 | Seden Sodo | South West Shewa | Oromia | 2 | 1265 | 55173 | 0.0040% |
| 771 | Gawo Kebe | Kelem Welega | Oromia | 1 | 258 | 32181 | 0.0040% |
| 772 | Selehad | Erer | Somali | 0 | 7 | 11338 | 0.0039% |
| 773 | Dali Fage | Harri (Zone 5) | Afar | 1 | 529 | 21008 | 0.0039% |
| 774 | Meinit Goldeya | West Omo | SNNPR | 1 | 4 | 14527 | 0.0039% |
| 775 | Goro (South West Shewa) | South West Shewa | Oromia | 1 | 578 | 30171 | 0.0039% |
| 776 | Guangua | Awi | Amhara | 2 | 1315 | 57632 | 0.0038% |
| 777 | Daratole | Dollo (Warder) | Somali | 1 | 164 | 32998 | 0.0038% |
| 778 | Gode | Shebele (Gode) | Somali | 1 | 16 | 31561 | 0.0038% |
| 779 | Mako | Buno Bedele | Oromia | 2 | 90 | 48942 | 0.0038% |
| 780 | Semen Bench | Bench Sheko | SNNPR | 1 | 5 | 25752 | 0.0037% |
| 781 | Meinit Shasha | West Omo | SNNPR | 1 | 465 | 35064 | 0.0036% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 782 | Horushagah | Nogob | Somali | 0 | 13 | 4174 | 0.0036% |
| 783 | Elwey | Nogob | Somali | 0 | 7 | 4174 | 0.0036% |
| 784 | Ayisha | Siti (Shinile) | Somali | 2 | 7 | 48747 | 0.0036% |
| 785 | Tikur Enchini | West Shewa | Oromia | 3 | 435 | 87746 | 0.0036% |
| 786 | Kolfe Keraniyo Woreda 6 | Kolfe Keraniyo | Addis Ababa | 1 | 129 | 22857 | 0.0036% |
| 787 | Gomole | Borena | Oromia | 1 | 16 | 17977 | 0.0036% |
| 788 | Leku Town | Sidama | SNNPR | 1 | 6 | 39311 | 0.0036% |
| 789 | Kemba Town | Gamo | SNNPR | 2 | 3 | 45351 | 0.0035% |
| 790 | Uraga | Guji | Oromia | 2 | 3 | 66409 | 0.0035% |
| 791 | Kolfe Keraniyo Woreda 8 | Kolfe Keraniyo | Addis Ababa | 1 | 278 | 40211 | 0.0035% |
| 792 | Deniboya | Kembata Timbaro | SNNPR | 1 | 36 | 27110 | 0.0035% |
| 793 | Awubere | Fafen (Jijiga) | Somali | 3 | 0 | 90562 | 0.0034% |
| 794 | Bole Woreda 8 | Bole | Addis Ababa | 1 | 371 | 22083 | 0.0034% |
| 795 | Dolo Odo | Liben | Somali | 1 | 1 | 40006 | 0.0034% |
| 796 | Adola | Guji | Oromia | 2 | 544 | 50876 | 0.0034% |
| 797 | Dawnt | North Wolo | Amhara | 2 | 1220 | 61740 | 0.0033% |
| 798 | Chere | Sidama | SNNPR | 2 | 51 | 55909 | 0.0033% |
| 799 | Soro | Hadiya | SNNPR | 1 | 39 | 42618 | 0.0033% |
| 800 | Moyale (Oromia) | Borena | Oromia | 0 | 24 | 14315 | 0.0033% |
| 801 | Dalocha | Silti | SNNPR | 1 | 118 | 32502 | 0.0033% |
| 802 | Gudeya Bila | East Welega | Oromia | 1 | 33 | 41384 | 0.0031% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 803 | Borena | South Wolo | Amhara | 2 | 2192 | 67050 | 0.0031% |
| 804 | Addis Ketema Woreda 10 | Addis Ketema | Addis Ababa | 0 | 174 | 11855 | 0.0031% |
| 805 | Bokol Mayo | Liben | Somali | 1 | 10 | 30238 | 0.0030% |
| 806 | Amigna | Arsi | Oromia | 3 | 139 | 86997 | 0.0030% |
| 807 | Kombolcha | East Hararge | Oromia | 1 | 147 | 40196 | 0.0029% |
| 808 | Gumer | Gurage | SNNPR | 1 | 27 | 39131 | 0.0029% |
| 809 | Tebela Town | Wolayita | SNNPR | 1 | 124 | 31032 | 0.0029% |
| 810 | Debewoin | Korahe (Keberidehar) | Somali | 1 | 10 | 22902 | 0.0028% |
| 811 | Anchar | West Hararge | Oromia | 2 | 82 | 79397 | 0.0028% |
| 812 | Aleta Chuko Town | Sidama | SNNPR | 1 | 7 | 35151 | 0.0028% |
| 813 | Daro Lebu | West Hararge | Oromia | 4 | 15 | 131633 | 0.0028% |
| 814 | Gesuba Town | Wolayita | SNNPR | 1 | 47 | 34511 | 0.0028% |
| 815 | Kindo Koyisha | Wolayita | SNNPR | 3 | 3 | 108755 | 0.0027% |
| 816 | Dalol | Kilbati (Zone 2) | Afar | 0 | 6 | 16057 | 0.0027% |
| 817 | Shashemene Zuria | West Arsi | Oromia | 3 | 1514 | 122387 | 0.0027% |
| 818 | Kinfaze Begela | Central Gondar | Amhara | 1 | 11 | 44746 | 0.0027% |
| 819 | Shewa Bench | Bench Sheko | SNNPR | 2 | 169 | 76757 | 0.0026% |
| 820 | Dodola | West Arsi | Oromia | 2 | 270 | 91107 | 0.0026% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 821 | Gola Oda | East Hararge | Oromia | 3 | 575 | 102917 | 0.0025% |
| 822 | Shala | West Arsi | Oromia | 1 | 219 | 20781 | 0.0025% |
| 823 | Misrak Azernet | Silti | SNNPR | 3 | 320 | 112871 | 0.0025% |
| 824 | Nono Sele | Ilu Aba Bora | Oromia | 1 | 64 | 45600 | 0.0025% |
| 825 | Bole Woreda 9 | Bole | Addis Ababa | 1 | 602 | 25613 | 0.0025% |
| 826 | Elwayne | Shebele (Gode) | Somali | 0 | 523 | 18548 | 0.0024% |
| 827 | Mehal Saynt | South Wolo | Amhara | 3 | 1029 | 109617 | 0.0024% |
| 828 | Mustahil | Shebele (Gode) | Somali | 1 | 7 | 24705 | 0.0024% |
| 829 | Shashago | Hadiya | SNNPR | 1 | 46 | 57614 | 0.0024% |
| 830 | Jarso (East Hararge) | East Hararge | Oromia | 1 | 16 | 31115 | 0.0023% |
| 831 | Shinshicho Town | Kembata Timbaro | SNNPR | 1 | 36 | 64865 | 0.0023% |
| 832 | Melka Belo | East Hararge | Oromia | 4 | 39 | 154898 | 0.0023% |
| 833 | Metehara Town | East Shewa | Oromia | 3 | 1215 | 127685 | 0.0023% |
| 834 | Hadero Tunito | Kembata Timbaro | SNNPR | 2 | 22 | 73684 | 0.0023% |
| 835 | Ginir | Bale | Oromia | 0 | 467 | 20995 | 0.0022% |
| 836 | Jimma Horo | Kelem Welega | Oromia | 1 | 10 | 51977 | 0.0022% |
| 837 | Doreni | Ilu Aba Bora | Oromia | 1 | 13 | 30193 | 0.0022% |
| 838 | Menz Gera Midir | North Shewa (Amhara) | Amhara | 1 | 281 | 38833 | 0.0022% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 839 | Semen Ari | South Omo | SNNPR | 1 | 49 | 29688 | 0.0022% |
| 840 | Adiyo | Kefa | SNNPR | 1 | 164 | 44737 | 0.0021% |
| 841 | Goro Damole | Liben | Somali | 0 | 25 | 18191 | 0.0021% |
| 842 | Shone Town | Hadiya | SNNPR | 2 | 24 | 86671 | 0.0021% |
| 843 | Dano | West Shewa | Oromia | 1 | 1119 | 71365 | 0.0021% |
| 844 | Berehet | North Shewa (Amhara) | Amhara | 1 | 526 | 69465 | 0.0021% |
| 845 | Lemo | Hadiya | SNNPR | 1 | 9 | 60606 | 0.0021% |
| 846 | Asagirt | North Shewa (Amhara) | Amhara | 1 | 706 | 64947 | 0.0021% |
| 847 | Kersadulle | Liben | Somali | 0 | 37 | 15578 | 0.0021% |
| 848 | Kelafo | Shebele (Gode) | Somali | 1 | 35 | 45171 | 0.0021% |
| 849 | Weeraa Dijjoo | Alaba Sp. Woreda | SNNPR | 1 | 150 | 45382 | 0.0020% |
| 850 | Haromaya | East Hararge | Oromia | 1 | 162 | 76624 | 0.0019% |
| 851 | Kebri Beyah Town | Fafen (Jijiga) | Somali | 0 | 6 | 8965 | 0.0019% |
| 852 | Bodaley | Korahe (Keberidehar) | Somali | 0 | 10 | 9551 | 0.0019% |
| 853 | Goglo-Kudunbur | Korahe (Keberidehar) | Somali | 0 | 4 | 9551 | 0.0019% |
| 854 | Marsin | Korahe (Keberidehar) | Somali | 0 | 2 | 26435 | 0.0019% |
| 855 | Emdibir Town | Gurage | SNNPR | 1 | 271 | 48244 | 0.0018% |
| 856 | Bursa | Sidama | SNNPR | 2 | 205 | 91485 | 0.0018% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 857 | Bilelbour | Jerer (Degahabur) | Somali | 0 | 14 | 24437 | 0.0018% |
| 858 | Tahtay Koraro | North Western Tigray | Tigray | 2 | 543 | 87302 | 0.0018% |
| 859 | Segen Town | Konso | SNNPR | 1 | 10 | 47623 | 0.0018% |
| 860 | Aleta Wondo | Sidama | SNNPR | 2 | 769 | 133587 | 0.0017% |
| 861 | Adilo Zuria | Kembata Timbaro | SNNPR | 1 | 264 | 33841 | 0.0017% |
| 862 | Kebri Beyah | Fafen (Jijiga) | Somali | 0 | 40 | 8965 | 0.0017% |
| 863 | Ameka | Hadiya | SNNPR | 1 | 41 | 76424 | 0.0017% |
| 864 | Angacha | Kembata Timbaro | SNNPR | 1 | 3 | 55727 | 0.0017% |
| 865 | Kurfa Chele | East Hararge | Oromia | 2 | 48 | 114866 | 0.0017% |
| 866 | Kadadumo (Le_e) | Dawo | Somali | 0 | 143 | 22195 | 0.0016% |
| 867 | Yubdo | West Welega | Oromia | 1 | 466 | 41368 | 0.0016% |
| 868 | Nejo | West Welega | Oromia | 0 | 10 | 17434 | 0.0016% |
| 869 | Kori | Awsi (Zone 1) | Afar | 1 | 1 | 53699 | 0.0016% |
| 870 | Aleta Chuko | Sidama | SNNPR | 1 | 874 | 36484 | 0.0016% |
| 871 | Harrey | Nogob | Somali | 0 | 7 | 9599 | 0.0016% |
| 872 | Tselemet | North Gondar | Amhara | 1 | 42 | 64834 | 0.0016% |
| 873 | Huka (Halu) | Ilu Aba Bora | Oromia | 2 | 158 | 96543 | 0.0016% |
| 874 | Teletele | Borena | Oromia | 1 | 17 | 33748 | 0.0016% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 875 | Wondo | West Arsi | Oromia | 1 | 88 | 66540 | 0.0016% |
| 876 | Kemba Zuria | Gamo | SNNPR | 0 | 18 | 7277 | 0.0015% |
| 877 | Gelhamer | Dollo (Warder) | Somali | 1 | 39 | 57349 | 0.0015% |
| 878 | Misha | Hadiya | SNNPR | 1 | 5 | 57688 | 0.0015% |
| 879 | Bole Woreda 15 | Bole | Addis Ababa | 0 | 469 | 25300 | 0.0015% |
| 880 | Gura Damole | Bale | Oromia | 1 | 874 | 66699 | 0.0015% |
| 881 | Daya Town | Sidama | SNNPR | 0 | 82 | 6604 | 0.0015% |
| 882 | Leka Dulecha | East Welega | Oromia | 1 | 79 | 45535 | 0.0015% |
| 883 | Erer | Siti (Shinile) | Somali | 1 | 48 | 37753 | 0.0015% |
| 884 | Abaya | West Guji | Oromia | 1 | 326 | 56124 | 0.0014% |
| 885 | Angot | North Wolo | Amhara | 2 | 1907 | 125948 | 0.0014% |
| 886 | Babo Gambel | West Welega | Oromia | 1 | 272 | 74985 | 0.0014% |
| 887 | Gumbi Bordode | West Hararge | Oromia | 0 | 203 | 31997 | 0.0014% |
| 888 | Duna | Hadiya | SNNPR | 1 | 7 | 81190 | 0.0014% |
| 889 | Geta | Gurage | SNNPR | 0 | 9 | 31938 | 0.0014% |
| 890 | Bilo Nopha | Ilu Aba Bora | Oromia | 0 | 206 | 24002 | 0.0013% |
| 891 | Goreche | Sidama | SNNPR | 0 | 317 | 16459 | 0.0013% |
| 892 | Disa | Dawuro | SNNPR | 0 | 189 | 12753 | 0.0013% |
| 893 | Dabo Hana | Buno Bedele | Oromia | 0 | 272 | 14289 | 0.0013% |
| 894 | Setema | Jimma | Oromia | 1 | 1802 | 77734 | 0.0013% |
| 895 | Chora Botor | Jimma | Oromia | 1 | 314 | 92829 | 0.0013% |
| 896 | Bedeno | East Hararge | Oromia | 1 | 243 | 118335 | 0.0013% |
| 897 | Dima (Oromia) | Guji | Oromia | 0 | 284 | 34863 | 0.0013% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 898 | Awasa Zuria | Sidama | SNNPR | 0 | 131 | 37152 | 0.0012% |
| 899 | Wadera | Guji | Oromia | 1 | 68 | 63528 | 0.0012% |
| 900 | Bidu | Kilbati (Zone 2) | Afar | 0 | 312 | 11773 | 0.0012% |
| 901 | Mesela | West Hararge | Oromia | 1 | 87 | 98952 | 0.0012% |
| 902 | Kokosa | West Arsi | Oromia | 2 | 905 | 124006 | 0.0012% |
| 903 | Sayilem | Kefa | SNNPR | 1 | 39 | 87277 | 0.0012% |
| 904 | Nyanigatom | South Omo | SNNPR | 1 | 55 | 41277 | 0.0012% |
| 905 | Seyo Nole | West Welega | Oromia | 0 | 13 | 33296 | 0.0012% |
| 906 | Damot Gale | Wolayita | SNNPR | 1 | 123 | 103059 | 0.0012% |
| 907 | Ibantu | East Welega | Oromia | 1 | 7 | 51711 | 0.0012% |
| 908 | Menesibu | West Welega | Oromia | 1 | 9 | 49919 | 0.0012% |
| 909 | Udet | Dawo | Somali | 1 | 35 | 89650 | 0.0011% |
| 910 | Limu Seka | Jimma | Oromia | 1 | 51 | 71541 | 0.0011% |
| 911 | Tiyo | Arsi | Oromia | 1 | 6 | 59998 | 0.0011% |
| 912 | Denibu Gofa | Goffa | SNNPR | 1 | 35 | 48701 | 0.0011% |
| 913 | Sigamo | Jimma | Oromia | 1 | 308 | 77723 | 0.0011% |
| 914 | Seru | Arsi | Oromia | 1 | 1028 | 49816 | 0.0011% |
| 915 | Qunoba | Kilbati (Zone 2) | Afar | 0 | 706 | 35971 | 0.0011% |
| 916 | Zala | Goffa | SNNPR | 1 | 2076 | 49457 | 0.0011% |
| 917 | Sheikosh | Korahe (Keberidehar) | Somali | 0 | 4 | 9551 | 0.0011% |
| 918 | Haru | West Welega | Oromia | 0 | 23 | 33956 | 0.0011% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 919 | Imiberi (Misrak Imi) | Shebele (Gode) | Somali | 1 | 54 | 47406 | 0.0011% |
| 920 | Gachit | West Omo | SNNPR | 0 | 135 | 10463 | 0.0011% |
| 921 | Selamago | South Omo | SNNPR | 0 | 310 | 45677 | 0.0011% |
| 922 | Sehala | Wag Himra | Amhara | 0 | 454 | 35514 | 0.0011% |
| 923 | Dedo | Jimma | Oromia | 1 | 40 | 90161 | 0.0010% |
| 924 | Illu Gelan | West Shewa | Oromia | 1 | 767 | 64709 | 0.0010% |
| 925 | Uba Debre Tsehay | Goffa | SNNPR | 1 | 1240 | 52909 | 0.0010% |
| 926 | Sodo Dacha | South West Shewa | Oromia | 1 | 52 | 96632 | 0.0009% |
| 927 | Meyu Muleke | East Hararge | Oromia | 0 | 341 | 31864 | 0.0009% |
| 928 | Arbegona | Sidama | SNNPR | 0 | 194 | 32846 | 0.0009% |
| 929 | Bensa | Sidama | SNNPR | 0 | 9 | 50219 | 0.0009% |
| 930 | Yeki | Sheka | SNNPR | 0 | 1465 | 21836 | 0.0009% |
| 931 | Dawa Serer | Bale | Oromia | 0 | 13 | 18490 | 0.0009% |
| 932 | Teru | Fanti (Zone 4) | Afar | 0 | 212 | 30388 | 0.0009% |
| 933 | Hobicha | Wolayita | SNNPR | 0 | 52 | 25168 | 0.0009% |
| 934 | Agalo Meti | Kemashi | Benishangul-Gumuz | 0 | 203 | 16760 | 0.0009% |
| 935 | Gimbichau Town | Hadiya | SNNPR | 1 | 23 | 77475 | 0.0009% |
| 936 | Mieso (Somali) | Siti (Shinile) | Somali | 0 | 46 | 10944 | 0.0008% |
| 937 | Ayun | Nogob | Somali | 0 | 3 | 18239 | 0.0008% |
| 938 | Selamber Town | Gamo | SNNPR | 0 | 4 | 57064 | 0.0008% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 939 | Abakerow | Shebele (Gode) | Somali | 0 | 7 | 22732 | 0.0008% |
| 940 | Boloso Bonibe | Wolayita | SNNPR | 0 | 4 | 40456 | 0.0008% |
| 941 | Yemalogi Welel | Kelem Welega | Oromia | 0 | 402 | 31934 | 0.0008% |
| 942 | Garda Martha | Gamo | SNNPR | 0 | 3 | 14522 | 0.0008% |
| 943 | Nunu Kumba | East Welega | Oromia | 1 | 1258 | 84755 | 0.0008% |
| 944 | Chewaka | Buno Bedele | Oromia | 1 | 9 | 68304 | 0.0007% |
| 945 | Lasdarkeyre | Korahe (Keberidehar) | Somali | 0 | 4 | 23801 | 0.0007% |
| 946 | Gablalu | Siti (Shinile) | Somali | 0 | 3 | 35884 | 0.0007% |
| 947 | Zaba | Dawuro | SNNPR | 0 | 4 | 19959 | 0.0007% |
| 948 | Silti | Silti | SNNPR | 1 | 44 | 84406 | 0.0007% |
| 949 | Kercha | West Guji | Oromia | 0 | 25 | 68475 | 0.0007% |
| 950 | Guba Koricha | West Hararge | Oromia | 1 | 142 | 86975 | 0.0007% |
| 951 | Guna | Arsi | Oromia | 1 | 23 | 96051 | 0.0007% |
| 952 | Daela | Sidama | SNNPR | 0 | 164 | 32243 | 0.0007% |
| 953 | Harshin | Fafen (Jijiga) | Somali | 0 | 105 | 25756 | 0.0007% |
| 954 | Bedele Zuria | Buno Bedele | Oromia | 0 | 16 | 47909 | 0.0007% |
| 955 | Darara | Sidama | SNNPR | 0 | 14 | 47755 | 0.0007% |
| 956 | Oda Bultum (Kuni) | West Hararge | Oromia | 0 | 326 | 54758 | 0.0007% |
| 957 | Ellele | Shebele (Gode) | Somali | 0 | 54 | 28573 | 0.0007% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 958 | Burka Dimtu | West Hararge | Oromia | 0 | 3236 | 18670 | 0.0006% |
| 959 | Higloley | Korahe (Keberidehar) | Somali | 0 | 13 | 28078 | 0.0006% |
| 960 | Damot Sore | Wolayita | SNNPR | 0 | 8 | 25168 | 0.0006% |
| 961 | Boji Chekorsa | West Welega | Oromia | 0 | 124 | 41990 | 0.0006% |
| 962 | Misrak Badawacho | Hadiya | SNNPR | 0 | 1528 | 42618 | 0.0006% |
| 963 | Bura | Sidama | SNNPR | 0 | 14 | 72260 | 0.0006% |
| 964 | Hawella | Sidama | SNNPR | 0 | 174 | 31380 | 0.0006% |
| 965 | Dig | Jerer (Degahabur) | Somali | 0 | 79 | 24437 | 0.0006% |
| 966 | Analimo | Hadiya | SNNPR | 1 | 16 | 105878 | 0.0006% |
| 967 | Boreda | Gamo | SNNPR | 0 | 4 | 53524 | 0.0006% |
| 968 | Ewa | Fanti (Zone 4) | Afar | 0 | 3 | 30507 | 0.0006% |
| 969 | Yaso | Kemashi | Benishangul-Gumuz | 0 | 420 | 14154 | 0.0006% |
| 970 | Wensho | Sidama | SNNPR | 0 | 314 | 58028 | 0.0006% |
| 971 | Chereti | Afder | Somali | 0 | 33 | 53864 | 0.0006% |
| 972 | Degasuftu | Liben | Somali | 0 | 27 | 5786 | 0.0006% |
| 973 | Degehabur | Jerer (Degahabur) | Somali | 0 | 14 | 66088 | 0.0006% |
| 974 | Legehida (Oromia) | Bale | Oromia | 0 | 6 | 42797 | 0.0006% |
| 975 | Kena | Konso | SNNPR | 0 | 28 | 51704 | 0.0005% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 976 | Boke | West Hararge | Oromia | 0 | 4 | 71557 | 0.0005% |
| 977 | Hoko | Sidama | SNNPR | 0 | 518 | 38650 | 0.0005% |
| 978 | Yahob | Erer | Somali | 0 | 52 | 39934 | 0.0005% |
| 979 | Jikawo | Nuwer | Gambella | 0 | 378 | 16053 | 0.0005% |
| 980 | Chabe Gambeltu | Sidama | SNNPR | 0 | 6 | 40501 | 0.0005% |
| 981 | Erebti | Kilbati (Zone 2) | Afar | 0 | 111 | 47395 | 0.0005% |
| 982 | Bicho | Ilu Aba Bora | Oromia | 0 | 250 | 40514 | 0.0005% |
| 983 | Kolfe Keraniyo Woreda 15 | Kolfe Keraniyo | Addis Ababa | 0 | 360 | 11119 | 0.0005% |
| 984 | Botor Tolay | Jimma | Oromia | 0 | 144 | 27542 | 0.0005% |
| 985 | Gomibora | Hadiya | SNNPR | 0 | 50 | 43590 | 0.0005% |
| 986 | Gota Bike | Siti (Shinile) | Somali | 0 | 82 | 58628 | 0.0005% |
| 987 | Kebridehar | Korahe (Keberidehar) | Somali | 0 | 4 | 22410 | 0.0004% |
| 988 | Dawe Kachen | Bale | Oromia | 0 | 394 | 27473 | 0.0004% |
| 989 | Wilbareg | Silti | SNNPR | 0 | 74 | 57225 | 0.0004% |
| 990 | Harena Buluk | Bale | Oromia | 0 | 40 | 73798 | 0.0004% |
| 991 | Deguna Fanigo | Wolayita | SNNPR | 0 | 18 | 105514 | 0.0004% |
| 992 | Aweday Town | East Hararge | Oromia | 0 | 356 | 18437 | 0.0004% |
| 993 | Sodo | Gurage | SNNPR | 0 | 132 | 44247 | 0.0004% |
| 994 | Mirab Soro | Hadiya | SNNPR | 0 | 45 | 50224 | 0.0004% |
| 995 | Nensebo | West Arsi | Oromia | 0 | 39 | 69114 | 0.0004% |
| 996 | Genabosa | Dawuro | SNNPR | 0 | 88 | 33299 | 0.0004% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 997 | Debub Mecha | West Gojam | Amhara | 0 | 382 | 79521 | 0.0004% |
| 998 | Gelealo | Gabi (Zone 3) | Afar | 0 | 641 | 12321 | 0.0004% |
| 999 | Girar Jarso | North Shewa (Oromia) | Oromia | 0 | 256 | 35985 | 0.0004% |
| 1000 | Mencho | Jimma | Oromia | 0 | 237 | 114855 | 0.0004% |
| 1001 | Argoba Liyu | South Wolo | Amhara | 0 | 636 | 88041 | 0.0004% |
| 1002 | South Sodo | Gurage | SNNPR | 0 | 655 | 41515 | 0.0004% |
| 1003 | Bereh | Finfinne Special Zone | Oromia | 0 | 14 | 77619 | 0.0003% |
| 1004 | Raso | Afder | Somali | 0 | 8 | 38011 | 0.0003% |
| 1005 | Shanan Kolu | Arsi | Oromia | 0 | 136 | 51230 | 0.0003% |
| 1006 | Homa | West Welega | Oromia | 0 | 15 | 41529 | 0.0003% |
| 1007 | Babile (Somali) | Fafen (Jijiga) | Somali | 1 | 6 | 188517 | 0.0003% |
| 1008 | Chiro Zuria | West Hararge | Oromia | 0 | 14 | 119393 | 0.0003% |
| 1009 | Wangay | Erer | Somali | 0 | 29 | 65206 | 0.0003% |
| 1010 | Merab Badwacho | Hadiya | SNNPR | 0 | 49 | 62408 | 0.0003% |
| 1011 | Siraro Badewacho | Hadiya | SNNPR | 0 | 7 | 46721 | 0.0003% |
| 1012 | Tercha Zuria | Dawuro | SNNPR | 0 | 4 | 32726 | 0.0003% |
| 1013 | Seweyna | Bale | Oromia | 0 | 515 | 83448 | 0.0003% |
| 1014 | Liben (Guji) | Guji | Oromia | 0 | 571 | 25381 | 0.0003% |
| 1015 | Damot Pulasa | Wolayita | SNNPR | 0 | 154 | 63829 | 0.0003% |
| 1016 | Kutcha Zuria | Gamo | SNNPR | 0 | 4 | 106352 | 0.0003% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 1017 | Chirone | Sidama | SNNPR | 0 | 62 | 78318 | 0.0003% |
| 1018 | Dita | Gamo | SNNPR | 0 | 174 | 45351 | 0.0003% |
| 1019 | Aroresa | Sidama | SNNPR | 0 | 18 | 81042 | 0.0003% |
| 1020 | Nebaru Chilga | Central Gondar | Amhara | 0 | 1739 | 92120 | 0.0003% |
| 1021 | Afambo | Awsi (Zone 1) | Afar | 0 | 814 | 13369 | 0.0003% |
| 1022 | Chobi | West Shewa | Oromia | 0 | 197 | 49832 | 0.0003% |
| 1023 | Kindo Didaye | Wolayita | SNNPR | 0 | 37 | 30450 | 0.0003% |
| 1024 | Kebena | Gurage | SNNPR | 0 | 1045 | 46610 | 0.0003% |
| 1025 | Jor | Angewak | Gambella | 0 | 523 | 7303 | 0.0003% |
| 1026 | Chilga | Central Gondar | Amhara | 0 | 54 | 102065 | 0.0003% |
| 1027 | Goba (SNNPR) | Kefa | SNNPR | 0 | 106 | 44748 | 0.0003% |
| 1028 | Gacho Baba | Gamo | SNNPR | 0 | 146 | 48049 | 0.0003% |
| 1029 | Dinsho | Bale | Oromia | 0 | 706 | 63153 | 0.0002% |
| 1030 | Denbel | Siti (Shinile) | Somali | 0 | 14 | 46034 | 0.0002% |
| 1031 | Omo Beyem | Jimma | Oromia | 0 | 6 | 148867 | 0.0002% |
| 1032 | Gumi Eldello | Guji | Oromia | 0 | 558 | 30641 | 0.0002% |
| 1033 | Cheta | Kefa | SNNPR | 0 | 215 | 29424 | 0.0002% |
| 1034 | Shafamo | Sidama | SNNPR | 0 | 31 | 105003 | 0.0002% |
| 1035 | Bonke | Gamo | SNNPR | 0 | 374 | 51757 | 0.0002% |
| 1036 | Surma | West Omo | SNNPR | 0 | 3 | 30942 | 0.0002% |
| 1037 | Atotii Ulo | Alaba Sp. Woreda | SNNPR | 0 | 247 | 45382 | 0.0002% |
| 1038 | Heben Arsi | West Arsi | Oromia | 0 | 19 | 117096 | 0.0002% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 1039 | Kucha | Gamo | SNNPR | 0 | 133 | 51781 | 0.0002% |
| 1040 | Humbo | Wolayita | SNNPR | 0 | 3 | 32490 | 0.0002% |
| 1041 | Gide Bench | Bench Sheko | SNNPR | 0 | 1566 | 73879 | 0.0002% |
| 1042 | Suro | West Guji | Oromia | 0 | 507 | 72180 | 0.0002% |
| 1043 | Teticha | Sidama | SNNPR | 0 | 7 | 95091 | 0.0002% |
| 1044 | Adaar | Awsi (Zone 1) | Afar | 0 | 348 | 20815 | 0.0002% |
| 1045 | Gorigesha | West Omo | SNNPR | 0 | 2 | 26651 | 0.0002% |
| 1046 | Nono Benja | Jimma | Oromia | 0 | 407 | 95328 | 0.0002% |
| 1047 | Horo | Horo Gudru Welega | Oromia | 0 | 873 | 37721 | 0.0002% |
| 1048 | Boniya Bushe | East Welega | Oromia | 0 | 359 | 78138 | 0.0002% |
| 1049 | Argoba Liyu-Gachene | Gabi (Zone 3) | Afar | 0 | 1 | 20849 | 0.0002% |
| 1050 | Kogota | Gamo | SNNPR | 0 | 5 | 47588 | 0.0002% |
| 1051 | Shinile | Siti (Shinile) | Somali | 0 | 7 | 41052 | 0.0002% |
| 1052 | Rayitu | Bale | Oromia | 0 | 19 | 79630 | 0.0002% |
| 1053 | Enkelo Wabe | Arsi | Oromia | 0 | 186 | 79415 | 0.0002% |
| 1054 | Chencha Zuria | Gamo | SNNPR | 0 | 5 | 47588 | 0.0002% |
| 1055 | Sherkole | Assosa | Benishangul-Gumuz | 0 | 1 | 44108 | 0.0002% |
| 1056 | Kedida Gamela | Kembata Timbaro | SNNPR | 0 | 58 | 56133 | 0.0002% |
| 1057 | Mena Mektawa | South Gondar | Amhara | 0 | 615 | 166950 | 0.0002% |
| 1058 | Eliwaye | Borena | Oromia | 0 | 1 | 17452 | 0.0001% |

| S.No | WOREDA | ZONE | REGION | New Infections, ages 15-49 | PLHIV 15-49 | Population ages 15-49 | Incidence ages 15-49 |
|---|---|---|---|---|---|---|---|
| 1059 | Bayira Koysha | Wolayita | SNNPR | 0 | 9 | 62361 | 0.0001% |
| 1060 | Kawo Koysha | Wolayita | SNNPR | 0 | 7 | 62250 | 0.0001% |
| 1061 | Abala Abaya | Wolayita | SNNPR | 0 | 1785 | 56559 | 0.0001% |
| 1062 | El-ogaden | Korahe (Keberidehar) | Somali | 0 | 33 | 35205 | 0.0001% |
| 1063 | Hawi Gudina | West Hararge | Oromia | 0 | 15 | 101289 | 0.0001% |
| 1064 | Liban Jawi | West Shewa | Oromia | 0 | 136 | 71119 | 0.0001% |
| 1065 | Kurmuk | Assosa | Benishangul-Gumuz | 0 | 307 | 45393 | 0.0001% |
| 1066 | Kumbi | East Hararge | Oromia | 0 | 10 | 151752 | 0.0001% |
| 1067 | Dulecha | Gabi (Zone 3) | Afar | 0 | 499 | 40440 | 0.0001% |
| 1068 | Masha | Sheka | SNNPR | 0 | 8 | 70398 | 0.0001% |
| 1069 | Togochale Town | Fafen (Jijiga) | Somali | 0 | 144 | 89701 | 0.0001% |
| 1070 | Menz Lalo Midir | North Shewa (Amhara) | Amhara | 0 | 51 | 89095 | 0.0000% |
| 1071 | Tuluguled | Fafen (Jijiga) | Somali | 0 | 20 | 8580 | 0.0000% |
| 1072 | Guchi | Borena | Oromia | 0 | 24 | 17977 | 0.0000% |
| 1073 | Mulla | Fafen (Jijiga) | Somali | 0 | 0 | 9645 | 0.0000% |
| 1074 | Harawo | Fafen (Jijiga) | Somali | 0 | 5 | 10939 | 0.0000% |
| 1075 | Goljano | Fafen (Jijiga) | Somali | 0 | 0 | 22061 | 0.0000% |
| 1076 | Jijiga Waqooyi (Harorays) | Fafen (Jijiga) | Somali | 0 | 0 | 60097 | 0.0000% |

# NATIONAL HIV PREVENTION ROAD MAP

2023 -2027

**Ministry of Health**
**June 2023**
**Addis Ababa, Ethiopia**