ETHIOPIAN STRATEGIC PLAN FOR INTENSIFYING MULTI-SECTORAL HIV/AIDS RESPONSE

(2004 - 2008)

Addis Ababa, Ethiopia
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INTRODUCTION

The ongoing multi-sectoral response to the HIV/AIDS epidemic is framed around the National policy and the Five-year Strategic Framework that were issued out in 1998 and 1999 respectively. Several independent attempts were undertaken to review and evaluate the performance and achievements of the ongoing interventions. These include:

- *The first, second and third Aid Memoirs of the Joint Supervision Missions (EG, IDA and other stakeholders)*
- *The Joint Mid-Term Review (2001, 2002, and 2003)*
- *EMSAP Review (March 2003)*
- *Critical Analysis of the Strategic Framework*
- *Minutes/proceedings of review meetings.*

All these discrete but participatory undertakings have generated a wealth of information on the situation of HIV/AIDS in Ethiopia including the prevalence rate, the major determinants, socio-economic impacts, and most vulnerable groups to HIV infection shed light on the major strengths/successes, limitations/gaps, opportunities and threats of the multi-sectoral response.

The exercise of developing a new and comprehensive Strategic Plan for the multi-sectoral HIV/AIDS response is based on these findings and is a logical continuation of the situation and response analysis undertaken earlier.

This Strategic Plan and Management (SPM) has been prepared mainly through desktop review. Critical analysis and synthesis of the relevant documents was carried out with the involvement of relevant individuals and institutions during regular consultation and brainstorming sessions. Among other documents, the Critical Review of the Original National Strategic Framework and the revised National

Strategic Framework (NSF) have formed the basis for this exercise and have been meticulously reviewed.

Excluding the introduction and executive summary, this SPM has NINE major parts and important annexes. Part one covers a synoptic overview of the situation of HIV/AIDS in Ethiopia and the national response to date. Part two consists of the mission, vision, goal and guiding principles of the national response, while part three elaborates on the six strategic issues that the Government of Ethiopia has identified. Part four focuses on the six thematic areas along with their corresponding objectives and strategies (unless prevented by paucity/absence of reliable baseline data, objectives have been presented in measurable terms). The fifth major part of the SPM is the strategic plan matrix, which outlines selected strategy, major activities, indicators, means of verification and responsible body for the activities of the given thematic areas. Part six covers the budgetary requirements and justification. Part seven and eight cover governance and institutional arrangement, and monitoring and evaluation respectively. Part nine elaborates on the major challenges and the ways forward. The SPM is subsequently concluded with the annexes which include the minimum service delivery package by institutional level, role of key implementing agencies, list of policy document and acronyms.

This SPM covers four years (2004-2008). Its implementation process and performance will be closely monitored and evaluated. Based on their comparative advantage, multi-sectoral actors at all levels working on HIV/AIDS issues are expected to develop and implement their respective plans based on this SPM.

Executive Summary

*According to the Fifth AIDS in Ethiopia report issued by the Ministry of Health, the national HIV prevalence rate is estimated to be 4.4%. Currently there are more than **1.5** million PLWHA in Ethiopia of which 817,000 are women and 96,000 are children under the age of 14.(MoH 2003).*

The government of Ethiopia has been steadfast in its response to the epidemic. In 1985, prior to the first laboratory diagnosis of HIV in Ethiopia, the government established a National HIV/AIDS Task Force within the Ministry of Health. In 1987-89 Short and Medium Term Plan were drawn out to respond to the budding epidemic. As the epidemic began to spread the government responded by issuing a national AIDS policy, the strategic framework and the establishment of a multi-sectoral and broad based National AIDS council (NAC) and the secretariat, which evolved to the current HIV/AIDS Prevention and Control Office (HAPCO). Despite these and other concerted efforts the epidemic still continues to grow steadily both in urban and rural settings claiming the lives of the most productive segment of the Ethiopian society. HIV/AIDS has now become one of the major challenges to the socio-economic development of the country.

The development of this SPM is geared towards enhancing and strengthening the ongoing multi-sectoral prevention and control activities. The SPM outlines the vision, mission, goals and guiding principles of the national multi-sectoral response to the HIV/AIDS epidemic. After a thorough analysis of the limitations, gaps and achievements of the prevention and control efforts thus far, the following six strategic issues are identified and addressed in this document

Capacity Building: *The health sector, the education sector and the community are the three priority focus areas for capacity building. The health sector shoulders the greatest responsibility in bringing a continued reduction in the spread of HIV as well as the care and treatment of those infected and affected. To this end the capacity of this sector has to be strengthened so that it can effectively assume its leadership role. Strengthening the capacity of the education sector and, integration of HIV/AIDS into the system would result in shaping the future generation and ensure a sustained human resource development. In order to realize the objectives of the multi-sectoral response against HIV/AIDS, the capacity of the community to contain the havoc HIV/AIDS is causing amongst individuals, families, and the community at large needs to be built.*

Community mobilization and empowerment: *Targeted prevention and care and support services cannot attain their maximum impact without community mobilization and empowerment. Community participation can be realized only when it is ignited from within and not imposed from outside. It is vital that the community is involved, and empowered in identifying its own problems and subsequently developing and implementing solutions for them. In this regard the involvement of the community including religious leaders, women's groups, youth organizations, farmers' associations, council members, health extension workers, teachers, development agents, and NGOs will significantly contribute to the fight against the epidemic and will be enhanced.*

Integration with Health programs: *The current health policy, the decentralization of health governance to woredas and Kebeles and the focus on the health extension program, has created a favorable working*

environment for the prevention and control of HIV/AIDS. Hence HIV/AIDS related services will be integrated, strengthened and expanded.

Leadership and mainstreaming: *Some Government Sectors have mainstreamed HIV/AIDS into their core policy and functions, however, HIV/AIDS is not yet mainstreamed as a priority development agenda by most sectors. Unless sectoral leaders at all levels provide the required guidance for mainstreaming HIV/AIDS in their program and are made accountable for ensuring its implementation, it will be impossible to curb the spread of the epidemic and mitigate its impact.*

Coordination and Networking*: Roles and responsibilities of the different actors in the multi-sectoral response of fighting HIV/AIDS needs to be clearly identified, clearly delineated and lucidly communicated to all involved. Lessons learned from the coordinating efforts of HAPCO, at different levels will be* strengthened *and built on to enhance coordination at all levels.*

Targeted Response: *Even though Ethiopia is in a state of generalized epidemic, it is important to give priority to selected vulnerable target groups. In line with the multi-sectoral response special attention will be given to the Youth, CSW, Mobile workers, uniformed people and teachers as there is demonstrable evidence for their vulnerability.*

The SPM has dealt in detail with the aforementioned six strategic issues and identified thematic area within each issue. Subsequently, under each thematic area, specific components are identified for which an objective is defined and selected strategies are designed. Overall, under the six thematic areas, sixteen components are identified for which objectives are defined with their specific selected strategies.

Budgetary need for the implementation of the SPM is estimated to be around 6 Billion Ethiopian Birr.

Under the new implementation arrangement of the national response, at the federal level HAPCO will be directly accountable to MoH and the RHAPCOs will be accountable to their respective RHBs. Zonal and woreda health bureaus will be directly responsible for coordinating HIV/AIDS activities in their respective areas.

1. Situation Analysis and Problem Statement

The HIV/AIDS pandemic continues to spread worldwide. Today some 37.8 million people (range 34.6-42.3 million) are living with the virus, which killed about 3 million in 2003, and over 20 million since the first case of AIDS were identified in 1981. (UNAIDS 2004.) Sub Saharan Africa, with only 10% of the total world population, is carrying the burden of 80% of the world HIV infection and AIDS cases.

With an estimated 1.5 million people living with HIV/AIDS and a national prevalence rate of 4.4% (12.6% urban and 2.6 rural), Ethiopia is one of the hardest hit countries by HIV/AIDS epidemic (AIDS in Ethiopia No. 5 2004 MoH). Ethiopia hosts the fifth largest number of people living with the virus globally**.** Out of the 1.5 million PLWHA, 817,000 are women and 96,000 are children under 15 years. There are about 537,000-orphaned children due to AIDS. Some 245,000 PLWHA will be in need of ART during 2004. Deaths due to AIDS brought down life expectancy gains from 53 to 46 in 2001. If the current death trend continues the projected life expectancy gain to 59 years in 2014 will be reduced to 50 years.

In Ethiopia, the major mode of HIV transmission is heterosexual which accounts for 87% of infections. Another 10% of infections occur due to mother to child transmission. In addition, empirical evidences suggest that utilization of unsafe sharp and skin piercing instruments play a role in HIV transmission in the rural setting in particular.

A number of underlying factors contribute to the spread of HIV/AIDS in Ethiopia including poverty, illiteracy, stigma and discrimination of those infected/affected by HIV/AIDS, high rate of unemployment, wide spread commercial sex work, gender disparity, population movement including rural to urban migration and harmful cultural and traditional practices. HIV/AIDS, in turn, contributes to the poverty situation of the individual, family and community and the nation at large. Thus HIV/AIDS creates a vicious cycle by increasing individual and community vulnerability to infection.

In Ethiopia, the spread of HIV/AIDS started and was initially localized in major urban areas located along major roads and commercial routes. The current surveillance report indicates a steady rise in HIV infection rate in the rural setting while on the other hand the trend in the urban areas seems to be stabilizing. (MOH 2004) Hence, without urgent attention and effective intervention, a potentially devastating epidemic is a threat to rural areas, where the majority of Ethiopians live (>85%) and upon which the economy of the country heavily relies. The Ethiopia Demographic and Health Survey (DHS) 2000 documented that the rural population had markedly lower knowledge and awareness about

HIV/AIDS compared to urban population. Rural women were found to be the least informed on HIV/AIDS, a fact that calls for urgent intervention.

The number of orphans due to AIDS is also growing and worsening the social and economic situation of children. The burden of their care falls on grandparents, older sibling, and the community at large. The magnitude of the problem and the general level of poverty have weakened social cohesion and traditional coping mechanisms. Providing care and support to orphans has overwhelmed traditional coping capacity, leaving many children without their basic social educational needs and rights unattended which in turn worsened their vulnerability.

The growing number of AIDS cases, people living with HIV/AIDS (PLWHA), orphans, other vulnerable children and their continued needs for health care services have placed a significant burden on resources in the already inadequate health services.

General primary health service coverage is already low, and human resources at this level already inadequate to meet needs. In addition, there is a lack of a strong health management structure, particularly at grass root level which amplifies the vulnerability of the rural communities.

Significant number of hospital beds is occupied by AIDS patients. The lack of community-based health care and service delivery mechanism for these needy patients has also contributed significantly to the lack of an appropriate care and support response.

In short, HIV/AIDS has now become a serious threat and challenge to the socio-economic development of the country. The epidemic is reversing social and economic development gains; deepening poverty; challenging the national priority of expanding and maintaining essential services; reducing labor and intellectual productivity.

Realizing the potentially enormous devastating impact of HIV/AIDS in the country, the government initiated the response in 1985, soon after the first report of laboratory confirmed HIV and AIDS cases. The initial major step taken by the government was the establishment of a National Task Force (NTF) within the MOH; this response focused on analyzing the situation, developing operational guidelines for prevention, and assessing the capacity required to arrest the spread of HIV infection.

In September 1987, the AIDS Control Program was established at a department level in the MOH, with the responsibility of coordinating the national prevention and control program. Subsequently Short and Midterm Plans for control were developed (1987-1989). In 1998 The National HIV/AIDS Policy was issued, followed by the development in 1999 of the Strategic Framework for the National Response. Both documents served as the basis for the expanded and scaled up

multi- sectoral response. However, the national response was slow, interrupted, and failed to keep up the momentum required for a sustainable and comprehensive prevention and control program.

In April 2000 the National AIDS Council (NAC) was established under the chairmanship of the country's president. The Council was composed of representatives from relevant government, Private, Faith Based, Non Government Organizations and prominent figures. A Secretariat accountable to the Prime Minister's Office was also established to coordinate the national multi-sectoral response. Similar structures with similar constituencies were also established in the regions and at lower administrative levels. The legal establishment of HIV/AIDS Control and Prevention Office in 2002 and the launching of multi-sectoral HIV/AIDS control and prevention programs were some of the major steps forward in the battle against HIV/AIDS.

Some of the major achievements include:

- An increased level of awareness and positive trends in behavioral change.
- An increased demand for voluntary counseling and testing (VCT)
- An increased trend in condom distribution and utilization
- Integration and expansion of VCT
- Initiation of prevention of mother to child transmission (PMTCT) and anti retroviral (ARV) services
- Positive trends in openness and reduction of stigma and discrimination
- Encouraging trends in involvement of PLWHA in the response.

However, it was found that the national response and intervention were still far from adequate considering the magnitude of the problem. The following were some of the major weaknesses:

- The health sector has been overwhelmed by the demand for services, and because of its low capacity has failed to adequately spearhead and integrate HIV/AIDS in health programs.
- There has been low implementation capacity in the education sector.
- There has been low implementation capacity in communities, and as a result lack of community ownership of the programs.
- There has been lack of focus on priority intervention areas and target groups.
- There has been limited coverage of basic prevention and care services, including VCT, ARV, and PMTCT.
- There has also been duplication of effort, wastage of resources and non-value adding and process oriented centralized activities.
- Discrimination and stigma are still widespread and contribute to lack of openness and continued spread.
- Some activities have resulted in dependency and externalization instead of community empowerment and mobilization.

- In general, limited capacity, inadequate leadership, coordination, mainstreaming and ownership at all levels have resulted in unchecked propagation of the epidemic.

Hence, this strategic plan must adequately learn from the gaps as well as build on the achievements. Accordingly capacity building, integration of HIV/AIDS interventions with health sector; community mobilization and empowerment; leadership and mainstreaming; coordination and networking have to be critically addressed.

2. Vision, Mission, Goals and Guiding Principles

Vision:

To see Ethiopia whereby HIV/AIDS is no more a development problem.

Mission:

To prevent and control the spread of HIV/AIDS and reduce its impact through intensified, result-oriented large-scale comprehensive programs with active participation of all partners and with special focus on social mobilization and community empowerment.

Goal:

- Reduce the spread of HIV infection
- Reduce the social and economic impact of HIV/AIDS

Guiding Principles:

Multi-sectoralism: The huge magnitude of the epidemic has left no sector untouched. HIV/AIDS affects persons in the productive age group both in agriculture and industrial sectors. Students, teachers, civil servants and private sector employees are also among the high-risk groups. Thus with the leading role of the government and community ownership there is a call for an integrated and comprehensive intervention strategy among all sectors including NGOs FBOs and the private sector. This can be best achieved if all sectors mainstream prevention, care, and support activities in their organizational mandate and plans. Therefore, multi-sectoralism remains to be the major guiding principle of HIV/AIDS prevention and control.

Empowerment: Reducing the spread of HIV/AIDS and mitigating its impact will remain difficult, unless ownership and means of empowerment of individuals, families, institutions and the community at large are in place. Understanding of the devastating nature of the epidemic by the actors with a shared vision, effective planning, implementation, monitoring and evaluation of results are only possible if all stakeholders in general, and the community in particular, is properly empowered.

Shared sense of urgency: The damage sustained by the country to date is severe and if the epidemic spreads further into rural areas its damage will even be more catastrophic. The fight against HIV/AIDS needs to be treated with shared sense of urgency if our fight against poverty is to be successful. HIV/AIDS has to be treated with a shared sense of urgency by all actors as the toll of people being infected and affected by the epidemic continues to rise day by day.

Gender sensitivity: The social, political and economic status of women as well as the attitude and perceived role of women in a society is an important determinant factor of collective vulnerability to HIV/AIDS. The transmission and impact of HIV/AIDS is skewed towards women. Hence, any intervention in HIV/AIDS has to be gender sensitive. Women must be actively involved in prevention, care and support activities.

Together with PLWHA: People living with HIV/AIDS have a tremendous power and influence to teach about HIV/AIDS from their personal and social experience. They can also be trained to provide care and support. The involvement of PLWHA in the fight against HIV/AIDS has been quite encouraging and has contributed a great deal towards openness, and a reduction of stigma, denial and discrimination. The continued involvement of PLWHA as a guiding principle should significantly contribute to the reduction of the spread of HIV/AIDS and improvement in the quality of people living with the virus.

Result Oriented: HIV/AIDS is eating up our investment and development gains. It is also diverting our meager resources from development. The HIV/AIDS response is characterized by "project" and fund driven initiatives, without sufficient consideration of the impact of the interventions. Serious scrutiny of intervention for results and impact must be a fundamental guiding principle.

Best use of resources: HIV/AIDS deepens and worsens poverty, which in turn increases vulnerability to HIV/AIDS. Our response has been dependent on external funding and on scarce government resources as well. Therefore, best use of available resources in terms of allocation, utilization, efficiency and accountability has to be a guiding principle. Community level investment and use of community resources must be streamlined in our programs and actions.

3. Strategic Issues

3.1 Capacity Building

In our response to HIV/AIDS to date, implementation capacity in all sectors and at all levels has been the major rate limiting and stumbling block. Capacity building has to be an important strategic component of HIV prevention, care and support activities. Planning for capacity building has to conform with the national capacity building strategy and to components focusing on human resources, organization and systems development. Capacity in planning, implementation, mainstreaming, coordination, leadership, financial management, monitoring and evaluation requires special attention. Capacity building has to specifically focus on the health and education sectors, and on communities and leadership.

Among, all sectors and actors in the prevention and control of HIV/AIDS, the health sector must bear the greatest responsibility to bring sustainable reduction in the impact and spread of the infection. Therefore, health sector capacity has to be built in such a way that the sector will be the centerpiece of the response, both in terms of leadership, and in preventive, care and support services. The present and future demand for treatment, care and support, the opportunity and comparative advantage of woreda health offices and rural health extension programs, and emerging local urban governance with urban health offices all put the health sector in the best position to combat HIV/AIDS in a sustainable and integrated manner. The official launch of the health extension program, which includes HIV/AIDS prevention and control as a major component to be implemented at household level, through the principles of communication and empowerment, will be used as a cutting edge for community involvement and behavioral change. Hence health sector capacity building in all aspects has to be the bedrock of our HIV/AIDS capacity building component.

The education sector employs a large number of teachers and touches a large number of students. The highly structured institutional nature of the educational system, the young age of students at first contact with the system, long periods of physical stay in the educational environment, and emotional contacts within school communities, increase the collective vulnerability of these communities to HIV/AIDS. Educating teachers and students means educating families and communities, particularly in rural areas where other means of communication are limited. Education sector capacity building and a virtual integration of HIV/AIDS in the education system means building a responsible generation and making a sustainable investment for development**.**

Without the involvement and ownership of the community, the prevention and care of HIV/AIDS is a futile exercise. The fight against AIDS and the preventive, care and support interventions have not yet brought intended changes, mainly

due to inadequate ownership and empowerment of the community at large. Therefore, community capacity should be built to enable communities to identify problems in their respective localities, and to develop and implement their own plans to the extent of ratifying social norms and regulations.
Strengthening the capacity of associations, local authorities and community leaders is of paramount importance to the implementation of the national strategic plan, and requires an extended and large-scale popular movement. Creating an enabling environment and protecting the rights of people living with HIV/AIDS and their families, will enable the infected and affected to live with dignity and responsibility and will limit the spread of the virus. It is also equally important to protect the general public from reckless transmission through appropriate legal measures and protections.

3.2 Community Mobilization and Empowerment

The spread of HIV/AIDS is fueled by myriads of individual and collective vulnerability emanating from the behavioral, social, cultural and economic dimensions of our reality. On the other hand, targeted prevention, care and support can only make root and be deeply anchored through community mobilization and empowerment. The approach to community involvement and participation has been a serious challenge and pitfall in many development endeavors and in our HIV/AIDS response to date. Community participation has not been ignited and sustained from within; rather it has been imposed from above without complete understanding of the problem and the issues raised by the local communities. This has made our community mobilization superficial and unsustainable; it has contributed to ineffectiveness, misuse of resources and externalization of the problem and the solution.

Various assessments have indicated that poor community mobilization and empowerment is one of the weakest links, a serious gap in our response, and an important contribution to our failure. The concept of community mobilization and empowerment must be taken a chapter forward to community movement whereby the community and the wider public become cognizant of the threat of HIV/AIDS to survival, and demand, initiate and sustain HIV/AIDS prevention activities. The community must own the movement and use its local knowledge, values, structures and resources to integrate HIV/AIDS activities into the existing socio-cultural and economic situation.

Support provided to communities must be in harmony with community needs for social mobilization in order to break the current dependency, externalization and piloting syndrome characterizing our current community HIV/AIDS responses. Such re-orientation to community mobilization and empowerment, coupled with community capacity building, will create sustainable local response and release the untapped potential of the communities.

The emphasis on women, youth and farmers associations, members of the council, kebele administration, health extension workers, rural teachers and development agents, effective use of traditional organizations, faith based organizations and non-governmental organizations as a venue and as forefront actors for community movement needs to be underscored. Community movement has to be guided by development and implementation of community driven plans.

3.3 Integration with Health Programs

It is true that HIV/AIDS is not only a health problem but rather a multifaceted development crisis. Yet it is equally true that HIV/AIDS is primarily a public health problem and a chronic infectious disease with its important implications for the health sector. The initial response to HIV/AIDS in the health sector was characterized by denial and neglect partly because of the overwhelming magnitude of the problem, lack of options and the resulting helplessness, but also because of limited capacity for leadership and services in the sector.

As a result, the health sector response with respect to its mandate has remained inadequate and slow. With continued global gain of knowledge and options to fight HIV/AIDS, particularly the development of highly active antiretroviral treatment (HAART) and other care and support interventions, the demand on the health sector has dramatically increased. Such demand makes health the critical sector and leads to the development of a guiding motto "integration without neglect" for the health sector.

Our health policy clearly stipulates prevention based health intervention strategies focused on major communicable diseases and with special attention to vulnerable groups such as women, children and youth and the rural population at large. The policy also recognizes and encourages public-private partnership in health. Hence integration of HIV/AIDS in health programs has to be addressed by all partners in the health sector i.e. public, private for profit and private nonprofit.

The health policy coupled with the recent major development of the decentralization of health governance to the woredas and kebeles, and the focus on the health extension program as a major mode of implementation of preventive and promotive health policy at household level, provides an outstanding chance to combat new infections and mitigate the impact of the disease. This approach will create an excellent opportunity and capacity for integration of HIV/AIDS response in health programs at the grassroots level and ensure sustainability.

A minimum package of services for targeted prevention, care and support has to be defined at the level of health post, health center and hospital and capacity building should occur at all levels. Universal coverage by the health extension

program, coupled with capacity building from primary to tertiary levels, can ensure effectiveness and sustainability of the programs in the fight against HIV/AIDS.

3.4 Leadership and mainstreaming

Highest-level political commitment and effective leadership are critical in the fight against AIDS in order to bring about the intended reduction of the spread of HIV and mitigate the overall impact. The magnitude of the crisis caused by HIV/AIDS can be successfully tackled only when all partners at all levels are actively mobilized and empowered, and when prevention and control interventions are taken as priority development agenda and effectively integrated into the core functions of all development partners. This requires vibrant and appropriate leadership at all levels and in all sectors.

Although some actions have been taken to mainstream HIV/AIDS in some government and private organizations and although work place guidelines have been developed, HIV/AIDS is not yet seriously taken as a priority development agenda and effectively mainstreamed into the main mandates of public, private and civil society sectors at all levels. Unless leaders at all levels provide the required guidance and are made accountable in their respective agencies, the epidemic will continue to spread causing incalculable damage. Leadership and mainstreaming should be considered as a critical strategic issue to be promptly addressed.

3.5 Coordination and networking

As HIV/AIDS is not merely a health problem but a broad socio-economic crisis, it requires the active and continued involvement of all sectors at all levels. The involvement of a wide range of actors- GO sectors, the community, NGOs and the POs in the on-going fight against the epidemic requires an effective and efficient coordination mechanisms and modalities; problem identification, information sharing, planning, implementation, monitoring and evaluation.

Coordination and networking between stakeholders and programs avoids resource wastage and duplication of efforts, enhances success through documenting and disseminating best practices and research findings, avails technical support, and ensures a smooth flow of funds and information dissemination.

Though initiatives have been taken to coordinate and facilitate a multi-sectoral response through HAPCOs at different levels, coordination was by no means enough, resulting in duplication of efforts, wastage of resources, and failure to achieve desired goals and objectives. This was partly due to lack of clarity of roles and mandates among stakeholders, poor management information systems,

inadequate monitoring and evaluation and lack of transparency and accountability. Institutional arrangements should be reviewed to bring effective coordination and synergy.

3.6 Focus on special target groups

Even though Ethiopia is in the stage of a generalized epidemic, it is very important to focus on special target groups to rapidly curb the epidemic and mitigate its impact. This will improve effective use of resources. Priority should be given to the segments of the population who are infected and affected most and who are highly vulnerable to infection.

The youth population between the ages of 15-29 years is highly affected by the epidemic. A large number from this age group are in schools, therefore, targeted behavioral change communication and integration of HIV/AIDS prevention issues in the curriculum and in civic education can effectively control the spread of HIV among the youth and the school community. In addition, youth out of school need to be targeted appropriately. Due to deep-rooted poverty, there is a rapid increase in the number of commercial sex workers, especially in urban settings, resulting in rapid transmission of the virus. Comprehensive and tailored packages of interventions should be in place to address their special need.

Long distance truck drivers, migrant laborers, and uniformed people, should also be addressed with targeted interventions focusing on their mobile nature.

HIV/AIDS is gradually but steadily spreading into the rural areas where 85% of Ethiopia's populations live, therefore mainstreaming of HIV/AIDS prevention and control programs in our rural development and the health extension programs is a strategic step to avoid the rapid spread of the epidemic in rural community.

The active involvement of people living with HIV/AIDS has to be given a central place in our response.

Orphans and other vulnerable children must and deserve to be targeted both from care and support point of view as well as prevention and reduction of vulnerability.

4. Thematic areas Objectives and Strategies

4.1 Capacity Building

4.1.1 Health Sector

Objective 1: Increase primary health service coverage from 60% to 80% and enable the facilities to provide HIV/AIDS related preventive, care and treatment services.

Selected Strategies:

- Construct and upgrade health institutions with emphasis on health posts and health centers.
- Furnish all health care facilities with improved diagnostic, medical equipment and supplies.
- Establish functional referral system.
- Strengthen the institutional capacity of health systems.

Objective 2: Staff 80% of health institutions as per the national standard

Selected Strategies:

- Improve the quality and increase uptake of health care training institutions.
- Train health care workers in the care, treatment and management, of HIV/AIDS.
- Decentralize basic in-service training and mainstream HIV/AIDS in all trainings**.**

4.1.2 Education Sector

Objective 3: Integrate HIV/AIDS education into the curriculum of all levels of schools.

Selected Strategies:

- Include HIV/AIDS education in teaching curricula
- Promote peer education
- Use effective communication and appropriate technology
- Strengthen civic education
- Mainstream HIV/AIDS into education

4.1.3 Community capacity building

Objective 4: Ensure execution capacity of communities and association leaders in effectively managing grassroots response.

Selected Strategies:

- Build the executive and managerial capacity of community and association leaders
- Encourage use of local and innovative educational approaches.

4.1.4 HIV/AIDS Prevention and Control Office

Objective5: Ensure efficient coordination, M&E and resource mobilization.

Selected Strategies:

- Strengthen the capacity for coordination, M&E and resource mobilization at national and regional level.
- Strengthen transparency and accountability in fund management, disbursement and liquidation.

4.1.5 Other Implementers

Objective 6: Ensure capacity building of implementing stakeholders.

Selected Strategies:

- Improve knowledge, attitude and practice as well as managerial capacity
- Promote involvement and ownership
- Strengthen partnership forum

4.1.6 Legal and human right issues

Objective 7: Protect the legal and human rights of individuals infected and affected by HIV/AIDS.

Selected Strategy:

- Review and update policies, legislations and guidelines with participation of PLWHA and their families.
- Organize PLWHA into organizations

4.2 Social Mobilization and Community Empowerment

Objective 8: Ensure community ownership and sustainable social mobilization.

Selected Strategies:

- Ensure community ownership of HIV/AIDS programs.
- Create a sense of urgency in all leaders and community organizations to take HIV/AIDS as social and development agenda.
- Reinforce relevant community bylaws and resolutions.

4.3 Integration with health Programs

4.3.1 Primary health care units

Objective 9. Ensure universal integrated primary health care services for HIV/AIDS.

Strategies:

- Establish and ensure the availability of the standardized minimum essential packages of HIV/AIDS services in all primary health care facilities
- Institute efficient and effective referral services including community based health care systems.

4.3.2 Hospital Services

Objective 10. Implement defined minimum services delivery package and support primary health care units.

Strategies:

- Establish and ensure the availability of the standardized minimum essential package of HIV/AIDS services in all different levels of hospitals
- Institute efficient and effective referral services including community based health care systems.

4.3.3 Safe Blood

Objective 11: Blood bank services expanded and blood transfusion and tissue transplants made 100% safe.

Strategies:

- Expand and strengthen blood banks in both public and private health facilities
- Establish a system of regular monitoring and supervision to ensure the quality of blood transfusion and tissue transplant services.

4.4 Leadership and Mainstreaming

4.4.1 Leadership

Objective 12: Ensure that leadership at all levels sustain HIV/AIDS as a priority development and emergency agenda

Strategies:

- Expand advocacy and advisory activities.
- Ensure that institutional leaders lead and manage the implementation of work place HIV/AIDS programs.
- Introduce accountability re-enforcing mechanism

4.4.2 Mainstreaming

Objective 13: Mainstream HIV/AIDS prevention and control efforts into the core, programs of all public, non- public and private development partners.

Strategies:

- Promote involvement and ownership
- Use own resources (sectors), provide resources
- Monitor and evaluate HIV/AIDS sector specific strategic plans and performance.

4.5 Coordination and networking

Objective 14: Ensure synergy of HIV/AIDS programs and efficient use of resources among different implementers.

Strategies:

- Promote decentralized decision making and coordination.
- Develop and disseminate net working guidelines and directories.
- Ensure timely and regular review and follow up mechanisms by HIV/AIDS councils and committees at different levels.
- Create consultation and partnership forum.

4.6 Special target groups

4.6.1 Commercial Sex Workers, truckers, migrant laborers, uniformed people, teachers, students and out of school youth.

Objective 15: Reduce vulnerability to HIV infection among the identified targeted group.

Strategies:

- Promote VCT and other behavioral change interventions.
- Promote the use of male and female condoms.
- Provide user-friendly Reproductive Health and STI services.
- Enhance bargaining and negotiations skills for safe sex where applicable.
- Provide safe and alternative income generating and employment opportunities where applicable.
- Strengthen and expand school anti AIDS clubs and mini Medias
- Integrate HIV/AIDS in life skill education and basic curriculum.
- Develop youth centers and entertainment resorts.
- Organize the youth on voluntary basis and provide peer education.

4.6.2 People living with HIV/AIDS, orphans and other vulnerable children

Objective 16: Improve quality of life of people living with HIV/AIDS, orphans and other vulnerable children (OVC)

Strategies:

- Promote care within the family and mobilize the community to address and accommodate the issue of PLWHA/OVC through traditional and extended family mechanisms.
- Provide counseling service, legal advice and protection to PLWHA/OVC.
- Provide access to basic health, education and other social services to PLWHA/OVC
- Provide vocational skill training and income generating opportunity for PLWHA/OVC
- Develop acceptable social security models towards the special needs of PLWHA/OVC
- Mobilize all stakeholders to address the needs of PLWHA/OVC in a sustainable manner.

5. Comprehensive HIV/AIDS Strategic Plan Matrix (2004-2008)

5.1 Thematic Area 1: Capacity Building

Objective 1:
Health Sector
Increase primary health service coverage from 60% to 80% and enable the facilities to provide HIV/AIDS related preventive, care and treatment services.

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Construct and upgrade health institutions with emphasis on health posts and health centers	Construct 2000 Health Posts	Number of health posts built	Site visit and	Regional Health Bureaus
	Upgrade 675 health stations to HC	Number of health stations upgraded to health centers	Report	
Furnish all health care facilities and improved diagnostic medical equipment and supplies	Procure HP equipment and supplies for all newly constructed health posts. Procure HC equipment and supplies for all upgraded health centers. Procure equipment and supplies for 119 hospitals.	Number of health institutions constructed, upgraded, equipped and furnished		RHB
Establish functional referral system	Develop and disseminate referral bylaws and guidelines	Number of referral guidelines developed		MoH, RHB
Strengthen the institutional capacity of health systems	Procure office equipment, radio receivers, vehicles, motorbikes	Number of wereda offices equipped		MoH RHB

Objective 2:
(Human Resource Development)

Staff 80% of Health Institutions as per the national Standard

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Improve quality and increase uptake of health care training institutions	• Construct additional blocks • Procure teaching aids and books for training institutions • Train critical mass of teachers	Number of training institutes expanded and equipped	Reports	RHB
Train health care workers in the care, treatment and management, of HIV/AIDS.	• Train HWs in best practice for the management of HIV/AIDS • Disseminate manuals and guidelines for the care, treatment, and management of HIV patients. • Provide supportive supervision for trained HWs • Conduct experience sharing forums	• Proportion of HWs trained • Number of supportive supervisions conducted	Reports Visits	MoH, RHB
Decentralize basic in service training and mainstream HIV/AIDS in all trainings.	• Develop TOT guidelines • Conduct training of trainers	Proportion of training sessions conducted in regions	Reports Visits	MoH, HAPCO, RHB

Objective 3:
(Education Sector)

Integrate HIV/AIDS education into the curriculum of all levels of schools

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Include HIV/AIDS education in teaching curricula	Review and develop existing curriculum	Percentage of schools that have incorporated HIV/AIDS education in the school curricula?	Document	MoH RHAPCOs MoE
Promote peer education	• Develop manuals and guideline for peer education • Train and refresh critical mass of model teachers and students • Establish and strengthen school anti AIDS clubs	Proportion of schools that established anti AIDS clubs and mini-media	Report Documents	MoH RHAPCOs
Use effective communication and appropriate technology	Expand and establish mini-media			MoH RHAPCOs MoE
Mainstream HIV/AIDS into education	• Establish fulltime formal unit/person at all levels of education system • Conduct joint operational research			MoH RHAPCOs MoE REB

Objective 4:

(Community capacity building)

Ensure execution capacity of communities and association leaders in effectively managing grassroots response.

Selected Strategies	**Major Activities**	**Indicators**	**Verification**	**Responsible Body**
Build the executive and managerial capacity of community and association leaders	• Train association leaders, council members etc. on mainstreaming and community mobilization • Develop guidelines and manuals for community mobilization and conversation	Number of manuals developed	Report Document	RHAPCO Wereda Admin RHB Sector Bureaus
Encourage use of local and innovative educational approaches	• Establish mini-media in all rural villages • Develop IEC/BCC for community based interventions • Conduct community conversation forums	Number of mini media & community conversation		RHB Wereda Admin

Objective 5:

(HIV/AIDS Prevention and Control Office)

Ensure efficient coordination, Monitoring & Evaluation and mobilization of recourses.

Selected Strategies	**Major Activities**	**Indicators**	**Verification**	**Responsible Body**
Strengthen the capacity of HAPCO for the coordination and M&E of HIV/AIDS programs and resource mobilization at national and regional level	• Review existing HIV/AIDS related guidelines and develop new ones as necessary. • Train on project coordination and evaluation • Develop guidelines for monitoring and evaluation	Timely and efficient use of funds	Document	HAPCO/RHAPCOs
Strengthen transparency and accountability in fund management disbursement and liquidation	• Develop decentralized procedures and guidelines		Report Documents	HAPCO

Objective 6:

(Other implementers)

Ensure capacity building by implementing stakeholders.

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Improve knowledge, attitude, practice and managerial capacity	• Develop guidelines and manuals for mainstreaming • Establish full time focal unit/person in all organizations • Train critical mass of workers on how to mainstream HIV/AIDS on their day to day activities	Number of institutions with mainstreamed HIV/AIDS programs	Document Report	HAPCO, MoH, Implementing stakeholders
Promote involvement and ownership	Develop and implement guidelines and manuals for community mobilization and conversation			HAPCO, MoH, Implementing stakeholders
Expand and strengthen partnership forum	• Strengthen existing forums • Establish new forums at all levels • Facilitate and coordinate their work	• No of forums established and operational • Meetings held	Reports	HAPCO, MoH, Implementing stakeholders

Objective 7:

(Legal and Human Rights)

Protect the legal and human right issue of individuals infected and affected by HIV/AIDS.

Selected Strategies	**Major Activities**	**Indicators**	**Verification**	**Responsible Body**
Review and update policies and legislation with participation of PLWHA and their families	Update existing laws Sensitize and train relevant people	Number of revised laws Number of people trained	Document Report	HAPCO, MoH, **MoJ** Implementing stakeholders
Organize PLWHA into associations	Sensitize PLWHA about their rights and obligations	Number of persons trained	Report	Association of PLWHA RHAPCOs Implementing Stakeholders

5.2 Thematic Area 2: Social Mobilization and Community empowerment

Objective 8:

Ensure Community ownership and sustainable social mobilization

Selected Strategies	**Major Activities**	**Indicators**	**Verification**	**Responsible Body**
Ensure community ownership of HIV/AIDS programs	• Enable the communities to assess the reality of HIV/AIDS and analyze the specific risk factors through regular consensus building forums	• Level of community knowledge, attitude, behavior and practice • New infection rate	Reports and Surveys	HAPCO RHAPCOs RHBs
• Create sense of urgency by all leaders and community organizations to take HIV/AIDS as social and developmental agenda • Re-enforce relevant community bylaws and resolutions	• Develop comprehensive integrated community based plan • Provide supportive supervision and follow-up • Revisit plans per experience gained			

5.3 Thematic Area 3: Integration with Health Programs

Objective 9:

(Primary Health Care units)

Ensure universal integrated primary health care services for HIV/AIDS

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
• Establish and ensure the availability of Standardized minimum essential packages of HIV/AIDS service in all primary health care facilities	• Define and deliver minimum service delivery package by level of institution • Review and develop standards and guidelines of operation • Implement health extension program at a larger scale	Proportion of Health facilities delivering minimum service delivery package	Reports and Surveys	Regional health Bureaus
• Institute efficient and effective referral services including community based health care systems.	• Develop and disseminate the referral system	Proportion of health facilities that established the system	Reports Visit	MoH RHB

Note: The targets set for the various programs (including ART, VCT, PMTCT, STI and others) based on the service delivery package for this level are presented in Annex I.

Objective 10:

(Hospital Services)

Implement defined minimum service delivery package and support primary health care units

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Establish and ensure the standardized minimum essential packages of HIV/AIDS services in all different levels of hospitals.	• Define and deliver minimum service delivery package • Review and develop standards and guidelines of operation • Deliver technical supportive supervision to primary health care units	Number of Hospitals delivering minimum service delivery package	Reports and Surveys	Regional Health Bureaus/MoH
Institute efficient and effective referral services including community based health care systems.	• Develop and disseminate the referral system	Number of hospitals and health facilities that established the system	Report	MoH

Note: The targets set for the various programs (including ART, VCT, PMTCT, STI and others) based on the service delivery package for this level are presented in Annex I.

Objective 11:
(Safe Blood)

Blood bank service expanded and blood transfusion and tissue transplants made 100% safe

Selected Strategies	**Major Activities**	**Indicators**	**Verification**	**Responsible Body**
Expand and strengthen blood banks in public and private health facilities	Establish, equip and staff new blood banks in selected government hospitals	Number, type and distribution of newly established blood banks	Report Visits	MoH *(ERCS, RHBs, IPs)*
	Provide technical support for the existing blood banks	type and frequency of support provided	Report	MoH *(ERCS, RHBs, IPs)*
	Train and retrain health workers	Number, type and distribution of staff trained and retrained	Reports	MoH *(ERCs, RHBs, EHNRI,IPs)*
Establish a system of regular monitoring and supervision to ensure the quality of blood transfusion and tissue transplant services.	Test all blood, blood products and tissues with sensitive screening tests and minimize the risk of window period transmission	No. of blood units collected, screened and data generated	Reports	MoH *(ERCS, RHBs)*

5.4 Thematic Area 4: Leadership and Mainstreaming

Objective 12:
(Leadership)

Ensure that leadership at all levels sustain HIV/AIDS as a priority development and emergency agenda.

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Expand Advocacy and advisory activities	Develop 5 coalition forums for (youth, women, religious leaders, business, cooperatives) at national and regional levels undertake 4 policy dialogue sessions per year per level	No. of coalition forums and policy dialogue sessions established and conducted No. of sessions	Reports/ Visits/ observation	Councils/MOH/ HAPCO/others
	Provide 2 thematic advocacy and advisory session per year per level for top policy makers at national, regional and wereda levels			
Ensure that institutional leaders lead and manage the implementation of work place HIV/AIDS programs	Institute a biannual mandatory public forum of reporting on sectoral HIV/AIDS response by the chief executive	No of reporting sessions	Reports/ Observations	All sectors/ Councils
Introduce accountability Reinforcing mechanism				

Objective 13: Mainstreaming

Mainstream HIV/AIDS prevention and control efforts into the core programs of all public, non-public and private development partners.

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Promote Involvement and ownership	Core government sectors undertake and document sectoral HIV/AIDS impact at limited intervals	Number of sectors with sectoral impact documented	Reports/ Documents	All core sectors
	HIV/AIDS guideline developed by Core government sectors to address the issue in their sectoral	Number of sectors with sectoral policy and guideline for HIV/AIDS	Reports/ Documents	All core sectors
Use own resources /sectors/ Provide resources	A minimum of 2% of their regular budget allocated for HIV/AIDS activities by public and non-public sectors	Number of government core sectors who have budgeted minimum of 2% of their budget for HIV/AIDS activities.	Reports/ Documents	All sectors/ Councils
	Adequately staff public and non-public sectors to implement HIV/AIDS activities in their sectors	Number of government core sectors with adequate staffing for HIV/AIDS activities.	Reports/ Documents	All core sectors
Monitor and evaluate HIV/AIDS sector specific strategic plans and performance	All sectors develop HIV/AIDS work plans related to their mandate and mobilize additional financial recourses to implement their activities.	Number of sectors that have integrated HIV/AIDS activities into their annual work plan	Reports/ Documents	All core sectors MoH/HAPCO

5.5 Thematic Area 5: Coordination and Networking

Objective 14:

Ensure synergy of HIV/AIDS programs and efficient use of resource among different implementers

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Promote decentralized decision making and coordination	Develop integrated woreda HIV/AIDS and development plans	No. of woredas with integrated HIV/AIDS and development plans	Reports/ Documents	RHAPCOs/ RHB/ All woredas/
	Operationalize decentralized project appraisal, funding and evaluation tailored to the needs of the community at grass root level.	No. of woredas with mechanisms to handle projects	Reports/ Documents	
	Develop clear working manuals and guidelines	No. of manuals and guidelines developed	Reports/ Documents	Councils/HAPCO
	Train all implementers	No. of people trained	Reports	Councils/MoH/ HAPCO
Ensure timely and regular review and follow up mechanism by HIV/AIDS councils and committees at all levels.	Share information and reports timely Undertake regular reviews	No. of reports and reviews	Reports/Documents	Councils/HAPCO
Create consultation and partnership forum	Create different thematic partnership and consultation forums at national, regional and wereda levels	No. of forums established	Reports	Councils/HAPCO
	Develop participatory one plan one budget emanating from the SPM at a given level	No. of aligned plans	Reports/ Documents	All implementers
Develop networking guideline and directory	Develop networking guidelines	No. of net working guidelines	Reports/ Documents	Councils/ HAPCO / RHB
	Develop and disseminate implementers' directory for each level Establish Information Center	No. of disseminated and used directories No. of information centers	Reports	Councils/ HAPCO/ RHB

5.6 Thematic Area 6: Special Target Groups

Objective 15: Targeted prevention for special Target Groups (CSWs, truckers, migrant laborers, uniformed people, teachers and students)
Reduce vulnerability among special target groups.

Selected Strategies	**Major Activities**	**Indicators**	**Verification**	**Responsible Body**
Promote VCT and behavioral change	Sensitize people to use VCT	No. of people counseled and tested	Reports	MoH/HAPCO/ others
	Expand VCT centers in all hospitals and health centers Establish free standing and mobile VCT	No. of VCT centers established	Reports/ Visits	
Promote the use of male and female condoms	Increase distribution outlets for social marketing	No. of condoms used	Reports/ Surveys	MoH/HAPCO/ NGO/others
	Avail free supply of condoms in relevant sites			
Provide user friendly RH/STI services	Expand packages of RH/STI services to all health centers and hospitals	No. of HIs rendering RH/STI services No. of people treated for STIs	Reports/ Visits	MoH/NGO/ others
Strengthen and expand school anti AIDS clubs and mini-medias	Develop guidelines and train the existing anti-AIDS clubs	No. of Students trained on guidelines	Reports	MoE/HAPCO
	Expand school clubs and mini-medias	No. of proportion of schools with clubs and mini-medias	Reports	MoE
Integrate HIV/AIDS in life skill education and basic curriculum	Review existing curriculum	Curriculum revised	Reports	MoE
	Integrate HIV/AIDS in life skill education and basic education	HIV/AIDS is integrated in curriculum	Reports	MoE

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Enhance the barraging and negotiation skill for safe sex where applicable	Provide life skill training Make condoms readily available		Reports	MoE, HAPCO, MOLSA Implementing partners
Provide safe and alternative income generating and employment opportunities.	• Facilitate vocational training for the vulnerable group • Access to micro fiancé credit facility		Reports	
Organize the youth on voluntary bases and provide peer education	Sensitize youth for self organizing into association	No of organization	Reports	MoLSA/ MoYSA/ HAPCO
	Develop peer education manuals Train school and out of school peer educators	No of manuals developed No. of people trained	Reports	MoYSA/MoH/ others
Develop youth centers and entertainment resorts	Establish youth recreational and resort centers	No. of youth resorts availed	Reports	MoYSA/ HAPCO
	Expand youth centers	No. of youth centers established	Reports	MoYSA/ HAPCO
	Establish out of school anti AIDS clubs and mini medias	No. and profile of AAC	Reports/ Visits	MoYSA/MoE/ Associations

Objective 16: People living with HIV/AIDS, Orphans and Other Vulnerable Children (OVC)

Ensure provision of adequate care and support services

Selected Strategies	**Major Activities**	**Indicators**	**Verification**	**Responsible Body**
Promote care within the family and mobilize the community to address and accommodate the issues of PLWHA/OVC	Train 15,000 volunteers on HBC Supply free essential supplies/kits for HBC	No. of people trained and actively reporting	Reports	MoH/PLWHA/ NGO/others
	Sensitize the community towards care and support Provide HBC for 150,000 people	No. of community sensitization sessions and people receiving care	Reports	MoH/PLWHA/NGO/ Community/ Volunteers
	Facilitate adoption and foster care	No. of OVC adopted	Reports Visits	MoLSA/ Community/FBO/ CBO /others
Provide counseling services, legal advice and protection to PLWHA/OVC	Revise existing laws and provide legal services	No. of people receiving legal services	Reports/ Visits	MoJ/ Associations/ Others
	Provide free basic health and education services	No. of beneficiaries	Reports/ Visits	MoH/MoE/ Associations/ NGO/ Others
Provide access to basic health, education and other social services to PLWHA/OVC	Provide backup training, supervision and referral services to HBC	No. of training and supervision sessions conducted. No. of clients referred	Reports/ Visits	MoH/ PLWHA/ NGO/ Community/ Volunteers/ others
	Provide finance for basic social service for needy PLWHA/OVC	No. of profile of beneficiaries	Reports/ Visits	MoLSA/PLWHA/ CBO/FBO/ Associations/ Others

Selected Strategies	Major Activities	Indicators	Verification	Responsible Body
Provide vocational skill training and income generation opportunity to PLWHA/OVC	Provide support for skill training, income and employment opportunity for 50,000 OVC and 10,000 PLWHA	No. of profile of people trained and employed	Reports/ Visits	CTVET/MoLSA/ PLWHA/ CBO/ FBO/ Associations/ Others
Develop acceptable social security models towards the special needs of PLWHA/OVC	Organize local self help groups for OVC and PLWHA with access to micro credit	No. of self help group organized	Reports/visits	CTVET/MoLSA/ PLWHA/ CBO/ FBO/ Associations/ Others/ HAPCO
	Create net work of school support sponsorship	No. and profile of OVC supported	Reports/ Visits	MoLSA/MoE/ MoJ/ FBO/ others
Mobilize all stakeholders to address the needs of PLWHA/OVC in sustainable manner	Sensitize, train FBO, AAC, CBO, NGO on care and support	No. and proportion of agencies actively engaged in care and support	Reports/ Visits	HAPCO/DPPC/ MoJ/ MoH/ Others

6. Budget requirement and Justification

The total budget required for the implementation of the strategic plan is around 6 Billion Birr.

In the allocation of funds, capacity building for the health and education sectors as well as the community at large has been given due attention, and accounts for 17% of the total budget requirement. Expansion of health services and human resources development to increase health coverage of the country, are the priority areas of the health sector. In this regard, funds are budgeted for providing the minimum package of service delivery for HIV/AIDS prevention, care and treatment at every level of health institution which is based on the programs identified for each level (Health Posts/Community, Health Centers, and Hospitals). The total budget required for these services amounts to 3.7 Billion birr 60% of which goes to procurement of drugs. In addition, a total of 1.1 Billion Birr is allocated for services to be rendered to PLWHA and orphaned children.

Some of the activities identified in the education sector are revision and development of curriculum, printing of educational materials, expansion of Anti-AIDS clubs and establishment of new and strengthening the already existing mini-media, training of critical mass of teachers and students for which is allocated.

In regards to fund allocation to community capacity building, emphasis is given to training of association leaders and communities as well as establishment of community and youth centers.

Some basic assumptions considered during budget allocations for the activities identified are:

- Health service coverage will increase from current 60%--80% in 4 years It is planned to construct 2000 new health posts and upgrade 675 health stations into health centers; however only 25% of the cost required for the construction and upgrading is budgeted in the SPM.

- Sufficient budget has been allocated in the plan in order to implement the minimum service package for HIV/AIDS at the various categories of health institutions.

- Mini media will be established in all schools.

- Curriculum on HIV/AIDS will be revised/developed and educational materials will be distributed to all schools.

- Community centers will be established in all kebeles and youth centers in all woredas.

- 150,000 patients will receive ART including comprehensive health care and the same number will receive financial support.

- 10% of orphans will receive financial support.

- HIV/AIDS prevention and control activities will be mainstreamed in all sector institutional policy and plans.

Budget Breakdown by Intervention area and Activity
Intervention Area

			Total
Capacity Building Health Sector			**1,214,352,000**
Health Facility Expansion	**Number**	**Unit Cost**	**1,141,172,000**
Health Post Construction and Equipment	2,000	120,000	240,000
Health Station Upgrading and Equipment	675	1,000,000	675,000,000
Hospital Equipment and Supplies	119	1,000,000	119,000,000
Radio Receiver	600	14,620	8,772,000
Motorbikes	700	12,000	8,400,000
Vehicles	600	150,000	90,000,000
Human Resource Development			**73,180,00**
Expansion of Training Institutions	26	2,000,000	52,000,000
Short Term Training	180,000	500	7,140,000
Upgrading of Junior Health Workers	27	520,000	14,040,000
Capacity Building Non Health Sector			**673,800,000**
Education			**211,800,000**
Review Existing Curriculum and conduct Operation Research	1	300,000	300,000
Printing of Educational Materials	7,500,000	10	75,000,000
Expand and Establish Mini-media and Anti-Aids Club	13,000	10,000	130,000,000
Train and Refresh Critical Mass of Teachers and Students	13,000	500	6,500,000
Community Capacity Building			**411,000,000**
Train Associations and Communities	150,000	500	75,000,000
Establish Mini-media and Community Information Center	15,000	10,000	150,000,000
Develop and Disseminate Local Educational approaches	600	10,000	6,000,000
Establish Wereda Youth Centers	600	300,000	180,000,000
Other Implementers (Mainstreaming)			**3,000,000**
Manpower Development	2,000	1,000	2,000,000
Guidelines and Manuals for Mainstreaming	1,000	1,000	1,000,000
HAPCO			**48,000,000**
General Capacity Building	12	4,000,000	48,000,000
Social Mobilization and Community Empowerment			**3,075,000**
Develop and distribute concept paper for community movement	15,000	5	75,000
Supervision and technical support to Kebele Administration	600	5,000	3,000,000

Integration with Health Programs			**3,750,949,200**
Primary Health Care Units and Hospital Services			
Health Posts/Community			**79,040,000**
IEC/BCC	1,000,000	40	40,000,000
Condom Distribution	2,000,000	12	25,400,000
Universal Precaution	9,000	960	8,640,000
Orphans and vulnerable children			0
Home Based Care			0
Surveillance	5,000	800	4,000,000
Referral Service			0
Networking			0
Health Centers			**340,084,600**
IEC/BCC	800,000	40	32,000,000
Condom Distribution	750,000	12	9,000,000
Universal Precaution	1,400	4,000	5,600,000
Orphans and vulnerable children			0
Home Based Care			0
Surveillance	1,400	2,000	2,800,000
Referral Service			0
Networking			0
VCT	840,000	60	50,400,000
PMTCT	29,641	600	17,784,600
OIs	75,000	500	37,500,000
STIs	500,000	50	25,000,000
ART	8,000	20,000	160,000,000
Training			0
Hospital Services			**2,015,224,600**
IEC/BCC	200,000	40	8,000,000
Condom Distribution	750,000	12	9,000,000
Universal Precaution	119	40,000	4,760,000
Orphans and vulnerable children			0
Home Based Care			0
Sentinel Surveillance	119	20,000	2,380,000
Referral Service			0
Networking			0
VCT	360,000	60	21,600,000
PMTCT	29,641	600	17,784,600
OIs	75,000	500	37,500,000
STIs	500,000	50	25,000,000
Safe Blood	50	984,000	49,200,000
ART	92,000	20,000	1,840,000,000
Mainstreaming			**1,316,600,000**
IEC/BCC	2,000,000	40	80,000,000
Condom Distribution	3,750,000	12	45,000,000
Universal Precaution			0
Orphans and Vulnerable Children	120,000	4,800	576,000,000
Home Based Care	75,000	7,200	540,000,000
Surveillance			0
Referral Service			0
Networking			0

VCT	100,000	60	6,000,000
ART	3,000	20,000	60,000,000
Leadership			**9,600,000**
Coalition and Policy dialogue Council forums	48	200,000	9,600,000
Coordination and Networking			60,800,000
Develop and disseminate guidelines for coordination and networking	4	200,000	800,000
Conduct Review and Experience sharing forums	600	100,000	60,000,000
Special Target Groups			**300,000,000**
Create micro credit revolving seed money	60,000	5,000	300,000,000
Human and Legal Rights			**1,500,000**
Monitoring and Evaluation	**12**	**200,000**	**2,400,000**
Total Cost for four Years			**6,006,876,200**

7. Governance and Institutional Arrangement

The HIV/AIDS epidemic is the world's most serious development crisis as well as most devastating epidemic in history. It is becoming the biggest obstacle to achieving the millennium development goals (MDGs)

HIV/AIDS requires high standard decentralized, effective and accountable governance and institutional arrangement at all levels. This has been one of the weakest links in our efforts so far. Hence, for our strategic plan to succeed and bear lasting fruit it is high time to review and rectify our method of governance and institutional arrangement. The mandate, role, duties and responsibilities of the leadership, implementers, community and their coordinating mechanisms have to be clearly defined and communicated.

The implementation arrangement of the multi-sectoral response to the epidemic, which should be framed around sustainable good governance, requires the active participation of various sectors whose activities are interdependent with a need for proper coordination and management. Hence, governance is given due attention in this SPM. It is identified as the key factor for intensifying the national multi-sectoral response, since it embraces management, coordination and accountability.

7.1 HIV/AIDS Councils and Executive Board

HIV/AIDS **Councils** will be strengthened at all levels of administration, from national to kebele levels. The councils at all levels will be composed of government, private, non-governmental, religious and civic society representatives and people living with HIV/AIDS. The NAC and RACs will elect their respective management boards. The Minister of Health and health officials at regional levels will be chairpersons of managing boards**.** The duties of the councils and management boards at all levels will be stipulated by the legislations of the respective governments.

7.2 The Ministry of Health

The Ministry of Health will spearhead the leadership in the national response to HIV/AIDS. Federal and Regional HAPCOs will be directly accountable to the Federal Ministry of Health and Regional Health Bureaus respectively. The zonal and woreda health offices and the health extension agents at kebele level will directly coordinate and implement the multi-sectoral HIV/AIDS response at their respective levels.

7.3 HIV/AIDS Prevention and Control Offices (HAPCOs)

The establishment of HIV/AIDS and Prevention and Control Offices shall be limited to national and regional levels only focusing on coordination, resource mobilization and multi-sectoral monitoring and evaluation. HAPCOs will coordinate interventions at zonal, wereda and kebele levels through the health structures at these levels, without opening separate zonal, wereda and kebele level offices.

This arrangement will allow for effective integrated and sustainable coordination and service provision, particularly at lower levels. HAPCOs at national and regional levels will be accountable to the Ministry of Health and Regional Health Bureaus.

7.4 Other Implementers

Multi-sectoral implementing partners at different levels will develop annual work plans and projects and submit them for possible funding to the level at which they are working. National and regional implementers will submit plans and reports to national and regional HAPCOs respectively while wereda level implementers will submit plans and reports to wereda health offices.

8. Monitoring and Evaluation

Monitoring and Evaluation of epidemiological, behavioral and socio-economical trends as a response to HIV/AIDS prevention and control efforts shall be an integral part of the realization of this national strategic plan. This requires development of key indicators and operational targets that can be objectively measured. Process and outcome indicators shall focus on major strategic issues including capacity building; social mobilization; integration with health programs; leadership and mainstreaming; coordination; networking and special target groups. Impact indicators will allow for monitoring trends in HIV infection and its socio-economic impacts.

A National HIV/AIDS Monitoring and Evaluation Framework that was developed in consultation with stakeholders can be used to select indicators to be measured. The framework also defines measurement methodologies for the indicators. The selected indicators will be measured through surveys, special studies and regular reports from implementing agencies and other partners. The framework outlines program indicators that stakeholders are required to report, and the frequency and hierarchy of reporting for the Multi-Sectoral Response to HIV/AIDS (December 2003).

The level and trend of the HIV/AIDS epidemic with particular attention to incidence and prevalence has not been monitored systematically in Ethiopia. Antenatal care based sentinel surveillance, with wide and fair representation of rural and urban health facilities shall be strengthened.

Efficient implementation of the Monitoring and Evaluation Framework requires a well established coordination mechanism at all levels. At the national level, HAPCO will be responsible for multi-sectoral monitoring and evaluation and will convene a meeting of key national level partners and regional HAPCOs to review progress biannually. Such meetings will not only allow for identification of pitfalls in time to take appropriate remedial actions, but will also allow for dissemination of best practices. The Ministry of Health, HAPCO, and other implementing and funding partners will also use the National Partnership Forums to implement the Monitoring and Evaluation Framework and to solicit the support of stakeholders.

Regional and Wereda Health Offices will also hold semi-annual and quarterly meetings respectively with stakeholders working in their areas to harmonize data collection for indicators at the national as well as local levels; to identify bottlenecks and take timely action and to disseminate best practices.

Last but not least, monitoring and evaluation shall track resource disbursement and utilization at all levels to ensure result-oriented performance and best use of resources.

9. Challenges and the Way Forward.

9.1 Challenges

This Strategic Plan is geared towards enhancing and scaling-up the ongoing multi-sectoral national response against the HIV/AIDS epidemic. The successful implementation of the plan will heavily depend on the commitment of the government, active participation of stakeholders at all levels, and direct involvement and ownership of the community. The main thrust in the implementation of the SPM will be strengthening grassroots activities through viable community mobilization and empowerment interventions to ensure the active involvement of the community. The following probable challenges have been identified for the implementation of the SPM.

- **Perception of and Consensus around the new implementation arrangement**

The main thrust of the new implementation arrangement for the SPM is on the two prongs of enhanced government commitment on the one hand and community mobilization and empowerment on the other. The government recognizes its critical role in accelerating the ongoing national multi-sectoral response and opts to organize its implementation mechanism for discharging its responsibilities in the combat against HIV/AIDS through the spearheading role of the MoH and the coordinating functions of HAPCO.

The departure (center piece) in this strategic plan is social mobilization – empowering the community for a meaningful impact on our fight against HIV/AIDS. All stakeholders need to have a clear understanding of the benefits of social mobilization and commitment to use this untapped resource effectively and efficiently.

The prevailing state of the community which is mainly characterized by passive involvement and dependency on external factors (government and others) may also pose as a challenge in community mobilization and in assuming its responsibility and ownership roles.

- **Resource Availability and Absorption/Utilization Capacity**

  The estimate of resource requirement for the implementation of the SPM, which is need based is quite enormous. The major source of fund for the hitherto activities are multi-lateral and/or bilateral foreign sources either through grant or soft loan. The new pledge through PEPFAR and other sources are promising. The situation will continue for long and though it appears that there may not be shortage of influx of assistance, sustainability is questionable. Availability of adequate and timely financial resources has always been and will continue to be a challenge. It has also been observed whereby funds have not been properly absorbed and utilized within a given period, which still remains to be a challenge.

- **Addressing the Growing Service Demand and Sustainability**

  The public is now sensitized and encouraged to seek for preventive, care and support services at all levels. However, the sustained availability and the expansion rate of services like VCT and ART may not commensurate with the growing demand. This could pose a serious challenge on the capacity of the government in making such services available adequately and in time.

- **Rapid Expansion of the Epidemic to the Rural Areas**

  As evidenced by the latest report on HIV/AIDS in Ethiopia No. 5 the epidemic is gradually spreading in the countryside. The phenomenon appears to be associated with urban-rural mobility and food insecurity both of which are linked to poverty and developmental issues. Hence, the issue becomes part of the all-round development challenge both urban and rural**.**

- **Manpower**

  Adequate number of qualified and committed manpower will be required at all levels but mainly at regional and woreda level. As in the past getting the right type of manpower, training and retaining them will pose a challenge.

9.2. Way forward

Despite the above-mentioned challenges, it is believed that the SPM could be implemented and the targets achieved through committed government leadership and the active participation of all stakeholders. The plan will be publicly launched, popularized and made operational. All efforts will be exerted to clarify issues and solve problems as they arise. The process will be flexible and accommodating of new developments.

10. Annexes

Annex 1 Minimum Service Delivery package by institution level

Institution	Functions
Health Post	• Awareness creation (IEC/BCC) • Condom distribution • Universal Precaution • Orphan and vulnerable children • Home based care • Surveillance • Referral service • Networking
Health Center	• IEC/BCC • Condom distribution • Home based care • VCT • STI • PMTCT • OIs • Universal precaution • Sentinel surveillance • Referral service • Networking • ART in selected health centers • Training (front line health workers)
Hospitals	IEC/BCC Condom distribution Home based care VCT STI PMTCT OIs Universal precaution ART Safe Blood Operational Research Training mid-level health staff Sentinel Surveillance Referral service Networking Technical support

Annex 2.
Role of key implementing agencies and stakeholders

This Strategic Plan provides a broad multi-sectoral plan for response to the epidemic. Each sector is expected to develop specific plans based on its role/mandate in the society and its capacity. The plans should focus on the sectors' comparative advantages in implementing the strategic plan. Each sector is expected to effectively mainstream HIV/AIDS in its sectoral policy and plan, to establish a focal taskforce/person responsible for advocating, managing and coordinating the implementation of HIV/AIDS activities within the sector and also to network with other sectors. The following scope of work is recommended for each sector.

- Launch workplace intervention for its staff and clients
- Identify the major determinants of the spread of HIV/AIDS specific to the sector
- Identify major obstacles to the response within the sector
- Integrate HIV/AIDS activities in the annual plans and ensure implementation
- Develop specific HIV/AIDS sectoral plans and budget
- Document best practices within the sector and share experiences
- Prepare and submit regular reports to the respective authorities and the coordinating bodies.

1. The Ministry of Health and the Health Sector

The health sector, both public and private, and from the national to the grassroots level, is the major and leading actor in the response against HIV/AIDS. The MoH has the responsibility of guiding the overall response to the epidemic. The majority of intervention areas are directly linked with the mandate of the health sector. The demand for HIV/AIDS-linked health services is growing rapidly, indicating the urgency of scaling up the implementation capacity of the sector at all levels. The core components of the sector's response to HIV/AIDS are focused on:

- Guiding the overall response to the epidemic
- Organizing and providing health services
- Providing a regulatory and implementation role
- Setting out and implementing health standards and health service delivery systems
- Informing policy, strategy and program development
- Training different categories of health workers including Health Agents (HA)
- Procuring drugs and medical supplies
- conducting research and surveillance
- Ensuring quality control (QC) and quality assurance (QA)
- Developing laboratory capacity
- Producing/updating relevant guidelines, protocols and manuals
- Monitoring, evaluating and providing backstop services for health providers.

2. The Ministry of Education and the Education Sector

The education sector has major responsibility in human resource development and molding the productive citizens of the country. The Sector is expected to actively engage in the following major HIV/AIDS related activities:

- Mainstreaming HIV/AIDS into the educational system
- Developing IEC/BCC, including expanding and strengthening the educational mass media and school mini-media
- Expanding and strengthening school Anti AIDS Clubs and peer education
- Promoting adolescent reproductive health services
- Including HIV/AIDS issues in the curriculum and life skill training programs
- Encouraging research/surveillance activities

3. The Ministry of Agriculture and the Rural Development Sector

The Sector has the comparative advantage of reaching farmers and pastoralist communities and facilitating the expansion of HIV/AIDS interventions to the rural areas through its rural development agents. The Sector will engage, among others, in:

- Mainstreaming HIV/AIDS issues in all rural development, agricultural and food security policies and activities
- Raising awareness through the Development Agents (Das)
- Enhancing the capacity of Kebele Farmers Associations in HIV/AIDS related project development and implementation
- Incorporating HIV/AIDS training in DA training packages
- Facilitating access to extension services for affected families and empowering female farmers,
- Assessing and reporting the impact of the epidemic on the sector.

4. The Ministry of Labor and Social Affairs and the Social Sector

The Sector is mainly responsible for developing and following up of workplace interventions and social rehabilitation schemes. Its roles/mandates, among others, will include:

- Mainstreaming HIV/AIDS into the Sector's overall policy and plan
- Drawing strategies for prevention, control and impact mitigation of HIV/AIDS in production and service giving facilities and developing workplace interventions
- Regularly updating the labor law and other social legislations
- Promoting social services (care and support) for PLWHA and OVCs

5. The Women's Affairs Bureau

The gender inequality that has prevailed in rural and urban communities for years has fueled the vulnerability of and contributed to the spread of the virus among women. The Sector is responsible for addressing gender inequality and advocating for mainstreaming gender in all sectors of development and services. Its major areas of focus will include, among other,

- Advocating for the empowerment of women and creating enabling environment to build their skills and thereby reduce risks
- Promoting and expanding reproductive health services in rural areas
- Enhancing the participation of women in all interventions mainly in prevention, HBC and support services, and PMTCT
- Advocating for and promoting vulnerability and risk reduction programs against rape, early marriage and harmful traditional practices

6. The Disaster Prevention and Preparedness Commission/ DPPC

Recurrent drought and food insecurity has led to an extensive population movement in the country. Internal displacement of drought affected people in search of assistance has attracted aid-seekers to food distribution and relief centers. The resettlement scheme has required translocation of people to new ecological zones. This, the Commission has the role/mandate of designing interventions tailored to the needs and realities of the displaced people. In collaboration with relevant sectors, the Commission will provide to displaced/resettled people by focusing on:

- Providing IEC/BCC
- Ensuring car and support and
- Ensuring access to VCT services

7. The Trade, Industry, Transport and Communications Sectors

These Sectors have the role/mandate of developing and implementing interventions targeted at transport workers (land and air), factory workers, migrant laborers and other groups practicing high-risk behavior by focusing on:

- Expanding workplace interventions
- Enhancing IEC/BCC activities
- Expanding user friendly VCT services (including mobile services)
- Promoting and distributing condoms

8. The Ministry of Information, the Media and Information Sector

The Sector has the comparative advantage of guiding and developing the use of the mass media in disseminating HIV/AIDS related information and messages to the

general public and special target groups in different languages. Besides intensifying specific workplace interventions it has the mandate/role for:

- Establishing a network of private and public media, promoting media campaigns, and inciting public dialogue on the epidemic
- producing and regularly updating the natural glossary of terms related to HIV/AIDS
- Developing and facilitating the expansion of edutainment programs through the mass media, etc.
- Developing guidelines for the involvement of the media in the fight against HIV/AIDS.

9. The Ministry of Youth, Culture and Sports Affairs

Youth, both in and out of school, and in both rural and urban settings, are amongst the most vulnerable groups. The Sector has the responsibility to develop, promote and expand innovative vulnerability reduction approaches that can provide for better life alternatives for the youth. Towards this end, the sector is expected to play pivotal role in:

- Advocating and facilitating for the productive engagement of the youth
- Developing strategies to establish comprehensive youth centers and edutainment facilities.
- Advocating for the expansion of youth friendly health services
- Enhancing youth focused IEC and Care and support activities

10. The Justice Sector

Widespread abuse of human rights and fundamental freedom associated with HIV/AIDS infection has emerged since the start of the epidemic in the country. Respecting the rights of PLWHA is one of the essential conditions for an effective response to HIV/AIDS. An environment in which the rights of PLWHA are respected ensures that vulnerability is reduced, and helps victims live dignified lives, ensures that their special needs are progressively realized and the impact on the family and community is mitigated. Towards this end, the Sector has the responsibility for:

- Periodically reviewing and modifying HIV/AIDS related legislation,
- Facilitating legal services for the PLWHA and their families
- Creating forum for dialogue on human right and other legal issues

11. The finance and Economic Development Sector

The Sector has the responsibility of assisting the multi-sectoral national response in:

- Fund raising and resource utilization
- Ensuring that relevant government line ministries and agencies have included HIV/AIDS prevention and impact mitigation activities in their annual work plans and budget and

- Facilitating the streamlining of HIV/AIDS in the overall development strategies

12. Parliament

As the supreme legislative power of the country, the Parliament has the responsibility of issuing relevant HIV/AIDS related legislation and demanding and enforcing:

- Mainstreaming of HIV/AIDS into government agencies annual work plans and budgets,
- Assigning special taskforces/committees to closely follow HIV/AIDS
- ensuring accountability

13. Uniformed Services

HIV/AIDS is not only a socio-economic problem but also becoming a security threat. Hence, it is important to mainstream HIV/AIDS in the general activities of the defense, militia and police forces at all levels. The uniformed services have the comparative advantage of organization and discipline and the capacity of extending civic services to remote areas and unreachable segments of the rural population including the pastoralists. The sector is expected to focus on:

- Fighting the epidemic within their domain and mitigating the security impact of the epidemic
- Playing the additional role of expanding the services to remote areas.

14. The Foreign Affairs Sector

The HIV/AIDS pandemic is already a global issue. Reponses to the pandemic require international collaboration in resource and experience sharing. Towards this end, the Sector has the responsibility of:

- Keeping the diplomatic community informed on the status of the epidemic
- Facilitating networking for accessing external resources and building diplomatic skills.

15. The Ethiopian Science and Technology Commission:

The Commission has the role/mandate of:

- Initiating and directing applied and basic research activities and disseminating findings to stakeholders.
- Enhancing the research capacity of regional institutions and researchers
- Creating networks with international and regional research institutions, academic centers and resource center
- Setting out a national research agenda and serve as a center for QC and QA

16. Civil Society Organizations

These are the principal actors and partners in the multi-sectoral response to the epidemic. They have the comparative advantages of mobilizing their constituencies and organizing and implementing community initiatives mainly at the grassroots levels. Associations have key roles in community mobilization and can play roles in the following:

- Organizing and implementing prevention activities,
- Providing of community-based care and social support services for PLWHA and OVCs.
- Sensitizing communities, mobilizing resources, and policy advocacy.

17. Associations of Persons Living with HIV/AIDS (PLWHA)

PLWHA are the key actors of the national response. they are expected to organize themselves in as many associations and at all levels as they find it fit and form a joint forum. They are expected to focus on:

- Protecting the rights of their members
- Educating the public at large through sharing their life experiences
- Promoting and participating in the provision of compassionate home based care
- Fighting stigma and discrimination
- Advocating for responsible behavior among their members
- Advocating for access to ART and policy formulation and legislation
- IEC/BCC

18. Faith Based Organizations (FBOs)

FBOs have the comparative advantage of unleashing the potentials and initiatives of their followers through their well-structured and cohesive system. The Ethiopian Orthodox church, the Ethiopian Islamic Affairs Supreme council, the Ethiopian Catholic Secretariat, the Ethiopian Evangelical Church Mekane Yesus, and other groups are expected to play more active roles in the prevention, care and support activities. These FBOs can play key roles in:

- IEC/BCC (Promoting abstinence before marriage and faithfulness after getting married)
- Counseling (spiritual support)
- Providing welfare support to the infected and affected including hospice service
- Providing care and support for OVC
- Promoting VCT before marriage

19. The Ethiopian Red Cross Society

As one of the oldest local voluntary organizations in the country, this society has played very important roles in expanding blood banks and a safe blood supply system, in providing relief and rehabilitation operations and now in providing HIV/AIDS prevention, care and support. It is expected to focus on:

- Expanding and improving the safe blood supply system
- Establishing sustained non-remunerated voluntary donors from the low risk group.
- Training health personnel and building the capacity of service giving institutions.
- Advocating for the formulation of blood policy
- Intensifying its youth focused prevention and care and support activities.

20. The Private Sector (Including the EEF, CETU)

The sector has the responsibility for

- Mainstreaming HIV/AIDS into the business sector
- Mobilizing resources for combating the epidemic
- Lobbying for the revision of labor laws
- Organizing and operating workplace interventions (IEC/BCC, care and support) for their workers and clients

21. International partners

The international development partners (bilateral, multi-lateral, NGOs, foundations, etc) have key roles to play in expanding and improving the response by rendering financial support, technical backstopping, training, exposure and experience sharing visits.

22. Professional Associations

Professional Associations including the Ethiopian Teachers' Association, the Ethiopian Medical Association, the Ethiopian Public Health Association, the Ethiopian Economists Association, etc, have key roles to play in their respective domains. They are responsible for focusing on:

- Providing professional backup service by mobilizing their professional members at all levels
- Providing consultancy services
- Actively participating in research and surveillance activities
- Organizing workplace interventions

Annex 3:

Identified List of policy documents, manuals and guidelines and their states

No	Description	Status		
		In use	Requires updating	To be newly developed
1	Policy on HIV/AIDS (FDRE)	☐	☐	
2	Strategic Framework for the National Response to HIV/AIDS	☐		
3	Strategic plan and Management to combat HIV/AIDS in Ethiopia			☐
4	Legislation on HAPCO	☐	☐	
5	HAPCO Organogram	☐	☐	
6	Project Implementation Manual (PIM) EMSAP	☐	☐	
7	Manual For Fund Management and Accounting	☐	☐	
8	National guideline on VCT	☐	☐	
9	National guideline on PMTCT of HIV in Ethiopia	☐	☐	
10	Policy on ARVD Supply and Use of (FDRE)	☐	☐	
11	Guideline on Community HBC for PLWHA	☐	☐	
12	National Monitoring and Evaluation Framework	☐		
	National Monitoring and Evaluation Guideline			☐
13	Mainstreaming Guideline on HIV/AIDS Intervention			
14	Guideline for the Appraisal of HIV/AIDS prevention and Control projects and WPs	☐		
15	Guideline on Workplace intervention (Amharic)	☐	☐	
16	Organization and Administration Manual	☐	☐	
17	Guideline on ARVD	☐	☐	
18	Guideline for project Holder	☐	☐	
19	OI Management guideline and Manual	☐	☐	
20	National HIV/AIDS communication Framework	☐		
21	HIV/AIDS communication Guideline	☐		
22	ART Guideline (Technical) and Manual			☐
23	Life Skills Education Manual			☐
24	Guideline for Establishment of Youth Center			☐
25	Guideline for Establishment of Anti-AIDS Club			☐
26	Guideline for Establishment of Community AIDS Funds			☐
27	National Glossary of Terms Related to HIV/AIDS			☐
28	Guideline on Research and Surveillance			☐
29	Guideline on Breast Milk Substitute for PMTCT			☐
30	Policy and Guideline on Blood Safety			☐
31	Policy and Guideline on UP and PEP			☐
32	Coordination Guideline			☐

Annex 4:
Acronyms

AAC	Anti-AIDS Clubs
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral
ARVD	Antiretroviral Drugs
BCC	Behavioral Change Communication
SS	Behavioral Surveillance Survey
BYCS	Bureau of Youth, Culture and Sports
CBOs	Community Based Organizations
CDC	Center for Disease Control
CSC	Civil Service Commission
CSWs	Commercial Sex Workers
CVET	Center for Vocational Education & Training
DAs	Development Agent
DHS	Demographic and Health Survey
DPPC	Disaster Prevention and preparedness Commission
EB	Education Bureau
EC	Ethiopian Calendar
EFY	Ethiopian Fiscal Year
EMSAP	Ethiopian Multi-Sectoral HIV/AIDS Prevention and Control Project
EHNRI	Ethiopian Health and Nutrition Research Institute
ERCS	Ethiopian Red Cross Society
FBOs	Faith Based Organizations
FP/RH	Family Planning/Reproductive Health
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home Based Care
HCs	Health Centers
HEWs	Health Extension Workers
HIV	Human Immuno Deficiency Virus
HTPs	Harmful Traditional Practices
IAs	Implementing Agencies
IB	Information Bureau
IDA	International Development Association
**Idir*	Community Based traditional self-help groups.
IDP	Internally Displaced people
IEC	Information Education and communication
GA	In Come Generating Activities
IMR	Infant Mortality Rate
IPs	International Partners
**Iquib*	Traditional Saving Group/association
KA	Kebele Administration
*Mahber	Religion or kinship based traditional self-help group

MoA	Ministry of Agriculture
MoD	Ministry of Defense
M&E	Monitoring and Evaluation
MoE	Ministry of Education
MoFED	Ministry of Finance and Economic Development
MoJ	Ministry of Justice
MoH	Ministry of Health
MoLSA	Ministry of Labor and Social Affairs
MoLTI	
MoYCS	Ministry of youth, Culture and Sport
MOV	Means of Verification
MTCT	Mother to Child Transmission
MTP	Mid Term Plan
NAC	National AIDS Council
NGOs	Non Governmental Organizations
NSF	National Strategic Framework
NTF	National Task Force
OIs	Opportunistic Infections
OVC	Orphan and Vulnerable Children
OVIs	Objectively verifiable Indicators
PEP	Post Exposure Prophylaxis
PLHA	Persons Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
POs	Private Organizations
QA	Quality Assurance
QC	Quality Control
RACs	Regional AIDS Councils
RBs	Regional Bureaus
REBs	Regional Education Bureaus
RFBs	Regional Finance Bureaus
RH	Reproductive Health
RHAPCOs	Regional HIV/AIDS Prevention and Control Office
RHBs	Regional Health Bureaus
*Senbetie	Religion based self-help group mainly of Orthodox Christians
SPM	Strategic plan and Management
SSH	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
STP	Short Term plan
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UP	Universal Precaution
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
WHOs	Woreda Health Offices