STRATEGIC PLAN FOR INTENSIFYING MULTISECTORAL HIV AND AIDS RESPONSE IN ETHIOPIA II (SPM II)
2009 - 2014

Federal HIV/AIDS Prevention and Control Office
Federal Ministry of Health

Addis Ababa, Ethiopia

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Acronyms

AACs	Anti-AIDS Clubs
ABC	Abstinence, Be faithful, Condom Use
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Antiretroviral Drug
BCC	Behavioral Change Communication
BPR	Business Process Reengineering
CAP	Community Anti-AIDS Promotion
CBO	Community-Based Organization
CHW	Community Health Worker
CRDA	Christian Relief Development Association
CSO	Civil Society Organizations
DHS	Demographic and Health Survey
E.C	Ethiopian Calendar
EIFDDA	Ethiopian Inter-faith Forum for Development, Dialogue and Action
EHNRI	Ethiopian Health and Nutrition Research Institute
ESDP	Education Sector Development Program
FBO	Faith-Based Organization
FMOH	Federal Ministry of Health
FP/RH	Family Planning/Reproductive Health
GBV	Gender-Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAPCO	HIV/IDS Prevention and Control Office
HBC	Home-Based Care
HCSS	Health Commodity Supply System Logistics Master Plan
HCT	HIV Counseling and Testing
HEP	Health Extension Program
HEWS	Health Extension Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resource
HRD	Human Resource Development
HSDP	Health Sector Development Program
IEC	Information Education Communication
IP	Infection Prevention

MAC-E	Millennium AIDS Campaign-Ethiopia
MARPs	Most At Risk Populations
MCH	Maternal Child Health
MDGS	Millennium Development Goals circulate
M&E	Monitoring and Evaluation
MIS	Management Information System
MOE	Ministry Of Education
MOH	Ministry Of Health
MTCT	Mother-To-Child Transmission of HIV
NAC	National Aids Committee
NEP+	Network of Networks of People Living with HIV
NGO	Nongovernmental Organization
OVC	Orphans and Vulnerable Children
PASDEP	Plan for Accelerated and Sustainable Development to End Poverty
PEP	Post-Exposure Prophylaxis
PEPFAR	Us President's Emergency Plan For AIDS Relief
PIHCT	Provider-Initiated HIV Counseling and Testing
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission of HIV
PNC	Post-Natal Care
RHAPCO	Regional HIV/AIDS Prevention and Control Office
RHB	Regional Health Bureau
STD	Sexually Transmitted Disease
STG	Standard Treatment Guideline
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWG	Technical Working Group
VCT	Voluntary Counseling and Testing
WrHO	Woreda Health Office

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INTRODUCTION

The multisectoral response to HIV/AIDS in Ethiopia is guided by the National HIV/AIDS Policy, 1998; the Strategic Plan for Intensifying Multisectoral HIV Response, SPM I (2004-2008); the Plan for Accelerated and Sustained Development to End Poverty, PASDEP 2007-2010; and on major plans, such as the road map for accelerated access to HIV prevention, treatment and care in Ethiopia 2007-2010, the Plan of action for universal access to HIV prevention, treatment, care and support in Ethiopia 2007-2010.

Series of attempts were made to monitor the situation of the epidemic and review and evaluate the achievements and effectiveness of the multisectoral response against HIV/AIDS. These include:

- Single point estimate calibration 2005 of ANC HIV sentinel surveillance report & 2005 DHS
- BSS 2002 and 2005 reports
- Epidemiological synthesis report, 2008
- Final Evaluation report of SPM I, 2004-2008
- Impact Evaluation Report of the Global Fund to Fight AIDS, TB & Malaria
- Final Evaluation report of EMSAP I
- Mid-term evaluation report of HSDP III
- Aide memoire and Mid-term review report of EMSAP II
- UNGASS report, 2007
- Proceedings of review meetings
- Consensus statement of the National Prevention Summit

The existing evidence has shown that the epidemic is more heterogeneous across the nation with more urban and females affected than rural areas and males. Urban epidemic is on decline in major towns while rural epidemic is leveling off. But small towns are becoming hotspots and could potentially bridge further spread of the urban epidemic to rural settings. The dynamics of sexual behaviors and networks in the hotspots and their surrounding communities as well as in the most at risk population groups and the general population is not fully understood, requiring further investigation to uncover the epidemic and its driving factors.

Further look into the response to the epidemic has depicted that during SPM I, remarkable achievements were made in mobilizing & empowering communities, and in creating access to and increasing utilization of HIV services. Dramatic achievements were observed in HCT service uptake where more than 13.2 million people counseled and tested for HIV during the period and over 180,455 patients were ever started on ART. However, the low coverage and poor uptake of PMTCT service, weak STI services, inadequate mainstreaming, low coverage of care and support services, lack of strategic information and weak non-health MIS were also observed.

The SPM II has eight major parts excluding the introduction and the executive summary. Part one covers a synoptic overview of the HIV/AIDS epidemic and the response analysis. Part two consists of the vision, mission, goal and guiding principles of the national response, while part three elaborates on the ten

strategic issues, in two sections: enabling thematic areas and programmatic and priority thematic areas with their objectives and key strategies. Part four of the SPM is the result matrix, which outlines selected strategies, major interventions, targets, indicators, means of verification and lead responsible bodies. Part five covers the budgetary requirements and justification. Part six and seven cover the implementation and monitoring and evaluation modalities respectively. Part eight deals with perceived risks and assumption.

The SPM covers five years (2009-2014). Consolidated operational annual plans will be prepared to translate the SPM into action. The implementation process and achievements will be closely monitored and evaluated. Multisectoral actors at all levels are expected to develop and implement their HIV/AIDS response plans based on this SPM in harmony with the principles of the "Three Ones".

EXECUTIVE SUMMARY

Epidemic Situation Analysis

Trend of the Epidemic

Since the detection of the first two reported AIDS cases in 1986 in Ethiopia, the epidemic has rapidly spread throughout the country. According to the single point estimate, the national adult HIV prevalence is 2.2% in 2008 with an estimated 1,037,267 people living with HIV in the country. The epidemic which started in the mid-1980's, expanded rapidly and reached a plateau around the mid-1990s. In major urban settings, the epidemic is on decline while stabilizing in rural areas. However, there is significant variation in the epidemic among geographic areas and population groups.

Heterogeneity of the Epidemic

Across the country, urban areas and females are more affected than rural areas and males. Urban HIV prevalence was 7.7% in 2008 with an estimated 62% of total PLHIV in the country residing in urban areas, while rural HIV prevalence was 0.9% in 2008, which accounts for 38% of total PLHIV population in the nation. Among urban settings, the epidemic varies greatly from 2.4% in Somali region to 9.9% in Tigray, 10.7% in Amhara and 10.8% in Afar regions. Rural HIV epidemic also varies significantly from region to region with rural HIV prevalence ranging from 0.4% in Somali region to 1.5% in Amhara region. Small towns are becoming hotspots and can potentially bridge further spread of HIV epidemic to rural settings. DHS 2005 has shown exceptionally high HIV prevalence in Gambella region. Addis Ababa and four regions: Amhara, Tigray, Oromia, and SNNPR account for 93.4% of the total PLHAs population in the country. Across all the regions, females are more affected than males in both urban and rural areas. In 2008, female HIV prevalence was 2.6% while male HIV prevalence was 1.8%. Females account for 59% of the total PLHIV in the country. According to DHS 2005, females are twice more affected than males.

Most at risk population groups

Traditionally most at risk population groups, such as female sex workers, uniformed forces, long distance drivers, never-married sexually active females, discordant couples, migrant laborers, people interfacing small towns, cross border population and in school youth particularly at tertiary education are increasingly at risk of HIV infection. There is a data gap to accurately measure the recent spread of HIV in these groups and their potential role in further spreading the epidemic to the general population.

Knowledge and sexual behavior patterns

Despite high awareness about AIDS, comprehensive knowledge on transmission routes and prevention methods is low. According to BSS 2005, only 57% of the studied population knew all three prevention methods and major misconception was high in the general population.

There is an encouraging trend of consistent, over 90% condom use among CSWs, uniformed forces and long distance drivers; but condom use in casual sex with non-regular partner is still low. Only 54% of people who had sex with non-regular partner used condom. Those who had sex with 2 or more non-

regular partner have slightly decreased, but there are still highly risky sexual practices of pre-marital and extra-marital sex in the society. Never married sexually active young women are at greater risk of HIV due to sexual mixing with older, high risk men through transactional and intergenerational sex.

Determinant Factors of the Epidemic

Determinant factors that drive the epidemic and sexual behaviors among different population groups are not adequately explored but limited studies and anecdotal evidences indicate that low level of comprehensive knowledge about HIV/AIDS, low level of perceived risk and threat of HIV and AIDS, increased population migration; high prevalence of unprotected sex through concurrent multiple partnerships, intergenerational transactional sex, high prevalence of STIs, alcohol and substance abuse, gender inequality and poverty could be cited as some of the drivers of the epidemic. As PMTCT service uptake and ANC coverage are low, there is considerably high vertical transmission from mother to child.

Response Analysis

The multisectoral response to HIV/AIDS in Ethiopia was expanded dramatically during the implementation of Ethiopian SPM 2004-2008. Capacity in the community and in the health sector was significantly increased. Over 30,100 health extension workers deployed into rural kebeles all over the country have ignited public movement against HIV/AIDS through community conversation, which has enabled community members to perceive the problem of HIV/AIDS, create consensus on what fuels the epidemic in their own settings and how to prevent it, by developing plan of actions and by crafting relevant community bylaws. These have resulted in social transformation and increased demand for & utilization of HIV services by communities. Some kebeles in Amhara and Tigray regions were able to voluntarily counsel & test 100% of the adult population in their areas with the provision of care & support to OVC and PLHIV by community members. Many religious organizations and community groups across the country have instituted the culture of pre-marital HIV counseling and testing into their bylaws.

The accelerated expansion of primary healthcare facilities with decentralization of HIV/AIDS services coupled with the innovative millennium AIDS campaign- Ethiopia (MAC-E), launched in November 2006 at the eve of the new Ethiopian Millennium, have increased HCT service uptake by 9 folds. People counseled & tested for HIV increased from less than ½ a million per year in 2004, to 4.6 million per year in 2008. The accelerated expansion of free ART programme by the government of Ethiopia improved survival and quality of life for AIDS patients. ART sites increased from 3 in 2005 to 483 in year 2008, while patients ever started on ART increased from 8,226 in 2005 to 180,455 by the end of 2008. However, the counties performance on PMTCT throughout the period was below par.

Moreover, capacity of PLHIV association was also strengthened by empowering them to play decisive roles in the governance, management and service delivery of the HIV/AIDS response. The Network of Networks of People Living with HIV in Ethiopia (NEP+) is a member of National AIDS Council (NAC), national management board, Country Coordinating Mechanism (CCM) for GFATM, review board and it is the principal recipient of the GFATM round 7 at national level with decentralized involvement at regional & sub-regional levels. The *Ethiopian Inter-faith Forum for Development, Dialogue and Action (* EIFDDA) has

become the principal recipient of round 7 GFATM along with public sector and NEP+ to enhance the faith based HIV/AIDS response in the country.

Many public sectors, NGOs, and the private sector have initiated mainstreaming HIV/AIDS into their core activities during this period. Education sector has integrated HIV/AIDS into curriculum and initiated peer education, life skills and school community conversation in considerable number of schools.

Other initiatives were undertaken to enhance behavioral change among most at risk population groups as evidenced by high condom use, over 98% by traditional MARPs such as CSWs, uniformed forces and truckers. Access to AIDS information was increased through expansion of AIDS resource centers, Hotlines for the general population and Fetun warm-line for health care service providers. BCC messages were transmitted using print & radio serial dramas. Condom was supplied principally by social marketing with limited supply through healthcare facilities.

However, there were limitations and challenges during the SPM I period. The major challenges include: inadequate capacity in the key strategic sectors, shortage of human resource & rapid turnover of staff, low coverage & poor uptake of PMTCT services, inadequate mainstreaming, weak STI services, low coverage of care & support services, limited coverage of services for most at risk population groups, inadequate strategic information and weak non-health MIS.

Strategic Thematic Areas of SPM II 2009-2011

After thorough analysis of the epidemic, the current response's major achievements, gaps, and challenges; two major strategic areas namely creating enabling environment for the response & priority programmatic thematic areas were identified. Strategic issues included in the enabling thematic area are capacity building, community mobilization & empowerment, leadership and governance, mainstreaming, coordination, and partnership & networking. Whereas strategic issues in the programmatic thematic areas include: intensifying HIV prevention, increasing access & quality of chronic care & treatment, strengthen care & support, and enhance generation & use of strategic information.

Creating Enabling Environments - Strategic Issues

Capacity Building

Building capacity is of utmost importance to sustain the gains in the fight against HIV/AIDS and accelerate the move towards universal access with the view of reversing & halting the epidemic. Efforts of capacity building during SPM II (2009-2014) will focus on consolidating the capacity in the health sector to further decentralize HIV services towards universal access with improved service linkage & quality. Community capacity will also be enhanced to enable social transformation on mass basis by creating health competent households & communities. Moreover, emphasis will be given to build the capacity of key strategic sectors, PLHIV associations, CSOs, and vulnerable at risk groups including the youth & women along with building the capacity of multisectoral response coordinating & governing bodies.

Community Mobilization and Empowerment

Communities should actively involve and own HIV/AIDS prevention & control efforts to make the fight against HIV/AIDS successful. Anti-HIV/AIDS community movement should be ignited, scaled up and sustained to effectively mobilize, engage and empower communities. This enables the communities to perceive & create consensus on the threat of HIV/AIDS to their survival and development, identify factors that make them vulnerable, come up with local solutions and use indigenous wisdom, values, resources, and structures to effectively respond to the epidemic by developing concrete community plans. The community must own the movement and integrate HIV/AIDS response into the existing socio-cultural and economic activities. All key actors at community level should be involved in the movement & institutional support should be strengthened to meet the demands that follow intensified community mobilization.

Leadership and Governance

Leadership and governance will be strengthened as it is essential to create capacity, synergy, responsiveness and accountability in the multisectoral response against HIV/AIDS. The response to HIV/AIDS should be set as a strategic development issue by all sectors with enforcement of implementation through sustainable leadership commitment, at various levels, to guarantee responsiveness to customer needs and create accountability.

Mainstreaming

The response to HIV/AIDS should be mainstreamed into core activities across all sectors to prevent further spread of HIV and mitigate its impact. Sectors should assess their vulnerabilities, existing response capacity, and the impact of HIV/AIDS on the sector and come up with sectoral polices, strategies, and action plans to mainstream HIV/AIDS using sector's own resources. HIV/AIDS response programs should be incorporated into sectoral planning, budget, information system, and M&E mechanisms. During SPM II period mainstreaming should be expanded to the private sector, NGOs and civil society organizations.

Coordination

Coordination of multisectoral response against HIV/AIDS should be strengthened by instituting the principle of the "Three Ones". Broad based multisectoral response framework will be developed with involvement of all stakeholders. Harmonized and synchronized one country plan should be produced at each level under the leadership of government coordinating body accompanied by one multi-sectoral M&E system to monitor & evaluate the progress jointly.

Partnership and Networking

Effective response against HIV/AIDS requires strong partnership at all levels to synergize efforts and resources to meet the complex needs of HIV prevention, treatment, care, & support. Evidences have shown that working in partnership between the government, private sector, faith-based entities, non governmental bodies, and others is of the essence to effectively, efficiently and sustainably respond towards the HIV epidemic. Partnership guidelines and frameworks will be developed to strengthen partnership with defined commitments & responsibilities based on comparative competencies among different players. HIV/AIDS service providers, and partners will be mapped & networked to increase efficiency through strengthened partnership and networking.

Programmatic Strategic Issues

Intensifying Prevention

The fight against HIV/AIDS cannot be successful unless further spread of the epidemic is reversed and ultimately halted. This requires among others bringing social transformation to reduce social, cultural & economic factors that make people individually or collectively vulnerable to HIV infection and creating comprehensive knowledge and behavioral change on a mass bases among the population at large with a particular focus on most at risk population groups. HIV prevention services should be promoted and availed to reduce and halt sexual as well as vertical transmission of HIV. Prevention of new HIV infection among young people & adult population must be intensified using combination prevention approaches to address structural, behavioral, and bio-medical issues in HIV prevention. Package of HIV prevention services for MARPs and PLHIV will be developed, implemented and scaled up towards universal access.

Strengthening chronic care & treatment

As a result of improved chronic care using OI drugs and HARRT, HIV/AIDS is becoming a manageable chronic disease with increased longevity and reduced morbidity and mortality among patients. Efforts made to improve quality of life for HIV patients during SPM I will be further strengthened by creating universal access to and increasing utilization of HIV chronic care & treatment services. Chronic care and treatment services will be further decentralized through expansion of services, task shifting & improving service integration, linkages and referral systems. Barriers to service delivery will be addressed by increasing the number and quality of human resource, availing OI & ARV drugs, and improving logistic, laboratory and strengthening HMIS systems. Health network model will be implemented to enhance service quality through clinical mentoring, public private partnership and community based services. Especial emphasis will be given to improve adherence and retention of patients on treatment.

Strengthening care & support

Mitigating the devastating impacts of HIV/AIDS is essential to improve the livelihood of the infected and affected segment of population. Care and support services will be provided to OVC and PLHIV in their familial networks with the active involvement of local communities. Efforts will be made to reduce dependency by scaling up income generation activities to the needy OVC and PLHIV through enhanced partnership, service mapping and institutional support.

Enhancing generation & use of strategic information

To institute evidence based informed policy making, program planning & management of HIV/AIDS response, generation and utilization of strategic information will be improved. Efforts will be enhanced to match the response to the epidemic by continuous generation, analysis and use of strategic information to know the epidemic, its driving factors and the current response as well as the effectiveness of existing interventions. Capacity to generate and use strategic information will be strengthened in key sectors by integrating of HIV strategic information into sectoral information management system

3. Monitoring and Evaluation

Monitoring and evaluation of the multisectoral response to HIV/AIDS will be strengthened at all levels, in accordance with the principle of the “three ones.” Multisectoral response inputs, processes, outputs,

outcomes, and impacts will be monitored and evaluated using routine reports, surveillances, surveys, and studies. A functional M&E system will be instituted by developing and implementing a costed plan of action of the monitoring & evaluation framework through creation of capacities at all levels and across key sectors. To facilitate the monitoring & evaluation of SPM II, the overall goal, objectives, and strategic results are set. The results matrix of the thematic areas outlines the selected strategies, major interventions, targets to be achieved, indicators, means of verifications, and responsible lead bodies to coordinate or carry out the activities.

PART ONE

1.1. SITUATION ANALYSIS

1.1.1. General Background

Ethiopia had a projected population of 77 million for 2007[1] (about 84% living in rural areas). Administratively, the country is a Federal Democratic Republic composed of 9 National Regional states and two city administrations, with 750 *Weredas* (districts). The *Weredas* represent the basic units of planning and political administration. Below the districts are *Kebeles* representing urban dwellers associations in towns and peasant associations in rural villages, which number approximately 15,000. Economically, Ethiopia is a low-income country with a per capita gross national income of $110 in 2005[2]. The overall health status of the Ethiopian people is poor. Life expectancy at birth stands at 54 years (53 years for men and 55 years for women). Infant Mortality Rate (IMR) is estimated to be about 77 per 1,000 and Under-5 mortality is about 123 per 1,000. Poor nutritional status, infections and a high fertility rate, together with low levels of access to reproductive health and emergency obstetric services, contribute to one of the highest maternal mortality rates in the world. Maternal Mortality Ratio is estimated to be 673[3].

The major health problems of the country are diseases of a communicable nature that are due to poor personal hygiene, improper garbage and waste disposal practices, lack of adequate and safe water supply. Significant proportions of others are due to inappropriate nutritional practices, lack of health awareness, and improper cultural taboos. Most of these communicable diseases are vaccine preventable and affect mothers and children under five years. In 2000 Ethiopian Calendar (EC) the geographic access with basic primary health care had reached 89.6% for public facilities, with an increase to more than 95% when the services of private facilities are included[4].

1 Central Statistical Authority. The 1994 Population and Housing Census of Ethiopia: Results at Country Level (Volume 1: Statistical Report). 1998. Addis Ababa, Ethiopia.

2 The World Bank. 2005. World Development Report 2006. Washington, DC, International Bank for Reconstruction and Development and World Bank.

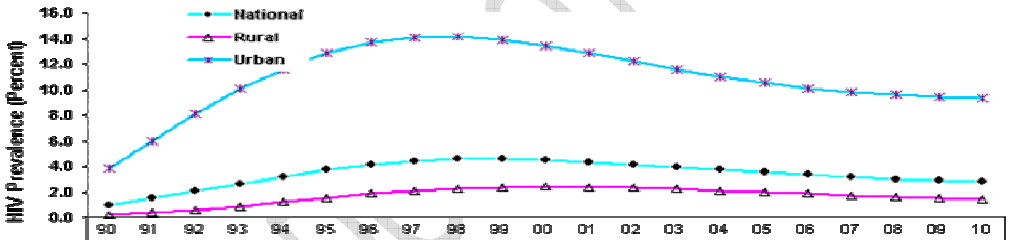
3 Central Statistical Authority. Ethiopia Demographic and Health Survey. 2005. Addis Ababa, Ethiopia

4 Ministry of Health. Health and Health Related Indicators. 2000 (2007/2008). Planning and Programming Department, Addis Ababa, Ethiopia.

1.1.2. Trends and Status of the HIV Epidemic

Ethiopia is among countries most affected by HIV and AIDS. The existence of HIV infection in Ethiopia was recognized in early 1980s with the first two reported AIDS cases in 1986. Since then, the epidemic has rapidly spread throughout the country. The epidemic peaked in mid-1990s and started to decline in major urban areas since 2000 while stabilizing in rural settings. According to projections based on the single point estimate – a calibrated estimate of ANC sentinel surveillance data up to 2005 - the national adult HIV prevalence was at 2.2% in 2008 with an estimated 1,037,267 PLHA. Out of the estimated 5.4 million orphans, 886,820 were orphaned due to AIDS. There were an estimated 58,000 deaths due to AIDS in 2008. The number of AIDS –related deaths would have been much higher if it had not been for the free ART program which has been scaled up in an accelerated manner by the government in collaboration with development partners since 2005. The estimated national adult HIV incidence of 0.28% in 2008 translates to over 125,000 new HIV infections on top of over 1 million Ethiopians living with HIV. With the current status it is evident that HIV and AIDS remain formidable development challenges to the country.

Figure 1 : Estimated and Projected HIV Prevalence By Year
Adult Population 15-49, Urban, Rural, and Total Country, 1990-2010



	90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05	06	07	08	09	10
National	0.9	1.5	2.0	2.6	3.2	3.7	4.1	4.4	4.5	4.5	4.5	4.3	4.1	3.9	3.7	3.5	3.3	3.2	3.0	2.9	2.8
Rural	0.2	0.4	0.6	0.8	1.2	1.5	1.8	2.1	2.3	2.4	2.4	2.4	2.3	2.2	2.1	1.9	1.8	1.7	1.6	1.5	1.4
Urban	3.8	6.0	8.1	10.0	11.6	12.8	13.6	14.1	14.1	13.9	13.4	12.8	12.2	11.6	11.0	10.5	10.1	9.8	9.5	9.4	9.3

Year and Estimated HIV Prevalence Values in Percent

1.1.3 Variability of the Epidemic

The HIV epidemic in Ethiopia is heterogeneous between different geographic areas and population groups. Five regions: Amhara, Tigray, Oromia, SNNPR and Addis Ababa account for 93.4% of total PLHA population in the country. Across all the regions, more urban and female population are affected than rural and male population.

- In 2008, the national urban HIV prevalence was at 7.7% and an estimated 643,395 PLHA resided in urban areas, which accounted for 62% of the total HIV positive population in the country. While the urban HIV epidemic presents a declining trend in major urban settings, small towns are

emerging as hotspots with increasing prevalence, according to findings of DHS 2005. There is considerable variation in urban epidemics from region to region with urban HIV prevalence ranging from 2.4% in Somali region to 9.9%, 10.7% and 10.8% in Amhara, Tigray and Afar regions respectively.

- The national rural HIV prevalence was 0.9% in 2008. The estimated 393,872 PLHAs living in rural areas accounted for 38% of the total population of PLHAs in the nation. The epidemic in rural settings is generalized but varies significantly from region to region with rural HIV prevalence ranging from o.4% in Somali region to 1.5% in Amhara.

- The likelihood of further spread of HIV to rural settings is becoming higher as small towns are becoming hotspots and bridging the urban epidemic with rural settings, unless combination prevention packages are intensified and scaled up to the hotspots.

- According to various surveys and studies, women are more affected than men and DHS 2005 found HIV prevalence to be twice as high among the female population as compared to the male population. In 2008, national HIV prevalence was 2.6% among women and 1.8% among men. An estimated 612,815 women were living with HIV in 2008, which accounted for 59% of total HIV positive population in the country.

- Further look into age specific HIV prevalence has indicated that young females aged 15-24 years are three times more affected than males in the same age group. HIV prevalence peaks at age group 15-24 years in females as opposed to 25-29 years in males[5].

Table1: HIV prevalence region, residence and sex in 2008

Region	Adult HIV prevalence (%) in 2008	HIV prevalence by Residence in 2008		HIV prevalence by sex in 2008	
		Urban (%)	Rural (%)	Females (%)	Males (%)
Tigray	2.8	10.7	0.9	3.4	2.3
Afar	2	10.8	0.9	2.4	1.6
Amhara	2.7	9.9	1.5	3.3	2.2
Oromia	1.5	6.1	0.6	1.8	1.2
Somali	0.8	2.4	0.4	0.9	0.6
Benshangul Gumuz	1.9	5.7	1.2	2.3	1.6
SNNPR	1.5	7.2	0.8	1.8	1.2
Gambela	2.4	7.5	1	2.8	1.9
Harari	3.3	5.2	0.3	4	2.7

[5] HIV prevalence trend among women is derived from ANC surveillance data and the trend among men is drawn from VCT data from blood donors, visa applicants, and police and army recruits

Addis Ababa	7.9	7.9		9.5	6.3
Dire Dawa	4.3	5.9	0.5	5.2	3.5
National	2.2	7.7	0.9	2.6	1.8

1.1.4 Most at Risk Population Groups

- Population groups most at risks of HIV infection include female sex workers, migrant workers, long distance drivers, in school youth, out of school youth, people in uniformed forces, displaced populations, discordant couples, people interfacing small towns and night markets, people engaged in harmful traditional activities, and men having sex with men.

  Common setting with concentrated most-at-risk populations (MARPs) are agricultural investment sites: flower plantation, spices farming, sugarcane plantations, cotton farming; infrastructure development sites: road and housing construction sites, hydro-electric power dam constructions; educational institutions: secondary, preparatory, colleges, and universities; restaurant, bars, pubs, brothels, and recreational establishments at major urban areas and semi-urban towns: market places and tourist destinations; and high risk transport corridors: major business and transport routes, cross border areas, and refugee camps and surrounding populations.

1.1.5 Risk factors driving HIV Epidemic in Ethiopia

The two primary modes of HIV transmission in Ethiopia are heterosexual intercourse (87%) and vertical transmission from mother to child (10%) during pregnancy, delivery and breastfeeding. The many behavior related risk factors for the epidemic in this country include:

- Practice of multiple concurrent partnerships
- Early initiation of sexual practices. The proportion with sexual debut before age 15 among the 15-19 years old boys and girls is high, and significantly higher among girls (11.1%) than boys (1.7%). *Source?*.
- Low and inconsistent condom use: There is a remarkable improvement in consistent condom use among female sex workers and uniformed forces, which reached 90%. However, condom use among sexually active young people is still low. For instance, the 2005 DHS showed that only 40% of out of school youth aged 15-24 used condoms while having sex with non-regular partner.
- Intergenerational and transactional sex.
- Repeated episodes of STIs and low treatment seeking behaviors for STIs.
- Mobility/migration of population. Due to the current development investments there are high number of seasonal and migrant laborers in different parts of the country. Separation from their families for a prolonged time increases the likelihood of risky sexual practices.
- Currently there are some emerging behaviors that make individuals and communities more at risk of acquiring and transmitting HIV infection in the country. These are injection drug use, substance abuse/dependency, anal sex and men having sex with men.

- Unprotected sexual practices among discordant couples and HIV positives. The DHS 2005 showed that HIV prevalence among cohabitating individuals in urban areas was 10.9% of whom 72% were discordant.
- The emerging epidemic pattern among couples of reproductive age, together with low PMTCT service up take, means that vertical transmission continues to contribute significantly to the spread of HIV.

1.1.6. Vulnerability factors and drivers of the epidemic

There are individual, socio-cultural, structural and institutional factors that influence and contribute to the spread of HIV in the country. These are:

- Lack of adequate knowledge and skills to protect oneself: According to the DHS 2005, 55.3% of the in-school youth knew the three HIV prevention methods for sexual transmission of HIV and 26.6% had comprehensive knowledge about HIV and AIDS. On the top of the low level of the comprehensive knowledge, there is also knowledge variation by sex.
- Socio cultural norms: Harmful traditional practices such as female genital mutilation, abduction, women inheritance, acceptance of premarital and extramarital sexual practices, etc are some of the beliefs and practices that may be fueling the spread of the epidemic.
- Inaccessible and inadequate basic HIV service coverage, including information and education. PMTCT services and STI control and prevention services are not widely available in all health facilities.
- Poverty: poverty is widespread in Ethiopia, and poor people generally lack good nutritional status, access to health care and information and education. Women disproportionately bear the burden of poverty due to low control over resources. Due to extreme poverty young women engage in transactional sex with older men, while many women are forced to support their family by selling sex, which puts them at greater risk of HIV infection.
- Gender inequality: women are at greater risk of HIV infection as they are often not in a position to make decisions on matters affecting their own health including sexual relations due to their socio-cultural and economic positions. Women increasingly bear the burden of AIDS resulting in higher stigma, discrimination and poorer access to services.

1.1.7. Impacts of AIDS

- Estimated number of total annual deaths due to HIV/AIDS in 2008 was 58,290 (33,084 females and 25,206 males). The estimated death was 99,360 (56,364 females and 42,997 males) in 2005[6]. The decline in AIDS related deaths is mostly due to the wide availability of free ART program in the country since 2005, initiated by the government in collaboration with development partners.
- As sexually and economically active segment of population, 15-49 years old, are highly affected by HIV/AIDS, it results in considerable productivity loss due to recurrent illnesses and deaths with loss of skilled labor across the sectors posing challenge to socio-economic development.
- Besides reducing household productivity and income, AIDS disrupts the families who are the building blocks of society increasing orphans and vulnerable children. It is estimated that the number of orphans from HIV in 2008 was 886,820.

6 Federal Ministry of Health. Single Point HIV Prevalence Estimate. 2007. HIV/AIDS Prevention and Control Office, Addis Ababa, Ethiopia.

1.2. RESPONSE ANALYSIS[7]

The response to the HIV/AIDS epidemic in Ethiopia is a collective effort by the government, multilateral and bilateral donors, national and international non-governmental organizations, community-based organizations, faith-based organizations, the private sector, civil societies, associations of PLHIV and individuals. The response has been guided by the national policy issued in 1998. The National AIDS Prevention and Control Council established in 2000 was charged with directing and overseeing the multi-sectoral response. The Council, chaired by the President of Ethiopia and comprising members from government, NGOs, religious bodies, and civil society, has declared HIV/AIDS a national emergency. In June 2002, the National HIV/AIDS Prevention and Control Office (HAPCO) was established by proclamation to coordinate and lead the multi-sectoral response. As indicated in the proclamation, the mandates of HAPCO are three; coordination, resource mobilization and monitoring and evaluating the multi-sectoral HIV response.

The Federal Democratic Republic of Ethiopia (FDRE) launched the first Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response for the period 2004-2008 (SPM I) with guiding principles that included multi-sectoralism, empowerment, shared sense of urgency, gender sensitivity, involvement of PLHIV, result oriented interventions, and best use of resources in terms of allocation, partnership, harmonization, efficiency and accountability. The major thematic areas in the SPM I were capacity building, community mobilization and empowerment, integration with health programs, leadership and mainstreaming, coordination and networking and targeted responses.

1.2.1. Major Achievements of the Response between 2004 - 2008

1.2.1.1. Integration with Health Programs

SPM I had greater emphasis on and assigned major roles of the HIV response to the health sector, and made great progress towards the strategic objective of *"integration with heath programs"*. The Federal Ministry of Health spearheaded the implementation of the integration. The Federal and most Regional HAPCOs became directly accountable to the Federal Ministry of Health and the Regional Health Bureaus respectively. During this period considerable achievements have been made in expanding health facilities and services to the general population as well as to PLHA. Most achievements of health facility based HIV interventions can be attested to this fact. The accomplishments in this regard are highly creditable. However, the period has been criticized for putting insufficient emphasis on primarily prevention and non-health sector responses.

1.2.1.2. Expansion of Health Facilities

Major Achievements:

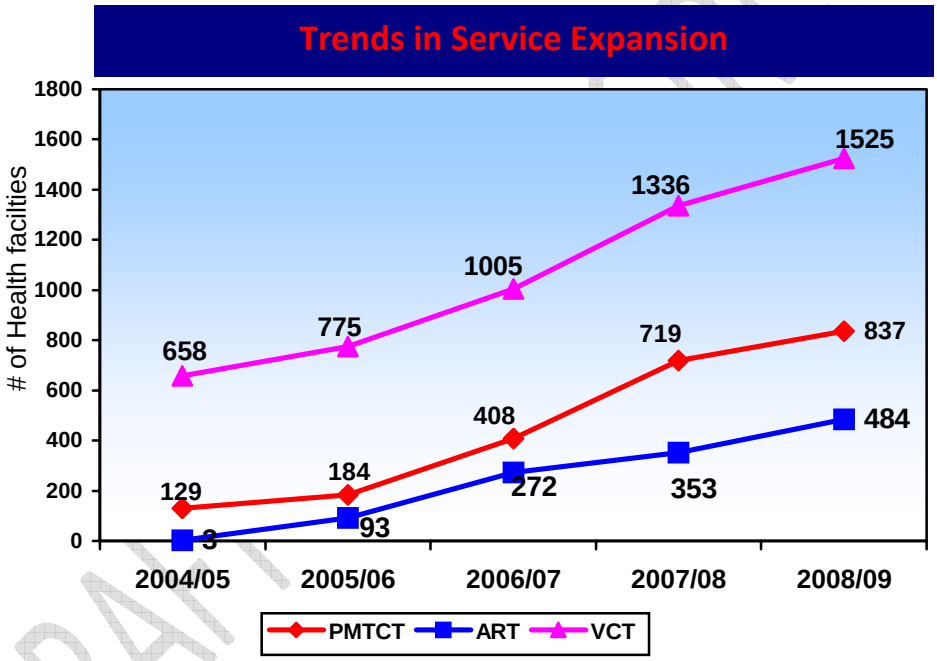
Indicators	Target	2004	2008	Remark
Number of health posts Built	2000	3XXX	11446	572% achievement
Number of health stations				107% achievement

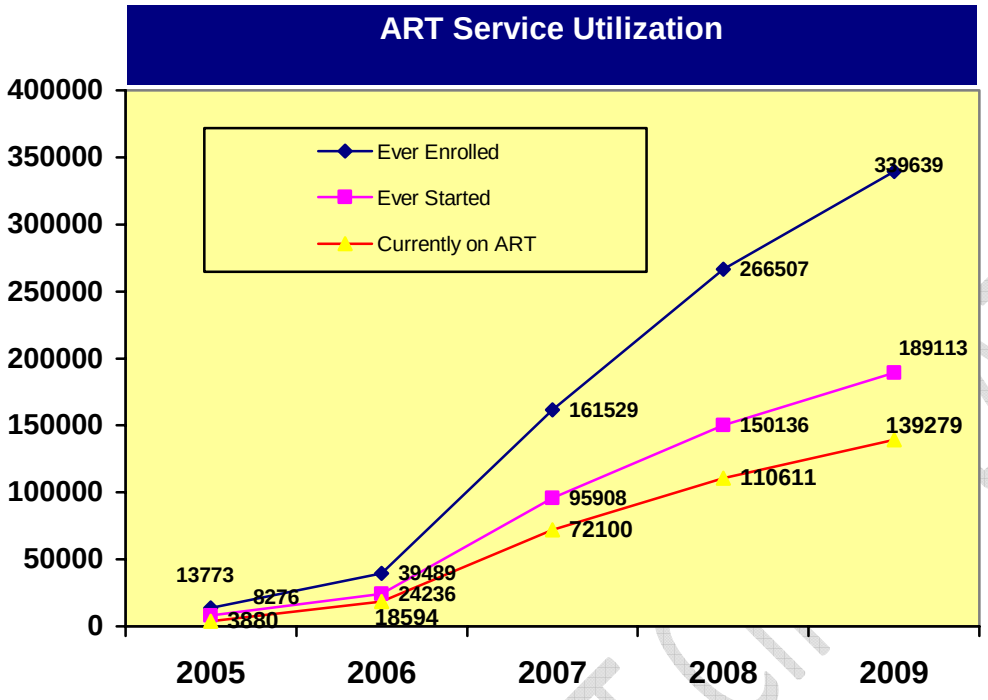
[7] This section is substantially based on the Evaluation of SMP-I

upgraded to health centers	675	24	721	
Health posts equipped	2000	63	5106	255%achievement
Health centers equipped	675	600	721	107% achievement
Hospitals constructed	No target set	119	143	20% increase in number of hospitals

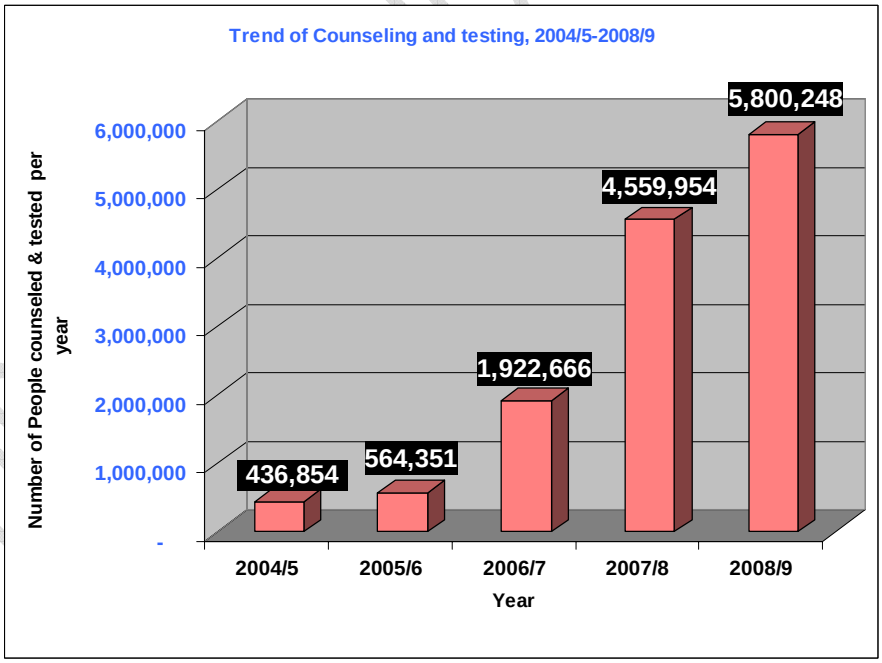
Availability and accessibility of health facility-based HIV services such as VCT, PMTCT and ART showed substantial increment. The Millennium AIDS Campaign (MAC) and Universal Access to ART expanded free HIV Counselling and Testing and ART services to a larger number of eligible individuals than ever imagined before. Noteworthy investments have been made in infrastructure, including upgrading of health facilities and procurement of equipment and supplies. As a result, the proportion of people counselled, tested and enrolled into chronic care and ART increased enormously. The following graphs show trends in service expansion and rapid expansion in service uptakes during SPM I period.

Service Expansion and Service uptakes





Trends in Counselling and Testing,2004/5 - 2008/9



Source: FHAPCO reports, January and August, 2009

PMTCT
XXXX

Although facility based HIV responses have increased noticeably, the performance on PMTCT yet remains a major concern.

- TB /HIV collaborative work which started in six hospitals and three health centres in 2004 now covers more than 330 health facilities in total.
- The percentage of TB patients counseled and tested increased from 10% to more than 80% on average.
- The TB/HIV patients referred to ART units get OI and ART treatments. Likewise, TB screening service is also provided in ART clinics
- Provider initiated counseling and testing service are integrated in most programs.
- Though they are not yet functional, (three???) new blood banks were constructed during the SPM I period. The number of blood units screened increased from 23,000 in 2006 to 32,000 by 2008.

1.2.1.3. Social Mobilization and Community Conversation

Social mobilization efforts, especially the Community Conversations (CCs), were successful in reaching millions of people and creating awareness about HIV and available services. Community conversations were exploited to advocate against harmful traditions, mobilize the community to mitigate the impact of HIV and AIDS on PLHA and OVC. Successful awareness creation through social mobilization during MAC I to III in both urban and rural areas, resulted in substantial reduction in social stigma and discrimination, which in turn created an increased demand for VCT, ART, and other health services.

Major Achievements:

- Better involvement of communities, mass organizations, faith based and civil society organizations in prevention, care, support, and impact mitigation services for PLWA and OVC was observed.
- Awareness creation through social mobilization especially during MACs resulted increased demand for services
- Systematic involvement of community based organizations was observed.
- Cultural and normative practices around marriage were challenged and are changing. Many communities are encouraging or demanding mandatory pre-marital HIV testing and outlawed widow inheritance, abduction marriage.
- Income Generating Activities (IGAs) and other social support mechanisms such as the AIDS Fund are increasingly available

1.2.1.4. Leadership and Mainstreaming

Improved leadership commitments and mainstreaming HIV in workplaces were observed at both national, regional and wereda levels. Most sectoral public agencies have recognized HIV as one of their core activities and some have gone as far as establishing a coordination office and allocating funding for HIV and AIDS activities.

Noticeable stride was accomplished in involving the leadership to actively guide HIV activities at all levels.

Major Achievements:

- Mainstreaming is recognized as a means of eliciting and mobilizing the multisectoral response to HIV.
- HIV mainstreaming guidelines were produced enabling mainstreaming of HIV at all level.
- Allocation of up to 2% of their budget for HIV has been initiated in many sectoral offices.
- Additional funds are also raised through voluntary individual contributions of 0.5% to 1% of staff salaries, mainly to augment care and support activities.
- HIV was integrated in school curricula and in multi-purpose educational TV programs
- Gender and HIV components were integrated in some trainings
- Some investments likewise were made on strengthening life-skills programs nationwide and in capacitating the education sector, resulting the development of education sector's HIV policy and guideline
- All teacher-training institutions, colleges and universities have incorporated life skills-based HIV education into their curricula.
- The level of commitment and active involvement of leaders from federal to woreda level has increased.
- The involvement of the First Lady in HIV work nationally and globally is a testimony to the leadership's commitment to fight HIV
- Provision of active leadership was evidenced by formation of AIDS councils at all levels, management and technical boards and Kebele AIDS committees broadly.
- Parliamentarians were trained to incorporate and monitor HIV activities in their respective constituencies.
- The involvement of religious and community leaders as well as eminent Ethiopian personalities in advocacy of HIV issues was greater than before.
- PLHA are represented at governance and leadership structures of HAPCOs, from Federal to Woreda level and at the CCM -Global Fund

1.2.1.5. Capacity Building

Under the capacity building efforts major achievements are: expanding and equipping of health facilities, technical and financial capacity building of public sectors, NGOs, faith-based and PLHA associations and training of human resources.

Major Achievements:

The increase in expansion of health infrastructure from 2004 to 2008 included an increase in number of health posts from 3,XXX to 11,446, health stations upgraded to health centers from 24 to 721, equipped health posts from 63 to 5106, equipped health centers from 600 to 721 and a 20% increase in the number of hospitals (from 119 to 143). During the SPM-I period the number of service providers has increased, numerous HIV related in-service and pre-service trainings were offered, new categories of health workers were added at the grassroots level (Health Extension Workers), and task-shifting was introduced, to overcome the staff turnover and attrition

- Short term trainings were provided to a large number of services providers. Intensive trainings have been given on various components of HIV programs by all partners.

- Since the formation of umbrella organizations, the number and capacity of PLHA organizations has increased considerably. As a result, expanding access to care and support services to those who are in need. PLHA furthermore, are represented at governance and leadership structures of HAPCOs, from Federal to Woreda level and at decision making processes and forums such as the Global Fund County Coordination Mechanism (CCM). In addition, several civil society organizations have been dynamic players in HIV field. As a result, the Network of Networks of People Living with HIV in Ethiopia (NEP+) and the Ethiopian Inter-faith Forum for Development, Dialogue and Action (EIFDDA) have been selected as principal recipients of the Global Fund Round Seven and Christian Relief and Development Association (CRDA – an umbrella organization of NGOs) is competing for Global Fund grants in Round nine.

1.2.1.6. Coordination and Networking

To ensure synergy of HIV programs to yield maximum impact and to increase efficient use of resources, working in coordination and networking is a demonstrated solution.

Despite the fact that the coordination role of HAPCOs has been enhanced at all levels, there is a need to strengthen coordination among sectoral ministries, development partners, civil society, the private sector, other stakeholders and the community at large.

Major Achievements:

Indicators	2004	2008
Number of manuals and guidelines developed on decentralized decision making and coordination	0	20
Number of people trained in decentralized decision making and coordination	N/A	166 Zonal and Woreda Coordinators trained
Number of reports and reviews conducted by HIV/AIDS councils and committees at all levels	N/A	Four Joint Review Meetings a year.

Number of joint supervisions conducted	N/A	two Integrated Supportive supervision per year, since 2007
Number of consultation and partnership forums established	N/A	20
Number of plans aligned	N/A	4
Number of networking guidelines developed	N/A	1
Number of AIDS information Centres opened	N/A	11

- One agreed national action framework was developed.
- Plan of action for Universal Access to HIV Treatment, Care and Support, 2007-2010 that is guiding efforts to achievement of universal access was produced.
- A Road Map for Accelerated Access to HIV Prevention, Treatment, Care and Support, 2004-2006, and second generation 2007-2010 was created
- Reasonable coordination and networking was achieved through regular joint review meetings and Joint integrated supportive supervisions.
- Various taskforces, and technical working groups comprising of stakeholders were established
- Better coordination of resources was achieved by aligning and harmonizing donors and their programs. To that effect, several memorandums of understandings were signed.
- The national partnership forum was formed and hosted at federal level.
- A significant achievement was made in developing a national Monitoring and Evaluation Framework for the Multi-Sectoral Response to HIV.
- Sectoral HIV policies, several regulations and work place guidelines that protect people living with HIV in Ethiopia against discrimination have been issued. The Civil Service Work Place HIV/AIDS Guideline, 2005, which prevents discrimination of HIV- positive employees were among regulations implemented as part of HIV prevention and control programs.

1.2.1.7. Special Target Groups

Nationwide targeted prevention programs on those believed to be particularly vulnerable to the epidemic were given insufficient consideration. The HIV responses were generally targeting the whole community with some specific attention to certain groups like the urban population, military, OVC, PLHIV, youths that are out of school and in school, long distance track drivers, and commercial sex workers. These activities are the main areas for involvement of NGOs, CBOs and FBOs.

Major Achievements:

- The youth dialogue program addressing issues of life skill training including reproductive health was provided
- Peer education manual developed and peer education programs were implemented in schools

- Over 400 school anti-AIDS clubs, more than 200 out of school anti-AIDS clubs, 200 youth centres and 6 recreational centres were established
- 200,000 students received life skills trainings
- 500 young people trained on vocational activities.
- 40,000 OVC were provided with vocational trainings
- Over 286 million condoms were distributed between 2004-2008. The number of condoms distributed in 2008 was 70.5 million as compared to 60 million in 2004.
- Over 194,299 orphans received various support,
- 3, 749 orphans were adopted
- 92,537 PLHA received basic social and financial services.
- 200,000 students were trained on school anti-AIDS club guidelines
- 200 schools have clubs and mini Medias.
- 150,000 PLHA received home based care
- 195,000 beneficiated from free health care and education services
- 49,147 self help groups were created
- 40,521 people were provided with vocational trainings and employments.
- High Risk Corridor Initiation that focuses on prevention activities for long distance drivers including condom promotion is one of the most successful programmes.

1.2.1.8. Monitoring and Evaluation, Surveillance and Research

In addition to producing the routine monthly, quarterly, bi-annual and annual reports, Ethiopia has been conducting many researches and surveillances

- ANC based sentinel surveillances every two years
- behavioural surveillance surveys every five years
- demographic health surveys every five years
- UNGASS report since 2006.
- Epidemiological synthesis,
- lost to follow up to treatment study,
- health assessment spending (including HIV spending),
- survival rate study,
- facility based survey, and
- Service linkages study was commissioned during this period.

1.2.2. Major implementation gaps and challenges

- Lack of adequately trained and experienced human resources both in technical and administrative areas, compounded by frequent turnover and attrition.

- The inadequate emphasis on the expansion of primary prevention programs and preventive services that are in particular implanted in non-health sector setup, and on mitigating the effects of the epidemic caused major concerns.
- The capacity building efforts for non-health sectors and the private sector appears to be limited.
- The demand for care and support services is growing throughout the country whilst there are limited services available for infected and affected groups.
- The health care delivery system is underequipped and understaffed and in most rural areas.
- The health commodities and supplies in general and HIV/AIDS related commodities shortages in particular is a serious challenge to the continuity of programs at health facilities level.
- The referral system from primary health care units up to the tertiary level is frail, which creates problems for ART compliance
- There is lack of more refined strategic information on HIV
- The inadequacy of the monitoring and evaluation system for non-health HIV activities.
- Continual inadequate performance in PMTCT

2. PART TWO

2.1. Vision, Mission, Goals, Strategic Results, and Guiding Principles

2.1.1. Vision

To see Ethiopia free of HIV/AIDS

2.1.2. Mission

To prevent and control HIV/AIDS epidemic and mitigate its impacts by creating universal access to HIV prevention, treatment, care and support services through intensified community mobilization and empowerment, by building capacity and ensuring the active involvement and ownership across the sectors, enhancing partnership under the principle of the "three ones", and mobilizing and ensuring appropriate use of resources by instituting result based financing and evidence based informed planning and response.

2.1.3. Goals

- To reduce new HIV infections, AIDS related morbidity and mortality and mitigate its impacts

2.1.4. Strategic Results

- Comprehensive knowledge and behavioral change created on a mass bases
- Reduced vulnerability to and risks of HIV infection
- Universal access created and increased utilization of HIV/AIDS services
- Impact mitigated

2.1.5. Guiding Principles

Multi-sectoralism: The HIV/AIDS epidemic is posing formidable challenge to the development of all sectors as illnesses and deaths from AIDS reduce productivity of their labor forces. Responding effectively to the behavioral, social, cultural, and economic factors that make individuals and communities vulnerable to HIV infection and mitigating the associated crises of AIDS require organized and concerted efforts from all actors in the public sectors, the private sector, NGOs, FBOs, PLHIV and communities at large. No single sector or segment of society alone can respond effectively to HIV/AIDS pandemic. All sectors should mainstream HIV/AIDS prevention and control into their core mandates, plans and programmes. Hence, multi-sectoralism remains to be the core guiding principle of comprehensive and expanded response against HIV/AIDS.

Empowerment: Reversing and in due course halting the spread of HIV and mitigating its impacts will not be successful, unless ownership and means of empowerment of individuals, families, most at risk population groups, PLHIV, institutions and the community at large are in place. Additional efforts should be made to build the capacity of all stakeholders in general and communities to enable them better understand the actual and potential devastating impacts of HIV/AIDS, and own HIV/AIDS programs.

Shared sense of urgency: Individuals, families, communities, organizations, and the nation as a whole have sustained severe damage due to HIV/AIDS and if further spread of HIV is tolerated, the crisis will be devastating. HIV/AIDS needs to be combated with a shared sense of urgency by all actors to reverse and stop further spread of the epidemic, mitigate its impacts and succeed in our fight against poverty.

Partnership: To defeat the spread of HIV and to respond to the growing need of the epidemic the need for a coordinated response has long been recognized. A partnership based response to HIV and AIDS need to be owned solidly and sustained by all partners. All sectors of the society have to be involved in order to effectively respond to the epidemic by minimizing duplication of efforts, pooling resources together, creating synergy and maximizing impact. Effective scale up of the HIV services requires a coalition approach which accommodates all partners working within the national HIV strategic plan framework.

Gender sensitivity: Both in urban and rural areas Women are more affected by HIV than men. The social, cultural, and economic status of women in our society makes them more vulnerable to HIV/AIDS. Gender inequality, gender based violence, abduction, rape, early sexual debut, intergenerational sex and harmful traditional practices make women at greater risk to HIV. Hence, the fight against HIV/AIDS cannot be successful unless it effectively addresses the social, cultural, and economic causes of gender inequality in our society. Women should be actively involved in the fight against HIV/AIDS and gender sensitive HIV/AIDS prevention and control programs should be ensured by all actors.

Customer focused: HIV prevention and control programs should focus on meeting the needs and creating value to customers. The HIV prevention needs of the general population and the most at risk population groups as well as the care and support needs of PLHIV and OVC should be met through joint efforts of all partners in a manner that satisfies their needs. The services provided to customers have to be measured using objective performance measures expressed in terms of time, cost, quantity, quality, and customer

satisfaction. Meeting customer needs and expectations should be major guiding principle in the fight against HIV/AIDS.

Together with PLHIV: Greater involvement of people living with HIV (GIPA) should be ensured in all programs of HIV/AIDS prevention and control at all levels. PLHIV can share their personal life and social experience by educating the public on HIV programs, promoting treatment literacy and adherence, promoting others to disclose their HIV status to their beloved ones and by providing care support including home and community based care services. Their involvement of PLHIV has contributed to increased openness on HIV/AIDS across the society, reduced stigma & discrimination and denial. The continued involvement of PLHIV in the fight against HIV/AIDS should be ensured as a guiding principle of our response to HIV/AIDS to keep the momentum ignited d by SPM I.

Result Oriented: The investment on HIV/AIDS prevention and control programs should yield the expected results in averting new infections and improving quality of life of the infected and affected population. The response should be led by evidence based informed planning and programming. The epidemic, its driving factors, and the effectiveness of interventions should be monitored and evaluated. Delivering results with demonstrated impact must be a fundamental guiding principle.

Best use of resources: Efficient use of resources requires knowing the epidemic and current response to match the response and resource allocation to the epidemic situation. Resources mobilized from external development partners, the government and communities should be utilized in an effective and efficient manner. Best use of resources should be the guiding principle to ensure efficiency in resource allocation, utilization and effectiveness whilst creating accountability.

Part Three

3.1. Creating Enabling Environment

3.1.1 Capacity Building

General Objective: ***To build the capacity for multisecoral response***

Specific Objectives:

- *Build the Capacity of Key strategic sectors to prevent the spread of HIV and mitigate its Impacts*
- *Ensure Universal Primary health care coverage by 2010 & maintain the gains to achieve MDG Goal 6 by 2015*

Building the capacity of key sectors and communities is of utmost importance to intensify the fight against HIV/AIDS. In light of the move towards universal access to HIV prevention, treatment, care and support by 2011 with the aim of attaining the MDG of "having halted by 2015 and begun to reverse the spread of HIV"; there is real and pressing need for creating adequate capacity at community and institution levels.

During SPM I remarkable achievements were made in building the capacity of the health sector and communities. Access to and utilization of HCT, chronic care and treatment services has increased dramatically through accelerated expansion of services and intensified community mobilization and empowerment. Number of health facilities providing HCT service has increased from 658 in 2005 to 1514 in 2008 whereas ART sites increased from 3 to 483 in the same period. Proportion of adult population counseled and tested for HIV increased from 1% in 2004 to 27% at the end of 2008, while patients ever started on ART has increased from 8,226 in 2005 to 180,477 at the end of 2008, reaching 62% of those estimated eligible population for ART. The capacity to mobilize and empower communities has also dramatically increased through deployment of over 30,190 health extension workers, who provide a package of health promotion and disease prevention services in the communities. Community-level capacity enhancement through community conversations facilitated by health extension workers has resulted in increased demand for and utilization of HIV services leading to social transformation. I

However, from the point of ensuring universal access and attaining dramatic results in the fight against HIV/AIDS as a nation, much remains to be done in building the capacity of the health sector, private sector civil society, communities and others across the country. Capacities of key sectors that can have significant effect on the fight against HIV/AIDS such as education, youth and sports, women's affairs, transport and communication, defense, culture and tourism, trade and industry, mines and energy, investment, agriculture, works and urban development, and legal and human rights should be strengthened to exert concerted efforts to prevent further spread of the epidemic and mitigate its impacts. Also building leadership capacity across sectors and communities as well as strengthening capacity among stakeholders such as different most at risk population groups, NEP+, EIFDDA and other CSOs is crucial to synchronize and harmonize efforts towards a common goal.

Thus, during SPM II (2009-20014) capacity building efforts will focus on:

- Consolidating the capacity in the health sector to attain universal access by further expanding services with improvement in service linkages and quality, community capacity enhancement to attain social transformation at population level, and building the capacity of key sectors, private sector, civil societies and their leadership
- Concerted efforts to organize and build the capacities of most at risk population groups to increase their active involvement in HIV services that are aiming at reaching them.
- Sustained efforts to build capacities at regional and sub-regional levels with special support to emerging regions.
- Strengthening the capacity of multisectoral response coordinating and governing bodies at various levels.

3.1.2. Community mobilization and empowerment

Objective: *To ensure community ownership, sustain social mobilization and social change*

Community mobilization and empowerment is crucial to attain success in the fight against HIV/AIDS. Without active involvement and ownership of communities at large, efforts made to prevent and control the epidemic will be futile. Hence, anti-HIV/AIDS community movement should be ignited in a sustained manner to effectively mobilize, engage and empower communities. Intensifying community movement against HIV/AIDS enables the communities to perceive the threat of HIV/AIDS to their survival and development, identify factors that make them individually and collectively vulnerable to and at risk of HIV infection, come up with local solutions and build consensus on how to resolve the problem using indigenous wisdom, values, resources, and structures as well as create an increased demand for HIV services. The anti-HIV/AIDS community movement should be anchored with the development and implementation of concrete action plan, which is to be reviewed regularly during the community health/HIV/AIDS days. The community must own the movement and integrate HIV/AIDS response into the existing socio-cultural and economic activities.

Achievements were made in mobilizing and empowering communities during SPM I. Anti-AIDS community movement was intensified since the star of the Millennium AIDS Campaign in November 2006 with over 82% of all communities across the nation covered with community conversation by the end of 2008. Some communities and faith based organizations in many parts of the country have adapted their bylaws to institute pre-marital HIV counseling and testing. Some Iddirs and kebele administrations have passed resolutions and provided care and support to OVC and PLHIV by mobilizing local community resources.

Although there are such rewarding accounts of community empowerment, their current scale is too limited to produce significant effect at a population level. There is need to further intensify and consolidate the anti-HIV/AIDS community movement to bring social transformation that enables creation of health competent families and communities across the nation The movement should engage key players in the community including the youth, women, farmers through their associations, kebele administrations, health extension workers, teachers and agricultural development agents, Iddirs, faith based organizations, non-governmental organizations and PLHIV. The overall movement should be led by kebele administration with technical leadership provided by the health extension workers. Community movement has to be guided by community driven concrete action plans indicating processes, outputs and outcomes to facilitate implementation, progress follow up and evaluation by the communities themselves. Community mobilization efforts need to be augmented with behavioral change interventions through the health extension programme, and institutional support to sustain the community movement and meet the demand created for HIV/AIDS services at all levels.

Strategies for community mobilization and empowerment during SPM II include:

- Documenting, sharing and scaling up best practices
- Ensuring community ownership and leadership of HIV/AIDS programs with creation of a sense of urgency to take HIV/AIDS as a social and development agenda

- Ensuring anti-HIV/AIDS community movement is led with a concrete plan with expected outcomes
- Augmenting community mobilization with behavioral change interventions
- Reinforcing relevant community bylaws and resolutions
- Strengthening institutional support to community anti-HIV/AIDS movement and service delivery commensurate to created demand

3.1.3 Leadership and Governance

Objective: *To ensure sustained commitment of leadership at all levels to take HIV/AIDS as strategic development Issue & to enforce accountability*

Strengthening leadership and governance is essential to create capacity, synergy, responsiveness and accountability in the multisectoral response against HIV/AIDS. Setting the response to HIV/AIDS as a national priority and strategic development issue by different sectors and enforcing its implementation requires a sustained leadership commitment from the executives and governing bodies at various levels.

During the implementation of SPM I, various initiatives were undertaken to build the capacity of leadership and governance structures of the multisectoral HIV/AIDS response. Thus, SPM II strategies on strengthening leadership and governance will build on SPM I achievements and focus on creating increased capacity to leading and governing bodies as well as ensuring greater responsiveness to customer needs with increased accountability.

Strategies to strengthen Leadership and Governance of the multisectoral HIV response:

- Build capacity of leadership and governing bodies at all levels
- Avail regular update on HIV/AIDS epidemic situation and response to leaders and governors
- Ensure regular performance review by governing bodies
- Create accountability mechanism to track the performance of leaders and governors

Build capacity of leadership and governing bodies at all levels

Leadership capacity of implementing bodies in the public sectors, PLHIV networks and associations, NGOs, FBOs, CBOs and governing bodies in the parliaments and AIDS councils at different levels can be strengthened by:

- Providing training on strategic leadership on the fight against HIV/AIDS
- Arranging experience sharing visits

Avail regular update on HIV/AIDS epidemic situation and response

Regular updates on the current epidemic and response will be provided by:

- Publishing and disseminating annual performance and other analytical report on the epidemic and response
- Establishing AIDS Information Centers in the federal parliament and in councils at regional and district levels

Ensure regular performance review by governing bodies

Regular performance review by governing bodies will be strengthened by:

- Setting agreed targets to be achieved by different implementing bodies in one consolidated plan and getting it approved by governance structures at various levels
- Conducting periodic review of multisectoral response and provision of feedback by governing bodies (AIDS councils and managing boards, parliaments, regional and district councils)

3.1.4 Mainstreaming

Objective: To Reduce the impact of HIV/AIDS on the sectors and enhance the attainment of sectoral development goals.

The HIV/AIDS epidemic is posing formidable impact on families, communities, and organizations as it affects the entire society. A concerted effort of all actors is required to effectively respond to the pandemic in the communities and across the sectors. Mainstreaming HIV/AIDS prevention and control into core mandates and activities of various sectors is crucial to prevent further spread of the epidemic and mitigate its impacts by increasing access to and utilization of HIV services. As HIV/AIDS is a development problem affecting all sectors, mainstreaming HIV/AIDS should be taken as a strategic issue to attain the development goals at all levels.

During SPM I, encouraging achievements were realized in mainstreaming HIV/AIDS in many public sectors in regions and in some federal sectors such as defence while in others proper mainstreaming was not yet materialized.

HIV/AIDS mainstreaming in the sectors requires assessing the impacts and vulnerabilities, identifying response needs, existing capacities and programs, developing sectoral policies and strategies, preparing plan of action, and implementing using sector's own resources. In this regard, strategies on mainstreaming will focus on creating capacities to better understand vulnerabilities to and impact of HIV/AIDS in the respective sectors and working towards reducing identified vulnerabilities and risks, and mitigating impacts.

Mainstreaming HIV/AIDS across the sectors will be strengthened by:

- Building capacity to mainstream HIV/AIDS
- Integrating HIV/AIDS programmes into sectoral work plans, budgets and review mechanisms

Building capacity to mainstream HIV/AIDS

Capacity to mainstream HIV/AIDS into sectoral core activities can be strengthened by:

- Conducting assessment on vulnerabilities to HIV, existing responding capacities and impact of existing programmes
- Increasing the knowledge and awareness of sectors management and staff on the real and potential impact of HIV/AIDS on the sector and how to prevent this impact
- Organize HIV mainstreaming taskforce based on the national guideline
- Establish a unit or focal person for mainstreaming HIV/AIDS across the sectors

- Develop and issue sector specific policies and strategies on HIV/AIDS
- Scale-up mainstreaming to private sectors, NGOs and others

Integrate HIV/AIDS prevention and control programmes into sectoral work plan, budget and review mechanisms

Integrating HIV/AIDS prevention and control programmes into sectoral work plan budget and review by:

- Allocating to 2% of sectoral budget to HIV/AIDS activities.
- Incorporating workplace and sectoral HIV/AIDS activities into the sectors' plans and ensuring its implementation.
- Ensure the sector management information system and review mechanisms tracks workplace HIV activities.

3.1.5 Coordination

Objective: *Ensure synergy of multisectoral HIV/AIDS response and improve effectiveness and efficiency*

HIV coordination in Ethiopia is based on the principles of the *'Three Ones'.* Coordination of HIV activities of all players at regional and wereda level will be more intensified during SPM II period. Strong leadership and broader coordination is required to translate the strategic plan into viable annual plan of actions. Adherence of wide range of actors to the 'Three Ones' principles will culminate in production of annual synchronized and harmonized plan and report.

HAPCOs are the coordinating bodies of the multi-sectoral HIV/AIDS response in Ethiopia. During the SPM II period HAPCOs will insure all sectors will identify their roles, responsibilities and relative advantages, and be actively involved in HIV programming from policy making to implementation and integration of programs.

At the national level Federal HAPCO will be coordinating the multi-sectoral response by outlining the responsibilities of the sectors, development partners and other stakeholders. Sectors are expected to have detailed work plan and sign a memorandum of understanding with HAPCO. In addition national partnership forum (NPF) will be utilized to bring together all stakeholders, including key sector ministries, the private sector, donors, NGOs and PLHIV and others that are involved in HIV activities.

At regional level the regional HAPCOs will replicate the coordination role and system of the federal HAPCO. Regional HAPCOs will coordinate and collaborate with the regional sectoral offices, NGOs, PLHIV, faith based organizations and others. Likewise, the regional partnership forums will be used to coordinate and work in synergy with all partners involved in HIV work in their respective regions.

At kebele and woreda levels HAPCO representative/s will work closely with local authorities, sector ministry representatives, NGOs, FBOs and traditional leaders to share information and jointly map and plan, monitor and evaluate local multi-sectoral responses. At kebele and woreda level a leaner HAPCO structure that can support the multi-sectoral HIV/AIDS response and coordinate including sectoral and partners report will be the ideal coordinating body.

HAPCO will advocate for coherence and close collaboration between the NPF, the main national level coordination forums and partners, such as PEPFAR, UNDAF, HIV Donors Forum, project-specific fora, among others, with the aim of further aligning and harmonizing HIV activities in the country. Participation of young people, women and PLHIV in all coordination bodies, including in leading and decision-making positions, will be systematically strengthened and ensured.

3.1.6 Partnership and Networking:

Objective: To strengthen collaboration and enhance efficiency in the multisectoral response against HIV/AIDS

Evidences have shown that working in partnership between the government, private sector, faith-based entities, non governmental bodies, and others is essential to effectively, efficiently and sustainably respond to the HIV epidemic. Partnership among sectors and stakeholders produces noteworthy results with each entity playing an important and unique role based on its core competencies. In order to partner and work in synergy the government's strong leadership role is required.

To strengthen collaboration for HIV, the national and regional partnership forums will be more active and strong during SPM II. Existing sub-forum members will be encouraged to take active roles, team up and interact among each other. A mapping exercise will be carried out to identify and include new members. It is also important to duplicate the HIV partnership forums at kebele and woreda levels. Other cross-sectoral and thematic partnerships will be established with agreed upon coordination principles and mechanisms. The participation of non-public and private sectors in HIV related services and activities will be facilitated and ensured. Additional partnership mechanisms, such as the CCM, PEPFAR-HAPCO partnership framework, and others will also be given due attention during this SPM period.

Networking among different organizations and entities that are providing different HIV services is indispensable in creating more access for people who are in need of services; people affected and infected by HIV have a wide range of needs spanning multiple dimensions of life, such as psychosocial services, nutrition, economic empowerment, legal services, and so on. Different organizations provide prevention, care, treatment and support services. A system is needed to link these services, and information on how to create standardized tools to facilitate effective functional networking is important. Networking among stakeholders and services at federal, facility and community levels, including intra and inter facility linkages must be encouraged to improve a referral network of HIV/AIDS-related services during SPM II.

3.2. Programmatic Thematic areas

3.2.1. PRIOTIRY AREA ONE: INTENSIFYING HIV PREVENTION

Goal: To reverse and ultimately halt the spread of HIV epidemic

Objective: To reduce the national HIV incidence by 85 percent by 2014

Targets:

- Increase HIV comprehensive knowledge among adult population aged 15-49 from 22.6% in 2005 to 95% by 2014.
- Reduce percentage of young people aged 15-19 years who start sexual intercourse at age of 15 years from 8.4% in 2005 to 1.7% (Female from 11.1% to 2.2% and male from 1.7% to 0.34%) by 2014.
- Increase percentage of young people aged 15-24 who use condom consistently while have sex with non-regular partners from 59% in 2005 to 95% by 2014.

There were vigorous efforts by the Government of Ethiopia to increase the availability and accessibility of HIV prevention services during the SPM I period. It is important to sustain these gains. In general all preventive services need to be further expanded and made available to a broader population in both the urban and rural areas. Services which need expansion include services targeted to specific populations, including out-of-school youth and students, uniformed services, sex workers, migrants, residents of small market towns and new business opportunity sites (flower farms, mining, dam construction sites, etc,) refugees and other displaced populations, including cross-border populations just to mention but a few.

Primary HIV prevention efforts must target non-infected individuals that are however susceptible to HIV infection, in other words vulnerable and high risk groups. Despite the fact that treatment, care and support need to be expanded further, prevention of new HIV infections needs to remain the keystone of the national HIV response in Ethiopia. Creating comprehensive HIV knowledge, increasing self risk perception and promoting behavioral changes at a population level must be intensified during SPM II targeting highly vulnerable and at risk populations to maximize the yield of efforts. The universal access targets can be only achieved if primary prevention is intensified to the level that can enable to reduce new infections among young people and adult population significantly. The evaluation of SPM I clearly indicated that the emphasis given to primary prevention was insufficient to stop the progress of the HIV epidemic; in fact many of the efforts in combating the HIV epidemic were medically oriented and the participation of the non-health sectors was limited.

To achieve maximum impact prevention of new HIV infection should utilize of a combination of proven social and medical approaches is paramount. Strategies and interventions need to be evidence based and should work in a concerted manner towards shared prevention goals. Knowing the epidemic and matching the response to the epidemic is the key guiding principle in developing successful prevention interventions.

Strategies: Three major strategies have been identified to achieve the overall goal and objective of the prevention efforts.

1. Expanding targeted behavioural change communication programs that enable creation of a high level of comprehensive and protective knowledge, adoption of safe sexual behaviours, and bring transformation in relevant social norms among all segments of the community.
2. Reducing vulnerability of young people, women, orphans and vulnerable children and others to HIV.

3. Increasing the availability and accessibility of basic facility based HIV services and increase utilization of preventive service.

3.2.1.1. Intensifying HIV prevention Programs

Expanding a targeted BCC programs addressing the prioritized groups and most at risk population
Behavioural change interventions are the foundation of prevention in high risk groups as well as in the general population. The BCC approaches need to be refined, re-focused, intensified and scaled up in all communities These interventions may lead to delay of onset of first intercourse, decrease in the number of sexual acts that are unprotected, reducing the number of sexual partners, re provide counseling and testing for HIV transmission, or lead to using condom consistently and correctly and so on. The following are selected behavioural change strategies for action during SMP II.

3.2.1.1.1. Strengthening community conversations through Health extension program.

Community conversation has evolved to one of the key tools for community diagnosis, priority setting and community capacity enhancement to fight against HIV and AIDS in the country. Furthermore, this was taken as good practice recently by the health sector and adopted as a means to strengthen health promotion and prevention of other communicable diseases such as malaria and TB. To sustain the current achievements, scaling up and improving the quality of the service, a continuous public anti AIDS movement, capacity building to the Health extension workers, and community anti AIDS promoters, model households, CBOs and key community structures at the Kebele level will be done. To achieve the desired sexual behavior and social norms, the community conversation will be escalated in a planned manner to reach all adult population in each kebele across the country. Behavioral change strategies mainly aim to increase knowledge on HIV/AIDS, increase self risk perception, adopt safe sexual behaviors, increase the utilization of HIV services at health facilities, reduce stigma and discrimination and increase condom use. They need to be coupled with combination of approaches based on identification of the various circumstances that enhance risk need and need to be addressed through different approaches. Identifying the HIV fueling factors, such as risk behaviors and activities, through which HIV is spreading in a particular locality is important in order to establish the right combinations to be employed with ultimately, a range of behavioural, social, economic, cultural and other determining factors need to be addressed in order to halt the spread of HIV.

3.2.1.1.2. Strengthening school based HIV interventions.

Preventive interventions must start at a younger age in order to reach the vulnerable segment of the population. Schools must be used as media of communication and interventions that are specific and employ age-appropriate targeting. Particular emphasis should be given to rural areas, secondary schools and to the girl chil. Gender sensitive HIV and reproductive health interventions, which are expected to enhance life skills, including negotiation, decision making and adoption of safe sexual behaviours, will be implemented in all primary and secondary schools. The specific interventions include:

- Peer and life-skills education
- School community conversation

- Training of teachers both in schools and teachers' training colleges on management of school HIVAIDS programs including life-skill education
- Youth leadership development
- Strengthening of clubs such as girls club, anti AIDS club, media club etc
- Intensified mass-media BCC campaign through school radio, school TV net and print serial dramas
- Expanding AIDS information centres into schools

3.2.1.1.3. Tailored comprehensive Prevention interventions addressing most at risk populations (MARPs)

Based on the existing evidence, tertiary level students, female sex workers, residents of small towns, discordant couples, migrant laborers in the different development schemes, residents in tourist destination areas, long-distance truck drivers and men who have sex with men are considered to be most-at-risk populations. Prevention strategies and activities need to be tailored according to the needs of these particular target populations. Although SPM II provides general directions at the national level with due consideration to the conditions in the regions, it is essential that regional entities take the necessary steps to analyze their situations and establish the evidence base for selecting prevention priorities depending on their respective regional realities. Regions must have specific intervention plans to give special attention to risk groups existing in their respective areas. For example, in SNNPR night markets are common and create a conducive environment for alcohol abuse, abduction, and rape; Tigray and Gambella with border areas are highly vulnerable to HIV due to the presence of mobile refugee populations that attract commercial sex activities, Ethio-Djibouti passage through Afar invites many truck drivers and commercial sex workers. These locations serve as fertile grounds to bridge the spread of HIV from urban to rural populations.

Interventions targeting CSW, disadvantaged women, and street children need to focus on amalgamated approaches, for instance prevention education coupled with negotiation skills and condom distribution. These and IGA trainings have shown encouraging results in the past. These activities are also the main areas for involvement of NGOs, CBOs and FBOs in Ethiopia. Consolidating efforts on this front and enhancing the involvement of all stakeholders are essential to create more opportunities to reduce vulnerability to HIV infection.
The specific strategies are:

- Determining the size, behavioral characteristics and HIV prevalence among the identified MARPs
- Developing comprehensive prevention package of HIV services and communication strategy for MARPs.
- Building the capacity of CSOs to provide outreach HIV education to MARPs
- Build the capacity of the members of the MARPs so as to make them part of the service providers to their peers.
- Provide comprehensive HIV services

3.2.1.1.4. HIV prevention programs for out-of-school youth

Out-of-school programs are equally important to those within school populations and the coverage and quality of the existing HIV prevention services is to be intensified. These include peer education, outreach HIV education; youth friendly services; HIV interventions focusing on young women, including domestic workers; expanding of recreational and educational centers (edutainment) to all Weredas; vocational training and income generating schemes.

3.2.1.1.5. Intensifying secondary prevention with positives

Effective positive prevention requires information, training and support for HIV positive people, their partners and health care providers. Prevention efforts should focus not only on individuals living with HIV, their partners and families, but also should include those who influence or restrict the behavior, options and choices of HIV positive people. Successful positive prevention needs resourcing and support to ensure that people have access to the information, commodities and services they need. Strategies include:

- HIV information, education and risk reduction
- HIV counseling, including couple counseling and testing
- Facilitation of post-test clubs and other peer support groups
- Family planning services

3.2.1.1.6. Intensifying HIV prevention in the development schemes including new business opportunity locations

Response capacity assessment of public and private sectors will be taken as the initial step either to revitalize or scale up mainstreaming during SPM II. Based on the assessment of vulnerability and capacity, sectors will develop workplace intervention guidelines and comprehensive plan, and overall integrate HIV prevention into their institutional programs and projects. In addition to the established way of mainstreaming HIV into government sectors, it is important to focus on newly created development opportunities and commercial activities which can provide fertile grounds for HIV spread due to increased vulnerability and/or lack of access to HIV prevention services. Places such as road construction sites, flower farms, mining, dam construction points will be given due attention, and they will be targeted by HIV prevention programs.

3.2.1.2. Reducing vulnerability of risk groups

In order to curb the spread of HIV in the country, Structural interventions that address societal factors such as poverty, socio-cultural norms, beliefs & practices, gender inequality, stigma and discrimination need to be intensified.

Some selected strategies for action during SPM II include:

- Addressing gender inequality, including gender based violence. HIV programs will be encouraged to systematically mainstream gender, including integration into sectoral policies and programs. Awareness creation and punitive approaches must be implemented on perpetrators of GBV. HIV post exposure prophylaxis will be available to victims of rape.
- Provision of vocational training and seed money support to vulnerable groups, especially to underprivileged women and orphans to engage in IGA and other alternatives.

- Integrate safety net programs with HIV/AIDS
- Promotion of girls' education and gender norms that facilitate equality of both sexes
- Fight against harmful traditional practices: FGM, abduction, rape, early marriage
- Interventions targeting stigma and discrimination, and protection of human rights will be given due consideration during SPM II period. These include stigma index study, advocacy on S&D, promoting respect for human rights, protection from gender-based violence, orphan adoption procedures, film/video/alcohol restriction for minors and protection from early marriage and female genital mutilation
- Expanding recreational centres, including establishment of youth centres.
- Income generating schemes
- Community conversation as major strategy to address structural issues

3.2.1.3. Increasing the availability and accessibility of basic facility based HIV services, and utilization of preventive services.

3.2.1.3.1. HIV counseling and testing

This intervention will be aimed at enabling knowledge of one's HIV status and linking HIV positives in need of care and treatment to relevant services. The specific strategies will be

- Public HIV education for universal testing
- Community mobilization through health extension workers, religious leaders and local community leaders for increased service demand.
- Increasing health facilities and making HIV counseling and testing available in all health facilities
- Expanding provider initiated testing and counseling services
- Ensuring uninterrupted supplies of test kits and other accessories.

3.2.1.3.2. PMTCT.

It is one of the weakest programs. A multiple and combined strategies are needed to address the current challenges and improve the service utilization. Some of the key strategies will be

- Strengthen the integration of PMTCT with MNCH in all health facilities
- Strengthen health extension service programs
- Community mobilization
- Ensuring male involvement
- Improving accessibility of PMTCT services
- Involving private health facilities to provide PMTCT services
- Improving ANC coverage
- Involving PLHIV
- Promoting routine offer of HIV testing of all pregnant women attending ANC

3.2.1.3.3. STI Prevention and control

STI services need to be revitalized in all health facilities through implementation of syndromic case management. The proposed interventions are:

- Health education to improve treatment seeking behaviors and utilization of services.
- Improving the capacity of health care providers on syndromic STI case diagnosis and management
- Ensuring availability of drugs and reagents in all public health facilities
- Promoting partner notification
- Improving capacity of laboratories to perform various bacteriological and serological tests
- Developing a follow up and data validation system

3.2.1.3.4. Increasing condom availability and use through supply of male and female condoms

- Increasing knowledge on proper and consistent use of condom
- Increase peripheral outlets of condom distribution
- Targeted distribution, particularly to at most risk population
- Ensuring adequate supplies of condom

3.2.1.3.5. Strengthening linkages between TB/HIV and RH/HIV

- Integrate HIV in reproductive and family planning services and family planning service into VCT and ART clinics
- Integrate HIV with TB services

3.2.2.1.3.6. Infection Prevention at health care setups (IP). Ensuring the availability of adequate infection protective materials and Provision of training to all healthy workers and other supporting staffs, particularly workers involved in waste/ disposal management will be implemented in al, health facilities so as to prevent HIV transmission in health facilities.

3.2.1.3.7. Availing post exposure prophylaxis (PEP) treatment

2.2.1.3.8. Accelerating male circumcision, in areas needed

While male circumcision is almost universal in most of Ethiopia, Gambella and SNNPR regions have below 90% prevalence of circumcision among adult males, with x% and x% respectively. In view of circumcision's over 60% protective factor to male, it is a highly cost-effective strategy to aim at reaching the non-circumcised adolescent and adult male population.

Details on the above, and other selected strategies and major targets will be presented in the Result Matrix section of this document. Further details on activities will be available in the subsequent operational plans.

3.2.1.3.9. Safe blood transfusion:

Maintenance of safe blood supply is important to reduce the risk for HIV transmission in medical settings.

3.2.2. PRIORITY AREA TWO: INCREASE ACCESS AND QUALITY OF CHIRONIC CARE TREATMENT

Goal: To Reduce HIV related morbidity and mortality and improve quality of life of PLHIV

Objective: Reduce AIDS mortality among who started ART by 95% by 2014.

Targets: Increase patients started on treatment from 62% in 2008 to 100% by 2014.

Strategies

Remarkable progress was made during SPM I (2004-08) in creating access and increasing utilization of HIV/AIDS services with the view of reaching universal access to HIV prevention, treatment, care and support in Ethiopia by 2010. With regards to chronic care and treatment, the interim SPM (2009-2011) strategies focus on further expanding ART services towards universal access and ensuring quality while further decentralizing service delivery.

- Expand treatment and care services with strengthened service linkage and integration
- Strengthen laboratory and referral system
- Ensure availability of essential OI and ARV drugs along with reagents and infection prevention materials
- Enhance treatment literacy and adherence counseling
- Strengthen public private partnerships
- Address human resource issues
- Adopt health network model

3.2.2.1 Expand treatment and care services with strengthening of service linkage and integration

Ensure universal access to and efficiency of HIV chronic care and treatment service delivery by:

- Expanding primary healthcare facilities and establishing new ART sites by fulfilling minimum standards.

- Roll-out of services by synchronizing training of health personnel with availing of essential equipment, drugs, reagents, registration, follow up and reporting formats.

- Strengthening intra-facility service linkage and integration by developing standardized service linkage forms and enforcing their use.

- Enhancing inter-facility referral system by defining catchment referral networks and feedback mechanisms

- Integrating TB-HIV and PMTCT/MNCH services in the facility by ensuring delivery of package of these services through provision of integrated training, guidelines and formats, and defining targets at health facility catchment.

3.2.2.2. Strengthen laboratory and referral system

Diagnosis and patient follow up of chronic HIV care and treatment requires ensuring access to and quality of laboratory services through:

- Availing minimum laboratory services packages at chronic care sites
- Networking laboratory system for transportation of specimen and providing feedback reports through lab information network.
- Emplacing quality assurance mechanism by calibration of laboratory equipment, and periodic sampling and testing for quality assurance.
- Training of laboratory personnel on quality assurance and preventive maintenance

3.2.2.3 Ensure availability of Essential OI and ARV drugs along with reagents and infection prevention (IP) materials:-

Adequate supply of drugs for OI management, ART, reagents and IP materials should be availed in uninterrupted manner for the delivery of chronic care and treatment services by:-

- Forecasting of the need for OIs, ARVs, reagents and IP materials for 5 years and adjusting need for every year
- Making planned procurement to avoid stock outs
- Enhancing decentralized direct distribution to health facilities through regional and sub-regional hubs.
- Monitoring consumption and stock levels through pharmaceutical supply management logistic information system
- Equipping supply management system with transportation means and expanding of warehouses as per the logistic master plan

3.2.2.4 Enhance treatment literacy and adherence counselling

As adherence to treatment is one of the major factors for optimal treatment outcomes, treatment literacy and adherence will be enhanced by:-

- Developing and enforcing guidelines for treatment literacy and adherence
- Strengthening adherence counselling by health workers and expert patients through provision training and follow up
- Advocate and disseminate treatment literacy and adherence messages in media
- Institute periodic monitoring and follow up of loss to follow up of patients
- Strengthen community support mechanism for adherence on treatment

3.2.2.5. Strengthen public private partnership

Considerable amount of urban population uses private health facilities and there is clear need to strengthen public private partnerships in order to provide HIV/AIDS services including chronic care and treatment in private health facilities to reduce missed opportunities. The following major activities have to be carried out to implement public private partnership to roll out services:

- Map and create directory of private health facilities.
- Organize public-private partnership forum.
- Develop public private partnership guideline.
- Make assessment of private health facilities to rollout HIV/AIDS services
- Jointly plan rollout of HIV/AIDS services in private health facilities
- Sign an MOU to rollout and monitor progress of implementation.

3.2.2.6. Address human resource issues

Addressing the human resource issues is among major strategic interventions in the accelerated scale up towards universal access. Areas to be focused include increasing the number, capacity, professional mix and retention of health workers through:

- Forecast HR needs for delivery of HIV/AIDS services including chronic care and treatment with identification of gaps
- Strengthen pre-service training on HIV/AIDS services in collaboration with universities for different categories
- Support capacity building efforts for education of mid- level and high level health professionals
- Provide a planed in-service training to result in subsequent expansion into new sites and strengthening of existing ones

- Scaling up task-shifting in the delivery of chronic care and ART with clinical mentoring, clinical seminars and supportive supervision
- Train health facility leadership and management on HIV/AIDS program management & integration of services
- Provide housing for key health personnel in rural hospitals and health centers by constructing living quarters
- Strengthen the involvement of staff on operational research using data generated in the facility on clinical cohorts, integrated services, community based services etc.

3.2.2.7. Enhance implementation of health network model

The health network model will be adopted to enhance efficiency in the delivery of HIV/AIDS services including chronic care and treatment by synchronizing and synergizing efforts through:-

- Mapping capacities in the health facilities both public and private, health system management structures, and community based support systems
- Provide guideline to implement health network model
- Define targets by each level from national to kebeles, indicating targets by health facility catchment
- Strengthen clinical mentoring and supportive supervision the health network whereby physicians from hospitals mentor and supervise health officers in the health centres, who in return mentor nurses. The nurses to provide mentor to health extension workers who in return mentor households and communities.
- Strengthen catchment area meeting and joint leadership meeting with multiple stakeholders at each level.

2.2.3. PRIORITY AREA THREE: STRENGTHENIN CARE AND SUPPORT TO MITIGATE THE IMPACT OF AIDS

Strategies

Goal: **Reduce socio-economic impacts of the epidemic**

Objective: **To improve the livelihood of the needy affected and infected people**

Targets: Increase care and support to OVC from 30% in 2008 to 85% by 2014

Increase care and support to PLHIV from 10% to 50% by 2014

As the country has large number of orphans and vulnerable children (over 5.4 million OVC) and PLHIV (over 1 million) out of which about 43% require care and support, taking into account the poverty line. Considering the enormous need, HIV impact mitigation strategies will focus on creating more access to and sustainability of care and support services. These include:

- Strengthening the involvement of local communities in care and support
- Enhancement on the provision of care and support through familial networks
- Strengthening institutional support for care and support

- Strengthening income generation activities to sustain the program
- Enhancing the development of OVC, youth, and destitute women

3.2.3.1. Strengthen involvement of local communities in care and support

Local community ownership and involvement in care and support will be enhanced through:

- Campaign for the need to provide care and support to OVC and PLHIV by the community
- Promote a culture of care in the community
- Map care and support needs in each kebele with existing care and support projects and identify gaps
- Encourage cash and in kind contributions by the community to care and support OVC and PLHIV

3.2.3.2. Enhancing the provision of care and support through familial networks

Through:

- Developing and issuing OVC care and support standard and service delivery guideline
- Mapping OVC
- Providing care and support to OVC in their familial networks

3.2.3.3. Strengthen institutional support for care and support program

Institutional support care and support will be strengthened by:

- Mainstreaming care and support to OVC and PLHIV in the public, private, and civil society organization as a work place response.
- Providing capacity building and oversight to community based care and support activities

3.2.3.4. Strengthen income generation activities

Income generation activities will be strengthened to sustain care and support services with the view of creating self-reliance through:

- Provision of training on how to carryout and manage income generation activities
- provision of seed money for income generating activities
- Mentor IGA activities and create links to markets
- Strengthen public private partnership

3.2.3.5. Enhance development of OVC and PLHA

Long ranging solutions to impacts of AIDS on OVC and PLHA will be achieved through:-

- Providing leadership and life skills training to OVC and PLHA
- Provide tutoring and enhance good schooling for OVC and youth
- Provide Psychosocial support to OVC and PLHA

3.2.4. PRIORITY AREA FOUR: STRENGTHEN GENERATION AND USE OF STRATEGIC INFORMATION

Objective: Enhance effectiveness and efficiency of multisectoral HIV/AIDS response by instituting evidence based informed policy, program planning and management.

Strategies

As the epidemic is changing overtime, the strategies will focus on enabling continuous generation and use of strategic information to institute evidence-informed decision making in the multi-sectoral response against HIV/AIDS through:

- Instituting a culture of evidence-based informed decision making
- Building capacity to generate and use strategic information
- Strengthening partnership

3.2.4.1. Institute a culture of evidence-based informed decision making

Leadership can play significant role in instituting the culture of evidence based informed decision making by:

- Establishing framework for generation and use of strategic information with the view of improving effectiveness and efficiency in attaining intended objectives.
- Enforcing evidenced based planning and prioritization to match the response to the epidemic
- Defining and agreeing on targets and responsibilities to ensure result based management with accountability.

3.2.4.2. Build capacity to generate and use of strategic information

- Produce guideline for the implementation of M&E framework.
- In line with SPM II, prepare a costed M&E framework plan of action
- Train staff at various levels
- Avail essential equipment and formats
- Conduct behavioral and biological surveillance and surveys on general population, most at risk population groups (on HIV/AIDS, STIs)
- Conduct incidence surveys on general population and most at risk population groups
- Conduct mode of transmission study
- Generate 2nd generation surveillance from blood donors, AIDS mortality etc.
- Conduct effectiveness and efficiency study on interventions
- Undertake regular review on multisectoral response programs on HIV/AIDS
- Conduct analytical study and triangulate the information,
- share and disseminate findings with all
- Enhance the use of strategic information for policy, program planning and management
- Identify priority research agendas and conduct research

3.2.4.3. Strengthen partnerships

Policy makers, program managers, public sectors, development partners, private sector, civil societies, PLHIV and most at risk population groups need to work in partnership in the design, delivery, and evaluation of HIV/AIDS prevention and Control programs including strategic information generation and use. Partnership in the strategic information can be enhanced by:-

- Strengthen the taskforce on M&E
- Jointly design, implement, monitor & evaluate strategic information generation and use
- Ensure broad involvement of stakeholders at all stages & define roles and responsibilities of partners
- Collaboratively enhance financing of strategic information generation and utilization

4. Part Four

RESULTS MATRIX FOR SPM II
(2009/10 – 2014)

PART ONE – CREATING ENABLING ENVIRONMENT					
Capacity building ***General Objective:*** *To build the capacity for multisecoral response*					
Health sector ***Objective:*** *Ensure Universal Primary health care coverage by 2010 & maintain the gains to achieve MDG by 2015*					
Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
1. 1. Expand , equip, and staff healthcare facilities					
Equip health facilities with medical equipment and supplies	Procure medical equipment and supplies for health posts	500 health posts equipped And supplied	No. of health posts equipped and supplied	Reports and supportive site supervisions	Regional Health Bureau, MoH HAPCO
	Procure medical equipment and supplies for health centers	800 health centres equipped and supplied	No. of health centres equipped and supplied		
	Procure medical supplies for hospitals	160 hospitals supplied with medical supplies	No. of hospitals supplied		
Staff health facilities as per national standard	Train mid and high level clinicians	8000 health officers, 10,000 physicians trained	No. of HO deployed, No. physicians deployed		MoE / MoH
	Train Para-medicals	Nurses, pharmacists, lab-technologists trained	No. of nurses, pharmacists, lab-technologists deployed		MoE / MoH
	Train urban health extension workers	2,500 urban health extension workers	No. of urban HEW deployed		RHB/MOH
Strengthen institutional capacity of health system	Procure office equipment, vehicles, motor bikes	350 Woreda health offices	No. woreda health offices equipped	Reports, site visits	RHB/MoH/ HAPCO

Key Strategic Sectors:

(*Education, Youth & Sports, Women's Affairs, Defence, Mines & Energy, Transport & Communication, Works & Urban Development, Agriculture & Rural Development, Trade & Industry, Culture & Tourism, Legal and Human Rights, NEP+, EIFDDA, CSOs, Water Resources)*

Objective: *To build capacity of Key strategic sectors to prevent the spread of HIV and to mitigate its impacts*

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
	Staff AIDS resource centers in key sectors	AIDS resource centers staffed in 16 key sectors			
	Create AIDS information networks	AIDS information networks in 16 key sectors	No. of AIDS information networks created		
Establishing Mini-media in key sectors	Procure mini-media equipment	Mini-media equipment in 16 key sectors	No. of Mini-media created in key sectors		
	Create mini-media networks for BCC in key sectors	BCC media networks in key sectors	No. of mini-media networks created		
Strengthen institutional capacity in key sectors	Procure vehicles to enable sectoral mainstreaming	16 Key sectors vehicles procured	No. of vehicles procured for key sectors		
	Staff key sectors with experts on prevention & impact mitigation	16 key sectors at least HIV unit strengthened by staffing	No. of experts assigned in key sectors		

Community mobilization and empowerment

Objective: *To ensure community ownership, sustain social mobilization and social change*

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Ensuring community ownership and leadership of HIV/AIDS	Train community leaders (4 per kebele/year)	350,000 Community leaders trained	No. of community leaders trained	Reports, on site visits	RHB/HAPCO
	Conduct community conversation	All adult population participated in CC	% of adult population participated in CC		
	Create concrete plan of action	17,500 kebeles have concrete plan	% of kebeles with concrete plan following CC		
Enforce relevant bylaws	Pass relevant community bylaws	17,500 Kebeles	% of kebeles enforced bylaws		
Augment community mobilization with BCC intervention	Train HEW on BCC	32,500 HEW trained	No. of HEWs trained		
	Train community anti-AIDS promoters from model households	770,000 anti-AIDS promoters trained	No. of community anti-AIDS promoters trained		
Strengthen institutional support to community anti-AIDS movement	Document, share and scale up best practices	Best practices documented, shared, & scaled up	List of best practices documented, shared, & scaled up	Reports, site visits	
	Provide technical support and ensure readiness to meet community demand	Technical support provided and readiness made	Community demands met	Reports, site visits, surveys	

Leadership and Governance

Objective: *Ensure sustained commitment of leadership at all levels to take HIV/AIDS as strategic development issue & to enforce accountability*

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Build capacity of leadership and governing bodies at various levels	Provide training on strategic leadership on the fight against HIV/AIDS to leadership	10,000 leaders trained	No. of leaders trained	Reports	HAPCO
	Arranging experience sharing visits	Experience sharing visits conducted	Best experiences benchmarked and adopted	Reports, on site visits	
Avail regular update on HIV/AIDS epidemic situation and response to leadership	Publish and disseminate annual performance report and analytical report on the epidemic and response	1 annual performance reports and 1analytical reports produced and disseminated yearly	No. of performance and analytical report published & disseminated	Reports	HAPCO/ MOH
	Establish AIDS resource Centers in the federal parliament and in councils at regional and district levels	712 AIDS resource centers established	No. of AIDS resource centers established	Reports and site visits	Parliament/ Councils
Ensure regular performance review by governing bodies	Get the consolidated multisectoral response plan approved by governing bodies	712 multisectoral plans prepared & approved. (woreda, region, national)	No. of multisectoral plans prepared & approved	Reports, site visits	Parliament and councils
	Conduct periodic review of multisectoral response and give feedback	At least bi-annual reviews conducted by governing bodies at each level	No. of reviews conducted & feedbacks given by governing bodies	Reports, site visits	Governing bodies: NAC, RACs, managing boards

Mainstreaming:

Objective: *Reduce* ***the impact of HIV/AIDS on the sectors and enhance the attainment of sectoral development goals.***

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Strengthen ownership of HIV/AIDS programs across the sectors	Conduct assessment on vulnerability and impact of HIV/AIDS and existing response capacity	Key sectors conduct assessment on vulnerability & impact of HIV and the existing response capacity	No. of key sectors with sectoral vulnerability, existing capacity, impact assessment documented	Reports	Key sectors, & HAPCO
	Establish a unit or focal person for mainstreaming HIV/AIDS in public & non-public sectors	100% Public and 80% non-public sectors established unit or assigned focal person	No. of public & non-public sectors with units or assigned focal person to mainstream HIV/AIDS	Reports, on site visits	
	public and non-public sectors allocate up to 2% of their budget to HIV/AIDS prevention and control activities in the sector	100% public & 80% non-public sectors allocated 2% of their budget to mainstream HIV/AIDS	No. of public sectors allocated 2% of budget No. of non-public sectors allocated 2% of budget	reports	Key sectors, & HAPCO
	Develop and issue sector specific policies and strategies on HIV/AIDS	Key sectors developed & issued sector specific policy & strategy on HIV/AIDS	No. of key sectors with sector specific policy and strategy on HIV/AIDS	Reports, site visits	
Integrate HIV/AIDS programmes into sectoral work plan, budget and review mechanisms	Incorporate HIV/AIDS plan into the sector's annual plans and ensure implementation	100% of Key sectors incorporated HIV/AIDS into sectors' plan and ensured implemented	No. sectors incorporated HIV/AIDS into sectoral plan No. of sectors implemented HIV/AIDS program plans	Reports, site visits	Key sectors & HAPCO
	Incorporate HIV/AIDS programs' M&E into sectoral MIS & review mechanism	All Key sectors incorporated HIV/AIDS M&E into sectors' MIS & review mechanism	No. of sectors incorporated HIV/AIDS M&E into sectoral MIS and review mechanism		

Coordination ***Objective:*** *Ensure synergy of multisectoral HIV/AIDS response and improve effectiveness and efficiency*					
Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Promote and institute " The Three Ones"	Prepare broad based multisectoral response strategic framework with participation of all stakeholders	Broad based Multisectoral response strategic framework prepared jointly with all stakeholders	Jointly produced document on Strategic framework	Report	HAPCO/ MoH, Stakeholders
	led by one coordinating body (HAPCO) prepare an annual harmonized and synchronized plan at each level	All regions and weredas produced harmonized and synchronized plans	Existence of harmonized and synchronized annual plan at each level	Reports, on site visits	
	Institute one national Multisectoral M&E system	One multisectoral M&E system adopted by all actors in the nation	No.(%) of multisectoral actors utilizing the multi-sectoral M&E system	Reports, on site visits	
Partnership and Networking: *Objective: To strengthen collaboration and enhance efficiency in the multisectoral response against HIV/AIDS*					
Strengthen partnership at all levels	Establish/strengthen partnership forums at national, regional, zonal/ woreda & kebele levels	11 regional partnership forums established & strengthened, 750 woreda partnership forums established.	No. of partnership forums established No. of partnership forums strengthened	Reports	Key sectors, HAPCO
	Develop partnership framework and guidelines	Partnership framework and guidelines developed with key development partners, the private sector, FBOs, NEP+	No of documents of partnership framework and guidelines produced	Documents	HAPCO

	Conduct regular partnership forum meetings at all levels	Partnership forum meetings conducted at all levels on regular basis	No. of partnership forum meetings conducted	Reports	
Strengthen networking at all levels	Produce networking guideline	Networking guideline produced	Produced networking guideline	Reports, site visits	Key sectors HAPCO
	Map HIV/AIDS services, providers and partners at all levels	HIV/AIDS services, providers, & partners mapped at all levels	Produced directory on HIV/AIDS services, providers, & partners		
	Create functional network of HIV/AIDS services, providers, & partners	Functional networks of HIV/AIDS services, providers & partners created at all levels	Number of networks created & functional		

PART TWO: PRIORITY PROGRAMATIC AREAS

PRIORITY AREA ONE: INTENSIFYING HIV PREVENTION

Goal: To reverse and begin to halt the spread of HIV epidemic

Objective: To reduce the national HIV incidence by 85 percent by 2014

Targets:

1. To Increase HIV comprehensive knowledge among adult population aged 15-49 from 22.6% in 2005 to 95% by 2014.
2. Reduce percentage of young people aged 15-19 years who start sexual intercourse at age of 15 years from 8.4% in 2005 to 1.7% (Female from 11.1% to 2.2% and male from 1.7% to 0.34%) by 2014.

3. Increase percentage of young people aged 15-24 who use condom consistently while have sex with non-regular partners from 59% in 2005 to 95% by 2014.					
Expand targeted behavioural change communication programs that create a high level of comprehensive and protective knowledge and adopt a safe sexual behaviour					
Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Ensure access of HIV and AIDS information education and communication to all adult population, in particular to young people aged 15-24.	Multiple HIV prevention interventions(Life skill education, peer education, serial drama, Community conversation, health extension, public HIV education, Media)	95 % Comprehensive knowledge	Percentage of adult population aged 15-49 years who both correctly identify ways of preventing sexual transmission of HIV and who reject the major misconceptions about HIV transmission	BSS/DHS	HAPCO
Strengthen school based HIV interventions	peer education programs in schools	2 million peer educators trained	No. of peer educators trained	Reports	MOE /REB
		weekly peer education sessions conducted in 10,000 primary complete and secondary schools	No. of schools conduced peer education sessions	Reports Site visits	MOE/REB
	life-skill education in schools	10 Million students received life skill education	No. of students reached by life skills- based HIV education in schools.	Reports and site visits	MOE/REB
		weekly life-skill sessions conducted in 20,000 schools	No. of schools conducted life-skill sessions	Reports and site visits	MOE/REB
	school community conversation	899 schools conducted cc	No of schools conducted cc	Reports and site visits	MOE /REB
		2 million pupils participated in CC	No. of pupils participated in CC	Reports	MOE/REB

	Train teachers on management of school HIV/AIDS programs	28,000 teachers trained on management of school HIV programs	No of teachers trained	Reports	MOE/REB
	Build youth leadership development programs	youth leadership programs introduced in 899 schools	No of schools with youth leadership programs	Reports and site visits	MOYSA/RYSA
		1 Million youth will be reached through youth leadership programs	No of youth reached through youth leadership programs	Reports	MOYSA/RYSA
	Strengthen girls club, anti-AIDS club, media clubs in schools	899 secondary schools will have at least 4 clubs each	No. Of school with clubs	Reports and site visits	MOSY
		449,500 pupils participating in clubs	No. of pupils participating in clubs	Reports and site visits	MOYSA
	BCC mass-media campaign via education media	6 campaigns (radio, TV, drama)	No of BCC campaigns conducted	Reports and site visits	MOE
		2 million pupils reached through school BCC campaigns	No. of pupils reached through school BCC campaigns	Reports and site visits	MOE
	Establish AIDS information centres in schools	600 AIDS info centres initiated	No of AIDS info centres newly initiated	Reports and site visits	MOE
		1.5 Million pupils utilized ARC	No of pupils utilized ARC	Reports and site visits	MOE
1.1.3. Scale up comprehensive HIV prevention services targeting most at risk population (MARPs)	Determine the size, behavioural characteristics and HIV prevalence among MARPs	A national MARPs survey conducted	Produced national MARPS survey	Survey report	HAPCO
	Develop a package of HIV services for MARPs	Minimum package of service developed	Developed package of service	Document and report	HAPCO
	Develop communication strategy for MARPs	A communication strategy developed	Developed communication strategy	The strategy and reports	HAPCO

	Build the capacity of service providers to MARPs	200 CSOs trained	No of CSOs trained	Reports	CSOs & HAPCO
	Build the capacity of members of MARPs to be active players in HIV services targeting MARPs.	100,000 of members of MARP trained as peer educators	Number of member of MARPs trained as peer educators	Reports	CSOs & HAPCO
	Provide comprehensive HIV services (peer education, condom, STI, VCT, drug substitution therapy etc) to MARPs	1 million MARPS reached with HIV prevention programs	Number of MARPS reached with HIV prevention programs	Reports and surveys	Youth, women group, & CSOs
Strengthen out of school youth HIV prevention programs	Peer education/ life education in out of school youth	95% of out school youth reached with HIV and AIDS education	Percentage of out of school youth reached with HIV & AIDS education	Reports	YSA
	Expanding educational recreational (edutainment) youth centres in district towns	200 youth centres	No. of youth centres established and equipped	Reports and site supervisions	YSA
Intensify secondary prevention with positives	HIV education and counselling	450,000 PLHIV received HIV education and counselling	Number of HIV positive people benefited from HIV education and counselling.	Reports	MOH / RHB
	Increase couple counselling	45,000 couples received counselling	Number of couples received counselling	Reports	MOH /RHB
	Increase correct and consistent Condom use	3.6 million condoms purchased and distributed	No. of condoms purchased and distributed	Reports	MOH/PFSA
Intensify HIV prevention in development schemes	Target new business opportunity locations, key sectors, industries and private sector.	150 new business opportunity locations, key sectors, industries and private sector will be targeted	No. of new business opportunity locations, key sectors, industries and private sector will be targeted	Reports and site supervisions	Respective sectors and Investment Authority

Reduce vulnerability of HIV infection among risk groups

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Address gender inequity including gender based violence.	Mainstream gender into sectoral policies and programs	100% sectoral policies and community bylaws integrate gender	No of sectors and communities integrated gender in to their policies and bylaws	Reports	MoWA
	avail PEP to victims of rape	3303 health facilities will provide PEP	No health facilities providing service	Reports and site supervisions	MOH
	Advocate for punitive measures on perpetrators of GBV.	Six round advocacy campaigns held	Number of sessions/ forums conducted by women groups	Reports	MoWA
	Ensure inclusion of gender dimension in HIV programs	All HIV prevention programs will integrate gender component	Number of HIV prevention programs r with gender dimension	Reports	HAPCO
Enhance Economic empowerment of vulnerable groups	Vocational training to vulnerable groups	248,339 vulnerable/ destitute women and FSW received vocational trainings	No of Women who receive vocational training	Reports	Regions/ women association/ Micro & small enterprises
	seed money support to vulnerable individuals	248,339 Women &FSW supported with seed money	No. Of women &FSW supported with seed money	Reports and site visits	Regions/ women association/ Micro & small enterprises
	Establish partnership with safety-net programs and integrate with HIV &AIDS prevention services	HIV integrated into all regional safety-net programs	No safety-net programs integrated with HIV	Reports	RAD
Combat harmful traditional practices fueling HIV	Sensitization and education on avoiding harmful traditional practices	Reduced FGM from 74.3% to 37% by 2014	Percentage of women aged 15-49 circumcised	Reports	MOH

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
promote interventions against stigma and discrimination and protection of human rights	Conduct the national stigma index study	2 national stigma index studies conducted	Number of stigma index studies conducted	Reports	NEP+/HAPCO
	Launch a national campaign against stigma and discrimination	Six national campaign on stigma and discrimination	Number of Campaign launched	Report	NEP+/HAPCO
	Sensitize and enforce laws to control minors from utilizing restricted Film/video and alcohol	Reduced by 80%. (baseline to be determined following conducting baseline survey in 2010)	Percent of minors avoid utilizing alcohol and substance and watching age restricted movies	Reports	Justice
Expand recreational centres such as the already established youth centres	Establish and equip the already built 200 youth centres	200 youth centres equipped	No youth centres equipped	Reports	YSA
Enhance implementation of youth and women development packages	Expand youth and women leadership development programs	70,000 youth and women leaders trained	Number of youth and women receiving training on leadership program	Reports	**YSA and WA**
	Roll out the implementation of youth and women packages to all districts	750 weredas	Number of weredas implementing youth and women development packages		**YSA and WA**
Increase the accessibility and utilization of facility based HIV services					
Ensure access and enhance up take of HCT services	Promote HIV universal testing using CC and health extension workers,	42 million people counselled and tested	No of people who received testing and counselling services for HIV and received their test results	Reports	MOH / RHB
	Promote HIV testing through religious leaders and local community leaders				Religious group
	Increase health facilities with counselling and testing services	3,703 health facilities providing counselling & testing	No of health facilities providing counselling & testing	Reports and site visits	MOH / RHB

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
	Expand provider initiated testing and counselling services	All health facilities with C&T will integrate PICT	No of health facilities integrated PICT	Reports and site visits	MOH /RHB
	Ensure uninterrupted supplies of test kits and other items.	Ensure availability of supplies of test kits and other items	No interruption reported	Reports and site visits	MOH /RHB
	Educate Public on HIV Universal testing though mass media campaigning	A mass media campaign on counselling and testing commissioned	Campaign launched	Reports	MOH/RHB
Ensure access and enhance uptake of PMTCT services	Strengthen the integration of PMTCT with MNCH in all health facilities	90% of HIV positive pregnant women received complete ARV prophylaxis	Percentage of HIV positive pregnant women who received antiretroviral prophylaxis	Reports	MoH / RHB
	Mobilize the community to be actively involved PMTCT program				
	Ensure male involvement in PMTCT service				
	Train health extension workers on PMTCT service provision and delivery	32500 HEWs	Number of HEW trained and engaged in PMTCT service provision	Reports	MoH / HAPCO
	Expand PMTCT services	3,303 public health facilities will provide PMTCT	No of public health facilities providing PMTCT	Reports and site visits	MOH / RHB
	Equip health facilities with ANC and , delivery equipments	3303 Health facilities equipped	Number of health facilities equipped to provide PMTCT services		
	Train health workers on basic and emergency obstetric care and PMTCT service provision	13212 health care workers trained	Number of health care workers trained to provide PMTCT services		
	Increase Involvement of PLHIV in PMTCT	700 PLHIV trained to give peer and expert patient	No. of PLHIV trained to give peer and expert	Reports	MOH/NEP+

		support	patient support		
	Involve private health facilities to provide PMTCT services	101 private health facilities provide PMTCT	No of private health facilities providing PMTCT	Reports and site visits	HMOH/RHB
	Promote PIHCT for all pregnant women attending ANC and delivery services using opt out approach	15, 400,000 pregnant women tested and knew their status over five years	Percentage of pregnant women who were tested for HIV and who know their status		MoH / HAPCO
	??? Provider Compulsory HIV testing of all pregnant women attending ANC	*Policy change campaign to introduce mandatory HIV testing at ANC clinics*			
Increase availability and utilization of STI Prevention and control services	Expand STI services to all health facilities	300,000 cases treated	Number of cases of sexually transmitted infections treated		MoH/ RHB
	Intensify health education to improve STI treatment seeking behaviour & utilization of services				
	Promote partner notification during STI case detection				
	Ensure availability of drugs and reagents in all public health facilities				
	Train heath care workers on syndromic STI case diagnosis and management	7406 health care providers will be trained on STI management	No of health care providers trained on STI management	Reports	MOH / RHB
	Train 3703 laboratory technicians to perform various bacteriological and serological tests	3703 laboratory technicians trained	No. of laboratory technicians trained	Reports and site visits	EHNRI
	Develop STI follow up and	Functional STI follow up &	Establishment of STI	Documents	MoH/RHB/EHNRI

	data validation system	validation system	follow up & validation system	produced & site visits	
Increase supply , distribution and utilization of male and female condoms	Promote and conduct campaigns on proper & consistent use of condom	six condom promotion campaigns will be commissioned	No. of condom promotion campaigns commissioned	Reports	MOH/RHB/CSO
	Expand peripheral outlets of condom distribution	Overall 1.776 billion condoms distributed over 5 years	No of condoms distributed per year	Reports	MOH/RHB/CSO
	Targeted condom distribution, particularly to MARPs	888 million condoms be distributed to MARPs (accounts for 50% of overall distribution)	No. of condoms distributed to MARPs	Reports	MOH/RHB/CSO
	Ensuring adequate supplies of condom	2 billion condoms will be procured over 5 years	No of male and female condoms available for distribution nationwide during the last 12 months per person aged aged 15-49 years	Reports	MOH/RHB/CSO
Strengthen linkages between TB/HIV and RH/HIV	Screening all TB patients for HIV	100% of TB patients counselled & tested for HIV	% of TB patients counselled & tested for HIV	Reports	MOH / RHB
	Link HIV positive TB cases to HIV services	100% of HIV positive TB cases linked to HIV care & treatment	% of HIV positive TB patients linked to HIV care & treatment		
	Screening all HIV positive cases for TB	100% of HIV positive cases screened for TB case detection	% of HIV positive cases screened for TB		MoH / HAPCO
	Provide INH prophylaxis for HIV positive and TB negative patients	100% of HIV positive TB negative cases received INH prophylaxis	Percent of HIV positive cases receiving INH prophylaxis		
	Strengthen TB-HIV co-	5368 health care	Number health care		

	infection management	providers trained	providers trained on TB-HIV co-infection management		
	Strengthen RH/HIV collaboration	100% of RH services l Integrated with HIV	% of RH services Integrated with HIV	Reports	
Prevent infection at health care setups (IP).	Ensure the availability of adequate infection protective materials	46 different type of IP materials will be purchased and distributed	No of Purchased and distributed IP materials	Reports	MoH / HAPCO
	Provide IP trainings to healthy workers and other support staffs	5000 healthy workers and support staffs trained on IP	No. of trained healthy workers on IP	Reports	MoH / HAPCO
Avail post exposure prophylaxis (PEP) treatment	PEP availed at health facilities	3303 health facilities avail PEP treatment	No. of health facilities availing PEP	Reports	MoH / HAPCO
Accelerate male circumcision in areas needed	Provide trainings on male circumcision	180 health care workers trained on MC	No. of health care workers trained on MC	Reports	HAPCO
	Avail male circumcision kits	300,000 MC kits	Number of MC kits availed		
	Provide safe circumcision	300,000 young male aged 10 to 24 years circumcised	No of males circumcised	Reports	HAPCO

PRIORITY AREA TWO: INCREASE ACCESS AND QUALITY TO CHRONIC CARE AND TREATMENT

Goal: To Reduce HIV related morbidity and mortality and improve quality of life of PLHIV

Objective: Reduce AIDS mortality among who started ART by 95% by 2014.

Targets: Increase patients started on treatment from 62% in 2008 to 100% by 2014.

Expand treatment and care services with strengthening of service linkage and integration

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Expand access to care and treatment at primary healthcare facilities	synchronize training of health personnel	5368 health providers trained on care and treatment management	Number of health care providers trained.	Reports	MOH/RHB
	strengthen intra and inter-facility service linkages	3303 facilities introduced standard Inter-facility service linkage	No. of facilities introduced standard Inter-facility service linkage	Reports and site visits	MOH / RHB
	Provide ART services in 3303 health facilities	484,966 PLHIV received ART	Number/Percentage of adults and children with advanced HIV infection receiving anti retroviral therapy.	Reports and site visits	MoH / RHB
Strengthen laboratory and referral system	Avail minimum laboratory services at chronic care sites	80% chronic care sites covered with minimum laboratory services	No. of chronic care sites covered with minimum laboratory services	Reports and site visits	EHNRI
	Improve laboratory support system including transfer of specimens	transfer of specimens improved and feed back given	Report of improved transfer of specimens	Assessment	EHNRI

	Ensure quality assurance by calibrating laboratory machines and periodic sampling and testing	Functional Quality assurance system in placed	Existence of quality assurance system	Reports	EHNRI
	Train laboratory personnel on quality assurance and preventive maintenance	58 laboratory personnel trained on quality assurance and preventive maintenance	No. of laboratory personnel trained on quality assurance and preventive maintenance	Reports	EHNRI
Ensure availability of essential OI and ARV drugs along with reagents	Ensure adequate procurement of OIs, ARV drugs, reagents and IP materials – avoid stock outs	adequate amount of OI, and ARV drugs availed	No of stock outs reported	Periodic assessments and reports	PFSA
	Direct distribution of materials to health facilities through regional and sub-regional hubs.				
	Ensure periodic monitoring of consumption and stock levels	Inventory mechanism / LMIS established	Existence of functional Inventory/ LMIS at all levels	Periodic assessments and reports	PFSA
	Equip the supply management system with transportation means	12 Vehicles procured	No of vehicles purchased to support supply management system	Reports and site visits	PFSA
	Construct and equip warehouses	23 warehouses constructed	No. of warehouses constructed	Reports and site visits	PFSA
Enhance treatment literacy and adherence	Develop and enforce guidelines on treatment literacy and adherence	Develop treatment literacy guideline	A guideline on treatment literacy developed	Reports and developed guideline	MOH

	Strengthen adherence counselling by health care workers and expert patients through provision of training and follow up	1342 people trained on adherence counselling	No. of people trained on adherence counselling	Reports	MOH
	Advocate treatment literacy and adherence through mass media	12 mass media campaigns on treatment literacy and adherence carried out	Number of mass media campaign conducted	Reports	MOH
	periodic monitoring and follow up of loss to follow up of patients	Functional tracing mechanism to lost –to-follow established	Established system of tracing of lost to follow up	Reports and site visits	MOH
	Strengthen community support mechanism for adherence on treatment	Community-based support mechanism for adherence strengthened	Existence of established community based adherence support system	Reports	MOH
Strengthen public-private partnership	Map and create directory of private health facilities.	Directory of private health facilities developed	Directory of private health facilities produced	Reports and directory	MOH/HAPCO
	Develop public private partnership guideline	public private partnership guideline developed	Available public private partnership guidelines	Reports	MOH/HAPCO
	Build up the public-private partnership forum.	Functional l public private partnership forum existed	Existence of functional public private partnership forums	Reports	MOH/HAPCO
	rollout ART/PMTCT services into private health facilities	101 private health facilities signed an MOU to provide ART/PMTCT services	No of private health facilities signed an MOU to provide ART/PMTCT services	Reports and visits	MOH/HAPCO
Address human resource issues	Forecast HR needs to render HIV services at health facility level	23121 health professionals required	No of resources required to render HIV services		HAPCO
	in collaboration with higher learning	Pre-service HIV trainings for health workers will be	No. of higher learning institutions incorporated HIV	Reports	Mo Education / HAPCO

	institutions strengthen pre-service trainings	assimilated	pre-service trainings		
	Support capacity building efforts and educate mid- and high level health professionals	3000 mid-level health professional trained	No. of mid-level health professional trained	Reports	MOH
	Scale up task-shifting in the delivery of care and treatment through clinical mentoring, clinical seminars and supportive supervision	350 clinical mentors will be deployed and clinical seminars conducted	No. of clinical mentors deployed and clinical seminars provided	Reports and site visits	MoH / HAPCO
		4 supportive supervision per a year provided	No. of supportive supervision per a year provided	Reports	MoH / HAPCO
	Train health facility leaders on HIV/AIDS program management & integration of services	3303 health facility leaders trained on HIV/AIDS program management & integration of services	No. of health facility leaders trained	Reports	MoH / HAPCO
	Construct living quarters for key health personnel in rural health facilities	50 living quarters constructed	No. of living quarters constructed	Reports and site visits	MoH / HAPCO
	Involve of staff in health facilities in conducting operational research	55 operational studies conducted	Number of operational studied conducted with the involvement of staff in health facilities.		
Enhance health network model	Create health networks	130 health Networks created.	No. of networks formed	Reports	MoH/HAPCO
	Provide health network model guideline	A health network model guideline developed	developed health network model guideline	Reports and site visits	MoH / HAPCO
	Strengthen catchment area meetings and joint leadership meetings with multiple stakeholders at each level.	Monthly catchment area meeting coverage reached 80%	% of coverage on monthly catchment area meeting	Reports and site visits	MoH / HAPCO

PRIORITY AREA THREE: STRENGTHEN CARE AND SUPPORT TO MITIGATE THE IMPACT OF HIV/AIDS

Goal: **Reduce socio-economic impacts of the epidemic**

Objective: **To improve the livelihood of the needy affected and infected people**

Targets: Increase care and support to OVC from 30% in 2008 to 85% by 2014

Increase care and support to PLHIV from 10% to 50% by 2014

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Strengthen the involvement of local communities in care and support	Promote a culture of care in the community	communities in 17,500 kebeles mobilized to support and care	No. of kebeles with care and support plan	Reports and site visits	MoWA / NEP+
		85% of OVC and 50 % of PLHIV supported	% of OVC and % of PLHA supported	Reports and site visits	MoWA / NEP+
	Map care and support needs in each kebele and identify gaps to be met	100% kebeles l mapped and produced identified care and support gaps	No. of kebeles mapped and produce identified care and support gaps	Reports and site visits	MoWA / NEP+ /
	Develop a multi-sectoral care and support plan	100% kebeles developed care and support plan	No. of kebeles developed a care and support plan	Reports and site visits	MoWA / NEP+ /
	Ensure provision of care for OVC in their familial community	85% of OVC supported	%. of OVC received external support in their familial community	Reports and site visits	MoWA / NEP+
Enhance the provision of standard care and support	Developing an OVC care and support standard and service delivery guideline	An OVC care and support standard and service delivery guideline developed	Existence of an OVC care & support standard & service delivery guideline	Reports	MoWA / HAPCO
	Enforce implementation of OVC care & support standard & service delivery guideline	Standard & the guideline implemented by all actors	No. of actors implementing the standard & the guideline	Reports	MoWA / HAPCO

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Strengthen institution-based assistance for care and support	Mainstream care and support for OVC and PLHIV in the public, private, and civil society organization as part of work place HIV response	107 public sector mainstreamed care and support into their plan	No of public sector mainstreamed care and support into their plan	Reports	MoWA / NEP+ / HAPCO
		100 private sector organizations initiated care and support services	No of private sector initiated care and support	Reports	Private sectors/MOW
		Ensure 250 civil society inclusion on C&S	No of civil society included on care and support plan	Reports	MoWA / NEP+ / EIFDDA / HAPCO
		1.9 million needy OVC supported	No. of needy OVC supported.	Reports	MoWA / NEP+ / EIFDDA / HAPCO
	Providing capacity building and oversight to community based care and support providers	35000 community based organizations received capacity building trainings on C&S	No. of CBOs received capacity building trainings	Reports	MoWA / NEP+ / EIFDDA / HAPCO
Strengthen income generating activities	Build the capacity of older OVC, OVC guardians and PLHIV on IGA	50,000 OVC and their guardian supported through IGA	No. of OVC and their guardians supported through IGA	Reports	MoWA / NEP+ / EIFDDA / HAPCO
		25,000 PLHIV supported through IGA	No of PLHA supported through IGA	Reports and site visits	MoWA / NEP+ / EIFDDA / HAPCO
	Encourage joint planning with beneficiaries to provide seed money to for IGA	75,000 of beneficiaries received seed money	No. of beneficiaries received seed money	Sites and site visits	MoWA / NEP+ / EIFDDA / HAPCO
	Mentor IGA activities and create links to markets	75,000 beneficiaries mentored with IGA	No. of beneficiaries mentored for IGA	Reports and site visits	MoWA / NEP+ / EIFDDA / HAPCO
Enhance the capacity of OVC and PLHA	Develop the capacity of OVC and PLHA on leadership, life-skills and livelihood	160,000 beneficiaries trained on leadership	No. of beneficiaries trained on leadership	Reports and site visits	MoWA / NEP+ / EIFDDA / HAPCO
		160,000 beneficiaries trained on life-skills and livelihood	No. of beneficiaries trained on life-skills and livelihood	Reports and site visits	MoWA / NEP+ / EIFDDA / HAPCO

	Increase comprehensive educational and psychosocial support to OVC	1 Million OVC received psychosocial support	No. of OVC received psychosocial support	Reports and site visits	MoWA / NEP+ / EIFDDA / HAPCO
		1.9 Million OVC received educational support.	No. of OVC received educational support	Reports and site visits	MoWA / NEP+ / EIFDDA / HAPCO

PRIORITY AREA FOUR: STRENGTHEN GENERATION AND USE OF STRATEGIC INFORMATION

Objective: Enhance effectiveness and efficiency of multisectoral HIV/AIDS response by instituting evidence informed policy, program planning and management.

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Institute culture of evidence informed decision making	Establish framework for generation and use of strategic information	Framework for generation & use of strategic information established	Existence of document on framework for generation & use of strategic information	Reports, on site visits	Key strategic sectors, HAPCO, MoH
	Evidence based planning and prioritization to match response to the epidemic	Planning & prioritization based on evidence of the epidemic & response	Proportion of budget allocated to priority programs based on evidence		
	Define and agree on targets & responsibilities to ensure result based management with accountability.	Targets & responsibilities are defined & agreed at all levels with enforcement of result based management	Existence of document on defined & agreed targets and responsibilities at each level		
Build capacity to generate and use strategic information	Produce guideline for implementation of M&E framework	Guideline for implementation of M&E framework produced	Existence of M&E framework implementation guideline	On site visit, reports	HAPCO
	Prepare costed M&E framework plan	Costed M&E framework plan prepared	Document of costed M&E framework plan	On site visit	HAPCO
	Train M&E staff & program managers	10,000 trained (8000 M&E staff & 2000 program managers)	No. of M&E staff & managers trained	reports	HAPCO/MoH

	Avail IT equipment and formats	IT equipment & formats availed	No. of stock outs of formats	Reports on site visit	HAPCO
	Conduct behavioural, biological & program effectiveness studies	Behavioural, biological & program effectiveness studies conducted at national & sub-national levels	BSS every 3 years, ANC based surveillance every 2 years, population sero -survey 5 years, effectiveness study 3 years	Survey reports	EHNRI
	Triangulate to synthesis the information	Synthesis report produced	Document of synthesis report		HAPCO
Strengthen partnership	Establish/strengthen taskforces for Strategic information	Multisectoral taskforce established for Strategic Information at all levels	No. of taskforces established	Reports, site visits	HAPCO
	Collaborate in financing HIV/AIDS strategic information	Increased funding for Strategic information by stakeholders	Budget allocated by stakeholders for strategic information	Reports	HAPCO, Partners

5. Part Five

5.1. Budget to be included soon.

6. PART SIX

Implementation modality and Institutional arrangements

The strategic plan will be translated into action by developing annual multisectoral response plans jointly with key stakeholders at each level. There should be one consolidated annual plan on the multisectoral response in line with the principle of the three ones at each administrative level. The harmonized annual plan for multisectoral response will outline targets to be achieved, responsible implementing bodies, inputs including budgets, and monitoring & evaluation mechanisms. The plan has to be reviewed and approved by the managing board and AIDS council at respective levels. Mainstreaming of HIV/AIDS prevention and control across the sectors has to be oversighted and enforced by the peoples representative councils at all levels. HAPCOs at each level will coordinate multisectoral HIV/AIDS response while the health sector will spearhead the leadership in the national response.

6.1. Multisectoral Response coordinating and governing bodies

HIV/AIDS prevention and control offices (HAPCOs) at all levels will coordinate the multisectoral response. HIV/AIDS councils and managing boards will govern the multisectoral HIV/AIDS response at their respective levels. The councils at all levels will be composed of government, private, non-governmental, religious and civic society representatives and people living with HIV. HIV/AIDS councils will be strengthened at all levels of administration, from national to kebele levels. The NAC, RACs, ZACs, and WACs will elect their respective management boards.

The Minister of Health and health officials at regional & sub-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.

The peoples' representative councils at each level will oversight and enforce multisectoral response to HIV/AIDS to ensure effective mainstreaming, responsiveness and accountability.

6.2. Multisectoral Response Implementers

Multisectoral response to HIV/AIDS will be implemented in a decentralized and synchronized manner. Implementing bodies at federal level will focus on capacity building, coordination and monitoring evaluation with provision directives such as policy, strategy, guidelines, and frameworks while implementers at regional level will further cascade these efforts to enable implementation in a planned and organized manner at weredas at operational level.

Multi-sectoral response implementers 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 HAPCOs. Projects are to be reviewed by Project Review Board at each level and approved by respective HAPCOs.

7. PART SEVEN

Monitoring and Evaluation

Monitoring and Evaluation of HIV/AIDS prevention and control interventions will focus on tracking the progress on attaining results with the view of reversing and halting further spread of HIV and improving quality of life for the infected and affected segment of population. A costed plan of the monitoring & evaluation framework will be developed through active involvement of stakeholders to guide the implementation of one M&E system in accordance with the principle of the three ones.
A functional multisectoral HIV/AIDS monitoring and evaluation system will be established to improve program performance by building capacity to collect, analyze and utilize data and instituting a culture of evidence informed decision making at all levels. During SPM II, HMIS will be further strengthened and HIV/AIDS MIS in the non-health sectors will be established. Multisectoral response inputs, processes, outputs and outcomes will be monitored and evaluated using routine service reports and program evaluations. Whereas the multisectoral response impacts will be monitored and evaluated by conducting surveillances, surveys, and studies. Emphasis will be given to monitor the epidemic trends and the driving behavioral, socio-cultural and socioeconomic factors to match the response to the epidemic. As the epidemic is heterogeneous across the country, attention will be given to ensure adequate representation of urban, rural populations and sub-population groups in surveillances and surveys. The level and trend of new HIV infections will be monitored using incidence surveys in the general population and in most at risk population groups. Moreover, effectiveness and efficiency in resource utilization will be monitored and evaluated by tracking resource allocation, disbursement, and utilization through performance based auditing and result based financing at all levels to ensure best use of resources.

To this end, to facilitate the monitoring & evaluation of SPM II, overall goal, objectives, and strategic results are set for thematic areas. The results matrix of the thematic areas outlines the selected strategies, major interventions, targets to be achieved, indicators, means of verification, and responsible lead bodies.
Multisectoral response monitoring & evaluation plan should be implemented through joint efforts in a coordinated manner. National level partners and regional HAPCOs will report to Federal HAPCO while regional level partners and wereda HAPCOs will report to regional HAPCOs. Federal HAPCO is responsible for coordination of multi-sectoral monitoring and evaluation and will convene semi-annual and annual joint review meetings and conduct quarterly joint supportive supervision to federal level implementers and regions in collaboration with development partners, sectors, CSOs, PLHIV networks and FBOs. Similarly, regional and sub-regional HAPCOs will coordinate the multisectoral M&E in their respective administrative levels; conduct quarterly supportive supervision, and convene quarterly, semi-annual and annual joint review meetings. Data collection and reporting formats will be harmonized to facilitate data summarization and analysis. Multisectoral response data base will be established at federal and regional levels to enhance data storage and retrieval. Information dissemination will be strengthened through posting on web, report publications and review meetings.

8. PART EIGHT

Assumptions, Risks and Mitigation of Risks:

The development of SPM II is created based on key assumptions along with key risks that are potentially associated with the implementation of the plan. Analyzing the assumptions, risks and risk mitigation options is de rigueur to preclude failure during operation of the plan.

Financing SPM II: It is believed that major partners such as the Global Fund and PEPFAR, will keep their commitment and considerably cover the funding needed for SPM II. Significant reduction in funding would create substantial gap in implementation of programs. To reduce this risk the Government of Ethiopia will intensify the multi-sectoral approach and engage development partners, civil society and others; increases the implementation capacity at all levels and significantly increase the utilization of funds and improve record keeping and documentation. All risks associated with potential loss of funding will be given utmost attention by the sectors, implanting partners and others benefiting from these funding. The government also will show that HIV is a priority in its agenda and confirm its firm commitment to the fight the epidemic.

Implementation of the "Three ones" and increasing the Coordination capabilities of HAPCOs: It is assumed that during SPM II all partners will be committed to supporting the national plan and abide by and comply with the principles of the three ones. Parallel and uncoordinated effort and lack of commitment by all players will create gaps. To avoid this risk the national annual HIV plan; one national monitoring and evaluating mechanism harmonized by one coordinating body "HAPCO" is indispensable. In order to achieve the set goals of SPM II, effective multi-sectoral coordination and leadership role is expected from HAPCOs. HAPCOs need to be in the lead to ensure all HIV actors adhere to the principle of the "three ones", share one plan, and one M&E tools. Lack of strong coordination, or if there is a lack accountability mechanism, duplication of efforts, wastage of resources and inadequate implementation is unavoidable and coverage and quality of services can not be achieved as planned.

Creating Capacity at all levels: implementation capability at all levels, in particular at district level assumed to be greatly increased. Lack of capability generates a gap on implementation of programs and timely utilization of funding. Ensuring creation of solid capacity and retaining of qualified and experienced human resource to shun this gap is desirable.

Sustainable mainstreaming: In order to achieve the priority areas of SPM II, it is presumed public, private and other sectors will mainstream HIV prevention, care and support programs in a sustainable manner. Lack of commitment to mainstream HIV will create a gap in achieving the anticipated SPM goals. To lessen this risk clear target need to be set for mainstreaming, and HAPCO needs to increase the capacity of partners to mainstream HIV.

Community Mobilization: sustainability of HIV programs at community and household levels can be achieved by creating social transformation through mobilizing the communities. Although there is a risk that some communities can have some other contending priorities; some may not perceive HIV as a problem and some can be fatigued by HIV issues. Effective communication strategy and continuous community

mobilization utilizing community leaders, gate keepers and other methods need to be in place in order to ensure continual awareness on HIV issues and sustainable response by the community.

Strong Leadership and Governance: Attaining the objectives of SPM II by reaching universal access requires strong leadership commitment and improved governance of the multi-sectoral HIV/AIDS response at all levels. If leadership commitment and governance of HIV weakness it will diminishes efficiency and acceptance ultimately affecting the fulfillment of the goals. SPM II clearly puts the leadership responsibilities. Moreover, a mechanism which ensures accountability needs to be in place to avoid such threats.

Increase cost of Treatment and shortage of ARV drugs: The cost of treatment is expected to stabilize as more companies start to produce imitation drugs. However, shortage of ARV drugs and other essential medical items has been occurrence in other African countries. Continual increase in enrollment of new patients can also cause shortage of drugs. The increase in cost of treatment or shortage of drugs either from lack of enough production or from weak supply chain management system both put HIV patients' lives at risk. It is therefore, very crucial to avoid this risk by intensifying primary prevention programs to curve new infection.

Fund Mobilization

To be included soon.