

Strategic Plan II

For Intensifying
Multisectoral HIV
and AIDS Response
in Ethiopia

2010/11 – 2014/15



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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARC	AIDS Resource Centre
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavioural Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organization
CC	Community Conversation
CCM	Country Coordination Mechanism
CSO	Civil Society Organizations
CSW	Commercial Sex Workers
DA	Development Army
DHS	Demographic and Health Survey
EIFDDA	Ethiopian Inter-faith Forum for Development, Dialogue and Action
EHNRI	Ethiopian Health and Nutrition Research Institute
EMSAP	Ethiopian Multi - Sectoral HIV/AIDS Program
ERCS	Ethiopian Red cross Society
FBO	Faith-Based Organization
FMOH	Federal Ministry of Health
GBV	Gender-Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with HIV/AIDS
HAPCO	HIV/AIDS Prevention and Control Office
HB	Health Bureau
HCT	HIV Counselling and Testing
HEWs	Health Extension Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resource
HSDP	Health Sector Development Program
ICASA	International conference on AIDS and STI in Africa
IEC	Information Education Communication
IGAs	Income Generating Activities
IP	Infection Prevention
MAC-E	Millennium AIDS Campaign-Ethiopia
MARPs	Most At Risk Populations

MC	Male Circumcision
MDGs	Millennium Development Goals
M and E	Monitoring and Evaluation
MIS	Management Information System
MNCH	Maternal, Neonatal, and Child Health
MOE	Ministry Of Education
MOH	Ministry Of Health
MOLSA	Ministry of Labour and Social Affairs
MTCT	Mother-To-Child Transmission of HIV
MWCYA	Ministry of Women, Children and Youth Affairs
NAC	National AIDS Council
NEP+	Network of Networks of HIV Positive in Ethiopia
NGO	Nongovernmental Organization
OC	Organisational Conversation
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PASDE	Plan for Accelerated and Sustainable Development to End Poverty
PEP	Post-Exposure Prophylaxis
PFSA	Pharmaceuticals Fund and Supply Agency
PIHCT	Provider-Initiated HIV Counselling and Testing
PLHIV	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission of HIV
RAC	Regional AIDS Council
REB	Regional Education Bureau
RHAPCO	Regional HIV/AIDS Prevention and Control Office
RHB	Regional Health Bureau
SNNPR	Region of Southern People Nations and Nationalities
SPM	Strategic Plan Management
STI	Sexually Transmitted Infection
TB	Tuberculosis
TVET	Technical and Vocational education and training
TWG	Technical Working Group
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCAP	Volunteer Community Anti AIDS Promoters
VCT	Voluntary Counselling and Testing
WrHO	Woreda Health Office
WA	Women Associations
YA	Youth Associations

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Preface

The multisectoral response to HIV/AIDS in Ethiopia is guided by the National HIV/AIDS Policy, 1998; the Strategic Plan for Intensifying Multisectoral HIV/AIDS Response, SPM I (2004-2008); the Plan for Accelerated and Sustained Development to End Poverty, PASDEP (2007-2010); the Road Map for accelerated access to HIV prevention, treatment and care in Ethiopia, (2007-2010); and the Plan of Action for Universal Access to HIV prevention, treatment, care and support in Ethiopia, (2007-2010).

This strategic plan (SPM II) is developed as a guide towards universal access to HIV/AIDS services in the country. Various documents have been used as inputs to prepare SPM II. These include:

- Final Evaluation report of SPM I, 2004-2008;
- Evaluation documents including Impact Evaluation Report of the Global Fund to Fight AIDS, TB and Malaria, Mid-term Evaluation Report of HSDP III, Aide memoire and Mid-term review report of EMSAP I;
- Survey reports such as BSS 2005, DHS 2005 , ANC 2005, single point HIV prevalence estimate 2005, HIV/AIDS Epidemiological Synthesis Report, 2008;
- Global Fund project proposals from Round 4 (2005-2010) and Round 7 grants (2008-12) and the Rolling Continuation Channel (2009-2014);
- Road Map for HIV Prevention, Care, and Treatment (2007-2010) and Costed Universal Access Plan for HIV/AIDS Prevention, Care and Treatment (2007-2012);
- Annual Report of 2008 and 2009, proceedings from various review meetings, UNGASS report of 2008 and proceeding and consensus statement of the National Prevention Summit.
- HSDP IV and
- Other strategic plans from key sectors.

The SPM II has six major parts. 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. Part three elaborates on the five thematic areas (along with their objectives and key strategies) including: (1) creating enabling environment; (2) intensifying HIV preventions; (3) increasing access to and improving quality of chronic care and treatment; (4) intensifying mitigation efforts against the epidemic; and (5) strengthening the generation and utilization of strategic information. Part four of the SPM II is about the programmatic targets and result matrix, which outlines selected strategies, major interventions, targets, indicators, means of verification and lead responsible bodies. Part five covers the implementation modality and institutional arrangements for the SPM. Part six covers the monitoring and evaluation of the SPM.

The SPM II has been developed through a collective effort and active participation of key government sectors, faith-based organizations, community-based organizations, civil societies and associations of people living with HIV, the private sector, multilateral and bilateral donors and individuals. The SPM is fully costed and will have a consolidated road map and operational annual plans, facilitating the SPM into action. The implementation process and achievements will be closely monitored and evaluated based on a costed M and E framework that will be developed shortly. Multisectoral actors will have shared responsibilities and accountability in harmony with the “three ones” principles.

Executive Summary

1. Epidemic Situation Analysis

Trend of the epidemic

Since the detection of the first two AIDS cases in Ethiopia in 1986, the epidemic has rapidly spread throughout the country. According to the single point estimate, the national adult HIV prevalence is 2.3% in 2009 with an estimated 1.1 million people living with HIV in the country. The epidemic which started in the mid-1980's, expanded rapidly reaching a plateau around the mid-1990s. Although the epidemic is on the decline in major urban settings and stabilizing in rural areas, there is significant variation in the epidemic among geographic areas and population groups.

Heterogeneity of the Epidemic

Across the country, the epidemic is generalized. However, urban areas and females are more affected than rural areas and males. Urban HIV prevalence was 7.7% in 2009 and this accounted for 62% of the total PLHIV in the country, while rural HIV prevalence was 0.9% in 2009, which accounted for 38% of total PLHIV population in the country. The estimated national adult HIV incidence of 0.28% in 2009 translates to over 131,000 new HIV infections. There is variation in the prevalence among regions both by urban and rural settings. The HIV prevalence in urban areas ranges from 2.3% in Somali region to 10.8% in Afar region. There is also variation in the urban HIV prevalence among big regions: Oromia (6.1%), SNNPR (7.2%), Amhara (9.9%), and Tigray (10.7%); whereas the rural HIV prevalence ranges from 0.4% in Somali region to 1.4% in Amhara region. Small towns are becoming hot-spots and can potentially bridge further spread of HIV epidemic to rural settings. Addis Ababa and four regions: Amhara, Tigray, Oromia, and SNNPR account for 93.4% of the total PLHIV population in the country.

In all regions, females are more affected than males in both urban and rural areas. In 2009, female HIV prevalence was 2.8% while male HIV prevalence was 1.8%. Females accounted 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

Based on the current available information, the most-at-risk populations (MARPs) in the country includes female sex workers, uniformed forces, long distance drivers, discordant couples, refugees, and migrant labourers, including cross-border and mobile populations. However, there are data gaps to show the full picture of MARPs, their magnitude and sexual behaviours as well as their potential in further spreading the epidemic to the general population.

Knowledge and Sexual Behaviour Patterns

Despite high awareness about HIV/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 condom use with over 90% condom use among Commercial Sex Workers and uniformed forces. However, consistent condom use in casual sex with non-regular partner among the sexually active population is low. Only 60% of out-of-school youth who had sex with a non-regular partner used condom. Although there has been a slight decrease in individuals who have had sex with two or more non-regular partners, sexual practices such as premarital and extra-marital sex exist in the society. Never married sexually active young women are at greater risk of HIV due to sexual mixing with older and high risk men.

Determinant Factors of the Epidemic

Determinant factors that drive the epidemic and sexual behaviours among different population groups are not adequately explored. Limited studies and anecdotal evidences indicate that low level of comprehensive knowledge about HIV/AIDS, low level of perceived risk and threat of HIV/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. In addition, as PMTCT service uptake and ANC coverage are low, there is considerably high vertical transmission from mother to child.

2. Response Analysis

The multisectoral response to HIV/AIDS in Ethiopia was expanded dramatically during the implementation of SPM I (2004-2008). Capacity in the community and in the health sector significantly increased. Over 30,000 health extension workers were deployed into rural Kebeles all over the country. This has 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 passing relevant community bylaws. These have resulted in social transformation and increased demand for & utilization of HIV/AIDS services by communities. Many religious organizations and community groups across the country have instituted the culture of premarital HIV counselling and testing into their by-laws.

The accelerated expansion of primary health care facilities, the decentralization of HIV/AIDS services, and the innovative millennium AIDS campaign- Ethiopia, launched in November 2006 at the eve of the new Ethiopian Millennium, have increased HCT service uptake by nine folds. Individuals counselled and tested for HIV increased from less than half a million per year in 2004, to 4.6 million per year in 2008. The accelerated expansion of free ART program by the government of Ethiopia improved the survival and quality of life for AIDS patients. Patients ever started on ART increased from 8,226 in 2005 to 180,455 by the end of 2008. Although Ethiopia has seen a marked improvement in a number of HIV/AIDS related areas, the performance of the PMTCT program has been below the target for universal access.

Moreover, the capacity of PLHIV associations was also strengthened by empowering them to have a decisive role in the governance, management and service delivery of the HIV/AIDS response. The Network of Networks of HIV Positive in Ethiopia is a member of the National AIDS Council, national management board, Country Coordinating Mechanism for GFATM and review board, as well as the principal recipient of the GFATM Round 7 at national level with decentralized involvement at regional and sub-regional levels. The Ethiopian Inter-faith Forum for Development, Dialogue and Action 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, non-government and private sector organizations have initiated mainstreaming of HIV/AIDS into their core activities during this period. The education sector has integrated HIV/AIDS into the curriculum, initiating peer education, life skills and school community conversation in a considerable number of schools.

Other initiatives were also undertaken to enhance behaviour change among most-at-risk population groups as evidenced by high consistent condom use by traditional MARPs such as CSWs and uniformed forces. Access to AIDS information increased through the expansion of AIDS resource centres, hotlines for the general population, and the Fetun warm-line for health care service providers. Behaviour Change Communication messages were transmitted using print and radio serial dramas and condoms were supplied principally through social marketing with a limited supply distributed through health care facilities.

However, there were a number of limitations and challenges during the SPM I period. The major challenges included: (1) inadequate capacity in the key strategic sectors, (2) shortage of human resource and rapid turnover of staff, (3) low coverage and poor uptake of PMTCT services, (4) inadequate HIV mainstreaming, (5) weak STI services, (6) low coverage of care and support services, (7) limited coverage of services for MARPs, (8) inadequate strategic information, and (9) weak non-health management information system (MIS).

3. Thematic Areas of SPM II

Five thematic areas were identified after a thorough analysis of the epidemic and the response during the SPM I (its major achievements, gaps and challenges). These include (1) creating enabling environment; (2) intensifying HIV prevention; (3) increasing access to and improving quality of chronic care and treatment; (4) intensifying mitigation efforts against the epidemic; and (5) strengthening the generation and utilization of strategic information

3.1. Creating Enabling Environment

This thematic area has five components: (1) capacity building, (2) community mobilization and empowerment, (3) leadership and governance, (4) mainstreaming, and (5) coordination and partnership.

3.1.1. 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. Efforts of capacity building during SPM II (2010/11-2014/15) will focus on consolidating the capacity in the health sector and in the community to achieve universal access to HIV/AIDS services and MDG 6. Moreover, emphasis will be given to building the capacity of key strategic sectors, PLHIV associations, CSOs, and vulnerable and at-risk groups including youth and women, along with building the capacity of multisectoral response coordinating & governing bodies.

3.1.2. Community Mobilization and Empowerment

Concerted efforts will be made to intensify and sustain the anti-HIV/AIDS community movement, engage and empower communities. Furthermore, due attention will be given to bring social transformation and create community ownership. All key actors at community level should be involved in the movement, and institutional support should be strengthened to meet the demands that follow intensified community mobilization.

3.1.3. Leadership and Governance

Leadership and governance will be strengthened to create responsiveness and accountability in the multisectoral response against HIV/AIDS. The response to HIV/AIDS will be taken as a strategic development issue by all sectors at various levels.

3.1.4. Mainstreaming

Mainstreaming of HIV/AIDS into core mandate of all sectors will be strengthened to prevent HIV epidemic and mitigate its impacts. The focus will be conducting an assessment of sectoral vulnerabilities, existing response capacity, and the impact of HIV/AIDS on the sector and to come up with sectoral policies, strategies, and action plans to mainstream HIV/AIDS using each sector's own resources. During SPM II period, mainstreaming should be expanded to the private sector, Non Governmental Organisations and civil society organizations.

3.1.5. Coordination and partnership

Coordination of a multi-sectoral response against HIV/AIDS will be guided by this SPM in line with the principle of the "Three Ones". "One country plan" and "one monitoring and evaluation system" will be taken as key tools to harmonize and coordinate the multisectoral efforts at all levels.

Partnerships will be strengthened to ensure an effective response against HIV/AIDS, create synergy and enhance efficient use of resources. Partnership guidelines will be developed to strengthen partnerships and networking.

3.2. Intensifying HIV Prevention

The fight against HIV/AIDS cannot be successful unless further spread of the epidemic is reversed and ultimately halted. This requires social transformation to reduce social, cultural and economic factors that make people individually or collectively vulnerable to HIV infection, as well as creating comprehensive knowledge and behavioural change on a mass basis among the population with particular focus on MARPS. Prevention of new HIV infection among young people and the adult population must be intensified using a combination prevention approach to address structural, behavioural, and biomedical issues in HIV prevention. A package of HIV prevention services for MARPs and PLHIV will be developed, implemented and scaled-up towards universal access.

3.3. Increasing access to and improving quality of chronic care & treatment

As a result of improved ART services, HIV/AIDS is becoming a manageable chronic disease. Chronic care and treatment services will be further decentralized through the expansion of services, task shifting and improving service integration, linkages and referral systems.

Barriers to service delivery will be addressed by increasing the number and quality of human resources, availing treatment for opportunistic infection and ARV drugs, as well as strengthening logistic, laboratory and health management information system. Special emphasis will be given to improve adherence and retention of patients on treatment.

3.4. Strengthening care and support services to mitigate the impact of AIDS

Mitigating the devastating impacts of HIV/AIDS is essential to improve the livelihoods of those infected and affected. Care and support services will be provided to orphans and vulnerable children (OVC) and PLHIV in their familial network through a sustainable approach. Efforts will be made to reduce dependency by scaling-up income generation activities to the needy OVCs and PLHIVs.

3.5. Enhancing generation and utilization of strategic information

To institute evidence based/informed policy making, program planning and 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 and use of strategic information. Capacity to generate and use strategic information will be strengthened in key sectors by integrating of HIV strategic information into sectors' management information system.

4. Monitoring and Evaluation

Monitoring and evaluation of the multi-sectoral response to HIV/AIDS will be strengthened at all levels. Response inputs, processes, outputs, outcomes, and impacts will be monitored and evaluated using routine reports, surveillances, surveys, and studies. A functional M and E system will be instituted by developing an appropriate system and strengthening M and E capacities at all levels. Appropriate indicators are identified in order to verify the achievement of the set targets for SPM II. Mid-term and final evaluations of the SPM will be conducted.

millions

of people were reached by CC

200,000

students received life skills trainings

5.8 million

people were tested for HIV just in one year (in 2009)

286 million

condoms were distributed during 2004-2008

73%

PLHIV ever started ART

49,147

self-help groups were established



Part One

Introduction

Part One: Introduction

1.1. Situation Analysis

1.1.1. General Background

Ethiopia has a population of 79.8 million. The country is a Federal Democratic Republic and administratively composed of nine National Regional States and two city administrations, with 750 Woredas (districts). The major health problems of the country are communicable diseases, most of which are preventable. In 2007/2008 potential access to primary health care had reached 89.6%.

1.1.2. Trends and Status of the HIV Epidemic

Ethiopia is among the countries most affected by HIV and AIDS. The existence of HIV infection in Ethiopia was recognized in the early 1980s with the first two AIDS cases reported in 1986. Since then, the epidemic has rapidly spread throughout the country. The epidemic peaked in the mid-1990s. Since 2000 the epidemic has declined in major urban areas and stabilized in rural settings. According to projections based on the single point estimate the national adult HIV prevalence for 2009 was estimated at 2.3% with 1,116,216 People Living With HIV/AIDS (PLHIV) and 855,720 orphans due to AIDS. For the same period the total number of Orphans and Vulnerable Children (OVCs) in the country was estimated at 5.4 million. There were an estimated 44,751 deaths due to AIDS in 2009. The number of AIDS-related deaths would have been much higher had it not been for the free Anti-Retroviral Therapy (ART) program which has been scaled-up in an accelerated manner since 2005. The estimated national adult HIV incidence of 0.28% in 2009 translates to over 131,000 new HIV infections. With the current status, it is evident that HIV and AIDS remains a formidable development challenge to the country.

1.1.3. Heterogeneity of the Epidemic

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

In 2009, the national urban HIV prevalence was 7.7% and an estimated 695,413 people living with HIV (PLHIV) resided in urban areas, which accounted for 62.3% 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 hot-spots, according to findings of Demographic and Health Survey (DHS) 2005. There is considerable variation in urban epidemics from region to region with urban HIV prevalence ranging from 2.3% in Somali region to 10.9% in Afar region in 2009, and urban HIV incidence ranging from 3.52% and 3.0% in Afar and Amhara to 0.56% and 0.71% in Somali and Gambella regions respectively. There is also variation in the urban HIV prevalence among big regions: Oromia (6.1%), SNNPR (7.2%), Amhara (9.9%), and Tigray (10.7%).

The national rural HIV prevalence was 0.9% in 2009. The number of PLHIV living in rural areas estimated to be 420,802, accounts for 37.7% of the total population of PLHIV in the nation. The epidemic in rural settings is generalized but varies significantly from region to region with rural HIV prevalence ranging from 0.4% in Somali region to 1.4% in Amhara.

The likelihood of the further spread of HIV to rural settings is increasing as small towns are becoming hot-spots and bridging the urban epidemic with rural settings. As a result, it is necessary for combination prevention packages be intensified and scaled up to the hot-spots.

According to various surveys and studies, women are more affected than men. DHS 2005 found that HIV prevalence among the female population to be twice that of the male population. In 2009, national HIV prevalence was 2.8% among women and 1.8% among men. An estimated 658,843 women were living with HIV in 2009, 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.

Table 1: HIV prevalence region, residence and sex in 2009

Region	Adult HIV prevalence (%) in 2009	HIV prevalence by Residence in 2009		Adult HIV incidence (%) in 2009	HIV incidence by Residence in 2009		HIV prevalence by sex in 2009	
		Urban (%)	Rural (%)		Urban (%)	Rural (%)	Females (%)	Males (%)
Tigray	2.9	10.8	0.9	0.35	2.95	0.13	3.5	2.4
Afar	2.1	10.9	0.9	0.27	3.52	0.25	2.5	1.7
Amhara	2.8	9.8	1.4	0.34	3	0.36	3.4	2.2
Oromia	1.5	6.1	0.6	0.17	1.82	0.11	1.8	1.2
Somali	0.8	2.3	0.4	0.1	0.56	0.11	1	0.7
Benshangul Gumuz	2	5.5	1.3	0.26	1.35	0.38	2.4	1.6
SNNPR	1.6	7	0.8	0.22	1.91	0.29	1.9	1.3
Gambela	2.4	6.6	1.1	0.2	0.71	0.33	2.8	1.9
Harari	3.5	5.2	0.3	0.51	1.51	0.06	4.2	2.8
Addis Ababa	8.5	8.5		1.53	1.53		10.1	6.8
Dire Dawa	4.6	5.9	0.5	0.68	1.74	0.16	5.5	3.7
National	2.3	7.7	0.9	0.28	1.91	0.19	2.8	1.8

1.1.4. Most-at-Risk Population Groups

Population groups with most-at-risk of HIV infection include female sex workers, migrant workers, long distance drivers, uniformed forces, and discordant couples. Common settings with most-at-risk populations (MARPs) include economic and infrastructure development schemes, brothels, high transport corridors, 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 breast-feeding.

The behaviour related risk factors for the epidemic in the country include:

- Practice of multiple concurrent sexual 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%).
- Low and inconsistent condom use: Although there is a remarkable improvement in consistent condom use among female sex workers and uniformed forces, which reached as high as 90%, condom use among sexually active young people is still low. For instance, the 2005 DHS showed that only 40% of sexually active out-of-school youth aged 15-24 used condoms while having sex with a non-regular partner.
- Intergenerational and transactional sex.
- Repeated episodes of Sexually Transmitted Infection (STIs) and low treatment seeking behaviours for STIs.
- Mobility/migration of population: Due to the current development investments, there are a number of seasonal and migrant labourers in different parts of the country. Separation from their families for a prolonged time increases the likelihood of risky sexual practices.

- 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.
- PMTCT and vertical transmission: The emerging epidemic pattern among couples of reproductive age, together with low prevention of mother-to-child transmission of HIV (PMTCT) service up take, means that vertical transmission continues to contribute significantly to the spread of HIV.
- Emerging behaviours: There are a number of emerging behaviours 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.

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 one-self:** According to the DHS 2005, only 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. In addition to the low level of the comprehensive knowledge, there is 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 fuelling 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:** 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, putting 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

There has been a noticeable decline in the estimated number of total annual deaths due to HIV/AIDS. The estimated death was 99,360 in 2005 while in 2009 it was 44,751. The decline in AIDS related deaths is mostly due to the wide availability of the free ART program in the country since 2005, initiated by the government in collaboration with development partners.

As the most sexually and economically active segment of population, 15-49 years old are highly affected by HIV/AIDS. Infection with HIV often results in considerable productivity loss due to recurrent illnesses and deaths with loss of skilled labour across the sectors and as a result, posing a challenge to the socio-economic development of Ethiopia. AIDS disrupts families and increases orphans and vulnerable children. It is estimated that the number of orphans due to HIV/AIDS in 2009 was 885,720.

1.2. Response Analysis

The response to the HIV/AIDS epidemic in Ethiopia is a collective effort by the government, communities, faith-based organizations, community-based organizations, civil societies, associations of PLHIV, national and international non-governmental organizations, the private sector, and multilateral and bilateral donors and individuals. The response was guided by the national policy issued in 1998 and Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response for the period 2004-2008 (SPM I).

The National AIDS Council was established in 2000, and was charged with directing and overseeing the multi-sectoral response. The Council, chaired by the President of the country and comprising members from government, NGOs, religious bodies, civil society, and PLHIV, 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.

1.2.1. Major Achievements of the Response

The major thematic areas in the SPM I (2004-2008) were capacity building, community mobilization and empowerment, integration with health programs, leadership and mainstreaming, coordination and networking and targeted responses. The major achievements, challenges and gaps are as follows.

1.2.1.1. Capacity Building

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

The expansion of health infrastructure from 2004 to 2008 included an increase in number of health centres from 600 to 1,500 and a 20 percent 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 grass roots 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.
- HIV was integrated in school curricula and in multi-purpose educational TV programs.
- A number of teacher-training institutions, colleges and universities have incorporated life skills-based HIV education into their curricula.
- Investments were made on strengthening life-skills programs nationwide and in capacitating the education sector, resulting in the development of education sector's HIV policy and guidelines.
- The capacity of PLHIV organizations has increased considerably and as a result, they have started to become service providers. Associations of PLHIV are represented at governance and leadership structures of HAPCO, from Federal to Woreda level and are involved in the 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 the HIV field.

1.2.1.2. 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. CCs were used to advocate against harmful traditions and mobilize the community to mitigate the impact of HIV and AIDS.

- Better involvement of communities, mass organizations, faith based and civil society organizations in prevention, care, support, and impact mitigation services for PLHIV and OVC were observed.
- Awareness creation through social mobilization, especially during Millennium AIDS Campaign-Ethiopia (MACs), resulted in increased demand for and utilization of Voluntary Counselling and Testing (VCT), ART and other health 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 premarital HIV testing and advocating to outlaw widow inheritance and abduction marriage.
- Income Generating Activities (IGAs) and other social support mechanisms are becoming more available.

1.2.1.3. Integration with Health Programs

SPM I had greater emphasis on the health sector to HIV/AIDS, and made great progress towards the strategic objective of "integration with health programs". The Federal Ministry of Health spearheaded the implementation of integration. During this period considerable achievements have been made in expanding health facilities and services to the general population as well as to PLHIVs. 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.

Availability and accessibility of health facility-based HIV services have increased from 658 and 129 in 2005 to 1596 and 843 in 2009, respectively, while free ART sites increased from 3 to 483 during the same period.

- Annual HIV Counselling and Testing (HCT) uptake has increased from 0.4 million in 2005 to 5.8 million in 2009. As a result 37 percent of the adult population know their HIV status. Millennium AIDS Campaign-Ethiopia (MAC-E) has made a significant contribution to this achievement.
- 73 percent of the PLHIV in need of treatment have been enrolled for ART as of 2009.
- 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 Tuberculosis (TB) patients counselled and tested for HIV increased from 10 percent to 80 percent.
- Noteworthy investments have been made in infrastructure, including upgrading of health facilities and procurement of equipment and supplies.

1.2.1.4. Leadership and Mainstreaming

Improved leadership commitments and mainstreaming HIV in the workplace were observed at both national, regional and woreda 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 strides have been made in involving leadership to actively guide HIV activities at all levels.

- Allocation of up to two percent 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.
- 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.
- Some sectors developed workplace HIV policies and guidelines.

1.2.1.5. Coordination and Networking

To ensure synergy of HIV programs in order to yield maximum impact and to increase efficient use of resources, it is necessary to work in coordination and through networking

- Responses guided by one agreed national action framework and use of one monitoring and evaluation system.
- Plan of action for Universal Access to HIV Treatment, Care and Support, 2007-2010 and a Road Map for Accelerated Access to HIV Prevention, Treatment, Care and Support, 2004-2006, and 2007-2010 were developed.
- Coordination and networking was achieved through regular joint review meetings and joint integrated support supervisions.
- Various task forces, and technical working groups comprising of stakeholders were established.
- Efficient resource utilization was noted.
- The national partnership forum was formed and hosted at federal level.

1.2.1.6. Special Target Groups

HIV responses were generally targeting the whole community with some specific attention to certain groups like the urban population, military, OVC, PLHIV, in-and out-of-school youth, long distance track drivers, and commercial sex workers. These activities are the main areas for involvement of Nongovernmental Organization (NGOs), Community-Based Organization (CBOs) and Faith-Based Organization (FBOs).

- Over 400 school-based anti-AIDS clubs, more than 200 out-of-school anti-AIDS clubs, and 206 youth and recreational centres were established.
- 200,000 students received life skills trainings.
- Over 286 million condoms were distributed during 2004-2008.
- Over 450,000 orphans received various support services.
- 92,537 PLHIV received basic social and financial services.
- 195,000 benefited from free health care and education services.
- 49,147 self-help groups were created.
- 40,521 people were provided with short training on small business management and employment.
- Successful high risk corridor initiative focusing on prevention activities for long distance drivers.

1.2.1.7. Monitoring and Evaluation, Surveillance and Research

In addition to producing the routine monthly, quarterly, biannual and annual performance reports, Ethiopia has been conducting many researches and surveillances. The key ones are:

- ANC-based sentinel surveillances, 2005 and 2007
- Behavioural surveillance surveys, 2005
- Demographic health surveys, 2005
- UNGASS report, 2006 and 2008.
- Epidemiological synthesis, and
- Health facility survey, 2005

1.2.2. Major challenges and gaps of the response

- Lack of adequately trained and experienced human resources both in technical and administrative areas.
- Frequent turnover and attrition of skilled human resources.
- Capacity building efforts for non-health sectors and the private sector appears to be limited.
- Health centres in rural areas and hospitals are under equipped and understaffed.
- Shortage of Opportunistic Infections (OI) drugs, test kits, laboratory reagents, Infection Prevention (IP) materials and limited capacity in equipment maintenance were among the challenges.
- The inadequate coverage and targeting of primary prevention programs and services, especially those addressing most-at-risk populations and vulnerable groups.
- The insufficient coverage of impact mitigating programs.
- Continual inadequate performance in PMTCT and STI programs.
- The referral system from primary health care units up to the tertiary level is frail, which creates problems for ART compliance.
- The response did not address the MARPs well.
- Limited strategic information on HIV/AIDS
- Delay in dissemination of results of surveys and surveillances.
- The inadequacy of the monitoring and evaluation system for non-health HIV/AIDS activities.



The fight against HIV/
AIDS needs enhanced
multisectoral and gender
sensitive response, which
empowers communities,
and moves with shared
sense of urgency,
stronger partnership,
greater involvement of
PLHIV, and best use of
resources...



Part Two

Vision, Mission, Goal,
Strategic Results, and
Guiding Principles

Part Two: Vision, Mission, Goal, Strategic Results, and Guiding Principles

Vision:

To see Ethiopia free of HIV/AIDS

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 sectors, enhancing partnership under the principle of the “three ones”, and mobilizing and ensuring appropriate use of resources.

Goal:

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

Strategic Results:

- Comprehensive knowledge and behavioural change created on individual and mass bases,
- Reduced new HIV infection, and
- Improved quality of lives of infected and affected people.

Guiding Principles

Multisectoralism: The HIV/AIDS epidemic is posing a formidable challenge to the development of all sectors as illnesses and deaths from AIDS reduce productivity of their labour force. Responding effectively to the behavioural, social, cultural, and economic factors that make individuals and communities vulnerable to HIV infection and mitigating the associated crises of AIDS requires organized and concerted efforts from all actors in the public and private sector, NGOs, FBOs, PLHIV and communities at large. 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: Families and communities should be empowered and own the HIV programs so as to halt and reverse the epidemic.

Shared sense of urgency: 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: 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: 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.

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.

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.

Best use of resources: Resources mobilized from external development partners, the government and communities should be utilized in an effective and efficient manner with accountability.



In order to effectively progress towards achieving MDG 6 by 2015, there is a pressing need to intensify HIV Prevention, increase access to quality chronic care and treatment, and strengthen care and support services by creating enabling environment, and establishing system for an effective strategic information...





Part Three

Thematic Areas

Part Three: Thematic Areas

3.1. Thematic Area One: Creating an Enabling Environment

General Objective: To create an enabling environment for scaled up and comprehensive HIV/AIDS multisectoral response.

This thematic area has five sub-thematic areas: (1) capacity building, (2) community mobilization and empowerment, (3) leadership and governance, (4) mainstreaming, and (5) coordination and partnership.

3.1.1. Capacity Building

Specific Objectives:

- To ensure the capacity of the health sector to achieve Millennium Development Goals 6 (MDG 6) by 2015.
- To build the capacity of key and strategic sectors, civil society organizations (CSOs) and private sectors to contribute to the achievement of MDG 6 by 2015.

Strategies:

- Strengthen the capacity of the health sector.
- Build the capacity of key sectors, CSOs and the private sector

Strengthening the health sector is indispensable to ensure effective HIV/AIDS multisectoral response. The expansion and equipping of health facilities together with availing adequate skilled human resource in the health facilities as well as at different levels of management of the health system is an important component of building the capacity of the health sector.

Building the capacity of key sectors and communities is also of utmost importance to intensify the fight against HIV/AIDS. In order to move towards the achievements of MDG 6 by 2015 ("to halt and reverse the spread of HIV"), there is a real and pressing need for creating adequate capacity at community and institution levels.

Capacities of key sectors that can have significant effect on the fight against HIV/AIDS such as, Education, Health, Mining, Defence, Industry, Communication, Culture and Tourism, Transport, Women, Children and Youth, Labour and Social, Water and Energy, Trade, Agriculture, Civil service, Urban Development and Construction, Federal affairs and Ministry of Finance and Economic Development, need to be

strengthened. In addition, the building of leadership across sectors and communities and strengthening the capacity among stakeholders such as Most At Risk Populations (MARPs), Network of Networks of HIV Positive in Ethiopia (NEP+), Ethiopian Inter-faith Forum for Development, Dialogue and Action (EIFDDA) and other Civil Society Organizations (CSOs) is crucial to synchronize and harmonize efforts towards a common goal.

Interventions:

- Support the expansion of health centres.
- Support universities and colleges to provide pre-service training for health science students.
- Train health workers on HIV/AIDS.
- Staff key sectors with experts on prevention and impact mitigation.
- Provide support to federal sectors to build the capacity of regional sectors on HIV.
- Prepare health facilities for people with disability.
- Build the capacity of networks of associations of PLHIV, OVC, elderly people, people with disability, CSOs and FBOs.
- Provide support to associations of PLHIV, OVC, the elderly, people with disability, CSOs and FBOs.

3.1.2. Community mobilization and empowerment

Specific objective:

- To sustain community movement and attain social change by 2015.

Strategies:

- Ensure community ownership and leadership of HIV/AIDS.
- Augment community mobilization with behavioural change interventions.
- Strengthen institutional support to community anti-AIDS movement.

Community mobilization and empowerment is crucial to attain success in the fight against HIV/AIDS. The anti-HIV/AIDS community movement should be anchored with the development and implementation of a concrete action plan. The community must own the movement and integrate an HIV/AIDS response into the existing socio-cultural and economic activities. Anti-AIDS community movement was intensified and over 80% of Kebeles across the nation covered with community conversation by the end of 2009.

However, social transformation, which can bring the required level of changes in behaviour and social norms, has not been fully realized in the community at large. Hence, there is a need to consolidate and intensify the anti-HIV/AIDS community movement to bring social transformation.

The movement should engage key players in the community including the youth, women, farmers through their associations, kebele administrations, health extension workers (HEWs), teachers and agricultural development agents, Iddirs, faith-based organizations, NGOs and PLHIV. The overall movement should be led by the Kebele administration with technical leadership provided by the HEWs.

Interventions:

- Train community leaders.
- Conduct community conversation.
- Enforce relevant community by-laws.
- Train Health Extension Workers (HEW) on Behavioural Change Communication (BCC).
- Train community anti-AIDS promoters from model households.
- Train health development armies (DA) on BCC.
- Strengthen Kebeles to provide support to community anti-AIDS movement.
- Document, share and scale-up best practices.

3.1.3. Leadership and Governance

Specific objective:

- To ensure responsiveness and accountability in the leadership and governance of the Multisectoral HIV/AIDS response.

Strategies:

- Build the capacity of leadership and governing bodies at various levels.
- Avail regular updates on the HIV/AIDS epidemic situation and response to leadership and governance.
- Ensure inclusion of HIV plans in the overall sector plan and oversight sector performance.

Strengthening leadership and governance is essential to create transparency, 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.

Interventions:

- Provide training on strategic leadership on the fight against HIV/AIDS to leadership and governing bodies.
- Select and document best practices.
- Arrange experience sharing visits for leadership and governing bodies from the regions.
- Disseminate annual performance reports and analytical reports on the epidemic and response.

- Establish AIDS Resource Centres (ARC) in the federal and regional parliament.
- Provide oversight in the inclusion of HIV/AIDS plans in the overall sectors' plans.
- Conduct periodic review by the parliament and other governing bodies.

3.1.4. Mainstreaming

Specific objective:

- To enhance the HIV/AIDS response across sectors.

Strategies:

- Strengthen ownership of HIV/AIDS programs across sectors.
- Ensure the inclusion of HIV M and E into sectors' management information system (MIS).

Mainstreaming HIV/AIDS prevention and control into core mandates and activities of various sectors (public, private and CSOs) is crucial to prevent further spread of the epidemic and mitigate its impacts. 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.

Interventions:

- Conduct assessment on vulnerability and impact of HIV/AIDS and the capacity of the existing response.
- Develop sector specific policies, strategies and plans on HIV/AIDS.
- Establish a unit for mainstreaming HIV/AIDS in both public and non-public sectors.
- Ensure allocation of resources by all sectors for HIV/AIDS mainstreaming.
- Incorporate monitoring and evaluation of HIV/AIDS into sectors' MIS.

3.1.5. Coordination and Partnership

Specific objective:

- To ensure synergy of multisectoral HIV/AIDS response at all levels.

Strategies:

- Build the capacity of HIV/AIDS response coordination of HAPCOs/ Health Bureau (HBs) at all levels.
- Strengthen partnerships at all levels.
- Strengthen networking among service providers.

Strong leadership and broader coordination is required to translate the strategic plan into a viable annual plan of action. Adherence of a wide range of actors to the 'Three Ones' principles will anchor the production of a synchronized and harmonized annual plan and report. HAPCO will ensure coherence and close collaboration among development partners, CSOs, FBOs and the private sector with the aim of further aligning and harmonizing HIV activities in the country. Strengthening partnership forums and sub-forums is essential for effective coordination of the Multisectoral response.

Interventions:

- Provide training on coordination.
- Develop a joint annual plan guided by SPM II.
- Institute one national multisectoral monitoring and evaluation system.
- Develop partnership guidelines.

- Establish/ strengthen partnership forums at national, regional and woreda levels.
- Strengthen partnerships for cross-boarder interventions.
- Map HIV/AIDS service providers and stakeholders at all levels.
- Establish/ strengthen linkages and networking of HIV/AIDS services.

3.2. Thematic Area Two: Intensifying HIV Prevention

General Objective: To reduce the rate of new HIV infections by 50 percent (from 0.28% in 2009 to 0.14% by 2014/15).

Specific Objectives:

- To increase comprehensive knowledge on HIV among the adult population aged 15-49 from 22.6 percent in 2005 to 80 percent by 2014/15.
- To reduce the percentage of young people, aged 15-19 years, who start sexual debut at age of 15 years from 8.4 percent in 2005 to 1.7 percent (Female from 11.1 percent to 2.2 percent and male from 1.7 percent to 0.34 percent) by 2014/15.
- To increase the percentage of young people aged 15-24 years, who use condoms consistently while having sex with non-regular partners from 59 percent in 2005 to 80 percent by 2014/15.
- To increase percentage of female sex workers reporting consistent use of condom from 93.4 percent in 2005 to 98 percent in 2014/15.

There were enormous efforts by the Government of Ethiopia to increase the availability and accessibility of HIV prevention services during the SPM I period. However, the evaluation of SPM I revealed that the scale of primary HIV prevention efforts was insufficient to stop the progress of the HIV epidemic. Moreover, primary HIV prevention efforts must target non-infected individuals that are vulnerable and at risk to HIV infection.

In general, all preventive services need to be expanded and made available to the broader population in both urban and rural areas. These services should also be expanded to specific population groups, including sex workers, in-school and out-of-school youth, uniformed services, migrants, residents of small market towns and new business opportunity sites (large scale farms, construction sites, mining, etc...) refugees and displaced populations including cross-border populations and populations with special needs like people with disability and the elderly.

Even though there is a need to expand treatment, care and support services further, prevention of new HIV infections needs to remain the cornerstone of the national HIV response in Ethiopia. Creating comprehensive HIV knowledge, increasing self-risk perception and promoting behavioural changes at a population level must be intensified, targeting highly vulnerable and at-risk populations to maximize the yield of efforts. The universal access targets can be achieved only if primary prevention is intensified to the level that can enable a reduction of new infections.

To achieve maximum impact, prevention of new HIV infection should utilize a combination of proven behavioural, structural and biomedical approaches. HIV prevention 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. Under this thematic area, there are three sub-thematic areas: behavioural, structural and biomedical HIV prevention approaches.

3.2.1. Behavioural HIV Prevention Approach

Expansion of behavioural change programs addressing the general population and MARPs is a key component of the combination prevention intervention strategy. The behaviour change intervention approaches need to be refined, re-focused, intensified and scaled-up in all communities to result in increased comprehensive knowledge on HIV/AIDS, delay of onset of initiation of sexual intercourse, increased self-risk perception, decrease in the number of unprotected sexual acts, reduce the number of sexual partners, increase demand for biomedical HIV prevention services like counselling and testing, STI treatment and use of condom. Behavioural intervention should be combined with interventions that address structural issues and the provision of biomedical HIV prevention services.

Strategies:

- Strengthen community based HIV prevention interventions to address the general population.
- Strengthen workplace HIV prevention interventions.
- Strengthen school based HIV prevention interventions.
- Scale-up comprehensive prevention interventions addressing MARPs.
- Strengthen out-of-school youth HIV prevention programs.
- Intensify secondary prevention.
- Intensify HIV prevention in development schemes including new business opportunity locations.
- Scale-up HIV prevention among population groups with special needs.

3.2.1.1. Strengthen community based HIV prevention interventions to address the general population

Community Conversation has evolved as one of the key tools for community capacity enhancement to bring about sustained social change at individual, family and community level. CC is used for diagnosis, priority setting and community level response to fight against HIV/ AIDS in the country. In addition, CC was recently taken as a best practice by the health sector and adopted as a way to strengthen health promotion and prevention of other communicable diseases such as malaria and TB.

Interventions:

- Ensure the scale-up of quality CC and integrate with existing community structures.
- Review existing CC guidelines and training manuals.
- Conduct training for volunteer community anti-AIDS promoters (VCAP) or model families.
- Develop and disseminate HIV prevention messages using print and electronic media.

3.2.1.2. Strengthen Work Place HIV prevention intervention

Mainstreaming HIV/AIDS is a process of analysing how HIV/AIDS impacts on all sectors now and in the future, both internally and externally. It entails sectors to conduct risk assessment and design appropriate work place interventions accordingly.

Interventions:

- Develop Organisational Conversation (OC) guidelines and training manual.
- Provide training on OC.
- Conduct OC in work places.
- Conduct condom promotion and distribution in the work place.

3.2.1.3. Strengthen school-based HIV prevention interventions.

Preventive interventions must start at a younger age in order to create behaviour change and generate far-reaching knowledge on HIV/AIDS. School interventions must be age-appropriate and particular emphasis should be given to rural areas, secondary schools and tertiary education. Gender sensitive HIV and reproductive health interventions, which are expected to enhance life skills, including negotiation, decision making and adoption of safer sexual behaviours, will be implemented in all primary and secondary schools, as well as in public and private tertiary education institutes.

Interventions:

- Conduct peer education programs in schools, higher education institutes and Technical and Vocational education and training (TVET).
- Conduct life-skill education in schools, higher education institutes and TVET.
- Conduct school based CC in high schools, higher education institutes and TVET.
- Integrate HIV/AIDS into school curriculum.
- Train teachers on management of school HIV/AIDS programs.
- Develop and disseminate targeted BCC message in schools, higher education institutes and TVET.
- Strengthen youth leadership development programs.
- Develop an HIV intervention strategy for school and higher education.
- Strengthen anti-AIDS clubs in schools, and higher education institutes and TVETs.
- Ensure active participation/ membership of students in anti-AIDS clubs of schools in higher education institutes and TVET.
- Expand ARC in schools, higher education institutes and TVET.

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

HIV prevention programs are important to young people who are out of the school system. The coverage and quality of the existing HIV prevention services needs to be further intensified. These include peer education, outreach HIV education and youth friendly HIV services. HIV prevention interventions focusing on young women, including domestic workers and expansion of edutainment centres to all Woredas will be given due attention.

Interventions:

- Expand/strengthen educational entertainment (edutainment) in youth centres in district towns.
- Train Peer educators on HIV.
- Implement outreach youth interventions.
- Conduct youth dialogue.

3.2.1.5. Combination Prevention interventions addressing MARPs

Improving the effectiveness of efforts to contain and reverse the spread of HIV requires identification of populations at risk of HIV infection, define what prevention measures are essential for these populations, and ensure adequate delivery of essential prevention measures to the identified populations. Prevention strategies and activities will be tailored and delivered as a package to address

the needs of the MARPs. Regions must have specific intervention plans based on evidence on the regional situation and their respective response analysis to give special attention to risk groups existing in their respective areas.

Interventions:

- Determine the identity, size, behavioural characteristics and HIV prevalence among MARPs.
- Map MARPs service providers.
- Develop a package of HIV behavioural services for MARPs.
- Develop comprehensive communication strategy for MARPs.
- Build the capacity of CSOs to provide outreach HIV education to MARPs.
- Provide comprehensive HIV prevention services to MARPs.

3.2.1.6. Intensifying HIV prevention in the development schemes

It is important to focus on newly created development opportunities and commercial activities that can provide fertile ground for the spread of HIV due to increased vulnerability and/ or lack of access to HIV prevention services. Construction sites (dam and road), large-scale farms (flowers and sugar cane), mining, and the likes will be given due attention and will be targeted by HIV prevention programs. Assessment of the response capacity in development schemes of public and private sectors will be taken as the initial step to either revitalize or scale-up HIV prevention interventions. Based on the assessment of vulnerability and response capacity, development schemes/ projects will create workplace interventions and guidelines, integrating HIV prevention into their overall development program/ projects. HIV/AIDS activities will be included in the appraisal criteria of projects of development schemes. Ensuring implementation of HIV/AIDS activities will be among the duties and responsibilities of project coordinators.

Interventions:

- Target business opportunity locations, industries and private development schemes.
- Integrate HIV prevention in the project proposals of development schemes.
- Develop and disseminate targeted HIV/AIDS messages.
- Conduct peer education.
- Referral and linkages with health facilities for VCT, STI and ART services.
- Ensure HIV prevention among development schemes/projects areas communities.

3.2.1.7. Scale-up HIV prevention among population groups with special needs

Tailored HIV prevention programs will be scaled-up to reach population groups with special needs such as people with disability and elderly. Interventions to such groups will be designed in a manner that addresses and fits the groups' special need.

Interventions:

- Conduct risk and vulnerability assessment.
- Develop prevention strategy for people with special needs.
- Customize HIV intervention guidelines and implementation manuals.
- Integrate BCC interventions in ARC of youth centres for people with disability.
- Develop and disseminate BCC materials for people with special needs.

3.2.2. Structural HIV Prevention Approach

Reduction of vulnerability factors that impair the ability of individuals and communities to avoid HIV infection will have great contribution to curb the spread of HIV in the country. Structural interventions that address factors such as gender inequality, poverty, socio-cultural norms, stigma and discrimination need to be intensified.

Strategies:

- Address gender inequality.
- Reduce economic vulnerability.
- Address socio-cultural factors.
- Protect human rights and provide legal support.

3.2.2.1. Address gender inequality

Addressing gender inequality, including gender-based violence (GBV) will be promoted. 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.

Interventions:

- Mainstream gender into sectoral policies.
- Avail PEP to victims of rape.
- Advocate for punitive measures on perpetrators of GBV.
- Ensure inclusion of gender dimension in HIV programs.

3.2.2.2. Reduce economic vulnerability

Poverty is one of the driving factors that increase individual's vulnerability to HIV infection. Women with low income, unemployed youth and orphans are such groups who need support to enhance their ability to avoid HIV infection.

Interventions:

- Provide IGA support to vulnerable women.
- Integrate HIV/AIDS services with safety-net programs.

3.2.2.3. Address socio-cultural factors

Socio-cultural norms and deep rooted beliefs and practices are fuelling factors that increase people's vulnerability to HIV/AIDS. Addressing socio-cultural issues that contribute to the spread of the epidemic such as harmful practices and GBV need to be intensified.

Interventions:-

- Address harmful traditional practices that fuel HIV/AIDS.

3.2.2.4. Protect human rights and provide legal support

Interventions targeting stigma and discrimination, and protection of human rights will be given due consideration during SPM II.

Interventions:

- Implement the principles of the “greater involvement of people living with HIV/AIDS (GIPA)”.
- Conduct the national stigma index study.

3.2.3. Biomedical HIV Prevention Approach

Biomedical HIV prevention consists of strategies and interventions implemented as part of the health sector response to HIV/AIDS. The services need to be accessible and meet the demands of the general population, MARPs and population groups with special needs.

Strategies:

- Ensure access and enhance uptake of HIV counselling and testing services.
- Ensure access and enhance uptake of PMTCT services.
- Increase availability and utilization of STI services.
- Increase supply, distribution and utilization of male and female condoms.
- Ensure infection prevention and safe blood supplies in health system.
- Avail post exposure prophylaxis (PEP).
- Accelerate male circumcision, in areas needed.
- Provide user-friendly biomedical services to people with special needs and MARPs.
- Intensify positive prevention.

3.2.3.1. Ensure access and enhance uptake of HIV counselling and testing services

This strategy aims at enabling knowledge of one’s HIV status and linking those who test positive to HIV to relevant chronic care services.

Interventions:

- Promote HIV testing using CC and health extension workers as well as mobile, outreach services.
- Promote HCT by the development armies.
- Educate households on HCT by health development armies.
- Promote HIV testing through religious leaders, local community leaders.
- Educate the general public on HIV testing through mass media campaigns.
- Provide training to HCT service providers.
- Provide HCT to people with disability.
- Ensure uninterrupted supply of test kits and other accessories.
- Rollout HCT services into private health facilities.

3.2.3.2. Ensure access and enhance uptake of PMTCT services

PMTCT is one of the weakest programs that requires multiple and combined strategies to address the current challenges and improve service utilization.

Interventions:

- Strengthen the integration of PMTCT with MNCH in all health facilities.
- Mobilize the community to be actively involved in PMTCT.
- Promote PIHCT for all pregnant women attending ANC and delivery services.
- Ensure male involvement in PMTCT service.
- Train health extension workers on PMTCT and delivery service provision.
- Promote PMTCT by the health development armies.
- Provide training to health development armies on PMTCT.
- Provide education to households on PMTCT by health development armies.
- Expand PMTCT services.
- Equip health facilities with ANC and delivery equipment.
- Train health workers on basic and emergency obstetric care and PMTCT service provision.
- Deploy mother support mentors in each PMTCT site.
- Provide PMTCT training for service providers to people with disability.
- Build capacities of private health facilities to rollout PMTCT service.
- Involve private health facilities to provide PMTCT services.

3.2.3.3. Increase availability and utilization of STI services

STI services need to be revitalized in all health facilities through implementation of syndromic case management.

Interventions:

- Create strong leadership for STI programs.
- Expand STI services to all health facilities.
- Intensify health education to improve treatment seeking behaviour and utilization of STI services.
- Promote partner notification during STI case detection.
- Ensure availability of drugs and reagents in all public health facilities.
- Train health care workers on syndromic STI case diagnosis and management.
- Train laboratory technicians to perform various bacteriological and serological tests.
- Develop STI follow-up and data validation system.
- Provide STI training for service providers to provide user-friendly services to people with disability.

3.2.3.4. Increase supply, distribution and utilization of male and female condoms

Adequate supply and distribution of male and female condoms to distribution points that are easily accessible is among one of the important HIV prevention strategies for which a number of interventions are designed.

Interventions:

- Develop national condom strategy.
- Promote and conduct campaigns on correct and consistent use of condom.

- Expand peripheral outlets of condom distribution.
- Conduct targeted condom distribution, particularly to MARPs.
- Ensure adequate supplies of condoms.
- Distribute male and female condoms.

3.2.3.5. Ensure infection prevention and safe blood supplies in Health system

Infection prevention (IP) and safe blood supply are important strategies to ensure safe environment of the health facilities with regard to HIV transmission, and HIV free blood supply.

Interventions:

- Ensure the availability of adequate infection protective materials.
- Improve waste disposal management in health facilities.
- Provide IP trainings to staff.
- Implement national blood transfusion services strategy.

3.2.3.6. Avail post exposure prophylaxis (PEP) treatment

Accessible post exposure prophylaxis is an important strategy that needs to be ensured for all eligible individuals, according to the National guideline.

Interventions:

- Conduct assessment on prevalence needle pierce/ prick & other sharp materials in health facilities.
- Avail PEP at health facilities.

3.2.3.7. Accelerate male circumcision in areas needed

Recent studies conducted in three African countries show that male circumcision has about a 60 percent protective effect to male. The evidence suggests that it is a highly cost-effective strategy in preventing HIV among non-circumcised adolescent and adult male population. In some parts of the country, such as in Gambella, the reported male circumcision prevalence is less than 50 percent while the male HIV prevalence in the region is high. Cognizant of this fact, male circumcision is proposed as one HIV prevention strategy in selected areas.

Interventions:

- Promote male circumcision.
- Provide trainings on male circumcision.
- Avail male circumcision kits.
- Provide safe male circumcision services.

3.2.3.8. Ensure user friendly biomedical services to special population groups

Interventions:

- Conduct consultative meetings to identify modalities of providing biomedical HIV/AIDS services for people with disability and the elderly.

- Conduct assessment of health facilities to evaluate user friendliness to the elderly and people with disability.
- Develop strategic documents to define package of HIV/AIDS services and modalities of delivering the services for People with disability and the elderly.
- Customize and disseminate HIV/AIDS-related training manuals for people with disability and the elderly.

3.2.3.9. Intensifying positive prevention

Effective positive prevention requires information, training and support for HIV positive people and their partners. It is important to ensure that HIV positive people have access to information, education, commodities and services they need so that they are better able to exercise positive living that helps in preventing transmission of HIV to others.

Interventions:

- Provide HIV information, education and risk reduction education and counselling.
- Strengthen couple counselling and testing.
- Conduct family-based HIV counselling and testing.
- Develop a special package on HIV counselling, Reproductive Health, and related issues for adolescents on chronic care and treatment.
- Provide services to HIV positive adolescents based on the package.
- Establish/ strengthen post-test clubs and other peer support groups.
- Distribute condom and provide education on correct and consistent condom use.
- Provide STI services.
- Provide family planning services.

3.3. Thematic Area Three: Increase Access to and Improve Quality of Chronic Care and Treatment

General Objective: To reduce HIV-related morbidity and mortality and improve quality of life of PLHIV.

Specific Objectives:

- To increase ART enrolment from 73 percent in 2009 to 95 percent in 2014/15.
- To increase survival rate among those who started ART to 85 percent in 2014/15.
- To increase patient retention rate among those who started ART from 73 percent to 85 percent in 2014/15.
- To improve paediatric ART coverage from 66 percent in 2010/11 to 90 percent in 2014/15.
- To increase percentage of pre-ART patients eligible for and taking cotrimoxazole prophylaxis from 68 percent in 2009 to 95 percent in 2014/15.

Strategies:

- Expand treatment and care services with strengthened service linkage and integration.
- Strengthen laboratory and referral systems.
- Improve TB/HIV collaborative activities.
- Ensure availability of essential OI and ARV drugs and reagents.

- Enhance treatment literacy and adherence counselling.
- Strengthen provision of chronic care and treatment services in the private sector.
- Address human resource issues.

3.3.1. Expand chronic care and treatment services

Provision of chronic care and treatment is an indispensable strategy for the effective prevention and control of HIV/AIDS. The services need to be accessible in all hospitals and health centres, and adherence to the treatment needs to be improved.

Interventions:

- Provide training of health personnel on chronic care and treatment.
- Strengthen intra-and inter-facility service linkages by developing standard operating procedures (SOP).
- Increase number of health facilities providing ART.
- Develop and disseminate ART-related service package and training manual for people with disability.
- Integrate ART-related service package for people with disability in the existing health facilities.

3.3.2. Strengthen TB/HIV Collaborative activities

This is an important strategy to reduce the burden of TB and HIV in patients affected by both diseases.

Interventions:

- Screen all diagnosed TB patients for HIV.
- Link HIV positive TB cases to HIV services.
- Screen all HIV positive cases for TB.
- Provide INH prophylaxis for eligible patients.
- Strengthen TB-HIV co-infection management.

3.3.3. Strengthen laboratory and referral system

Chronic care and treatment sites require access to laboratory services directly or through an effective laboratory referral system.

Interventions:

- Avail minimum laboratory services at chronic care sites.
- Strengthen preventive and curative maintenance (training, workshop and spare parts).
- Strengthen quality assurance system.
- Strengthen laboratory information system.
- Build capacity of laboratory personnel.
- Strengthen HIV laboratory services.

3.3.4. Ensure supply management system in relation to availability of essential OI, ARV drugs and reagents

The availability of essential OI and ARV drugs and reagents must be ensured all the time in the sites that provide the services. This requires ensuring the existence of strong supply management system.

Interventions:

- Forecast the need for OI, ARVs and reagents.
- Ensure timely procurement and distribution of OI and ARV drugs and reagents.
- Expand warehouses.
- Strengthen logistics management information system.
- Equip the supply management system with transportation services.

3.3.5. Enhance treatment literacy and adherence counselling

Treatment literacy and adherence are very important strategies to ensure effective provision of chronic care and treatment services. This includes interventions that will help to reduce patients who discontinue treatment, as well as interventions that will help to trace lost to follow up patients.

Interventions:

- Develop and enforce guidelines on treatment literacy and adherence.
- Strengthen adherence counselling by health care workers, case managers and adherence supporters.
- Disseminate treatment literacy education through mass media.
- Institute periodic monitoring and follow-up of lost to follow-up patients.
- Provide ART training for service providers on user friendly service provision to people with disability.
- Rollout ART services into private health facilities.
- Strengthen clinical mentoring.
- Increase number of adult and paediatric service beneficiaries receiving ART.

3.3.6. Strengthen provision of chronic care and treatment in the private Health sector

The number of private health facilities is growing with time. Private health facilities are mainly found in urban areas. Availing HIV/AIDS services in these facilities is very important to increase access, reduce the burden on public health facilities, as well as provide alternatives to patients so they access services wherever it is convenient for them. Considerable number of the urban population utilizes private health facilities. There is a clear indication of the need to strengthen the ongoing public-private partnership in order to improve access and utilization of HIV/AIDS services.

Interventions:

- Map and create directory of private health facilities.
- Organize public-private partnership forum.
- Develop and avail guidelines, which direct the process of providing chronic care and treatment service.

3.3.7. Address human resource issues

Ensuring availability of adequately trained human resource is among the major strategic issues to achieve universal access to HIV/AIDS services.

Interventions:

- Support higher learning institutions to provide pre-service HIV/AIDS training to all health science students.
- Provide in-service training on HIV/AIDS in health sector.
- Strengthen task-shifting, clinical mentoring and supportive supervision.
- Train health facility leaders on HIV/AIDS program management and integration of services.
- Promote involvement of staff in health facilities to conduct operational research.

3.4. Thematic Area Four: Strengthen Care and Support Services to Mitigate the Impact of AIDS

General Objective: To improve the livelihood of the needy OVC and PLHIV.

Specific objectives:

- To increase care and support to needy OVC from 30 percent in 2009 to 50 percent by 2014/15.
- To increase care and support to needy PLHIV from 60,000 in 2009 to 100,000 in 2014/15.

Strategies:

- Strengthen the involvement of local communities in care and support.
- Enforce the provision of standardized care and support to OVC and PLHIV.
- Enhance school based OVC support.
- Strengthen income generation activities to sustain the program.

3.4.1. Strengthen the involvement of local communities in care and support

The involvement of the community and growing ownership of care and support services to OVCs is the basis for sustainable provision of the services.

Interventions:

- Strengthen and use existing community structures.
- Map care and support needs in each Kebele with existing care and support projects and identify gaps.
- Provide care and support to OVC in their familial networks.

3.4.2. Enforce the provision of standardized care and support to OVC and PLHIV

There is a need to have appropriate standards for the provision of care and support services to OVCs as well as to PLHIV. This helps to ensure efficient use of resources in providing effective care and support services in terms of HIV prevention and control.

Interventions:

- Develop OVC care and support standard and service delivery guidelines.
- Conduct OVC situational analysis and map OVC services.
- Develop referral networks among service providers.
- Strengthen school-based OVC support activities.
- Provide home-based care services for PLHIV.

3.4.3. Strengthen income generating activities to sustain the program

Income generation activities will be strengthened to ensure productivity of the beneficiaries thereby ensuring self-reliance which in turn significantly contributes to the sustainability of the care and support services.

Interventions:

- Provide IGA support.
- Follow and support IGA beneficiaries and create links to markets.

3.5. Thematic Area Five: Strengthen Generation and Utilization of Strategic Information

General Objective: To ensure timely generation and utilization of strategic information and thus enhance evidence-based decision making for the multisectoral HIV/AIDS response.

Specific Objectives:

- To ensure the generation of quality data from routine program monitoring, surveys, surveillances and studies.
- To disseminate and utilize strategic information to guide policy formulation, program planning and improvement.

Strategies:

- Build the capacity for monitoring and evaluation.
- Institute a culture of evidence-based/informed decision-making.
- Strengthen timely generation of strategic information.
- Enhance dissemination and utilization of strategic information.

3.5.1. Build the capacity for Monitoring and Evaluation (M & E)

Building M and E capacity at all levels requires due attention. This includes developing various manuals and ensuring availability of skilled human resource at various levels of implementation.

Interventions:

- Ensure availability of HIV/AIDS M and E HR capacity at multilevel.
- Develop M and E implementation manual and training manual.
- Conduct training for M and E officers.
- Establish/strengthen regional HIV M and E Technical Working Groups.

3.5.2. Institute culture of evidence-based/ informed decision making

The monitoring and evaluation of HIV /AIDS multisectoral response at various levels, as well as the planning process need to be based on evidence for which it is important to institute culture of informed decision making. This helps to ensure timely and progressive achievements.

Interventions:

- Establish framework for generation and utilization of strategic information.
- Enforce evidenced-based planning and prioritization.
- Conduct regular review of HIV programs performance.
- Establish database for HIV/AIDS M and E
- Conduct advocacy workshops on M and E at all levels.

3.5.3. Strengthen timely generation of strategic information

The timeliness of information that will be generated for use is very important to ensure an appropriate response during an appropriate period of time.

Interventions:

- Work with sectors to include HIV/AIDS indicators within their own monitoring and evaluation systems.
- Conduct HIV surveillance.
- Conduct effectiveness study on interventions.
- Identify priority research agendas and conduct research.
- Develop and implement community based information system to be used at all levels.

3.5.4. Enhance dissemination and utilization of strategic information

It is important to take into account that the strategic evidence/information generated should be disseminated and utilized for practical purposes. It also helps to disseminate best practices which will help to strengthen the overall response to the epidemic.

Interventions:

- Disseminate research and evaluation findings regularly.
- Prepare, print and distribute HIV/AIDS M and E reports regularly.
- Prepare summary of key HIV evaluation and research findings and post reports on web sites.
- Document and disseminate best practices.

By the end of 2014/15:

384

health centers will be constructed and equipped

60 million

people will receive BCC community outreach

13 million

students will receive HIV education each year

3,303

health centers will provide ART service

1 million

MARPs will be reached with HIV prevention programs

1.967 billion

condoms will be distributed

85%

of HIV positive women will receive ARV prophylaxis

9.27 million

people will be tested for HIV annually

484,966 PLHIV

will be ever started on ART

75,000 OVC and PLHIV

will receive IGA support

Part Four

Five-year Programmatic
Targets and Results
Matrix

Part Four: Five-year Programmatic Targets and Results Matrix

4.1 Five-year Programmatic Targets

Ser. No	Programs	Indicators	Targets by year					
			Baseline (2009)	2010/11	2011/12	2012/13	2013/14	2014/15
1. Prevention								
1.1	BCC: community outreach	Number of people reached through outreach with at least one HIV IEC/BCC	35M	50M	52M	55M	58M	60M
1.2	BCC: School	Percentage of schools that provide life skills-based HIV education in the last academic year	38%	60%	75%	90%	95%	98%
		Number of students (10 years & above) who received HIV education per academic year	11.7 M	12M	12M	13M	13M	13M
1.3	BCC: MARPs	Number of most-at-risk population reached with HIV prevention programs	200,000	400,000	700,000	1,000,000	1,000,000	1,000,000
1.4	Testing and counselling	Number of adult people who received testing and counselling in the last 12 months	5.8M	9.271M	9.271M	9.271M	9.271M	9.271M
1.5	Condom	Number of condoms distributed during the last 12 months	93M	367M	400M	400M	400M	400M
1.6	PMTCT	Percentage of HIV positive pregnant women who received ART to reduce the risk of MTCT.	10%	80%	80%	82%	82%	85%
1.7	Treatment of STI	Number of cases of STI treated	39,267	180,000	180,000	180,000	180,000	180,000

Ser. No	Programs	Indicators	Targets by year					
			Baseline (2009)	2010/11	2011/12	2012/13	2013/14	2014/15
1.8	IGA: Vulnerable women and FSWs	Number of vulnerable women and FSWs supported to engage in IGA	34,661	48,789	56,920	55,000	50,630	37,000
1.9	Post-exposure prophylaxis	Number of health facilities with PEP available	NA	1,355	1,842	2,329	2,816	3,303
1.10	Blood safety & universal precaution	Percentage of donated blood units screened for HIV in Quality assured manner	100%	100%	100%	100%	100%	100%
2. Treatment								
2.1	Antiretroviral therapy and monitoring	Number of adults and children with advanced HIV infection receiving antiretroviral therapy	241,250	397,539	429,384	453,134	471,189	484,966
		Number of health facilities that offer ART	481	1355	1842	2329	2816	3303
2.2	Prophylaxis for opportunistic infections	Percentage of pre-ART patients eligible for and taking cotrimoxazole prophylaxis	68%	75%	80%	85%	90%	95%
3. Impact Mitigation: Care & Support								
3.1	Support for OVC	Percentage of orphan and vulnerable children aged 0-17 years whose households received free basic external support in caring for the child	30%	35%	40%	43%	45%	50%
3.2	Care and support for PLHIV	Number of People living with HIV who receive support(financial or IGA)	60,000	70,000	80,000	85,000	95,000	100,000

4.2 Results Matrix

Thematic Area One: Creating Enabling Environment

General Objective: To create an enabling environment for scaled up and comprehensive HIV/AIDS multisectoral response

Selected Strategies	Interventions	Targets	Key Indicators	Source of Verification	Lead Agency
<p>Capacity Building:</p> <p>Specific Objective 1: To ensure the health sector capacity to achieve MDG 6 by 2015</p> <p>Specific Objective 2: To build the capacity of key and strategic sectors, civil society organizations (CSOs) and private sectors to contribute to the achievement of MDG 6 by 2015</p>					
Strengthen the Health Sector Capacity	Support the expansion/construction of health centres	384 health centres constructed	Number of health centres constructed	Reports, supportive supervisions MoE/ MoH MoH	Regional HB & MoH
	Support equipping of health centres	384 health centres equipped	Number of health centres equipped		
	Support universities and colleges to provide pre-service training for health science students	40 universities and colleges will provide pre-service training for health science students	Number of higher learning institutions provided pre-service training for health science students		
	Train health workers on HIV/AIDS	23,121 health workers will be trained	Number of Health workers trained		
	Develop standard for Health facility preparedness for People with disability	Package will be developed	Developed package	Document of developed packages	MOH
	Prepare health facilities to provide user friendly services in Health facilities for People with disability and the elderly	All Health facilities will provide user friendly services to people with disability	Number of Health facilities providing user friendly services to people with disability	Reports, surveys supportive supervisions	MOH
Strengthen institutional capacity of key sectors, CSOs and private sectors	Staff key sectors with experts on prevention & impact mitigation	17 key federal sectors will assign experts	Number of key sectors that assigned experts	Reports and supportive supervisions	Key Sectors

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Selected Strategies	Interventions	Targets	Key Indicators	Source of Verification	Lead Agency
Strengthen institutional capacity of key sectors, CSOs and private sectors	Support federal sectors to build the capacity of regional sectors on HIV (guidelines, trainings, logistics)	17 key Federal sectors will support their respective bureaus in all region and city administrations	Number of Federal sectors supporting their respective bureaus in all regions and 2 city administrations	Reports and supportive supervisions	Key Sectors
	Build the capacity of networks of associations of PLHIV, OVC, the elderly people, people with disability, CSOs FBOs	All networks of associations will be strengthened	Number of networks of associations strengthened	Reports and supportive supervisions	Net work of networks of associations, networks of associations, FHAPCO
	Provide support to 500 associations of PLHIV,OVC, the elderly, people with disability, CSOs, FBOs	500 associations will be supported	Number of associations supported	Reports, supportive supervisions	Net work of networks of associations, networks of associations, FHAPCO

Community mobilization and empowerment:

Specific Objective 3: To sustain community movement and to attain social change by 2014/15

Ensure community ownership and leadership of HIV/AIDS	Train community leaders (4 per kebele/year)	350,000 Community leaders will be trained	Number of community leaders trained	Surveys, Reports, supportive supervision	RHB/RHAPCO
	Conduct community conversation	100% adult population will participate in CC	% of adult population participated in CC		
	Develop concrete plan of action	17,500 Kebeles (smallest administrative units of the country) will have concrete plan	Number of kebeles with concrete plan following CC		
	Enforce relevant community bylaws	17,500 Kebeles will enforce bylaws	Number of kebeles enforced bylaws		
Augment community mobilization with BCC intervention	Train HEW on BCC	34,000 HEW will be trained	Number of HEW's trained on BCC		

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Selected Strategies	Interventions	Targets	Key Indicators	Source of Verification	Lead Agency
Augment community mobilization with BCC intervention	Train community anti-AIDS promoters from model households	770,000 anti-AIDS promoters will be trained from model households	Number of community anti-AIDS promoters trained	Reports, supportive supervision, surveys	RHB/RHAPCO
	Train Health development armies (DA) on BCC	34,000 Health development armies will be trained on BCC	Number of Health development armies trained on BCC	Reports	
	Strengthen Kebeles to provide support to community anti-AIDS movement	100% of Kebeles will be strengthened to provide support to community anti-AIDS movement	Percentage of Kebeles strengthened to provide institutional support	Reports, supportive supervision, surveys	RHB/HAPCO
Strengthen institutional support to community anti-AIDS movement	Document, share and scale up best practices	Best practices will be documented, shared, & scaled up	List of best practices documented, shared, & scaled up	Reports, supportive supervision, surveys	
Leadership and Governance: Specific Objective 4: To ensure, responsiveness and accountability of the leadership at all levels in the HIV/AIDS multisectoral response					
Build capacity of leadership and governing bodies at various levels	Provide training on strategic leadership in the fight against HIV/AIDS to leadership and governing bodies	10,000 leaders from the governing bodies of all regions will be trained	Number of leaders trained	Reports	HAPCOs
	Select and document best practices of regions	55 best practice documentations will be prepared (5 by each Region)	Number of best practices documentations prepared (by each region)	Documentations, Reports	
	Arrange experience sharing visits for leadership and governing bodies from regions	All Leadership and governing bodies in the 11 regions will participate in experience sharing visits	Number of governing bodies from each region participated in experience sharing visits	Reports	

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Selected Strategies	Interventions	Targets	Key Indicators	Source of Verification	Lead Agency
Avail regular update on HIV/AIDS epidemic situation and response to leadership and governance	Publish and disseminate annual performance report and analytical report on the epidemic and response	1 annual performance report and 1 analytical report will be produced and disseminated yearly	Number of performance and analytical report published & disseminated	Reports	HAPCO/ MOH
	Establish AIDS resource Centres in the federal and regional parliaments	12 AIDS Information centres will be established	Number of AIDS resource centres established	Reports, site visits	Parliament and councils
Ensure inclusion of HIV plans in the overall sector plan and oversight sector performance	Oversee the inclusion of HIV/AIDS plan in the overall sectors' plan	All sectors at each level will include plan in the sectors plan	Number of Sectors developed plans on HIV/AIDS	Reports, site visits	Parliament and councils
	Conduct periodic review by the parliament and other governing bodies	Biannual reviews will be conducted by governing bodies at each level	Number of review sessions conducted by governing bodies	Reports, site visits	Parliament, NAC, RACs, WACs
	Conduct regular HIV/AIDS board meetings at each level	Regular board meetings will be conducted at each level as per the guidelines	Number of Regular board meetings conducted at each level	Minutes, Reports,	HAPCOs
Mainstreaming:					
Specific Objective 5: To enhance the HIV/AIDS response across sectors					
Strengthen ownership of HIV/AIDS programs across the sectors	Conduct assessment on vulnerability and impact of HIV/AIDS and existing response capacity	All sectors will conduct assessment on vulnerability & impact of HIV and the existing response capacity	Number of sectors conducted impact assessment / Number of sectors documented impact assessment findings.	Reports, site visit	All Sectors
	Develop sector specific policies, strategies and plans on HIV/AIDS	All sectors will develop sector specific policy, plan & strategy on HIV/AIDS	Number of key sectors with sector specific policy, plan and strategy on HIV/AIDS	Policies, plan documents	All sectors

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Selected Strategies	Interventions	Targets	Key Indicators	Source of Verification	Lead Agency
Strengthen ownership of HIV/AIDS programs across the sectors	Establish a unit for HIV/AIDS mainstreaming in public & non-public sectors	80% Public and 60% non-public sectors will establish unit or assign focal person to mainstream HIV	Number of public & non-public sectors with units or assigned focal person to mainstream HIV/AIDS	Reports, site visits	All sectors
	Ensure allocation of resources by all sectors for HIV/AIDS mainstreaming	100% of sectors will use their own resources	Percentage of sectors allocated budget for HIV mainstreaming	Reports	
Ensure the inclusion of HIV M and E into sectors' management information system	Incorporate M and E of HIV/AIDS into sectors' management information system	17 key sectors will incorporate HIV/AIDS M and E into sectors' MIS & review mechanism	Number of key sectors incorporated HIV/AIDS M and E into sectoral MIS and review mechanism	Reports, site visits	Key sectors
Coordination and Partnership: Specific Objective 6: To ensure synergy of multisectoral HIV/AIDS response at all levels					
Build HIV/AIDS response coordination capacity of HAPCOs and HBs at all levels	Provide training on HIV/AIDS Multisectoral response coordination and partnership	2,000 regional health and HIV staff will be trained on coordination and partnership	Number of staff trained on Multisectoral response coordination and partnership	Report	RHAPCOs
	Develop joint annual plan guided by SPM II	All regions and weredas will produce harmonized and synchronized plans	Existence of harmonized and synchronized annual plans at each level	Reports, on site visits	HAPCOs
	Institute one national Multisectoral M and E system	One national multi-sectoral M and E system will be adopted by all actors in the nation	% of multi-sectoral actors utilizing one national multi-sectoral M and E system	Reports, site visits	
Strengthen partnership at all levels	Develop partnership guidelines	Partnership guideline will be developed	Existence of partnership guideline	Document	HAPCO

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Selected Strategies	Interventions	Targets	Key Indicators	Source of Verification	Lead Agency
Strengthen partnership at all levels	Establish/strengthen partnership forums at national, regional and woreda levels	11 regional partnership forums will be established or strengthened; 750 woreda partnership forums established.	Number of partnership forums established at regions and woredas	Reports, Site visits	HAPCO
		Regular partnership meetings will be conducted	Number of regular partnership meetings conducted	Reports, minutes, proceedings	
	Strengthen partnership for cross boarder interventions.	Biannual cross boarder partnership meetings will be conducted with each of three countries	Number of cross boarder partnership meetings conducted	Report, Site visit	HAPCO
Strengthen networking among service providers	Map HIV/AIDS services, providers and stakeholders at all levels	Directory of HIV/AIDS services providers, & stakeholders will be developed	Produced directory on HIV/AIDS service providers & stakeholders	Document	HAPCOs
	Establish/strengthen linkages and networking of HIV/AIDS services	Improved Network among all mapped service providers will improve	Number of service providers networked	Site verification, report, survey	

Thematic Area Two: Intensifying HIV Prevention

General objective: To reduce the rate of national HIV new infections incidence by 50% (from 0.28% in 2009) by 2014/15. **Specific objectives:**

- To increase HIV comprehensive knowledge among adult population aged 15-49 from 22.6% in 2005 to 80% by 2014/15.
- To reduce percentage of young people aged 15-19 years who start sexual debut 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 2014/15.
- To increase percentage of young people aged 15-24 who use condom consistently while having sex from 59% in 2005 to 80% by 2014/15.
- To increase percentage of female sex workers reporting consistent use of condom from 93.4% in 2005 to 98% in 2014/15

Behavioural approaches for HIV Prevention approaches

Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Strengthen community based prevention intervention to address the general population	Ensure Scale up of community conversation and integrate with existing community structure	All kebeles will conduct CC on HIV integrating with existing community structures	Number of kebeles integrated and conducted community conversation on HIV/AIDS	Reports, Site visits	MOH/RHBs/HAPCOs
	Review existing CC guideline and training manuals	CC guideline and training manuals will be reviewed	Reviewed CC guideline and training manuals produced	Documents prepared	MOH/HAPCO
	Conduct training for voluntary community anti-AIDS promoters (VCAP) or model families	100% of model households received VCAP training	Percentage of VCAP/ model families trained	Report, survey	MOH, HAPCO
	Develop HIV prevention messages	5 messages on HIV prevention will be developed and disseminated to all levels	Number of messages developed and disseminated	Report, document	HAPCOs/RHBs
Strengthen HIV prevention across sectors	Disseminate HIV BCC messages on print, and electronic media	1,250,000 print materials will be disseminated	Number of print BCC materials disseminated		
	Develop organisational conversation guideline and training manual	Organisational conversation guideline and training manual will be developed	Developed organisational conversation guideline and training manual	Documents HAPCOs/Sectors	HAPCO

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Strengthen HIV prevention across sectors	Conduct TOT on Organisational conversation for facilitators selected from sectors	200 trainers will receive TOT on organisational conversation	Number of trainers that took TOT on organisational conversation	Documents HAPCOs/Sectors	HAPCO
	Conduct organisational Conversation in work places	All sectors will Conduct organisational Conversation	Number of sectors that Conducted organisational Conversation		
	Provide training to program managers of sectors on HIV prevention programs	8,000 program managers will be trained on HIV prevention	Number of programs managers of sectors' trained on HIV prevention	Reports	Sectors/ HAPCOs
	Conduct condom promotion and distribution in all sectors	All sectors will conduct condom promotion and distribution	Number of sectors that conduct condom promotion and distribution	Reports, surveys, site visits	
Strengthen school based HIV interventions	Provide training on peer education	500,000 peer educators will be trained from schools, TVET, and higher education institutes	Number of peer educators trained	Documents /report	MOE/REB/ Higher education Institutes / HAPCO
	Conduct peer education programs in schools, TVET and higher education institutes	Peer education sessions will be conducted in 26,409 primary complete and secondary schools in, 458 TVET and 72 higher education institutes as per guideline	Number of schools/ TVET/higher education institutes that conducted Weekly peer education sessions	Report, survey	MOE/REB/ Higher education Institutes / HAPCO
		10 million pupils reached	Number of pupils reached	Report, survey	MOE/REB/ Higher education Institutes / HAPCO

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency	
Strengthen school based HIV interventions	Conduct life-skill education in schools, higher education institutes and TVET	13 Million students will receive life skill education	Number of students reached by life-skills based HIV education in schools.	Reports	HAPCO/MOE/REB	
		Review school CC guideline and training manual	Reviewed school CC guideline and training manual	Documents	MOE/REB/Higher education Institutes / HAPCO	
	Conduct Community Conversation in high schools, higher education institutes and TVET	1,197 high schools, 458 TVET, and 72 higher education institutes will conduct CC	Number of schools conducted CC	Number of schools conducted CC	Reports, Site visits	MOE/REB/Higher education Institutes / HAPCO
		2.4 million pupils will participate in CC	Number of pupils participated in CC	Reports	Reports	
	Ensure incorporation of HIV into school curriculum	School Curriculum will incorporate HIV	School Curriculum will incorporate HIV	Curriculum incorporate HIV	Document	MOE
		Train teachers on management of school HIV/AIDS programs	28,000 teachers will be trained on management of school HIV programs	Number of teachers trained on management of school HIV programs	Number of teachers trained on management of school HIV programs	Reports and site visits
	2,600 higher education and TVET teachers trained on management of school HIV programs		Number of teachers trained on management of school HIV programs	Number of teachers trained on management of school HIV programs	Reports and site visits	MOE/REB
	Develop and disseminate targeted BCC message for University/colleges and high schools		5 types of targeted BCC messages will be developed and disseminated	Types of targeted BCC messages developed and disseminated	Types of targeted BCC messages developed and disseminated	BCC material, reports, surveys
		2 million pupils reached through school BCC campaigns	Number of pupils reached through school BCC campaigns	Number of pupils reached through school BCC campaigns	Reports & site visits	MOE/REBs/HAPCOs
		600,000 million pupils in higher education institutes and TVET reached through school BCC campaigns	Number of pupils reached through school BCC campaigns	Number of pupils reached through school BCC campaigns	Reports & site visits	Higher education Institutes / MOE/REB

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency	
Strengthen school based HIV interventions	Strengthen youth leadership development programs	Student councils in 1,197 high schools will be strengthened	Number of high schools with functional youth leadership programs	Reports	MOE/REB/ Higher education institutes	
	Strengthen HIV related school clubs	1,197 secondary schools will have at least 4 strengthened clubs each	Number of schools with at least 4 clubs strengthened	Reports		
	Strengthen at least 4 HIV related clubs of universities and colleges	72 higher education institutes and 458 TVET will have at least 4 clubs strengthened	Number of higher education institutes and TVET with at least 4 clubs strengthened	Reports	MOE/REB/ Higher education institutes	
	Ensure active participation/ Membership in clubs of schools, higher education institutes and TVET	598,500 pupils of schools will participate in clubs	Number of pupils of high schools participating in clubs	Report, site visit, survey		
		229,000 students will participate in clubs of higher education institutes	Number of pupils of TVET participating in clubs			
		36,000 pupils will participate in clubs of higher education institutes	Number of pupils of higher education institutes participating in clubs			
	Expand ARC in schools, higher education institutes and TVET		1,197 high schools; 72 higher education institutes and 458 TVETs will have ARC	Number of high schools having ARC	Reports, Surveys	MOE/REB/ Higher education institutes
				Number of higher education institutes having ARC		
				Number of TVET having ARC		
			2.1 Million pupils will utilize school based ARCs	Number of pupils utilized school based ARCs		MOE/REB

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency	
Scale up comprehensive HIV prevention interventions addressing most at risk population (MARPs)	Determine the identity, size, behavioural characteristics and HIV prevalence among MARPs	A national MARPs survey will be conducted	Produced national MARPs survey report	Document produced	EHNRI/MOH/ HAPCO	
	Map MARPs service providers	Service providers will be mapped	Service directory produced	Reports & site visits	HAPCO	
	Develop package of HIV services for MARPs	Minimum package of services will be developed for MARPs	Developed package of service	Reports & site visits	HAPCO	
	Develop comprehensive communication strategy for MARPs	A communication strategy will be developed	Developed communication strategy	The strategy document and reports	HAPCO	
	Build the capacity of CSOs to provide outreach HIV education to MARPs	200 CSOs will be trained to provide HIV education to MARPs	Number of CSOs trained to provide HIV education to MARPs	Reports, Survey	HAPCO	
	Provide training to peer educators among MARPs	100,000 peer educators will be trained among MARPs	Number of member of MARPs trained as peer educators	report, Survey	HAPCO, CSOs	
	Provide comprehensive HIV prevention services to MARPs	1 million MARPs will be reached	Number of MARPs reached with HIV prevention programs	Report, Survey	HAPCO, CSOs	
	Strengthen out of school youth HIV prevention programs	Establish 200 new youth centres	200 new ARCs will be established	Number of ARCs established	Report	MoWCYA/ HAPCO
		Develop minimum service package for youth centres	Minimum package of HIV services will be developed for youth centres	Document developed with minimum package of HIV services for youth centres	Report	MoWCYA/ HAPCO
		Strengthen youth centres to provide user friendly HIV/AIDS services at youth centre according to the package	100% of youth centres will provide user friendly HIV/AIDS services	Percentage of youth centres providing user friendly HIV/AIDS services	Report, surveys	MoWCYA/ HAPCO
Expand/strengthen educational entertainment (edutainment) youth centres in district towns		60% of youth centres will be strengthened	Percentage of youth centres strengthened	Reports	MoWCYA	
	Train Peer educators on HIV	175,000 peer educators will be trained on HIV	Number of peer educators trained on HIV	Reports, survey		

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Strengthen out of school youth HIV prevention programs	Provide Peer education	80% of out of school youth will be reached	Number of out of school youth reached with HIV & AIDS education	Survey, reports	MoWCYA
	Implement Outreach Youth interventions	60% youth centres will conduct youth dialogue	Number of Youth centres conducting youth dialogue	Reports, survey	
Intensify HIV prevention in development schemes	Conduct youth dialogue	150 business opportunity locations, industries and private development schemes will be targeted	Number of business opportunity locations, industries and private development schemes be targeted	Reports,	HAPCO
	Target business opportunity locations, industries and private development schemes	100% of development schemes/projects will integrate HIV prevention	Percentage of development schemes/projects integrated HIV prevention	Surveys, Reports, Documents	Responsible sectors
	Develop and disseminate targeted HIV message on 5 issues	5 message will be developed and disseminated on HIV issues	Number of message developed and disseminated on HIV issues	Surveys, Reports, Documents	HAPCO
	Conduct Peer education	100 % of development scheme/project will conduct peer education	Percentage of development schemes/projects conducted peer education	Reports, site supervisions, surveys	Respective sectors and Investment Agency
	Map development schemes for outreach services	Development schemes will be identified for outreach services	Number of development schemes identified for outreach services	Reports, surveys	
	Conduct outreach programs for development schemes	All development schemes will be networked for outreach services	Number of development schemes received outreach HIV/AIDS services	Reports, surveys	
	Referral linkage with health facilities for VCT, management of STI and ART for the HIV positive	100% of development schemes/projects will create referral linkages with health facilities for HIV services	Percentage of development schemes created referral linkages with health facilities	Report	

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Intensify HIV prevention in development schemes	Ensure HIV Prevention among communities in areas of development schemes/projects	100% of development schemes/projects will conduct prevention interventions among communities in the project areas	Percentage of development schemes/projects conducted prevention among communities in the project areas	Report	Respective sectors and Investment Agency
	Conduct risk and vulnerability assessment	One assessment addressing the different forms of people with special needs will be conducted	Assessment conducted	Document with Assessment result	HAPCO/ MOLSA
Expand HIV prevention among population groups with special needs (elderly and people with disability)	Develop prevention strategy for people with special needs	Prevention strategy will be developed	Strategic document developed	Document	
	Customize HIV intervention guidelines, implementation manuals, and BCC interventions	BCC guideline and implementation manual will be produced	Produced BCC guideline and implementation manual documents	Documents	
	Integrate BCC interventions in ARC of youth centres for people with disability	All youth centres of ARC will integrate BCC interventions for people with disability	Number of youth centres with ARC that integrated BCC intervention for people with disability	Reports, site visits, surveys	
	Develop and disseminate BCC materials for people with special needs	5 types of messages on HIV will be developed to people with special needs	Type of messages developed	Documents	
		80,000 copies BCC print materials will be developed and disseminated for people with disability	Number of BCC print materials developed and disseminated for people with disability	Documents	

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Expand HIV prevention among population groups with special needs (elderly and people with disability)	Develop and disseminate BCC materials for people with special needs	120,000 BCC print materials will be disseminated for elderly	Number of BCC print materials developed and disseminated for elderly	Documents	HAPCO/ MOLSA
	Develop and disseminate BCC materials for people with special needs	2,500 BCC audio/visual materials will be disseminated for people with disability and elders	Number of BCC audio/visual materials developed and disseminated for people with disability	Documents	HAPCO/ MOLSA
Structural HIV prevention approach					
Address gender inequality	Mainstream gender into sectoral policies	All sectoral policies will integrate gender issues	Number of sectors integrated gender in to their policies	Reports	MoWCYA
	Avail PEP to victims of rape	3,303 health facilities will provide PEP	Number health facilities providing service	Reports & supervision	MOH
Address gender inequality	Advocate for punitive measures on perpetrators of GBV.	Six round advocacy campaigns will be held	Number of campaigns by women groups	Reports	MoWCYA
	Ensure inclusion of gender dimension in HIV programs	All HIV prevention programs will integrate gender component	Number of HIV prevention programs with gender dimension	Reports	HAPCO
Reduce economic vulnerability	Provide training on IGA to vulnerable groups	248,339 vulnerable and women and FSW will receive vocational trainings	Number of vulnerable women and FSW who received training	Reports	Regions/ women associations./ Micro & small enterprise
	Provide seed money support to vulnerable individuals	248,339 Women & FSW will be supported with seed money	Number of women & FSW supported with seed money	Reports and site visits	
	Establish integration of HIV/AIDS services with safety-net programs	HIV services will be integrated into all regional safety-net programs	Number of safety-net programs integrating HIV/AIDS services	Reports	RAD

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Address socio-cultural factors fuelling HIV transmission	Provide sensitization and education on avoiding harmful traditional practices	All kebeles where FGM is practiced shall enforce bylaws against FGM	Number of kebeles (where FGM is practiced) enforced bylaws against FGM	Reports	MOH/ MoWCYA
	Conduct the national stigma index study	2 national stigma index studies conducted	Number of stigma index studies conducted	Reports	NEP+ / HAPCO
Protect human rights and provide legal support	Implement GIPA	Operationalize GIPA (i.e. PLHIV will be involved in policy and strategy development, service delivery and M and E)	Involvement of PLHA in policy and strategy, service delivery and M and E	Survey	NEP+
Enhance implementation of youth and women development packages human rights and legal support	Expand youth and women leadership development programs	70,000 youth and women leaders trained	Number of youth and women trained on leadership	Reports	MoWYSA/ YSA and WA
	Rollout the implementation of youth and women packages to all districts	750 Woredas	Number of Woredas implementing youth & women development packages	Reports	
Biomedical HIV prevention services					
Ensure access and enhance up take of HCT services		46.35 million of people will receive HIV testing	Number of people received HIV testing	Reports	MOH / RHB
	Promote HIV testing using CC and health extension workers, mobile, outreach service	100% of CC groups will address HCT service	Percentage of CC groups that addressed HCT service	Reports/Surveys	MOH / RHB
	Integrate HCT Promotional activities in the package of Health development armies	HCT promotional activities will be integrated in the package of Health development armies	Document of development armies with package integrating HCT	Reports, survey	MOH/HAPCO/ RHB
	Educate households on HCT by Health development armies	100% of households visited by Health development army members will receive HIV education	Percentage that received HIV education out of households visited by development army members	Reports, survey	MOH/HAPCO/ RHB

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency	
Ensure access and enhance up take of HCT services	Promote HIV testing through religious leaders, local community leaders	80% Religious leaders will receive orientation on HCT promotion	Percentage of religious leaders received orientation on HCT promotion	Report, survey	HAPCO / Religious groups	
	Educate Public on HIV testing through mass media campaigning	Mass media campaign on counselling and testing will be conducted	Campaign conducted	Reports	MOH/RHB/ HAPCOs/	
	Provide training to HCT service providers	200 HCT service providers will be trained on HCT for people with disability and elderly	Number of HCT service providers trained on HCT for people with disability and the elderly	Report		
	Provide HCT to People with disability and elderly	50% of people with disability and elderly will receive HCT	Percentage of people with disability and the elderly who received HCT	Reports, surveys		
	Ensure uninterrupted supplies of test kits and other accessories	100% of Service rendering facilities will get adequate test kits and other items all the time	Percentage of Service rendering facilities getting adequate test kits and other items all the time	Reports and site visits	MOH/PFSA/ RHB/	
	Build capacities of private health facilities to rollout HCT service	Capacity building to 400 Private Health facilities will be conducted to provide HCT services	Number of private Health facilities with ensured capacity to provide HCT	Reports and visits	MOH/ RHB	
	Rollout HCT services into private health facilities	400 private health facilities will provide HCT services	Number of private health facilities signed an MOU and provide HCT services	Reports and visits		

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Ensure access and enhance uptake of PMTCT services		85% of HIV positive pregnant women will receive complete ARV prophylaxis)	Percentage of HIV positive pregnant women received antiretroviral prophylaxis	Reports, Surveys	MOH/ RHB
	Strengthen the integration of PMTCT with MNCH in all health facilities	3,303 Health facilities will have effective integration of PMTCT and MNCH	Number of Health facilities with effective integration of PMTCT and MNCH	Reports	MoH/ RHB
	Mobilize the community to be actively involved in PMTCT	100% of Kebeles will conduct scheduled community mobilization regarding PMTCT	Percentage of Kebeles that conducted CC sessions that addressed PMTCT issues	Surveys	MoH/ HAPCO/ RHB
	Promote PIHCT for all pregnant women attending ANC and delivery services using opt out approach	Health facilities will Promote PIHCT to all Pregnant women	Number of Health facilities Promoting PIHCT to all Pregnant women	Surveys	MoH /RHB
	Ensure male involvement in PMTCT service	50% of partners of HIV positive PMTCT clients will be tested for HIV and provide support to their family	Percentage of pregnant women whose partners received testing and provided support to family	Surveys	MoH /HAPCO/ RHB
	Train health extension workers on PMTCT and delivery service provision	34,000 HEWs will be trained on PMTCT and delivery service provision	Number of HEW trained & engaged in PMTCT and delivery service provision services	Reports	MoH / HAPCOs/ RHB
	Integrate PMTCT into the package of Health development armies	Document of development armies integrating PMTCT will be produced	Document of Health development armies with package integrating PMTCT	Reports, survey	MoH / HAPCOs/ RHB
	Promote PMTCT by the health development armies	PMTCT promotional activities will be integrated in the package of health development armies	Document of health development armies with package integrating PMTCT	Document, Reports	MoH/ RHB

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency	
Ensure access and enhance uptake of PMTCT services	Provide training to development armies on PMTCT	100% of health development armies trained on PMTCT	Number of health development armies trained on PMTCT	Reports	MoH / RHB	
	Provide education to households on PMTCT by development armies	100% of households visited by health development armies received HIV education	Percentage of households visited by development army members received HIV education	Reports	MoH /RHB	
	Expand PMTCT services	3,303 public health facilities will provide PMTCT	Number of public health facilities providing PMTCT	Reports & site visits	MoH / RHB	
	Equip health facilities with ANC and delivery equipment	3,303 Health facilities will be equipped with ANC and delivery equipment	Number of health facilities equipped with ANC and delivery equipment		MoH / RHB	
	Train health workers on basic and emergency obstetric care and PMTCT service provision	13,212 health care workers will be trained on basic and emergency obstetric care and PMTCT service provision	Number of health care workers trained to provide PMTCT services		MoH / RHB	
	Deploy mother support mentors in each PMTCT site	6,606 mother support group mentors (i.e. 2 per Health facility)will be deployed	Number of mother support group mentors deployed		MOH / RHB/ PLHIV	
	Provide PMTCT training for service providers to people with disability	600 service providers will be trained	Number of service providers trained		MOH / RHB/ PLHIV	
	Build capacities of private health facilities to rollout PMTCT service	Capacity of private health facilities will be strengthened to provide PMTCT	Number of private Health facilities with strengthened capacity to provide PMTCT		MOH/RHB	
	Involve private health facilities to provide PMTCT services	All private health facilities that provide Maternal Health services will provide PMTCT	Number of private health facilities providing PMTCT	Report, Site assessment	Report, Site assessment	
					Report, Site assessment	
					Report, Site assessment	

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Increase availability and utilization of STI services		900,000 cases will be treated	Reports	Reports	MoH/RHB/ EHNRI
	Create strong leadership for STI programs	1,600 program managers will be trained	Number of program managers trained	Reports & site visits	MOH/RHB
	Expand STI services to all health facilities	3,703 Health facilities will provide STI service	Number of health facilities providing STI service	Reports	
	Intensify health education to improve STI treatment seeking behaviour & utilization of services	All Kebeles will conduct community mobilization on STI	Number of CC sessions that addressed STI issues	Surveys	
	Promote partner notification during STI case detection	50% of STI clients will refer their clients for STI screening	Percentage of STI cases who successfully referred their partners for STI screening	Surveys	
	Ensure availability of drugs and reagents in all public health facilities	STI drugs and reagents will be available all time in 3,703 Health facilities	Number of Health facilities with available STI drugs and reagents all the time	Reports and site visits	MOH/PFSA/ RHB
	Train health care workers on syndromic STI case diagnosis and management	7,406 health care providers will be trained on STI management	Number of health care providers trained on STI	Reports	MOH / RHB
	Train 3703 laboratory technicians to perform various bacteriological and serological tests	3,703 laboratory technicians will be trained	Number of laboratory technicians trained	Reports and site visits	EHNRI
	Develop STI follow up and data validation system	Functional STI follow up & validation system will be ensured	Establishment of STI follow up & validation system	Documents produced & site visits	MoH/RHB/ EHNRI
	Provide STI training for service providers to people with special needs	200 service providers will be trained	Number of service providers trained	Report, Site assessment	MoH/RHB

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency	
Increase supply, distribution and utilization of male and female condoms	Develop National condom strategy	Strategic document on condom will be developed	Document produced	Report	MOH/ FHAPCO// Partners	
	Promote and conduct campaigns on proper & consistent use of condom	Six condom promotion campaigns will be conducted	Number of condom promotion campaigns conducted	Reports	MOH/RHB/ CSO	
	Expand peripheral outlets of condom distribution	30,000 outlets created	Number of condom outlets created	Reports		
	Targeted condom distribution, particularly to MARPs	888 million condoms be distributed to MARPs (accounts for 50% of overall distribution)	Number of condoms distributed to MARPs	Reports		
	Ensure adequate supply of condom	1.967 billion condoms will be procured over 5 years	Number of male and female condoms available for distribution nationwide during the last 12 months	Reports	MOHPFSA / RHB/CSOs	
Strengthen infection prevention and blood safety services	Distribute male condom	1.7703 billion male condoms will be distributed	Number of male condoms distributed	Reports	MOH/RHB/ CSOs	
	Distribute female condom	196.7 million female condoms will be distributed	Number of female condoms distributed	Reports	MOH/RHB/ CSOs	
	Ensure the availability of adequate infection protective materials	All facilities will be supplied with minimum required IP materials as per service standard	Number of facilities supplied with minimum IP materials	Reports, site visits	MoH, RHB s	
	Improve waste disposal management in health facilities.	Waste disposal will be improved in all health facilities	Health facilities with improved Waste disposal	Reports, site visits	MoH	
	Provide IP trainings to staff	7,000 staff will be trained on IP	Number of trained staff on IP	Reports		

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Strengthen infection prevention and blood safety services	Implement national blood transfusion services strategy	National blood transfusion services strategy will be implemented	Implementation of strategy	Reports	MoH/ERCS
	Conduct assessment on prevalence needle pierce/prick & other sharp materials in health facilities	An assessment will be conducted	Assessment document produced	Document	MoH
Avail post exposure prophylaxis (PEP) treatment	Avail PEP in all health facilities	3,303 health facilities will provide PEP treatment	Number of health facilities providing PEP	Reports, site assessment	MoH
	Conduct baseline assessment on PEP	Baseline assessment will be conducted	Assessment report produced	Reports	MOH/RHB
Accelerate male circumcision in areas needed	Provide PEP for all eligible clients	100% of clients eligible for PEP among clients claiming the service will receive PEP	Percentage of eligible clients among those claiming the service received PEP	Surveys	MOH/RHB
	Conduct feasibility assessment on male circumcision in the community and assess the capacities of health facilities	Feasibility and health facility capacity assessment will be conducted	Assessment report produced	Reports	MoH/RHB
	Promote male circumcision (MC)	Advocacy, community mobilization on MC will be conducted	Advocacy reports	Reports	RHB
	Provide trainings on MC	180 health care workers will be trained on MC	Number of health care workers trained on MC	Reports	MOH
	Avail male circumcision kits	100,000 MC kits will be made available	Number of MC kits availed	Reports	MoH
	Provide safe male circumcision services	100,000 young male aged 10 to 24 years will get safe circumcision service	Number of males circumcised	Reports	MOH

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Ensure provision of user friendly biomedical HIV Prevention services to people with special needs	Conduct assessment of Health facilities to evaluate status in providing user-friendly services to elderly and people with disability	Assessment of Health facilities to evaluate status in providing user-friendly services to elderly and people with disability will be done	Assessment conducted	Reports	MOH
	Conduct consultative meetings to identify modalities of providing biomedical HIV/AIDS services for people with disability and the elderly	2 Consultative meetings will be conducted	Number of consultative meetings conducted	Proceedings	MOH /RHB
	Develop strategic document to define package of HIV / AIDS services and modalities of delivering the services for People with disability and the elderly	Strategic document will be developed	Strategic document developed	Document	
	Customize and disseminate training manuals on HIV/AIDS biomedical services for people with disability and the elderly	Manual will be customized and disseminated	Number of training materials developed on biomedical services for people with special needs	Document	
Intensify positive prevention	Provide HIV information, education and risk reduction education and counselling	450,000 PLHIV will receive HIV education and counselling	Number of HIV+ people received from HIV education and counselling.	Reports and Survey	MOH/RHBs
	Strengthen couple counselling and testing	45,000 couples will receive counselling	Number of couples received counselling	Reports, survey	MOH/RHBs
	Conduct Family based HIV counselling and testing	50% of families of HIV positive clients will have all their family members tested for HIV	Percentage of families of HIV positive clients who have all their family members tested for HIV	Survey, Reports and site supervisions	
	Develop special package for adolescents on ART on HIV counselling, Reproductive Health, and related issues	Package on HIV counselling, Reproductive Health, and related issues will be developed for adolescents on ART	Document with package on HIV counselling, Reproductive Health, and related issues	Reports	MOH / HAPCOs/RHBs

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Selected Strategies	Interventions	Targets	Indicator	Verification	Lead Agency
Intensify positive prevention	Provide service to the HIV positive adolescents based on the package	100% of HIV positive adolescents will be provided with service based on the package	Percentage of teens provided with service based on the package	Reports	MOH / HAPCOs/RHBs
	Establish/strengthen post test clubs and other peer support groups	100% of HCT sites will have post test clubs and other peer support groups	Percentage of HCT sites with post test clubs and other peer support groups	Reports and surveys	
	Provide Education on consistent condom use to PLHIV	100% PLHAs will be educated on appropriate and consistent use of condom	Percentage of PLHAs who received education on consistent use of condom		
	Condom provision and distribution	89.4 million condoms will be distributed	Number of condoms distributed		
	Provide STI services	100% of HIV/AIDS patients on chronic care will receive STI services	Percentage of HIV/AIDS patients on chronic care received STI services	Reports and surveys	
	Provide family planning services	100% of HIV/AIDS patients on chronic care will receive family planning services	Percentage of HIV/AIDS patients on chronic care who receive family planning services	Reports, site visits and surveys	

Thematic Area Three: Increase Access to and Improve Quality of Chronic Care and Treatment

General objective: To reduce HIV related morbidity and mortality and improve quality of life of PLHIV

Specific objectives:

- To increase ART enrolment from 73% in 2009 to 95% by 2014/15
- To increase survival among those who have started ART to from 73% in 2009 to 85% by 2014/15.
- To increase patient retention rate among those who started ART to 85% by 201/15
- To increase paediatric ART coverage from 66% in 2010 to 90% in 2014/15
- To increase percentage of pre-ART patients on cotrimoxazole prophylaxis from 68% to 95% in 2014/15

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Ensure access and enhance up take of ART services		455,190 adult PLHIV will receive ART	Number of adult PLHIV receiving antiretroviral therapy	Reports	MOH/FHAPCO
		29,776 Paediatrics PLHIV will receive ART	Number of Paediatrics PLHIV receiving antiretroviral therapy	Reports	MOH/FHAPCO
Expand access to care and treatment at primary health care facilities with strengthened service linkages and integration	Provide training of health personnel	5368 health providers will be trained on care and treatment management	Number of health care providers trained.	Reports	MoH/ RHBs/ HAPCO
	Increase number of Health facilities providing ART	ART services will be provided in 3,303 health facilities	Number of Health facilities providing antiretroviral therapy.	Reports	
	Develop and disseminate service package and training manual on ART for people with disability	Manual will be developed	Developed manual	Document	
	Develop SOP and standardize intra and inter facility referral formats	SOP and formats will be developed and standardized	SOP and referral formats developed/ standardized	Documents	
	Monitor effectiveness of the referral system	3,303 facilities will have effective Inter-facility service linkage	Number of Health facilities with effective Inter-facility service linkage	Reports and site visits	
	Integrate ART service package of people with disability in the existing Health facilities	100% of the Health facilities will integrate the package	Percentage of Health facilities integrating the package	Report, Site assessment	MoH/ RHBs/ HAPCO
Strengthen laboratory services and referral system	Avail minimum laboratory services at chronic care sites	80% chronic care sites will be covered with minimum laboratory services	Number of chronic care sites covered with minimum laboratory services	Reports and site visits	EHNRI
	Strengthen preventive and curative maintenance (training, workshop and spare parts)	Preventive maintenance service will be undertaken by all laboratories	Number of laboratories with functional preventive maintenance service	Reports	
		Curative maintenance service will be provided at regional and federal level	Regions with maintenance centres	Reports	

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Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Strengthen laboratory services and referral system	Strengthen quality assurance system	Functional Quality assurance system will be put in place	Existence of quality assurance system	Reports	EHNRI
	Strengthen laboratory information system	Functional LIS system will be put in place	Existence of LIS	Supervision	
	Build capacity of laboratory personnel	Capable laboratory personnel in running HIV investigations and QA will be available	Improved capacity of Laboratory personnel	Supervision	
Ensure availability of Essential OI, ARV drugs and reagents	Forecast the need for OI, ARVs and reagents	Adequate amount of OI, and ARV drugs will be availed	Reported number of stock outs in the last one month	Reports	PFSA
	Ensure timely procurement and distribution of OIs, ARV drugs and , reagents	All service rendering sites will have adequate ARV/OI supplies all times	Number of Health facilities with uninterrupted supply of ARV and OIs		
	Expand warehouses	Construction of 12 warehouses will be Supported	Number of warehouses constructed	Reports & site visits	
	Strengthen logistics management information system	Inventory mechanism/ LMIS will be established	Existence of functional Inventory/ LMIS at all levels	Periodic assess & reports	
	Equip the supply management system with transportation means	12 Vehicles will be procured	Number of vehicles purchased to support SM system	Reports and site visits	
Strengthen TB/ HIV collaborative activities	Screen all diagnosed TB patients for HIV	90% of TB patients will be counselled & tested for HIV	% of TB patients counselled & tested for HIV	Reports	MoH/RHB
	Link HIV positive TB cases to HIV services	80% of HIV positive TB cases will be linked to HIV care & treatment	% of HIV positive TB patients linked to HIV care & treatment	Reports	
	Screen all HIV positive cases for TB	100% of HIV positive cases will be screened for TB case detection	% of HIV positive cases screened for TB	Reports	

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Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Strengthen TB/HIV collaborative activities	Provide INH prophylaxis for eligible patients	80% of eligible clients will receive INH prophylaxis	Percent of HIV positive cases receiving INH prophylaxis	Reports	MoH/RHB
	Strengthen TB-HIV co-infection management	5368 health care providers will be trained	Number health care providers trained on TB-HIV co-infection management	Reports	
Enhance treatment literacy and adherence to treatment	Develop and enforce guidelines on treatment literacy and adherence	Treatment literacy guideline will be developed	A guideline on treatment literacy developed and enforced	Reports & developed guideline	MoH/RHB
	Strengthen adherence counselling by health care workers, case managers and adherence supporters	Adherence education /counselling will be strengthened	Availability of adherence counselling/education	Reports	
	Provide training on adherence counselling to health workers, case managers and adherence supporters	1,342 people will be trained on adherence counselling	Number of people trained on adherence counselling	Reports	
	Disseminate treatment literacy education through mass media	12 mass media campaigns on treatment literacy and adherence will be carried out	Number of mass media campaigns conducted	Reports	
	Institute periodic monitoring and follow up of lost to follow up patients	All ART rendering facilities will establish Facility based functional tracing mechanism	Number of facilities with Functional tracing system	Reports and site visits	
	Provide ART training for service providers on identified modalities of service provision to people with disability	600 service providers will be trained	Number of service providers trained	Report, Site assessment	
	Develop and avail guideline which directs the process of providing chronic care and treatment service in private health facilities.	Guideline for provision of Chronic care and treatment in private health facilities will be developed and availed	Developed guideline which directs the process of providing chronic care service treatment in private health facilities.	Reports and visits	

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Enhance treatment literacy and adherence to treatment	Conduct assessment in private health facilities	Assessment on private health facilities will be Conducted	Result of assessment conducted on private health facilities	Reports	MoH/RHB
	Build capacities of private health facilities to rollout HIV/AIDS chronic care services	101 Private Health facilities will have capacity to provide chronic care services	Number of private Health facilities with ensured capacity to provide Chronic HIV care	Reports and visits	
	Rollout ART services into private health facilities	101 private health facilities signed an MOU and provide ART services	Number of private health facilities signed an MOU and provide ART /PMTCT services	Reports and visits	
	Strengthen clinical mentoring	Health facilities will receive regular clinical mentoring	Number of Health facilities receiving regular clinical mentoring	Reports and site visits	
Strengthen public-private partnership	Map and create directory of private health facilities	Directory of private health facilities will be developed	Directory of private health facilities produced	Reports and directory	MOH/HAPCO
	Organize public-private partnership forum.	Functional public private partnership forum will be established	Existence of functional public private partnership forums	Reports	MoH / RHB
Address human resource issues	Support higher learning institutions to provide pre-service HIV training to all health science students	All new graduates will be equipped with HIV programs and service protocols prior to graduation	Integration of HIV in universities curriculum	Reports	Universities
	Provide in-service training on HIV and AIDS in health sector	23,121 health workers will be trained on HIV/AIDS	Number of health workers trained	Reports	
	Strengthen task-shifting, clinical mentoring and supportive supervision	task-shifting and clinical mentoring will be strengthened	Availability of clinical mentoring and task shifting	Reports and site visits	MoH /Regions

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Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Address human resource issues	Strengthen task-shifting, clinical mentoring and supportive supervision	4 supportive supervisions per year will be conducted to health facilities	Number of supportive supervisions conducted per health facility per year	Reports	MoH /Regions
	Train health facility leaders on HIV/AIDS program management & integration of services	3,303 health facility leaders will be trained on HIV/AIDS program management	Number of health facility leaders trained	Reports	MoH /Regions
	Promote Involvement of staff in health facilities operational research	55 operational researches/studies will be conducted	Number of operational studies conducted	Published studies	MOH/HAPCO/ Regions

Thematic Area Four: Strengthen Care and Support to Mitigate the Impact of HIV/AIDS

General objective: To improve the livelihood of the needy affected and infected people

Specific objectives:

- To increase care and support to OVC from 30% in 2008 to 50% by 2014/15
- To increase care and support to needy PLHIV from 60,000 in 2009 to 100,000 in 2014/15

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Strengthen the involvement of local communities in care and support	Identify care and support needs and gaps in each Kebeles	All Kebeles will identify care and support needs and gaps	Number of Kebeles with identified care and support gaps	Reports & site visits	MoWYC / NEP+ /
	Strengthen and use existing community structure to provide care/support in the OVCs' familial environment	Communities in 17,500 kebeles will be mobilized to support and care for OVC	Number of kebeles with care and support plan	Reports and site visits	
	Enhance the provision of standardized care and support to OVC	50% of the OVC will get care & support based on package		Reports	MoWYCA / HAPCO

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Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Enhance the provision of standardized care and support to OVC	Develop an OVC care and support standard and service delivery package	An OVC care and support standard and service delivery package will be developed	Existence of an OVC care/support standard & service delivery guideline	Reports	MoWYCA / HAPCO
	Conduct OVC situational assessment	Situation analysis will be conducted	Situational analysis document produced	Document	
School-based support for OVC	Map OVC services and develop referral network among service providers	Referral network will be created	Availability of functional referral networks	Document and site supervision	MoWYCA/ HAPCO
	Build the capacity of organizations engaged in service provision and assistance to implementing agencies	1000 Implementing agencies and organizations will be supported	Number of Implementing agencies and organizations supported	Reports	
Strengthen household economic capacity	Provide support to school based OVC programs	Schools will provide OVC support	Number of Schools providing OVC support	Reports	MoE
	Build the capacity of older OVC, guardians of OVC and PLHIV on IGA	50,000 OVC and their guardian will receive training on IGA	Number of OVC and their guardians supported through IGA	Reports	
	Provide seed money	25,000 PLHIV will receive training on IGA	Number of PLHIV supported through IGA	Reports and site visits	MoWYCA/ CSOs/HAPCO
	Follow up and support to create links to markets	75,000 of beneficiaries will receive seed money to start IGA	Number of beneficiaries received seed money	Sites and site visits	
			Number of beneficiaries mentored for IGA	Reports and site visits	

Thematic Area Five: Strengthen Generation and Utilization of Strategic Information

General objective: To ensure the timely generation and utilization of strategic information to enhance evidenced-based decision making of Multisectoral HIV/AIDS response

Specific objectives:

- To ensure the generation of quality data from routine program monitoring, surveys, surveillances and studies.
- To disseminate and utilize data from the M & E system to guide policy formulation and program planning and improvement

Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Capacity Building for M & E	Ensure availability of M and E officer or HIV/AIDS M and E capacity at regional, key sectors and CSOs	All regions, CSOs, sectors will ensure availability of human resource with M and E capacity	Number of regions, CSOs, sectors with available trained Human resource on M and E	Site visit, Reports	Regions, Sectors, CSOs
	Develop M and E implementation manual	M and E implementation manual will be developed	Developed M and E implementation manual	Document produced	HAPCO
	Develop M and E training curriculum	M and E training curriculum will be developed	Developed M and E training curricula	Document produced	HAPCO
	Conduct training for M and E officers	10,000 trained (8000 M and E staff & 2000 program managers) will be trained	Number of M and E officers trained	Report	
	Establish/strengthen and meetings of federal and regional HIV M and E Technical Working Groups	Conduct TWG meeting will be conducted in all regions	Regions with functional TWG	Minutes	RHAPCO/RHB
Institute culture of evidence based informed decision making	Establish/strengthen and conduct federal and regional HIV M and E advisory committee meetings	FHAPCO and All regions will conduct Regular meetings of M and E advisory Committee	Number of regions conducting M and E Advisory Committee meetings regularly	Reports, Minutes of the meeting	HAPCO
	Ensure one national M and E system	One functional M and E system will be established	One M and E system information	Reports, site visits Proceeding reports	Key strategic sectors, HAPCO, MoH HAPCO

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Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Institute culture of evidence based informed decision making	Establish framework for generation and utilization of strategic information	Framework for generation & use of strategic information will be established	Document developed on framework for generation & use of strategic information	Reports, site visits Proceeding reports	Key strategic sectors, HAPCO, MoH HAPCO
	Enforce evidenced based planning and prioritization	All regions, sectors, CSOs will prepare plans and prioritize activities based on current information	Number of regions, sectors, CSOs that use information for planning and prioritization	Surveys, Site visits	Key strategic sectors, HAPCO, MoH HAPCO
	Conduct regular review of HIV programs performance	40 regular review of HIV Programs performance at Federal level	Number of Review of HIV Programs performance	Reports, site visits Proceeding reports	Key strategic sectors, HAPCO, MoH HAPCO
	Establishment of database	One database established	Established database system		
	Conduct advocacy workshop on M and E and Strategic Information at all level	24 advocacy workshops will be conducted at all levels on M and E and Strategic Information	Number of workshops conducted	Reports, proceedings	HAPCO
	Work with sectors to include HIV/AIDS indicators within their own M and E systems	All sectors will include HIV/AIDS indicators within their own M and E systems	Number sectors included HIV/AIDS indicators in their own M and E systems surveillance	Reports, reports	FHAPCO/ RHAPCOs/ RHBs
	Conduct HIV surveillance	5 HIV surveillance studies conducted	Number of Surveillance studies conducted	Surveillance results	Sectors, EHNRI
	Conduct effectiveness study on interventions	Intervention Effectiveness studies will be conducted	Effectiveness studies completed	Study, Reports and supervision	EHNRI, Sectors
	Identify priority research agendas and conduct researches	Researches on priority area conducted	Produced research results	Researches conducted	FHAPCO/ FMOH/ Universities
	Allocate 5-10% of the SPM financing to strengthen strategic information generation	5-10% Of the SPM financing will be allocated for M and E	Allocated budget for M and Es	Reports, site visits	Universities

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Selected Strategies	Interventions	Targets	Key Indicators	Verification	Lead Agency
Strengthen timely generation of strategic information	Develop and implement community based information system to be used at all levels	Community Information system will be developed and implemented	Developed and implemented Community Information system	Documents, Surveys, Site visits	HAPCO
	Disseminate research and evaluation findings regularly	1 BSS, 2 ANC, population based survey, blood donors survey, drug resistance survey results disseminated	Behavioural, biological & program effectiveness studies released at national & sub-national levels	Reports	HAPCOs, CSOs
Enhance dissemination and utilization of strategic information	Prepare, print and distribute HIV/AIDS M and E reports regularly	Five Annual report and five bi annual reports and UNGASS report printed and distributed	Number of reports prepared and distributed	Reports HAPCO/EHNRI HAPCO	HAPCO/EHNRI
	Prepare key HIV evaluation and research findings summary and post reports on web sites	20 key HIV evaluation and research findings summarized and posted reports on web sites	Number of key HIV evaluation and research findings summary and posted reports on web sites		
	Organize international HIV/AIDS related conferences such as ICASA 2011	ICASA 2011 will be effectively organized and conducted	ICASA meeting conducted		
	Conduct best practice documentation & dissemination	20 Best practices documented & disseminated	Number of best practice documented and distributed	Document, reports	HAPCO

Part Five

Implementation Modality
and Institutional
Arrangements

Part Five: **Implementation Modality and Institutional Arrangements**

5.1. Multisectoral HIV/AIDS response governing and coordinating bodies

HIV/AIDS councils and management 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. The duties of the councils and management boards at all levels will be stipulated by the legislations of the respective governments. The Minister of Health and health officials at regional & sub-regional levels will be chairpersons of the management boards.

HIV/AIDS prevention and control offices at all levels will coordinate the multisectoral response. The House of Representatives at each level will oversight and enforce multisectoral response to HIV/AIDS to ensure effective mainstreaming, responsiveness and accountability.

5.2. Implementation of the multisectoral HIV/AIDS response

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, resource mobilization and monitoring evaluation. They will also develop and provide directives such as policy, strategy, guidelines, and frameworks while implementers at Regional level will further cascade these efforts to facilitate implementation of the multisectoral response at Woredas in a planned and organized manner.



Part Six

Monitoring and Evaluation

Part Six: Monitoring and Evaluation

Monitoring and Evaluation of HIV/AIDS multisectoral response will focus on tracking the progress on attaining results. A multisectoral HIV/AIDS monitoring and evaluation system will be strengthened to improve program performance. During SPM II, a community information system will be established and strengthened to track the progress of the non-health response. Outcomes and impacts of the multisectoral response will be monitored and evaluated by conducting surveillances, surveys, and studies. Emphasis will be given to monitor the epidemic trends and driving behavioral, socio-cultural and socio-economic factors to match the response to the epidemic. Moreover, appropriate indicators will be selected with clear targets for each thematic area for whole period of SPM II and annually.

A multisectoral response monitoring and evaluation plan will be developed and implemented through joint efforts in a coordinated manner, in line with the principle of “three ones”. Federal HAPCO, in collaboration with federal level stakeholders, is responsible for the coordination of the multi-sectoral monitoring and evaluation, and will convene semi-annual and annual joint review meetings and conduct semi-annual and annual joint support supervision at national level. Similarly, regional and sub-regional HAPCOs will coordinate the multisectoral M and E in their respective administrative levels. They will conduct quarterly support supervision, semi-annual and annual joint review meetings. A mid-term review and final evaluation of SPM II will also be conducted.

Data collection and reporting formats will be harmonized to facilitate data summarization and analysis. A multisectoral response database will be established at the federal and regional levels to enhance data storage and retrieval. Information dissemination will be strengthened through web postings, report publications and review meetings.

