Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support in Ethiopia

2007 –2010

HIV/AIDS Prevention and Control Office (HAPCO)

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Acknowledgements

This Plan of Action is an important milestone in efforts to realize the "Three Ones" principles. The preparation of the document is the result of a number of exercises, including the single point HIV prevalence estimate, a costing of HIV/AIDS commodities, the Epidemiological Synthesis report, the National Social Mobilization Strategy, and the Health Sector Road Map for Accelerated Access to HIV Prevention, Care and Treatment. Though it is impossible to list all the organizations and individuals involved in the above mentioned exercises, HAPCO would like to express its deepest appreciation for their coordinated efforts to make the document comprehensive. The National Partnership Forum and the HIV/AIDS Donors Forum are given great recognition for their invaluable inputs and close follow up of the process. Appreciation also goes to the Technical Working Group members drawn from the National Partnership Forum and the consultants for their commitment and professional competency in the development of the document. Finally, HAPCO sincerely acknowledges its international partners—particularly UNAIDS, UNDP and Irish Aid—who were instrumental in providing technical as well as financial support from the initial project formulation to the publication of the document.

Foreword

Over the last years, Ethiopia's response to the AIDS epidemic has shown considerable progress and achieved encouraging results. However, HIV and AIDS continue to pose formidable social and economic challenges at individual, family, community and national levels. The Government of the Federal Democratic Republic of Ethiopia fully recognizes the impact of AIDS on the overall development of the country and gives particular attention to fighting the epidemic within the broader development plan of the country. Accordingly, the response to HIV and AIDS is one of the eight development interventions of the Plan for Accelerated and Sustainable Development to End Poverty (PASDEP), which provides clearly articulated strategies and puts forward a number of ambitious targets to be achieved by 2010. Realization of the PASDEP's HIV and AIDS objectives and targets is the responsibility of all stakeholders in the public, private and civil society sectors under the coordination and leadership of the government.

In addition, Ethiopia has joined the international commitment to move towards universal access to HIV prevention, treatment, care and support by 2010. Despite the efforts made and the number of achievements recorded, the lack of an evidence-based, costed and prioritized comprehensive national plan of action for HIV and AIDS that can serve as a common reference for all partners was a constraint. This *Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support* has been developed to serve as the main implementation framework for the country's AIDS response for the PASDEP period.

The plan was developed in consultation with a broad range of stakeholders, who shared the lessons learned during implementation of the AIDS response, and it has also benefited from a number of key documents such as the single point HIV prevalence estimate, a costing of HIV/AIDS commodities, the Epidemiological Synthesis report, the National Social Mobilization Strategy, and the Health Sector Road Map for Accelerated Access to HIV Prevention, Care and Treatment.

While the development of this plan is a significant achievement, it would be meaningful only if the operational plans of all stakeholders engaged in the response to HIV are built on this common framework. Realization of the targets requires effective leadership by the government and the commitment, dedication, and concerted action of all parts of the community. Launching of this plan serves to reaffirm government's commitment to provide the required leadership for the achievement of universal access to HIV prevention, treatment, care and support.

Betru Tekle
Director General, HIV/AIDS Prevention
and Control Office (HAPCO)

List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BSS	Behavioral Surveillance Survey
CCM-E	County Coordinating Mechanism for Ethiopia
CDC	United States Centers for Disease Control
DHS	Demographic and Health Survey
EC	Ethiopian Calendar
EMSAP	Ethiopian Multisectoral AIDS Project
ETB	Ethiopian Birr
HAPCO	HIV/AIDS Prevention and Control Office
HCT	HIV Counseling and Testing
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HP	Health Post
IGA	Income-Generating Activity
IMR	Infant Mortality Rate
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
NGO	Non-governmental Organization
NPF	National Partnership Forum for the Fight Against HIV/AIDS in Ethiopia
NSF	National Strategic Framework
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
STI	Sexually Transmitted Infection
SPM	Ethiopian Strategic Plan for Intensifying Multisectoral HIV/AIDS Response 2004-2008
UNDAF	United Nations Development Assistance Framework
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
USAID	United States Agency for International Development

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CHAPTER 1:
Situational Overview and Development of the Plan of Action

1.1. Development of the Plan of Action

The Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care and Support 2007 – 2010 has been developed by the Government of Ethiopia's HIV/AIDS Prevention and Control Office (HAPCO), in collaboration with government ministries, civil society and international partners. The general objective of the Plan of Action is to serve as a common action plan for all partners to attain universal access to HIV prevention, treatment, care and support.

The document is divided into five chapters:

- Chapter 1: An introduction that summarizes the purpose and process of development of the Plan of Action, as well as the national AIDS epidemic and response.
- Chapter 2: An outline of the principles of universal access; Ethiopia's universal access commitment; the national targets for universal access to HIV prevention, treatment, care and support; a summary of the programme areas, objectives and strategies of the Plan of Action; and a summary of the monitoring and evaluation plan.
- Chapter 3: A detailed estimate of the financial resources required to implement the Plan of Action.
- Chapter 4: A mapping of current or committed financial resources and a resource gap analysis.
- Chapter 5: A detailed matrix of the programme areas, sub-programmes, targets, key activities and responsible institutions for implementation of the Plan of Action,

1.2. National Context

1.2.1. Geography and Administrative Structure

Ethiopia is located in the eastern horn of Africa with a total surface area of 1.1 million square kilometers. It shares borders with Djibouti, Eritrea, Sudan, Kenya and Somalia. It has a projected population of 77 million for 2007[1], with about 84% living in rural areas. Administratively, the country is a Federal Democratic Republic with a bicameral parliament: the House of Representatives and the House of Federation. Administrative boundaries are composed of nine regional states and 700 Woredas (districts). The Woredas are the basic units of planning and political administration. Below the districts are approximately 15,000 village associations and urban neighborhood associations known as Kebeles.

1.2.2. Economy, Health and Social Status

Economically, Ethiopia is a low-income country with a per capita gross national income of $110 in 2005[2]. Its economy is largely dependent on the agriculture sector, which also provides about 85% of employment. Recurrent famines and civil wars, as well as high population growth have contributed to this low socio-economic status. The Ethiopian population is young (with 44% under the age of 15 years) and rapidly growing, resulting in a high dependency ratio. The population growth is also putting pressure on cultivable lands and contributing to environmental degradation, which is worsening the level of poverty[3].

The overall health status of the Ethiopian people is poor. Life expectancy at birth stands at 54 years (53 years for men and 55 years for women). The infant mortality rate is estimated to be about 77 per 1,000 births, and Under-5 mortality is about 123 per 1,000. Poor nutritional status, infectious diseases and a high fertility rate, together with low levels of access to reproductive health and emergency obstetric services, contribute to one of the highest maternal mortality rates in the world. Maternal mortality is estimated to be 673 per 1,000 births[4].

The major health problems of the country are communicable diseases resulting from poor personal hygiene, improper garbage and waste disposal practices, and lack of an adequate and safe water supply. Significant proportions of other health problems are due to inappropriate nutritional practices lack of health awareness, and improper cultural taboos. Most of these communicable diseases are vaccine preventable and affect mothers and

1 Central Statistical Authority. The 1994 Population and Housing Census of Ethiopia: Results at Country Level (Volume 1: Statistical Report). 1998. Addis Ababa, Ethiopia.
2 The World Bank. 2005. World Development Report 2006. Washington, DC, International Bank for Reconstruction and Development and World Bank.
3 The World Bank. Ethiopia: A country status report on health and poverty. 2004. The World Bank Africa Region Human Development and Ministry of Health, Addis Ababa, Ethiopia.
4 Central Statistical Authority. Ethiopia Demographic and Health Survey. 2005. Addis Ababa, Ethiopia

children under five years of age.

In 1997 EC, the geographic access with basic primary health care had reached 76.9% for public facilities, with an increase to 92% when the services of private facilities are included[5].

1.3. Trends and Status of the AIDS Epidemics

The first two cases of HIV infection in Ethiopia were reported in 1986. Since then, the disease has spread at an alarming rate. Prevalence projections are mainly based on infection rates in antenatal clinic attendees. However, the proportions of rural to urban ANC sentinel sites do not match the distribution of the general population. A combination of the increase in the number of sites (especially rural sites, which provided more representative data), use of more advanced statistical analyses, improved data management, and the possible impact of the various prevention programmes resulted in a decline of the estimated adult HIV prevalence to 3.5% in 2005. A Demographic and Health Survey (DHS) was also conducted in 2005, and it concluded that 1.4% of Ethiopian adults ages 15-49 years are infected with HIV (prevalence among women was nearly 1.9% while that among men was just under 0.9%)[6].

Since the results of the two surveys varied due to their different methodologies, it was decided to use both sets of data to establish one common estimate for national reference. The ANC and DHS results were reconciled into a single-point estimate of 2.1% in 2007 with an estimated total of 977,394 PLHIV (578,018 female and 399,376 males) and a total of 898,350 AIDS orphans.

The data also indicates stabilizing urban prevalence with a rise in prevalence in rural areas. However, even with this lower estimate in prevalence and the stabilizing trends, it should be noted that the number of people affected by the AIDS epidemic in Ethiopia is comparably high, as the country has the second largest population in sub-Saharan Africa.

The group with the highest HIV prevalence in the country is women aged 15 to 24. Data from blood donors, visa applicants, and police and army recruits indicating that HIV prevalence among men peaks between ages 25 and 29 years. As the most affected groups are people in their prime productive and reproductive years, this has resulted in the loss of the country's human capital. Decreased labor productivity and increased health care expenditure due to AIDS have been documented in some industrial plants around Addis Ababa[7].

The difference in HIV prevalence among males and females in Ethiopia (1.7% against 2.6% in 2007) demonstrate the higher vulnerability of Ethiopian women to HIV infection, a trend witnessed in many African countries with generalized epidemics. The peak age range for AIDS cases is 20-29 years old for women and 25-34 years old for men. The contributing factors for this situation are due to many sexual, social and economic issues creating differences among women and men. Among the contributors: women engage in sex earlier to men, young women have sex with older men, and women are less able to negotiate safe sex than men.

Women are also much more exposed to various forms of sexual violence, such as rape, abduction, spousal abuse and marital rape. A study conducted among adolescents from six peri-urban centers in Ethiopia found that 9% of sexually active women reported having been raped, while 74% reported sexual harassment (UNDP, HIV/AIDS and gender in Ethiopia, 2004). Female genital mutilation and customary laws and practices governing divorce, marriage and widowhood increase the risk of infection among both men and women. Women also appear to have more limited access to HIV information sources, and their understanding of HIV prevention measures is lower than men. According to the 2005 Demographic and Health Survey, 35% of women (compared to 57% of men) were aware that using condoms and limiting sex to one uninfected partner can reduce the risk of getting the AIDS virus. Additionally, only 27% of the interviewed women rejected two of the more common misconceptions surrounding HIV in Ethiopia and understood that a healthy-looking person can be living with HIV.

The increasing number of AIDS orphans is among the manifestations of the social impacts of the disease—the disintegration of families and a tearing of the basic social fabric. The single point estimate exercise determined that in 2006 there were a total of 656,058 children in Ethiopia who had lost at least one parent to AIDS. In addition, some studies in Addis Ababa have indicated the collapse of some indigenous social support systems such as Elders being unable to withstand the financial crises that resulted from increased AIDS-related mortality[8].

5 Ministry of Health. Health and Health Related Indicators. 1998 (2005/2006). Planning and Programming Department, Addis Ababa, Ethiopia.

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

7 The Impact of HIV/AIDS on Labour Productivity in Akaki Fiber Products Factory, Ethiopia. 2001. MPH Thesis. School of Graduate Studies, Addis Ababa University.

8 Pankhurst A and Haile Mariam D. The Iddir in Ethiopia: Historical development, social function, and potential role in HIV/AIDS prevention and control. North East African Studies 2004;7(2):35-58.

Studies have also shown the increased AIDS-related costs incurred by the health sector in terms of specific expenditure for hospitalization, treatment and supportive care. It has been documented that HIV-related patients occupy approximately half of all hospital beds, and that the increasing numbers of AIDS patients strain the capacity of the already overburdened health professionals[9]. In addition the high cost of for AIDS care affects budget allocation from other programmes such as primary health care and essential drugs services.

1.4. The National Response

The Government of the Federal Democratic Republic of Ethiopia has taken many measures to fight the disease and mitigate its impact. Even before the first AIDS case had been officially diagnosed in the country, it established a national HIV/AIDS task force in 1985. The task force played a major role in sensitizing the public about AIDS and its consequences and also issued the first AIDS control strategy.

In 1987, the government established an AIDS department within the Ministry of Health, and in 1988 an HIV surveillance system was established. In 1989, the Ministry of Health drafted a four-point policy statement on HIV prevention, and the first draft of a national policy was created in 1991, though not approved until 1998. The HIV/AIDS Policy had the overall objective of providing an enabling environment for the prevention of HIV and mitigation of the impact of AIDS[10].

Following the enactment of the National HIV/AIDS Policy, the Ministry of Health coordinated a process of strategic planning and programme development in Ethiopia's nine regions and two city administrations that resulted in the five-year Federal Level Multisectoral HIV/AIDS Strategic Plan and accompanying Regional Multisectoral HIV/AIDS Strategic Plans. Together, these plans were synthesized into the Strategic Framework for the National Response to HIV/AIDS in Ethiopia for 2001-2005[11].

The National HIV/AIDS Prevention and Control Council was established in 2000 by Proclamation Number 276/2002 as an autonomous federal government organ having its own legal status and charged with implementing the Strategic Framework. The response was later focused around six strategic issues by the Ethiopian Strategic Plan for Intensifying Multisectoral Response to HIV/AIDS 2004-2008 (SPM):

1. Capacity Building
2. Community Mobilization and Empowerment
3. Integration with Health Programmes
4. Leadership and Mainstreaming
5. Coordination and Networking
6. A Targeted Response

This focus has been maintained in the national Plan for Accelerated and Sustained Development to End Poverty (PASDEP), which includes AIDS as one of its main components.

1.4.1. International Initiatives and Resources Supporting the National Response

The turn of the 21st Century saw a dramatic increase in the level of international partnership and support towards addressing the overall health needs of developing countries in general, and to the prevention and control of poverty diseases (including AIDS) in particular. These partnerships and support activities range from initiatives and declarations that advocate and coordinate concerted efforts and resource mobilization, to the injection of considerable magnitude of financial resources through a number of global initiatives such as the Global Fund and PEPFAR.

These initiatives and declarations are contributing to the enhancement of partnership and in making the global environment conducive for responding to the major health problems of developing countries, including AIDS. Ethiopia is signatory to most such international declarations and initiatives, and it is also beneficiary to the various forms of international assistance and donations, especially to the health sector. Among others, the major international initiatives and declarations that have facilitated and enhanced the national response to the AIDS problem one can mention:

9 Kello A. Impact of AIDS on the economy and health care services in Ethiopia. Ethiop J Health Dev 1998; 12(3): 191-201.

10 Federal Democratic Republic of Ethiopia. Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia. Addis Ababa, August 1998.

11 Ministry of Health. Summary Federal Level Multisectoral Plan 2000-2004. Ministry of Health, Addis Ababa, 1999.

1. At the Millennium Summit in September 2000 the largest gathering of world leaders in history adopted the **UN Millennium Declaration**, committing their nations to a new global partnership to reduce extreme poverty and setting out a series of time-bound targets, with a deadline of 2015. These targets have been translated into eight **Millennium Development Goals** (MDGs), which range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015[12].
2. The **Abuja Declaration** sets out the commitments made by African leaders at the Abuja Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, in 2001. Among other commitments, the Abuja Declaration sets a target of allocating at least 15% of each country's annual budget to the improvement of the health sector. It also calls upon donor countries to help by assigning 0.7% of gross national product (GNP) as official development assistance;
3. The **Paris Declaration**, made by 42 Heads of Government or Representatives on 1 December 1994, named AIDS as a global priority and committed signatories to ensuring that all PLHIV are able to realize the full and equal enjoyment of their fundamental rights and freedoms without discrimination. The Declaration also named the Joint United Nations Programme on HIV/AIDS, as the appropriate framework to reinforce partnerships between all involved and give guidance and worldwide leadership in the fight against AIDS;
4. The **UN Declaration of Commitment on HIV/AIDS** is an important international policy commitment made by heads of state and representatives of governments who met at the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001. The Declaration includes time-bound targets and regular reporting requirements, which serve as a powerful tool in helping to guide and secure action, commitment, support and resources for the AIDS response.
5. The **Brazzaville Commitment** was adopted on 8 March 8 2006 by about 250 delegates from 53 African countries representing governments, parliaments, civil society, faith-based organizations and the private sector. It contains a broad list of 26 actions to be taken by African countries to move towards meeting the goal of universal access to HIV treatment, prevention, care and support;
6. The **"Three Ones"**—the harmonization and alignment of country-level efforts around national structures, systems and priorities—were established as guiding principles for improving the country-level response during the 13th International Conference on AIDS and Sexually Transmitted Infectious in Africa (ICASA 2003) held in Nairobi, Kenya in September 2003.
7. The **Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT)** reviewed the global response to AIDS with the theme, "Making the Money Work: The "Three Ones" in Action"[13]. It made recommendations in the following areas: 1) Empowering inclusive national leadership and ownership, 2) Alignment and harmonization, 3) Reform for a more effective multilateral response, and 4) Accountability and oversight. These recommendations are being implemented by major multilateral institutions, including the Cosponsors of UNAIDS and the Global Fund.

Thus, the development of the current National Plan of Action is in particular based on the principles of the "Three Ones" for improving the ability of the Ethiopian Government and all the donors to work more effectively together through:

- One agreed AIDS action framework as the basis for coordinating the work of all partners
- One national AIDS Coordinating authority, with broad-based multi-sector mandate and
- One agreed country-level monitoring and evaluation system

This is expected to improve the harmonization and alignment of planning, programming and monitoring and evaluation at national, regional and Woreda levels. Within the framework of the "Three Ones", the Government and its partners have developed the current Plan of Action as the one agreed-upon AIDS action framework under one national AIDS coordinating authority (HAPCO), and the National AIDS Monitoring and Evaluation Framework that was been developed in 2003[14] by HAPCO and its partners.

12 http://www.un.org/millenniumgoals/

13 UNAIDS. The Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. Final Report, June 2005.

14 HIV/AIDS Prevention and Control Office (HAPCO). National Monitoring and Evaluation Framework for the Multisectoral Response to HIV/AIDS in Ethiopia 2003. HAPCO, Addis Ababa, Ethiopia.

1.4.2. Multilateral and Bilateral Resources

Among the major external initiatives and resources that are supporting the government's response to AIDS are: the World Bank assisted Ethiopian Multisectoral AIDS Project (EMSAP), the Global Fund and PEPFAR.

Ethiopia received USD 59.7 million through the World Bank's EMSAP I initiative. The purpose of EMSAP I was to support multisectoral AIDS activities throughout the country. In addition to beneficiary institutions and organizations at the Federal level, over 260 Woredas have been covered through EMSAP. The Ethiopian Government and the World Bank also recently signed agreement for a USD 30 million EMSAP II.

The Global Fund has approved over USD 400 million for the country focusing on interventions to: increase access to prevention services, expand entry points to ART, expand access to other forms of treatment and care, and improve supportive environment and crosscutting aspects. As in other developing countries, the Global Fund's decision to make generic antiretrovirals (ARVs) eligible for funding in 2002 drastically reduced the price of these drugs. Ethiopia is also one of PEPFAR's 15 focus countries. Through PEPFAR, Ethiopia received $254.7 million between 2004 and 2006 to support comprehensive HIV prevention, treatment and care programmes. PEPFAR and the Global Fund are providing support to programme activities, including systems and infrastructural capacity building, purchase and distribution of ARVs and related commodities, and organization and delivery of clinical, pharmacy and laboratory services.

The financial contributions of the World Bank, Global Fund, PEPFAR, the United Nations and other multilateral and bilateral partners are mapped in Part 5 of this Plan of Action.

1.5. Key Achievements

Although additional efforts are needed to prevent new HIV infections and provide universal access to treatment, care and support, good achievements have been recorded especially over the last few years through the multisectoral response of the country and global partnership. Among those achievements, the following are of particular note:

- As behavioral surveys show, awareness of the population about HIV and AIDS is high and behavioral change is increasing.
- Site expansion for access of services of HCT, PMTCT and ART has shown dramatic change over the last three years.

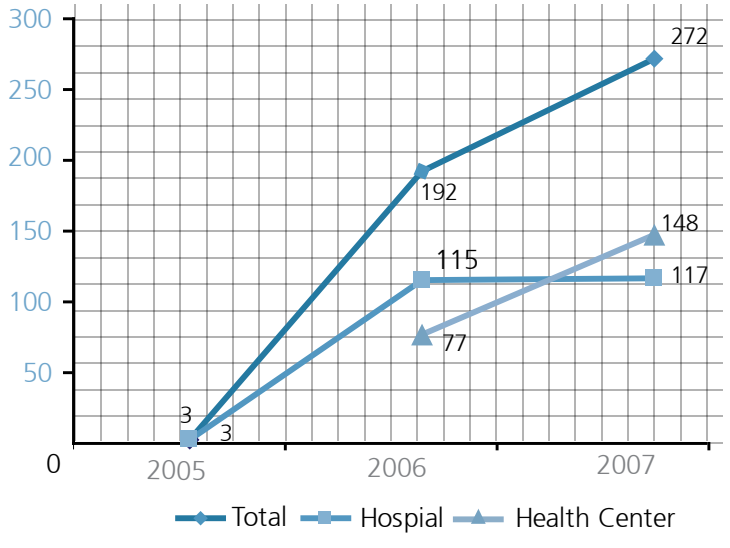

Figure 1.1: Art Site Expansion

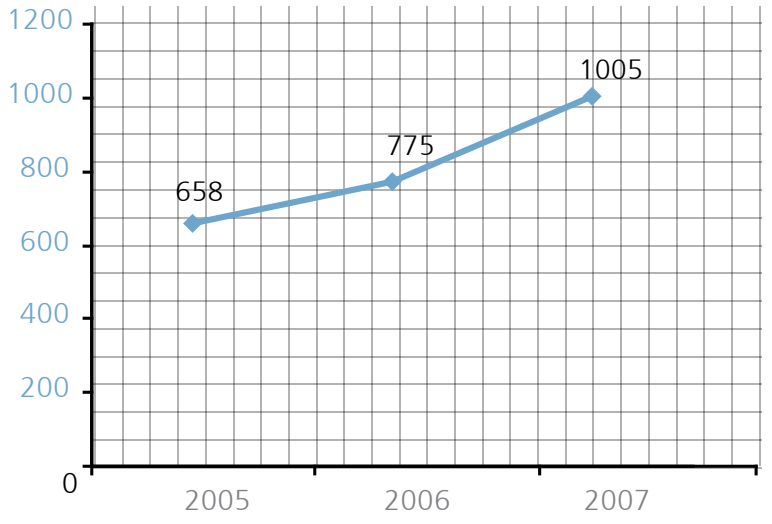

Figure 1.2: HCT Site Expansion

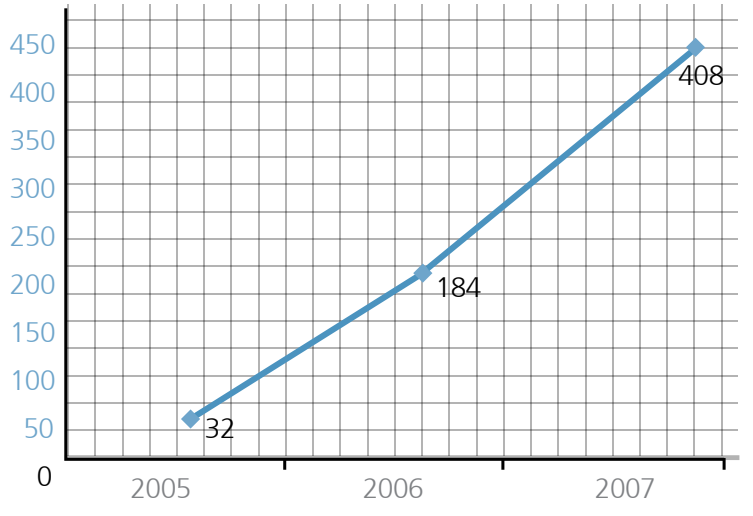

Figure 1.3: PMTCT Site Expansion

- Number of people tested has increased three fold, from 564,000 in 1998 EFY to 1.9 million in 1999 EFY, due to National Millennium AIDS Campaign initiative all over the country and sustainable advocacy.

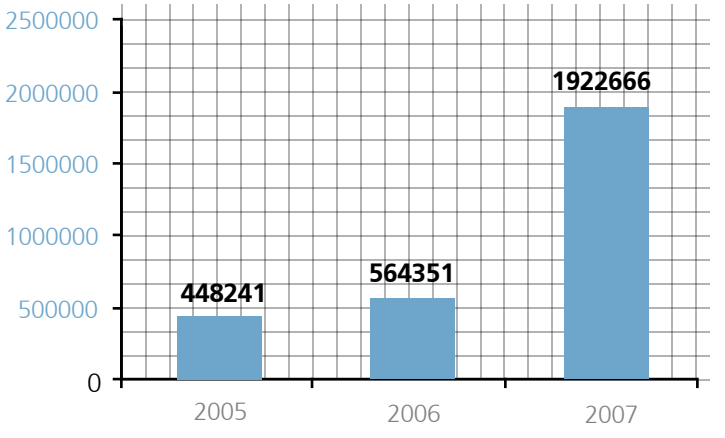

Figure 1.4: HCT Scale Up

- Free ART provision has increased from 53,889 in 1998 EFY to 72,600 in 1999 EFY.

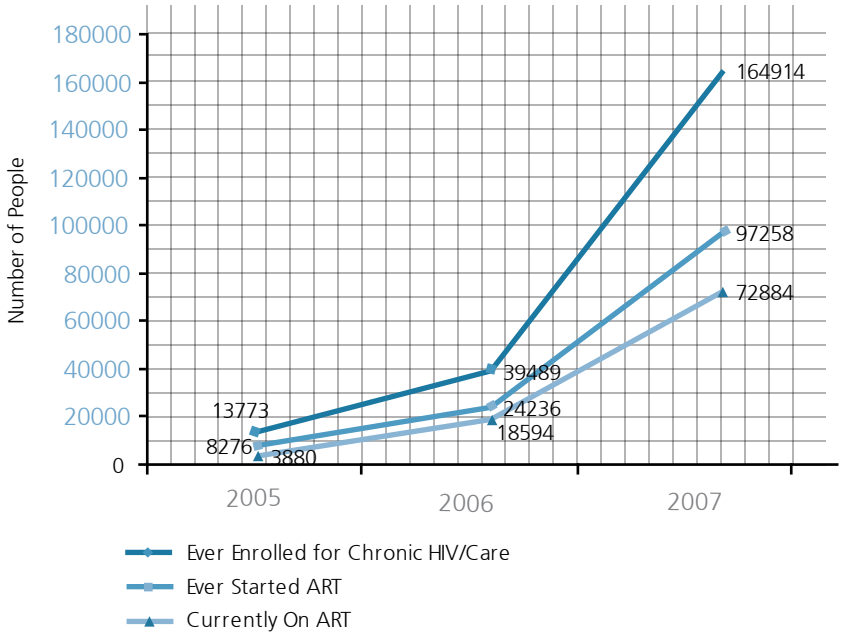

Figure 1.5: ART Scale Up

- A number of institutions have mainstreamed AIDS programmes into their mandated business by establishing anti-AIDS Funds, increasing budget allocations and implementing various workplace interventions
- About 160,000 OVCs and 35,000 PLHIV are accessing psychosocial, educational, nutritional, training for income generation and fund for income generation activities.

1.6. Challenges

Despite all of the above considerable achievements, Ethiopia's multisectoral AIDS response faces a number of key challenges:

Insufficient human resources: Although human resource constraints—especially in the health sector—have been addressed by a number of different initiatives, it remains a critical challenge at both facility and programme levels.

Weak health infrastructure, transportation and general systems: Addressing this challenge requires huge investment to improve services and scale up towards universal access all over the country.

Harmonization and alignment: Although developments have been made towards the coordinated and integrated efforts of all partners from national to the facility level, additional alignment to national plans, priorities and systems, as called for in the "Three Ones", is required.

Mainstreaming and leadership: Some developments in mainstreaming and leadership have been recorded. However response of institutions, leadership at all level and level of mainstreaming is at its low level.

Ownership and empowerment: A number of advocacy works, community dialogues and workplace interventions have been undertaken, but the translation of these discussions into doable actions at grassroots level is still low. More effort is needed in the future until all communities have developed and are implementing concrete action plans.

1.7. Development of the Plan of Action

The national AIDS response is one of the development priorities of the country. Accordingly, HIV/AIDS is one of the components of the national Plan for Accelerated and Sustained Development to End Poverty (PASDEP). The HIV/AIDS component of the PASDEP was taken from the Ethiopian Strategic Plan for Intensifying Multisectoral Response to HIV/AIDS 2004-2008 (SPM) with exception of updating the targets based on current developments. According to the SPM and the PASDEP, the country's national response to AIDS is built around six strategic issues: capacity building; community mobilization and empowerment; integration with health programmes; leadership and

mainstreaming; coordination and networking; and a targeted response. The SPM also emphasizes the importance of a multisectoral approach, and multi-sectoralism remains a major guiding principle of HIV/AIDS prevention and control[15].

Ethiopia's multisectoral response to AIDS is also guided by the overarching principles of the "Three Ones": the harmonization and alignment of all partners around one national AIDS action framework, one national AIDS coordinating authority and one monitoring and evaluation system. Thus far, the country has made all efforts to fully implement these principles:

1. PASDEP and the SPM are recognized by all actors as a common multisectoral framework for action.
2. The Federal HIV/AIDS Prevention and Control Office (HAPCO) is the national coordination authority.
3. The National M&E Framework launched in 2003 has accelerated efforts toward a common M&E system accepted by all stakeholders.

Following the finalization of the PASDEP, Ethiopia adopted on 2 June 2006 the UN General Assembly resolution 60/262: the Political Declaration on HIV/AIDS. This Political Declaration strengthened previous international and continental commitments—such as the 2001 Declaration of Commitment on HIV/AIDS and the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Diseases—by committing UN Member States to moving towards universal access to HIV prevention, treatment, care and support by 2010, including the setting of national targets and developing updated, costed and prioritized national action plans.

To realize the objectives set in the PASDEP, and move the Ethiopian response towards universal access to HIV prevention, treatment, care and support by 2010, there is also a need for a common agreed, evidence-based plan of action that all partners use as a common reference for implementation. HAPCO, therefore, initiated a process to develop in consultation with its partners a detailed national action plan that would serve as an updated HIV/AIDS component of the PASDEP.

Figure 1.6: The Relationship of the Plan of Action to Other National Plans and Processes

This document is the final product: a costed, multisectoral Plan of Action for the period 2007-2010. The Plan of Action consists of detailed activities categorized within 16 major programme areas. Its development has been guided by the SPM, Ethiopia's universal access commitment and the Three Ones principles. The Plan of Action mainly bases itself to related national plans and processes, in particular:

15 Reference SPM, page and paragraph of deleted text.

- The Road Map for Accelerated Access to HIV/AIDS Prevention, Treatment, Care and Support that guides the health sector's response to the epidemic from 2007-2010;
- The National Universal Access process that set national targets for non-health sectors for 2007-2010; and
- The National Social Mobilization Strategy which is designed to intensify mobilization of all parts of the society with special attention to the community towards a broad based participatory action.

It also takes in to account the sectoral directions of the Health Sector Development Programme (HSDP); the Education Sector Development Programme (ESDP); and the Health Sector Facility Expansion Plan (see Figure 1.6). Moreover, resource requirements for the Plan of Action were projected for the period 2007-2012, currently available/committed resources to the national AIDS response were mapped, and a financial gap analysis has been conducted.

The Plan of Action, therefore, is the one agreed national AIDS action framework of the "Three Ones" principles.

CHAPTER 2:
Major Targets for Prevention, Treatment, Care and Support for the Period 2007-2010

2.1. Basic Principles of Universal Access

Ethiopia has adopted UN General Assembly resolution 60/262, also known as the Political Declaration on HIV/AIDS, which was passed on 2 June 2006. The declaration includes a commitment by UN Member States to move towards the goal of universal access to HIV prevention, treatment, and care and support services by 2010. It also calls on each country to set ambitious national targets to be achieved by the year 2010, and to work with partners at country level to overcome the barriers that block access to prevention, care and treatment.

Universal access is an extraordinary commitment by world leaders, signaling the political will to devote the resources and energy required to end AIDS. However, provision of HIV prevention, treatment, care and support to all who need them by 2010 is an extremely ambitious goal, even for developed countries. Therefore, the progress of individual countries universal access will vary, depending upon their ability to overcome the chief obstacles identified during country consultations that preceded the UN General Assembly meeting: poor planning and coordination, insufficient financial resources, inadequate human capacity, weak systems, expensive medicines and prevention commodities, lack of respect for human rights, stigma and discrimination and insufficient accountability for results.

The concept of universal access nonetheless implies that all people should be able to have access to information and services. Scaling up towards universal access, should therefore be guided by the following principles: **equitability, accessibility, affordability, comprehensiveness and sustainability in the long-term**.

National-level universal access processes take these issues into account by building on past efforts, reviewing existing data and data collection systems, building country ownership and participation, integrating a limited number of targets within national planning frameworks, focusing on country-specific obstacles, setting priorities, and mobilizing sufficient financial resources.

2.2. Ethiopia's Universal Access Targets

The process of setting Ethiopia's Universal Access targets included the following steps: reviewing the status and transmission dynamics of the HIV epidemic;

1. Defining and prioritizing the interventions to be included in the national response;
2. Estimating the size of populations in need;
3. Reviewing the current coverage rates and historic rate of scaling up and projecting the potential achievements by 2010;
4. Determining the resources available, the current coverage capacity and what would be required to overcome identified obstacles; and
5. Estimating the impact on rate of scale up that would result from investments in overcoming specific obstacles.

Based on these exercises, the following universal access targets and coverage targets have been set:

Condom use by sexually active population (age 15-49) will increase from 10% in 2007 to 60% by 2010.	Numerical targets: 8 million sexually active people using condoms by 2010 National indicator: Percentage of people aged 15-49 years reporting the use of a condom during last sexual intercourse with a non-regular sexual partner *Numerator: Number of respondents (15-49) who reported having had a non-regular (i.e., non-marital and non-cohabitating) sexual partner in the last 12 months who also reported that a condom was used the last time they had sex with this partner* *Denominator: Number of respondents (15-49) who reported having had a non-regular sexual partner in the last 12 months* Assumptions: Sexually active pairs (15-49) will have four sexual intercourse /month (50/yr.): 60 % of condom use coverage satisfactory level for effective HIV prevention
People treated for STIs will be 94% of those who seeks the service by 2010	Numerical target: 1.5 million STI cases receiving comprehensive services in 2010. National indicator: Percentage of patients with STIs at health-care facilities who are appropriately diagnosed, treated and counseled *Numerator: Number of STI patients for whom the correct procedures were followed on (a) history-taking; (b) examination; (c) diagnosis and treatment; and (d) effective counseling on partner notification, condom use and HIV testing* *Denominator: Number of STI patients for whom provider-client interactions were observed*
9.27 million People to be counseled and tested in 2010.	National indicator: Number of individuals receiving HIV counseling and testing in the last 12 months: a) Number of individuals who received pre-test counseling, b) Percent of those counseled who received HIV testing, c) Percent of those tested who were positive, d) Percent of those tested who received their results through post-test counseling services, and e) Percent of those tested HIV-positive who were referred to care and support services (disaggregated by type of service (voluntary/diagnostic), age, sex, region and urban/rural)
80% of HIV Positive Pregnant women will receive PMTCT service by 2010	Numerical target: 72,167 HIV-positive pregnant women to receive PMTCT services in 2010. National indicator: Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT in accordance with nationally approved treatment protocol in the last 12 months *Numerator: Number of HIV-infected pregnant women who received antiretrovirals during the last 12 months to reduce mother-to-child transmission* *Denominator: Estimated number of HIV-infected pregnant women in the last 12 months.*
People receiving ART will increase from 32% in 2007 to 100% by 2010.	Numerical target: 397,000 people living with HIV receiving antiretroviral therapy by 2010. National indicator: Percentage of people with advanced HIV infection receiving ARV combination therapy *Numerator: Number of people (i.e., adults and children) with advanced HIV infection who receive antiretroviral combination therapy according to the nationally approved treatment protocol* *Number of people with advanced HIV infection receiving treatment at start of year + Number of people with advanced HIV infection who commenced treatment in the last 12 months - Number of people with advanced HIV infection for whom treatment was terminated in the last 12 months (including those who died)* *Denominator: Number of people with advanced HIV infection*
1.68 million OVC receiving care and support by 2010	National indicator: Number of OVC who received free external support in the last 12 months (disaggregated by age and sex of OVC, region and type and level of free support) Assumptions: Out of the 43% of orphans and vulnerable children (OVC) who need support, 20% will get external support and 23% community support by 2010
50% of people living with HIV (PLHIV) to receive care and support services by 2010	Numerical targets: 560,000 people living with HIV receiving care and support services by 2010 National indicators: • Percentage of people aged 15-59 who has been ill for 3 or more months in the last 12 months and whose household received free basic external support in caring for the chronically ill person (disaggregated by age, sex, region and source, type and level of free support) • Number of people aged 15-59 who has received help from home-based programme in the last 12 months (disaggregated age, sex, region and type and level of support) Assumptions: Out of the total PLHIV 50% are made eligible for food and shelter , 30% for HBC and 20% for IGA targeted and 20% IGA trainings

Figure 2.1: Universal Access Targets

continued...

All Kebeles conduct community conversation sessions by 2009	Numerical targets: Conduct eight community conversation sessions per Kebele every 15 days for 10 months (15,000x8x20 = 7,200,000) National indicators: • Number of Kebeles undertaking community conversation • Number of community conversations conducted in each Kebele
All schools will have HIV/ AIDS information centers	Assumptions: Primary and Junior Schools (20,000 Desks) High Schools, colleges and Universities (700 Desks) considering the expansion by 20%
100% access to primary health care services by 2008	Numerical targets: Each Kebele will have two health extension workers (HEWs) and one Health Post by 2008 National indicator: Number of Kebeles with two health extension workers (HEWs) and one Health Post by 2008

Figure 2.1: Universal Access Targets

The above targets represent the political commitment of the Ethiopian Government to move towards universal access to HIV prevention, treatment, care and support. Underneath these political targets, the Plan of Action contains objectives for each of its 16 Programme Areas and specific annual targets for each key activity. All partners are expected to plan with reference to these common commitments and to work with HAPCO to develop annual plans that prioritize the implementation of the Plan of Action in accordance with the dynamics of the epidemic, such as:

- Targeting prevention programmes to vulnerable groups (e.g. women and youth) and populations most at risk of HIV infection (e.g. sex workers, truck drivers);
- Linking VCT, PMTCT and ART scale up with HIV prevalence and incidence data.

2.3. Plan of Action Matrix for Major Programme Areas

A total of 16 programmes will be implemented to achieve universal access to HIV prevention, treatment, care and support by 2010. A summary of the objectives, strategies, responsible institutions and selected key activity targets for each programme area is presented in Figure 2.2 below. A detailed implementation matrix for the plan of action including sub programme areas and a full listing of major activities and annual targets is presented in Chapter 2.

Programme Area	Objectives And Programme Targets	Strategies	Selected Key Activity Targets	Unit Of	2007/08	2008/09	2009/10	2010/11	Lead Institutions
Social Mobilization	Objectives: i) intensify the comprehensive response against HIV/ AIDS by creating comprehensive knowledge, shared sense of urgency, increased community ownership and involvement at the community level on a mass scale	Ensure community participation and ownership of HIV/AIDS programmes, create a sense of urgency in all leaders and community organizations to take HIV/AIDS as a social and development agenda, reinforce relevant community bylaws and resolutions, ensure leadership commitment	Conduct 8 community conversation sessions per Kebele every 15 days for 10 months (15,000x8x20)	# of sessions		7,200,000			WACs, NGOs, FBOs, CSOs, Schools
Condom Use	Objective: increase condom use among people aged 15-24 years reporting the use of condom during the last sexual intercourse with non regular partners to 60%	Conduct aggressive social mobilization among the sexually active population (15-49) for behavioral change, make condoms available to the population free of charge or affordable price	Procurement of condoms (95% male and 5% female):	# of condoms in millions	189.5	290	367	400	HAPCO, DKT, FGAE, PEPFAR
			Introduce community condom distribution outlets through associations, VCAPS, CC facilitators, etc.	# of outlets	6,750	9,000	13,500	15,750	HAPCO, WACs, Vulnerable Groups Associations/ Partnership Forums

Figure 2.2: Plan of Action Matrix by Programme Areas

continued...

Programme Area	Objectives And Programme Targets	Strategies	Selected Key Activity Targets	Unit Of	2007/08	2008/09	2009/10	2010/11	Lead Institutions
HIV Counselling and Testing (HCT)	Objective: Increase number of people counselled and tested to 8.986 million	Increase coverage and quality of HCT services Strengthen public and private institutions and integrate HCT services into these institutions, enhance community mobilization	Expansion of HCT centers (public and private)	# of facilities	1,121	820	849	728	Ministry of Health/PASS, Regional Health Bureaus
			Train health workers in public and private health facilities on HCT	# of Health Workers	5,706	3,928	3,994	3,584	Ministry of Health, Regional Health Bureaus
			Procure and distribute HCT kits:	# of Kits in millions)	3.2	5.65	7.2	9.3	Ministry of Health, Regional Health Bureaus
Sexually Transmitted Infection (STI) Syndromic Management	Objective: Reduce vulnerability to HIV infection	Strengthen public and private institutions and integrate STI syndromic management	Train nurses from public and private health facilities on the syndromic management of STI:	# of Nurses		5,823	2,547	2,184	Ministry of Health, Regional Health Bureaus
			Procure and distribute STI drugs	# of people treated	470,000	827,000	1,200,000	1,500,000	Ministry of Health/PASS
Prevention of Mother-to-Child Transmission (PMTCT)	Objective: Increase the percentage of HIV positive pregnant women receiving complete course of ART to at least 80%	Integrate PMTCT services in both public and private health institutions	Establish additional PMTCT centers in hospitals, health centers and health posts (public and private)	# of Centers	1,281	598	589	546	Ministry of Health, Regional Health Bureaus
			Train health workers in public and private health facilities on PMTCT (4 per facility):	#of health workers	11,559	4,108	4,078	3,780	Ministry of Health, Regional Health Bureaus
			Procure and distribute PMTCT drugs for mothers:	# of Mothers	15,011	30,955	48,781	72,167	Ministry of Health/PASS

Figure 2.2: Plan of Action Matrix by Programme Areas

continued...

Programme Area	Objectives And Programme Targets	Strategies	Selected Key Activity Targets	Unit Of	2007/08	2008/09	2009/10	2010/11	Lead Institutions
TB/HIV Prevention and Treatment	Objective: Increase the number of patients accessing HIV and TB related services	i) Mainstreaming TB/HIV communication and social mobilization in the TB communication activities ii) Incorporating TB/HIV in the pre-service curricula of health care providers	Strengthen public ART centers and DOTS centers for HIV/TB prevention and treatment with HIV/TB diagnostic and treatment equipment and supplies	# of centers	1,485	572	574	532	Ministry of Health, Regional Health Bureaus
			Provide in-service training to 5 health workers from each public and private ART centers on the provision of TB/HIV services	# of health Workers	2,847	1,697	975	953	Ministry of Health, Regional Health Bureaus
			Procure and supply TB drugs to HFs	# of people served	14,100	34,350	47,900	52,000	Ministry of Health/PASS
Antiretroviral Therapy (ART) Service	Objective: To provide ART services to 100% of the eligible HIV positive population	Expand public and private sector health facilities and integrate ART services into these HFs	Establish ART services in public health facilities	# of HFs	328	328	189	185	FMOH, RHBs
			Establish ART services in private health facilities	# of HFs	46	36	15	14	RHBs, MAPP
			Procure and distribute adult ARV drugs to HFs	# of Drugs	140,000	208,000	305,000	397,000	FMOH/PASS
Comprehensive Palliative Care	Objective: To improve the quality of life of PLHIV by providing palliative care to those who need it	integrate the service with ART and HBC services	Strengthen referral linkage between health facility-based palliative care and community-based palliative care services	# of activities	-	1	1	1	FMOH, RHBs

Figure 2.2: Plan of Action Matrix by Programme Areas

continued...

Programme Area	Objectives And Programme Targets	Strategies	Selected Key Activity Targets	Unit Of	2007/08	2008/09	2009/10	2010/11	Lead Institutions
Care and Support	Objectives: i) To improve the quality of life of PLHIV, and OVC and reduce vulnerability	Promote care within the family and mobilize the community to address and accommodate the needs of PLHIV/ OVC through traditional and extended family mechanisms, provide counseling services, legal advice and protection to PLHIV, provide access to basic health, education and other social services to PLHIV and OVC.	Provision of support for OVC						WEO, NGOs, FBOs, CBOs
			• Psychosocial		504,000	1,008,000	1,344,000	1,680,000	
			• Educational		504,000	1,008,000	1,344,000	1,680,000	
			• Food & shelter		151,200	302,400	403,200	504,000	
			• IGA		20,160	40,320	53,760	67,200	
			Provision of support for PLHIV						Volunteers, NGOs, FBOs
			• Psychosocial		120,000	220,000	400,000	560,000	
			• Food & shelter		52,800	96,800	176,000	246,000	
			• IGA		12,000	22,000	40,000	56,000	
			Provide financial assistance to the selected vulnerable women for income generating activities	# of Women	16,895	22,526	33,789	39,420	WACs, WLSAO, NGOs, CSOs, FBOS
Leadership and mainstreaming	Objectives: i) To ensure that leadership at all levels sustain HIV/AIDS as a priority development and emergency agenda. ii)To ensure that 100% of institutions (public, private and civil society) operationalize workplace policies and programmes and allocate 2% of their budget for HIV/AIDS	Ensure that institutional leaders lead and manage the implementation of workplace interventions and external mainstreaming of HIV/AIDS	Train HIV/AIDS focal persons for mainstreaming at Woreda, region and federal level:	# of trainees	4,592				HAPCO, RHAPCOs

Figure 2.2: Plan of Action Matrix by Programme Areas

continued...

Programme Area	Objectives And Programme Targets	Strategies	Selected Key Activity Targets	Unit Of	2007/08	2008/09	2009/10	2010/11	Lead Institutions
			Ensure that public and private sectors at federal and regional levels have allocated 2% of their budget to HIV/AIDS workplace interventions preventions; have developed guidelines for use of fund; and have subsequently started using funds:	# of public and private sectors	-	382	392	392	All public sector ministries, Private sectors, Partnership Forum
Coordination and Networking	Objective: To ensure synergy of HIV/AIDS programmes and efficient use of resources among different implementers	Promote decentralized decision making, develop and disseminate networking guidelines and directories, ensure timely and regular review and follow up mechanisms by HIV/AIDS councils and communities at different levels, create consultation and partnership forums	Establish/strengthen partnership and consultation forums at national (1), regional (11) and Woreda (700) levels- 3 partnership forums per level	# of Forums	3	33	2,100	-	HAPCO, RHAPCOs, Partnership Forums
			Institutionalize participatory planning (one plan, one budget and one M&E system) at national, regional and Woreda levels	# of annual plans	2,136	2,136	2,136	2,136	HAPCOs, Partnership Forums

Figure 2.2: Plan of Action Matrix by Programme Areas

2.4. Monitoring and Evaluation

Monitoring and evaluation (M&E) is an integral part of the implementation of the Plan of Action throughout its four-year time span. Routine monitoring will be conducted by the individual implementing organizations, while overall coordination and monitoring will be assumed by federal HAPCO and its regional offices. Building the M&E capacity of HAPCO at the various levels is given particular attention within this plan to ensure successful monitoring and reporting.

The cost of routine monitoring is built into each programme and is calculated at 5% of the total budget for the specific programme area. In addition to this, the cost of stand-alone M&E activities (e.g. operationalization of the national M&E framework, conducting national surveys) is planned and costed separately and amounts to 3% of the overall budget. The total cost of M&E is therefore estimated to be around 8% of the total budget.

The main progress monitoring mechanism for the plan will be a joint annual review and planning process, which will be held at the end of each Ethiopian fiscal year with the involvement of public, private, and civil society sectors, as well as the donor community and the United Nations. In addition, HAPCO will develop yearly M&E plans that are coordinated and synchronized with surveillance and research. The M&E plan together with the annual review meeting will serve as a basis of an annual M&E report on the implementation status of the plan, as well as major input to annual operational planning for the AIDS response.

Evaluation of the entire Plan of Action shall be done in its final year, based on epidemiological and sociological surveys, as well as programmatic and financial reports to measure the impact and outcome of the supported activities/interventions according to the initial (baseline) process and target indicators.

CHAPTER 3:
Costing of the Plan of Action

3.1. The Rationale and Approach to Costing

The Plan of Action provides a comprehensive, multisectoral picture of planned AIDS interventions as well as annual targets. A costing of the national AIDS response was also included to project resource needs (internally and externally), identify gaps, guide resource mobilization and support informed decision-making and evidence-based resource allocation during implementation of the Plan of Action. The results of the costing may also serve as the basis for a rolling (five-year) national budget for AIDS.

In order to meet the above objectives during the entire timeframe of the Plan of Action, this costing and the closely related gap analysis exercise should be reviewed and updated annually.

3.1.1. Methodology

An approach combining "participatory planning" and an "activity-based costing approach" was chosen to maximize the accuracy of the costing within the following challenges and constraints:

- The need to develop an ambitious and complex multisectoral national plan (as opposed to a health sector plan);
- A time horizon that would not go beyond 2012, i.e. five years from now;
- Limited time and available resources to conduct and finalize this exercise; and
- The need to develop a simple, sustainable, transparent, and flexible tool.

3.1.2. Documentation Phase

The costing exercise started with a documentation phase aimed at reviewing the general context of AIDS in Ethiopia, national priorities and strategies implemented in the fight against the disease, at identifying programmatic and financial data availability, and at defining the general approach and methodology.

Specifically, this documentation phase included:

- A comprehensive review of key strategic and operational documents guiding the multisectoral AIDS response in Ethiopia:
- An analysis of existing linkages and/or discrepancies between strategic and operational documents (e.g. due to different time horizons or approaches);
- A preliminary analysis of committed funds, work plans and financial documents;
- A critical review of existing costing models and methodologies.

3.1.3. Framework and Foundation Setting

Parallel to this background research, several harmonization, coordinating, and synchronizing meetings took place with key stakeholders/teams engaged in recent or on-going planning and costing exercises A harmonized planning and costing template was then developed defining key programmatic and crosscutting areas, but also linking costs, activities and related annual targets with national Universal Access targets.

3.1.4. Costing

Strategies used to estimate related unit costs varied. In general, an activity-based, bottom-up approach was used; it consists in identifying key components and/or steps for each activity, and then to apply related estimated costs. This exercise involved many stakeholders and experts coming from the public sector, nongovernmental organizations and civil society representatives. Alternatively, existing budget figures (e.g. for health infrastructure and equipment costs) or recent quantification exercises (e.g. for drugs and commodities) were used. In some cases, estimations produced by individual programmes or partners (e.g. for blood transfusion or procurement and supply of condoms) were adopted. Some "soft" items (e.g. related to some of the crosscutting activities) were discussed with respective programme managers and/or finance officers. Costs were grouped as follows:

- Infrastructure and equipment costs
- Human resource and training costs
- Drugs and commodities
- Other costs (included communication material, development and dissemination of guidelines or tools, IT material and office supply, national overheads, monitoring/field visits, surveys, meetings, etc.)

The cost estimates generated can be qualified as 'need-based', in the sense that they assume proper implementation and management of activities according to Ethiopian standards and guidelines. This means that they are not necessarily a simple extrapolation of current practice or observed spending of the past.

All costs are expressed in Ethiopian Birr (at the rate of 8.7 Birr per US dollar).

3.1.5. Key Assumptions

It should however be emphasized that the costing exercise was based on some critical assumptions, including:

- Universal Access targets will be reached by 2010;
- Financial needs will be met by national and external sources.

3.2. Projected Financial Needs (2007-2012)

The main findings of the costing exercise are presented in this section. For the six-year period 2006-2012, total estimated financial needs to fight AIDS in Ethiopia are estimated at 34.2 billion Birr (US$ 3.9 billion), including 5.6 billion Birr for prevention, 8.5 billion Birr for treatment and 14.2 billion for care and support (Figure 3.1). Main cost drivers are the care and support (42% of total costs) and treatment (25%) areas. The ART programme, on its own, represents 24% (i.e. 8.2 billion Birr) of the total. After ART, PLHIV and OVC programmes are the main cost drivers.

	Programme Area	In Birr	In %
Prevention	Condom	1 603 512 000	5%
	HCT	1 476 268 066	4%
	Blood Safety	48 307 000	0%
	PMTCT	2 381 349 652	7%
	STI	102 869 102	0%
	Other	24 225 000	0%
	SUB-TOTAL Prevention	**5 636 530 820**	**16%**
Treatment	ART	8 241 500 563	24%
	Other	300 911 199	1%
	SUB-TOTAL Treatment	**8 542 411 762**	**25%**
Care and Support	OVC	7 028 191 800	21%
	PLHIV	7 194 752 500	21%
	Other	9 920 000	0%
	SUB-TOTAL Care and Support	**14 232 864 300**	**42%**
Other	Capacity building	156 876 300	0%
	Social Mobilization	2 111 331 925	6%
	Leadership and Main.	410 719 477	1%
	Coordinating and Networking	458 430 000	1%
	M and E	955 938 940	3%
	Programme Management	272 381 600	1%
	Other	1 406 715 607	4%
	SUB-TOTAL Other	**5 772 393 849**	**17%**
	GRAND TOTAL (in Birr)	**34 184 200 732**	**100%**

Figure 3.1: Estimated Financial Needs (2006-2012), by key programme (in ETB)

Figure 3.2 presents financial needs estimates, by year and by programme. Financial needs for the current year (2006/2007) are estimated at 3 billion Birr. As illustrated in the table, annual financial needs are expected to increase and reach almost 7 billion Birr (US$ 764 million) by 2009/2010. This increase is mainly due to the scaling up of activities (to reach the Universal Access targets by 2010) and the increasing number of people being served (e.g. people receiving ART, PLHIV and OVCs receiving care and support). In 2010/2011, a small decrease is observed as investment costs go down; however, this decrease is quickly counter-balanced as the number of people served continue to increase and the total financial needs establishes at 7.4 billion Birr in 2011/2012.

		BASELINE	PLANNED					TOTAL (5 years)
		2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2007/12
Prevention	Condom	170 056 000	245 071 000	326 150 000	363 425 000	246 330 000	252 480 000	1 433 456 000
	HCT	227 360 558	263 850 602	338 127 254	382 510 476	131 907 088	132 512 088	1 248 907 508
	Blood Safety	7 953 550	9 071 400	12 407 100	14 074 950	2 400 000	2 400 000	40 353 450
	PMTCT	181 424 623	316 901 775	398 188 873	471 971 130	502 155 348	510 707 903	2 199 925 029
	STI	3 925 440	14 210 018	17 411 886	21 846 963	22 483 840	22 990 955	98 943 662
	Other (AB, PEP ...)	0	11 245 000	3 245 000	3 245 000	3 245 000	3 245 000	24 225 000
	SUB-TOTAL Prevention	**590 720 172**	**860 349 796**	**1 095 530 113**	**1 257 073 518**	**908 521 276**	**924 335 946**	**5 045 810 649**
Treatment	ART (incl. OI)	728 139 576	888 478 795	1 176 084 324	1 560 784 834	1 783 645 029	2 104 368 006	7 513 360 988
	Other (TB/ HIV...)	22 981 473	54 422 014	76 299 593	82 949 919	28 540 350	35 717 850	277 929 726
	SUB-TOTAL Treatment	**751 121 048**	**942 900 809**	**1 252 383 917**	**1 643 734 753**	**1 812 185 379**	**2 140 085 856**	**7 791 290 714**
Care and Support	OVC	441 504 000	883 008 000	1 177 344 000	1 471 680 000	1 508 472 000	1 546 183 800	6 586 687 800
	PLHIV	340 120 000	635 066 250	1 122 476 250	1 549 110 000	1 685 720 000	1 862 260 000	6 854 632 500
	Other (Palliative C...)	1 194 000	3 204 000	2 812 000	2 710 000	0	0	8 726 000
	SUB-TOTAL Care & Support	**782 818 000**	**1 521 278 250**	**2 302 632 250**	**3 023 500 000**	**3 194 192 000**	**3 408 443 800**	**13 450 046 300**
Other	Capacity building	64 077 796	61 194 304	11 338 200	8 962 000	5 652 000	5 652 000	92 798 504
	Social Mobilization	241 346 227	380 163 958	332 451 637	310 276 743	253 221 000	593 872 360	1 869 985 699
	Leadership and Main.	107 237 477	110 310 000	48 428 000	48 248 000	48 248 000	48 248 000	303 482 000
	Coordinating and Networking	68 255 000	68 555 000	119 680 000	67 380 000	67 180 000	67 380 000	390 175 000
	MandE	102 188 660	164 819 795	202 346 871	185 298 628	159 455 994	141 828 994	853 750 280
	Programme Management	14 284 960	31 828 800	47 717 440	59 516 800	59 516 800	59 516 800	258 096 640
	Health System Strengthening	331 882 234	305 791 305	332 349 145	332 292 922	52 200 000	52 200 000	1 074 833 373
	SUB-TOTAL Other	**929 272 354**	**1 122 663 162**	**1 094 311 293**	**1 011 975 094**	**645 473 794**	**968 698 154**	**4 843 121 495**
	GRAND TOTAL (in ETB)	**3 053 931 574**	**4 447 192 017**	**5 744 857 572**	**6 936 283 365**	**6 560 372 448**	**7 441 563 756**	**31 130 269 158**

Figure 3.2: Current and Projected Financial Needs by key programme and crosscutting areas and by year (2006-2012) (in ETB)

Evolution of annual financial needs is also illustrated in Figure 3.3 below:

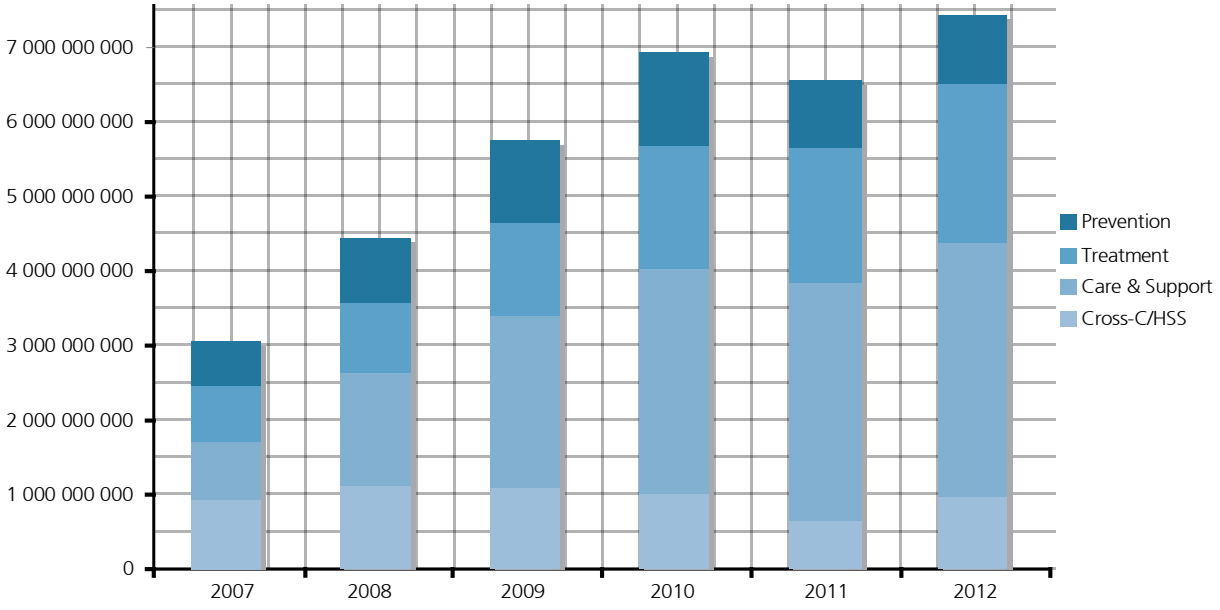

Figure 3.3: Estimated Financial Needs by key area and by year (in ETB)

CHAPTER 4:
Mapping of Existing Resources and Gap Analysis

A mapping of available/committed resources to the national AIDS response was undertaken and compared to the resource needs estimated by the costing exercise. This produced an analysis of the financial gaps that must be filled to meet Ethiopia's Universal Access targets.

4.1. Constraints

Prior to starting the mapping exercise, consultative meetings were held with key donors/partners, including HAPCO Finance department, Global Fund Primary Recipients, PEPFAR, CDC, USAID, UN organizations and the World Bank. Available work plans and budgets were collected and reviewed as well. The consultative meetings showed that mapping of projected and/or planned activities by donors and partners would not be possible in the allocated timeframe, and that provision of budget breakdown beyond programme area would create some challenges as well. The reason is that most donors allocate lump sum budgets to implementing partners, which are not required to report such type of information routinely.

The lack of budget breakdown raised another challenge: most of the international donors' financial system cannot distinguish funds specifically allocated to field programmes and/or supporting activities (i.e. activities included in the Plan of Action and quantified in the costing exercise) from those allocated to domestic and/or foreign implementing organizations to cover their overheads, salaries or to provide high-level, often donor-driven, technical assistance or field supervision. This spending contributes significantly to the fight against AIDS in Ethiopia, but it was not included in the costing exercise or the Plan of Action.

However, not addressing this issue would have had dramatic consequences for the financial gap analysis, as mapped funds committed by partners largely overestimate funds available for operations and activities listed in the national plan. Indeed, preliminary research (e.g. literature review, internet search, discussions with some partners) suggested that these overheads and type of technical and scientific assistance can typically absorb between 20% and 50% of total budgets. A programmatic gap analysis would have avoided the issue, but as mentioned before, could not be implemented in the allocated timeframe. Therefore, after extensive discussions with different partners, it was decided to apply some (partner-specific) corrective factors to committed total budgets. This important issue will need to be addressed in a more satisfactory way before the next annual budget review.

The following corrective factors were applied:

- Global Fund grants, government resources, FBOs: None (as total amounts are available to implement activities listed in the Plan of Action);
- PEPFAR: 45% of total budgets were subtracted to account for estimated international overheads and technical assistance/donor-driven supervision visits;
- Other external partners: 20% of total budgets were subtracted to account for estimated international overheads and technical assistance;

Another major difficulty in anticipating financial contributions by external donors (i.e. beyond 2008) is that most of them are committed on an annual basis (e.g. PEPFAR and most other bilateral organizations) with no assurance that next year's contribution will be of the same magnitude or will follow current trends.

4.2. Data Collection

The next phases of the mapping exercise included the development and dissemination of a standardized data collection form aimed at collecting annual projected resources up to 2012 sorted by programme and sub-programme areas and by budget categories. The data form was sent to all identified or potential donors in the country, including ministries, bilateral and multilateral organizations, NGOs and FBOs. Because of the time constraints and the need to implement different methodologies, some key financial contributors to the national AIDS response, e.g. the community (through out-of-pocket expenses or associations) and big companies (which sometime can provide health care services or coverage to their employees and their families) were not included in this exercise.

Total committed budgets by domestic and external partners are estimated at 6 billion Birr (US$684 million) for the six-year period (2006-2012). For 2006-2007, the committed funds reported by partners total 1.66 billion Birr. For

2007-2008, the projected amount committed by partners is 2.33 billion Birr (+41%). After 2007-2008, committed funds diminish quickly and only represent 57 million Birr by 2011-2012. Figure 4.1 breaks down these figures by programmatic area.

		BASELINE	PLANNED					TOTAL (5 years)
		2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2007/12
Prevention	Condom	N/A	71 241 255	4 517 040	4 517 040	0	0	80 275 335
	HCT	N/A	178 291 003	125 539 966	3 306 000	0	0	307 136 969
	Blood Safety	N/A	274 790 483	245 730 221	807 360	0	0	521 328 064
	PMTCT	N/A	56 233 380	22 767 415	0	0	0	79 000 796
	STI	N/A	83 293 767	105 043 767	0	0	0	188 337 534
	Other (AB, PEP ...)	N/A	121 028 873	60 086 327	60 086 327	45 397 247	25 163 077	311 761 849
	SUB-TOTAL Prevention		**784 878 760**	**563 684 737**	**68 716 727**	**45 397 247**	**25 163 077**	**1 487 840 547**
Treatment	ART	N/A	888 774 032	469 131 130	0	0	0	1 357 905 163
	Other (TB/ HIV...)	N/A	130 441 512	53 113 500	0	0	0	183 555 012
	SUB-TOTAL Treatment		**1 019 215 544**	**522 244 630**	**0**	**0**	**0**	**1 541 460 174**
Care and Support	OVC	N/A	113 045 282	20 000 000	20 000 000	20 000 000	20 000 000	193 045 282
	PLHIV	N/A	80 295 630	95 359 244	93 532 244	93 532 244	0	362 719 363
	Other (Palliative C...)	N/A	13 833 000	13 833 000	13 833 000	0	0	41 499 000
	SUB-TOTAL Care & Support		**207 173 912**	**129 192 244**	**127 365 244**	**113 532 244**	**20 000 000**	**597 263 645**
Other	Capacity building	N/A	73 384 958	59 519 197	8 686 080	0	0	141 590 235
	Social Mobilization	N/A	22 055 577	34 536 232	34 536 232	34 536 232	0	125 664 273
	Leadership & Main.	N/A	13 461 278	18 774 308	18 774 308	16 414 868	0	67 424 761
	Coordinating & Networking	N/A	31 409 395	15 441 644	11 634 046	11 959 968	12 557 967	83 003 021
	M&E	N/A	70 670 378	22 387 675	1 374 600	0	0	94 432 654
	Programme Management	N/A	1 941 283	1 941 283	0	0	0	3 882 566
	HSS & Other	N/A	108 258 204	20 288 400	19 766 400	0	0	148 313 004
	SUB-TOTAL Other		**321 181 075**	**172 888 738**	**94 771 666**	**62 911 068**	**12 557 967**	**664 310 514**
	GRAND TOTAL (in Birr)	**1 656 204 021**	**2 332 449 291**	**1 388 010 350**	**290 853 637**	**221 840 559**	**57 721 044**	**4 290 874 880**

Figure 4.1: Projected Financial Resources by key programmatic area and by year (in ETB)

The Global Fund and PEPFAR remain the main funding sources in Ethiopia for the implementation of the national AIDS response (i.e. 74% of total funds identified). However, the mapping exercise also confirmed the significant contribution of other external donors to the fight against AIDS in the country. These institutions include the World Bank, UN agencies like UNICEF, WHO, UNDP (identified under the joint UNDAF initiative), and bi-lateral organizations.

It should be mentioned that many partners and well-identified donors (domestic and external) did not participate to this mapping exercise, due to time constraints and difficulties in providing detailed budgets. The financial figures presented in Table 3 and 4 thus represent an underestimation of total committed funds. Sources of committed resources are summarized in Figure 4.2.

	BASELINE	PLANNED					TOTAL(5 years)
	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2007/12
DOMESTIC SOURCES							$0
Government	*N/A*	*10 331 470*	*10 848 044*	*11 390 446*	*11 959 968*	*12 557 967*	57 087 896
FBOs	*N/A*	*20 000 000*	*20 000 000*	*20 000 000*	*20 000 000*	*20 000 000*	100 000 000
Sub-Total	**N/A**	**30 331 470**	**30 848 044**	**31 390 446**	**31 959 968**	**32 557 967**	**157 087 896**
EXTERNAL SOURCES							0
Global Fund (R2 & R4)	*1 041 428 043*	*1 079 959 831*	*1 097 699 115*	*0*	*0*	*0*	2 177 658 946
PEPFAR	*526 603 380*	*987 256 057*	*0*	*0*	*0*	*0*	987 256 057
UNDAF	*88 172 598*	*126 445 056*	*164 717 514*	*164 717 514*	*164 717 514*	*0*	620 597 596
World Bank	*N/A*	*69 582 600*	*69 582 600*	*69 582 600*	*0*	*0*	208 747 800
SIDA	*N/A*	*25 163 077*	*25 163 077*	*25 163 077*	*25 163 077*	*25 163 077*	125 815 385
DFID	*N/A*	*13 711 200*	*0*	*0*	*0*	*0*	13 711 200
Sub-Total	**1 656 204 021**	**2 302 117 820**	**1 357 162 306**	**259 463 191**	**189 880 591**	**25 163 077**	**4 133 786 984**
TOTAL	**1 656 204 021**	**2 332 449 291**	**1 388 010 350**	**290 853 637**	**221 840 559**	**57 721 044**	**4 290 874 880**

Figure 4.2: Projected Financial Resources by source and by year (in ETB)

4.3. Financial Gap Analysis

Finally, the financial gap between needed and committed resources was calculated, for each of the programme/crosscutting area and for each year until 2012, by subtracting available/committed resources (mapping results) from the projected financial needs (costing exercise). Results of the financial gap analysis are presented in Figure 4.3.

Based on current cost estimations and available information, the overall financial gap (or unmet financial needs) can be estimated at 28.2 billion Birr (US$ 3.2 billion) for the six-year period 2006-2012. For the reasons explained before, this gap increases dramatically as we move towards 2012.

		BASELINE	PLANNED					TOTAL (5 years)
		2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	**2007/12**
Prevention	Condom	N/A	173 829 745	321 632 960	358 907 960	246 330 000	252 480 000	1 353 180 665
	HCT	N/A	85 559 600	212 587 287	379 204 476	131 907 088	132 512 088	941 770 539
	Blood Safety	N/A	-265 719 083	-233 323 121	13 267 590	2 400 000	2 400 000	-480 974 614
	PMTCT	N/A	260 668 395	375 421 458	471 971 130	502 155 348	510 707 903	2 120 924 233
	STI	N/A	-69 083 749	-87 631 881	21 846 963	22 483 840	22 990 955	-89 393 872
	Other (AB, PEP ...)	N/A	-109 783 873	-56 841 327	-56 841 327	-42 152 247	-21 918 077	-287 536 849
	SUB-TOTAL Prevention	N/A	75 471 036	531 845 376	1 188 356 792	863 124 029	899 172 869	**3 557 970 102**
Treatment	ART	N/A	-295 237	706 953 194	1 560 784 834	1 783 645 029	2 104 368 006	6 155 455 825
	Other (TB/ HIV...)	N/A	-76 019 498	23 186 093	82 949 919	28 540 350	35 717 850	94 374 714
	SUB-TOTAL Treatment	N/A	**-76 314 735**	**730 139 286**	**1 643 734 753**	**1 812 185 379**	**2 140 085 856**	**6 249 830 539**
Care and Support	OVC	N/A	769 962 718	1 157 344 000	1 451 680 000	1 488 472 000	1 526 183 800	6 393 642 518
	PLHIV	N/A	554 770 620	1 027 117 006	1 455 577 756	1 592 187 756	1 862 260 000	6 491 913 137
	Other (Palliative C...)	N/A	-10 629 000	-11 021 000	-11 123 000	0	0	-32 773 000
	SUB-TOTAL Care & Support	**N/A**	**1 314 104 338**	**2 173 440 006**	**2 896 134 756**	**3 080 659 756**	**3 388 443 800**	**12 852 782 655**
Other	Capacity building	N/A	-12 190 654	-48 180 997	275 920	5 652 000	5 652 000	-48 791 731
	Social Mobilization	N/A	358 108 381	297 915 405	275 740 512	218 684 768	593 872 360	1 744 321 425
	Leadership & Main.	N/A	96 848 722	29 653 692	29 473 692	31 833 132	48 248 000	236 057 239
	Coordinating & Networking	N/A	37 145 605	104 238 356	55 745 954	55 220 032	54 822 033	307 171 979
	M&E	N/A	94 149 416	179 959 195	183 924 028	159 455 994	141 828 994	759 317 627
	Programme Management	N/A	29 887 517	45 776 157	59 516 800	59 516 800	59 516 800	254 214 074
	Health System Str.	N/A	197 533 101	312 060 745	312 526 522	52 200 000	52 200 000	926 520 369
	SUB-TOTAL Other	**N/A**	**801 482 087**	**921 422 554**	**917 203 428**	**582 562 726**	**956 140 187**	**4 178 810 981**
	GRAND TOTAL (in Birr)		**2 114 742 726**	**4 356 847 222**	6 **645 429 728**	**6 338 531 889**	**7 383 842 712**	**26 839 394 278**

Figure 4.3: Financial Unmet Needs (to date) by source and by year (in ETB)

4.4. Challenges and Limitations

It is important to present the results of the costing exercise and the related financial gap analysis with several caveats:

- There are missing interventions and activities. For instance, plans of CBOs and FBOs private stakeholders (big companies), and the community were not fully captured, due to time limitations and resource constraints.
- Level of activity breakdown is not always consistent; some sub-programme and even programme areas are described in more details than others (e.g. Social Mobilization vs. HCT).
- Different approaches have been used to estimate unit costs. It is believed that possible over or under-estimation of these costs is either counter-balanced between each other or represents a non-significant deviation.
- Lack of budget breakdown for most stakeholders/donors. This limitation – already discussed above was addressed by subtracting estimated cost elements not included in the costing exercise (e.g. international overheads and technical assistance, donor's driven supervision visits).
- Oversimplification of the "unit cost" approach, as it is well known that some unit costs can vary dramatically by implementing partner or donor (e.g. cost of a PMTCT client in a government health facility as opposed to an internationally supported facility);
- Financial years vary across stakeholders (e.g. Ethiopian calendar/fiscal year, bilateral organization fiscal year, Global Fund budget years starting at the signature of grant agreements); reconciliation has been a challenge and could not always be addressed in a most satisfactory way.

THE WAY FORWARD

This Plan of Action is intended to serve as a common reference as stakeholders jointly plan and implement the AIDS responses and regularly review achievements against these targets.

Since the Plan of Action is based on the international commitment of moving towards universal access by 2010, the targets are ambitious and costs are high. A critical next step will be a prioritization exercise to determine which activities should be done first based on the available resources. The prioritization exercise will balance the components of a comprehensive response (prevention, treatment, care and support), as well as the resources expected to be mobilized within the country and abroad.

HAPCO will also coordinate a bottom-up approach of joint annual planning and review involving all stakeholders at each level (Kebele, Woreda, zonal, regional and federal level). All partners—government, nongovernmental organizations, civil society organizations, PLHIV associations, donor partners, the United Nations and targeted groups—are urged to participate in this joint annual planning and review process, which will review performance and resource mobilization efforts, and then update targets, priorities, costings and gap analyses accordingly.

A resource mobilization strategy will also be developed to facilitate the attainment of the universal access targets. The resource mobilization strategy will consider the following main categories:

1. **Government Contributions**: All form of government contributions at all level will be mapped, and a strategy will be developed on how these contributions will pave the way for the whole multisectoral response and effective resource utilization.
2. **Community Contributions:** The strategy will take into account a broad range of community responses in the areas of prevention, treatment, care and support and focus funding on the most effective roles communities can play.
3. **Institutional Contributions:** This includes resource mobilization from within government and private institutions through mainstreaming, the establishment of AIDS Funds, budget allocation and undertaking different HIV/AIDS activities integrating with their mandated business.
4. **Global Resources:** This will be the development of a resource mobilization strategy towards attaining universal access. The process includes alignment and harmonization of all efforts within the framework of the Three Ones principles to maximize the impact of donor-funded programmes.

CHAPTER 5:
Implementation Matrix

Plan of Action for the National Response to HIV/AIDS Prevention, Treatment, Care and Support by 2010

General: This multisectoral plan of action is to be implemented with the support of all stakeholders—government institutions, nongovernmental organizations, civil society organizations, the private sector and the donor community—at all levels, and in a coordinated manner. The lead institutions indicated in the matrix are responsible for facilitating the programmes or activities.

1. PROGRAMME: Social Mobilization

Objective: To i) intensify the comprehensive response against HIV/AIDS by creating comprehensive knowledge, shared sense of urgency, increased community ownership and involvement at the community level on a mass scale ii) increase the utilization of prevention, care and support and treatment services iii) Strengthen the comprehensive social and behavioural change responses to HIV.

Strategies: Ensure community participation and ownership of HIV/AIDS programmes, create a sense of urgency in all leaders and community organizations to take HIV/AIDS as a social and development agenda, reinforce relevant community bylaws and resolutions, ensure leadership commitment

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
1. Social Mobilization								
1.1 Public movement meeting to create awareness and sense of urgency in the general population	1.1.1 Prepare and distribute manual on public movement for facilitators and leaders	# of copies		75,000				HAPCO
	1.1.2Train trainers for public movement meeting facilitators at federal and regional levels.	# facilitators			200			HAPCO, RHAPCOs
	1.1.3 Train trainers for public movement meeting facilitators at Woreda level (700x3)	# facilitators			2,100			RHAPCOs
	1.1.4 Train public movement meeting facilitators at Kebele level. (15,000x4)	# facilitators			60,000			RHAPCOs, WACs
	1.1.5 Train public movement meeting facilitators at got/sub-Kebele level 15,000x8)	# facilitators			60,000	60,000		RHAPCOs, WACs
	1.1.6 Conduct public movement meeting at national level (1 per year for 2 days)	# meetings		1	1	1	1	HAPCO
	1.1.7 Conduct public movement meeting at regional level (1 per year for 2 days)	# meetings		11	11	11	11	RHAPCOs
	1.1.8 Conduct public movement meeting at Woreda level (1 per year for 2 days)	# meetings		700	700	700	700	RHAPCOs, WACs, NGOs

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
	1.1.9 Conduct public movement meeting at Kebele level (2 per year for 2 days)	# meetings		30,000	30,000	30,000	30,000	WACs, NGOs, CSOs, FBOs, HEWs, Schools
	1.1.10 Conduct public movement meeting at sub-Kebele level (2 per year for 2 days)	# meetings		240,000	240,00	240,000	240,000	WACs, NGOs, CSOs, FBOs, Schools
	1.1.11 Provide refresher training for facilitators	# facilitators					60,000	RHAPCOs, WACs
	1.1.12 Develop and disseminate to each Kebele copies of an operational manual/guideline on coordination and social mobilization (5x15,000)	# of copies of operational manual			75,000			Ditto
	1.1.13 Provide financial support to the establishment and activities of community media	# of Kebeles with media			7,500	7,500		RHAPCOs, WACs
	1.1.14 Undertake annual review meetings on public movement (1x15,000)				15,000	15,000	15,000	WACs, NGOs
1.2 Community Conversation at sub-Kebele level	1.2.1 Train trainers (TOT) for each Kebele for the mobilization and execution of community conversation (15,000x 4)	# of trainers persons trained			840	840	420	WACs, NGOs
	1.2.2 Train facilitators for each got (sub-Kebele) for conducting community conversation (15,000x 4 x 1)	# of facilitators trained			24,000	24,000	12,000	Ditto
	1.2.3 Grant to cohort CC participants to translate plans to action			100	300	500	500	Ditto
	1.2.4 Conduct 8 community conversation sessions per Kebele every 15 days for 10 months (15,000x8x20)	# of sessions			7,200,000			WACs, NGOs, FBOs, CSOs, Schools
	1.2.5 Conduct FTC HIV/AIDS sessions 15000x2	# of sessions			30,000	30,000	30,000	WACs, NGOs
	1.2.6 Support coordinated mass media campaign segmented by audience to raise awareness, raise public debate and reduce stigma and discrimination (24x11)	# of media spots		264	264	264	264	Ditto
	1.2.7 Prepare in local languages and distribute IEC materials to at least 60% of the 15-49 age group population (leaflets, posters, stickers etc.) that reach to support the community conversation. (77.0mx0.4x0.6)	# of copies of materials		550,0000	12,950,000			FMOH/HLMD
	1.2.8 Provide refresher training to CC facilitators	# of facilitators					60,000	WACs, NGOs
	1.2.9 Training of health workers on BCC	# HWs			3,300	1,200	1,700	RHBs, HFs

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
1.3 School-based interventions	1.3.1 Prepare and distribute school -based community conversation manual to primary and secondary schools, TVTs, colleges and universities (20630+918 +264+40) x2	# of copies of manuals		43,704				REBs, RHAPCOS
	1.3.2 Undertake master training of trainers (TOT) at federal and regional levels on CC (1+11) x10	# of trainees			120			FMOE
	1.3.3 Train TOTs for school-based community conversations on life skills and peer education in government primary and secondary schools (20630+918) x4	# of trainers			86,192			Ditto
	1.3.4 Conduct facilitators training on life skills in primary and secondary schools, TVETS (government and private), colleges and universities (20,630+918+264+40) x3	# of trainees			65,556			REBs, Private schools
	1.3.5 Conduct training of trainers (TOT) in each school, college and university on life skills and peer education (20,630+918+264+40) x4	# of trainees		21,852	65,556			Ditto
	1.3.6 Refresher training of teachers and students	# of teachers			6,057	12,114	12,114	Ditto
	1.3.7 Train school community conversation facilitators in CC life skills and peer education (469,000x2)	# of trainees		281,400	657,000			Ditto
	1.3.8 Prepare peer education kits (standard messages)	# of copies		315,000				FMOE
	1.3.9 Support peer education facilitators	# of peer facilitators		5,000	5,000	5,000	5,000	REBs
	1.3.10 Conduct orientation meeting for anti-AIDS club members	# of club members			100,000	100,000	50,000	REB, WEO
	1.3.11 Update, improve and print school life skills manual, teachers training manual, students hand book (50 copies per school)	# of copies				360,000		REB
	1.3.12 Develop and print visual aids	# of prints			120,000			REB
	1.3.13 Provide mini media materials for school anti-AIDS clubs	# of mini-media		150	150	200	200	REB, WEO
	1.3.14 Train AAC on club management and leadership (Community level)	# of trainees		600	4,500	4,500	4,500	WEO
	1.3.15 Establish multi purpose information canters at community level	# of centers		20	20	20	20	WACs

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
	1.3.16 Conduct community conversation sessions in each school, TVET, college and university classes (469,000x20)	# of sessions		1,407,000	1,876,000	2,814,000	3,283,000	WEOs, WACs
1.4 Reaching the window of hope in grade 5-8	1.4.1 Equip and supply HIV/AIDS coordinating units of the FMOE and REBs (1+11x 150,000 birr)	Millions of birr		540,00	1,260,000			Ditto
	1.4.2 Establish and strengthen information desks, A.A clubs, and mini media in each high school, by providing financial assistance of 30,000 birr per school (1224x30,000)	(# of schools)		919	92	101	112	Ditto
	1.4.3 Undertake TOTs in reproductive health and HIV/AIDS	# of trainers			2,100			REBs
	1.4.4 Train teachers in 5-8 grades on reproductive health and HIV/AIDS (2 per school)	# of schools			38,920	9318	11,180	REBs
	1.4.5 Provide essential IEC materials relevant to the window of hopes	# of copies			75,000			REBs
	1.4.6 Strengthen the institutional capacity of uniformed and prison services at federal and regional levels engaged in HIV/AIDS prevention in terms of office furniture, equipment and materials (4+11)	# of institutions		15				Prison Administration, Ministry of Defence
1.5 Voluntary anti AIDS promoters	1.5.1 Train trainers (TOT) for community anti-AIDS promoters (VCAP)			250				WACs, NGOS
	1.5.2 Train voluntary community ant-AIDS promoters (VCAP) for every 20 HHs in both rural and urban Kebeles	# of trainees		154,000	231,000	231,000	154,000	RHAPCOS, WACs, NGOs
	1.5.3 Distribute uniforms, caps, bags to VCAPs	# of t-shirts		770,000	770,000	770,000	770,000	RHAPCOs
	1.5.4 Undertake refresher training for VCAPs						231,000	Ditto
	1.5.5 Develop and distribute manual to VCAPS			154,000	231,000	231,000	154,000	RHAPCO
	1.5.6 Conduct house-to house sensitisation on HIV and AIDS.	# of households		2,310,000	3,080,000	4,620,000	5,390,000	WACs, CSOs, FBOs
	1.5.7 Production and distribution of reference material and IEC packs for VCAP. (770,000x6 pads)	# of pads of reference and IEC materials		115,500	154,000	231,000	269,500	HAPCO, RHAPCOs

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
1.6 Behavioral change among targeted vulnerable groups (CSWs, people with disability, vulnerable children, truck drivers)	1.6.1 Train peer educators from each targeted vulnerable groups and communities (CSWs, extension workers, people with disability, truck drivers, displaced people, vulnerable children)	# of peer educators trained		7,200	9,600	7,200		RHAPCOs, WSCs Partnership Forums
	1.6.2 Train peer educators from federal (4x5) and regional prisons 20+(11x5)	# of peer educators trained		75				HAPCO, RHAPCO
	1.6.3 Train educators for the uniformed service (1500) and police (1+11x12) +15000	# of educators trained		1,644				Ditto
	1.6.4 Provide these peer educators with teaching learning materials	# of copies of training materials			25,719			HAPCO
	1.6.5 Provide these peer educators with kit containing standardized messages and adapt them to local contexts (180,000+75+1644)x10	# of kits prepared			25,719			HAPCO
	1.6.6 Develop and disseminate to each Kebele copies of an operational manual/guideline on coordination and social mobilization (5x15,000)	# of copies of operational manual		75,000				Ditto
	1.6.7 Establish youth friendly canters in each Kebele (15000x1)	# of youth centers			5000	5,000	5,000	WLSAO, WACs, NGOs, CSOs, FBOs
1.7 Behavioral change communication out of school youth)	1.7.1 Conduct youth dialogue every month in each Kebele (15000x8x12)	# of dialogue sessions		3,600,000	3,600,000	3,600,000	3,600,000	Ditto
	1.7.2 Train and deploy in each Kebele 2 out of school youth peer educators (15000x2)	# of peer educators			30,000			Ditto
	1.7.3 Support publication of monthly newspapers to disseminate issues coming from dialogues and conversations	# of publications		120,000	120,000	120,000	120,000	Ditto
	1.7.4 Carry out life skills TOT	# of trainees		1,500	1,500	1,500	1,500	Ditto
	1.7.5 Build the capacity of Anti-AIDS/youth associations, clubs c/o provision of equipment and materials	# of associations		200	200	200	200	Ditto
	1.7.6 Support peer learning groups/resource teams	# of teams		50	50	50	50	Ditto
	1.7.7 Train life skills facilitators	# of trainees		1,500	1,500	1,500	1,500	Ditto
	1.7.8 Update and disseminate BCC tools & guidelines	# of copies			75,000			RHAPCOs
	1.7.9 Provide TOT on BCC	# of trainees				275	275	WACs, NGOs, CSOs, FBOs
	1.7.10 Prepare peer education manuals for	# of copies			10,000			RHAPCOs, NGOS

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
1.8 BCC among targeted vulnerable groups (police, soldiers, daily labourers and seasonal workers,	1.7.11 Undertake TOT for peer educators for each vulnerable group	# of trainers			200			RHAPCOS
	1.8.1 Train peer educators for daily labourers and seasonal workers	# of peer educators			5,000			WACs, NGOs
	1.8.2 Train peer educators among the police	# of peer educators			2,000			Ditto
	1.8.3 Train peer educators among soldiers	# of peer educators			3,500			Ditto
	1.8.4 Establish information centers in appropriate places the police (2000), military (3000), daily and seasonal workers (5000)	# of information centers			5,000	5,000		Ditto

2. PROGRAMME: Condom Use

Objective: To increase condom use among people aged 15-24 years reporting the use of condom during the last sexual intercourse with non regular partners to 60%

Strategies: Conduct aggressive social mobilization among the sexually active population (15-49) for behavioral change, make available condoms to the population free of charge or affordable price

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
TARGET: POPULATION USING CONDOM (IN MILLIONS)		**# of sexually active population**		**3,700,000**	**5,800,000**	**7,340,000**	**8,000,000**	
2. Condom Use								
2.1 Condom promotion	2.1.1 Conduct peer education sessions at national and regional levels on condom among special target groups (CSWs, long distance truck drivers, people in uniform, migratory workers, in school and out of school youth etc) (15,000x6x20)	# of peer educators		**270,000**	**360,000**	**540,000**	**630,000**	HAPCO, WACs, Vulnerable Groups Associations/ Partnership Forums
	2.1.2 Strengthen multiple media condom promotion at national, regional, and local, levels (TV, Radio, print media, billboards, etc…) (20% of total condom cost)	Amount of money in millions of birr		**37,900,000**	**58,000,000**	**73,400,000**	**80.000,000**	HAPCO, RHAPCOs FMOI, DKT, FGAE

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
2.2 Development of a comprehensive condom strategy	2.2.1 Conduct consultative workshops on the development of a strategy	# of workshops		2	2			FMOH, HAPCO
	2.2.2 Disseminate outcome of workshops	# outcomes			2			HAPCO
	2.2.3 Print and distribute dissemination materials	# of copies			5,000			Ditto
	2.2.4 Prepare and print reference material for public movement	# of copies		140,000				Ditto
	2.2.5 Prepare and print reference material for community conversations	# of copies		140,000				Ditto
	2.2.6 Conduct advocacy workshops for media professionals, community leaders and high officials	# of participants			3,000	4,000	2,500	HAPCO, MOI
2.3 Female condom promotion	2.3.1 Undertake media campaign on female condom	# of campaigns			2	2	2	HAPCO, MOI, DKT
2.4 Condom purchase	2.4.1 Procure female and male condoms (95% male and 5% female) in millions	# of condoms in millions	89,000,000	189,500,000	290,000,000	367,000,000	400,000,000	HAPCO, DKT, FGAE, PEPFAR
2.5 Condom distribution	2.5.1 Introduce community condom distribution outlets through associations, VCAPS, CC facilitators…. etc. (15,000Kebeles x 3 outlets)	# of outlets		6,750	9,000	13,500	15,750	HAPCO, WACs, Vulnerable Groups Associations/ Partnership Forums
	2.5.2 Strengthen and expand existing public condom outlets to full potential	# of existing outlets		2,343	3,123	4,685	5,466	RHAPCOs, WACs, DKT

3. PROGRAMME: HIV Counselling and Testing (HCT) Service

Objective: To increase number of people counselled and tested to 9.27 million

Strategies: Strengthen public and private institutions and integrate HCT services into these institutions, enhance community mobilization

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline (2005/06	2007/08	2008/09	2009/10	2010/11	
TARGETS: PEOPLE COUNSELED AND TESTED		**# of people**	**1,960,000**	**3,175,000**	**5,650,000**	**7,190,000**	**9,271,000**	
3. HCT Service								
3.1 Expansion of HCT centers	3.1.1 Establish HCT in public HFs	# of HFs	899	866	572	574	532	FMOH/PASS, RHBs
	3.1.2 Establish HCT in private HFs	# of HFs	140	255	248	275	196	Ditto
3.2 1Establish/promote HCT at the community level	3.2.1 Train community counsellors	# of counselors		700	750	800	850	RHAPCO
	3.2.2 Develop and disseminate educational and communication materials on HCT	# of copies			330,000	420,000	500,000	FMOH, HAPCO
	3.2.3 Establish/strengthen referral linkages between community and health institutions	# actions			1	1	1	1
3.3 Training of health workers	3.3.1 Train HWs in public HFs on HCT (2 per facility)	# of HWs trained		5,196	3,432	3,444	3,192	FMOH, RHBs
	3.3.2 Train HWs in private HFs on HCT	# of HWs		510	496	550	392	Ditto
3.4 Procurement and distribution of HCT kits	3.4.1 Procure and distribute HCT kits	# of HCT kits		3,175,154	5,650,216	7,190,418	9,271,195	Ditto

4. PROGRAMME: Sexually Transmitted Infection (STI) Syndromic Management

Objective: Reduce vulnerability to HIV infection

Strategies: Strengthen public and private institutions and integrate STI syndromic management

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
TARGETS: STI CASES RECEIVING COMPRHENSIVE SERVICES		**# of STI cases**		**470,000**	**827,000**		**1,500,000**	**1,200,000**
4. STI Syndromic Management								
4.1 Expansion of STI services in HFs	4.1.1 Strengthen private health facilities	# of HF with capacity to provide syndromc mgt	**140**	**255**	**248**	**275**	**196**	Ditto
	4.1.2 Reprint and disseminate STI guidelines to public (3303) and private (1578) health facilities (4881x2)	# of copies of guidelines	**1**		**9,762**			FMOH
4.2 Training of health workers	4.2.1 Train nurses from public HFs on the syndromic management of STI (4881x2)	# of HWs trained			**4,314**	**1,722**	**1,596**	FMOH, RHBs
	4.2.2 Train nurses from private HFs on the syndromic management of STI	# of HWs trained			**1,509**	**825**	**588**	Ditto
4.3 Communication on STI	4.3.1 Develop and disseminate educational and communication materials on STI	# of copies			**330,000**	**420,000**	**500,000**	HAPCO
4.4 Procurement and supply of drugs	4.4.1 Procure and distribute STI drugs	# of people treated		**470,000**	**827,000**	**1,200,000**	**1,500,000**	FMOH/PASS

5. PROGRAMME: Post-Exposure Prophylaxis

Objective: To prevent HIV infection due to exposure to infected blood and contaminated materials and equipment

Strategies: Create awareness on occupational hazards and provide post-exposure prophylaxis to HIV infection

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
5.1 Expansion of Post Exposure Prophylaxis (PEP) services	5.1.1 Develop and disseminate national PEP implementation guidelines	# of guidelines			**1**			FMOH
	5.1.2 Train health workers (service providers) on PEP	# of trainees			**1,000**	**1,000**	**1,000**	Ditto
	5.1. 3 Provide ART drugs for PEP	# of people treated			**2,000**	**2,000**	**2,000**	FMOH/PASS

6. PROGRAMME: Prevention of Mother to Child Transmission (PMTCT) Service

Objective: To increase the percentage of HIV positive pregnant women receiving complete course of ART to 80%

Strategies: Integrate PMTC services in both public and private health institutions

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Units of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
TARGETS: HIV + PREGNANT WOMEN RECEIVEING PMTCT SERVICES		**# of women**	**-**	**15,011**	**30,955**	**48,781**	**72,167**	
6. PMTCT Service								
6.1 HF expansion	6.1.1 Establish PMTCT centers in hospitals, HCs and HPs (public)	# of PMTCT centers	390	1,235	572	574	532	FMOH, RHBs,
	6.1.2 Establish PMTCT centers in hospitals, HCs and HPs (private)	# of PMTCT centers		46	26	15	14	FMOH, RHBs, MAPP
	6.1.3 Involve NGOs in PMTCT activities	# of NGOs			165			RHBs
6.2 Training of health workers	6.2.1 Train TOTs on PMTCT	# of TOTs		172				FMOH, RHBs
	6.2.2 Train health workers in public HFs on PMTCT (4 per facility	# of HWs		11,375	4,004	4,018	3,724	Ditto
	6.2.3 Train HWs in private HFs (4 per facility)	# of HWs		184	104	60	56	Ditto
	6.2.4 Train regional PMTCT coordinators 1/region	# of coordinators		11				FMOH
	6.2.5 Recruit, train and employ social workers (2/region)	# of SWs			44			HAPCO
	6.2.6 Provide pre-service training to HEWs on PMTCT (before graduation)			8,125	8,125			Ditto
6.3 Procurement and supply of drugs and supplies	6.3.1 Procure and distribute PMTCT drugs for mothers	# of drugs		15,011	30,955	48,781	72,167	FMOH/PASS
	6.3.2 Procure and supply PMTCT test kits (mothers)	Birr			1,910,000	2,581,000	3,341,000	Ditto
	6.3.3 Procure and distribute test kits (children)	Kits		15,011	30,955	48,781	72,167	Ditto
	6.3.4 Procure and distribute PMTCT supplies to HFs	HFs		1,671	2,269	2,858	3,404	FMOH/PASS
6.4 Promotion/establishment of PMTCT at community level	6.4.1 Provide nutrition support to mothers and children	Mothers		15,011	30,955	48,781	72,167	HFs

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Units of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
	6.4.2 Provide supportive supervision to community workers (HEWs, TBAs, CHWs etc) engaged in the promotion, refereal and follow up of PMTCT services	# of community HWs			2,000	2,000	2,000	RHBs
	6.4.3 Undertake skills reinforcement training to existing community level HWs (CHWs, TBAs, etc)	# of trainees			1,700	1,700	1,700	FMOH, RHBs
	6.4.4 Undertake regular progress review meetings at national and regional levels	# of participants			200	200	200	FMOH, RHBs
6.5 Linking PMTCT with the community	6.5.1 Provide additional training to HEWs on PMTCT referral and other related services	# of training events			1	1	1	RHBs, HFs
6.6 BCC on PMTCT	6.6.1 Conduct BCC sessions on PMTCT at community levels 3x15,000	# of sessions			45,000	45,000	45,000	HFs
6.7 Conducting reviewing workshops	6.7.1 Organize and conduct workshops at national and regional levels to review progress and identify and learn lessons and practices	# of workshops			1	1	1	FMOH, HAPCO

7. PROGRAMME: Blood Safety

Objective: To expand blood bank services and to make blood transfusion and tissue transplants 100% safe

Strategies: Expand and strengthen blood banks in both public and private health institutions, establish a system of regular monitoring and supervision to ensure the quality of blood and tissue transplant services

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
TARGETS: PEOPLE RECEIVING BLOOD TRANSFUSION		**# of people**	**57,000**	**78,300**	**88,000**	**97,800**	**107,600**	
7. Blood Safety								
7.1 Safe blood	7.1.1 Provide existing blood banks with test kits, laboratory equipment and supplies	# of labs	12	12	12	12	12	FMOH,, ERCS
	7.1.2 Train the technical staff in the existing blood banks on blood safety and quality assurance	# of blood banks	12	12	12	12	12	Ditto

7.2 Universal precaution	7.2.1 Develop a national policy and guideline universal precaution and distribute to health institutions (5140x5).	# of copies		25,700				FMOH, ERCS
	7.2.2 Train health workers on universal precaution	# of HWs trained		5,004	6,671	10,006	11,676	FMOH
	7.2.3 Procure and distribute regularly to health facilities universal precaution supplies. (gloves, mask, detergents) (1x a year)	# of HFs that receive supplies		2,020	2,840	3,689	4,417	FMOH/PASS

8. PROGRAMME: TB/HIV Prevention and Treatment

Objective: To increase/scale up the number of patients accessing HIV and TB related services

Strategies: i) Mainstreaming TB/HIV communication and social mobilization in the TB communication activities ii) Incorporating TB/HIV in the pre-service curricula of health care providers

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
TARGET: NO. OF PPATIENTS SCREENED FOR TB					5,950,000	8,300,000	9,000,000	
TARGET: NO. OF TB PATIENTS SCREENED FOR HIV					450,000	387,000	270,000	
8. TB/HIV Prevention and Treatment								
8.1 HF expansion	8.1.1 Strengthen public ART centers and DOTS centers for HIV/TB prevention and treatment with HIV/TB diagnostic and treatment equipment and supplies	# of ART and DOTS centers	262	1,485	572	574	532	FMOH, RHBs
8.2 Guideline development	8.2.1 Prepare and institutionalize standardized guidelines for TB/HIV prevention, care, treatment and support services	# of copies of guidelines			25,700			FMOH
	8.2.2 Prepare and institutionalize standardized guidelines for linking TB clinics with VCT centers and VCT centers with TB clinics	# of copies of guidelines			25,700			FMOH
8.3 Training	8.3.1 Provide in-service training to 5 health workers from each public ART centers on the provision of TB/ HIV services (551x5), (329x5), (189x5), (185x5)	# of HWs		2,755	1,645	945	925	FMOH, RHBs

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
	8.3.2 Provide in-service training to 2 health workers from each private ART centers on the provision of TB/HIV services (46x2), (26x2) (15x2), (14x2)	# of HWs		92	52	30	28	Ditto
	8.3.3 Provide in service training to HWs on TB/HIV communication and social mobilization	# of HWs		5004	6671	10006	11676	RHBs
8.4 Procurement and distribution	8.4.1 Procure and supply TB drugs to HFs)	Drugs		14,100	34,350	47,900	52,000	FMOH/PASS
	8.4.2 Procure and supply IPT drugs	Drugs		33,000	80,100	111,700	121,200	

9. PROGRAMME: Antiretroviral Therapy (ART) Service

Objective: To provide ART services to 100% of the eligible HIV positive population

Strategies: Expand public and private sector health facilities and integrate ART services into these health facilities

PROGRAMMES AND SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
TARGETS 1: HIV POSITIVES RECEIVING ART (Public +private HFs)		# of PLWHA		140,000	208,000	305,000	397,000	
TARGETS 2: HIV POSITIVES RECEIVING ART IN PUBLIC HFs		# of PLWHA	69,000	137,200	201,500	293,500	380,000	
TARGETS 3: HIV POSITIVES RECEIVING ART IN PRIVATE HFs		# of PLWHA		2,800	6,600	11,500	17,000	
TARGETS 4: CHILDREN RECEIVING ART		# of children		5,400	10,500	17,800	26,300	
9. ART Service								
9.1 Expansion of HFs	9.1.1 Establish ART services in public health facilities	# of HF providing ART	233	328	328	189	185	FMOH, RHBs,
	9.1.2 Establish ART services in private health facilities	# of HF providing ART	10	46	36	15	14	RHBs, MAPP
	9.1.3 Establish ART services in existing NGO HFs	# of HF providing ART			165			RHBs
	9.1.4 Establish paediatrics ART in public HFs	# HF strengthened		295	277	266	376	Ditto
	9.1.5 Establish paediatrics ART in private HFs	# of HFs		46	26	15	14	FMOH, RHBs
	9.1.6 Train health workers in public and private health facilities on ART	# of HWs trained		1,194	710	408	398	FMOH, RHBs

PROGRAMMES AND SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
9.2 Laboratory strengthening	9.2.1 Establish and equip laboratories	# of labs		364	355	204	199	EHNRI
	9.2.2 Expand paediatrics HIV diagnostics in all public and private HFs		243	364	355	204	199	Ditto
	9.2.3. Supply laboratories with commodities	# of labs		1,625	2,197	2,771	3,303	Ditto
	9.2.4 Develop and distribute policy/QA protocol on rapid tests and others	# of policy			1			Ditto
9.3 Training	9.3.1 Train HWs in public HFs on ART, OI, IP (9 per facility)	# of HWs		2,952	2,961	1,701	1,665	Ditto
	9.3.2 Train HWs on pre-ART ART, OI and in private HFs	# of HWs		216	156	90	84	Ditto
	9.3.3 Train HWs at public sectors and laboratory workers in private HFs on quality assurance and success rate (6 per facility)	# of lab workers			156	90	84	Ditto
9.4 Procurement and supply of ART drugs	9.4.1 Procure and distribute adult ARV drugs to HFs	Drugs	?	140,000	208,000	305,000	397,000	FMOH/PASS
	9.4.2 Procure and distribute pediatric drugs to HFs	Drugs		5,400	10,500	17,800	26,300	Ditto
	9.4.3 Procure and distribute OI drugs	Drugs		220,000	220,245	361,281	528,657	Ditto

10. PROGRAMME: Comprehensive Palliative Care

Objective: To improve the quality of life of PLWHA by providing palliative care to those who need it.

Strategies: integrate the service with ART and HBC services

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
10. Palliative Care								
10.1 Increase access, coverage and integration	10.1.1 Undertake situation analysis and mapping of existing palliative care services	# of SA & mapping				1		FMOH
	10.1.2 Conduct national consultation, publication and dissemination of mapping document	# of consultations				1		Ditto
	10.1.3 Promote integration and linkage of clinical palliative services	# of promotions			1			Ditto
10.2 Capacity development of implementing partners	10.2.1 Train health professionals on palliative care	# of HWs		597	952	1,156	1,355	FMOH, RHBs
	10.2.2 Conduct local/inter country experience	# of visits			2	2	2	FMOH, HAPCO
	10.2.3 Develop capacity of NGOs and CBOs identified through the mapping	Birr			500,000			HAPCO, RHAPCOs
10.3 Advocacy for institutionalisation and integration of quality palliative care services	10.3.1 Promote integration of palliative care in public and private health training institutions through workshops	# of workshops			2			FMOH, RHBs
10.4 Palliative care guidelines, training manuals and services	10.4.1 Develop standard guidelines and support policy revision	# of guidelines developed			1			FMOH
	10.4.2 Develop training manual/modules and related packages	Ditto			1			Ditto
	10.4.3 Print and distribute guidelines	# of copies			25,000			Ditto
10.5 Promoting and expanding prevention, integrated palliative care services	10.5.1 Develop standardized basic care packages	Packages				1		Ditto
	10.5.2 Support the development of simplified tools for nutrition assessment and counseling	Tools				1		Ditto
	10.5.3 Print and distribute guidelines and tools	# of copies				25,000		Ditto

11. PROGRAMME: Care and Support

Objective: To i) improve the quality of life of PLWHA, and OVC ii) ii) provide support to OVC guardians, and iii) increase the current school attendance ratio among orphans to that of non-orphans (age 10-14) from 60% to 80%.

Strategies: Promote care within the family and mobilize the community to address and accommodate the use of PLWHA/OVC through traditional and extended family mechanisms, provide counseling services, legal advice and protection to PLWHA, provide access to basic health, education and other social services to PLWHA and OVC, provide vocational skills training and income generating opportunities to PLWHA and OVC, develop acceptable social security models towards the special needs of PLWHA and OVC, mobilize all stakeholders to address the needs of PLWHA and OVC in a sustainable manner, use extended family and traditional mechanisms for care and support of OVC, ensure that 30% of beneficiaries of care and support services are women and female children, ensure the involvement and participation of beneficiaries (PLWHA, OVC/guardians), communities etc.

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
TARGET: ORPHAN & VULNERABLE CHILDREN (OVC) RECEIVING CARE AND SUPPORT			165,000	504,000	1,008,000	1,344,000	1,680,000	
11.1 Care and Support to OVC								
11.1.1 Psychosocial and material support	11.1.1 Provide psychosocial and material support to all targeted OVC	# of OVC		504,000	1,008,000	1,344,000	1,680,000	BOE, WEO, NGOs, FBOs, CSOs
11.1.2 Food, shelter and material support	11.1.2.1 Provide food, shelter and material support to 30% of targeted OVC	# of OVC		151,200	302,400	403,200	504,000	WEO, NGOs, FBOs, CBOs
11.1.3 IGA support	11.1.3.1 Develop and distribute IGA guideline that ensures effectiveness of IGA	# of guidelines			1			HAPCO
	11.1.3.2 Provide training (4% OVC) on IGA activities and employment opportunities	# of OVC		20,160	40,320	53,760	67,2000	NGOs, FBOs
	11.1.3.3 Provide IGA support (4% OVC)	# of OVC		20,160	40,320	53,760	67,2000	NGOs, FBOs, medium and small enterprises
	11.1.3.4 Train associations involved in IGA on group management and conflict management	# of trainees from NGOs, FBOs and Associations			15,000			WACs, NGOs, FBOs-
11.1.4 Educational support	11.1.4.1 Provide educational material support	# of OVC		504,000	1,008,000	1,344,000	1,680,000	REB, WEOs, NGOS, FBOs
	11.1.4.2 Ensure the integration of life skills education	# of checks in the school system			1	1	1	REB

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
11.1.5 Community involvement	11.1.5.1 Mobilize communities to be involved in OVC care and support through their respective CBOs (idirs, Afochas etc.)	# of communities reached			15,000			WACs, NGOs
11.1.6 Protection of child rights and children headed households (15000x2)	11.1.6.1 Create awareness among Kebele elects on protection of child rights, children headed households and management of inheritance	# of Kebele leaders trained			10,000	10,000	10,000	RBJ, WACs
	11.1.6.2 Create awareness among selected children on protection of child rights, children headed households and management of inheritance (15,000x3 45,000)	# of children			15,000	15,000	15000	RBJ/WACs
TARGET: PEOPLE LIVING WITH HIV/AIDS (PLWHA) RECEIVING CARE AND SUPPORT SERVICES		**# of PLWHA**		**120,000**	**220,000**	**400,000**	**560,000**	
11.2 Care and Support to PLWHA								
11.2.1 Psychosocial and other supports	11.2.1.1 Provide psychosocial and other supports to PLWHA	# of PLWHA who received support		**120,000**	**220,000**	**400,000**	**560,000**	Volunteers, NGOs, FBOs
11.2.2 Food and housing support	11.2.2.1 Purchase and distribute prescribed food items to PLWHA (44% of target PLWHA)	# of PLWHA who received food		**52,800**	**96,800**	**176,000**	**246,000**	NGOs, FBOs, CSOs, PLWHA Associations/ networks
	11.2.2.2 Provide HBC to severely malnourished PLWHA and children (10% of target PLWHA)	# of PLWHA who received HBC		**12,000**	**22,000**	**40,000**	**56,000**	Ditto
	11.2.2.3 Provide training to PLWHA on income generating activities (IGA) and employment opportunities (10% of target PLWHA)	# of PLWHA trained		**12,000**	**22,000**	**40,000**	**56,000**	WLSAO, NGOs, FBOs PLWHA Associations/ networks, medium and small enterprises
	11.2.2.4 Provide IGA support to PLWHA (10% of target PLWHA)	# of PLWH A who received support		**12,000**	**22,000**	**40,000**	**56,000**	WLSAO, NGOs, FBOs PLWHA Associations
11.2.3 Policy and guideline on HBC for PLWHA and OVC	11.2.3.1 Develop and distribute IEC/BCC materials on HBC	# of copies	**1 (Devt.)**		**314,240**			Ditto

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
	11.2.3.2 Train volunteer care-givers from idirs, anti-AIDS clubs, women, youth and PLWHA associations on HBC and community-based care (palliative care, nutrition, adherence and psychosocial support) from each Kebele (15, 000x3)	# of volunteers			15,000	30,000		RHAPCOs, RLSABs
11.2.4 Training of volunteers	11.2.4.1 Train peer PLWHA on ART and adherence	# of PLWHA			1,500	1,500		RHBS
	10.2.4.2 Procure and distribute free essential kits for home-based nursing care (15, 000x3)	# of kits			45,000	45,000	45,000	WACs, NGOs, FBOs
11.2.5 Treatment, literacy and adherence	11.2.5.1 Provide HBC to bed ridden PLWHA	# of PLWHA		36,000	66,000	120,000	168,000	Ditto
	11.2.5.2 Train peer PLWHA volunteers in ART and adherence	# of trainees			1,500	1,500		Ditto
	11.2.5.3 Develop and distribute IEC/BCC materials	# of copies of materials	1		500,000			FMOH, HAPCO
	11.2.5.4 Establish support groups for PLWHA on pre-ART/ART	# of groups			200	250	300	NGOs, FBOs
	11.2.5.5 Develop a coordinated client follow up system	system developed			1			HFs, NGOs, FBOs
	11.2.5.6 Undertake evaluation on ART services	# of evaluations			1		1	
11.2.6 Protection of human rights	11.2.6.1 Integrate and enforce laws and policies that reduce stigma and discrimination on PLWHA into the existing legal and policy frameworks	# of laws& policies		1				FMOJ, Partnership Forums
	11.2.6.2 Train and assign paralegals to render advices on the rights of PLWHA associations at national and regional levels (federal 3 and region 11x2)	# of paralegals			25	25	25	MOJ, RBJ, HAPCO RHAPCO
	11.2.6.3 Train judges, social workers and educators etc. on the rights of PLWHA (federal (1x10), region (11x10), Woreda 700x3)	# of judges trained			1,220			Ditto
	11.2 6.4 Train PLWHA on human and constitutional rights in all regional levels (11x50)	# of PLWHA			550	550	550	RBJ

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
TARGET: VULNERABLE POOR WOMEN RECEIVING IGA SUPPORT		**# of women**	**112,630**	**16,895**	**22,526**	**33,789**	**39420**	
11.3 Care and Support to Vulnerable Poor Women								
11.3.1 Training	11.3.1.1 Train vulnerable women in income generating activities	# of trainees		**16,895**	**22,526**	**33,789**	**39420**	WACs, WLSAO, NGOs, CSOs, FBOS
11.3.2 Financial support	11.3.2.1 Provide financial assistance to the selected vulnerable women for income generating activities	# of poor women		**16,895**	**22,526**	**33,789**	**39420**	Ditto
11.4 Support to Poor Vulnerable Youth								
TARGET: VULNERABLE POOR OUT OF SCHOOL YOUTH RECEIVING IGA SUPPORT		**# of youth**		**51,300**	**68,400**	**102,600**	**119,700**	
11.4.1 Training	11.4.1.1 Train selected vulnerable poor out of school youth in income generating activities	# of trainees		**51,300**	**68,400**	**102,600**	**119,700**	Ditto
11.4.2. Financial support	11.4.2.1 Provide financial assistance to the selected vulnerable poor youth for income generating activities	# of youth		**51,300**	**68,400**	**102,600**	**119,700**	Ditto
TARGET: COMMERCEIL SEXWORKERS RECEIVING IGA SUPPORT		**# of commercial sex workers**	**50,000**	**7,500**	**10,000**	**15,000**	**17,500**	
11.5 Support to Commercial Sex Workers								
11.5.1 Training	11.5.1.1 Train selected vulnerable commercial sex workers in income generating activities	# of CSWs		**7,500**	**10,000**	**15,000**	**17,500**	Ditto
11.5.2 Financial support	11.5.2.1 Provide financial assistance to the selected commercial sex workers for income generating activities	# of CSWs		**7,500**	**10,000**	**15,000**	**17,500**	Ditto
TARGET: DISABLED POOR PEOPLE RECIVING IGA SUPPORT		**disabled people**	**105,340**	**15,801**	**21,068**	**31,602**	**36,869**	
11.6 Disabled Poor People								
11.6.1 Training		disabled people		**15,801**	**21,068**	**31,602**	**36,869**	Ditto
11.6.2 Financial support		disabled people		**15,801**	**21,068**	**31,602**	**36,869**	Ditto

12. PROGRAMME: Capacity Building

Objective: To i) increase primary health care service coverage from 72% to 100% and provide access to and optimal care and treatment to patients/ clients ii) integrate HIV/AIDS in curriculum at all levels (primary, secondary, tertiary schools) iii) ensure the execution capacity of communities and association leaders in effectively managing grassroots response

Strategies: Construct and upgrade health institutions, mainstream HIV/AIDS into education and include HIV/AIDS education in teaching curricula to bring behavioural change among in school youth and teachers, promote peer education, build the executive and managerial capacity of community association leaders, strengthen the capacity for coordination, M and E and resource mobilization at national and regional levels, promote the involvement of other sectors (agriculture, information, labour and social affairs, youth and sports affairs and women affairs) in HIV/AIDS prevention, strengthen partnership forums

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
TARGET: NUMBER OF HEALTH CENTERS			635	1,493	2,052	2,621	3,153	
TARGET: NUMBER OF HEALTH POSTS			4,264	5,874	8,021	11,242	15,000	
12. Capacity Building								
12.1 Health system	12.1.1 Upgrade health stations to HC level and equip them	# HSs upgraded	523	858	559	569	532	RHBs
	12.1.2 construct and equip new health centers	# of HC constructed	600	858	559	569	532	RHBs
	12.1.3 Construct and equip zonal hospitals	# of hospitals constructed	132		2			Ditto
	12.1.4 Construct and equip rural hospitals	# of hospitals constructed			5			RHBs
	12.1.5 Construct new health posts	# of HPs constructed	4,264	1,610	2,147	3,221	3,758	FMOH, RHBs
	12.1.6 Equip the new health posts	# of HPs equipped	4,264	1,610	2,147	3,221	3,758	FMOH, RHBs
12.2 Health workers training	12.2.1 Train and deploy health extension workers	# of HEWs trained	9,900	3,135	4,180	6,270	7,315	FMOH, RHBs, REBs
	12.2.2 Support the training of nurses and other health workers by providing material and financial assistance to training institutions	# of training institutions			25	25	25	FMOH, HAPCO RHAPCO, RHBs
12.3 Health learning material development	12.3.1 Strengthen the capacity of the Health Education and Health Extension Service Department (HLMD) of the FMOH in terms of financial and material and equipment for better preparation, production and distribution of print and electronic IEC/BCC materials on HIV/ AIDS	# of institutions strengthened			1			FMOH/HLMD

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
12.4 Community	12.4.1 Strengthen the management system for the health network system by providing training 2 managers from each health network entities (health stations(1206), health centers(635+2204), hospitals (86+7), Woreda offices (700), zonal depts. (77) regional bureaus (11), and the FMHO (1),	# of health network managers trained		1,117	1,489	2,233	2,605	FMOH, RHBs
	12.4.2 Define the roles, responsibilities and linkages between of all health entities at community, Woreda, zonal, regional and national levels, develop and distribute 5 copies of manual for each entity (3722x5)	# of manual that defines the roles and responsibilities			18,610			Ditto
	12.4.3 Strengthen the information network of all entities which includes the IT and communication systems by providing one IT equipment sets for each entity (2840+93+700+77+11+1=3722)	# of equipment sets			3722			Ditto
	12.4.4 Train women, youth, and PLWHA, religious, professional and traditional associations leaders at national, regional, Woreda and grassroots levels on the implementation of grassroots activities: (5x2)+(5x2x11)+ (5x2x700)+(5x2x15000)	# of association leaders trained		47,136	109,984			HAPCO, RHAPCO
12.5 Women, youth, PLWHA Associations and trade unions	12.5.1 Develop and disseminate operational guidelines/materials on grassroots level HIV/AIDS prevention, treatment, care and support activities for these leaders	# of copies of guidelines		47,136	109,984			HAPCO, RHAPCO
	12.5.2 Provide financial assistance to women, youth and PLWA associations/ networks, trade unions at national and regional levels for building their capacity in terms of office furniture and equipment (3x20,000) + (3x11x20,000)	# of associations/ networks			170	90	50	Ditto
	12.5.3 Assign project coordinators in these association offices (1x3x2)+(11x3x2)	# of coordinators		72	72	72	72	Ditto

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
	12.5.4 Train project coordinators in project management and financial skills				350	200	50	Ditto
	12.5.6 Provide the association offices with operational guidelines and other materials (36x15copies each)	# of copies of guidelines		540	540	540	540	Ditto
	12.5.7 Equip and supply the existing and newly opened PLWHA associations and their network offices	# of associations			170	90	50	Ditto
12.6 Education sector	12.6.1 Train HIV/AIDS coordinators in the education sector working at national (2), regional (11x2) and Woreda (2x700) levels to integrate, plan and coordinate HIV/AIDS programmes in the education sector	# of coordinators		427	997			FMOE, REBs

13. PROGRAMME: Leadership and Mainstreaming

Objective: i) To ensure that leadership at all levels sustain HIV/AIDS as a priority development and emergency agenda. ii)To ensure that 100% of institutions (public, private and civil society) operationalize workplace policies and programmes and allocate 2% of their budget for HIV/AIDS through the involvement of MOFED, BOFEDs and Partnership Forums.

Strategies: Ensure that institutional leaders lead and manage the implementation of workplace interventions and external mainstreaming of HIV/AIDS

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
13. Leadership and Mainstreaming								
13.1 Advocacy and advisory	13.1.1 Organize partnership/coalition forums (youth, women, religion leaders, PLWHA, business cooperatives at national, regional and Woreda levels and joint forums at national and regional levels (1+11)(1+11+700x5)+12)	# of forums organized		1,057	2,467			HAPCO, RHAPCO, WACs, Partnership Forums
	13.1.2 Conduct policy dialogue sessions at national (1) and regional (11) levels (1+11) x4	# of sessions		12	12	12	12	Ditto
13.2 Mainstreaming	13.2.1 Establish/strengthen the HIV/AIDS programme management and coordination units created in the 26 line ministries/agencies, 26 regional bureaus, and 80 public and private enterprises (26+26x11+80)	# of units established		1,192				Line ministries, regional bureaus, and public and private institutions, Partnership Forums

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
	13.2.2 Train HIV/AIDS focal persons for mainstreaming at Woreda, region and federal level. (26+26x11+80)	# of focal persons		4,592				HAPCO, RHAPCOs
	13.2.3 Promote the allocation of 2% of budget for HIV/AIDS by public and private sectors at national and regional levels (26+26x11+80)	# of public and private sectors		392				Ditto
	13.2.4 Ensure that public and private sectors at federal and regional levels have allocated 2% of their budget to HIV/AIDS workplace interventions preventions	# of sectors			382	392	392	MOFED, BOFED, Private Partnership Forum
	13.2.5 Ensure that all line ministries/agencies, regional bureaus, 700 Woredas, and enterprises develop and implement HIV/AIDS plans of action/ work plans (26+26x11+80) x4	# of plans of action		4,592	4,592	4,592	4,592	Ditto
	13.2.6 Mobilize media from the federal (4) and regional (4) levels and provide financial assistance 2x a year for the preparation and dissemination of information on prevention, treatment, care and support [(1x4)+(11x4) x36, 000 birrx4]	# of media		48	48	48	48	HAPCO, MOI, RHAPCOs, RBOI
	13.2.7 Ensure integration and management of HIV/AIDS activities in departments /work units	# of departments/ units		12				HAPCO, RHAPCs
	13.2.8 Update and disseminate mainstreaming guidelines	3 of copies				10,000		HAPCO
	13.2.9 Establish/strengthen follow up on AIDS funds (national, regional, private sector)	# of institutions			392			HAPCO, RHAPCOs
	13.2.10 Prepare and disseminate AIDS fund operationalization /management guidelines	# of copies			5000			HAPCO

14. PROGRAMME: Coordination and Networking

Objective: To ensure synergy of HIV/AIDS programmes and efficient use of resources among different implementers

Strategies: Promote decentralized decision making, develop and disseminate networking guidelines and directories, ensure timely and regular review and follow up mechanisms by HIV/AIDS councils and communities at different levels, create consultation and partnership forums

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
14. **Coordination and Networking**								
14.1 Strengthening HAPCOs	14.1.1 Review and update the coordination and networking functions and the human resource gaps of HAPCOs at national, regional and Woreda levels	# of reviews undertaken	?	1				HAPCO, RHAPCOs, Partnership Forums
	14.1.2 Strengthen the capacity of HAPCOs through recruitment and placement of professional staff and provision of office equipment and supplies at national, regional and Woreda levels [1x5+(11x3) +(700x2)]	# of professional staff placed	?		1,569			HAPCO, RHAPCOs
	14.1.3 Develop and implement networking guidelines	# of guidelines developed		1				HAPCO, Partnership Forums
	14.1.4 Organize and undertake joint study tours within and outside the country at least 2x a year to improve their coordination and networking functions	# of study tours undertaken	?	4	4	4	4	HAPCO, RHAPCOs, Partnership Forums
14.2 Strengthening HIV/ AIDS Councils	14.2.1 Strengthen HIV/AIDS councils at national, regional and Woreda levels by providing financial assistance	Birr		62,848	62,848	62,848	62,848	HAPCO
	14.2.2 Conduct capacity building sessions for HIV/AIDS Council members at federal, regional and Woreda levels (one per year)	# of sessions		712	712	712	712	HAPCO, RHAPCOs
14.3 Strengthening parliaments	14.3.1 Conduct capacity building sessions for parliamentarians (national and regional)	# of sessions		12	12	12	12	HAPCO, RHAPCO
14.4 Strengthening communities	14.4.1 Strengthen Kebele AIDS committees on thematic areas (3x15,000)	# of groups			45,000	45,000	45,000	WACs, NGOs, FBOs, CSOs, Kebele AIDS committees

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
14.5 Partnership strengthening	14.5.1 Establish/strengthen partnership and consultation forums at national (1), regional (11) and Woreda (700) levels- 3 partnership forums per level (1x3)+(11x3)+(700x3)	# of forums		3	33	2100		HAPCO, RHAPCOs, Partnership Forums
	14.5.2 Share information and reports timely and regularly and undertake annual reviews at national and regional levels with partners. (1+11x4x1=192)	# of annual reviews		48	48	48	48	FMOH, HAPCO, RHBs, REBs, RHAPCO, WACs
14.6 Planning, reporting and budgeting	14.6.1 Institutionalize participatory planning (one plan, one budget and one M and E system) at national, regional and Woreda levels (1+11+700x4 plans)	# of annual plans		2,136	2,136	2,136	2,136	HAPCOs, Partnership Forums
	14.6.2 Develop and adapt, a clear planning, budgeting and M and E guidelines and frameworks	# of copies of planning guidelines		1				HAPCO, Partnership Forums
	14.6.3 Conduct training for partners at national (1), regional (11) and Woreda (700) levels on one plan, one budget and one M and E system (1+11+700)	# of training workshops		2 at national and regional levels	11 at regional level for all Woredas			HAPCO

15. PROGRAMME: Programme Management and Resource Mobilization

Objective: To secure adequate resource from domestic and external sources for the implementation of the plan of action for the national response to HIV/AIDS prevention, treatment care and support

Strategies: Develop and use a resource mobilization strategy

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
15.1 Program Management								
	15.1.1 Recruit/retain program managers (national/ regional level)	# of trainees		20	27	31	39	HAPCO
	15.1.2 Recruit/retain program & finance officers (national/regional)	# of trainees		26	36	42	52	HAPCO
	15.1.3 Recruit/retain program & financial officers, support staff (Woreda level)	# of trainees		420	1,050	1,680	2,100	HAPCO
	15.1.4 Recruit/retrain support staff (national, regional level)	# of trainees		14	36	57	71	HAPCO

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
	15.1.5 Train programme managers, finance officers and support staff at national, regional and Woreda levels	# of trainees		480	1,149	1,810	2,262	HAPCO, RHAPCOs
	15.1.6 Provide IT equipment and supplies to national, regional and Woreda HAPCOs	# offices			712			Ditto
15.2 Resource Mobilization								
15.2.1 Capacity building	15.2.1.1 Establish resource mobilization offices/units within HAPCO and RHAPCOs	# of offices			12			HAPCO, RHAPCOs
	15.2.1.2 Train and assign at least 2 resource mobilization officers in each office/unit				24			Ditto
15.2.2 HAPCO management	15.2.2.1 Undertake supervision visits	# of supervisions			2	2	2	HAPCO, FMOE
	15.2.2.2 Provide IT computers and furniture for HAPCO	# of computers +furniture			2			HAPCO
15.2.3 Mapping	15.2.3.1 Undertake resource mapping and gap analysis for HIV/AIDS prevention, treatment, care and support	# of gap analysis made	1 (2007)	1	1	1	1	CCM/E, HAPCO
15.2.4 Strategy development	15.2.4.1 Develop a resource mobilization strategy for HIV/AIDS	# of strategies developed			1			CCM/E, HAPCO
15.2.5 Resource mobilization campaigns	15.2.5.1 Conduct resource mobilization campaign at national, regional and international levels	# of rounds of campaigns		2	2	2	2	CCM/E, HAPCO
15.2.6 Experience sharing	15.2.6.1 Organize and conduct resource mobilization experience sharing between the federal and regional HAPCOs	# of workshops			1	1	1	HAPCO

16. Programme: Monitoring and Evaluation (M and E)

Objective: To ensure efficient implementation and effective resource utilization

Strategies: Strengthen the capacity of efficient programme implementation and resource utilization monitoring and evaluation at national and regional levels, develop and use M and E systems, indicators and other tools,

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
16. Monitoring and Evaluation (M and E)								
16.1 Capacity building	16.1.1 Recruit and retain M and E officers (HAPCO=2, RHAPCO=22, and FMOH, FMOE, FMLSA, FMOYA, FMOARD, MOWA, Networks/ women, youth, PLWHA =one M and E officer for each	# of M and E officers	7	7	14	19	24	HAPCO, FMOH, FMLSA, FMOYA, FMOARD, MOWA, Networks
	16.1.2 Recruit and retain M and E facilitating officers at parliament, DPPC (federal and regional levels) and CRDA	# facilitators			25	25	25	HAPCO, parliament
	16.1.3 Recruit and retain M and E officers at regional HAPCOs level	M and E officers			20	39	39	RHAPCO
	16.1.4 Recruit and deploy M and E officers in zones (71x1				20	20	31	Zone desks
	16.1.5 Recruit and deploy M and E officers in WAC (700x1				200	200	300	WACs
	16.1.6 Recruit & retain data clerks (Woreda level)	# of trainees			150	450	700	RHAPCOs, RHBs
	16.1.7 Recruit & retrain data clerks (Health Centers)	# of trainees		0	430	430	430	Ditto
	16.1.8 Train regional trainers	# of trainees		0	38	0	0	Ditto
	16.1.9 Train data clerks	# of trainees		0	618	338	338	Ditto
	16.1.10 Provide training & refresher training to staff involved in M and E at national and regional levels	# of trainees		0	35	35	0	Ditto
	16.1.11 Recruit/retrain M and E officers (national/ regional level) MSc course	# of trainees			35	35	35	Ditto
16.2 IT supply office furniture	16.2.1 Provide IT equipment and office furniture to HAPCO, RHAPCO, RHB (1+11+11)	# of equipment and furniture		23	291	591	791	HAPCO, RHAPCOs, RHBs
	16.2.2 Develop website for all RHAPCOs and RHBs (11+11)	# of websites			11	11		HAPCO, RHAPCOs

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
	16.2.3 Connect HAPCO and RHAPCO with networks	Connection				1		HAPCO, RHAPCOs
	16.2.4 Establish data warehouses in HAPCO, RHAPCOs, RHBs	# of warehouse				12	11	HAPCO, RHAPCOs, RHBs
	16.2.5 Develop HIV/AIDS Research Directory with quarterly updates	# of directory			4	4	4	HAPCO
16.3 M and E system strengthening (mechanism, tools, formats, timing)	16.3.1 Review the existing M and E framework at national levels	# of frameworks reviewed			1			HAPCO, RHAPCOs, RHBs WACs
16.4 Additional capacity strengthening for non-health indicators	16.4.1 data collection systems established in MOE, MOWA, MOLSA, DACA, MOARD, MOD, Ministry of Transport and communication, Ministry of Trade, private sector (Chamber of Commerce, Employers federation), others	# of institutions with data collection systems established			6	4		HAPCO
	16.4.2 Undertake training and refresher training to staff involved in M and E in all sectors and at all levels (MOH, MOE, MOLSA, DACA, etc)	# of participants			80	80		HAPCO
	16.4.3 Develop, print and distribute data forms for social mobilization, education sector, OVC, HBC	Data forms developed and distributed			1			Ditto
16.5 Monitoring, reporting and reviewing	16.5.1 Conduct joint annual M and E field visits by national, to RHAPCOs and RHBs eda institutions	# of joint field visits		1	1	1	1	FMOH, HAPCO,
	16.5.2 Conduct joint bi-annual M and E field visits by RHAPCOs and RHBs to Woredas and HFs	# of joint field visits			22	22	22	RHBs, RHAPCO,
	16.5.3 Conduct annual review meeting				1	1	1	HAPCO/M and E
	16.5.4 Programme review by parliaments	# of reviews			24	24	24	Parliaments
	16.5.5. Print and distribute quarterly HIV/AIDS statistical bulletin	# of editions			4	4	4	HAPCO
	16.5.6 Prepare annual HIV/AIDS M and E reports	# of copies		3,000	3,000	3,000	3,000	Ditto
	16.5.7 Print and distribute registers for HCT, PMTCT etc. to all public and private health facilities	# of copies						RHAPCOs /RHB
	16.5.8 Document and share good practices and lessons learned across regions and within regions	# of publications		1	1	1	1	HAPCO, FMOH

PROGRAMMES and SUB-PROGRAMMES	KEY ACTIVITIES	Unit of measurement	TARGETS					LEAD INSTITUTIONS
			Baseline 2005/06	2007/08	2008/09	2009/10	2010/11	
16.6 Logistics	16.6.1 Procure and distribute 4x4 wheel drive vehicles to HAPCO and RHAPCOs	# of vehicles			8	5	3	HAPCO, RHACOs
	16.6.2 Procure and distribute motorcycles to Woredas	# of motorcycles			250	250	200	HAPCO
16.7 Promoting Operational Research (OR)	16.7.1 Organize and conduct consultation meetings to promote and plan for OR	# of consultation meetings		1		1		FMOH, HAPCOs
	16.7.2. Conduct training on surveillance and research	# of training sessions		1		1		FMOH, HAPCO
16.8 Surveys and operational research	16.8.1 conduct health facility survey	# of surveys			1			Ditto
	16.8.2 Conduct BSS	# of surveys				1		Ditto
	16.8.3 Conduct DHS	# of surveys					1	Ditto
	16.8.4 Conduct welfare monitoring survey	# of surveys				1		Ditto
	16.8.5 Conduct workplace survey	# of surveys			1			Ditto
	16.8.6 Conduct ANC sentinel surveillance survey	# of surveys		1		1		Ditto
	16.8.7 Conduct condom survey	# of surveys			1		1	Ditto
	16.8.8 Conduct special surveys	# of surveys			1			Ditto
	16.8.9 Conduct review of drivers of the epidemic and most affected population	# of reviews		1		1		HAPCO, RHAPCO
	16.8.10 Study on response mapping (prevention and protection)	# of studies		1		1	1	HAPCO
	16.8.11 Make a follow up on the incorporation of study findings in policies/programmes at all levels	# of follow ups		1	1	1	1	HAPCO, RHAPCO
	16.8.12 Conduct assessment of the M and E programme	# of assessments			1	1	1	HAPCO

National HIV/AIDS Prevention and
Control Office (HAPCO)
Tel: +251 11 550 3506/08/60
PO Box 122326
Addis Ababa, Ethiopia
E-mail: hiv.aids@ethionet.et