The State of Eritrea

National Strategic Plan on HIV/AIDS/STIs

2003-2007

April 2003
I am pleased to introduce readers to the National Strategic Plan on HIV/AIDS/STIs, 2003-2007. The HIV/AIDS epidemic is perhaps the greatest challenge that Eritrea faces today. This is an enemy that lives together with us in our communities, in our homes and our loved ones, and indeed within ourselves.

This document, the National Strategic Plan on HIV/AIDS/STIs, 2003-2007, provides all of us in Eritrea with visionary leadership and clear guidance to focus Eritrea's national response to this global epidemic. In Eritrea, we are very fortunate to be at the early stages of a generalised HIV/AIDS epidemic. However, the epidemic is already firmly established in our country. It is only with continued vigilance, concerted hard work and persistent effort that we will overcome this formidable foe, including the related obstacles of stigma and discrimination.

All those who have been involved in preparing this Plan should be rightly proud of the truly multisectoral partnership that has led, contributed to and participated in the development and refinement of this Plan. A multidisciplinary and multisectoral Task Force led the strategic planning process on behalf of the Ministry of Health. A broad cross section of interested and committed organisations and individuals participated in developing this document. Stakeholders participated in two Strategic Planning Workshops and provided the Task Force with insights, comments, constructive criticisms and valuable contributions to the Plan. The stakeholders included representatives from many Government sectors, civil society organisations, religious organisations, non-governmental organisations and representatives of bilateral and multilateral organisations working in Eritrea.

We have been especially fortunate to benefit from the valuable contributions and critical reviews of colleagues, collaborators and friends from inside and outside of Eritrea. All this has helped the Task Force to develop a current and comprehensive document that acknowledges and builds upon the lessons learned and best practices accumulated during more than twenty years of experience with the HIV/AIDS epidemic worldwide. As a result, the Plan is up-to-date and contains the best of current international thinking and practice in the field.

However, I am proud to note that this is a truly Eritrean document based upon what we know about the HIV/AIDS epidemic and our capabilities and limitations to respond to the epidemic. The new Plan has built upon Eritrea's first Strategic Plan (1997-2001). In preparation for developing the new Plan, the Ministry of Health carried out a comprehensive situation and response analysis at the end of 2002. This study provided us with an understanding of the current HIV situation, as well as a frank assessment of what we have done so far to respond to the epidemic.

Although this document is up-to-date and appropriate for the current situation at mid-2003, we must recognise that our knowledge and understanding about HIV/AIDS is constantly evolving. For this reason, we are compelled to take stock of the situation on a regular basis and readjust our thinking and our actions to respond to the epidemic.

The HIV/AIDS epidemic in Eritrea threatens to undo all of the years of struggle, the exceptional efforts against seemingly insurmountable forces and all the sacrifices that led to the establishment, growth and development of a flourishing State of Eritrea. In order to preserve and protect our nation, our communities, our families and ourselves, we must respond to the challenge of this epidemic and overcome HIV/AIDS, the enemy from within. The priorities and the strategies for action detailed in this Plan provide us with the guidance to lead our battle against HIV/AIDS in the coming years.

Saleh Meky
Minister of Health
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral therapy (or drugs)</td>
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<tr>
<td>BCC</td>
<td>Behavioural Change Communication</td>
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<td>BIDHO</td>
<td>meaning “challenge”. Association of people living with HIV/AIDS in Eritrea</td>
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<td>CCA</td>
<td>Common Country Assessment</td>
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<td>CDC</td>
<td>Communicable Diseases Control</td>
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<td>CHL</td>
<td>Central Health Laboratory</td>
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<td>CMS</td>
<td>Central Medical Stores</td>
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<td>CSW</td>
<td>Commercial Sex Workers</td>
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<td>CPA</td>
<td>Country Programme Adviser</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>DOTS</td>
<td>Directly Observed Treatment of Short courses</td>
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<td>ECE</td>
<td>Evangelical Church of Eritrea</td>
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<td>EDF</td>
<td>Eritrean Defence Force</td>
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<td>EFE</td>
<td>Employers Federation of Eritrea</td>
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<td>ENCC</td>
<td>Eritrean National Chamber of Commerce</td>
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<td>ENLD</td>
<td>Eritrean National List of Drugs</td>
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<td>ErCS</td>
<td>Eritrean Catholic Secretariat</td>
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<td>ERCS</td>
<td>Eritrean Red Cross Society</td>
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<td>ERIPA</td>
<td>Eritrean Pharmaceutical Association</td>
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<td>ESMG</td>
<td>Eritrean Social Marketing Group</td>
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<td>FHI</td>
<td>Family Health International</td>
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<td>FRHA</td>
<td>Family Reproductive Health Association of Eritrea</td>
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<tr>
<td>GFATM</td>
<td>Global Fund on AIDS, Tuberculosis and Malaria</td>
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<td>GIPA</td>
<td>Greater involvement of people living with HIV/AIDS</td>
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<td>GNP</td>
<td>Gross National Product</td>
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<td>GoE</td>
<td>Government of the State of Eritrea</td>
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<td>HAMSET</td>
<td>HIV/AIDS, Malaria, STIs, Tuberculosis Control Project</td>
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<td>HBC</td>
<td>Home-Based Care</td>
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<td>HIMSS</td>
<td>Health Information Management System</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HQ</td>
<td>Headquarter</td>
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<td>HW</td>
<td>Health Worker</td>
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<tr>
<td>IDSRR</td>
<td>Integrated Disease Surveillance and Response</td>
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<tr>
<th>Acronym</th>
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<tr>
<td>IEC</td>
<td>Information, Education &amp; Communication</td>
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<tr>
<td>IMCI</td>
<td>Integrated Maternal and Child Illnesses</td>
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<td>KAP</td>
<td>Knowledge, Attitudes and Practices (survey)</td>
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<td>MoA</td>
<td>Ministry of Agriculture</td>
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<td>MoD</td>
<td>Ministry of Defence</td>
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<td>MoE</td>
<td>Ministry of Education</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoI</td>
<td>Ministry of Information</td>
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<tr>
<td>MoLG</td>
<td>Ministry of Local Government</td>
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<td>MoLHW</td>
<td>Ministry of Labour and Human Welfare</td>
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<td>MoT</td>
<td>Ministry of Tourism</td>
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<td>MoTC</td>
<td>Ministry of Transport and Communication</td>
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<td>MTCT</td>
<td>Mother-To-Child Transmission</td>
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<tr>
<td>NACP</td>
<td>National AIDS Control Program</td>
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<td>NATC</td>
<td>National AIDS Technical Committee</td>
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<td>NATCoD</td>
<td>National HIV/AIDS/STI and Tuberculosis Control Division</td>
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<tr>
<td>NBTC</td>
<td>National Blood and Transfusion Centre</td>
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<td>NCA</td>
<td>Norwegian Church Aid</td>
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<td>NCEW</td>
<td>National Confederation of Eritrean Workers</td>
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<td>NFA</td>
<td>Nakfa</td>
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<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>NSC</td>
<td>National Service Conscripts</td>
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<td>NTCP</td>
<td>National Tuberculosis Control Program</td>
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<td>NUEYS</td>
<td>National Union of Eritrean Youth and Students</td>
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<tr>
<td>NUEW</td>
<td>National Union of Eritrean Women</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic Infections</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PLHAs/PLWAs</td>
<td>People living with and affected by HIV/AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-To-Child Transmission</td>
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<tr>
<td>STDs/STIs</td>
<td>Sexually Transmitted Diseases/Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>TOR</td>
<td>Terms of reference</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<td>UN</td>
<td>United Nations</td>
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I. BACKGROUND

1.1 Socio-economic background and context

Eritrea today is confronting a complex emergency. The HIV/AIDS epidemic is unfolding in the midst of a post-conflict situation, with thousands still internally displaced, a large proportion of the young and productive force mobilized into the military, and a severe drought threatening the lives of over a million people. These factors contribute to the spread of HIV/AIDS as well as challenge the nation's capacity to mount an effective and expanded response to prevent and control the spread of the epidemic.

Eritrea, with an estimated population of 3.3 million, is one of the poorest countries in the world. The GNI per capita is 170 USD and approximately 60-70% of the population lives below the poverty line. Over 70% of the population survives on subsistence agriculture, with only 16% of GDP in 1999 from agricultural production. The industrial sector only accounts for 27% of GDP. Unemployment, excluding those in agriculture sector, is estimated to be 15-20%.

The border conflict between Eritrea and Ethiopia, which erupted into a full-fledged war, resulted in considerable loss of life and property and the displacement of over a million people in 1999-2000. Currently there are 58,180 people still living in IDP camps and host communities. Many who cannot yet return to their villages due to the landmine threat are commuting between their home village and the IDP camp in an effort to rebuild their livelihood, which is mostly based on agriculture and livestock. This has meant the disruption of family and community life. Mobility of populations and separation of families threatens the stability of social and cultural values that influence behaviour. Prevention and control of sexual and other modes of transmission of HIV in this context is even more difficult. National service conscripts (NSC), young men and women in the most vulnerable age group (18-40 years) are travelling back and forth from the frontlines to their communities on occasional home leave potentially spreading the virus. Unless there are adequate safeguards in place (counselling and social and economic support for those infected) the imminent demobilization of up to 200,000 of the NSC is a potential threat of further spread of the epidemic: from urban to rural areas and from high-risk groups to low-risk groups.

The prolonged drought conditions in the country has caused shortfalls in the cereal harvest forecast for 2002, which is expected to meet only 15% of the country's food requirement this coming year. The government has declared a national drought emergency warning that the lives of over 1 million people are under threat.

As indicated above, Eritrea's initial promising growth was disrupted by the recent border conflict with Ethiopia. This conflict resulted in damage to physical infrastructure, considerable loss of life and the displacement of nearly one third of the total population. The conflict and post-conflict situation reversed the positive economic trends of the post-independence period, resulting in:

- Decline in real GDP growth from 7.7% in 1997 to a negative 11.9% in 2000.
- Increase in inflation from an average of 6% during 1994-97 to 27% in 2000.
- Increase in the deficit from 6% of GDP in 1997 to 48% of GDP in 2000.

The government's two-pronged approach to development has been outlined in the Macro Policy Document (1994), which aims to address the immediate problems of resuscitating the economy and rehabilitating certain key sectors through a program of recovery and rehabilitation, as well as to address the long-term development problems and prospects through strategies focusing on human capital formation, with education and health as key inputs; export-oriented development both in agriculture and industry; infrastructural development; environmental restoration and protection; and the promotion of the private sector. The most critical constraints that continue to affect Eritrea's socio-economic recovery are human resource deficiency; financial and foreign exchange gaps; inadequate physical infrastructure, institutional capacity, and lack of accurate data for major development indicators.

1.2 Health sector policy and strategy

Since independence in 1991, provision of basic social services such as health and education have improved through the Government's program to rehabilitate and expand the number of health stations and schools, which are now more equitably distributed throughout the country. The Government's health policy

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1 Common Country Assessment, Volume 1, United Nations, March 2001
promotes activities that will minimize and eventually eliminate easily controllable diseases and enhance community awareness of good health practices. Primary Health Care (PHC) has been adopted as the most appropriate strategy, based on the principles of equity and community participation, to provide preventive health services supported by regional and central referral health facilities for curative care. The health policy aims to ensure the equitable distribution of health services to rural and urban areas, and the provision of primary health care and immunization as well as mother and child health care services.

The Demographic Health Survey (2002) findings indicate that access to health services has improved since 1995, but much remains to be done. National immunization coverage is at 76% of children, and although antenatal coverage has increased to 70% in 2002, only 28% of all deliveries are assisted by health professional. The nutritional status of children is still poor with 38% of children under 5 stunted and 16% severely stunted. Infant mortality is 48 per 1000 live births and under-5 mortality is 93 per 1000 live births.

Literacy levels are low for adults (15 years and above), with only 62% of males and 48% of females ever having attended school. School attendance of primary school age children is only one in three, in the middle school age population only one in five is attending, and one in four secondary school age youth is attending secondary school.

1.3 Health priorities

Strengthening PHC services such as vaccinations, environmental sanitation, nutrition, and community education has been given considerable emphasis by the Ministry of Health. The control of communicable diseases such as malaria, TB, STIs and HIV/AIDS is one of the top priorities. The most serious public health problem in the country is malaria with 67% of the population living in malaria areas. Tuberculosis is a major public health problem with an annual risk of infection of 2.3%. HIV/AIDS and TB have in recent years become the second and third (respectively) leading causes of inpatient deaths in the age group 5 years and above.

Cognizant of the potential devastating social and economic impact of the HIV/AIDS epidemic on Eritrea, the government launched a multi-sector response to prevent the transmission of HIV, and promote care and support interventions for PLHAs and their families. Important milestones in the Government's response to the HIV/AIDS epidemic in the past 10 years include: (i) the establishment of the National AIDS Control Program (NACP) in 1992; (ii) the adoption in 1997 of a 5-Year Strategic Plan, which emphasized a multisectoral approach and decentralization of HIV/AIDS prevention and control program; (iii) the ratification in 1998 of the HIV/AIDS and STIs policy and policy guidelines, and (iv) the launching of the HAMSET Control Project in 2001.

II. HIV/AIDS/STI STRATEGIC PLANNING PROCESS

Recognizing the need to re-evaluate, update and expand the national response to the HIV/AIDS epidemic, the Ministry of Health initiated the process of revising and updating the Strategic Plan during 2001, one year before the expiry of the existing Strategic Plan (1997-2001). Ministry of Health technical officials, together with international organizations and donors, and with the support of the top management of the Ministry of Health agreed upon a draft process and time line for the development of the new 5-Year Strategic Plan on HIV/AIDS/STIs (2003-2007).

The Strategic Planning process was directed by a Task Force comprised of officials from the Ministry of Health, representatives from UN agencies, Family Health International (FHI), consultants as well as co-opted members from the Ministry of Labour and Human Welfare and UNDP. The Terms of Reference and membership for the Task Force are detailed in Annex A.

In October 2002, the Task Force met for the first time to set forth the time frame for the strategic planning process and identified the need for additional technical assistance to carry forward the planning process in a timely fashion. The Task Force developed terms of reference for the technical assistance and initiated the process of recruiting two consultants, one international and one national.

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The first phase of the strategic planning process was the situation and response analysis. First step in this activity was to gather the available epidemiological and surveillance data and to inventory actions taken in response to HIV/AIDS/STIs by Government and partner organizations in the various sectors. The methodologies used to collect relevant information and data included carrying out a desk review of key documents, an inventory of key activities, interviews with key stakeholders and field visits to three zobas. This basic information was compiled and critically analysed in order to formulate a realistic and up-to-date picture of the HIV/AIDS/STIs situation in Eritrea.

In the middle of this process, UNAIDS sponsored and facilitated a two-day ‘HIV and Development Workshop’ for top managers from Government sectors. At the conclusion of the first phase, the Ministry of Health convened a two-day Stakeholders’ Workshop on 28th and 29th November 2002. On the first day of the workshop, the participants critically discussed the draft situation and response analysis that was presented and made valuable contributions, deletions and corrections to the final document. On the second day of the workshop, the participants reviewed and critically discussed the strategic priorities that were presented by the consultants on behalf of the Task Force.

The second phase of the strategic planning process focussed on finalizing the situation and response analysis and elaborating the details for the new 5-Year Strategic Plan for HIV/AIDS/STIs in Eritrea. The outline for the development of the Strategic Plan was based upon the discussions of the priorities areas identified during the situation and response analysis and the consensus that was reached during the first stakeholders’ workshop. Members of the Task Force and co-opted members contributed to elaborating and filling out the outlined sections of the draft Strategic Plan. The Task Force convened an extended meeting including officials from the Ministry of Health and other stakeholders to review the draft Strategic Plan, to harmonize the inputs and to discuss the implementation arrangements prior to finalizing the document.

During the same period, upon request from the Task Force, UNAIDS Intercountry Team for Eastern and Southern Africa provided technical assistance to develop a budgeting and costing framework. The mission, which took place from 12 to 16 January, as well as the participation of the NACP Manager and of a finance officer from MoH to the 2nd Budgeting and Costing Workshop jointly organized by UNAIDS and UNDP in Dar-es-Salaam, Tanzania, 22-24 January 2003, enabled Task Force members to develop the Eritrea Budgeting and Costing Framework for the National Strategic Plan on HIV/AIDS/STIs 2003-2007 which will be completed a later stage.

At the conclusion of phase two, a second Stakeholders’ Workshop was held on 4 April 2003 to present the final draft of the Strategic Plan and to reach a consensus on the document before putting it forward for final ratification by the appropriate national authorities.

III. SUMMARY OF THE SITUATION AND RESPONSE ANALYSIS

3.1 Situation analysis

Epidemiological data of HIV infection in Eritrea is based on routine health facility reports, and results of research and surveys. From the first case identified in Assab in 1988, the cumulative number of reported AIDS cases reached 15,698 in December 2002. The MoH calculates that among AIDS cases the peak age for males is between 25-34 years while in females it is between 20-29 years. The male to female ratio has been decreasing over the years and has reached 1.55 in 2000. Details on geographic distribution, risk factors and kind of populations are not known for the cumulative number of AIDS cases. However, it was found that Asmara accounts for 49.4%, Massawa (5.8%) and Keren (2.7%) of a limited number of AIDS cases reported over a period of time. The remaining 42% are from all over the country, which include rural areas, farmers, fishermen, students and housewives, indicating a shift to low risk population. Members of the EDF account for 26.5% of the reported AIDS cases in 2000, followed by housewives (11.3%), and daily labourers and unemployed (11%). Risk factors described among the reported cases are as follows: a history of travel outside the country (35.8%); a lifetime history of any STI (22.7%); unsafe injection (7.8%), and blood transfusion (3.4%).

An HIV sero-survey and behavioural survey was conducted in 2001 among five population subgroups in Eritrea. The weighted HIV sero-prevalence in the target population subgroups were as follows: secondary school students, 0.1%;
general population, 2.4%; military personnel, 4.6%; antenatal clinic attendees, 2.8% and female bar workers (including commercial sex workers), 22.8%.  

HIV prevalence among blood donors in 2001 was 0.5% among voluntary blood donors and 2.6% among family replacement donors. In 2002, a decrease can be seen in HIV prevalence rate among voluntary blood donors (0.25%), and family replacement donors (1.46%). This has been possible because of improvements in the blood donor recruitment and screening. Donors are first assessed for their behaviour and then given pre-test counselling to rule out risks of unsafe sexual behaviour. Also, most of the donors belong to the younger age group (secondary schools students).

The HIV prevalence among VCT clients (excluding clients referred for clinical diagnosis) calculated from data collected between July and October 2002 shows that 2.9% are seropositive.

There is no current data available on HIV prevalence among STI patients, although NACP synthesis report of 2001 shows 9.5% in STI patients in Asmara in 1994, 13.2% in all six zobas in 1997, 14.6% in 4 zobas in 1999. There has not been any sentinel seroprevalence study on TB patients. However, a limited study was carried out in the national referral hospital (Halibet), which indicated that the HIV seroprevalence among TB patients had increased from 8.5% in 1996 to 29.2% in 2000.

The 2001 seroprevalence and behavioural survey has identified risk groups and risk behaviours. HIV prevalence rate is high (10.9%) among those who started sex before age 15. HIV prevalence was high amongst those who got married at age 30 and above with prevalence rate of 12.2%. Among those who reported having had casual sex partners 40% were HIV positive. Those who reported having co-wives, married more than once, individuals with behaviours such as high alcohol intake and gambling are more likely to be infected with a seroprevalence of about 12%, 18% and 14% respectively. Among those who reported having had STDs in the 12 months prior to the survey, the HIV prevalence was at 32% compared to 7% among those who did not report STDs.

The behavioural survey findings showed that the majority (72%) of the respondents perceived themselves to have no risk of contracting HIV infection. Females are more likely to claim they are at no risk at all. A high proportion of bar workers and military personnel (60% and 62% respectively) considered themselves at "low risk" or to have "no risk" of contracting STIs. Risk factors related to behaviour include: (i) the early age of exposure to STI (18 to 20 years); (ii) the early age of first sexual intercourse (average is 19 years); (iii) the average age of first condom use (23 years); (iv) use of condom at first sex (18%).

The behavioural survey shows that while awareness of HIV/AIDS was nearly universal at 99% there was poor understanding among respondents of the means of transmission and prevention of HIV. Only 43% of the respondents cited "sexual intercourse", 41% "injections" and 38% "not using condoms" as means of HIV transmission. More than 54% of the respondents cited "having sex with multiple partners" as a main method of HIV transmission. Approximately 15% cited "blood transfusion" and "having sex with prostitutes" as a means of HIV transmission. Only 5% of the respondents were aware that HIV could be transmitted from mother to child and through breastfeeding.

Other qualitative behavioural studies indicate that there is low self-risk perception; little understanding of the difference between exposure to HIV and infection by HIV, as well as between HIV infection and AIDS; misconceptions regarding modes of transmission of HIV and sexual risk factors are common; poor health seeking behaviour for STIs; lack of partner negotiation skills regarding mutual protection, and other social barriers to consistent condom use.

3.2 Response analysis

3.2.1 The response from the health sector

The MoH institutional response to the HIV/AIDS epidemic begun as early as 1992, with the establishment of NACP as a unit under the Communicable Disease Control division. NACP at the central level has a staff of four,

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including the program manager, those responsible for counselling and PMTCT interventions, social mobilization and condom promotion, care and support activities as well as STI management. At the Zoba level, a CDC coordinator is in charge of TB and HIV/AIDS prevention and care activities.

The HIV/AIDS and STIs policy and policy guidelines, adopted in 1998, provide direction for the implementation of interventions such as: promotion of safer sex behaviours; early diagnosis and treatment of STIs; provision of condoms; use of aseptic techniques to prevent infections in health facilities; counselling health care and social support for PLHAs; community empowerment; home-based care and mobilization of the international community. However, this policy document needs to be reviewed in light of the ongoing health sector review, new developments such as the launching of PMTCT activities and the pilot introduction of ARV treatment, and to address issues related to consent and confidentiality.

**HIV surveillance system: HIMS, IDSR**

In the early years of the epidemic, AIDS cases were reported through the Central Health Laboratory (CHL) to NACP. Since 2000, AIDS cases are reported by health facilities through the Integrated Disease Surveillance and Response (IDSR) and the Health Information Management System (HIMS).

Due to the war with Ethiopia, the establishment of an HIV sentinel surveillance system has been delayed. It is important that such a system be set up as a key objective of the next strategic plan. There is also a need to integrate VCT and PMTCT reporting systems as well as standardize AIDS case reporting from all the sectors to NACP.

**The Central Health Laboratory (CHL), as the national referral centre for HIV confirmatory tests, performs HIV serology with either Elisa or Rapid tests, based upon requests from health facilities, and monitors a quality control program on all laboratories in the country for HIV testing.** About 160 lab technicians, trained by the CHL, are currently working in health facilities throughout the country. There is a need to identify the main causes of opportunistic infections presented by AIDS patients in Eritrea by strengthening and standardizing laboratory diagnosis of opportunistic infections and developing referral systems to enhance the links between clinical health workers and the CHL. In light of the growing demand for ARV treatment for HIV patients, and the start of the PMTCT program, there is a need to develop the capacity of CHL to perform CD4 counts and viral load monitoring.

The National Blood bank and Transfusion Centre (NBTC), which became operational in March 2002, is expected to supply all national and zonal referral hospitals with safe blood and build up zonal blood banks. The NBTC conducts donor recruitment campaigns, and volunteers are screened and given pre-donation counselling. Family replacement donors are also screened and counselled prior to donation of blood. Accepted donors are tested for HIV, Hepatitis B, Hepatitis C and Syphilis. The seroprevalence among voluntary blood donors has reduced from 1.6% in 1999 to 0.25% in 2002. In the same period, the seroprevalence among family replacement blood donors has also reduced from 4.6% to 1.46%. This has happened because of improvements in the blood donors recruitment system. Risk behaviours of blood donors are assessed through the use of a questionnaire during the pre-test counselling. Based on this assessment, the donor is either eligible for donation or deferred as a donor. Practically all blood donors belong to the young age group (secondary schools students), where the HIV seroprevalence is at 0.1%. The main constraints in ensuring blood safety by the NBTC have been the scarcity of volunteer blood donors, and the shortage of safe blood supply for the zonal hospitals. There is a need to develop a blood donor recruitment policy and strategy to build up a regular pool of donors who are free from HIV, Hepatitis B, Hepatitis C, and Syphilis infections, and to improve the capacity of zonal hospital laboratories to ensure blood safety with regard to Syphilis and other diseases.

**Voluntary Counselling and Testing**
The national Guidelines for HIV testing were adopted in June 2002. They describe the recommended use of HIV tests in a variety of situations: VCT, diagnosis, blood donation. VCT is recognized as an important element of HIV/AIDS prevention, care and support programs and an entry point for the control of HIV transmission. Mandatory testing for military recruits at entry into national service is the only stated policy in the HIV/AIDS and STIs policy and policy guidelines. However, religious institutions encourage pre-marital testing, and visa applicants are required by some countries to take an HIV test.

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To date 120 counsellors have been trained, mainly nurses, but only 20 are involved in counselling activities on a regular basis. The training is ongoing (22 new counsellors were being trained in Asmara during the strategic planning process). HIV testing is available at the following facilities: Edaga clinic, Halibet Hospital, Mekane Hiwet Maternity and Paediatric Hospitals, in each of the six regional referral hospitals as well as in hospitals of 7 other towns. VCT is also available in the military hospitals of the five operational zones, but with only 10 counsellors currently available.

The demand for VCT is exceeding the existing capacity to provide clients, both those coming voluntarily and those referred by health facilities for diagnosis purposes, with adequate services. There is a need to increase the quantity and quality of VCT centres, to integrate HIV testing for patients with all other clinical and laboratory diagnosis activities at the hospital and health centre levels, to strengthen the capacity for VCT at the zonal hospitals and to expand VCT services to all Zobas, especially through freestanding centres.

Prevention of Mother-To-Child Transmission of HIV
The MoH has selected three sites in Asmara to pilot PMTCT: Mekane Hiwet Maternity and Paediatrics hospitals and Edaga Hamus Maternity regional hospital. Counsellors and medical teams of the selected sites have been trained on PMTCT strategy and implementation guidelines. HIV test kits and ARV drugs have been provided to them. Due to constraints related to the availability of counsellors, space and laboratory facilities at the MCH centres, PMTCT activities has begun utilizing the existing freestanding VCT centre at Edaga for the counselling and testing of antenatal clients. The ultimate goal is to integrate VCT services in MCH clinics with adequately trained staff and facilities for counselling and laboratory services available on site. Various issues related to the current implementation of the PMTCT pilot project include the need to train physicians on AIDS case management, post-delivery counselling and follow-up of mothers and children – including paediatric counselling –, monitoring and evaluation to follow main indicators of the PMTCT program.

Medical care for HIV/AIDS patients
NACP has developed over the past few years with physicians from Halibet Hospital, a core team of trainers for health workers on comprehensive AIDS case management at the referral hospital level. To date, the medical care provided to AIDS patients is symptomatic treatment for opportunistic infections and home-based care for terminal patients. Very little has been done with regard to biological diagnosis and training for opportunistic infections and AIDS case management. ARV drugs are not yet available in the country and there is no laboratory backup for biological follow-up. The HIV/AIDS care, counselling and home-based care manual is planned to be available in January 2003. The guidelines do not emphasize the use of prophylaxis against OI and chemoprophylaxis treatment is currently not being prescribed except for children in the Mekane Hiwet Paediatrics’ Hospital since two years, and for children in the PMTCT activities that have just recently started. The physicians from Mekane Hiwet Paediatrics’ Hospital indicate that the prescription of cotrimazole as prophylaxis to children with HIV infection has been a success. Training of health workers, laboratory diagnosis of opportunistic infections, and the use of prophylaxis treatment in the management of AIDS cases are major priorities that need to be addressed in the upcoming strategic plan.

Early STI diagnosis and treatment
Prevention of STIs through behavioural change communication strategies and condom promotion, and early diagnosis and treatment of STIs are priority actions indispensable in the effort to prevent the spread of HIV/AIDS. The syndromic diagnosis approach for management of symptomatic STI patients has been adopted for diagnosis, case finding and early treatment of all infections associated with STDS. Health workers have been trained on the syndromic approach in all Zobas, but monitoring and supervision of the use of algorithms by health workers is weak due to shortage of human resources at NACP and at zoba level. There is a great need of training and re-training of health workers on the syndromic management of STIs.

The Behaviour Change Communication strategy
HAMSET is currently funding implementation of the BCC strategy. The Winning Through Caring communication strategy uses peer facilitation, community-based –participatory drama and interactive radio. Implementation of the strategy is based on a multisectoral management and implementation approach. Sixty-two peer coordinators have been employed. These peer coordinators manage peer facilitators for respective target audiences. The target audiences are: community women, worksite employees, commercial sex workers and youths in junior and high schools. One thousand peer facilitators have been trained in 15 model communities. Each of these peer facilitators will

have a fixed group of up to 28 peers. So far the implementation of the BCC strategy is operational in the selected model communities, with the impression that this will be scaled-up to the larger community. Early adopters of behaviour change will be "magnified" through radio and drama.

3.2.2 The HAMSET Control Project

The GoE HAMSET Control Project, a World Bank financed 5-Year multi-sector project launched in 2001, aims at reducing the economic, social and disease burden due to HIV/AIDS, Malaria, STDs and TB. The outcome/impact indicators are a 15% reduction of HIV prevalence in the general population as well as target groups by 2006, reduction of case fatality rate of malaria and reduced stigma of STDs, TB and AIDS among the population. The project includes the following five major components:

1) Establishment of an effective monitoring system for HAMSET by expanding the existing management information system (SEMISH) to include a surveillance and epidemic forecasting and alert system as well as an effective monitoring and evaluation system.

2) Development of guidelines and training of key staff to establish an epidemic preparedness system for HAMSET disease.

3) Control of the transmission of HAMSET diseases by promoting behaviour change communication in target groups; improving access to personal protection measures for HAMSET diseases; improving educational curriculum to include concerns on HAMSET in the education sector; improving prevention, diagnosis and treatment techniques for HAMSET diseases in medical services; improving vector control to make it more environmentally sound and cost-effective.

4) Strengthening of the capacity of HAMSET health care services by improving blood safety at Zoba level; improving health workers’ skills on diagnosis, treatment and counselling techniques; improve availability of drugs and facilities at health facilities; provision of social and economic support to TB patients and AIDS orphans.

5) Community managed HAMSET prevention and mitigation program.

A review of the implementation of the HAMSET Control Project by the IDA team was underway at the time of the strategic planning process. The general observations of the team on the HAMSET Control Project were that the project is on track and is likely to meet its development objectives. It is mentioned in the Aide-Mémoire that the mission was pleased to note that the membership of the HAMSET National Technical Committee has been extended to include a representative from UNAIDS as well as one from BIDHO, the organization of people living with HIV/AIDS. The report also noted that most activities planned for the first year have been implemented and a serious "bottom-up" planning process for the fiscal year 2002 action plan has been carried out with an important input from the six zobas, sector ministries and civil society organizations. The mission also indicated that the community-managed response, which had a late start, is now on track. Besides this, the team noted very important issues for action during the coming period on each of the HAMSET Control Project components. Moreover, it appreciated the commitment of the Government and the close follow-up of the project by the Minister of Health.

3.2.3 The response from non-health sectors

The partnership for an expanded response to HIV/AIDS has included government ministries, civil society organizations, private sector organizations, and bi-lateral and multi-lateral donors. The public sectors involved include Ministry of Education, Ministry of Information, Ministry of Labour and Human Welfare, Ministry of Defence, Ministry of Transport and Communications, Ministry of Tourism, Ministry of Agriculture, Ministry of Local Government as the coordinating body at the Zoba level. Civil society organizations active in HIV/AIDS prevention and support activities include NUEYS, NUEW, NCEW, ESMG, FRHAE, BIDHO, ERIPA, and all the religious institutions in the country. The Eritrean National Chamber of Commerce (ENCC) and the Employers Federation of Eritrea (EFE) have also been active partners in the partnership against HIV/AIDS. International partners include all the UN agencies present in the country, USAID, the Italian Cooperation, the Swedish Red Cross and the Norwegian Church Aid.

The main objectives of the multi-sector response have been prevention of sexual transmission of HIV and providing psychosocial and economic support for people infected and affected by HIV/AIDS. The main areas of activity have been the following: advocacy, community sensitisation, behaviour change
communication, condom promotion and distribution, life skills education in the school system, prevention activities targeting military populations, youth, women, commercial sex workers, and interventions at the workplace and mobile workers.

Community sensitisation of the HIV/AIDS epidemic has taken place through use of mass media, music and drama, and community meetings. Public awareness has increased to 96% but much remains to be done to dispel misconceptions, low risk perception and build skills and confidence in abstinence, fidelity and negotiating safe sex and condom use by strengthening and expanding the implementation of the BCC strategy.

Condom promotion and distribution has improved availability but there is a need to overcome social and cultural barriers to increase social acceptability of condom use as well as accessibility of condoms to youth and women.

Life skills-based education on HIV/AIDS needs to be incorporated into the school curriculum, by accelerating curriculum development that is currently carried out by the MoE, and the increased involvement and coordination of activities undertaken by all stakeholders in the school setting: teachers, parents, students and NGOs.

Prevention activities targeting high-risk and vulnerable groups such as the youth, women, military, commercial sex workers and mobile workers have to be strengthened and expanded by improving access to voluntary testing and counselling, early diagnosis and treatment of STIs, condom distribution, peer education and support groups.

To date, provision of psychosocial and economic support to people infected and affected by HIV/AIDS has depended on the Ministry of Labour and Human Welfare, BIDHO, ECE and ErCS with the support of NCA, WFP and UNICEF. It is estimated that about 1,500 PLHAs (10% of known PLHAs) and their families and 556 AIDS orphans have accessed support from government and non-government sources. The main constraints are: the limited number of counsellors and social workers; the limited capacity for food distribution and the inadequate referral linkages between HIV/AIDS patients identified through health facilities to the social service providers.

3.2.4 Priority areas for 2003-2007

The situation and response analysis identified the following nine priority areas for the strategic plan covering the period 2003-2007:

1. **Strengthening the multi-sector response** to HIV/AIDS by mainstreaming HIV/AIDS in development programs; facilitating an enabling environment to address/reduce stigma and discrimination, with civil society; developing workplace-based HIV/AIDS prevention and care programs; improving the collection and dissemination of key socio-economic impact information between all sectors, and strengthening coordination mechanisms at national and zoba levels.

2. **Scaling-up activities to prevent the sexual transmission of HIV** by implementing the behaviour change communication strategy on a national level; promoting the use of male and female condoms; introducing life-skills-based education for in-school youth; improving and expanding peer education and youth-friendly reproductive health services.

3. **Increasing the availability and capacity of human resources in the health sector** to respond to the needs of HIV/AIDS/STI prevention, care and support at all levels through improvement of the human resource planning, development and management capacity of the MoH.

4. **Promoting early diagnosis and treatment of STIs** by increasing the knowledge of MoH decision-makers on STI aetiology and drug sensitivity; ensuring the availability of appropriate drugs for the rational management of STIs; improving the availability and quality of STI clinical services, and promoting behaviour change in STI patients to seek early and appropriate treatment.

5. **Promoting early diagnosis of HIV infection through increased access to VCT and PMTCT** for the general population and especially for the military, youth and women, by improving the availability and quality of counselling and testing services; involving non-health workers in the provision of VCT services; improving VCT and PMTCT data monitoring; developing capacity of zonal and national referral hospitals to implement the PMTCT strategy.

6. **Ensuring blood safety and adherence to universal precautions** in health care settings and in traditional medical practices by improving access to safe blood supply in all zonal hospitals, and preventing HIV infection from accidental exposure to blood and contaminated items.

7. **Improving the availability and quality of comprehensive health care for people living with HIV/AIDS** through increased knowledge and capacity among health workers at zonal and national level to conduct specific biological
diagnosis of opportunistic infections and on chemoprophylaxis; early diagnosis and treatment of OI for adults and children, and enhanced access to appropriate drugs for OI treatment, including ARV therapy. 

(8) Expanding the availability and quality of psychosocial and economic support for people infected and affected by HIV/AIDS by ensuring access to VCT services; improving opportunities for PLHAs for continued employment and self-employment; ensuring provision of nutritional support to PLHAs and their families; ensuring psychosocial and economic support to PLHAs and AIDS orphans; strengthening and expanding the delivery of home-based care for PLHAs.

(9) Strengthening research, surveillance, monitoring and evaluation of the HIV/AIDS/STIs epidemic by improving data management capacity in all sectors; promoting operational research for decision making in HIV/AIDS and STI programs, and establishing a surveillance system on HIV/AIDS and STIs.

IV. INSTITUTIONAL FRAMEWORK

In Eritrea, the Government institution responsible for leading and coordinating the fight against HIV/AIDS and STIs is the Ministry of Health. As described in section 3.2.1 above, the MoH response to the HIV/AIDS epidemic begun as early as 1992, with the establishment of a NACP as a unit under the Communicable Disease Control division (CDC).

4.1 Restructuring of the Ministry of Health

In early 2003, the Ministry of Health restructured itself in order to make optimal use of available resources and to improve the efficiency and effectiveness of its management units. 

The Ministry of Health is now divided into three principal Departments, headed by three Directors General who report directly to the Minister. The Departments are: Health Services; Regulatory Services, and Research and Human Resources Development

In addition to these, there are other Divisions and Support Units in the Ministry of Health (such as Health Promotion) that report directly to the Minister of Health.

The new organisational structure of the Ministry of Health will facilitate the achievement of the overall goals of the Ministry by: (1) Rationalising the functional authority, functional responsibility and the functional lines of command within the Ministry; (2) Rationalising the horizontal and vertical relationships among the Departments, Divisions and Units within the Ministry, and (3) Aligning the Ministry policies and strategies with the operational aspects of the Ministry.

4.2 The National HIV/AIDS/STI and TB Control Division (NATCoD)

Within the new structure of the Ministry, the National HIV/AIDS/STI Control Programme has been combined with the National Tuberculosis Control Programme and promoted to the status of Division. The new National HIV/AIDS/STI and Tuberculosis Control Division (NATCoD) reports directly to the Director General for Health Services.

NATCoD is responsible for the overall programme planning, implementation, management, monitoring and evaluation for HIV/AIDS/STI and tuberculosis by the Ministry of Health and partners. The Division is also responsible for coordination of activities and collaboration with partners within and outside of the Ministry of Health. The Division works closely with other parts of the Ministry of Health as well as other Ministries and Government organisations, the non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs), AIDS service organisations (such as BIDHO), etc. The Current HIV/AIDS Coordination Bodies in Eritrea are detailed in Annex B.

The strategic plans for HIV/AIDS/STI and tuberculosis are guiding the implementation of activities carried out by the NATCoD.

The NATCoD is functionally divided into five Units: (1) Prevention and Counselling Unit; (2) HIV/AIDS Care Unit; (3) Tuberculosis Control Unit; (4) Sexually Transmitted Infections Unit and (5) Epidemiology and Monitoring Unit.
V. STRATEGIC PLAN FOR 2003-2007

5.1 Foundation for the plan

The plan is articulated around the nine priority areas identified as a result of the situation and response analysis. Each main objective for the period 2003-2007 corresponds to one of the priority areas.

Since Eritrea is among the 189 countries that have adopted the Declaration of Commitment on HIV/AIDS at the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS held in New York, in June 2001, the Strategic Planning Task Force decided to make reference to the appropriate Governments commitments in the new 5-year plan. In order to do so, a simple matrix was developed with the goal of enabling the reader to practically visualize to which national main objective and UNGASS global goal/target the selected specific objectives, strategies and key activities for the next five years are responding to. This will also facilitate future reporting on national follow-up to the UNGASS Declaration of Commitment, the first report being due by June 2003.

5.2 Format of the plan

On the basis of the above, the format adopted to develop the strategic plan for 2003-2007 is a matrix, which includes the following components:

- On the top: Title of Main Objective numbered from I to IX. The Main Objectives address the priority areas identified during the situation and response analysis).

- First column (on the left): Specific Objectives (could be several for each Main objective).

- Second column: Corresponding UNGASS global goals / targets (Summary text of relevant paragraphs taken from UNAIDS document entitled “Keeping the Promise”). To be used as benchmark for future reporting on UNGASS Declaration of Commitment.

- Third column: Presents core indicators that will be used to gauge overall progress toward each specific objective. The core indicators are consistent with those of UNGASS. The National Monitoring and Evaluation Framework currently under development will contain additional indicators for tracking process outcomes.

- Fourth column: Strategies selected to achieve the specific objectives over the 5-year period.

- Fifth column: Key Activities identified for each strategy (the list of identified activities is not meant to be exhaustive as, over a 5-year period, significant re-strategising will certainly occur).

- Sixth (last) column: main agency/agencies responsible for implementing the key activities (lead agency/agencies in bold) followed by the list of partner organizations supporting financially and/or technically these activities (main partner/partners in bold). Here also, the list of identified lead agencies and partners is only indicative,

The particulars of the plan are detailed in the following pages (10 to25).

5.3 Goals

The overall goals of Eritrea’s national response to the HIV/AIDS epidemic and STIs for 2003-2007 are:

(1) To reduce the transmission of HIV.
(2) To mitigate the personal, social and economic impact of HIV/AIDS.
### 5.4 Objectives, indicators, strategies, and key activities

#### Main Objective I:
To strengthen the multisectoral response to the HIV/AIDS epidemic

<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Corresponding Global Goals / Targets</th>
<th>Core Indicators</th>
<th>Selected Strategies</th>
<th>Key Activities</th>
<th>Lead Agencies &amp; Partners</th>
</tr>
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<tbody>
<tr>
<td><strong>SpeObj-I.1</strong> To facilitate multi-sectoral coordination at the national and zoba levels.</td>
<td><strong>Develop mechanisms to monitor and evaluate progress, with adequate epidemiological data (para. 95).</strong></td>
<td>- Total no. of government ministries and CSOs represented at meetings of national HIV/AIDS coordination bodies. - No. of zobas with “active” multi-sectoral HIV/AIDS task forces.</td>
<td><strong>ST I.1.1 Strengthening and harmonizing the coordination of HIV/AIDS/STIs interventions between sectors, at central and zoba levels, and with all partners.</strong></td>
<td>- Review and harmonize terms of reference of existing coordination bodies (i.e. HAMSET, NACPOD, UN, etc.).</td>
<td>MoH, UNTG, UNAIDS, FHI</td>
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<tr>
<td><strong>SpeObj-I.2</strong> To integrate prevention, care, support and impact mitigation priorities into the mainstream of development planning, including in poverty eradication strategies and sectoral development plans.</td>
<td><strong>By 2003, implement multi-sectoral strategies and finance plans that: confront silence, denial, stigma and discrimination; involve civil society, business, people living with HIV/AIDS, vulnerable groups, women and young people; are resource as much as possible by national budgets; address human rights, gender, age, risk, vulnerability, prevention, care, treatment, support and reduction of impact; and strengthen health, education and legal systems (para. 37).</strong> By 2003, integrate prevention, care, treatment, support and mitigation priorities into development planning (para. 38).</td>
<td>- Proportion of the national budget allocated to HIV/AIDS/STI prevention, care and support, and impact mitigation activities. - No. of government sectors with HIV/AIDS action plans. - No. of national policies or programs that address HIV/AIDS-related issues.</td>
<td><strong>ST I.2.1 Advocating for the meaningful involvement of all sectors, CSOs and the private sector in the national response.</strong> <strong>ST I.2.2 Building national capacity for the development and implementation of integrated and multi-sectoral HIV/AIDS programs.</strong></td>
<td>- Conduct advocacy seminars for policy-makers, high-government officials and leaders of CSOs. - Organize study tours for high-government officials. - Train a core group of multidisciplinary trainers on HIV &amp; Development. - Conduct HIV &amp; Development workshops for key decision makers in Government and Industry, including sectoral managers and zoba administrators. - Develop sectoral plans. - Conduct HIV &amp; Development workshops for key leaders and managers of partner organizations, CSOs and FBOs. - Conduct skills-building workshops on mainstreaming for key decision makers in Government and Industry, including sectoral managers &amp; zoba administrators. - Conduct skills-building workshops on mainstreaming for key leaders and managers of partner organizations.</td>
<td>MoH, MoCT, UNDP, UNAIDS, USAID/FHI</td>
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8 Adapted from UNGASS Declaration of Commitment Core Indicator.
<table>
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<tr>
<th>Specific Objectives</th>
<th>Corresponding Global Goals / Targets</th>
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<th>Key Activities</th>
<th>Lead Agencies &amp; Partners</th>
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<tbody>
<tr>
<td>ST 1.2.4 Promoting the greater involvement of people living with or affected by HIV and AIDS (GIPA).</td>
<td>- No (or %) of policymaking, planning, and/or coordinating bodies with PLHA representation.</td>
<td>- Provide institutional support to PLHAs groups/associations. - Conduct self-empowerment workshops for PLHAs. - Conduct operational research projects on stigma &amp; discrimination in various settings. - Ensure effective representation of PLHAs in all relevant policy-making, planning and coordination bodies. - Ensure effective representation and participation of PLHAs to relevant sub-regional, regional and international workshops and conferences.</td>
<td>- Ensure effective representation of PLHAs in all relevant policy-making, planning and coordination bodies.</td>
<td>MoH, MoLHW, BIDHO, FBOs, MoE, Health Associations, ERREC WHO, UNAIDS, NCA, UNICEF, WHO, USAID/FHI</td>
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<td>SpeObj-I.3</td>
<td>To establish public and private sector policies and programs that address HIV/AIDS in the workplace.</td>
<td>By 2005, implement prevention and care programs in the workplace (public, private and informal), to provide supportive environments for people living with HIV/AIDS (para. 49). By 2003, develop laws and policies that protect in the workplace the rights of people living with, affected by or at risk of HIV/AIDS (para. 69).</td>
<td>- No. of targeted ministries, industries, and unions that have HIV/AIDS workplace policies and programs.9 - No. of workplace-based clubs or support groups for PLHA and their families.</td>
<td>ST I.3.1 Establishing workplace-based prevention, care and support programs in key national economic and social sectors, CSOs and in the private sector, including FBOs.</td>
<td>- Conduct HIV/AIDS in the Workplace workshops for key decision makers in selected ministries, industries and unions. - Develop HIV/AIDS Policy/Code of Conduct for key sectors/workplaces. - Review labour law, civil service law, workplace health and safety laws and regulations to ensure that they take into account HIV/AIDS in a non-discriminatory way. - Train employees, including PLHAs, to undertake key leadership role in the establishment of workplace-based prevention, care &amp; support programs. - Ensure the active participation of employees, including PLHAs, in the development of workplace-based prevention, care &amp; support programs. - Assist in the formation of PLHA Clubs/support groups within the work environment.</td>
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<td>SpeObj-I.4</td>
<td>To improve the collection and dissemination of key socio-economic impact information capable of facilitating evidence-based decision-making.</td>
<td>By 2003, evaluate the economic and social impact of the epidemic and develop strategies to address it at all levels, including poverty eradication strategies for families, communities, women and the elderly (particularly as caregivers), and development policies to counter the impact of HIV on economic growth, economic services, labour, government revenues, and public resources (para. 68).</td>
<td>- Dissemination of results from socio-economic impact studies/surveys. - CRIS established and operational. - No of Information Resource Centres established and operational.</td>
<td>ST I.4.1 Generating relevant information on the impact of HIV/AIDS at family, community and sectoral levels.</td>
<td>- Carry out a survey on the HIV/AIDS impact at household level. - Holding consultations with relevant partners regarding commissioning of needed socio-economic impact studies. - Carry out socio-economic impact studies in relevant economic and social sectors.</td>
</tr>
<tr>
<td>SpeObj-I.4</td>
<td>To improve the collection and dissemination of key socio-economic impact information capable of facilitating evidence-based decision-making.</td>
<td>By 2003, evaluate the economic and social impact of the epidemic and develop strategies to address it at all levels, including poverty eradication strategies for families, communities, women and the elderly (particularly as caregivers), and development policies to counter the impact of HIV on economic growth, economic services, labour, government revenues, and public resources (para. 68).</td>
<td>- Dissemination of results from socio-economic impact studies/surveys. - CRIS established and operational. - No of Information Resource Centres established and operational.</td>
<td>ST I.4.2 Establishing a national system to provide relevant information to decision makers at all levels on a regular basis.</td>
<td>- Create HIV/AIDS Information Resource Centres within appropriate institutions. - Establish and update regularly a country response information system (CRIS). - Publish and disseminate Newsletter on a regular basis. - Conduct regular dissemination workshops at national and zoba level.</td>
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9 Adapted from UNGASS Declaration of Commitment Core Indicator.
Main Objective II: To strengthen the prevention of sexual transmission of HIV

Specific Objectives

<table>
<thead>
<tr>
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<th>Selected Strategies</th>
<th>Key Activities</th>
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</thead>
<tbody>
<tr>
<td>SpeObj-II.1</td>
<td>To maintain non-risk behaviours by promoting delayed onset of sexual activity, and avoiding casual unprotected sexual intercourse with one or more individuals of unknown STI status.</td>
<td>By 2003, establish prevention targets that address factors that spread the epidemic, and reduce HIV incidence among young people aged 15-24.</td>
<td>Establish a referral system to services for medical conditions; Develop a national HIV and AIDS logo; Develop an advocacy kit for key opinion leaders and policy makers; Establish a referral system to services for medical conditions; Train peer supervisors, coordinators and facilitators to cover the entire project area.</td>
</tr>
<tr>
<td>ST II.1.1</td>
<td>By 2003, establish prevention targets that address factors that spread the epidemic, and reduce HIV incidence among young people aged 15-24.</td>
<td>Train peer supervisors, coordinators and facilitators to cover the entire project area.</td>
<td>Train peer supervisors, coordinators and facilitators to cover the entire project area.</td>
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<tr>
<td>ST II.1.2</td>
<td>By 2005, ensure a wide range of prevention approaches while working in, designated areas.</td>
<td>Develop skills of existing theatre groups and starting new ones, which will use more participatory theatre approaches.</td>
<td>Develop skills of existing theatre groups and starting new ones, which will use more participatory theatre approaches.</td>
</tr>
<tr>
<td>ST II.1.3</td>
<td>By 2005, ensure that 90%, and, by 2010, 95% of young aged 15.24 have information, education, services and life-skills that enable them to reduce their vulnerability to HIV infection (para. 53).</td>
<td>Develop with the target audience an interactive radio program, which will use more participatory theatre approaches.</td>
<td>Develop with the target audience an interactive radio program, which will use more participatory theatre approaches.</td>
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<tr>
<td>ST II.1.4</td>
<td>By 2005, ensure that 90%, and, by 2010, 95% of young aged 15.24 have information, education, services and life-skills that enable them to reduce their vulnerability to HIV infection (para. 53).</td>
<td>Utilizing quick feedback in programming and management.</td>
<td>Utilizing quick feedback in programming and management.</td>
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Lead Agencies & Partners

MoE, MoH, NUEYS, CSOs, UNICEF, USAID/FHI, PATH, UNFPA, UNAIDS, UNDP, IFC, ESMG.
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<thead>
<tr>
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<th>Key Activities</th>
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</tr>
</thead>
</table>
| SpeObj-II.2 To promote the adoption of safe sexual practices among in and out-of-school youth. | - Percentage of young people aged 15–24 reporting the use of a condom at last sex with a non-marital, non-cohabiting sexual partner in the last 12 months.\(^{11}\) | ST II.2.1 Introducing HIV/AIDS into the school curricula. | - Conduct advocacy seminars for policymakers, high-government officials and leaders of CSOs.  
- Conduct situation analysis.  
- Develop culturally acceptable curricula.  
- Introduce new curricula. | MoH, MoE, MoLG, NUEYS, CSOs  
UNICEF, UNAIDS, USAID/FHI, UNFPA, UNAIDS |
| ST II.2.2 Building the capacity of school-teachers to teach life-skills HIV/AIDS education. | | ST II.2.2 | - Finalise, pre-test and introduce syllabus for life-skills education in schools.  
- Train a group of core trainers on life-skills HIV/AIDS education.  
- Conduct training of teachers on life-skills HIV/AIDS education. | | |
| ST II.2.3 Strengthening existing anti-AIDS clubs in secondary schools, and/or establishing new ones. | - Conduct advocacy seminars for policy-makers, high-government officials and leaders of CSOs.  
- Conduct situation analysis.  
- Develop culturally acceptable curricula.  
- Introduce new curricula. |
| ST II.2.4 Involving families, FBOs and other CSOs in the planning of HIV/AIDS/STIs education for youth. | | ST II.2.4 | - Conduct sensitization seminars for PTAs, religious leaders & school directors.  
- Establish school supports. | | |
| ST II.2.5 Establishing AIDS information centres in institutions where the youth can have access to; e.g. through the NUEYS & Eritrean Red Cross Society, etc. | | ST II.2.5 | - Develop and disseminate IEC/BCC resource materials.  
- Assess and strengthen the existing resource centres.  
- Promote use of sport activities & leisure centres.  
- Review legal issues re alcohol consumption & sex activity. | | |
| SpeObj-II.3 To promote the use of male and female condoms. | - No. of socially-marketed condoms sold to retail outlets or directly to customers in the last calendar year. | ST II.3.1 Strengthening and expanding the condom social marketing program. | - Expand availability of quality of condoms by increasing # of outlets where Abusalama condoms are sold.  
- Address barriers to condom use.  
- Address barriers to condoms.  
- Assess quality of condoms. | MoH, ESM/GPSI  
UNFPA, USAID, MOI |
| ST II.3.2 Facilitating the distribution of condoms through both non-traditional and traditional outlets. | | ST II.3.2 | - Conduct baseline survey to assess the current status of condom availability and distribution in health facilities.  
- Develop training materials for condom promotion and distribution in the health care context.  
- Train health workers, pharmacists, drug vendors etc. to ensure that condoms are promoted and distributed to all STI patients, CSWs and other risk clients. | MoH HQ, Pharm. Department, Pharmecor, CMS, Health Units |
| ST II.3.3 Ensuring that condoms are distributed to all high-risk clients especially those with active STIs, CSWs and to others who may transmitted STIs including HIV | | ST II.3.3 | - Conduct training of health workers.  
- Develop IEC materials. | | |
| ST II.3.4 Introducing female condoms. | | | | | |

\(^{11}\) UNGASS Declaration of Commitment Core Indicator.
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| SpeObj-II.4 To expand/strengthen youth or adolescents reproductive health services. |                                       | - Percentage of reproductive health service delivery points offering “youth-friendly” services. | ST II.4.1 Establishing/strengthening adolescent reproductive health services.       | - Carry out a survey on the accessibility & quality of the existing centers.  
- Train service providers.  
- Establish youth friendly services  
- Increase accessibility of health facilities to youth  
- Train health workers | MoH, NUEYS, NUEW, UNFPA, USAID/FHI, UNICEF                                         |
| SpeObj-II.5 To improve access to services & adapt safe sex practices among CSWs.   |                                       | - Percentage of commercial sex workers who used a condom during the last sexual encounter. | ST II.5.1 Developing and carrying out a comprehensive package of interventions to reduce HIV transmission among commercial sex workers (CSWs) and their clients. | - Organise stakeholders’ consensus building and planning workshop to disseminate the results of the situation analysis on Commercial Sex Work in Eritrea and formulate a comprehensive plan of interventions.  
- Organise a study visit to Kenya for four to six representatives of main partners.  
- Conduct TOT on Peer Education for CSWs.  
- Trains peers leaders among CSWs.  
- Provide quality STI services for CSWs. | MoH, MoLHW, NUEW, ESMG/PSI, ECE, Vision Eritrea, UNFPA, UNAIDS, USAID/FHI           |
| SpeObj-II.6 To prevent HIV transmission among Uniformed services, through the promotion of safer sexual behaviours. | By 2003, address the spread of HIV in armed services and civil defence and use HIV-trained service personnel to assist in HIV awareness and prevention, including in emergency relief [para.77]. | - Reduction of HIV/STI incidence in uniformed servicing population. | ST II.6.1 Scaling up mass campaign activities to increase HIV/AIDS awareness and promote safer sexual behaviours among all uniformed services. | - Train new peer educators.  
- Finalize, translate and disseminate Peer Education Manual for all peer educators.  
- Develop and incorporate an HIV/AIDS/STIs module in the training curriculum for uniformed services in all training institutions.  
- Produce video films based on PLHAs testimonies and interventions.  
- Conduct mass HIV/AIDS awareness sessions in all operational zones with available audio-visual equipment and newly developed videos.  
- Disseminate behaviour change communication (BCC) materials.  
- Ensure regular supply and availability of condoms in all operational zones. | EDF, MoH, MoLHW, MOI ESMG/PSI, US DoD, UNAIDS, UNFPA, FHI                         |
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| **ST II.6.3** | Identifying and training of “change agents” among young women and men serving in the NSC to foster awareness and build skills to respond to HIV/AIDS challenges within communities across the nation. | - Number of “change agents” effectively trained and posted in communities.  
- Number of community-based prevention and care programmes launched with support from “change agents”. | ST II.6.3 | - Develop strategy and tools to identify and select up 1000 “change agents”.  
- Develop a minimum skills package and conduct training of “change agents”.  
- Placement of trained “change agents” in communities across the nation.  
- Establish and monitor start-up community fund to support “change agents” activities at community level. | EDF, MoH, NUEYS, NUEW, NCEWI, UNFPA, UNAIDS, FHI/USAID |
| **ST II.6.4** | Encouraging and strengthening the greater involvement of people living with HIV/AIDS in EDF HIV/AIDS prevention and care activities. | - Number of PLHA clubs/support groups created and active.  
- Number of PLHAs involved fulltime in EDF prevention and care activities. | ST II.6.4 | - Send PLHAs on a study tour of PLHAs’ networks and interventions to neighbouring countries.  
- Provide treatment for opportunistic infections for all PLHAs involved in EDF prevention and care activities.  
- Identify and distribute information on and establish collaboration with existing referral services, including supports groups of people infected or affected by HIV/AIDS | EDF, MoH, ESMG/PSI, US DoD, UNAIDS, UNFPA, FHI/USAID |
| **SpeObj-II.7** | To improve access to HIV/AIDS prevention programs for mobile populations. | By 2005, implement prevention programs for migrants and mobile workers, including provision of health and social services (para. 50). | ST II.7.1 | - Conduct needs assessment/survey among selected mobile populations.  
- Organise stakeholders’ consensus building and planning workshop to disseminate the results of the survey on mobile populations and formulate a comprehensive plan of interventions.  
- Adapt, translate and disseminate Peer Education curriculum to the specific needs of mobile population.  
- Train peer education trainers through TOT in various settings.  
- Train peer educators. | MoH, NUEYS, NUEW, USAID/FHI, UNHCR, WFP, UNICEF, UNAIDS |
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<td>SpeObj-III.1 To increase the presence of quality health staff in health facilities offering HIV/AIDS/STI prevention, care and support services.</td>
<td>By 2005, implement comprehensive care strategies to strengthen family and community health care systems to provide treatment for people living with HIV/AIDS, including children; support individuals, households, families and communities affected by HIV/AIDS; improve the capacity and working conditions of health-care workers... (para. 56).</td>
<td>- Percentage of health facilities offering HIV/AIDS/STI services with at least one health worker specially trained in HIV/AIDS/STI service provision.</td>
<td>ST III.1.1 Creating opportunities for fellowship placement and/or distant education programs. - Identify staff and send for scholarship.</td>
<td>WHO, USAID, FHI, UNAIDS, UNICEF</td>
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<td>SpeObj-III.2 To improve the human resource planning capacity of the MoH.</td>
<td>- No. of staff and decision makers trained and applied the skill for planning.</td>
<td>ST III.2.1 Capacity building on planning for staff and decision makers.</td>
<td>- Conduct training for staff &amp; decision makers.</td>
<td>MoH, MoD, MoE, UoA, NUEYS, NUEW</td>
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<td>SpeObj-III.3 To improve the management of existing human resources.</td>
<td>- Percentage of health facilities providing HIV/AIDS/STI services that received at least one supervisory visit in the last six months which included an assessment of health worker performance.</td>
<td>ST III.3.1 Assessing existing staff performance/efficiency in relation to needs.</td>
<td>- Conduct rapid assessment for staff efficiency in HIV/AIDS/STI management, care &amp; support.</td>
<td>WHO, USAID, FHI, UNAIDS, UNICEF</td>
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<td>ST III.3.2 Strengthening the HIV/AIDS/STI control program at all levels to achieve maximum efficiency.</td>
<td>- Conduct rapid assessment of existing human resources in the health sector.</td>
<td>MoH, MoD, MoE, UoA, NUEYS, NUEW</td>
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Main Objective III:
To increase availability and capacity of human resources in the health sector to combat the HIV/AIDS epidemic & STIs
## Main Objective IV:
To reduce the incidence of HIV infection through early diagnosis and treatment of STIs

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<tr>
<td>SpeObj-IV.1 To increase the knowledge of MoH decision makers on STI aetiology and drug sensitivity.</td>
<td>By 2005, ensure a wide range of prevention programs in all countries that are culturally sensitive and available in local languages; reduce risky behaviour; encourage responsible sexual behaviour; reduce harm related to drug use; and expand access to male and female condoms, clean injecting equipment, safe blood supplies, treatment for sexually transmitted infections, and voluntary and confidential counselling and testing (para. 52).</td>
<td>- Increased knowledge and understanding among MoH decision makers about STIs in Eritrea. - Improved utilization of scientific data for program development and elaboration.</td>
<td>ST IV.1.1 Determining the validity of the syndromic approach to STI management in Eritrea.</td>
<td>Carry out a study to validate the syndromic approach to STI management.</td>
<td>MoH, MoD, Uniformed Services, UOA, WHO, USAID/FHI</td>
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<td>SpeObj-IV.2 To ensure the availability of appropriate STI drugs for the rational management of STIs.</td>
<td></td>
<td></td>
<td>ST IV.2.1 Revising the essential drug list to include the most appropriate treatments for STIs.</td>
<td>Update the essential drug list based on the results of the studies undertaken under SpeObj-IV.1</td>
<td>MoH, MoD, Uniformed Services, UOA, WHO, USAID/FHI</td>
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<td>SpeObj-IV.3 To improve capacity in STI diagnosis and management in all six zobas.</td>
<td></td>
<td></td>
<td>ST IV.3.1 Establishing clinical centres of excellence for STI management in all six zobas and developing the staff of these centres to function as zonal supervisors and focal persons for STI management.</td>
<td>- Identify sites in each zoba that have sufficient number of patients, trained personnel and space for teaching. - Ensure that each site is adequately staffed and equipped to provide exemplary diagnosis and management for STI patients. - Provide additional training for the staff to enable them to teach and supervise other health staff. - Provide supplemental supervision to ensure that the facility is set up properly and provides the highest quality of care.</td>
<td>MoH, MoD, Uniformed Services, NUEYS, NUEW, UOA, WHO, USAID/FHI</td>
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<td>ST IV.3.2</td>
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<td>ST IV.3.2</td>
<td>Training of health workers, pharmacists and drug vendors in the civilian and military sectors on the comprehensive syndromic management of STIs and complementary skills.</td>
<td>- Review and rewrite the STI syndromic management algorithms based on the results of update the STI syndromic management guidelines. - Update and rewrite the counselling, referral, partner notification and condom distribution training guidelines for STI patients. - Conduct trainings for targeted health workers and others on the quality provision of STI services.</td>
<td>MoH, WHO, USAID/FHI</td>
</tr>
<tr>
<td>SpeObj-IV.4</td>
<td>To improve the quality of STI diagnosis and case management.</td>
<td>- Percentage of patients with STIs at health-care facilities who are appropriately diagnosed, treated and counselled.</td>
<td>ST IV.4.1 Ensuring that the laboratory and clinical practices related to the provision of STI diagnosis and clinical management are of the highest quality.</td>
<td>- Set up and implement a national quality assurance program for STI laboratory diagnosis and clinical management. - Monitor the laboratory and clinical practices for STI diagnosis and management through support supervision and periodic facilities surveys. - Provide training in quality assurance, refresher courses and support supervision for health workers and others. - Ensure sustainability of Lab supplies.</td>
<td>MoH, MoD, Uniformed Services, UOA, USAID/FHI</td>
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<tr>
<td>SpeObj-IV.5</td>
<td>To increase the detection and treatment of syphilis.</td>
<td>- Percentage of pregnant women who were screened for syphilis.</td>
<td>ST IV.5.1 Providing syphilis screening for risk populations such as CSWs and STI patients including pregnant women at the time of clinical visits, routine checks and other health system contacts.</td>
<td>- Carry out a survey to describe the current situation, policy and practice for syphilis screening at the present time. - Develop methodology and list of materials required for syphilis screening. - Develop materials for training health workers to screen clients for syphilis. - Train health workers to screen clients and patients for syphilis. - Procure and distribute syphilis test kits and other required screening materials.</td>
<td>MoH, NUEYS, NUEW, FRHAE, USAID/FHI</td>
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<td>ST IV.5.2</td>
<td>Ensuring proper case management for syphilis-infected individuals including drug treatment, counselling, partner notification etc.</td>
<td>- Develop materials for training health workers to screen clients for syphilis. - Develop materials for training health workers to manage patients who are found to be syphilis infected including counselling and partner notification. - Train health workers to manage detected cases of syphilis infection. - Procure and distribute appropriate drugs and other required materials for the treatment of syphilis at a variety of stages.</td>
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<tr>
<td>SpeObj-IV.6 To increase the early and appropriate treatment seeking behaviour for persons with STI symptoms.</td>
<td></td>
<td>- Percentage of individuals who know at least two signs of STI in a) men, b) women.</td>
<td>ST IV.6.1 Ensuring that patients recognize and acknowledge STI symptoms and seek treatment promptly at a place where they are likely to be diagnosed accurately and treated appropriately.</td>
<td>- Conduct a baseline survey to assess current level of knowledge about STI symptoms and current treatment seeking behaviour. - Develop promotional materials for BCC and IEC to help define normal and abnormal reproductive tract health. - Develop promotional materials targeting STI patients and other risk populations to direct them to competent caregivers. - Carry out a promotional campaign to ensure the early STI symptom recognition and acknowledgement and early and appropriate treatment seeking behaviour.</td>
<td>MoH, Health Units USAID/FHI</td>
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### Main Objective V:
**To promote the early diagnosis of HIV infection through increased access to VCT and PMTCT**

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<tr>
<td>SpeObj-V.1</td>
<td>To increase access to early diagnosis of HIV infection for the general population and the military.</td>
<td>By 2005, ensure a wide range of prevention programs in all countries that are culturally sensitive and available in local languages; reduce risky behaviour; encourage responsible sexual behaviour; reduce harm related to drug use; and expand access to male and female condoms, clean injecting equipment, safe blood supplies, treatment for sexually transmitted infections, and voluntary and confidential counselling and testing (para. 52).</td>
<td>- No. of VCT service delivery points (freestanding, health facility based).</td>
<td>ST V.1.1 Expanding access to VCT services for the general population and the Military.</td>
<td>- Establish freestanding VCT centres in all Zonal Capitals and major health facilities, including 2 more in Asmara (17) - Establish VCT services in Youth Centres. - Provide test kits and other supplies.</td>
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<tr>
<td>SpeObj-V.2</td>
<td>To increase knowledge of HWs on testing and counselling, including in the military.</td>
<td>- Number of newly trained counsellors and other HWs. - VCT guidelines provided.</td>
<td>ST V.2.1 Training HW in hospitals, health centres and military hospitals on pre- and post-test counselling (All Zobas).</td>
<td>- Conduct counselling Training of Trainers. - Develop and disseminate VCT Guidelines. - Conduct training on pre- and post-test counselling for staff of STI and MCH clinics.</td>
<td>MoH, NACP, HAMSET, NUEYS USAID/FHI</td>
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<td>SpeObj-V.3</td>
<td>To design a national procurement and distribution system for HIV test kits. Specific and well-designed stock control system.</td>
<td>- No. of VCT sites with no stock-outs of HIV test kits in the past year.</td>
<td>ST V.3.1 Developing monitoring and evaluation study for a panel of HIV tests.</td>
<td>- Develop protocol for monitoring and evaluation of test kits (first-line tests and confirmatory tests identified). - Disseminate testing strategy guidelines.</td>
<td>MoH, NACP, CHL Pharmecor WHO</td>
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<td>SpeObj-V.4</td>
<td>To ensure high quality of counselling and testing.</td>
<td>- Percentage of VCT sites that received a supervisory visit to assess quality of care in the last six months.</td>
<td>ST V.4.1 Ensuring quality counselling and testing services.</td>
<td>- Organize periodic supportive supervision of VCT centres all over the country for counsellors and HWs. - Organize periodic refresher training. - Provide checklists and reference materials. - Organize post basic training program for counsellors.</td>
<td>MoH, NACP, CHL HAMSET WHO, UNAIDS USAID/FHI</td>
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<td>SpeObj-V.5</td>
<td>To improve VCT data monitoring.</td>
<td>- Percentage of VCT sites that submitted on-time and complete reports to IDSR every month in the past year.</td>
<td>ST V.5.1 Integrating VCT reporting to the IDSR.</td>
<td>- Train health staff and counsellors on data collection analysis and reporting. - Provide VCT centres with appropriate database materials and reporting formats. - Establish a policy of high level of reporting completeness to IDSR.</td>
<td>IDSR, NACP</td>
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<td>SpeObj-V.6</td>
<td>To increase pregnant women’s access to high-quality services aimed at preventing MTCT.</td>
<td>By 2005, reduce 20% and, by 2010, by 50% the number of babies infected by HIV by ensuring that: 80% of pregnant women in antenatal receive HIV information, counseling and other prevention services; HIV-infected women and babies receive treatment to reduce mother-to-child transmission; and HIV-infected women receive voluntary and confidential testing and counseling, treatment, including antiretroviral drugs, and, if needed, breast-milk substitutes (pars. 5-4).</td>
<td>ST V.6.1 Promoting comprehensive MCH services that include antenatal, postnatal, childcare and PMTCT services.</td>
<td>- Support the health management system and perform systematic assessment of the quality and reach of MCH services in the country.</td>
<td>MoH, NACP, UNICEF, WHO, UNFPA</td>
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<td>SpeObj-V.7</td>
<td>To develop the capacity of health facilities to implement the PMTCT strategy.</td>
<td>No. of health facilities that have the necessary staff, equipment and drugs to offer PMTCT services.</td>
<td>ST V.7.1 Planning for a gradual scaling up of PMTCT services to zonal hospitals and other health facilities.</td>
<td>- Train HW from antenatal sites and Zoba referral hospitals on PMTCT strategy.</td>
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<td>ST V.7.2 Integrating post delivery follow up of HIV+ mothers and newborn babies.</td>
<td>ST V.7.3 Strengthening linkages and referral systems (MCH and Referral Hospitals)</td>
<td>- Train HW on post delivery follow-up of HIV+ women and children.</td>
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Adapted from UNGASS Declaration of Commitment Core Indicator.
Main Objective VI:
To ensure the safe transfusion of blood and adhere to universal infection prevention precautions in the health care settings and in the traditional practices

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<tr>
<td>SpeObj-VI.1 To ensure that blood units included in the national blood supply, at central and zoba levels, are not infected with HIV.</td>
<td>By 2003, implement universal precautions in health-care settings to prevent transmission of HIV (para. 51). By 2005, ensure a wide range of prevention programs in all countries that are culturally sensitive and available in local languages; reduce risky behaviour; encourage responsible sexual behaviour; reduce harm related to drug use; and expand access to male and female condoms, clean injecting equipment, safe blood supplies, treatment for sexually transmitted infections, and voluntary and confidential counselling and testing (para. 52).</td>
<td>- Percentage of blood units transfused in the last 12 months that have been adequately screened for HIV according to national or WHO guidelines. - Percentage of zoba blood banks (one per zoba) with access to blood transfusion services that do not pay blood donors, and do not recruit donors from among relatives of the client.</td>
<td>ST VI.1.1 Promoting national blood donor recruitment. ST VI.1.2 Developing and widely distributing blood policy &amp; guidelines at all level. ST VI.1.3 Expanding new blood banks in the zobas. ST VI.1.4 Equipping &amp; staffing all blood bank settings.</td>
<td>- Assess existing blood recruitment practices. - Formulate policies &amp; guidelines. - Establish blood banks where appropriate.</td>
<td>MoH, MoD, MoE, NUEYS, NUEW WHO, UNAIDS, UNICEF, USAID, FHI, Swiss Red Cross</td>
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<td>SpeObj-VI.2 To prevent HIV transmission due to accidental exposure to blood and blood products in health-care settings.</td>
<td>- Percentage of health facilities with posted guidelines on the prevention of accidental HIV transmission and a written protocol for post-exposure prophylaxis.</td>
<td>ST VI.2.1 Formulating policies and guidelines for post exposure prophylaxis.</td>
<td>ST VI.2.2 Developing training materials on safe injections and surgical procedures. ST VI.2.3 Introducing HBV vaccine to HWs.</td>
<td>- Train health workers on management of occupational exposure to HIV. - Develop policies regulating PEP; make PEP drug kits available at health facilities level. - Train health workers on safe injections &amp; surgical procedures. - Vaccinate all HWs against HBV.</td>
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<td>SpeObj-VI.3 To minimize risk of getting infections from injections, disposal of potentially contaminated items including sharp instruments and harmful traditional practices.</td>
<td>- Percentage of health facilities that have guidelines to prevent nosocomial transmission of HIV, adequate sterilization procedures, and surgical gloves in stock.</td>
<td>ST VI.3.1 Developing &amp; distributing infection prevention guidelines for skin piercing and other traditional/cultural procedures. ST VI.3.2 Training health workers and traditional practitioners who practice invasive procedures in universal precaution &amp; sterilization techniques. ST VI.3.3 Building appropriate infrastructure for hazardous waste disposal system. ST VI.3.4 Creating a mechanism by which traditional practitioners could be organized and given training.</td>
<td>ST VI.3.1 Promoting national blood donor recruitment. ST VI.3.2 Developing and widely distributing blood policy &amp; guidelines at all level. ST VI.3.3 Expanding new blood banks in the zobas. ST VI.3.4 Equipping &amp; staffing all blood bank settings.</td>
<td>- Assess current waste disposal practices at facilities and equipment in health care settings and other settings. - Initiate appropriate technology for hazardous waste disposal in all health settings. - Organize traditional practitioners as groups. - Develop training materials on safe practices. - Conduct training. - Carry out supportive supervision.</td>
<td>MoH, MoD, MoE, MoLG, NUEYS, NUEW WHO, UNAIDS, UNICEF, USAID, FHI, Swiss Red Cross</td>
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<td>SpeObj-VII.1</td>
<td>To increase specific biological diagnosis capacity for OI at centre &amp; zonal level.</td>
<td>By 2003, develop strategies, in collaboration with the international community, civil society and the business sector, to strengthen health-care systems and address factors affecting access to drugs, e.g., affordability, pricing, and system capacity. Urgently make every effort to provide the highest standard of treatment for HIV/AIDS, including prevention, treatment for opportunistic infections, and antiretroviral therapy. Cooperate in strengthening pharmaceutical policies to promote innovation and the development of domestic industries consistent with international law (para. 55).</td>
<td>Percentage of central and zonal facilities that have functioning equipment and supplies to diagnose opportunistic infections (OI) and at least one health worker who has undergone specialized training in the diagnosis/management of OI in children and adults.</td>
<td>ST VII.1.1 Determining the aetiologies for OI among AIDS patients in Eritrea.</td>
<td>- Conduct a study to determine OI aetiologies in all hospitals.</td>
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<td>ST VII.1.2 Setting up national reference laboratory for HIV/OI related diagnosis.</td>
<td>- Build laboratory set up for OI diagnosis</td>
<td>WHO, UNAIDS</td>
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<td></td>
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<td></td>
<td>ST VII.1.3 Building set up of HIV/OI diagnosis at national referral hospitals &amp; zonal hospitals including military hospital.</td>
<td>- Conduct training of laboratory technicians on OI diagnosis.</td>
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</tr>
<tr>
<td>SpeObj-VII.2</td>
<td>To increase knowledge of health workers from all referral hospitals on chemoprophylaxis &amp; early diagnosis of &amp; treatment of OI of adults &amp; children.</td>
<td>By 2005, implement comprehensive care strategies to: strengthen family and community health-care systems to provide treatment for people living with HIV/AIDS, including children; support individuals, households, families and communities affected by HIV/AIDS; improve the capacity and working conditions of health-care workers; improve supply systems, financing plans and referral systems to provide access to drugs, diagnostics, and medical, palliative and psychosocial care (para. 56).</td>
<td>ST VII.2.1 Building national capacity for management of OI.</td>
<td>- Train a core group of multidisciplinary trainers on HIV OI management.</td>
<td>MoH</td>
</tr>
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<td></td>
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<td></td>
<td>ST VII.2.2 Developing OI management guidelines.</td>
<td>- Conduct HIV OI management workshops at all levels.</td>
<td>WHO, FHI</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ST VII.3.1 Improving availability and access to appropriate drugs for OI management</td>
<td>- Conduct operational research project OI management.</td>
<td></td>
</tr>
<tr>
<td>SpeObj-VII.3</td>
<td>To ensure the availability of drugs for OI management.</td>
<td>By 2003, develop national strategies to: provide psychosocial care for individuals, families and communities affected by HIV/AIDS (para. 57).</td>
<td>ST VII.4.1 Building national capacity of HNs in counselling for adults &amp; children.</td>
<td>- Conduct capacity building/training workshops for OI management abroad.</td>
<td>MoH, CHL</td>
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<td></td>
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<td></td>
<td>ST VII.5.1 Develop linkage between VCT, PMTCT activities &amp; health services and support organizations.</td>
<td>- Conduct capacity building/training workshops for OI management locally.</td>
<td>WHO, UNAIDS</td>
</tr>
<tr>
<td>SpeObj-VII.4</td>
<td>To improve counselling capacity of HW in health facilities including children counselling.</td>
<td>ST VII.5.1 Develop linkage between VCT, PMTCT activities &amp; health services and support organizations.</td>
<td>- Conduct operational research project on stigma and discrimination.</td>
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<td></td>
</tr>
<tr>
<td>SpeObj-VII.5</td>
<td>To build up continuum of care &amp; support for HIV+ and AIDS patients and their families.</td>
<td>ST VII.5.1 Develop linkage between VCT, PMTCT activities &amp; health services and support organizations.</td>
<td>Create referral/mechanism of VCT, PMTCT</td>
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</tbody>
</table>

Note: ST VII.1.1, ST VII.1.2, ST VII.1.3, ST VII.2.1, ST VII.2.2, ST VII.3.1, ST VII.4.1, ST VII.5.1 refer to specific strategies and activities under the corresponding global goals and targets.
<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Corresponding Global Goals / Targets</th>
<th>Indicators</th>
<th>Selected Strategies</th>
<th>Key Activities</th>
<th>Lead Agencies &amp; Partners</th>
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</thead>
<tbody>
<tr>
<td>SpeObj-VII.6 To increase response capacity from HW, TBAs, relatives and support organization members, for home based care including nursing care.</td>
<td></td>
<td>- No. of communities with mechanisms for providing home-based care to PLHA and their families.</td>
<td>ST VII.6.1 Building national capacity for HBC for HW, TBAs &amp; relatives and support organization.</td>
<td>- Train a core group of multidisciplinary trainers on HIV on HBC management. - Conduct HIV on HBC management workshops at all levels. - Develop, adopt, translate and disseminate HBC manual. - Conduct needs assessment for HBC kits. - Prepare and distribute HBC kits. - Conduct operational research on cost implications of HIV/AIDS care in health care facilities.</td>
<td>MoH, CHL</td>
</tr>
<tr>
<td>SpeObj-VII.7 To ensure access to ARV treatment in selected hospitals.</td>
<td></td>
<td>- No. of hospitals that are currently stocked with nationally approved anti-retroviral drugs and report no stockouts of these drugs in the past 12 months.</td>
<td>ST VII.7.1 Building set up of Virology diagnosis reference laboratory for ARV monitoring.</td>
<td>- Build laboratory set up for ARV monitoring diagnosis. - Conduct training of laboratory technicians on ARV monitoring. - Conduct training of laboratory technicians on HIV biology and ARV monitoring diagnosis locally.</td>
<td>MoH, CHL</td>
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<td></td>
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<td></td>
<td>ST VII.7.2 Establishing ARV drug monitoring laboratory set up, including ARV resistance surveillance system.</td>
<td>- Develop TOR for ARV task force. - Establish ARV task force. - Develop and disseminate policy for access to ARV.</td>
<td>WHO, UNAIDS</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>ST VII.7.3 Defining a policy and strategy for access to ARV.</td>
<td>- Develop and disseminate ARV guidelines.</td>
<td>MOH, CHL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ST VII.7.4 Development of ARV therapy guidelines.</td>
<td>- Carry out need assessment for drugs in ARV management. - Conduct workshop to update the essential drug list. - Procure and distribute ARVs included in the essential drugs list.</td>
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<td></td>
<td></td>
<td></td>
<td>ST VII.7.5 Updating of the essential drug list to include ARV generics for procurement.</td>
<td>- Train a core group of multidisciplinary trainers on ARV management. - Conduct ARV management workshops at all levels.</td>
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<td></td>
<td></td>
<td></td>
<td>ST VII.7.5 Building national capacity for HW on ART from selected sites for adults &amp; children.</td>
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</tr>
</tbody>
</table>
### Main Objective VIII:
To expand the availability and quality of psychosocial and economic support for people infected with and affected by HIV/AIDS

<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Corresponding Global Goals / Targets</th>
<th>Indicators</th>
<th>Selected Strategies</th>
<th>Key Activities</th>
<th>Lead Agencies &amp; Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>SpeObj-VIII.1 To improve access of people infected and affected by HIV to voluntary testing and counselling services, and social and economic support.</td>
<td>By 2005, implement comprehensive care strategies to strengthen family and community health care systems to provide treatment for people living with HIV/AIDS, including children; support individuals, households, families and communities affected by HIV/AIDS; improve the capacity and working conditions of health-care workers; improve supply systems, financing plans and referral systems to provide access to drugs, diagnostics, and medical, palliative and psychosocial care (para. 56). By 2003, develop national strategies to provide psychosocial care for individuals, families and communities affected by HIV/AIDS (para. 57).</td>
<td>- No. of faith-based or community-based organizations providing care and support services to PLHA and their families.</td>
<td>ST VIII.1.1. Strengthening policies that encourage health workers and non-health workers to get involved in HIV counselling with clear and specific roles and responsibilities, and mechanisms for quality assurance.</td>
<td>- Conduct policy development and implementation workshops on involvement of lay people in HIV counselling to identify roles and responsibilities of the sectors and ensure quality of service. - Organize study tours and orientation programs for national and zoba level representatives of social service providers and CSOs.</td>
<td>MoLHW, MoH, MoD, BIDHO, NUEYS, NUEW, ECE, EBC, WFP, UNAIDS</td>
</tr>
<tr>
<td>SpeObj-VIII.2 To strengthen and expand facilities for providing home-based care for PLHAs.</td>
<td></td>
<td>- No. of fully equipped HBC providers active in all zobas and community level.</td>
<td>ST VIII.2.1 Strengthening capacity of health facilities and other social service providers (MoLHW, FBOs) to provide VCT and HBC services.</td>
<td></td>
<td>MoLHW, MoH, FBOs (ErCS, ECE)</td>
</tr>
<tr>
<td>SpeObj-VIII.3 To improve opportunities for people living with and affected by HIV/AIDS to continue being productive citizens able to support themselves and their families as long as possible.</td>
<td></td>
<td>- Prolonged productivity and better quality of life for people living with and affected by HIV/AIDS.</td>
<td>ST VIII.3.1 Establishing small business advisory services to promote self-employment opportunities for PLHAs.</td>
<td></td>
<td>MoLHW, MoH, BIDHO, NCEW, EFE, ILO, UNAIDS</td>
</tr>
<tr>
<td>Specific Objectives</td>
<td>Corresponding Global Goals / Targets</td>
<td>Core Indicators</td>
<td>Selected Strategies</td>
<td>Key Activities</td>
<td>Lead Agencies &amp; Partners</td>
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<tr>
<td>SpeObj-VIII.4 To ensure that PLHAs and their families who are in need of nutritional support have access to food aid.</td>
<td></td>
<td></td>
<td>ST VIII.4.1 Strengthening the logistical capacity of FBOs to distribute food and monitor nutritional status of people infected and affected by HIV/AIDS.</td>
<td>- Provide logistical support to public sector social services providers and FBOs for food storage and distribution.</td>
<td>MoLHW, BIDHO, ECE, ErCS, WFP</td>
</tr>
<tr>
<td>SpeObj-VIII.5 To improve the delivery of psychosocial support for AIDS orphans.</td>
<td></td>
<td></td>
<td>ST VIII.5.1 Strengthening care and support activities targeting AIDS orphans and their caretakers.</td>
<td>- Conduct baseline studies on situation of AIDS orphans. - Train professionals and lay counsellors in paediatric and child counselling skills. - Provide counselling and follow-up with nutritional support and medical treatment for AIDS orphans in institutions, group homes or extended family settings.</td>
<td>MoLHW, MoH, Vision Eritrea, Community support groups, UNICEF</td>
</tr>
<tr>
<td>SpeObj-VIII.6 To strengthen the coordination of care and support activities between and among the health and non-health sectors and improve quality assurance mechanisms.</td>
<td></td>
<td></td>
<td>ST VIII.6.1 Building national capacity for monitoring and supervision to ensure quality of service in VCT and care and support activities run by non-health workers.</td>
<td>- Establish M&amp;E unit within the NACP. - Develop M&amp;E protocols and formats for VCT, care and support activities.</td>
<td>MoLHW, Vision Eritrea, Community support groups</td>
</tr>
</tbody>
</table>
| | | | ST VIII.6.2 Improving the referral systems between health services and other social service providers and coordination between all public and private sector care and support programs. | - Develop referral system. | }
### Main Objective IX:
To promote research and improve surveillance, monitoring and evaluation of the HIV/AIDS epidemic and STI in all sectors, including the military

<table>
<thead>
<tr>
<th>Specific Objectives</th>
<th>Corresponding Global Goals / Targets</th>
<th>Core Indicators</th>
<th>Selected Strategies</th>
<th>Key Activities</th>
<th>Lead Agencies &amp; Partners</th>
</tr>
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<tbody>
<tr>
<td>SpeObj-IX.1</td>
<td>To promote medical/clinical operational research for decision making on HIV/AIDS and STI programs.</td>
<td>Support the development of research infrastructure, laboratory capacity, surveillance systems, data collection, processing and dissemination, and training of researchers, social scientists, health-care providers and technicians, particularly in countries most affected by, or at high risk of, HIV/AIDS (para. 71).</td>
<td>- No. of HIV/AIDS-related studies conducted in the past 12 months.</td>
<td>ST IX.1.1 Building capacity on research methodology and research.</td>
<td>- Train staff on research &amp; research methodology.</td>
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<td>ST IX.1.2 Establishing research centre at national and zoba level.</td>
<td>- Establish research centres. - Make resource materials available in the research centres.</td>
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<td></td>
<td>ST IX.1.3 Establishing information centre at national and zoba level.</td>
<td>- Make resource materials available in the information centres.</td>
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<td></td>
<td></td>
<td></td>
<td>ST IX.1.4 Establishing operational linkages with collaborating institutions.</td>
<td>- Identify collaborating institutions. - Establish working platform. - Coordinate research activities.</td>
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<td>ST IX.1.5 Opening of a website.</td>
<td>- Develop and launch website.</td>
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<tr>
<td>SpeObj-IX.2</td>
<td>To strengthen the surveillance system of HIV/AIDS and STIs.</td>
<td>By 2003, ensure that all research protocols are evaluated by independent ethics committees that include people living with HIV/AIDS and caregivers (para. 74).</td>
<td>- No. of zobas that have held at least two multisectoral HIV/AIDS Review Meetings to discuss surveillance estimates, trends, and other routinely collected information in the past 12 months.</td>
<td>ST IX.2.1 Establishing a surveillance, monitoring &amp; epidemiology sub- in NACP.</td>
<td>- Develop surveillance &amp; epidemiology procedures &amp; materials. - Conduct regular sentinel surveillance on a routine basis. - Conduct second-generation surveillance periodically. - Collect and analyze HIV data from other sources (EDF, Blood bank, VCT). - Collect and analyze AIDS cases data.</td>
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<td>ST IX.2.2 Building capacity on surveillance systems, including on computer applications and epidemiology.</td>
<td>- Develop training materials. - Equip and staff surveillance sites. - Train staff.</td>
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<tr>
<td></td>
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<td></td>
<td>ST IX.2.3 Establishing HIV sentinel surveillance sites in the zobas for different risk groups.</td>
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<tr>
<td>SpeObj-IX.3</td>
<td>To strengthen ethics in research.</td>
<td></td>
<td>No. of research projects assessed and approved by Research Ethics Committees at both the national and zoba levels.</td>
<td>ST IX.3.1 Developing guiding protocols.</td>
<td>- Assess existing ethical and legal aspects in the country. - Develop guiding protocols. - Develop TOR for legal consultative committees. - Establish legal consultative committees at national and zoba level. - Conduct regular meetings.</td>
</tr>
<tr>
<td>SpeObj-IX.4</td>
<td>To build data management capacity for decision making processes and purposes on HIV/AIDS and STIs.</td>
<td></td>
<td>- No. of sectors using appropriate data for decision making processes and purposes.</td>
<td>ST IX.4.1 Developing staff on computer applications and epidemiology.</td>
<td>- Assess existing practices of data monitoring. - Develop tools for data monitoring. - Disseminate information for decision makers and others who need the information for action.</td>
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</tbody>
</table>
VI. ANNEXES

Annex A
Terms of Reference of the HIV/AIDS National Strategic Planning Task Force

In order to oversee the development of the State of Eritrea new 5-Year National Strategic Plan to Control HIV/AIDS/STIs (2003-2007), the Ministry of Health is establishing an HIV/AIDS National Strategic Planning Task Force, whose main responsibilities are:

(1) To ensure that the new 5-Year National Strategic Plan to Control HIV/AIDS/STIs (2003-2007) will be drafted, costed and ready for submission to the Eritrean Partnership Against AIDS, Tuberculosis and Malaria or any other relevant government body by the end of December 2002, as per the proposed timeline for key events.
(2) To supervise and guide the work of the national and international consultants recruited to assist with the drafting the Situation and Response Analysis, and of the plan new 5-Year National Strategic Plan.
(3) To regularly review the proposed process (see below) for the development of the national strategic plan and timeline of key events, make necessary adjustments and assign tasks accordingly.
(4) To provide all necessary logistical support for activities including in the process, such as gathering of documents, organizing field trips, preparing stakeholders’ meetings and workshops, etc.
(5) To call upon and secure all necessary technical expertise.
(6) To liaise with partners supporting the process, i.e. FHI/USAID, UNAIDS, UN Theme Group on HIV/AIDS, for delivery of agreed upon inputs.

Composition of the Task Force

Dr. Andeberhan Tesfazion, Manager, NACP/MOH, Task Force Leader
Dr. Eskinder Hadgu, Medical Adviser, NACP/MOH
Sr. Nighisti Tesfamicael, Counselling Coordinator, NACP/MOH
Mr. Dominique Mathiot, CPA, UNAIDS
Dr. John Cutler, Country Director, FHI
Mr. Temesghen Araya, HIV/AIDS National Program Officer, UNICEF
Dr. Yohannes Ghebrat, DPC Adviser, WHO

Mr. Maina Kiranga, HIV/AIDS BCC Adviser/MOH, FHI
Mr. Hagos Ghirmay, Chairman, BIDHO
Dr. Dominique Kerouedan, International Consultant, FHI
Ms. Saba Issayas, National Consultant, FHI


Phase I: Situation Analysis

The core team: international consultant, local consultant(s), NACP staff and others as needed.
Time frame: 4 weeks.

Desk review and analysis of key documents
- Collect key documents, summarize their content and critically assess their content.
- Existing strategic plan: critically examine the plan to identify its strengths, weaknesses and gaps; determine what elements continue to be relevant and which are obsolete, assess what has been accomplished and what remains to be implemented and expanded.
- Policy, legal and political documents including other relevant background documents that define the policy and structural environment for planning and executing HIV/AIDS/STI activities that will respond effectively to the epidemic.
- Basic country and regional data that are relevant to set the scene for the situation analysis.
- Specific HIV/AIDS data including HIV sero-prevalence and HIV/STI surveillance data, HIV screening results from military/national service, results of behavioural studies etc.

Outputs
- Situation analysis that outlines the basic epidemiological situation and predicts future trends based on the available data.
- Impact assessment of epidemic at the current time and, if possible, based on the predicted growth of the epidemic in the future.
Identify any threats and situations that contribute to the spread of HIV, that hinder care and support and mitigation efforts including behavior, stigma, ignorance etc.

Analysis of the context of the epidemic and the response including the social, economic, political, cultural and legal framework.

Partner analysis
- Inventory of current and potential partners with a special focus on the health, military, social, legal/ethical, education, cultural, economic, communications, research, university and institutional partners etc.
- Critical analysis of the strengths, weaknesses and gaps of the current and potential partners identified.

Outputs
- Inventory of current and potential stakeholders, organizations and partners.
- Analysis of the strengths, weaknesses and gaps of current and potential partners.
- Recommendations of how to ensure greater involvement of partners in the strategic planning process and in the response to the epidemic.

Response analysis
- Inventory of activities and efforts being carried out by Government and partners to combat the HIV/AIDS epidemic.
- Including past, current and planned activities for prevention, care and support and mitigation of the epidemic.
- Analysis of past, ongoing and planned project activities including those of the Government, the military, HAMSET, the UN family, Care and Support, faith-based organizations, NGOs, CBOs etc.

Outputs
- Inventory of activities and actions taken.
- Detailed analysis of the response citing strengths, weaknesses and gaps of each activity.
- Identify model activities and approaches that have potential for expansion, modification and scaling up.
- Global analysis of the response citing strengths, weaknesses and gaps in the overall response to the HIV/AIDS epidemic.

Suggested methodology
- Develop basic data collection format for reviewing documents and for conducting interviews with key individuals.

Collect documents from key sources.
Meet with stakeholders, organizations and partners.
Visit operational areas at central, zoba, subzoba and community level.
Meet and interview key individuals involved with the response.
Review findings and draft reports with the help of NACP staff and others.

Skills building workshop for top managers from line ministries and partner organizations. This training coordinated by the MOH/NACO and UNAIDS shall take place concurrently with Phase I activities. This workshop will build basic HIV/AIDS skills and understanding among the top managers in line ministries, zobas and partner organizations. These skills will focus on AIDS competency and multisectoral programming skills. These skills will enable the managers from line ministries, zobas and partner organizations to understand the basic issues of HIV/AIDS, how it affects their sector and constituency and what role they and their sector must play in responding effectively to the epidemic. This advanced understanding and these skills will enable the top managers to participate actively in the multisectoral strategic planning process that follows in Phase II.

Conclusion of Phase I Activities
- Written draft situation analysis and response analysis.
- Presentation of the draft report to the Stakeholders’ Meeting.
- Facilitate Stakeholders’ Meeting.
- Written final report of Phase I based including the contributions from the Stakeholders’ Meeting.

Stakeholder meeting
- Present and disseminate the draft situation and response analysis document.
- Ensure broad-based understanding and support for the current situation, threats, opportunities etc.
- Ensure the commitment and support for the strategic planning process.
- Review upon the proposed next steps for the strategic planning process.
- Agree upon and ratify the expanded and comprehensive strategic planning approach.
- Ratify the strategic planning process, work out a detailed workplan for the process including concrete activities, responsible individuals and organizations and a committed time frame for action.
Phase II: Developing the New Strategic Plan (2003-2007)

**The core team:** international consultant, local consultant(s), NACP staff, focal persons and top managers from sectors, partner organizations and key stakeholder representatives.

**Time frame:** 4 weeks

**Sectoral Strategy Development Process**
- Consultants (in consultation with the NACP) shall:
  - Define the overarching principles for the strategic planning process.
  - Write guidelines provide a general outline and general methodology for the sectoral strategic planning process.
  - Assist the sectors to establish a task force to draft the sectoral plan.
  - Ensure that each sector involves the relevant levels and sub-sectors in the sectoral strategic planning process.
- Consultants shall facilitate the strategic planning process at the sectoral level.

**Outputs**
- Guidelines, methodology and outline for sectoral strategic planning.
- Sectoral strategic plans for each of the sectors.

**Sectoral Strategy Development**
- With the assistance and facilitation, each major sector and level shall develop a *costed* sectoral strategy and short-term (one to two year) plan for implementation of activities based upon the analysis carried out in Phase I and the concurrent sectoral managers’ skill-building workshop.

**Outputs**
- Sector strategic plans with costings and with short-term implementation plans

**Conclusion of Phase II Activities**
- Written draft sectoral strategic plans that are costed and presented in a harmonized format.
- Written draft national strategic plan that synthesizes the sectoral strategic plans and fills any remaining gaps that are not covered by the sectoral strategic plans.
- Presentation of the draft national strategic plan to the Second Stakeholders’ Meeting.
- Facilitate Second Stakeholders’ Meeting.
- Written final report of Phase II including a final draft of the national strategic plan that includes the contributions from the Second Stakeholders’ Meeting.

**Stakeholders’ meeting**
- Each sector will present their sectoral strategic plan.
- Facilitators will present the national strategic plan.
- Facilitate the discussion and plans and bring them into alignment with one another.
Annex B. Current HIV/AIDS Coordinating Bodies in Eritrea

A. Government

A.1 The National AIDS Technical Committee (NATC)

Established in September 2001 by the Minister of Health. Members of the committee include: NATCoD staff; the Director of the Blood Bank; the Director of the Central Laboratory; the Chief of the IEC Unit of the MOH; a representative from the EDF Health Service; the UNAIDS CPA; the FHI Resident Adviser; the PSI Country Representative. The chairperson of the committee is the Director of NATCoD. This committee meets by weekly.

The purpose of the NATC is: 1) to enhance the coordination of all HIV/AIDS-related activities in the country; 2) to facilitate joint planning of programmes and activities, and 3) to accelerate the implementation of programmes.

A.2 The National HAMSET Technical Committee (NHTC) and the National HAMSET Steering Committee

The Director General of Health Services of the Ministry of Health chairs the National HAMSET Technical Committee. Its Secretary is the Director of NATCoD. Members include: the PMU Director, and technical experts designated by all concerned line ministries (Health, Education, Labour and Human Welfare, Local Government, Tourism, Agriculture, Defence) as well as NUEYS, NUEW and NCEW. The NHTC meets normally once a month. It reports to the National HAMSET Steering Committee through its chair.

The main function of this committee is to provide guidance for all project activities, review technical aspects and progress.

The Ministry of Health chairs the National HAMSET Steering Committee, which includes the Ministers of the same lined ministries, plus the six Zoba Governors.

The main function of this committee is to provide strategic directions and policy guidelines. It meets at least quarterly.

A.3 The Eritrean Partnership Against HIV/AIDS, Tuberculosis and Malaria (“The Partnership”)

The Government, as part of the process to submit its first proposal to the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), officially established the Partnership in March 2002. The Partnership is chaired by the Ministry of International Cooperation, Macro-Policy and Economic Coordination (ICMPEC). The Vice-Chair is the Chairperson of the UNDAF Theme Group on HIV/AIDS (see B.1 below). The Executive Secretary is the Minister of Health. The Partnership meets bi-annually and on an ad-hoc basis.

The major functions and responsibilities of The Partnership are: 1) To provide input for the preparation of national strategic plans for the three diseases; 2) To review bi-annually progress made toward the implementation of national programmes on the three diseases, in line with indicators set in: a) The United Nations Declaration of Commitment on HIV/AIDS, New York, 27 June 2001; b) The Abuja Declaration and Framework for Action for the Fight Against HIV/ AIDS, Tuberculosis and other Related Infectious Diseases in Africa, 27 April 2001, and c) The United Nations Millennium Declaration, New York, 8 September 2000; 3) To continue advocacy at all levels for implementation and resource mobilization with regards to the prevention of the three diseases in Eritrea; 4) To review and recommend policies and guidelines related to the three diseases.

The Secretariat of The Partnership is located in the Ministry of Health and is composed of the following members: Executive Secretary; Deputy Executive Secretary; Director General of Health Services; Director General of Regulatory Services; Director of NATCoD; Director General of Research and Human Resources Development; Director Project Management Unit (PMU); NATCoD Director; UNAIDS Country Programme Adviser.

The main functions of the Secretariat of the Partnership are to carry out the following functions on behalf of the The Partnership: 1) Review and approve workplans submitted by various implementing partners; 2) Instruct the Principal Recipient to disburse funds according to these workplans; 3) Review regularly the progress made towards the implementation of The Partnership programme.
A.4 Standing Government Task Forces and Committees

The Government, through the Ministry of Health, has also formed a number of standing or ad-hoc Task Forces and Committees whose main functions are generally to coordinate inputs of various partners (government, CSOs, UN and bilateral donors, etc.) for specific tasks and/or technical areas.

The main ones are as follows:

- HIV/AIDS National Strategic Planning Task Force
- Ad-Hoc Task Force on the Global Fund
- HIV/AIDS Care and Support Committee
- Ad-Hoc Committee for the World Aids Campaign
- ARV Treatment Expert Group

B. United Nations

B.1 The UNDAF Theme Group on HIV/AIDS (UNTG)

The governing body of UNAIDS is the UN Theme Group (UNTG). In Eritrea, all UN agencies having offices in the country are associated with the UNTG, namely, FAO, UNDP, UNFPA, UNHCR, UNICEF, UNMEE, WB, WFP, WHO, plus UNAIDS.

Following the development of the 1st United Nations Development Framework (UNDAF) for Eritrea (2002-2006), an UNDAF Theme Group on HIV/AIDS was established with the following terms of reference: (a) To monitor the implementation of the UN Integrated Workplan on HIV/AIDS (on a six month basis); (b) To share information on HIV/AIDS activities undertaken or supported by members; (c) To promote political commitment, multisectoral involvement and appropriate policies, including human rights policies, with the counterparts of UNTG members; (d) To identify and address specific financial and technical gaps; (e) To assist the government in organizing coordinated resource-mobilization exercises (round-tables) in support of the national strategic plan; (f) To identify and address specific policy issues.

The UNDAF Theme Group is currently chaired by the UNFPA Representative, and co-chaired by the Director General of Health Services of MoH. The Chair rotates every two years. Members include heads of UN agencies mentioned in paragraph above, as well as senior representatives of key lines ministries (MoD, MoE, MoLHW, MoLG) and CSOs (NUEYS, NUEW, NCEW). The UNDAF Theme Group on HIV/AIDS met for the first time on 7 November 2002.

B.2 The Technical Working Group on HIV/AIDS (TWG)

The Technical Working Group (TWG) is the “operational arm” of the UNTG. It is composed of the UNTG member organizations, plus the NATCoD Director and representatives of BIDHO (a recently created association of people living with or affected by HIV/AIDS), the EDF Health Service, FHI, NCA, NCEW, NUEW, NUEYS, PSI and the UN Clinic Physician. The Chair of the TWG rotates every six months. The current chair is the UNDP HIV/AIDS focal point.

Under the direct supervision of the UNTG, its main functions are: (a) To assist/reinforce the capacity of the national leadership to coordinate, manage and monitor the expanded response to the HIV/AIDS epidemic and its consequences; (b) In close collaboration with NATCoD, to prepare, implement and monitor annual integrated workplan of the UNTG; (c) To jointly review HIV/AIDS activities of the Cosponsors; (d) To ensure that policies and broad activities of the respective Cosponsors and of UNAIDS are reflected in UNTG support to the national response; (e) To identify and plan appropriate areas for joint action by the UNTG; (f) To promote the integration of HIV/AIDS in the regular programmes of the Cosponsors; (g) To identify the technical support needs of the Cosponsors and of NATCoD, and assist in mobilizing such support; (h) to undertake continuous monitoring and annual evaluation of the integrated workplan of the UNTG. 14

The TWG forms ad-hoc Task Forces 1) to carry out specific tasks (i.e. CCA revision and update, UNDAF preparation, Integrated Support Plan development); 2) to develop and coordinate special programmes (i.e. the World AIDS Campaign 2001 Programme of activities, or the UNTG “Caring For Us” Programme, and 3) to monitor the implementation of various projects (i.e. projects on GIPA, CSW, Female condom, with the military, etc.)

Annex C. Selection of key reference materials

Government/Ministry of Health
- Proposal to Expand and Accelerate the Fight against AIDS, Tuberculosis and Malaria submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria, The Eritrean Partnership against AIDS, Tuberculosis and Malaria, September 2002.

ESMG/PSI
- Qualitative Study to Identify Barriers to the Incidence & Consistency of Condom Use Among Youth in Eritrea, ESMG, November 2000.

United Nations
- Guide to the strategic planning process for a national response to HIV/AIDS, UNAIDS Best Practice Collection Key Materials.
- Project appraisal document on a proposed credit in the amount of SDR 31.4 million (USD 40 million equivalent) to the Government of Eritrea for HIV/AIDS, Malaria, STIs and TB (HAMSET Control Project), The World Bank, November 2000.
- Study on potential food aid assistance to people with HIV/AIDS living in Eritrea, WFP, December 2001.
- Access to care including antiretroviral therapy: Eritrea, UNAIDS (Sozi C.) and UNDP (Katana M.) Trip Report, Asmara, 5-12 September 2002.
- Staying Safe on the Streets, A Situational Analysis of Commercial Sex Work in Eritrea, ESMG for NACP, UNFPA and UNAIDS, March 2003

USAID/FHI
- Effective prevention strategies in low HIV prevalence settings, USAID, FHI Impact, UNAIDS Best Practice Collection Key Materials.