NATIONAL GUIDELINES

FOR

VOLUNTARY HIV COUNSELING AND TESTING IN ETHIOPIA

The National AIDS Council Secretariat

The National HIV/AIDS Council Secretariat recognizes WHO for covering the printing costs of the Guidelines

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti Retro-viral
CRDA	Christian Relief and Development Association
CSW	Commercial Sex Workers
ELISA,	Enzyme Linked Immuno Sorbent Assay
GPA	Global Program on AIDS
HIV	Human Immuno Deficiency Virus
IEC	Information Education & Communication
MOH	Ministry of Health
MTCT	Mother To Child Transmission
NAC	National AIDS Council
NGO	Non-Governmental Organization
OI	Opportunistic Infections
OSSA	Organization of Social Services for AIDS (OSSA)
PMTCT	Prevention of Mother to Child Transmission
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
TB	Tuberculosis
TWG	Technical Working Group
UNAIDS	Joint United Nations Program on AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Introduction

Although Ethiopia has been hit by the HIV/AIDS epidemic later than many East African countries, the Ministry of Health (MOH) estimates adult HIV prevalence in Addis Ababa is estimated to be 16.8%; other urban adult prevalence is 13.4%; rural adult prevalence is 5%. The AIM model calculates that in mid 2000, 2.6 million Ethiopians are infected with HIV. This includes 2.4 million adults and 250,000 children.[1] As much as 20% of all hospital beds in the country are occupied by AIDS patients. This has lead to a severe burden for health service provision.[2]

Studies show that the highest prevalence for HIV/AIDS occurs between 20-29 for females and 20-39 for males. These infections were likely acquired several years earlier, suggesting that young people are becoming infected in their teens[3]. An earlier study of the distribution of sexually transmitted infections (STI) conducted in 1991 and 1992, found that the 15-24 age group had the highest prevalence of STIs (54%), followed by the 25-35 age group (26.3 %). These figures suggest a serious STI/HIV epidemic among young people.

Misconceptions and inadequate knowledge of HIV transmission among the youth in Ethiopia are common. Data on the rate of infection for youth aged 5-18 is almost non-existent, with few cases of HIV/AIDS having been officially reported for this age group. In addition to MTCT, a significant number of HIV infections may occur as early as 10 years of age for girls due to harmful traditional practices including early marriage. Few counseling services exist for youth, particularly for young girls.

Many people with HIV in Ethiopia do not know that they are infected. Up until now, only a small percentage of those with HIV/AIDS have had access to reliable voluntary counseling and testing services. As there is no cure for HIV/AIDS, voluntary HIV counseling and testing remains a key strategy to control the spread of HIV and to provide care and support to those who are positive.

In Ethiopia HIV counseling began in the late 1980s with services expanding throughout the 1990s. In the early 1990s, several national level training programs were conducted for nurses and social workers from all regional hospitals and those in Addis Ababa.

In addition to setting up counseling services in health institutions, the Ministry of Health collaborates with other NGOs to provide social services for those infected through the Organization of Social Services for AIDS (OSSA), Medical Missionaries of Mary(MMM), Mother Theresa Home and others.

Situation Assessment of VCT Practices in Ethiopia

A situation assessment was conducted in September 2000 on voluntary counseling and testing practices in Ethiopia. According to available information, there are 80 institutions in the country involved in providing either HIV testing or counseling or both. Out of these, 38 were selected for the current assessment. The findings indicate that most health institutions in the regions do not follow standardized VCT or safety precautions guidelines. Health facilities have no private rooms for HIV counseling.

Confidentiality of test results is maintained in many of the institutions. Information about individuals is kept secret by minimizing access to the records. The assessment reveals that the demand for HIV testing is growing but service provision by government facilities is limited due to shortages of physical facilities, test kits and trained man power. The mechanism for quality control and assurance of HIV test kits is also not well established.

Few health facilities have full time counselors. In some places counseling and testing services were interrupted for months due to transfer of trained staff.

Referral system for HIV positive individuals to care and support centers and to other institutions involved in VCT services is not well developed. As the number of people coming to the institutions for VCT is growing , this service needs consideration.

There is no system to monitor or evaluate VCT services. Neither the quality of counseling service provided, the efficacy of the service nor the problems associated are assessed.

The majority of health facilities have a shortage of test kits and these are delivered to them with, short shelf life. It was observed that the facilities had kits which had expired or were about to expire. Only one type of rapid test kit was used by all rural and most regional hospitals for both diagnosis and screening. The mechanism for sending blood specimen to referral laboratories and getting test results on time was not well developed.

Objectives of the Guidelines

These guidelines are written as a practical guide for those who are providing voluntary HIV counseling and testing services in the following places: government, non-government and private health facilities and free standing VCT centers. They elaborate on the counseling and testing components of the Ethiopian National Policy on HIV/AIDS produced by MOH in 1998. The guidelines will help to standardize VCT services in the country.

Definitions

HIV counseling has been defined as a confidential dialogue between a client and a care provider aimed at enabling the client to cope with stress and to take personal decisions related to HIV/AIDS.

Voluntary HIV counseling and testing is the process by which an individual undergoes counseling enabling him or her to make an informed choice about being tested for HIV. This process is also aimed at helping them to cope with stress and to make personal decisions related to HIV/AIDS.[5]

HIV testing, for the person being tested, has far reaching consequences beyond that of the diagnosis. Although there are many benefits to knowing one's HIV status, in communities where HIV is perceived as a stigmatizing condition, there may be negative consequences of testing. Consequently no one should be coerced into being tested but agree voluntarily.

In VCT, HIV testing should only be performed after the client has given informed consent. *Informed* in this context, means that during discussion (pre-test counseling), the client has been made aware of all the risks and benefits, as well as of alternatives to such testing in a language he/she can understand. *Consent* means accepting to be tested for HIV in a situation devoid of coercion, in which the client should feel equally free to grant or withhold consent.

HIV testing is application of an assay (e.g. ELISA, rapid test or Western Blot) for laboratory markers of HIV infection such as HIV antigen or antibodies. In VCT, HIV testing occurs with the intention to determine an individual's infection status at the time the test is performed.

Anonymous testing is HIV testing in which the blood sample and test result are identified only by code, not by name, with no personal identifiers to link the sample to the client.

Confidential testing is HIV testing in which only the client and the health professionals involved in the client's direct care know that the test was performed and have access to the results.

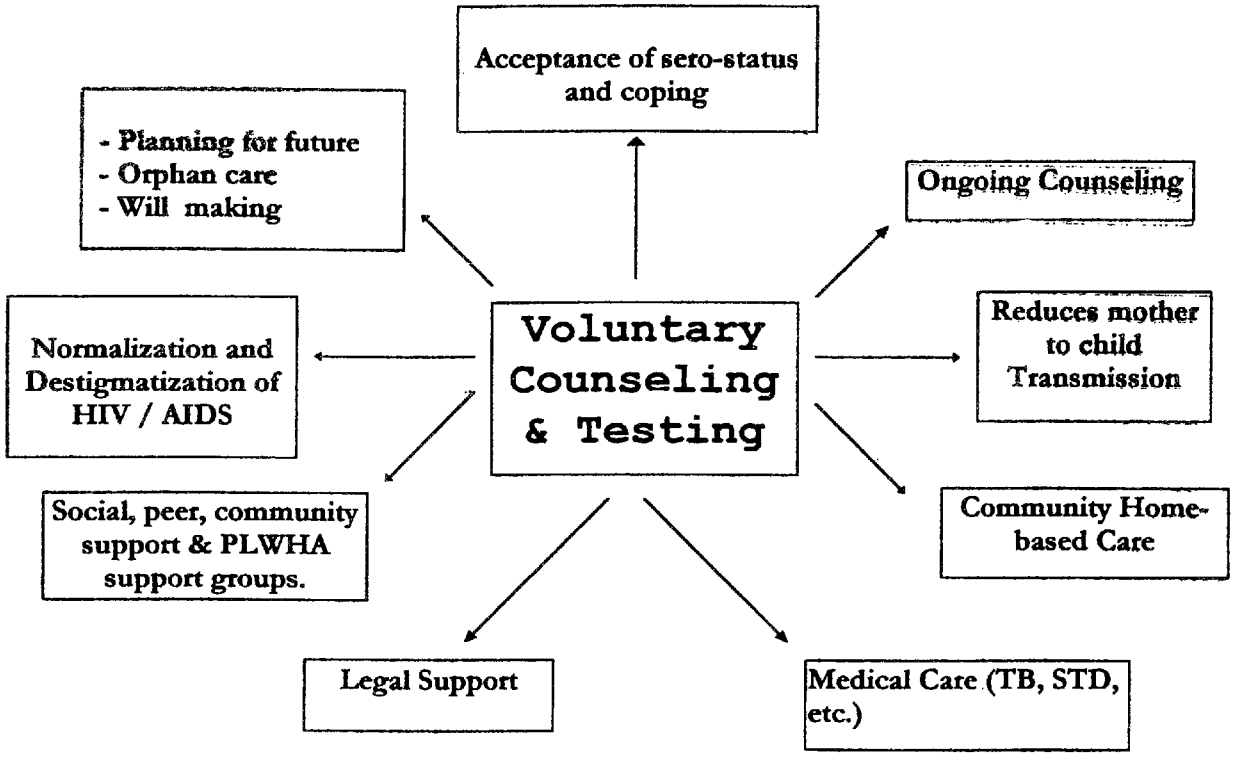
In VCT settings, HIV testing could be either anonymous or confidential.

Objectives of Voluntary HIV Counseling and Testing

1. To provide information on the mode of HIV transmission and methods of prevention.
2. To help those who wish to consider HIV testing, make a decision about whether or not to be tested and to help provide support following the testing.

3. To provide information on the increased risk of HIV transmission associated with other sexually transmitted infections (STIs), and give referrals for STI examination and treatment.
4. To provide information on the increased risk of opportunistic infections including tuberculosis (TB) associated with HIV infection.
5. To provide family planning information and referrals for women of child bearing age who are infected or at high risk of HIV infection.
6. To provide referrals to HIV positive and high risk HIV negative persons for necessary medical, preventive and psycho-social services and home based care in the community.

VCT as an entry point for HIV Prevention and Care



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HIV Counseling Guidelines

Necessary Elements of Voluntary HIV Counseling and Testing

The following are the necessary elements of VCT that counselors and supervisors should know very well.

Maintenance of Confidentiality

Many people are afraid to seek HIV services because they fear stigma and discrimination from their families and community. Strict protection of client confidentiality must be maintained for all persons receiving HIV counseling services. Confidentiality forbids any reference to, or discussion about a client or a test result, except within a professional relationship, and only then with the consent of the client.

Prevention Counseling

Prevention counseling should include the individual face to face or large and small group counseling.

- Risk assessment is the portion of the discussion that encourages the client to identify, understand, and acknowledge his or her personal risk for acquiring HIV. It serves as a basis for developing a plan to reduce risk, therefore is an essential component of prevention counseling.
- The session should be focused on HIV risk reduction
- Important misconceptions about HIV transmission risks must be clarified
- Seek flexibility in the counseling process and prevention approach
- Provide skill building exercises
- Acknowledge and provide support for positive steps that have already been made
- Have client return to the same counselor, if possible
- Use a written protocol/outline of points for discussion
- Ensure ongoing support of supervisors and administrators
- Use materials appropriate for the setting
- Avoid using counseling sessions as a time for collecting surveillance data
- Avoid very long counseling sessions

Provision of information about HIV/AIDS and correction of misconceptions

- Discuss what the virus is and how it is transmitted
- Discuss the appropriate preventive measures and correct misconceptions

- Assist the client to identify his/her risk of acquiring HIV and prepare the client for taking the test

Development of a personalized risk reduction plan

- HIV prevention should be directed at risk reduction particularly for those with high risk of acquiring or transmitting HIV
- Knowledge of HIV transmission is important information that a client can use to plan behavior change.
- Give information about preventive services for related infections

Provision of support to implement the risk reduction plan

- Provide condoms
- Plan for ongoing counseling
- Provide updated information

Explanation of the meaning of HIV test result

- A negative test result means that the person is either (1) not infected, or (2) so recently infected that the test could not detect the infection. In the latter case, the person could be in the "window period". During this period, which may last up to 6 months after the initial infection, the person is infected with HIV and can infect others, but will have a negative test and possibly no physical complaints.

- A positive result means that the person is infected with HIV and can transmit it to others.
  - Discuss the need for retest
  - Discuss the client's expectations of test results.
  - Discuss the client's plan to cope while waiting for the result.
  - Explore with the client support systems that may be available.
  - Ensure that the client understands what will happen in the post-test counseling session.
  - Discuss risk reduction options / strategies.

Provision of Test Results

An HIV test can be helpful to a client only if the client understands the test result. Providing HIV test result to a client involves interpretation that is based upon the test result and the client's specific risk for HIV infection. Knowledge of HIV status is important information that a client can use to plan behavior change and if infected, to learn to live positively. Skillful counseling is required to support the client.

Informed Consent

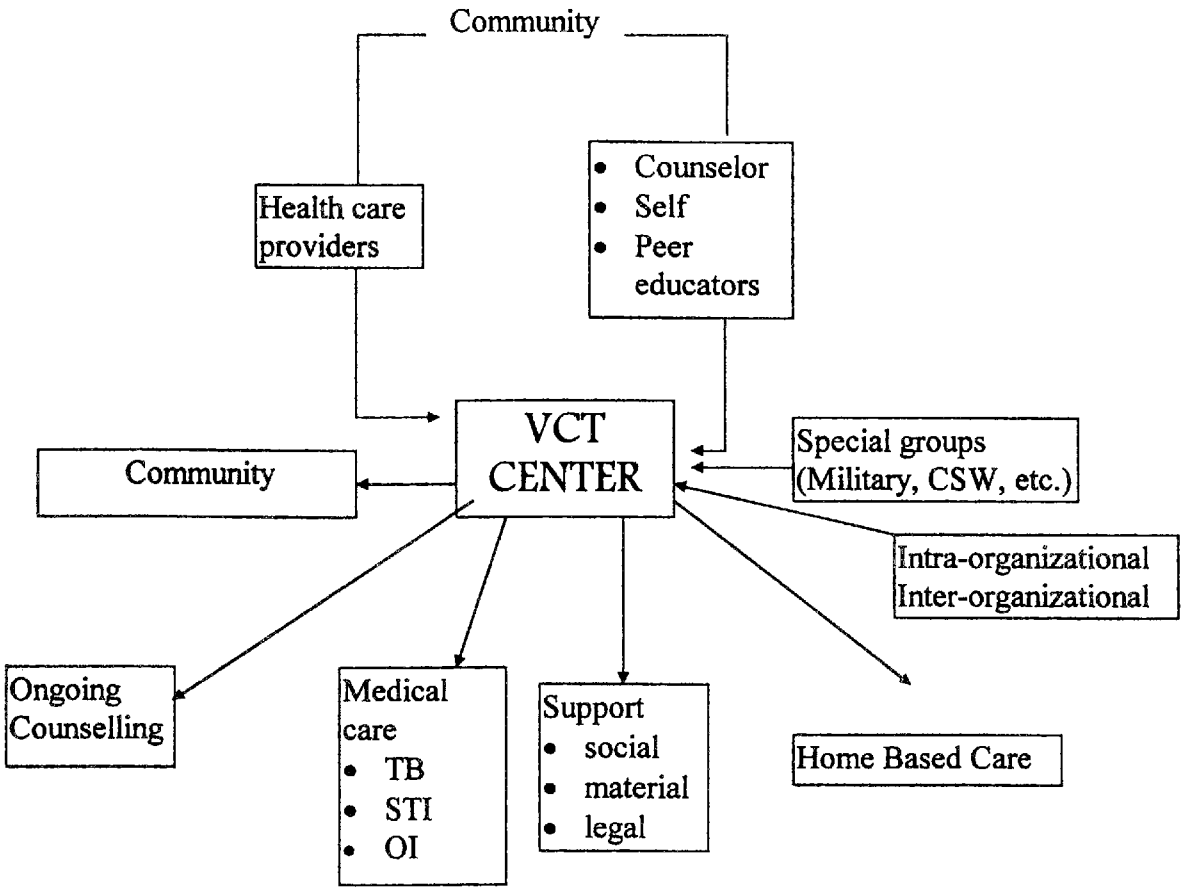
HIV Testing should be preceded by informed consent as it may have far-reaching implications for the person being tested. While there are benefits to knowing one's status, HIV is a stigmatizing condition in some communities and this can lead to negative outcomes for some people following testing. Therefore, HIV testing should always be voluntary and with informed consent.

Provision of Referrals

Together, the provider and client should assess and prioritize the client's referral needs. Clients often require referral for medical treatment, TB, STDs and ongoing psycho-social support. A referral system should be developed in consultation with local hospitals, faith-based organizations, youth groups and/or anti-AIDS clubs, other community-based organizations as well as with any networks/groups of people living with HIV/AIDS.

A process for routine referrals should be established by maintaining a list of community and institutional referral resources such as clinics, social service agencies, women's associations, hospitals, orphan care and support services, prenatal care clinics, family planning clinics, HIV/AIDS community based organizations and religious institutions and establish a liaison with these resources.

Referral Diagram



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Where should VCT services be provided?

Voluntary Counseling and Testing services in health facilities should continue with further extension into the specialized clinics: like ante-natal clinics, TB clinic, STI clinic services.

Due to the inconvenient locations of many health facilities and the work load that exists in these facilities, people coming for VCT services do not get the service quickly and efficiently. Therefore, Free standing VCT centers could be other options where people may prefer to go for the service to get it right away. Free standing VCT centers are institutions where voluntary counseling and testing is given outside the classical or conventional integrated health institutions. They are usually placed with in the community where the public can have easy access. Therefore, their number should be increased in appropriate locations where the public can have access easily. The involvement of community leaders(Kebeles) in sensitization and mobilization will be highly essential in this regard.

While establishing a free standing VCT site, each site should have at least the following :

- An appropriate private room for counseling
- A room for HIV testing
- Appropriate equipment and recommended test kits Appropriate supplies for testing
- A trained counselor
- A health worker certified in rapid HIV testing from an authorized institution.
- Appropriate record keeping, monitoring and evaluation system.
- IEC materials and condom stock.

Who should be provided with HIV prevention counseling?

- Clients seeking services at facilities which serve people at increased risk e.g. STD clinics,
- Clients seeking services in VCT sites, family planning clinics, ante natal clinics, Red Cross blood banks and youth facilities.
- Sex partners of HIV infected persons
- Persons seeking repeat HIV testing
- Persons who specifically seek HIV test regardless of known or suspected HIV risk

Who should be a Counselor?

- Influential and respected persons of a community
- Dedicated school teachers
- Motivated health workers
- Peer counselors/volunteers
- PLWHAs

Anyone selected to be a counselor should be given at least two weeks of training on counseling

Guidelines for Program Managers/Supervisors

HIV/AIDS counseling takes place in a wide variety of settings. Regardless of the HIV prevalence in a region, counseling services should be available at:

- Sites where care is being provided for HIV-positive persons or those suspected of being infected.
- Sites where HIV tests are done and can be traced to the individual (linked HIV testing).
- Sites which are accessible; and should be culturally and linguistically appropriate.
- Non medical settings for youth on a pilot basis.

In defined geographical areas where HIV prevalence is high, HIV/AIDS counseling services should also be considered for:

- Designated independent sites where VCT can be sought,
- Sexually transmitted infection (STI) clinics, tuberculosis clinics, ante-natal clinics, non medical sites which provide services for youth, and sites which serve persons with high risk behaviors such as commercial sex workers, military, and long distance truck drivers.

Managers/supervisors should accomplish the following:

- Ensure that VCT centers operate during appropriate hours and with minimal delay in providing services
- Provide rapid HIV test kits regularly to ensure **same day** results.
- Establish systems to ensure that strict confidentiality and/or anonymity is maintained for all persons coming for voluntary HIV counseling and testing services.
- Ensure that all persons who seek HIV testing are offered pre- and post-test counseling.
- Target counseling to persons who engage in high risk behaviors.
- Ensure that HIV counseling is tailored to the individual clients needs and should involve clients in identifying their own risk behaviors
- Ensure that there is quality control for counseling

- Ensure training and re-training for counselors
- Ensure appropriate information, education and communication(IEC) materials are available and distributed.
- Ensure that condoms are available at all VCT sites.

Guidelines for Counselors

The VCT process consists of pre-test, post-test and follow-up HIV counseling. HIV counseling should be adapted to the needs of the clients. Therefore a counselor should take into account the following:

Approaches to Counseling

Counseling could be carried out using various approaches such as:

- Face to face Sessions
- Group Sessions(small and homogeneous)
- Couple Counseling
- Telephone Sessions

Pre-test Counseling

Counseling should be offered before doing an HIV test. As part of the pre-test assessment, the counselor should accomplish the following[6]:

- Ascertain the client's understanding of HIV transmission and the meaning of the antibody results.
- Correct misconceptions.
- Conduct an individualized risk assessment and develop a personalized risk reduction plan.
- Ensure that the client understands the risks and benefits of knowing his/her HIV infection status.
- Discuss what the test results mean(*see page 9*).
- Assess the capacity to cope with HIV positive result.
- Discuss potential needs and available resources.
- Ensure that all blood samples collected are coded when they are sent to the laboratory and test results are kept confidential(where counselors do the blood collection)
- Conduct a condom use demonstration.
- Obtain consent for HIV testing.
- Prepare the client for the results.

Post-test Counseling:

Post-test counseling should always be offered. The main goal of this counseling session is to help the clients understand their test results and initiate adaptation to their sero-positive or sero negative status. For post-test counseling, the counselor should therefore:

- Discuss what a positive and negative result mean based on the client's risk of infection.
- Assure the client that the test results and any other information he/she provides will remain confidential.
- Provide HIV positive results only by personal contact with the client, ensuring a confidential environment.
- Provide counseling when giving the results to assess the client's readiness to receive HIV test results
- Ensure the client understands what the results mean and address immediate emotional concerns
- Reinforce the plan for reducing risk considering the client's HIV status.
- Discuss with the client the need to appropriately disclose HIV status and encourage partner/s to go for counseling and testing.
- Assess and refer the client for additional medical and/or social services as appropriate.

Counseling Without Testing:

In areas where testing is unavailable, counseling services can be developed for people with symptomatic HIV and their families, and those seeking HIV prevention counseling (such as counseling about safer sex in family planning clinics). In these circumstances, the counselor should:

- Review knowledge of HIV, including transmission and prevention.
- Conduct a personal risk assessment with the client.
- Discuss the possibility of an HIV-related diagnosis combining risk profile, symptoms and clinical state.
- Review the client's understanding.
- Discuss personal risk reduction.
- Discuss personal and family implications if infected.
- Discuss strategies/options for referral and testing and/or further care and support.
- Provide condoms on the client's request.

Guidelines on VCT for Special Groups

Ante-natal clinic women:

Counseling and testing can benefit women who are or who want to become pregnant. Ideally, all women should be recommended for and have access to VCT before they become pregnant, so that they can make informed decisions about pregnancy and family planning. Women receiving VCT in ante-natal clinic settings should have discussed their options.

- Preventing mother-to-child transmission(PMTCT)
  - Counseling about infant feeding options.
  - Counseling about all available PMTCT including care and support services [7].
- Sero positive women should have referral for ongoing medical and emotional support and should be informed about the advantages and disadvantages of disclosure, particularly to spouse or partner, in order to involve them in decision making[8].
- Negative women should have counseling about prevention of HIV infection

Youth (14-30 years of age):

Youth are particularly vulnerable to HIV because of the strong influence of peer pressure and the development of their sexual and social identities which often leads them to experiment. VCT for youth should:

- Provide "user friendly" services offered in safe, non-threatening environments.
- Be age-appropriate, using language and situations youth understand.
- Respect the dignity and confidentiality of the young person
- Be provided, where possible, by trained peer counselors.

Youth should be approached in the following ways:

Youth in school

- Approach through youth anti-AIDS clubs.
- Approach school health clubs.
- If possible, introduction of youth counseling in the school curriculum.
- Training of teachers on counseling.
- Training of peer counselors

Youth out of school

- Approach through Woreda and Kebele Youth Associations.
- Training of peer counselors.
- Group counseling, followed by back-up individual counseling

Children (9-13) 'window of hope':

The rise in HIV infection affects children and almost no counseling services exist for them. HIV testing, for children usually occurs with a parent's request. If the child is positive, counselors need to consider:

- Future medical care of the child.
- Emotional support, including dealing with his/her illness and parental illness or death.
- Anxieties about other children in the family who may be infected.
- What and when to tell the child (at counselor's discretion).
- Coping with stigma and discrimination in the community.
- Provision of the child's future - what to do if the child's mother or father becomes ill or dies i.e. consulting with support and care organizations.

Infants (under 16 months of age):

HIV testing of infants must be considered carefully because:

- Diagnosis is difficult in children aged less than 16 months.
- There are implications for the mother and the rest of the family.
- All children born to HIV positive mothers will have maternal antibodies for HIV at birth. This means that they will test sero-positive using ELISA or rapid testing, but does not necessarily mean that the baby is infected. The mother's antibodies start to disappear when the baby is 9-15 months old and so HIV antibody testing is recommended after 16 months.

Commercial Sex Workers

Sex workers are often under considerable pressure to perform risky activities e.g. sex without a condom, either through coercion or financial inducement. Counselors should understand these issues and help the sex workers find ways to reduce obstacles they face when trying to reduce risk. The following strategies should be used:

- Establishment of VCT centers near to red-light areas to reduce fear of being stigmatized.

- Sensitization of commercial sex workers through distribution of HIV/AIDS educational leaflets. In these leaflets they should be informed of the location of the counseling centers.
- Operating the centers late afternoons, evenings and early mornings, since these hours are convenient for Commercial Sex Workers.
- Provision of treatment for STIs, condoms and contraceptives at these centers

Military/Uniformed persons

The military in Ethiopia represent a mobile high risk group. VCT services for the military should be developed with the support of the military command and should include the following:

- Avoidance of blame and stigma.
- Comprehensive services for STIs.
- Active condom promotion and distribution.
- Partner/spouse referral.
- Referral for care and support for those infected.

Other Groups

Long distance truck drivers, internally displaced people and others who do not fit into the above mentioned groups, may use the established VCT centers; integrated or free-standing.

Management of Records:

Supervisors and counselors should ensure availability of client cards and referral formats. Client records must be confidential and at a minimum should include:

- Unique client identifier code.
- Client demographics
- Reasons for seeking VCT and client risk behavior.
- Date of pre-test counseling
- Laboratory result
- Date of notification of results and post-test counseling
- Any referral and follow-up.

Reporting

- Ensure that data are compiled by the counselors at the end of every month and sent to the manager's/supervisor's office. The report should also be sent quarterly to Zonal and Regional Health Bureaus. The manager/Supervisor should ensure that there is no double reporting

- Establish a system for quarterly reporting from the regions to the national level.

Quality Assurance:

Setting up VCT and ensuring quality that will create demand is a considerable challenge. In counseling - perhaps more than in any other area of service provision - service quality determines outcome. Poor quality counseling can result in misunderstanding and even resistance to behavior change.

To ensure quality, program managers/supervisors should accomplish the following:

For Staff:

- There should be observation of and feedback on the counseling process both routine and periodic.
- Ensure that staff designated as counselors have the necessary time and resources to devote to counseling.
- Ensure that counseling staff have adequate and continuous training, skills in HIV/AIDS counseling, prevention methods such as condom use and negotiating risk reduction.
- Ensure that HIV counseling is provided by trained counselors.
- Ensure adequate on-site supervision of staff.

For education and risk reduction materials:

- Culturally appropriate and linguistically specific HIV/AIDS information must be available to clients.
- IEC materials for illiterate clients must be available.
- Condoms should be readily available to the clients.

Monitoring and Evaluation:

Monitoring and evaluation is a critical element of VCT. Therefore managers and supervisors should accomplish the following[9]:

- Routine audit of counseling and assessment questions and risk reduction plans.
- New counselors should be observed with the client's consent until proficiency is assured.
- Each counselor should be given additional information through training and/or in service about HIV, STD, TB, family planning, preventing MTCT, youth interventions and new treatments, etc.
- Develop indicators to assess the quality of counseling such as:

- interpersonal relationship
- counseling skills
- ability to gather and provide information

Some of the indicators are the following:

- number of clients who received pre-test counseling
- number of clients notified of results and who received post-test counseling,
- number of clients referred for additional services

HIV Testing Guidelines

According to the Ethiopian policy on HIV/AIDS(1998),and the consensus reached on a national workshop in Oct 2000, all testing for HIV should be voluntary with informed consent[10]. There should be no mandatory testing other than those exceptions stated in the policy. Even under such circumstances pre and post-test counseling should be offered.

In Ethiopia, the type of facilities for HIV testing varies from area to area. Some use ELISA tests while others use rapid tests only or both. The Ministry of Health recommends the use of two different ELISA tests for those blood samples which test positive. Where testing facilities are limited, two rapid tests of different antigen composition are to be made available.[11]

Evaluations of the World Health Organization[12] have demonstrated that rapid tests perform as well as ELISA tests. Errors in HIV antibody testing could occur due to errors in the laboratory(technical errors), or clerical errors. Operational studies examining the use of rapid tests in developing country settings, such as the AIDS Information Center (AIC) in Uganda, have shown that the majority of errors were clerical and the performance of the rapid tests was comparable to that of ELISAs.[13]

Although the cost per individual rapid test may appear higher than the cost per test of ELISA test kits, in situations where small numbers of tests are carried out, often many of the wells per test are not used(due to small sample size) and when accurate costing is made, the use of rapid tests is more cost effective.

What HIV test algorithm should be used in Ethiopia?

After assessing the current situation in the country regarding the technical and logistic problems of ELISA machines and kits, the use of two rapid tests of different principles is recommended as the minimum HIV test algorithm and a third rapid test as a tie breaker in cases where there is discordance between the first and second test. This strategy shall be followed at all levels of health care delivery system (hospitals, health centers, clinics etc.) in government, private and NGO settings. However, health facilities having ELISA machines may continue to use ELISA test kits if that is their choice.

Reasons for Selection of Rapid Tests:

- They could be used in situations where small number of tests are performed per day i.e. in small laboratories or for emergency testing
- Do not require highly skilled professional staff and can be interpreted with less chance of error.

- Do not require sophisticated/expensive equipment and maintenance of the equipment.
- Do not require electric power supply -most rapid test kits could be stored at room temperature
- Rapidity of performance(for both initial and confirmatory tests)- results could be made available on the same day

Criteria for Selection of Specific Rapid Test Kits

Specific rapid test kits should be selected using the following criteria:

- High sensitivity and specificity of the kits
- Long shelf life at ambient temperatures
- Reasonable cost
- Ease of performance
- Rapidity of performance

What specific test kits could VCT centers use?

The HIV test kits bulk purchase program established by WHO in collaboration with UNAIDS in order to provide national AIDS control programs with tests giving the most accurate results at the lowest possible cost should be fully utilized. This list of HIV test kits is updated annually. Private health facilities and NGOs involved in VCT should also procure test kits from drug companies recommended by WHO.

The type of specific test kits to be procured into the country should primarily be evaluated by the National Reference Laboratory for AIDS and external quality control mechanism established with in each region.

Who should be involved in HIV testing?

In order to expand the availability and accessibility of VCT services to the public, all health professionals (doctors, nurses, laboratory technicians and other qualified professional staff)should be involved in HIV testing procedures using rapid assays. For this purpose, a standardized training on the testing procedures should be given subsequently to the health care workers. They should be certified to perform the rapid testing. Regional Referral HIV laboratories should be strengthened and mandated to train and certify health workers in HIV testing.

The participation of non-medical people(e.g. peer counselors) in HIV testing using rapid assays will be implemented in the future based on the outcome of a pilot study in few selected sites.

Guidelines for Program Managers/Supervisors in relation to testing

Managers/supervisors in VCT services should accomplish the following:

- Ensure that each VCT center has an HIV testing room.
- Ensure that the appropriate equipment, recommended test kits and supplies are ordered/brought from the authorized distributors on time
- Establish the WHO recommended system for disposing expired test kits and other medical supplies
- Create a system to maintain confidentiality by allocating a private room for testing, by improving the quality of training of health workers in HIV testing and by restricting the access to test results.
- Make sure that referral hospitals for HIV testing have, in addition, rapid tie-breaker test kits.
- Ensure that the networking of health facilities and community care and support institutions is established in all areas
- Ensure that there is a strong referral system
- Ensure that there is a strong reporting system
- Establish a system for refresher training of staff
- Ensure that guidelines on safety issues developed nationally and by WHO are distributed to all HIV testing facilities
- Ensure that HIV test results are compiled by the laboratory staff and counselors at the end of every month and sent to the manager's/supervisor's office. The report should also be sent quarterly to Zonal and Regional Health Bureaus.
- Establish a system for quarterly reporting from the regions to the national level.

Guidelines for health workers performing rapid tests

Health workers trained in HIV testing using rapid tests should accomplish the following:

- Ensure that the HIV testing room is separate from the general laboratory (in health facilities).
- Ensure that all samples are coded and test results are kept confidential.
- Ensure that specimen with indeterminate results are regularly sent to the HIV referral hospital.
- Ensure that the appropriate test kits are delivered
- Report if there are any test kits that have expired or are almost expired
- Ensure that internal quality control is always done
- Ensure that universal precautions are followed all the time
- Make sure that appropriate recording and reporting is done by:

- Regular registration of all test results in a log book
- Ensuring that test results are reported to the counseler as soon as they are ready
- Ensuring regular participation in external quality assurance program.

Interpretation of HIV test results(Test Algorithm)

1. All specimen are first tested with one rapid assay(T1)which is **highly sensitive**.

2. Any specimen found positive on the first assay(T1) is re-tested with a second **highly specific** rapid assay(T2) which is based on a different antigen and/or different test principle (e.g. indirect versus competitive).

3. Specimen that is positive on both tests is considered HIV antibody positive.

4. Specimen that is negative on the first test is considered to be HIV antibody negative.

5. Any specimen that is positive on the first test but negative on the second test, should be re-tested with the first test kit(T1) in order to rule out technical error. If the result is negative then it should be considered HIV antibody negative. The positive result at the first test(T1) was probably a technical error associated to(T1)

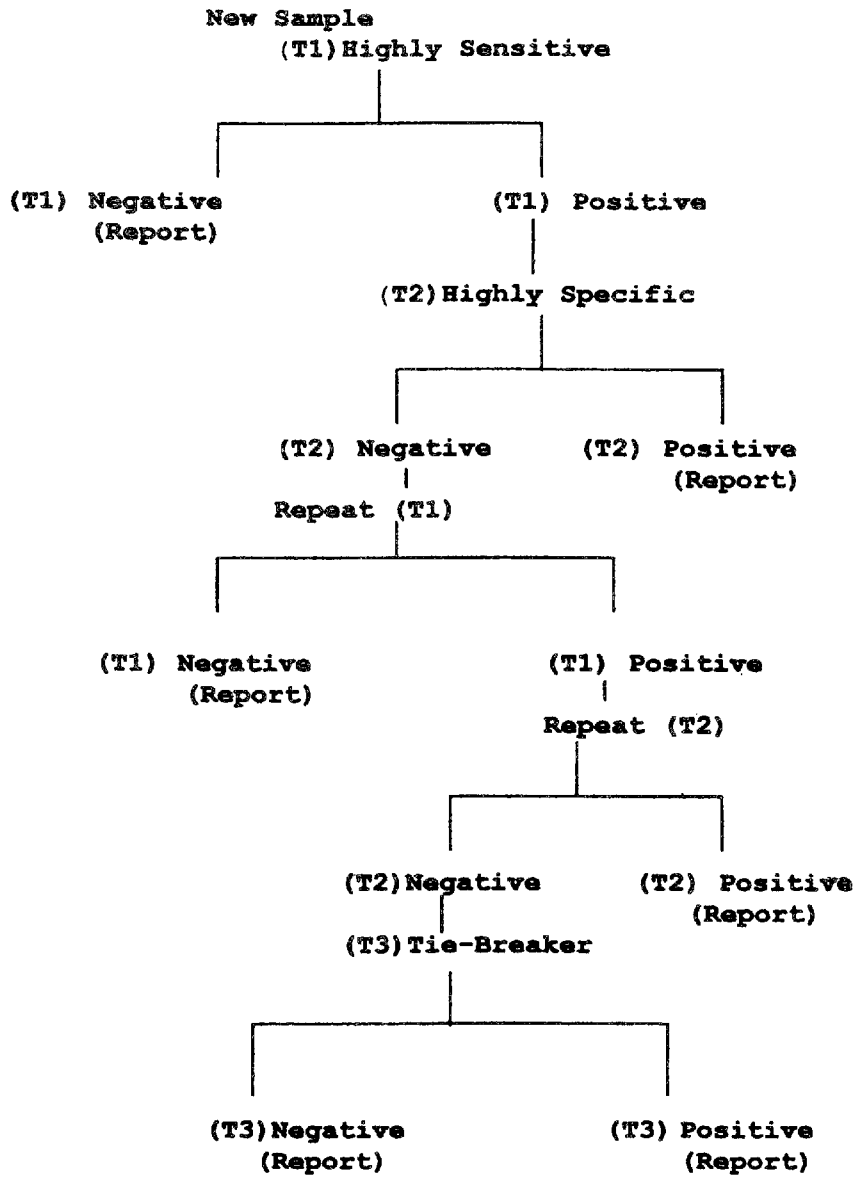
6. When specimen that is positive on the first test(T1)and negative on the second test(T2) is again positive with first test(T1),then one should repeat the second test (T2)in order to rule out technical error. If the result is positive with (T2), then it is considered HIV antibody positive. It means that there was a technical error associated to (T2).

7. However, if the test result is negative with (T2), then a tie- breaker test (T3) is needed. The result of the rapid tie-breaker test is reported as HIV antibody positive or negative.

These rapid tie-breaker test kits will be needed in about 2% of cases. Therefore, it is suggested that, for economic reason, tie breaker test kits should be kept only at referral hospitals.

Schematic Representation of HIV Testing for VCT in Ethiopia, Oct 2000

(Testing Algorithm)



When should a person testing negative for HIV antibodies have a subsequent test?

The diagnosis of HIV infection is usually made on the basis of the detection of antibodies to HIV. Because of the window period, a person who is HIV infected will take about three months in most cases until sero-conversion takes place. Therefore, during post test counseling this fact should be communicated to the person testing negative what a negative result may mean and the need for a repeat test after three months particularly to some one who has been involved in recent risky sexual inter-course. This will avoid any misunderstanding if the person is found HIV antibody positive in the future even with out any sexual intercourse in between.

HIV Testing Referrals

Referral system is a key component of comprehensive HIV prevention services because not all facilities can address the variety of medical, psycho-social, socio-cultural, environmental, and structural issues that influence individual's ability to initiate and sustain behavioral changes.

In relation to HIV testing, sending specimens to regional HIV referral laboratories is not practical. Therefore, all hospitals and selected VCT centers should be designated as referral centers for confirmation of indeterminate results using a third rapid test tie-breaker. The referral centers should be easily accessible for sending blood samples and getting feed back. Clinics, health centers and free VCT centers within a certain radius could be linked to those nearby hospitals and selected VCT centers for this purpose. The referral system and net working between the institutions providing the testing as well as other medical services, community based organizations and faith-based institutions providing care and support should be well designed.

Referral services in general should be offered to all clients who are infected or at increased risk for HIV to facilitate access to any necessary medical, nutritional, preventive, and psycho social support and faith based services.

Quality control.

External quality control of VCT centers should be done twice a year by the regional referral HIV laboratories. The National Referral Laboratory for AIDS will have to give technical support to the regions. The procurement unit of the National AIDS Council will regulate the technical and logistic procedures of importation of test kits into the country, maintenance of cold chain system at the airport while awaiting clearance of test kits from the customs office and the transportation mechanism of the kits within Addis Ababa and to the regions.

Quality assurance

The quality of HIV testing centers could be assured by:

- Assessing the efficiency of the staff involved in the testing as well as making the results ready on time.
- Good counseling facility in relation to testing
- Maintaining the standards of universal precautions
- Record keeping procedures
- Procedures for maintaining confidentiality etc.
- Good networking with care and support organizations

Monitoring and Evaluation

Monitoring and evaluation of activities should be part of the planning process and the mechanism for follow up of VCT centers should be established by the National AIDS Council.

Some of the indicators are the following:

- Number of persons trained in HIV testing
- Number of test kits ordered
- Number of test kits utilized
- Number of tests performed
- Number of positive samples

Legal, Ethical and Policy issues

It is the responsibility of the managers and professional staff to ensure that:

- Providers have legal and ethical responsibilities to protect sexual partners and others at risk.
- Quality pre-test counseling is given to those in need.
- VCT is done in a confidential manner with informed consent.
- There is no mandatory testing except in special cases as stated within the policy.
- People living with HIV/AIDS have equal access to all basic social services and human rights.

It is the responsibility of the Woreda and Zonal Health Officers to ensure that the VCT managers and professional staff have fulfilled the requirements.

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ETHIOPIAN HIV/AIDS NATIONAL RESPONSE 2001 - 2005

Consolidated National Report

Of the

Joint Mid Term Review
21st February – 19 March 2003

Draft

HAPCO
March 2003
Addis Ababa

Table of Contents

ACRONYMS

AAC –Anti-AIDS Club

AIDS – Acquired Immuno-Defficiency Syndrome

ART –Anti-Retroviral Treatment

ARV – Anti-Retroviral

BCC – Behavioral Change Communication

BOLSA – Bureau of Labor and Social Affair

BSS – Behavioral Surveillance Survey

CBOs – Community Based Organizations

CC –Chamber of Commerce

CETU –Confederation of Ethiopian Trade Union

CSOs – Civil Society Organizations

CSW – Commercial Sex Workers

EAF – Emergency AIDS Fund

EEF – Ethiopian Employers Federation

EMSAP – Ethiopian Multi-Sectoral AIDS Project

ERCS – Ethiopian Red Cross Society

ETV – Ethiopian TV

FBOs – Faith Based Organizations

FGAE – Family Guidance Association of Ethiopia

FMOH – Federal Ministry of Health

GO – Governmental Organizations

GTZ – German Technical Cooperation

HAPCO- HIV/AIDS Prevention and Control Coordination Office

HBC – Home Based Care

IEC /BCC–Information Education Communication, Behavioral Change Communication

ILO – International Labor Organization

IOM – International Organization of Migration

JTC – Joint Technical Committee

M&E –Monitoring and Evaluation

MOD –Ministry Of Defense

MOH – Ministry of Health

MOLSA – Ministry of Labor and Social Affair

MTR –Mid-Term-Review

NAC S– National AIDS Control Secretariat

NGOs – Non-Governmental Organizations

OI –Opportunistic Infection

OSSA – Organization for Social Service for AIDS

PCU –Project Coordination Unit

PLWHA – People Living With HIV/AIDS

PMTCT – Prevention of Mother to Child Transmission

RACs – Regional HIV/AIDS Control Secretariat

RHB – Regional Health Bureau

STI –Sexually Transmitted Infections

TOTs –Training of Trainers

UNAIDS –United Nations Joint HIV/AIDS Program

UNDP –United Nations Development Program

UNICEF –United Nations Children Education Fund

UP –Universal Precaution

USAID – United States Agency for International Development

VCT – Voluntary HIV/AIDS Counseling and Testing

WACs –Woreda HIV/AIDS Counsels

WHO –World Health Organization

1. INTRODUCTION

The first evidence of HIV infection was found in 1984. The first AIDS case was reported in 1986. Since the beginning of the epidemic MOH has received repots of 107,575 cases of AIDS. It is, however, suspected that there is much more to the epidemic than is revealed by the number of reported cases. It is estimated that about 2.2 million people in Ethiopia are currently infected with HIV/AIDS including 2 million adults and 200,000 children.

The epidemic has affected a large segment of the urban population and continues to expand into the rural areas. Available data do not allow for estimating the level of infection in rural areas accurately. In 2001, based on the assessment of existing data, the overall prevalence in the general adult population is estimated to be 6.6%, rural prevalence is 3.2% (ranges from 1.1% to 4.6%). Urban HIV prevalence rates continue to be high at 13.7%. Currently the MOH has increased the number of sentinel sites from 34 to 63, especially rural areas are now representing 50% of the sites.

According to the AIDS case reports of the MOH, the most affected population is the young and productive group as over 90% of reported cases are between the age of 15 to 49 years. In some of the age groups such as in the 15 to 19 and 20 to 24, the number females is higher than the males, showing how women are significantly affected by the epidemic.

The Government of Ethiopia has issued a Policy on HIV/AIDS in 1998 advocating a multi -sectoral approach in response to the epidemic. In addition the Government has developed a a five-year Strategic Framework and a three-year Multi-sectoral AIDS Project (EMSAP) to implement the policy. The EMSAP is financing a total amount of 63.4 million USD through World Bank Loan and government contribution, to cover three years component of the country's 2001-2005 HIV/AIDS Strategic Plan. Forty percent of the fund is allocated for community driven HIV/AIDS initiatives. UN and bilateral donors and international NGOs are also providing funds to the multi-sectoral response. The first year of the response project was aimed at expanding and accelerating existing prevention and mitigation efforts, and building managerial capacities at various levels while the second and third years were aimed at progressive implementation of the various interventions by utilizing multi-sectoral channels. The national response is designed for implementation by a wide variety of public, private and NGOs both national and international, civil society organizations and community-based organizations.

A joint mid-term review (JMTR) of the Ethiopia HIV/AIDS national response was conducted from February 21 to March 19, 2003 with the participation of government, bilateral and multilateral organizations. The purpose of the MTR

was to assess progress towards executing the country's *Strategic Framework for the National Response to HIV/AIDS in Ethiopia.*

The review objectives were:

1. To review and assess the institutional arrangement, institutional capacity and the enabling environment that, make up the national response. The focus was accorded to four areas; Capacity and Coordination, Community and Civil Society Participation, Government involvement and Donor Involvement.

2. To review and assess progress towards achieving the programmatic outputs of the National response. Focus was accorded to prevention, treatment, care and support Interventions.

2. METHODS

A joint technical committee (JTC) was formed by drawing members from HAPCO, MOH, UNAIDS, USAID and Action AID Ethiopia (AAE) to facilitate the JMTR. Led by the JMTR Coordinator from HAPCO, the JTC prepared a TOR and planned other arrangements for the JMTR. A review mission with a total of eighteen members was formed consisting representatives from HAPCO, MOH, representatives from NGOs, donors and consultants. The review team was divided into six, sub-groups consisting of three members each.

Regional review mission teams visited all regional states and Addis Ababa and Dire Dawa City Administrations. The mission teams visited a total of 33 woredas out of which about a third were non MAP woredas. While in the regions and woredas they visited different government, and non-governmental organizations, religious organizations and community organizations. One team was assigned to review the federal level institutions, which included government offices, donors, faith based organizations, private sector and NGOs.

This report is a consolidation of the findings from the federal report and eleven reports from 9 regions and two city administrations. The report focuses on findings, issues and recommendations that are common to all or most regions. Details of regional findings and recommendations emanating from there off are available in the regional reports.

3. OBSERVATION AND FINDINGS

3.1 Capacity Building and Coordination

3.1.1 Administration and Structure

HIV/AIDS Prevention and Control Councils have been established in the country from federal to community levels. These councils are composed of high level government officials, leaders of the civil society including religious leaders, PLWHA associations and the private sector. Organizations relevant for the multi-sectoral response at each level are as much as possible, included in the councils.

The Federal HIV/AIDS Council has attained its legal status recently by a proclamation by which HAPCO is established with its executive management board. Similarly, 7 of the regional councils have obtained legal status by proclamations, while the remaining few are in process. Due to a current re-structuring process undergoing in Addis Ababa administration, the Addis Ababa HIV/AIDS Secretariat is organized under the bureau of Social and Civil Reform. The mission noted that the Addis Ababa Administration has decided to assign facilitators at kebele level, which is positive, a step to bring coordination and technical support at community level.

HIV/AIDS Councils have also been established in woredas with broad representation of relevant government and civil society groups with the majority (>50%) drawn from the civil society and private sector. While all EAF woredas have established Woreda AIDS Councils, a number of the other woredas have also established WACS with varying composition and strength.

According to the current structure, HAPCO reports to the Executive Management Board and RACs report to their respective regional management boards. There is no direct structural linkage between HAPCO and RACS.

Woredas covered by EMSAP are selected based on an agreed selection criteria, which includes level of prevalence of HIV in woredas. While the number of woredas covered has recently shown a very rapid increase much more needs to be done to expand the number of woredas (205 woredas out of 556) to effectively reduce the incidence and impact of the epidemic. Some Woredas that are not benefiting from the EMSAP fund are engaged in HIV/AIDS activities. It was learned that various donors fund these woredas. It was reported that the level of support and encouragement from the RACS and other government bodies is to the non-MAP woredas is not satisfactory.

3.1.2 Institutional Capacity

A. Human Resource

According to its current organizational structure, at federal level, HAPCO will have 40 staff and when all positions are filled HAPCO will have relatively adequate staff. However, concern is raised on the appropriate mix of professionals to provide support to various programs and activities. For example there is a shift from awareness creation to behavioral change communication and yet there is no indication to include BCC experts in HAPCO staff. In most regions there is an increase in staff but not sufficient enough to handle the enormous coordination activities and technical support. It is encouraging to note that the majority of regions have planned to improve the organization and staffing of the regional secretariats. In view of the urgency to rapidly mitigate the impact of the epidemic, regional councils should take urgent measures to increase the staff of the regional and lower level secretariats and offices. Inaction on this will lead to slow implementation resulting in further expansion of the epidemic.

One woreda facilitator is assigned to each woredas under the EAF support. In most of the regions, woreda facilitators are employed on full time basis. However in two regions, woreda facilitators are assigned from other sector offices and HIV/AIDS is given as an additional task to their routine activities. Even though, they are remunerated for the additional task they have taken they have problem of allocating enough time for HIV/AIDS coordination and technical support.

The mission was informed that there is no incentive to recruit or maintain competent staff at all levels. It is reported that some have left and others are considering leaving because of low salary and absence of other benefits.
Most of the regions are in the process of getting a structure with a better staffing, approved by their respective civil service commissions. While most regional governments have shown their commitment by providing support and generous budget allocation to HIV/AIDS activities, some appear to be less committed as indicated by the limited support they give to HIV/AIDS activities.

B Administration and Management Capacity

The HIV/AIDS Prevention and Control Office and most of the regions in collaboration with partners agencies,. have provided training to focal persons from government sectors, NGOs, woreda facilitators, woreda AIDS council members, and kebele AIDS Committees in project planning, management, and financial management and accounting systems. It was, however, observed that most of the training was confined to EMSAP benefiting areas and agencies or

communities and has not significantly reached those outside. Although implementing manuals and guideline are at hand in the RACS, they have not reached the woredas and implementing agencies.

With the exception of two regions, others managed to approve only half or less of the proposals submitted to them by implementing agencies (range from 6 out of 100, to 58 out of 61). Major reasons mentioned for the delays are; inability to conduct regular review board meetings, low quality of proposals, shortage of staff to make preliminary review of proposals for decision by the respective boards. Similar situations account for the reported delays in reviewing and approving proposals at HAPCO.

Project Proposals Received and Approved by the RCSs

Status	Afar	Amh ara	Ben/ Gum	Dire Dawa	Gamb- ella*	Harari	Oromia*	SNNP	Somali	Tigray*	Addis Ababa	HAPC(
Received	?	100	?	42	30	68	30	29	49	26	99	213
Approved		6		22	25	5	18	6	33	25	43	91
%		6		52.4	50	7.4	60	20.7	67.3	96.2	43.4	42.7

* One-year information

Review board members at all levels are volunteers and most often heads of organizations who are often busy with ranges of commitments, and have limited time to attend regular meetings. With their varied experience and professional expertise, board members are expected to contribute to the review, but they need to be supported by professional staff that would provide them with initial review and suggestion for action. The absence of sufficient support from HAPCO/Secretariats may also account for the delay in proposal review and approval.

C. Technical Capacity

Training and technical support on project planning and management, and financial management are the types of support provided by RACS to implementing agencies. The preparation of strategic or annual plans is evident in few of the regions where a three years strategic plan, a community planning and implementation manual and annual plans are prepared in consultation and support of partners.

Many of the woreda facilitators interviewed by the review teams have expressed their dissatisfaction regarding the little amount of supervisory support they received from the regional or the zonal level. Civil society organizations and

government sector focal persons also have similar views. The level of support rendered from the federal to the regional level is reported unsystematic and insufficient

Despite the various training conducted, the technical capacity of implementing agencies (discussed under various sectors) has been observed to be very low. This shows that the training conducted by HAPCO or RACS in collaboration with different partners has not been adequate to build the capacity and skills. Most of the trainings are adhoc in nature and are limited in scope and content, which do not help capacity and skill development. Woredas have critical strategic role to play in the success of the community-based responses, however due to limited human and material resource and weak support, they are unable to develop their capacity to play their role effectively.

D. Financial Management

Major sources of fund for the regions are government, EMSAP, UNICEF and other multi-lateral and bilateral donors. Regular flow of fund is impaired due to several reasons which include the following: a) limited capacity at local level to prepare and regularly submit Statements of Expenditures (SOEs); b) inefficiency of HAPCO and Secretariats to process financial request; and c) low levels of the special account to facilitate rapid release of funds.

Most regions reported that, many planned activities could not be implemented on time due to the delays in transfers. On the other hand, it was observed that, almost all of the regions have not been able to utilize more than 60% of the fund transferred to them for capacity building. In one of the regions SOEs are submitted for only 26% of the total funds transferred. Implementing agencies particularly sector ministries and regional bureaus have not used the fund transferred to their accounts and as a result could not submit SOEs and this has adversely affected regular replenishments to the special account. At national level HAPCO has transferred fund for a total of 25 line ministries and 41 CSO including PLWHA associations. Many of these institutions have not submitted SOEs by the time of the JMTR.

Fund Allocations/Transfers by Region and Source

"000" Birr

Source of Fund	Afar	Amhara	Ben/ Gum.	D. Dawa	Gamb-ella	Harari	Oromia	SNNP	Somali	Tigray	A.Ababa
EMSAP*	3616.0 -	5031.2 -	1186.4	520.5	1608.8	480.0	10981.5	4423.0	1040.9	5420.4	2465.1
UNICEF+	-	4825.2	673.8	2954.8	524.0	-	3532.3	542.7	-	5100.0	800.0
AAE-SI.+	-	-	-	-	463.4	-	743.3		-	-	
CDC+											2000.0
Total	3616.0	9856.4	1860.2	3995.8	2596.2	480.0	15257.1	4965.7	1040.9	10520.4	5265.1

*Source: HAPCO
+Source: Regions

In general, the financial management of the national response is being challenged by two interrelated situations. Low utilization rate on the side of implementing partners and delays in responding to replenishment requests by HAPCO and RACS. The low level of technical capacity of the implementers is recognized as a factor affecting financial flow. The use of different procedures by the different donors providing financial support has added to the capacity constraints.

3.1.3 COORDINATION

The most common mechanism of coordination is conducting joint review meetings. Most of the RACS have conducted such review meetings with their partners at least once in the recent past. Some of the regions conduct quarterly meetings with their partners regularly. Only few regions have consultative meetings for networking with their partners.

In most of the regions, government offices and civil organizations feel that they have very little communication with RACS. As a result, RACS have limited information about the various activities of sectors and civil organizations in their respective regions. Some sector office reported to have better communication with the health bureaus than the RACS. The coordination in the woredas is also very weak. There are very few examples where WACS have been successful in coordinating the efforts in their woredas. This has been noted, as a very critical gap in view of the paramount need for a coordinated effort at Woreda level.

Similarly, at federal level, most donors felt that there is little coordination between donors and HAPCO and among themselves. On the other hand, the inability of donors to attend meetings and fully participate in collaborative efforts organized by HAPCO is also cited.

There is an initiation at HACPCO for the creation of a national partnership forum involving the government, donors, FBOs, NGOs, the private sector, and the media. Each group is supported by HAPCO to form a sub-forum and select steering committees, which will represent each group in the national forum. This is deemed necessary in view of the need for resource mobilization and coordination strategies compatible with the magnitude of the problem.

The formation of partnership forums is always challenged by the difficult task of creating a common vision, a mutual understanding, and developing the required trust among would be partners. Information with regards to functional responsibilities, mandates, spheres of activities, interests, are not adequately delineated at regional level, which makes the process of partnership more difficult.

3.1.4 Monitoring and Evaluation

Three of the RACS have a focal person for M&E and in only one region a staff is trained in M&E. Implementing agencies do not report to RACS on regular basis. EMSAP reporting format is used in all regions except in one of the regions, which has prepared its own reporting format. No M&E guidelines are available at the federal and regional level. RACS use donor specific reporting formats to report for the various donors operating in their regions. Only two regions have allocated budget for M&E activities.

Activities pertaining to M&E are scanty and are done in an ad-hoc manner. Proper institutional arrangements for M&E are not in place in almost all regions. Unrelenting effort is needed to establish a functional M&E system, which is long overdue.

HAPCO has established an M&E unit Under the Planning and Programming Department. The unit is working to finalize the National M&E Framework, which has been prepared in collaboration with various partners.

Key Issues Regarding Institutional Arrangements

- There is a structure to coordinate HIV/AIDS activities from federal to woreda and community levels. HAPCO and the majority of the RACSs have obtained legal status. WACS are, however, established only in the MAP Woredas, which codnstitute only 35% (205) of the Woredas in the country
- There is shortage of staff in all levels of the structure and the technical competence and professional mix of available staff is less than desired.
- With the exception of one region women are poorly represented in the staffing at all levels.
- The staff salary scale is not attractive to maintain competent staff and bring in new ones. Morale is observed low among existing Staff, which is believed is affecting their performance
- The level of technical support provided at all levels is insufficient. There is lack of technical capacity in all aspects but more so for directing and leading the different programs.
- Vary weak coordination mechanism other than some initiatives at few regions and at HAPCO.

- M&E is not well developed and most of the information obtained is through unsystematic and irregular reporting.

Recommendations

Administration and management:

- Select members of management and review boards at all level on the basis of their technical and managerial capacity.
- Introduce an incentive and accountability mechanisms to ensure effective appraisal of proposals.
- Improve the project appraisal capacity at the center and the decentralized level by recruiting qualified staff in sufficient number to make the system fast moving so that the process is compatible with the emergency nature of the epidemic.

Human Resource capacity:

- Recruit or assign qualified people on full time basis to lead and coordinate the response activities at all levels and institutions. Special emphasis is due to Woreda level where severe gaps are observed but on the other hand most community activities are implemented.
- Strengthen the capacity of the existing staff through systematic and sustained training program, which is tailor made to the prevailing needs as much as possible.
- Recruit staff specializing in critical technical areas even if it is for a short period to help move the response.
- The process of rectifying the current gender imbalance (in fever of male) in staffing at all level should be given due attention.
- Introduce a level of remuneration which could attract competent professionals and also retain those in the system but attached to high quality delivery and accountability mechanism.

Financial Management:

- Revisit the existing financial management system in HAPCO from expediency and accountability aspect particularly regarding executing timely transfers and replenishments.
- Provide technical support and training to all fund users to expedite the utilization and reporting of funds at project level.
- In addition to devolving the management of EAF, enhance the financial management capacity of RACS and Woredas by providing enough staff and training tailor made to the situation.

- Encourage donors/partners to join hands and develop financial systems harmonization strategy among other things so as to reduce the workload of an already constrained capacity.

Coordination

- Review the working link between HAPCO and the RACS in view of the reported gap in information necessary for effective coordination.
- Move forward the ongoing initiatives to establish partnership forums at all levels to ensure exchange of information among stakeholders and coordination of initiatives, which in turn would improve efficiency by avoiding duplication of efforts.
- Woreda level coordination ought to be given special attention in view of the number of uncoordinated activities reported underway by various implementers.
- Develop resource mobilization strategy and mechanisms to be used at all levels and by all partners.
- Map out local responses, in terms of who is doing what and where, which mainly exist at Woreda level.

Monitoring and Evaluation

- In-spite of its importance M & E systems for HIV/AIDS prevention and control response is not yet fully developed. It is therefore imperative that HAPCO bring the preparation of the M & E strategy and the guideline to follow to an end as soon as possible.
- HAPCO speed up the role out of M & E to all levels as soon as it is finalized.
- HAPCO strive to create the necessary collaborative mechanism and well-structured linkage with key stakeholders to facilitate time bound generation, transfer and utilization of information.
- RACSs and Sectors offices should put in-place a functional M & E as soon as possible.
- Develop a mechanism to scale-up exchange of best and innovative practices .

3.2. Community and Civil Society Participation

3.2.1 Participation

A number of community groups and civil society organizations (CSO) are involved in the national response. The participation of communities and CSOs have increased. This can be attributed to the massive mobilization efforts exerted nationally.

Bruh-Tesfa is an AAC in SNNPR, supportd by DSW in Leku a non-grant woreda,. The club has activities ranging from awareness raising, condom ditribution to education for CSW, IGA through barbery shop, table tennis and a library

a. **CBOs** : *Kebele HIV/AIDS Committees* are the prominent structures by which communities have been able to organize HIV/AIDS interventions in their localities. Almost all of the Kebele HIV/AIDS Committees in EMSAP are supported by the EAF. Very few regions, those with small number of woredas, have been able to cover all kebeles with the EAF. So far 205 woredas have been covered using EAF and the majority of the Woredas in the country do not benefit from EAF.

IDIRS – *are* traditionally established to support families of the deceased during death. In many places these institutions have expanded their role in the fight against the epidemic with strong motivation and interest. In most instances IDIRs also get support from EAF, but there are IDIRS which function on their own or with some support from other organizations.

Youth Anti-AIDS Clubs (AAC) are highly motivated and innovative groups present in most communities. In some places where there is little or no support available to them in spite of the fact that , they are the only active community groups working on HIV/AIDS they run their activities using their own initiatives and resources. They are also used to mobilize the youth.

Associations – different types of community associations are getting involved in the response. CSW association in Afar, virgin girl association in Amhara, Associations for the deaf and disabled in Dire Dawa are just some of the examples.

b. **FBO :** All the major religious organizations are playing significant role in the fight against HIV/AIDS. All of them have formed HIV/AIDS coordinating offices and in most instances have designated focal responsible persons at the various levels of their hierarchies. The FBO have attempted to integrate HIV/AIDS into their routine activities.

C. **NGOs :** Although they are present in every region, their number varies among the regions. Due to the weak coordination mechanism present in the regions, not all NGOs operating in the region report or communicate with the respective RACS or other coordinating levels. NGOs have special role in reaching hard to reach communities and focusing on specific community groups or interventions.

d. **PLWHA Associations:** The major PLWHA associations are Down of Hope and Mekdim, and each have prepared a 3 -year strategic plans.

Down of Hope has 7 and Mekdim has 3 branches in the regions. The link between branch associations and the central ones is not strong..

e. **The Private Sector:** At national level, the private sector is involved, through the Ethiopian Employees Federation (EEF), The Confederation of the Ethiopian Trade Union (CETU),and the Chamber of Commerce. The involvement of the private sector at the regional level is weak.

Taxi Drivers in Dessie provide free service to sick PLWHAs to take them to health facilities.

EEF and CETU have each developed HIV/AIDS policies and five years strategic plan, each have opened AIDS coordination offices and assigned responsible persons at all administrative levels. The EEF has developed a national guideline on workplace HIV/AIDS prevention and control. CETU, in collaboration with Pathfinder, ILO and HAPCO, is actively involved in more than 115 workplace HIV/AIDS projects. One third of the CETU members (about 100,000) are reached by the projects. Under union auspices, many workplaces have created joint committees to coordinate HIV/AIDS activities. Committee members are selected from management, association members, employee representatives and health workers from health institutions. The Ethiopian Chamber of Commerce has set up secretariat for Business and HIV/AIDS.

The Chamber of Commerce, CETU, EEF and MOLSA in collaboration have drafted a policy on workplace HIV/AIDS interventions using ILO's framework.

3.2.2 Capacity and Management

While communities and CSOs have contributed significantly to the national response, their achievements have been impeded by lack of capacity due to inadequate material, financial, human and technical resources. This is evident by the quality of proposals and reports produced by most of these organizations.

A number of community groups and CSOs, which could access the EAF were provided with training on project planning, management, and financial management. Donors and NGOs have also provided training, material and financial support to community groups and CSOs.

Communities and CSOs have been engaged in different types of HIV/AIDS prevention, care and support and impact mitigation interventions. To mention

some of the areas of achievements for these groups; awareness raising and sensitization, educational material production and dissemination, provision of training for various community groups and CSOs, provision of financial and material support to organizations, community based care for PLWHAs, their families, orphans and elderlies. The support includes financial, food, shelter, school materials and/or fee, networking, policy and advocacy, condom promotion and distribution, and provision of VCT services. CBOs such as Idirs, AACs, are supported by different organizations from GO, FBOs and NGOs. In many of the woredas where the WACS are very active, there is a very close working relationship between CSOs and WACs.

Key Issues

- The formation of Kebele AIDS committees is limited to MAP woredas
- The contribution of the Community and CSOs is impeded by lack of technical capacity, finance and other capacity building materials.
- There is very little support from government and non-government organizations with better capacity to CSOs. Government support is reported limited to those benefiting from EAF.

Recommendations

- In view of their comparative advantage in reaching the grass root level intensive measures should be taken to strengthen the material, human and financial capacity of CSOs
- RACSs and NGOs at all levels should work closely under defined roles including reporting and exchange of all relevant information to enhance coordination.
- Supporting sustainable organizational development should be given due attention to strengthen the involvement of PLWHAs in planning and execution.
- Community organizations and groups such as AACs should be supported by training and other capacity building input.

3.3. Government Involvement

3.3.1 Institutional Arrangement

The institutional arrangement made by government organizations to run HIV/AIDS programs can be broadly categorized into; forming a task force, and/or assigning a focal person, or putting HIV/AIDS under the responsibility of a department. Most of the line ministries and some of sector offices have formed a

task force with the assignment of a focal person while, some sector offices such as Bureau of Youth, Culture and Sport, BOLSA have put HIV/AIDS under Youth, or Social Affair department. Among the line ministries MOH, MOD and MOLSA have an AIDS unit. These and few of the sector offices have assigned a full time coordinator. Only one region reported that all sector offices have trained focal persons working full time.

3.3.2 Capacity and Management

Ministries of Defense, Health and Education have visible and formal capacity building and technical assistance strategies. Bureaus of Health, Education, Labor and Social Affair have the capacity to integrate HIV/AIDS in their routine activities. Some of the line ministries and sector bureaus have prepared work plans. On the other hand, all ministries and regional sector offices require an extensive support and training on mainstreaming.

3.3.3 Commitment

Federal and Regional Governments have shown their commitments by endorsing the establishment of HIV/AIDS prevention and control offices by proclamation and approved structures with better staffing. Most regional governments have passed resolution for all government institutions to make HIV/AIDS a priority and to mainstream it into routine activities. Further more some regions have made it a requirement for all sector plans to include HIV/AIDS to be approved. However, concern was expressed by some regions that some ministries and corresponding regional bureaus that should play key role do not show adequate commitment to the multi-sectoral response.

In terms of facilitation of the implementation of HIV/AIDS activities, some government offices both at federal and regional levels have created taskforces and assigned a focal person. Workplace interventions have been initiated in some federal and regional level offices. Apparently, the level of commitment at the presidential and ministerial level was reported higher in some regions than others. The level of commitment of Bureau heads and lower officials followed that of the higher levels.

3.3.4 Mainstreaming

Many of the government offices at federal and regional level, have prepared work plan to access fund from EMSAP. Some of these organizations have been able to integrate HIV/AIDS in their annual work plans with their budgets. Even though not in its full spectrum, mainstreaming have been initiated in a considerable number of government offices both at federal as well as at regional

level. Members of government offices have been trained on mainstreaming locally and abroad. Some RACS have prepared guidelines on mainstreaming, in collaboration with sector offices. Some sector offices both at federal and regional level, have implemented workplace interventions.

On the other hand, the review mission observed that, understanding of the principles and mechanisms of mainstreaming among the government sector offices and RACS is limited and variable. As a result, the level of mainstreaming HIV/AIDS into regular sector activities at all levels of government remains weak.

Key Issues

- Level of commitment from officials is varied.
- There is hardly mainstreaming going on in most of the sector offices at all levels.
- Most focal persons are given HIV/AIDS responsibility as an "add-on" task to other activity and is not considered in the evaluation of their performance.

Recommendations.

- The level of commitment observed among the political and administrative leadership is reported high. But on the other hand this could not be verified from the delivery perspective. It is therefore important that a mechanism of accountability be established at all levels to ensure that commitments are demonstrated by delivery.
- More effort should be made to ensure that there is clear understanding about mainstreaming among officials and focal persons.
- The practice of making HIV/AIDS activities "add-ons" to regular sector assignments in some sector office should be rectified.
- Training and other supports be provided by HAPCO and RACSs as necessary to enhance the capacity of the persons involved in HIV/AIDS coordination and mainstreaming activities.
- A system be introduced to make sector offices account for their performance in HIV/AIDS together with their regular activities.

Donor Involvement and Coordination

Donors have played crucial role in expanding the response from the very beginning of the epidemic. Among the several donors working in multiple regions, those that are commonly cited at regional level are; World Bank, UNICEF, UNDP, AAE, GTZ, IOM, Irish AID and MSF-Belgium. Donors are involved in assisting various activities of the government and CSOs, both at national and regional levels. The distribution of donors varies among the regions. Some of regions where several donors are present have faced coordination problems. On the other hand regions, which have frequent meetings with individual donors,

and those, which held regular review meetings with their stakeholders, have reported better success in coordinating donors.

The issue of each donor having a different reporting format, financial and procurement procedures has added to the difficulty in the coordination effort. On the other hand the attempt of AAE to harmonize its financial procedures with other donors such as the World Bank is considered as exemplary.

Absence of networking except the "Technical Working Groups" has led to the weak sharing of experiences and resources between government and donors and among donors themselves. With the numerous donors working with different sectors at federal level and at different places of the regions in a situation where there is little or no coordination, duplication and overlap of activities is an avoidable. In fact few donors felt overlap and duplication is a problem. There is a strong need to reverses the situation in order to make the national response efficient and effective.

Key Issues

- The different reporting formats and financial and procurement procedures of donors have added to the already constrained capacity particularly at lower levels.
- Donors have little or no networking and collaboration amongst themselves and with government and this has lead to weak coordination.

Recommendations

- Government and donors should work towards the realization of the long anticipated harmonization of procedures.
- Both parties should work hard to bring the formation of the national partnership forum to a completion.

4. Achievements Towards Programmatic Output

4.1 IEC/BCC

Following the current increase in the engagement of the communities, civil society including PLWHAs and the private and the public sectors, awareness creation activities have increased immensely. Awareness raising and sensitization activities are organized using various forums such as; public meetings, mass rallies, religious settings, public holidays, sports events and on the commemoration of the World AIDS Day. Other channels like drama, theaters, music, puppet shows and use of mini-media are commonly practiced. Public and civil society organizations are widely involved in the production of IEC materials in all regions. Local languages are used in preparing the materials. Two regions have reported using local radios to transmit HIV/AIDS messages, while Addis

Ababa uses radio stations of nation wide coverage and ETV for transmitting various HIV/AIDS related messages sponsored by several government institutions and NGOs. Though only few do it on regular basis, a number of public and private newspapers publish HIV/AIDS related issues.

Training of professionals on IEC/BCC was conducted in only three regions. TOTs and training of peer educators of various community groups especially members of youth AAC have been conducted through out the country. Youth AAC and associations have been instrumental in performing youth targeted IEC activities. Women associations and Women affair offices have organized sensitization programs specifically for women, integrating HIV/AIDS with topics such as harmful traditional practices.

Community outreach activities such as house-to-house visits and organizing coffee ceremonies by peer educators are commonly practiced in urban settings. Use of extension workers to reach the larger rural community is limited. Apart of forming a large number of AAC in schools and few work places, awareness raising as part of workplace interventions has not progressed much particularly in the sector offices. Various activities undertaken by the Health Education Center of the federal MOH have been noted. Health education units at RHBs are also engaged in IEC activities related to HIV/AIDS.

All regions reported the involvement of traditional leaders, elders, religious leaders and traditional organizations such as Idirs women's associations in awareness raising activities. Except in one region where stigma and discrimination has subdued their participation, PLWHAs or their associations are involved in awareness creation activities to some extent.

A National HIV/AIDS Communication Framework has been developed by Pact-Ethiopia in collaboration with UNAIDS, HAPCO and other partners. A guideline for the implementation of the framework at the regional level is under development. Only one region has reported preparing a regional communication framework based on the national one with the participation of national and local partners.

As much as awareness raising is the most common intervention undertaken by organizations, duplication of efforts is observed in awareness creation activities due to inadequate coordination mechanism. Various groups are involved in production of education materials and messages. A standard for the production of IEC materials and messages has not been set nationally. Pre-testing of education materials and message is not considered as quality assurance procedure.

Increased use of condoms, rising public demand for VCT services, and reduced stigma and discrimination, have been reported which indicate some form of

behavioral changes. House to house visits, peer educators training for youth and CSW, and the involvement of PLWHAs are expected to facilitate behavioral change if applied systematically and continuously. Innovative approaches used at different places such as the establishment and involvement of CSW association, the association for the blind and disabled, and virgin girls association will further enhance the process of behavioral change in communities.
The absence of effective behavioral change interventions nationwide has resulted in persistence of high-risk behavior and low risk perceptions in key and vulnerable social groups.

On the other hand, it is observed that institutional capacity to properly plan execute and monitor IEC/BCC interventions is inadequate both in public and civil society organizations at all levels,from federal to grass root.

4.2 Condom Promotion and Distribution

As part of awareness raising activity, various groups promote condom use. Communities, youth AAC and associations, NGOs and few government offices have distributed condoms free of charge. Some Woreda secretariats have purchased condoms using EAF and distributed it to community AIDS committees and CBOs in their areas. Free access through the RHB, and free promotion through FGAE and OSSA have been reported. DKT is the major agency, which does condom social marketing throughout the country. In the year 2002, DKT reported distributing 67 million condoms through social marketing scheme. Important outlets noted are health institutions, kiosks, workplaces, clubs, bars, and hotels.
Reports from few NGOs and government offices indicated the distribution of condoms in bus terminals and among long distance bus and truck drivers.

Condom Night in Harari

Condom Night is an organized forum initiated by OSSA where people from different walks of life meet in selected sites, mainly in hotels and bars to talk about condom, get free condom supply, participate in questions and answers competition, demonstrate condom use and freely talk about HIV/AIDS. During the event, different youth AAC present music show, short plays and dramas focusing on different HIV/AIDS related issues. This initiative is widely supported by hotel, bar owners and RACS.

A regular check for the quality of condoms is reported in only one region. Targeted activities for specific vulnerable groups are scarce except by AAC, which could access free condoms from WACS, FGAE and OSSA. One region, has organized CSW into an association, is using the CSW to promote and distribute condom.

In spite of success stories regarding increased condom distribution through various outlets both at national as well as regional levels, systematic assessment of actual condom utilization is not apparent. Promotion of condom use as part of Behavioral change intervention is not well addressed. This is evident by the results of the national behavioral surveys and other studies, which have revealed very low rate of condom utilization by significant population groups.

The experience of CSW association and a locally made condom vending machine, are innovative experiences, which should be shared to improve condom use.

4.3 VCT

As a result of considerable promotion campaign by various groups, the demand for VCT has increased in all parts of the country. The expansion of VCT centers is not uniform among the regions. The increase has been fast in some regions while in others it is slow. While the government establishes most of the VCT centers, NGOs and private sectors are also involved. Most regions are planning to establish VCT in all government health facilities to respond to the rising demand for VCT services. Validation study is underway and the findings will be used to set standards for monitoring quality of tests in VCT centers nationally.

The current review has shown that the number of VCT center is increasing, numerous training have been conducted for professionals, and test kits have been procured and distributed to all regions. This indicates that considerable improvement has been made in this intervention area. However, there is no standard for training counselors and there no monitoring on the quality of counseling and testing services. It was also noted that there are very few trained counselors and the attrition rate is high requiring special attention in terms of ensuring a continuous standardized training to increase the number of counselors.

VCT Centers by Region

A.Ababa	Afar	Amhara	Ben/Gum	D.Dawa	Gambella	Harari	Oromia	SNNP	Somali	Tigray	Total
54	?	?	3	2	1	3	15	20	1	21	120

4.4 STI Case Management

Even though training on Syndromic Case Management of STI is reportedly given in most regions the service is actually provided regularly by only two of the regions. Generally public institutions suffer from shortage of essential drugs and this is stated as the main cause for not having the service. Due to this reason, patients prefer to go to private institutions or use self-treatment for STI.

STI counseling linked with VCT services were not mentioned in any of the review reports. Screening of CSW organized by their association is reported in one region and it is an exemplary work, which should be replicated in all other regions.

Some regions have reported that STI is not among the top ten causes of visits to health facilities. In the past STI drugs used to be dispensed free and this has been discontinued resulting in low utilization of STI services in public institutions.

4.5 PMTCT

According to the national PMTCT guideline, most health facilities above the health center level are eligible to render PMTCT service. The National Policy on Use of ART has indicated the commitment of the government to make PMTCT services available for considerable proportion of the population. On the other hand, the availability of the service at the moment is limited to pilot projects in one region. Few regions have laid ground for the national program by doing preliminary assessment or conducting training of professionals. HIV/AIDS screening of pregnant women has not expanded and PMTCT is limited to few places.

4.6 Blood Safety

Currently, the Ethiopian Red Cross Society blood banks are by and large responsible for blood safety in the country. The presence of blood safety measures is not uniform among the regions. Screening is done in all health facilities in six regions, while in two screening is available in few of the facilities. In three regions no blood screening and transfusion facility is available. Training of professionals on blood safety is reported from one region.

4.7 Universal Precaution (UP)

Shortage of protective material is problem for majority of the regions. Few regions have prepared policies and strategies and conducted training for professionals on UP.

4.8 Treatment of Opportunistic Infection (OI) including ART

Drug shortage for OI is universally reported from regions. Provision of drugs from other sources like from FGAE and Down of Hope are mentioned in few places. Training on case management has been conducted to health professionals. Guidelines for case management are available in most regions.

The responsibility of providing proper institutional care for AIDS cases and monitoring of quality of services and setting standards is given to the MOH and regional health offices. Lack of progress in provision of key intervention areas such as PMTCT and ART, inadequate prevention and control measures in health facilities, lack of quality assurance, standards in the rest of the key intervention areas has been identified as areas of concern.

4.9 Community Based Care and Support

Community Based Care and Support is a major intervention area where variety of public, community and civil society groups are engaged. Government offices, youth AAC, kebele AIDS committees, NGOs, PLWHAs associations, women associations, FBOs are involved in various activities of care and support for PLWHAs, their families and AIDS orphans. EAF is the major source of finance for most groups to carry out the program.

Care and support is provided in different forms and these include provision of; cash, shelter, food, material, medical expenses, school fees, uniforms and utensils, provision of HBC, pastoral and other psychosocial support. Impact mitigation measures for vulnerable groups such as income generating activities, micro-financing and vocational training, are mentioned in very few instances. In some of the regions the deliveries of care and support in general, and HBC in particular, has been significantly weakened by high level of stigma and discrimination. There is enormous variation in the type and level of support provided by various implementers. Since there is no standard for the amount of cash provided to beneficiaries, there are marked variations in the amount paid by organizations for similar categories of beneficiaries.

Most regions do not have accurate information on the number of beneficiaries getting care and support. Neither do they have estimates of those requiring it. For example, in a region where such estimates are available, out of 400,000 PLWHAs, only 1276, and out of 200,000 orphans 4265 are getting care and support. Though not supported by numerical facts, many of the regions admit that the number of beneficiaries from this intervention is very small compared to those requiring it. Lack of criteria to select beneficiaries, and lack of standard for HBC, is among the major problems existing in many regions.

Although there are other sources, most of the financial support for cares and support comes from the Emergency AIDS Fund of EMSAP. With exception of few instances communities have not developed mechanism for sustaining care and support activities without EAF and other temporary supports. A working group on care and support to orphans and vulnerable children, composed of HAPCO,

MOLSA, UNICEF, and Save the Children USA, has been processing criteria on major forms of activities of care and support to orphans and vulnerable children.

Key Issues

- Very little attention is given to behavioral change communication (BCC) interventions.
- Institutional capacity at all levels is inadequate to properly lead or direct the implementation of BCC interventions.
- No systematic assessment for the quality and effective utilization of condom is done.
- The expansion of VCT services appears to be slow as compared to the rise in demand. Few regions have reported not to have more than one or two places where the service is provided.
- There is no standardized training for counselors and the turn over of those trained is high.
- Syndromic case management of STD is little practiced in public health facilities due to drug shortage.
- Initiatives on PMTCT are still at an early stage compared to the need.
- Some regions do not have blood banks to handle blood screening and transfusions.
- There is shortage of protective materials (UP) in the majority of the regions.
- Shortage of drugs and supplies for the treatment of OI was observed from most of the regions.
- Various types and levels of care and support activities are underway in the country. There is no standard guideline for the selection of beneficiaries, for types and levels of care and support.

Recommendations

IEC/BCC

- Include a BCC specialist in the staffing of HAPCO. with a mandate to coordinate the development and promotion of a national BCC strategy.
- Support the development of a broad national behavior change and communication strategic framework and tools as how to translate it into community level action..
- Facilitate the production of targeted and standard IEC materials in consultation with regions and other stakeholders to enhance quality and cost effectiveness.
- BCC campaigns be developed using behavior change methods tailored to address different groups, groups whose knowledge, attitude or behavior need be changed.

- The development of SDD reduction strategy and intervention should be given appropriate emphasis.

Condom Utilization

- Encourage further expansion in the accessibility and effective utilization of male condom and promotion of female condom.
- Monitor effective demand and utilization of condom.

STI Management

- Promote the expansion of the delivery of quality services with optimum coverage for STD infected people using primary health facilities by availing qualified staff and regular supply of drugs.

VCT Service

- VCT service must be accessible and affordable to those at high risk of infection or those suspected to have related illness.
- The Partnership among the public sector, private sector. CSOs and donors in expanding VCT centers should be encouraged and supported.
- Work has to be done in setting standard of services and ensuring the quality of the service through regular monitoring such as yearly reports.

Care and Support

- There is strong need for standardizing the community care and support currently underway and developing a clear and easy to follow guideline.
- In the meantime it is important to enhance the role played by organizations engaged in care and support by providing the necessary technical and material resources.
- Since sustainability is a critical element in providing care and support, it should be expanded within a wider developmental context and a mechanism must be sought to foster local developmental initiative, which would lead to self- sustenance.

- Efforts to establish and/or strengthen the social safety net that supports orphans and vulnerable children should be interlinked to social development initiatives.
- The care and support continuum should include clear linkage with health facilities.

- Study be carried out regarding issues of sustainability, social safety net and technical support mechanisms to care and support.

Management of OI

- Expand effective OI intervention linked with home care by maintaining provisions for access to drugs and supplies and qualified personnel.

PMTCT

- Expedite the on going preparatory activities including the training of health professional to expand the PMTCT services throughout the country

Blood Safety

- The provision of blood screening and transfusion services should be extended to all regions.

Universal Precaution (UP)

- Ensure the supply of adequate protective and safety materials to health professionals and community-based caregivers to prevent occupational transmission of HIV/AIDS by allocating sufficient budget.
- Provide appropriate support including training and undertake regular supervision and monitoring to ensure that all safety rules are properly adhered to.

Annex 1

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14. World Bank, March 2002. "Ethiopian Multi-Sectoral HIV/AIDS Project, Second EMSAP Joint Supervision Mission (March 4-20, 2002) AIDE MEMOIR."
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Annex 2

List of Regions and Woredas Visited by the JMR Teams

S/R	Region	Woreda	Number
1	Amhara	Anchefer Bahirdar Debrebirehan Dessie Kombolcha Woldia	6
2	Addis Ababa	-	2
3	Afar	Asayta Awash Gewanie Mile	4
4	Benshangul Gumuz	Assosa Bambasi Menjie	3
5	Dire Dawa	Woreda 2 " 4	2
6	Gambella	Gambella Itang	2
7	Harari	North Woreda South Woreda	2
8	Oromia	Girar Jarso Shashemenie Zway	3

9	SNNP	Arba Minch Humbo Leku	3
10	Somali	Erer Jijiga	2
11	Tigray	Adigrat Adwa Mekele Tembien	4
	Total		**33**

33

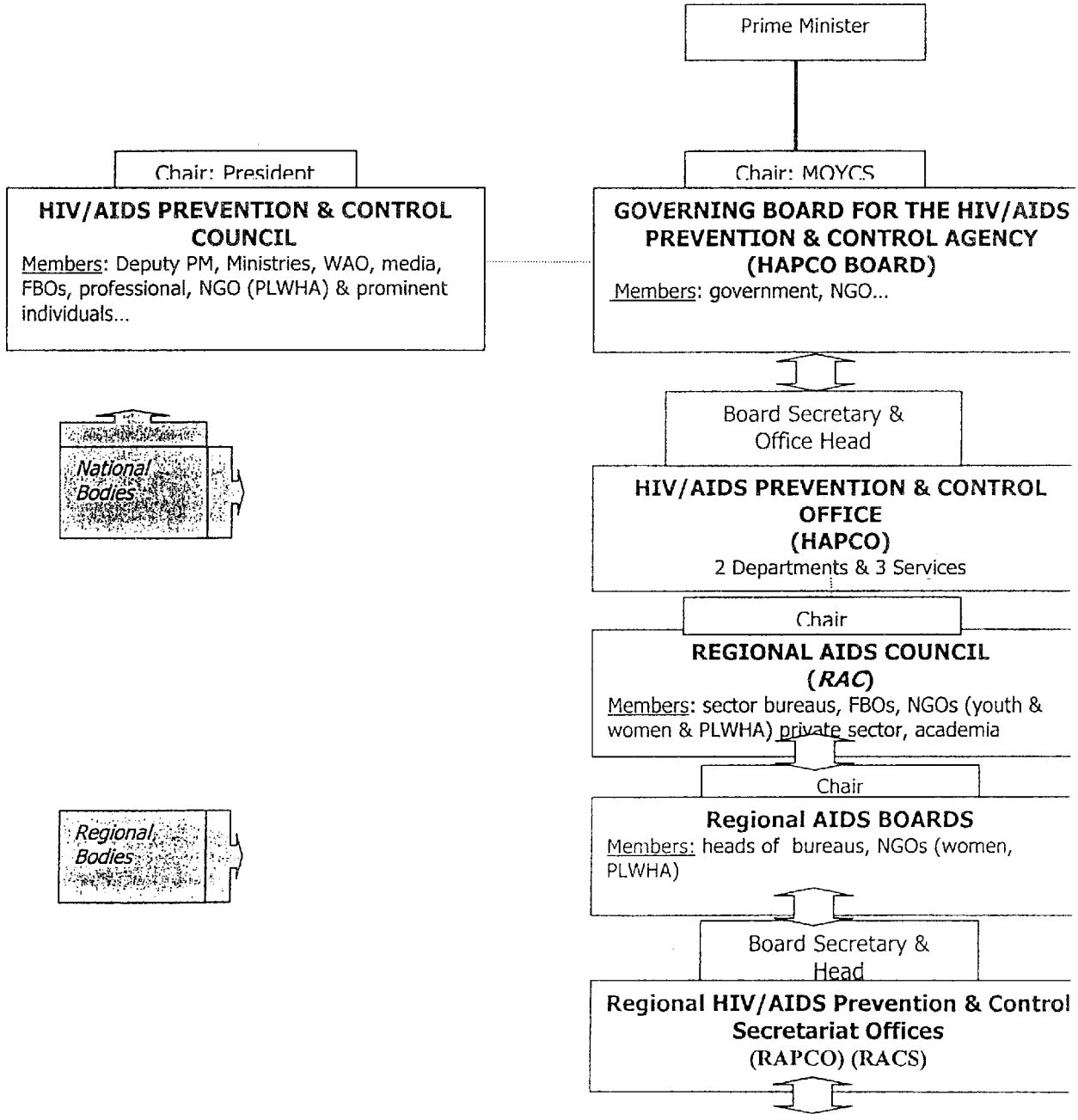
Annex 3

List of Joint Technical Committee and Review Mission Members

S/N	NAME	ORGANIZATION
Joint Technical Committee Members		
1	Dr. Gebreselassie Okubagzih	World Bank + mission member
2	Mrs. Holly Fluty Dempsey	USAID
3	Geradina.....	UNAIDS
4	Ato Jemal Ahmed	AAE-SIPA
5	Dr. Asseged Woldu	MOH + Mission member
6	Ato Shimeles Worku	HAPCO - + JRM Coordinator
Joint Mid-Term Review Mission Members		
8	W/O Fetlework Kesela	UNIPA-Consultant
9	Dr. Brehanie K/Mariam	USAID/FHI-Consultant
10	Dr. Woldemdhin T/Teadik	AAE-Consultant
11	Dr. Hailu Regasssa	CDC
12	Ato Shemsu Ali	HAPCO
13	Dr. MeazaDemissie	UNDP-Consultant
14	Ato Asrat Kelemework	HAPCO
15	Dr. Michael Dejene	UNAIDS-Consultant.
16	Dr. Berhanu Demeke	USAID/FHI-Consultant
17	Ato Mirgissa Kaba	UNICEF
18	DR. Mekonneb Meshesha	R Norwegian Embassy
19	Ato Belay Shiferaw	HAPCO
20	Dr. Altayie Habtegorgis	WHO-Consultant
21	Ms. Wendy Roseberry	DFID-Consultant
22	Dr.Filimona Bisrat	CRDA
23	Dr. Shabir Ismael	CDC

Annex 4

Governmental Institutional Arrangements For AIDS In Ethiopia



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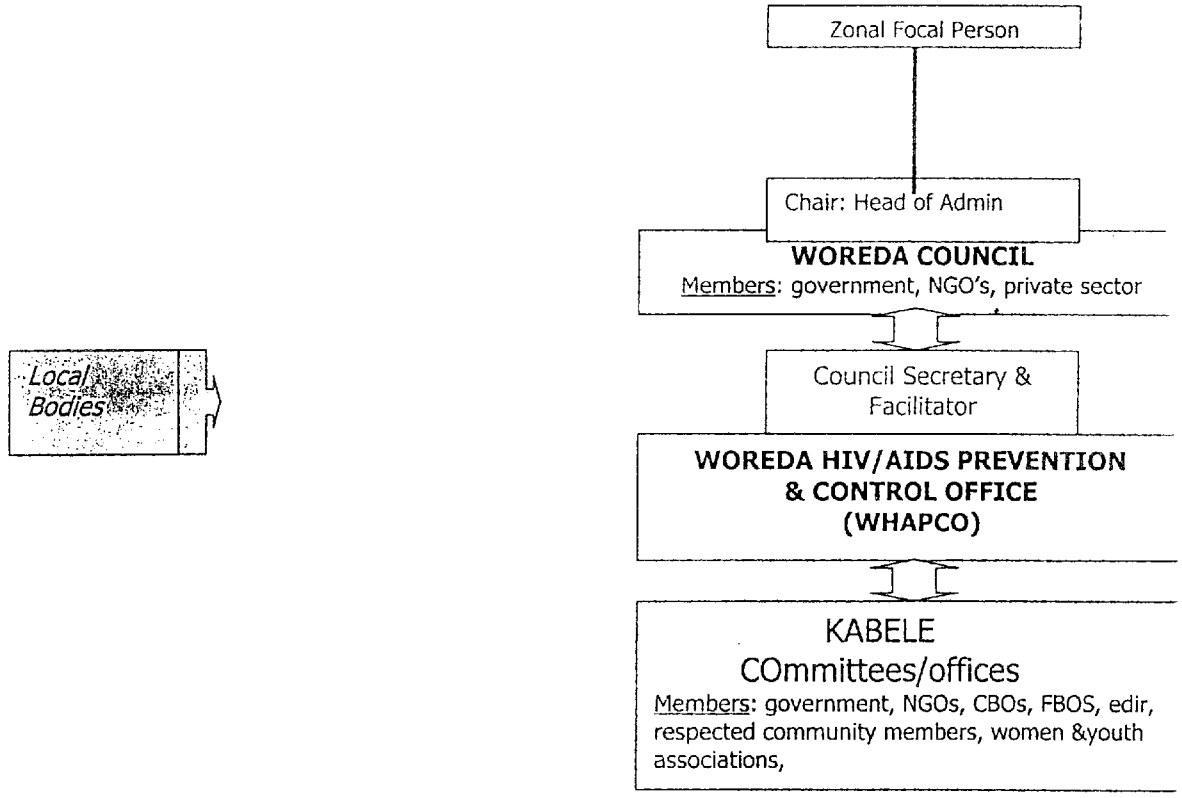
Zonal Focal Person
Chair: Head of Admin
WOREDA COUNCIL
Members: government, NGO's, private sector
Local Bodies
Council Secretary & Facilitator
WOREDA HIV/AIDS PREVENTION & CONTROL OFFICE (WHAPCO)
KABELE COmmittees/offices
Members: government, NGOs, CBOs, FBOS, edir, respected community members, women &youth associations,

Annex 5

HAPCO -PCU
Sumary of Disbursement and Settlement
2001- April 2003

No.	Particulars	Amount Settled	Amount Paid	Balance Unsettle	Remark
	PCU Level Projects	13,633,724.47	22,802,781.44	9,169,056.97	
	Woreda and Kebele				
1	Addis Ababa Weredas	1,126,348.58	1,337,320.50	210,971.92	
2	Oromiya Weredas	4,815,091.40	6,589,913.18	1,774,821.78	
3	Somali Weredas	538,729.26	781,369.00	242,639.74	
4	Gambella Weredas	563,165.50	1,045,638.00	482,472.50	
5	Tigri Weredas	1,861,593.18	4,021,144.06	2,159,550.88	
6	Harari Weredas	139,376.16	226,800.00	87,423.84	
7	Amhara Weredas	2,194,546.83	2,981,833.90	787,287.07	
8	DireDawa Weredas	200,648.50	328,912.25	128,263.75	
9	Benshangul Weredas	404,759.85	699,743.00	294,983.15	
10	SNNP Weredas	636,757.53	3,807,610.00	3,170,852.47	
11	Afar Weredas	1,679,549.70	2,145,038.00	465,488.30	
	Total for Weredas	14,160,566.49	23,965,321.89	9,804,755.40	
	Regional Secretariat EAF Activit	11,315,413.74	26,647,308.00	15,331,894.26	
	Grand Total	39,109,704.70	73,415,411.33	34,305,706.63	

Annex 6

EAF fund
Summary of Expenses by Intervention Activity
2001-April2003

Region /Woreda/Civil Society	Awareness Creat.	Care & Support	Data Collection	Traning	Condom Distribution	VCT	Admin.Cost	Total
Addis Ababa	142,583.07	915,021.95		11,845.20	1,090.00	2,163.00	55,048.06	1,127,751.28
Afar	1,073,028.10	95,378.40	47,323.00	76,302.00	24,760.00	13,700.00	140,558.20	1,471,049.70
Amhara	541,240.21	1,307,809.91	1,928.50	55,232.49	1,971.90		141,207.71	2,049,390.72
Benshangul	314,344.80	80,606.01	250.00	37,024.85			54,494.19	486,719.85
DireDawa	94,540.70	91,521.40					14,586.40	200,648.50
Gambella	474,453.50	33,096.00	3,565.00		4,320.00		47,731.00	563,165.50
Harari	89,644.01	103,630.43	1,784.00	2,664.00	360.00	1,455.00	53,684.11	253,221.55
Oromiya	1,669,241.43	1,470,112.38	107,472.11	659,275.09	9,288.46	10,506.50	465,685.61	4,391,581.58
SNNP	251,993.82	77,073.00					286,370.98	615,437.80
Somali	183,073.00	10,196.50	4,386.00			4,390.00	57,496.62	259,542.12
Tigri	1,025,802.50	13,979.05		4,270.00			355,226.43	1,399,277.98
NGO & Civil Society At Central I	4,894,254.05	4,634,472.44	75,320.00	1,106,197.91	93,949.37	1,118,439.04	1,878,926.69	13,801,559.50
Toal	10,754,199.19	8,832,897.47	242,028.61	1,952,811.54	135,739.73	1,150,653.54	3,551,016.00	26,619,346.08

Annex 7

HIV/AIDS PREVENTION & CONTROL OFFICE
Project Coordination Unit

Emergency AIDS Fund

S.N	Project Name	PUC Level Projects			Fund Transferred						
		Total Project Cost	EMSAP Share	P.Holder Share	1993Up to 00/01	1994 2001/2002	1995 1st Quart(1995) 2002/2003	2nd quarter(Jan8/02 2002/2003	3rd quarter Jan9 - April 8/02 2002/2003	4th Quarter April 9 -July 7/02 2002/2003	Total
1	Dawn of Hope	3,349,643.00	3,014,678.70	334,964.30	500,000.00	1,000,000.00	658,831.00	176,168.00	160,000.00		2,494,999.00
2	Mekidim P.P.	1,614,448.50	1,563,065.70	51,382.80	500,000.00	527,656.00	146,698.00		209,839.00		1,384,193.00
3	Evangelical Church F	142,858.00	128,268.00	14,590.00	128,268.00						128,268.00
4	Ebenezer Literature &	476,550.00	381,240.00	95,310.00	95,310.00	190,620.00		47,655.00			333,585.00
5	Tesfa Theatre & Mus	173,500.00	138,800.00	34,700.00	34,700.00	104,100.00					138,800.00
6	Mary Joy Aid Throug	3,102,000.00	2,791,800.00	310,200.00	697,950.00	1,237,338.00		600,000.00	256,512.00		2,791,800.00
7	Ethiopian Employers	689,100.00	551,280.00	137,820.00	60,296.00	137,820.00					198,116.00
8	Aagency for the Assis	631,800.00	568,620.00	63,180.00	142,155.00	426,465.00					568,620.00
9	Organization for Social Service for										0.00
	AIDS Programm	2,022,221.27	1,819,999.17	202,222.10		329,049.00		329,049.00			658,098.00
10	Berhan Integrated Co	610,735.40	549,661.86	61,073.54		219,864.00	109,932.00				329,796.00
11	Family Guidance Ass	1,698,396.00	1,111,020.00	587,376.00		277,755.00	277,755.00		277,755.00		833,265.00
12	Radio Fana	1,986,000.00	724,500.00	1,261,500.00		181,125.00			207,224.00		388,349.00
13	Habesh Theatre and M	389,760.00	311,808.00	77,952.00		155,904.00	77,952.00		77,952.00		311,808.00
14	Tewannay Studio	225,650.00	180,520.00	45,130.00		90,260.00	90,260.00				180,520.00
15	Confederation of Eth.	2,795,453.00	2,207,153.00	588,300.00		551,788.00					551,788.00
16	Abebech GobenaOrpl	732,458.00	659,212.20	73,245.80		329,606.10		164,803.00	164,803.10		659,212.20
17	Atbia Kokob Publish	212,855.00	170,284.00	42,571.00		85,142.00		85,142.00			170,284.00

18	Eth. Orthodox Churcl	8,870,043.00	8,870,043.00			2,192,510.75					2,192,510.75
19	Walta Information Ce	27,600.00	22,080.00	5,520.00		22,080.00					22,080.00
20	Eth. Islamic Affairs S	2,529,915.30	2,403,419.53	126,495.77		600,854.88					600,854.88
21	Ethiopian Aid	2,025,614.50	1,823,053.05	202,561.45		244,878.97			182,874.00		427,752.97
22	Ethiopian Teachers A	272,760.00	245,484.00	27,276.00		61,371.00		61,371.00			122,742.00
23	EECMY- CES Yehiwot Tesfa										0.00
	counseling and Social	940,766.32	846,689.69	94,076.63		211,672.00			211,672.00		423,344.00
24	Eth. National Ass. Of	130,427.00	114,752.00	15,675.00		28,688.00			28,688.00		57,376.00
25	Behzatha Medical Ce	2,898,065.00	2,236,015.00	662,050.00		559,003.00		203,731.00			762,734.00
26	Society for The Advancement of										0.00
	Human Rights Educa	243,425.60	219,083.04	24,342.56		54,771.00		54,771.00	54,771.00	54,770.00	219,083.00
27	Awareness Through I	542,012.00	216,798.80	325,213.20		54,200.00	54,200.00	54,200.00			162,600.00
28	AGAPE IN ACTION	258,120.00	234,108.00	24,012.00		58,527.00					58,527.00
29	Kembata Women's Cu	533,890.00	480,501.00	53,389.00		120,125.00					120,125.00
30	Canadian Physician fo	1,474,455.00	1,062,600.00	411,855.00		265,650.00			265,650.00		531,300.00
31	Salaish Fine Arts & A	25,537.00	21,937.00	3,600.00		10,968.00	10,968.00				21,936.00
32	Gasto Prom. Comm. I	1,383,800.00	1,333,800.00	50,000.00			550,000.00	450,000.00			1,000,000.00
33	MEGA Advertising I	887,234.64	596,234.64	291,000.00			594,234.64				594,234.64
34	Welfare for the Street	646,655.00	581,989.50	64,665.50			145,497.00				145,497.00
35	Children AID Ethiopi	646,429.00	552,275.00	94,154.00			138,068.00				138,068.00
36	Yeteem Childrefn & I	371,326.00	334,193.40	37,132.60			83,548.00				83,548.00
37	Hope for Rural Child	351,830.00	309,830.00	42,000.00				77,457.00			77,457.00
											0.00
	Total	45,913,333.53	39,376,797.28	6,536,536.25	2,158,679.00	10,329,791.70	2,937,943.64	2,304,347.00	2,097,740.10	54,770.00	19,883,271.44

1.In addition to EAF fund Birr 60,296.00 (Eth. Employers Federation)

2. Birr 125,950.00 has been transferred from capacity building component to OSSA

3. Walta Information Centre 2nd round project Total cost 640850.00 128170.00 own cost 512680.00 EMSAP share

4. Mekdim has submitted 2nd project

National HIV\AIDS Secretarial
Project Coordination Unit

Emergency AIDS Fund

S.N	Project Name	PUC Level Projects			Fund Transferred						
		Total Project Cost	EMSAP Share	P.Holder Share	Up to July8/01		2nd quarter Oct.11/01-	3rd quarter(Jan9/02	3rd quarter Jan9 - April 8/02	4th Quarter April 9 -July 7/02	Total
S.N	Project Name	PUC Level Projects			Fund Transferred						
		Total Project Cost	EMSAP Share	P.Holder Share	1993Up to July 7/01	1994	1995 1st Quart	2nd quarter(Jan9/02	3rd quarter Jan9 - April 8/02	4th Quarter April 9 -July 7/02	Total
	BCF	45,913,333.53	39,376,797.28	6,536,536.25	2,158,679.00	10,329,791.70	2,937,943.64	2,304,347.00	2,097,740.10	54,770.00	19,883,271.44
38	Population Media Ce	1,420,635.00	901,275.00	519,360.00				100,000.00	100,000.00		200,000.00
39	Progynist	987,712.00	895,312.00	92,400.00				200,000.00			200,000.00
40	Eth. Red Cross Socie	6,981,003.00	6,346,367.00	634,636.00				400,000.00	1,100,000.00		1,500,000.00
41	Global Diagnostic La	3,467,750.00	2,584,500.00	883,250.00					500,000.00		500,000.00
42	Eth. Orthdox Church Dev't.and Inter-										0.00
	Church Aid Commiss	1,523,983.00	1,371,584.70	152,398.30					342,896.00		342,896.00
43	Redeem The Generati	224,642.00	193,776.00	30,860.00					48,444.00		48,444.00
44	Walta Information Ce	640,850.00	512,680.00	128,170.00					128,170.00		128,170.00
	Total	61,159,908.53	52,182,291.98	8,977,610.55	2,158,679.00	10,329,791.70	2,937,943.64	3,004,347.00	4,317,250.10	54,770.00	22,802,781.44

7. HIV／AIDS 関連 NGO リスト

NGOs AND STAKEHOLDERS HIV/AIDS PROGRAMME FOCUS MATRIX

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
1. Aba Woldetensae Gizaw Mothers & Children Welfare Association (AWWA)	➢ Prevention ➢ Care ➢ Training ➢ Service Provision ➢ Support	➢ Addis Ababa	Ato Zenebe Mamo Tel: 614110/ 622075 P.O. Box: 20110 code 1000
2. Abebech Gobena Orphanage and School	➢ Services Provision ➢ Education ➢ Training ➢ Prevention ➢ Care ➢ Support	➢ Addis Ababa ➢ Oromiya	Ato Abaineh Abebe Tel: 553622 Fax: 550152 P.O. Box: 24998 E-mail: agos@telecom.net.et
3. Action Aid Ethiopia	➢ Prevention ➢ Care ➢ Support ➢ Training ➢ Funding ➢ Research and Surveillance ➢ Partnership/Coordination/Network	➢ Addis Ababa ➢ Afar ➢ Amhara ➢ Gambella ➢ Oromiya ➢ Tigray ➢ SNNPR	Ato Jemal Ahmed Tel: 654671 P.O. Box: 1261 E-mail: Jemala@actionaidethiopia.org
4 Addis Ababa University Center for Resource, Training and Information on Women in Development (CERTWID)	➢ Training ➢ Education ➢ Research and Surveillance	➢ All Regions	Dr. Emebet Mulugeta Tel: 123338 Fax: 551333 P.O. Box 1176 E-mail: certwid@telecom.net.et
5. Adventist Development and Relief Agency	➢ Education ➢ Prevention ➢ Training	➢ Oromiya	Ato Gelgelu Sadhu Tel: 512212 Fax: 511319 P.O. Box: 145 E-mail: 112671.2632@compuserve.com adra-et@tadis.gn.apc.org
6. Afar Pastoralist Development Association	➢ Prevention ➢ Training ➢ Education	➢ Afar	Ato Ismael Ali Gardo Tel: 03-550157/ 01-159787 P.O. Box: 592 code 1110 E-mail: afarpastoral@telecom.net.et
7. African AIDS Initiative Inc. (AAII)	➢ Training ➢ Prevention ➢ Partnership/Coordination/Network ➢ Service Provision ➢ Education ➢ Research and Surveillance	➢ All Regions	Tel: 444033 Fax: 513264 P.O. Box: 60035 E-mail: aaintl@whoet.org

Matrix Updated June 4, 2002

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
8. African Development and Relief Agency	➢ Prevention	➢ Oromiya	
9. African Medical and Research Foundation	➢ Prevention ➢ Care ➢ Training ➢ Education	➢ Addis Ababa	Dr. Roma Hein Tel: 531919/ 514117/ 520642 Fax: 534148 P.O. Box: 20855 code 1000
10. Africare/ Ethiopia	➢ Prevention ➢ Training ➢ Partnership/Coordination/Network	➢ SNNPR ➢ Gambella	Dr. Robert Kagbo Tel: 531150/ 152484 Fax: 511248 P.O. Box: 2309 E-mail: afrieth@telecom.net.et
11. Agency for Cooperation and Research in Development (ACORD)	➢ Services Provision ➢ Prevention ➢ Training ➢ Funding ➢ Education	➢ Oromiya ➢ Addis Ababa	Ato Asfaw Mekonnen Tel: 09-200136/ 613931/ 534809 Fax: 655229/ 627763 P.O. Box: 12377 E-mail: acord.eth@telecom.net.et
12. Agency for the Assistance of Refugees, Displaced and Returnees	➢ Prevention ➢ Care ➢ Support	➢ Amhara ➢ Addis Ababa ➢ Oromiya	Ato Amanuel Worque Abebe Tel: 713254 or 718712 Fax: 716463 P.O. Box: 12998 E-mail aardr@telecom.net.et
13. Agri-Service Ethiopia	➢ Prevention ➢ Education ➢ Training	➢ Amhara ➢ Oromiya ➢ SNNPR	Ato Getachew Worku Tel: 654183/ 651212 Fax: 654088 P.O. Box: 2460 E-mail: ase@telecom.net.et
14. Amhara Development Association (ADA)	➢ Prevention ➢ Training ➢ Education ➢ Care ➢ Support	➢ Amhara	Ato Fikru Kebede Tel: 08-203235/ 01-517886 Fax: 08-201088/ 01-517795 P.O. Box: 307 Bahir Dar 13685 Addis Ababa E-mail: ada.hq@telecom.net.et
15. Association for the Rehabilitation of Girls	➢ Funding ➢ Education ➢ Training	➢	Dr. Fantaye Mekibib Tel: 508164 P.O. Box: 29448

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
16. Bahir Dar Medhanealem Orphans Family Support & Training Center	➢ Training ➢ Education	➢ Amhara	Ato Sendeku Guadie Semieneh Tel: 08-201123/ 01-293399 Fax: 08-206321 P.O. Box: 191 Bahir Dar 9631 Addis Ababa E-mail: modfstc@telecom.net.et
17. Beza Organizing Association of Women in Need	➢ Care ➢ Support	➢	Wzo. Gennet Lemma Tel: 113271 P.O. Box: 24535 code 1000
18. Birhan Integrated Community Development Organization	➢ Prevention ➢ Training ➢ Services provision ➢ Education	➢ Oromiya ➢ Addis Ababa ➢ SNNPR	Ato Jemal Abdella Tel: 551559/ 571221/ 571222 Fax: 571220 P.O. Box: 9310 E-mail: Bicdo@telecom.net.et
19. Bisrat Development and Aid Organization	➢ Prevention ➢ Care ➢ Support ➢ Training ➢ Education	➢	Ato Tesfaye Meshesha Tel: 602621 P.O. Box: 32959
20. Canada Physicians for Aid & Relief	➢ Prevention ➢ Training ➢ Education	➢ Amhara ➢ Oromiya ➢ Benishangul	Ato Getachew Abegaz Tel: 425575/ 423944 Fax: 424655 P.O. Box: 2555 E-mail: cpar@telecom.net.et
21. Catholic Relief Service (CRS)	➢ Prevention ➢ Care ➢ Support ➢ Training (All regions) ➢ Education ➢ Funding	➢ Oromiya ➢ Harari ➢ Addis Ababa ➢ Dire Dawa	Ms. Anne Bousquett Tel: 653513/ 653588 Fax: 654450 P.O. Box: 6592
22. CARE International Ethiopia	➢ Prevention ➢ Service Provision ➢ Care ➢ Support ➢ Research and Surveillance ➢ Education ➢ Training	➢ Amhara ➢ Oromiya ➢ Addis Ababa ➢ Harari	Dr. Kidmealem Lulseged Tel: 613422 Fax: 611900 P.O. Box: 4710 E-Mail: care.eth@telecom.net.et

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
23. Center for Disease Control and Prevention -Ethiopia	➢ Research and Surveillance ➢ Service Provision	➢ Addis Ababa	Dr. Tadesse Wuhib Tel: ~~771066/ 666769~~ 539983 FAX: 771070 P.O. Box 1014 (09-228543 E-mail twuhib@cdc.gov
24. Center for African Family Studies (CAFS)	➢ Partnership/Coordination/Network ➢ Training ➢ Research and Surveillance	➢ All Regions	Ms. Sara Tadiwos Tel: 663801/ 565041/ 09-236426 Fax: 663801 P.O. Box: 27389 E-mail: stadiwos@yahoo.com
Center for Human Development	➢ Prevention ➢ Support ➢ Care ➢ Education ➢ Training	➢ Addis Ababa ➢ Benishangul	Dr. Mekonnen Meshesha Tel: 116883/ 09- 214616/ 711958 P.O. Box: 12499 E-mail: cdaddis@yahoo.com
26. Centro Voluntari Marchigiani (C.V.M.)	➢ Prevention ➢ Education ➢ Support ➢ Training ➢ Partnership/Coordination/Network	➢ Amhara	Ato Kibret Shiferaw Tel: 164309 Fax: 655600 P.O. Box: 8429 E-mail: cvm@telecom.net.et
27. CHER Ethiopia (Society for Humanitarian Development Assistance)	➢ Prevention	➢ SNNPR	Dr. Alemayehu Areda Tel: 517364 Fax: 514595 P.O. Box: 6652 E-mail: alemayehuareda@hotmail.com
28. Cheshire Foundation of Ethiopia	➢ Education ➢ Support ➢ Services provision ➢ Prevention ➢ Training	➢ Addis Ababa ➢ Amhara ➢ Oromiya	Ato Nigussie W/Selassie Tel: 630571 Fax: 610804 P.O. Box: 31938 E-mail: cheshirefoundation@telecom.net.et
29. Children Aid-Ethiopia Organization	➢ Care ➢ Prevention ➢ Training ➢ Research and Surveillance ➢ Support ➢ Education	➢ Orormiya ➢ Addis Ababa	Ato Annania Admassu Tel: 519128 P.O. Box: 5854 E-mail: Chad-et@telecom.net.et

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
30. Christian Aid	➢ Funding ➢ Partnership/Coordination/Network	➢ Addis Ababa ➢ Oromiya ➢ SNNPR ➢ Somali ➢ Tigray	Ato Tewodros Tigabu Tel: 615812/ 613147 Fax: 615812 P.O. Box: 20172 code 1000 E-mail: caid-ethiopia@telecom.net.et
31. Christian Children's Fund Inc. Eth.	➢ Education ➢ Prevention ➢ Support	➢ Oromiya ➢ Addis Ababa ➢ SNNPR ➢ Amhara	Ato Dereje Dejene Tel: 612865/ 612928/ 613426 Fax: 624540 P.O. Box: 5545 E-mail: ccfethiopia@telecom.net.et
. . Christian Relief & Development Association (CRDA)	➢ Partnership/Coordination/Network ➢ Training ➢ Care ➢ Support ➢ Services provision	➢ All Regions	Dr. Agonafer Tekalegn Tel: 650846 Fax: 652280 P.O. Box: 5674 E-mail crda@telecom.net.et
33. Community Aid Abroad/OXFAM Australia	➢ Funding ➢ Education ➢ Training	➢ Tigray ➢ Afar	Ato Esayas Girma Tel: 652000/ 622969 Fax: 615578 P.O. Box: 22649 E-mail: esayascaa@telecom.net.et
34. CONCERN Ethiopia	➢ Partnership/Coordination/Network ➢ Funding ➢ Prevention	➢ Addis Ababa ➢ SNNPR	Mr. Paul Sherlock Tel: 611730/ 610729 Fax: 611544 P.O. Box: 2434 E-mail: concern.ethiopia@telecom.net.et
35. Consortium of Family Planning NGOs in Ethiopia (COFAP)	➢ Partnership/Coordination/Network	➢ All regions	Ato Hailu Belachew Tel: 516642/ 154070 Fax: 512435 P.O. Box: 5775
36. Dawn of Hope	➢ Prevention ➢ Care ➢ Support ➢ Training ➢ Education ➢ Service Provision	➢ Amhara ➢ Addis Ababa ➢ SNNPR ➢ Harari ➢ Oromiya	Ato Zewdu Getachew Tel: 564329/ 510154 Fax: 560245 P.O. Box: 24378 E-mail: dhe@telecom.net.et

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
37. Department for International Development (DFID)	➢ Prevention ➢ Partnership/Coordination/Network ➢ Training ➢ Service Provision ➢ Education ➢ Funding ➢ Care	➢ Addis Ababa ➢ Amhara ➢ Gambella ➢ Oromiya	Dr. Nicholas Taylor Tel: 612354 FAX: 610588 P.O. Box: 858 E-mail: n-taylor@telecom.net.et
38. DKT Ethiopia	➢ Education ➢ Training ➢ Research and Surveillance ➢ Prevention	➢ All regions	Ato Girma Degfie Tel: 519300 Fax: 519966 P.O. Box: 8744 E-mail: dktethiopia@telecom.net.et
39. EIASC (donor agency Pathfinder International)	➢ Prevention ➢ Care	➢ Oromiya ➢ Harari ➢ Dire Dawa	Sheik Abdurahman Hussein Tel: 756430 Fax: 756430 P.O. Box: 503
40. Emmanuel Development Association	➢ Education ➢ Training	➢ Addis Ababa	Ato Tessema Bekele Tel: 625769 Fax: c/o CRDA 652280 P.O. Box: 908 E-mail: tessema.bekele@telecom.net.et
41. Environmental Protection and Assistance Organization	➢ Education ➢ Training	➢	Ato Fesseha Gedamu Tel: 713360 Fax: c/o CRDA 652280 P.O. Box: 12790 E-mail: enprao@telecom.net.et
42. Ethiopian Aid	➢ Prevention ➢ Training ➢ Partnership/Coordination/Network ➢ Service Provision ➢ Education ➢ Care ➢ Support	➢ Amhara ➢ Addis Ababa ➢ Oromiya	Ato Yeshiwas Bekele Tel: 504408/ 154661 Fax: 504409 P.O. Box: 101992 E-mail: et.aid/wass@telecom.net.et
43. Ethiopian Catholic Church Archdiocese Of Addis Ababa	➢ Prevention ➢ Service Provision ➢ Care	➢ Addis Ababa	C/O MMM Tel: 559960 Fax: 552950 P.O. Box: 19934

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
44. Ethiopian Catholic Secretariat/ Ethiopian Catholic Church Nationally	➢ Care ➢ Support ➢ Services Provision ➢ Prevention ➢ Training ➢ Funding ➢ Research and Surveillance ➢ Partnership/Coordination/Network	➢ Addis Ababa ➢ Amhara ➢ Benishangul ➢ Dire Dawa ➢ Gambella ➢ Oromiya ➢ SNNPR ➢ Somali ➢ Tigray	Dr. Eyerusalem Kebede Tel: 550300/ 550009 Fax: 553113 P.O. Box: 2454 E-mail: ecs@telecom.net.et
45. Ethiopian Gemini Trust	➢ Prevention ➢ Service Provision ➢ Education ➢ Care	➢ Addis Ababa	Dr. Carmela Green Abate Tel: 531986/ 531985/ 151947 Fax: 501941 P.O. Box: 3547 E-mail: geminitrust@telecom.net.et
46. Ethiopian Orthodox Church/ DICAC	➢ Prevention ➢ Support ➢ Training ➢ Education	➢ All regions	Ato Kibur Genna Tel: 119661/ 553566 Fax: 551455 P.O. Box: 503 E-mail: eoc.dicac@telecom.net.et
47. Ethiopian Evangelical Church Mekane Eyesus (EECMY)	➢ Training ➢ Service Provision ➢ Support ➢ Prevention ➢ Partnership/Coordination/Network ➢ Education ➢ Care	➢ Amhara ➢ Oromiya ➢ Benishangul ➢ SNNPR ➢ Addis Ababa ➢ Dire Dawa ➢ Gambella ➢ Tigray	Ato Feyissa Kayemo Tel: 531919/ 531922 Fax: 534148 P.O. Box: 2087 E-mail: eecmy.co@telecom.net.et etsegeneth@eecmy.org elsabethg@eecmy.org
Ethiopian Youth League, Self-Help Association	➢ Prevention	➢ Benishangul	Ato Seife Tadele Tel: 557913/550612 P.O. Box: 7704 E-mail: eyl.seife@telecom.net.et
49. Ethiopian Red Cross Society	➢	➢	E-mail ercs@telecom.net.et
50. Ethio-Swedish Children & Youth Rehabilitation and Prevention Project	➢ Prevention ➢ Education ➢ Training	➢ Oromiya ➢ Addis Ababa ➢ SNNPR	Ato Samson Arefaine Tel: 560922/ 124056 P.O. Box: 8660
51. Ethiopian Health & Nutrition Research Institute	➢ Research and Surveillance	➢ Addis Ababa	Ato Dawit Dikasso Tel: 756309/ 751522 ext. 258 Fax: 754744/ 757722 P.O. Box 1242 E-mail: EHNRI@telecom.net.et

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52. Ethiopian Health & Nutrition Research Institute (EHNRI) /ENARP	➢ Prevention ➢ Research and Surveillance ➢ Training ➢ Education	➢ Oromiya ➢ Addis Ababa	Dr. Aberra Geyid Tel: 130642/ 765340 Fax: 756329 P.O. Box: 1242 E-mail: enarp@telecom.net.et
53. Ethiopian Rural Self-Help Association	➢ Prevention ➢ Education ➢ Care ➢ Support	➢ Amhara ➢ Oromiya ➢ SNNPR	Ato Zeleke Tesfaye Tel: 654652/ 661493 Fax: 661492 P.O. Box: 102367 E-mail: ersha@telecom.net.et
54. Ethiopian Society of General Medical Practice (ESGMP)	➢ Training ➢ Prevention ➢ Partnership/Coordination/Network ➢ Education	➢ All regions	Dr. Benalfew Tesfaye Tel: 569263 P.O. Box: 8528 E-mail: esgmp@telecom.net.et
55. European Union	➢ Prevention ➢ Care ➢ Support	➢ Amhara ➢ Addis Ababa ➢ SNNPR	Mr. Karl Harbo Tel: 612511 Fax: 612877 P.O. Box: 5570 E-mail: European.union@telecom.net.et
56. Evangelical churches Fellow ship of Ethiopia (ECFE)	➢ Prevention ➢ Care	➢ Tigray ➢ Amhara ➢ Oromiya ➢ Somali ➢ SNNPR	Pastor Seyum Geberetsadik Tel: 511498 Fax: 511327 P.O. Box: 8773 E-mail: ecfe@telecom.net.et
57. Family Guidance Association of Ethiopia (FGAE)	➢ Prevention ➢ Services provision ➢ Training ➢ Education ➢ Care ➢ Support	➢ SNNPR ➢ Amhara ➢ Addis Ababa ➢ Dire Dawa ➢ Harari ➢ Oromiya	Ms. Tewabetch Mengistu Tel: 514111 Fax: 512192 P.O. Box: 5716 E-mail: fgae@telecom.net.et
58. Family Health International-Ethiopia (FHI)	➢ Prevention ➢ Partnership ➢ Training ➢ Service Provision ➢ Funding ➢ Care ➢ Support ➢ Research and Surveillance	➢ Addis Ababa ➢ Amhara ➢ Oromiya ➢ SNNPR	Ms. Francesca Stuer Tel: 628809/ 628814-17/ 09-228669 FAX: 628804 P.O. Box 121789 E-mail fhi@telecom.net.et f_stuer@yahoo.com

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59. Fatumatu Zehara Aid Organization (FZAO)	➢ Prevention ➢ Education ➢ Care ➢ Support.	➢ Amhara	Wzo Yemsrach Ayele Tel: 754293/ 09-200872 Fax: 511236 P.O. Box 14049 E-mail: f.z.a.o@telecom.net.et
60. Federal Civil Service Commission	➢ Training	➢ Addis Ababa	Ato Tezera W/Medhun Tel: 553488 Fax: 553902 P.O. Box 101992 E-mail: fcsc@telecom.net.et
61. Feed the Children-Ethiopia	➢ Prevention	➢ Addis Ababa ➢ SNNPR	Ato Wondimagegnew Gizaw Tel: 431134 Fax: 431135 P.O. Box: 5683 E-mail: wondim@telecom.net.et
62. Finnish Mission	➢ Prevention ➢ Services Provision ➢ Training ➢ Education	➢ Oromiya	Mr. Heikki Penttinen Tel: 712592 Fax: 713188 P.O. Box: 3833 E-mail: FFFM@telecom.net.et
63. Food for the Hungry International	➢ Support	➢ Amhara	Mr. Thomas Stocker Tel: 660261 Fax: 660260 P.O. Box: 4181 E-mail: tstocker@fhi.net
64. Forum on Street Children-Ethiopia	➢ Prevention ➢ Training ➢ Service Provision ➢ Education ➢ Support	➢ Amhara ➢ Addis Ababa ➢ Dire Dawa	Ato Fassil Wolde Mariam Tel: 534432/ 534722/ 524294 Fax: 534469 P.O. Box: 9562 E-mail: fsce@telecom.net.et
65. Forum for Social Studies	➢ Policy Research	➢ All Regions	Ato Esaetu Bekele Tel: 552025 P.O. Box: 25864 code 1000 E-mail: fss@telecom.net.et

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66. Finish Evangelical Lutheran Mission	➢ Service Provision ➢ Prevention ➢ Care ➢ Support ➢ Training	➢ Addis Ababa (including the surrounding 200 K.M. radius)	C/O EECMY Tel: 531919/22 Fax: 534148 P.O. Box: 2087
67. German Technical Cooperation (GTZ) Promotion of Reproductive health in Ethiopia (PRHE)	➢ Partnership/Coordination/Network ➢ Training ➢ Prevention	➢ Tigray ➢ Amhara ➢ Oromiya ➢ Addis Ababa	Dr. Peter Herzig Tel: 660242/ 660245 Fax: 652731 P.O. Box: 23962 code 1000 E-mail: gtzmlp_cea@telecom.net.et
. Goal Ethiopia	➢ Care ➢ Support ➢ Service Provision ➢ Prevention	➢ Addis Ababa	Ms. Catherine Fitzgibbon Tel: 531882 P.O. Box: 6552 E-mail: goal.ethio@telecom.net.et
69. Godanaw Rehabilitation Integrated Project	➢ Prevention ➢ Support ➢ Education	➢ Addis Ababa	Ato Mulatu Tafesse Tel: 154157/ 531492 FAX: c/o CRDA 652280 P.O. Box: 1581
70. Gonder Relief, Rehabilitation & Development Association	➢ Prevention ➢ Training ➢ Education	➢ Amhara	Wzo Nigest G/Hiwot Tel: 512090/ 156428 Fax: 511844 P.O. Box: 2348
71. Grace Baptist Church Development Programme	➢ Prevention ➢ Education ➢ Training	➢	Ato Shewaye Molla Tel: 03-511811 Fax: c/o CRDA 652280 P.O. Box: 333 Wollo
72. Goh Family Welfare and Development Association	➢ Prevention ➢ Training ➢ Support	➢	Tel: 157351 P.O. Box: 16714
73. Guardian-Somali Ethiopian Relief and Rehabilitation Organization	➢ Care ➢ Support ➢ Prevention ➢ Education ➢ Training	➢ Somali	Dr. Korfa Garance Ahmed Tel: 167885 Fax: 534688 P.O. Box: 2198 E-mail: guardian@telecom.net.et
74. Handicap National Action for Children with Disabilities	➢ Prevention ➢ Training ➢ Service Provision ➢ Education ➢ Care ➢ Support	➢ Addis Ababa ➢ Oromiya	Wzo Etenesh W/Agegnehu Tel: 502563/ 509342/ 524990 FAX: 534469/ 524991 P.O. Box: 40861 E-mail: hnacd@telecom.net.et

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75. Harari Relief and Development Association	➢ Prevention ➢ Education ➢ Training	➢ Harari	Ato Mawardi Ibrahim Tel: 559966/ 128777 Fax: 511283 P.O. Box: 26359 E-mail: ibrahim@telecom.net.et
76. Health Aid/ Ethiopia and Integrated Community Development	➢ Prevention ➢ Support ➢ Training ➢ Education ➢ Care ➢ Research and Surveillance	➢ Addis Ababa	Dr. Gobena Kebede Tel: 651833/ 162299 FAX: 651833 P.O. Box: 876 E-mail: gobenak@yahoo.com
77. Help Age International	➢ Funding ➢ Research and Surveillance ➢ Prevention	➢ All regions	Mr. Peter Bofin Tel: 611580/ 631020/ 631021 Fax: 611563 P.O. Box: 3384 E-mail: hai@telecom.net.et
78. Help for Persons with Disabilities Organization	➢ Education ➢ Training ➢ Funding	➢	Ato Woldesenbet Berhanemesquel Tel: 124093/ 563704 P.O. Box: 34711
79. Hope Enterprises	➢ Prevention ➢ Training ➢ Education ➢ Support	➢ Addis Ababa	Dr. Minas Hiruy Tel: 553102/ 710628/ 711800 Fax: 552638 P.O. Box: 30153 E-mail: hope@telecom.net.et
80. Hope for Rural Children and Orphans (HORCO)	➢ Prevention	➢ Oromiya	Ato Getachew Yemane Tel: 661783/ 661785 Fax: c/o CRDA 652280 P.O. Box: 14225 E-mail: horco@telecom.net.et
81. Hundee-Oromo Grassroots Development Initiative	➢ Prevention	➢ Oromiya	Ato Zegeye Asfaw Tel: 519026/ 150429/ 505979 P.O. Box: 9062 E-mail: hundee@telecom.net.et

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82. ILO a. ILO/USAID	➢ Training ➢ Prevention	➢ All Regions	Ms. Rania Duri Tel: 444003/ 510346/ 514313 Fax: 513633 P.O. Box: 2788 E-mail: rania@ilo.org
b. ILO/ENARP/AAU	➢ Research and Surveillance	➢ Oromiya	
c. ILO/WHO	➢ Research and Surveillance	➢ Addis Ababa & surrounding	
d. ILO/UNDP/UNESCO	➢ Training	➢ National	
e. UNAIDS/ILO	➢ Partnership/Coordination/Network ➢ Prevention ➢ Education	➢ All Regions (Particularly Addis Ababa)	
f. ILO/UNAIDS	➢ Training ➢ Education	➢ Addis Ababa	
g. ILO	➢ Partnership/Coordination/Network ➢ Support	➢ All Regions	
83. Integrated Family Service Organization (IFSO)	➢ Prevention ➢ Education	➢ Addis Ababa	Wzo Mekedes Zelelew Tel: 631677/ 613308 Fax: 613308 P.O. Box: 110201 E-mail: ifso@telecom.net.et
84. Integrated Holistic Approach-Urban Development Project	➢ Prevention ➢ Training ➢ Education	➢ Addis Ababa	Sr. Jember Teferra Tel: 156375/ 714671/ 713575 Fax: 512177/ 717740 P.O. Box: 6889 E-mail: ihaudp@telecom.net.et
85. Integrated Service for AIDS Prevention and Support Organization (ISAPSO)	➢ Prevention ➢ Training ➢ Service Provision ➢ Education ➢ Care ➢ Support	➢ Addis Ababa ➢ Afar ➢ Amhara ➢ Benishangul ➢ Dire Dawa ➢ Gambella ➢ Oromiya ➢ SNNPR ➢ Somali	Wzo Beletu Mengistu Tel: 551650 Fax: 555179 P.O. Box 27320 E-mail: ISAPSO@telecom.net.et
86. Inter Africa Group	➢	➢	Mr. Jalal Abdel-Latif Tel: 514575 FAX: 517554 P.O. Box 1631 ias@telecom.net.et

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87. Inter-Aide France	➢ Prevention ➢ Training	➢ SNNPR	Mr. Frank Wiegandt Tel: 159914 Fax: 514708 P.O. Box: 100231 E-mail: interaide@telecom.net.et
88. IOM	➢ Prevention	➢ Oromiya ➢ Addis Ababa ➢ SNNPR	Dr. Micheline Diepart Tel: 515188/ 504028/ 511673 Fax: 514900
	➢ Research and Surveillance	➢ Africa and Asia	
89. Ireland Aid	➢ Prevention ➢ Partnership/Coordination/Network ➢ Training ➢ Education ➢ Funding ➢ Care ➢ Support	➢ SNNPR ➢ Tigray	Ms. Helen Amdemichael Tel: 665050/ 715825/ 710365 Fax: 665020/ 712774 P.O. Box: 9585 E-mail: ireland.emb@telecom.net.et helen.amdemichael@iveagh.irlgov.ie
	➢ Federal Level Support	➢ All regions	
90. Japan International Cooperation Agency (JICA)	➢	➢	Mr. Yujro Yabe Tel: 615880/ 1/ 2/ 3 FAX: 615563 P.O. Box 5384 E-mail jica@telecom.net.et
9.. Jerusalem Association Children's Homes	➢ Prevention ➢ Training ➢ Education	➢ Amhara ➢ Oromiya	Ato Mulugeta Gebru Tel: 611091/ 611093/ 620862 Fax: 611094 P.O. Box: 41742 E-mail: jach@telecom.net.et
92. Johns Hopkins Center for Communication	➢	➢	Ato Ariya Demisei Tel: 631062 FAX: 627752

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93. Kale Heywet Church Development Program	➢ Care ➢ Prevention ➢ Services provision ➢ Support ➢ Training ➢ Partnership/Coordination/Network ➢ Education	➢ SNNPR ➢ Oromiya	Dr. Tesfaye Yakob Tel: 515844/ 154170/ 156616 Fax: 512763 P.O. Box: 5829 E-mail: AMKHC@telecom.net.et Khcmed.serv@telecom.net.et
94. Kangaroo Child and Youth Development Society	➢ Prevention ➢ Training ➢ Education ➢ Partnership/Coordination/Network	➢ Oromiya	Ato Mulugeta Amena Tel: 564453 P.O. Box: 80028
. Kembatta Women's Self-Help Center-Ethiopia	➢ Prevention ➢ Training ➢ Research and Surveillance	➢ SNNPR	Ato Bogaletch Gebre Tel: 504472 FAX: 507803 P.O. Box 13438 E-mail: kmg.selfhelp@telecom.net.et
96. L' Esperance Children's Aid	➢ Prevention	➢ Addis Ababa	Ato Teklehaimanot Zelalem Tel: 340284 P.O. Box: 100713
97. Lutheran World Federation-Ethiopia	➢ Prevention	➢ Afar ➢ Amhara ➢ Oromiya ➢ Somali ➢ SNNPR ➢ Dire Dawa	Dr. Colette Bouka Coula Tel: 553288 Fax: 552514 P.O. Box: 40132 E-mail: Lutheran.world@telecom.net.et
98. Mary Joy Aid through Development	➢ Care ➢ Support ➢ Prevention ➢ Services Provision ➢ Training ➢ Education ➢ Funding ➢ Partnership/Coordination/Network ➢ Research and Surveillance	➢ Addis Ababa ➢ SNNPR	Sr. Zebider Zewdie Tel: 792108/ 09-208518 P.O. Box: 12939 E-mail: maryjoy@telecom.net.et
99. Marie Stopes International Ethiopia (MSIE)	➢ Prevention ➢ Training ➢ Education	➢ Addis Ababa ➢ Amhara ➢ Oromiya ➢ SNNPR ➢ Dire Dawa	Ato Geachew Bekele Tel: 516642/ 154070 Fax: 512435 P.O. Box: 5775 E-mail: MSIE@telecom.net.et

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100. Medical Missionaries of Mary (MMM), Counseling and Social Services Center and St. Mary's Laboratory	➢ Prevention ➢ Care ➢ Support ➢ Services Provision ➢ Training ➢ Education	➢ Addis Ababa	Sr. Dr. Carol Breslin Tel: 559960 Fax: 552950 P.O. Box: 19934 E-mail: counscen@telecom.net.et
101. Medico Social Development Assistance for Ethiopia	➢ Prevention ➢ Service Provision ➢ Education ➢ Care ➢ Support ➢ Training ➢ Research and Surveillance ➢ Partnership/Coordination/Network	➢ Addis Ababa	Dr. Iyassu Haileselassie Tel: 152020/ 157777 Fax: 518877/ 518855 P.O. Box: 2575
102. Medicins du Monde	➢ Education ➢ Training	➢ Amhara ➢ Tigray	Mr. Jose Fernandes Tel: 613057/ 180144 Fax: 613059 P.O. Box: 2339 E-mail: Med-du-monde@telecom.net.et
103. Medecins Sans Frontiers-Belgium (MSF-B)	➢ Service Provision ➢ Prevention ➢ Training ➢ Care ➢ Support	➢ Addis Ababa ➢ Tigray	Dr. Jo Robays Tel: 610398/ 612870/ 610011 Fax: 610533 P.O. Box: 2441 E-mail: MSFbaa@telecom.net.et
104. Medecins Sans Frontieres-Holland (MSF-H)	➢ Care ➢ Training ➢ Education ➢ Prevention	➢ Tigray	Dr. Rik Nagelkerke Tel: 626559 FAX: 614908 P.O. Box 34357 E-mail msfh-ethiopia@telecom.net.et
105. Ministry of Health (MOH) ➢ WHO	➢ Research and Surveillance ➢ Service Provision ➢ Care	➢ All regions	Dr. Desta W/Yohanned Tel: 517011/ 517309 Fax: 519366 P.O. Box: 1234
➢ UNICEF	➢ Prevention ➢ Training		
➢ USAID	➢ Research and Surveillance		
106. Mekdim HIV Positive persons and AIDS Orphans National Association	➢ Prevention ➢ Care ➢ Support ➢ Education ➢ Training	➢ Addis Ababa ➢ Amhara ➢ Oromiya	Ato Mengistu Zemene Tel: 560380/ 563003/ 127674 Fax: 568733 P.O. Box: 31218 E-mail mek@telecom.net.et

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107.Meserete Kristos Church Relief & Development Association	➢ Prevention ➢ Training ➢ Service Provision ➢ Education ➢ Care ➢ Support ➢ Partnership/Coordination/Network	➢ Amhara ➢ Oromiya ➢ Addis Ababa ➢ SNNPR ➢ Dire Dawa ➢ Harari ➢ Tigray	Dr. Samson Estifanos Tel: 526794 Fax: 506141 P.O. Box: 24227 E-mail: Meserete_kirstos@telecom.net.et
108.Multi-Purpose Community Development Project	➢ Prevention ➢ Training ➢ Education ➢ Support	➢ Addis Ababa	Wzo Mulu Haile Tel: 765995/ 09-227382 P.O. Box: 26456
).National Aid & Rehabilitation Center for Needy Children (NARC)	➢ Prevention ➢ Training ➢ Service Provision ➢ Education ➢ Care ➢ Support	➢ Addis Ababa	Ato Tesfaye Worese Tel: 715792/ 726140 P.O. Box 18252
110.National Committee on Traditional Practices of Ethiopia	➢ Prevention ➢ Training ➢ Education ➢ Care ➢ Support	➢ All Regions	Wzo Abebech Alemneh Tel: 181163 Fax: 515311 P.O. Box: 12629
111.Nazareth Children's Center and Integrated Development (NACID)	➢ Care ➢ Prevention ➢ Support ➢ Research and Surveillance ➢ Training ➢ Partnership/Coordination/Network ➢ Service Provision ➢ Education	➢ Tigray ➢ Oromiya ➢ Afar ➢ Amhara	Ato Kassaye Haile Tel: 200081/ 204876/ 204827 Fax: 711288 P.O. Box: 40943 E-mail: nacid@telecom.net.et
112.Nile Children and Family Support Organization	➢ Training ➢ Education	➢ Amhara	Wzo Almaz Kebede Tel: 08-200910 P.O. Box: 1086 Bahir Dar E-mail: ncfsoyh@hotmail.com
1.3.NOHE Anti AIDS Club	➢ Prevention	➢ Addis Ababa	
114.Norwegian Church Aid (NCA)	➢ Prevention ➢ Care ➢ Support ➢ Education ➢ Training ➢ Prevention	➢ SNNPR	Ato Belete Teferra Tel: 511291/ 512922 Fax: 518167 P.O. Box: 1284 E-mail: nca@telecom.net.et

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115.Organization for African Unity (OAU)	➢ Partnership/Coordination/Network ➢ Prevention ➢ Education ➢ Service Provision ➢ Research and Surveillance	➢ All Regions ➢ Africa, National	Tel: 517700 Fax: 512622 P.O. Box: 3243
116.Organization for Social Services for AIDS in Ethiopia	➢ Care ➢ Support ➢ Services Provision ➢ Prevention ➢ Training ➢ Funding ➢ Education ➢ Partnership/Coordination/Network	➢ Addis Ababa ➢ Amhara ➢ Dire Dawa ➢ Harari ➢ Oromiya ➢ SNNPR ➢ Tigray	Ato Zewde Tamrat Tel: 518286/ 518424/ 158782 Fax: 515306 P.O. Box: 2385 E-mail: OSSA@telecom.net.et
117.Oxfam-Great Britain	➢ Funding	➢ Addis Ababa ➢ Amhara	Ato Gezahegn Kebede Tel: 613344 Fax: 613533 P.O. Box: 2333 E-mail: gkebede@oxfam.org.uk
118.Pact Ethiopia	➢	➢	Fekerte Belete Tel: 623796 FAX: 623789 P.O. Box 13180 E-mail: Fbelete@pacteth.org
119.Pastoralist Concern Association Ethiopia (PCAE)	➢ Prevention ➢ Training ➢ Education	➢ Somali	Ato Abdi Abdullahi Hussein Tel: 661214/ 661374/ 09-212075 Fax: 661197 P.O. Box 41757 E-mail: pcae@telecom.net.et
120.Pathfinder International	➢ Prevention ➢ Support ➢ Care ➢ Partnership/Coordination/Network ➢ Research and Surveillance ➢ Funding ➢ Service Provision ➢ Education ➢ Training	➢ Amhara ➢ Oromiya ➢ Harari ➢ Addis Ababa ➢ Afar ➢ SNNPR ➢ Dire Dawa ➢ Tigray	Dr. Mulugeta Betre Tel: 187808/ 613330 Fax: 614209 P.O. Box: 12655 E-mail Mbetre@pathfind.org tmelesse@PATHFIND.org

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121.Peace and Development Committee	➢ Prevention ➢ Partnership/Coordination/Network ➢ Training ➢ Education	➢ Afar ➢ Amhara ➢ Benishangul ➢ Dire Dawa ➢ Gambella ➢ Harari ➢ Oromiya ➢ Somali ➢ Tigray	Dr. Mulugeta Eteffa Tel: 511966/ 515714 Fax: 515714 P.O. Box: 41879 E-mail: pdc@telecom.net.et
122.People to People	➢ Training ➢ Support ➢ Research and Surveillance	➢ Addis Ababa	Dr. Abraham Asnake Tel: 526674 Fax: 526675 P.O. Box 30329 E-mail: P2peth@telecom.net.et
123.PLAN International Ethiopia	➢ Prevention ➢ Training ➢ Education	➢ Amhara ➢ Addis Ababa	Mr. Zein Ei Mahdi Tel: 652067/ 655651 Fax: 654279 P.O. Box: 12677 E-mail: c-ethiop@plan.geis.com
124.Propride	➢ Prevention ➢ Training ➢ Partnership/Coordination/Network ➢ Care ➢ Support ➢ Service Provision ➢ Education	➢ Addis Ababa	Ato Digafe Feleke Tel: 751688/ 137599 Fax: 756399 P.O. Box: 13047 E-mail: propride@telecom.net.et
125.Professional Alliance for Development in Ethiopia (PADET)	➢ Prevention ➢ Training ➢ Education	➢ Oromiya	Ato Amare Worku Tel: 666683/ 666684 P.O. Box: 365 E-mail: amarewor16@hotmail.com
126.Progynist	➢ Care ➢ Support ➢ Prevention ➢ Training ➢ Education	➢ Addis Ababa	Ms. Netsanet Mengistu Tel: 504379 Fax: 504941 P.O. Box: 34069 E-mail: netsanet@telecom.net.et

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127.Redeem the Generation	➢ Training ➢ Prevention ➢ Service Provision ➢ Care ➢ Support ➢ Education ➢ Partnership/Coordination/Network	➢ Addis Ababa ➢ Amhara ➢ Oromiya	Ato Ashenafi Tel: 623720/ 623725 Fax: 555175 P.O. Box: 33036 E-mail: redeem@telecom.net.et generation@telecom.net.et
128.Relief Society of Tigray (REST)	➢ Care ➢ Support ➢ Training ➢ Education	➢ Tigray	Ato Tekelewoini Assefa Tel: 514378 Fax: 512694 P.O. Box: 8078 E-mail: rest@telecom.net.et
129.Rift Valley Children and Women Development	➢ Education ➢ Training	➢ Oromiya	Ato Berhanu Geleto Tel: 184183 P.O. Box: 12916
130.Royal Netherlands Embassy	➢ Funding ➢ Partnership/Coordination/Network	➢ All Regions	Dr. Klaas Wit Tel: 711100 Fax: 711577 P.O. Box: 1241 E-mail: klaas.wit@minbuza.nl
131.Royal Norwegian Embassy (NORAD)	➢ Prevention ➢ Training ➢ Funding ➢ Partnership/Coordination/Network	➢ Addis Ababa ➢ Amhara ➢ Dire Dawa ➢ Harari ➢ Oromiya ➢ SNNPR ➢ Tigray	Ms. Inge Herman Rydland Tel: 710799 Fax: 711255 P.O. Box: 8383 E-mail: ihr@norad.no
132.Salem Women Self-Help Training and Production Center	➢ Prevention ➢ Care ➢ Support ➢ Training ➢ Service Provision ➢ Education ➢ Partnership/Coordination/Network	➢ Addis Ababa ➢ Benishangul ➢ Oromiya	Ato Zelalem Teferra Tel: 362396/ 510221 P.O. Box: 50 Ambo E-mail: CRDA@telecom.net.et
133.Save the Children-USA Ethiopian Field Officer	➢ Prevention ➢ Training ➢ Research and Surveillance ➢ Partnership/Coordination/Network ➢ Service Provision ➢ Care ➢ Support ➢ Funding ➢ Education	➢ Oromiya ➢ Addis Ababa ➢ Gambella ➢ Somali ➢ Afar ➢ Dire Dawa	Mr. Dennis Walto Tel: 655409 Fax: 653615 P.O. Box: 387 E-mail: ussave.children@telecom.net.et

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
134.Save the Children-Sweden	➢ Prevention ➢ Training ➢ Research and Surveillance ➢ Partnership/Coordination/Network ➢ Education ➢ Funding	➢ Addis Ababa ➢ Gambella (refugee camp)	Mr. Kassa Romissa Tel: 711401/ 721418 Fax: 710149 P.O. Box 3457 E-mail: Kassa.rorisa@swedsave-et.org
135.Save the Children-UK	➢ Prevention ➢ Partnership/Coordination/Network ➢ Training ➢ Education ➢ Funding	➢ Amhara ➢ Harari ➢ Oromiya ➢ Somali	Dr. Minaleshoa Hailu Tel: 293469 FAX: 293470 P.O. Box 7165 E-mail: scukethiopia@scfuk.org.uk
ɔ.Save the Children - Denmark	➢ Prevention ➢ Partnership/Coordination/Network ➢ Training ➢ Service Provision ➢ Education ➢ Funding	➢ Amhara	Ms. Birgit Lundbak Tel: 523249 Fax: 508999 P.O. Box: 13375 E-mail: redbarnet@telecom.net.et
137.Save the Children –Norway	➢ Prevention ➢ Partnership/Coordination/Network ➢ Support	➢ Addis Ababa ➢ Amhara ➢ Oromiya	Ato Solomon Kelkai Tel: 518964/ 518956 Fax: 515286 P.O. Box: 6589 E-mail: solomonk@scne.org
138.Save your Generation Association (Ethiopia) SYGA	➢ Partnership/Coordination/Network ➢ Prevention ➢ Training ➢ Service Provision ➢ Education	➢ Oromiya ➢ Addis Ababa ➢ Amhara ➢ SNNPR	Ato Alemneh Cherinet Tel: 123882/ 565026 P.O. Box: 14685 E-mail syg@telecom.net.et
139.Sike Women's Development Association	➢ Education ➢ Training	➢	Wzo Zertihun Tefera Tel: 523400/ 156699 P.O. Box: 22642
140.Sisters' Self Help Association	➢ Prevention ➢ Partnership/Coordination/Network	➢ Addis Ababa	Ato Samson Bekele Tel: 156192/ 159834 P.O. Box: 101926 E-mail: Turuworktef@yahoo.com
141.SNV-Netherlands Development Organization-Ethiopia	➢ Partnership/Coordination/Network	➢ Addis Ababa ➢ Amhara ➢ Dire Dawa	Mr. Ton Haverkort Tel: 654386/ 654387/ 654389 Fax: 654388 P.O. Box: 40675 E-mail: SNV@telecom.net.et

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
142.Society for the Advancement of Human Rights Education (SAHRE)	➢ Care ➢ Support ➢ Prevention	➢ Tigray ➢ Oromiya ➢ SNNPR ➢ Dire Dawa	Ato Gebremedhin Kidane Tel: 120254 Fax: 550877 P.O. Box: 2669
143.Society for Women Against AIDS-In Africa Ethiopia (SWAA-E)	➢ Prevention ➢ Education ➢ Support ➢ Partnership/Coordination/Network ➢ Training	➢ Addis Ababa	Wzo Bossena Kassa Tel: 622787 P.O. Box: 170265
144.Society of International Missionaries (SIM)	➢ Prevention ➢ Education ➢ Care ➢ Support	➢ Addis Ababa	Mr. Terry Early Tel: 503899 Fax: 511242 P.O. Box: 127 E-mail: SIMoffice@yimesgin.org SIM.eth@directmail.org
145.SOS Enfants Ethiopie	➢ Prevention ➢ Education ➢ Care ➢ Support	➢ Tigray ➢ Harari ➢ Addis Ababa	Mr. Yves Ferez Tel: 185764 P.O. Box: 3506
146.SOS Children's Village Ethiopia	➢ Prevention ➢ Education ➢ Training	➢ Tigray ➢ Harari ➢ Addis Ababa ➢ SNNPR ➢ Amhara	Ato Zenebe Tesfaye Tel: 611655/ 611501 Fax: 611633 P.O. Box: 3495 E-mail: sos.eth@telecom.net.et
147.South Ethiopia Peoples Development Association (SEPDA)	➢ Prevention ➢ Partnership/Coordination/Network ➢ Training Service Provision ➢ Education ➢ Support	➢ SNNPR	Ato Kussia Bekele Tel: 06-200893/ 06-203043/ 01-552915 Fax: 06-201050/ 01550563 P.O. Box: 812 Awassa
148.Swiss Evangelical Nile Mission	➢ Prevention	➢ SNNPR	Mr. Rudolph Herman Tel: 120465 P.O. Box: 30732
149. UNAIDS	➢ Partnership/Coordination/Network ➢ Education ➢ Support ➢ Funding	➢ All Regions	Dr. Emelia Timpo Tel: 510152/ 444131 Fax: 511021 P.O. Box: 5580 E-mail: Emilia.Timpo@undp.org unaids.ethiopia@undp.org

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
150.UNDP	➢ Partnership/Coordination/Network ➢ Support ➢ Prevention	➢ All Regions	Ms. Barbara Torggler Tel: 444280 Fax: 515147 P.O. Box: 5580 E-mail: Barbara.Torggler@undp.org
151. UNESCO	➢ Support ➢ Prevention ➢ Training ➢ Partnership/Coordination/Network ➢ Service Provision ➢ Education ➢ Care	➢ All Regions ➢ Africa, National	Ms. El-Fadli Neguede Wafaa Tel: 513953/ 517200 Fax: 511414/ 514416
152.UNECA	➢ Partnership/Coordination/Network ➢ Prevention ➢ Training	➢ All Regions ➢ Africa, National	Mr. Kasirim Nwuke Tel: 443375/ 517200 Fax: 510389 P.O. Box: 3001 E-mail: Knwuke@uneca.org
153.UNFPA UNFPA/NORAD	➢ Prevention ➢ Care ➢ Training (all regions)	➢ Tigray ➢ Oromiya ➢ Amhara ➢ Somali ➢ Addis Ababa	Ms. Nina Sreenivasan Tel: 444072 Fax: 515311 E-mail: nina.sreenivasan@undp.org
UNFPA/UNAIDS (PAF Projects)	➢ Prevention (all regions) ➢ Care ➢ Support ➢ Service Provision	➢ Addis Ababa	
154. UNHCR	➢ Prevention	➢ Gambella ➢ Benishangul ➢ Somali	Dr. Mesfin Haile Tel: 61 28 22 Fax: 61 16 66
155. UNWFP	➢ Prevention ➢ Support	➢ Addis Ababa	Ms. Georgia Shaver Tel: 515188/ 514425 FAX: 514433 P.O. Box 25584 code 1000 E-mail: Georgia.Shaver@wfp.org Purnima.Kashyap@wfp.org

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
156.UNICEF	➢ Prevention ➢ Funding ➢ Research and Surveillance ➢ Training ➢ Education ➢ Partnership/Coordination/Network ➢	➢ All Regions	Ato Mirgissa Kaba Tel: 444177/ 515155 Fax: 511628 P.O. Box: 1169 E-mail: mkaba@unicef.org
157.USAID	➢ Prevention ➢ Care ➢ Support ➢ Education ➢ Research and Surveillance	➢ Addis Ababa ➢ Amhara ➢ Oromiya ➢ SNNPR	Ms. Anne Nolan Tel: 510716/ 510088 Fax: 510043 P.O. Box: 1014 E-mail: anolan@usaid.gov vathani@usaid.gov
158.VOCA-Ethiopia	➢ Prevention ➢ Training	➢ Amhara ➢ Oromiya ➢ SNNPR ➢ Tigray	Ms. Jennifer Bielman Tel: 534650 Fax: 515728 P.O. Box: 548 code 1110 E-mail: ethiopiavoca@hotmail.com
159.Venus United Humanitarian Organization	➢ Prevention ➢ Training ➢ Partnership/Coordination/Network ➢ Service Provision ➢ Education ➢ Care ➢ Support	➢ Addis Ababa	Ato Menkir Mahteme-Work Tel: 113526/ 09-217760 P.O. Box: 13101
160.VSO	➢	➢	Ms. Michelle Evans Tel: 183552 FAX: 627780 P.O. Box 23531 E-mail: vsoeth@telecom.net.et
161.Wabe Children's Aid and Training	➢ Prevention ➢ Education ➢ Training	➢	Ato Mestika Negash Tel: 561359 Fax: c/o CRDA 652280 P.O. Box: 10158 E-mail: wcat@telecom.net.et
162.Welfare for the Street Mothers and Children Organization	➢ Prevention ➢ Partnership/Coordination/Network ➢ Training ➢ Education ➢ Care ➢ Support	➢ Benishangul ➢ Addis Ababa	Ato Eshetu Mengistu Tel: 558711/ 566820/ 566821 Fax: 558710 P.O. Box: 14643 E-mail: wesmco@telecom.net.et

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
163. Wollo Development and Rehabilitation Association	➢ Prevention ➢ Training ➢ Education	➢ Amhara	Dr. Mohammed Mussa Tel: 160001 Fax: 511976 P.O. Box: 22153 code 1000
164. Women Aid Ethiopia	➢ Prevention ➢ Partnership/Coordination/Network ➢ Training ➢ Service Provision ➢ Education ➢ Care ➢ Support	➢ Addis Ababa	Sr. Hirut H/Mariam Tel: 663775/ 343382 Fax: 663775 P.O. Box: 12664 E-mail: wae@telecom.net.et
165. Women and Children Development Organization	➢ Prevention ➢ Partnership/Coordination/Network ➢ Training ➢ Care ➢ Support	➢ Addis Ababa	Ato Melaku Hailu Tel: 153409/ 526746/ 526747 Fax: C/O CRDA 652280 P.O. Box: 12796 E-mail: wcdo@telecom.net.et
166. World Bank	➢ Funding ➢ Prevention ➢ Partnership/Coordination/Network ➢ Training ➢ Service Provision ➢ Education ➢ Care ➢ Support ➢ Research and Surveillance	➢ All regions	Dr. Gebreselassie Okubagzhi Tel: 627700 Fax: 627717 P.O. Box 5515 E-mail: Gokubagzhi1@worldbank.org abachbaouab@worldbank.org
167. World Health Organization	➢ Training ➢ Prevention ➢ Partnership/Coordination/Network ➢ Care ➢ Support ➢ Service Provision ➢ Education ➢ Research and Surveillance	➢ All Regions	Dr. Michel Jancloes Tel: 531550 Fax: 514037 P.O. Box: 3069 E-mail: jancloesm@whoet.org
168. World ORT Union Ethiopia	➢ Prevention ➢ Training ➢ Education	➢ Addis Ababa	Ato Daniel Belayneh Tel: 614242 Fax: 342033 P.O. Box: 12659 E-mail: woue@telecom.net.et
169. World Vision Ethiopia	➢ Prevention ➢ Training ➢ Education	➢ Amhara ➢ Oromiya ➢ Addis Ababa ➢ SNNPR	Ato Getachew Wolde Michael Tel: 293348/ 293351/ 293367 Fax: 293346 P.O. Box: 3330 E-mail: abebe@telecom.net.et

NAME OF THE ORGANIZATION	PROGRAM FOCUS	REGION	CONTACT PERSON AND ADDRESS
170. Yeteem Children's and Destitute Mothers Fund	➢ Prevention	➢ Afar ➢ Addis Ababa	Ato Yimer M/Mohammed Tel: 110744/ 591474 P.O. Box: 27109 E-mail: yeteem@yahoo.com

This NGOs AND STAKEHOLDERS HIV/AIDS PROGRAMME FOCUS MATRIX was updated by NACS in collaboration with UNAIDS. Special appreciation goes to CRDA and \CT for taking the initiative of preparing the first Programme Focus Matrix last year and providing essential information to this update issue. In addition, NACS would like to thank all government organization, NGOs and other civic institutions for supplying information on their projects/programmes being performed on HIV/AIDS in the country. This matrix will later be supplemented by a HIV/AIDS National Project/ Programme Directory Guide, which will provide detailed information on HIV/AIDS activities being performed by all NGOs and Stakeholders in the country. If changes to this matrix need to be made to any information in respect to your organization, please e-mail NACS at hiv.aids@telecom.net.et or write to NACS at P.O. Box 1031; Addis Ababa, Ethiopia.

HIV／AIDS ローカルNGOリスト

Christian Relief and Development Association (CRDA)
List of CRDA member indigenous NGOs involved in HIV/AIDS prevention

S/No	Name of NGO	Major basic HIV interventions	Geographic Location	Contact Person (Manager)	Address (Telephone)	Remarks
1	Anti Malaria Association	Awareness raising	Amhara	Ato Abera Mihratie	565721/23	
2	Berhan Integrated Community Development Organization	-Care and support -Counseling -Awareness raising -Policy Advocacy and lobbing	Amhara, N.Shoa, Angolala & Asagirt	Ato Jemal Abdela	551559/571221-22	
3	Dawn of Hope Ethiopia	-Care and support -Counseling -Awareness raising -Policy Advocacy and lobbing	Addis Ababa Oromiya SNNPRS	Ato Mulugeta Gassese	564329/568615	
4	Ethiopian Catholic Secretariat	-Care and Support -Counseling -Education and Training -Project funding -Research into pest practices	Amhara, Addis Ababa, SNNPRS, Oromiya, Tigray, Diredawa	Bro. Gregory Flynn	550300/553305	
5	Ethiopian Evangelical Church Mekane Yesus	-awareness raising -Care and Welfare -Counseling -Education and training -Testing	Oromiya, SNNPRS, Addis Ababa, Tigray Amhara Gambella	Ato Feyesa Keyamo	531919/531922	
6	Ethiopian Gemini Trust	-Education and training	Addis Ababa	Dr. Camela Green Abate	531986/151947	
7	Ethiopian Orthodox Church /DICAC	-Education -Care and Support -Awareness raising	Tigray, Amhara, Gambella	Ato Abadi Amdo	119661/553566	
8	Health Aid Ethiopia	-Care and Welfare -Education and training -Treatment of common diseases and injuries	Addis Ababa	Dr. Gobana Kebede	651833/162299	
9	Integrated Service for Aids Prevention & Support Organization	-Counseling -Education and training -Research on best practices	-SNNPRS -Addis Ababa	Wzr. Beletu Mengistu	551650	

10	Organization for social Services for Aids in Ethiopia	-Care and Welfare -Counseling -Education and Training -Youth group Organization and support	Addis Ababa Oromiya, Amhara , Tigray	Ato Zewdie Tamrat	158782/518286	
11	Mary Joy Aid Through Development	-Care and support Programe -Establish and strengthen anti-Aids clubs -STD control -Counseling -IEC material development -Peer educators training on stepping stones	Addis Ababa SNNPRS	Sr. Zebider Zewedie	09-208518/792108	
12	Medico-Social Development Assistance for Ethiopia	-Counseling -Education and training -Research on best practices	Addis Ababa Oromiya	Dr. Iyasu H/Silasie	152020/157777	
13	Mekidem HIV AIDS + persons and Orphans Association	-Care and support -Counseling -Awareness raising -Policy Advocacy and lobbing	Addis Ababa	Ato Mengistu Zemene	563003/560380	
14	Relief Society of Tigray	-Care and Welfare -Counseling -Education and Training -IEC material production and dissemination -Skill training for people affected and infected	Tigray	Ato Teklewoini Asefa	514378/514497	
15	Welfare for the Street Mothers and Children Organization.	-Care and Support -Counseling -Awareness Raising	Addis Ababa Benshangul	Ato Eshetu Mengistu	558711/117401	