THE STATE OF ERITREA
Ministry of Health

UNGASS REPORT 2008

NATIONAL AIDS AND TB CONTROL DIVISION (NATCoD)

January 2008

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinic
ANC SS	Sentinel Surveillance in Ante Natal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change Communication
BIDHO	Association for people infected and affected by HIV/AIDS
CBO	Community Based Organization
CCM	Country's Coordinating Mechanism
CDC	Communicable Disease Control
CRIS	Country Response Information System
NHL	National Health Laboratory
CSO	Civil Society Organization
CSW	Commercial Sex Workers
DHS	Demographic Health Survey
EDF	Eritrean Defence Force
ESMG	Eritrean Social Marketing Group
FBO	Faith Based Organization
GoE	Government of Eritrea
HAMSET	HIV/AIDS, Malaria, Sexually Transmitted Infections, and Tuberculosis
HPC	Health Promotion Center
HIV	Human Immunodeficiency Syndrome
IDA	International Development Agency
IDU	Injecting Drug Users
IEC	Information, Education, Communication
JUNP	Joint UN Program of Support on AIDS
LQAS	Lot Quality Assurance Survey
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MoD	Ministry of Defence
MoE	Ministry of education
MoH	Ministry of Health
MoI	Ministry of Information
MoLHW	Ministry of Labor and Human Welfare
MoT	Ministry of Tourism
MoTC	Ministry of Transportation and Communication
MSM	Men who have Sex with Men
NA	Information Not Available
NASA	National AIDS Spending Assessment
NACC	National AIDS Control Committee
NACP	National AIDS Control Program
NAP	National AIDS Program
NATCoD	National AIDS and TB Control Division

NBTC	National Blood Transfusion Center
NCA	Norwegian Church Aid
NCPI	National Composite Policy Index
NGO	Non Governmental organization
NRS	Northern Red Sea
NSP	National Strategic Plan
NCEW	National Confederation of Eritrean Workers
NUEW	National Union of Eritrean Women
NUEYS	National Union of Eritrean Youth and Students
OI	Opportunistic Infections
OVC	Orphans and Other Vulnerable Children
PHC	Primary Health Care
PLHA	People Living with HIV/AIDS
PMU	Project management Unit
PMTCT	Prevention of Mother-To-Child-Transmission
SS	Sentinel Surveillance
STD	Sexually Transmitted Disease
STI(s)	Sexually Transmitted Infection
TB	Tuberculosis
TOR	Terms of Reference
UN	United Nation
UNAIDS	Joint United Nations program on HIV/AIDS
UNICEF	United Nations International Children's Emergency Fund
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary Counseling and Testing
WB	World Bank
WHO	World Health Organization

I. Status at a Glance

Eritrea is strategically located in the Horn of Africa and has a long seacoast of about 1,200 kms. The coastline stretches from Ras Kessar to Ras Dumera in the Bab el Mandeb area, which links the Red Sea with the Gulf of Eden in the Indian Ocean. Its total surface area is about 125,000 square kilometers (GOE, 1996). The country borders the Red Sea on its East Coast, Sudan to the North and West, Ethiopia to the South, and the Republic of Djibouti to the South East. No population census has been carried out in Eritrea. The population of Eritrea, however, is estimated at 3.6 million (DHS, 2002), and the population growth rate is about 3 percent (UNDP, 2001:156). The population is essentially rural with 80 percent living in the country side (DHS, 2002).

Eritrea is a new nation which became independent from Ethiopian colonialism in 1991. Since independence, the achievement of sustainable economic development has been the major declared goal of the government. The achievement of such a goal primarily depends on the quantity and quality of its human resources, the size of capital investment and the effective utilization of these resources. The determinant factor for sustainable economic development, however, is the human capital. This is because healthy and productive citizens have a decisive role for achieving sustainable development.

Since the 1980s, every country has been faced by a new threat- HIV/AIDS disease that mainly infects the people within the age of 15-49 years, who are the main productive labor force. As a consequence, the economic development of many developing countries has stagnated or has been in a declining trend. The fight against HIV from a broader perspective is securing sustainable development by safeguarding the human resource, which is the key to sustainable development. A major pre-requisite for safeguarding the human resources is the implementation of coordinated and effective methods of prevention to contain the spread of HIV/AIDS and the provision of treatment, care and support services to PLHAs.

Like in other developing countries, HIV/AIDS has become a major threat for Eritrea's socio-economic development as it affects its major productive labor force. The first AIDS case was reported in 1988. At present, the estimated number of people living with HIV is in the range of 70,000-100,000. According to the nationwide ANC sentinel surveillance conducted in 2005, the prevalence of HIV in pregnant women was 2.38%. There were variations between regions/zones, age groups and occupations. In 2006, special surveys were also conducted on the most-at-risk populations, namely CSWs in Asmara, Massawa and long distance truck drivers nationwide. The HIV prevalence rates were 8.08%, 14.67% and 7%, respectively. Another study that was conducted in TB patients in Asmara showed HIV prevalence of 34.33% indicating that co-infection rate was high. In comparison to the 2.38% prevalence in the general population HIV prevalence in the most at risk populations is very high and needs extensive targeted intervention.

Since the liberation of the country, the government has shown its strong commitment in the control of the epidemic. In 1992, it put in place the National AIDS Control Program Unit (NACP) in the MOH which was later promoted to a division as NATCoD in 2003.

HAMSET project was also launched in 2001. HAMSET stands for HIV/AIDS, Malaria, Sexually Transmitted Diseases and Tuberculosis. It is a World Bank supported multi-sectoral project which involves government ministries, civil society (Non Government Organizations, Faith based organizations, private sector and people living with HIV/AIDS).

Furthermore, the government formulated HIV/AIDS policy and guidelines in 1998 and adopted its first five-year National Strategic Plan (NSP) on HIV/AIDS/STIs for the period 1997-2002 and its second NSP for 2003-2007, where the bilateral and multilateral development partners have been involved. Currently the country is in the process of developing its third NSP that runs from 2008-2012. In line with the UNAIDS guidelines, Eritrea's national response to the HIV/AIDS epidemic is based on multisectoral approach and is in line with the principles of the "Three Ones":

Eritrea has also formulated its Millennium Development Goals in 2004 and has set its Universal Access Targets on prevention, treatment, care and support services in 2007 and is expected to be realized by 2010. Some of these percentage targets to be achieved by 2010 include: percentage of women, men and children with advanced HIV infection receiving ARV combination treatment to reach 80%; percentage of OVC who received a basic external support package to reach 28%; percentage of HIV+ pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT to reach 78%; percentage of general population who received an HIV test in the past 12 months and informed their results to reach 13.2%(NATCoD, 2007).

Notwithstanding with the on going efforts on the prevention of the HIV epidemic, the high HIV prevalence among the most-at-risk populations calls for concerted multisectoral and targeted interventions. This will include government entities, civil society organizations, faith-based organizations, the private sector and development partners. The main aim would be to bring behavioral change, especially among the sexually active population. To this end, the country has to overcome the following major challenges to halt the HIV epidemic and sustain the response. These challenges are:

- Mainstreaming HIV/AIDS in development programs ;
- Building or strengthening the human and institutional capacity: weak institutional capacity where the human and technical capabilities need to be developed for more effective data management and timely interventions to halt the HIV epidemic ; and
- Resources mobilization to halt the HIV epidemic with out compromising other development programs such as reduction of poverty, food security and protection of the environment which all require large proportion of the national resources.

Inclusiveness of stakeholders in the report writing process

The task force, with defined TOR, was established to lead and facilitate the UNGASS reporting process for 2008. A local consultant was hired to facilitate the data collection process and the writing of the report. The preparation of the UNGASS reporting 2008 was launched in the presence of all stakeholders including the joint UN team members in the national HIV and AIDS response programme. Orientation was done to stakeholders on content and process on 18 October 2007 which also served as a basis for identification of data needs, its collection and agreement on which indicators to be reported by the country.

Based on the guidelines for UNGASS reporting 2008, a detailed presentation was made on the expected roles and responsibilities of all partners, through the leadership of NATCoD and collaboration of UNAIDS, during the preparation of the report. The guideline on construction of core indicators for 2008 was distributed to participants to orientate and familiarize themselves with the guidelines well ahead of the workshop. During the workshop the draft road map that led towards finalizing and submitting the report in time was fine-tuned and the TOR for the task force that will coordinate the process was discussed.

Data was collected by local consultant by consulting the government, civil society and development partners. The NCPI data were collected by local consultant from CSO and government from NATCoD and analysed by the local consultant. The UNGASS task force held three meetings to discuss the draft report of the local consultant. The report was also reviewed and discussed with the UNGASS international consultant who reviewed the report and gave his comments on the completeness level of the indicators to be reported in the Eritrean context and explained on the way the indicator sources and methodology of arriving at the indicators to be presented in the report. His comments and advices to proceed with the reporting process were also valuable and helpful.

The third version of the report was then thoroughly discussed involving the relevant stakeholders to look and verify the data used and its sources, NATCoD leading the process. This process has led to greatly cross check the representativeness of the data reflected in the writing process through the leadership of NATCoD. This was an opportunity to seriously look at the data verification and validity from the HIV & AIDS authority.

The edited version of this report was presented at the data vetting workshop where all participants, stakeholders of the HIV and AIDS, discussed the report as working groups based on their priority areas and their active involvement in the national response and made the necessary changes and endorse the report as Eritrea UNGASS report 2008.

Finally the local consultant rewrote the report by taking into account all relevant notes and recommendations of participants of the vetting workshop. The rewritten report was then finally edited by the UNGASS task force on January 10, 2008 to send it to Geneva. The CRIS training organized by the international consultant was not done with

completeness due to late arrival. The orientation done proved to be useful way of summarising data but the soft ware was not user friendly. Some functions and fields were not functioning and contacting Geneva by the international consultant did not yield results.

Table 1: UNGASS Core Indicators Chosen by Eritrea 2007 [1 USD = 15 Nakfa]

National Indicators	2006	2007
National Commitment and Actions		
1. Domestic and international AIDS spending by categories and financing sources	**107,747,387.85** Nakfa	**116,890,221.15**Nakfa
2. National Composite Policy index		80% Based on questionnaire A; 72% based on questionnaire B
National Programs Indicators		
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%	100%
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral	15%	24%
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother –to-child transmission	2.10%	3.72%
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	NA	NA
7. Percentage of women and men aged 15-49 who received an HIV test in last 12 months and who know their results	5.4%	5.88%
8. Percentage of most-at- risk populations that have received an HIV test in the last 12 months and who know their results	78.35%	NA
9. Percentage of most-at-risk populations reached with HIV prevention programs	45.80%	87.90%
10. Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child	3.75%	3.91%
11. Percentage of schools that provided life skills-based HIV education in the last academic year	26%	26%
Knowledge and Behavior		
12. Current school attendance among orphans and among non-orphans aged 10-14	NA	NA
13. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV	NA	NA
14.Percentage of most-at-risk population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	79.30%	NA
15. Percentage of young women and men aged 15-	NA	NA

24 who have had sexual intercourse before the age of 15		
16. Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	NA	NA
17. Percentage of women and men aged 15-49 who had more than one partner in the past 12 months reporting the use of a condom during their last sexual intercourse	NA	NA
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	76%	NA
National impact		
22. Percentage of young people aged 15-24 who are HIV infected	NA	NA
23 Percentage of most-at-risk populations who are HIV infected	9.7%	NA
24.Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	NA	93.3%%

Note: The main modes of transmission are heterosexual sex and MTCT. Homosexuality and injecting drug users are not the driving force behind the epidemic in the country.

NA represents no data available

II. Overview of the AIDS Epidemic

HIV surveillance data in Eritrea is based on health facilities reports, ANC sentinel surveillance, and special surveys conducted on different population sub-groups. The MOH conducts ANC SS every two years. The most representative ANC SS studies were conducted in 2003, 2005 and the 2007 ANC SS is underway. Special studies for the high risk groups such as CSWs, long distance truck drivers and TB patients were also conducted in 2006.

In 2003, the MOH conducted a nationwide HIV sentinel surveillance in which 14 urban and 29 rural sites from all six zones were included. The study found that the national HIV prevalence rate was 2.40%. The study also found that the prevalence rates were highest in Southern Red Sea Zone (7.2%) and Central Zone (3.6%). Women whose age lies in the range of 20-24 and in the 25-29 years also had higher-than-average rates of infection (2.7% and 3.6%) respectively. It was also found that HIV prevalence was higher among pregnant women attending urban ANC sites (3.3%) than pregnant women in rural ANC sites (0.90).

With 2.38% HIV prevalence rate in pregnant women and high prevalence rates in high risk population groups, the HIV epidemic in Eritrea is of a generalized epidemic type. It has to be acknowledged that the ANC HIV Sentinel Surveillance Studies are conducted every two years. Eritrea has conducted such study in 2005 and its 2007 study has been completed. However, the data collected are at a stage of analysis and the nationwide HIV prevalence cannot be included in the table for comparative purpose.

In 2005, the sentinel surveillance was conducted by taking a sample of 5,033 pregnant women. The sample included those who were attending antenatal care in 19 urban and 26 rural sentinel surveillance sites. The study found that the overall HIV prevalence among pregnant women attending ANC was 2.38%, which was almost similar to that of 2003 (2.40%). As in 2003, this study also showed variations in geographic area, age groups, residence, occupation of participants and partners and their marital status.

In terms of geographic areas, high HIV prevalence rates were found in the Southern Rea Sea Zone (5.90%) followed by the Central Zone (3.48%, Gash Barka (2.06%), while lower prevalence rates were observed in the Northern Red Sea Zone (1.77%), Debub Zone (1.65%), Anseba zone (1.3%). Assab and Asmara located in two different zones also showed prevalence rates higher than the national average, with 7.4% and 4.18% respectively.

As to the place of residence, the HIV prevalence rate was higher in women residing in the urban areas (3.04%) than in women residing in rural areas (0.90%). In terms of age groups, high HIV prevalence was observed in the young pregnant women whose age was in the range of 25-29 years (3.8%). The HIV prevalence among the age group 15-24 is a good proxy indicator for the incidence of HIV in the country. The prevalence in this age group was 2.1% in 2003 and 1.8% in 2005, showing a reduction of 0.3%.

As to the occupations, high HIV prevalence rates were observed in pregnant women who work in bars restaurants and teashops (8.5%), followed by women employed in the private sector (6.6%) and in women who work as daily laborers (5.9%). The unemployed women and those who work as government employees showed prevalence rates of 5.6% and 3.4%, respectively. The study also indicated a relatively low prevalence in those women who were housewives (1.9%).

The occupation of the women's partners was another determinant factor in the HIV prevalence. High HIV prevalence rates were observed in women whose partners were truck drivers (5.4%) and merchants (3.8%). On the other hand, low HIV prevalence was observed in pregnant women whose spouse/partners were farmers (0.80%). With respect to marital status, high HIV prevalence rate was observed in single women (7.2%) and relatively low prevalence rate in married women (2%).

Another round of a nation wide ANC sentinel surveillance was conducted by the National AIDS and TB Control Division of the MOH in the final quarter of 2007. Though expected to provide ample information on the HIV prevalence and trend in the country, data processing has not been completed, and it was not possible to include the findings in this report.

Studies in specific population groups

In 2006, the MOH conducted behavioral and biological studies targeting long distance truck drivers, CSWs and TB patients. As shown in table 2, the prevalence of HIV in CSWs in Massawa (Northern Red Sea Zone) was 14.68%, while in Asmara (Central Zone), it was 8.08%. In long distance truck drivers, the HIV prevalence rate was 7%. These prevalence rates are above the national average of 2.38%, urging the need for targeted intervention among these population sub-groups in order to bring behavioral change and eventually reduce the prevalence rates. The HIV prevalence in TB patients was 34.33% when compared with that of 2004 figure, which was 22.6%, a trend showing a strong association between TB and HIV/AIDS.

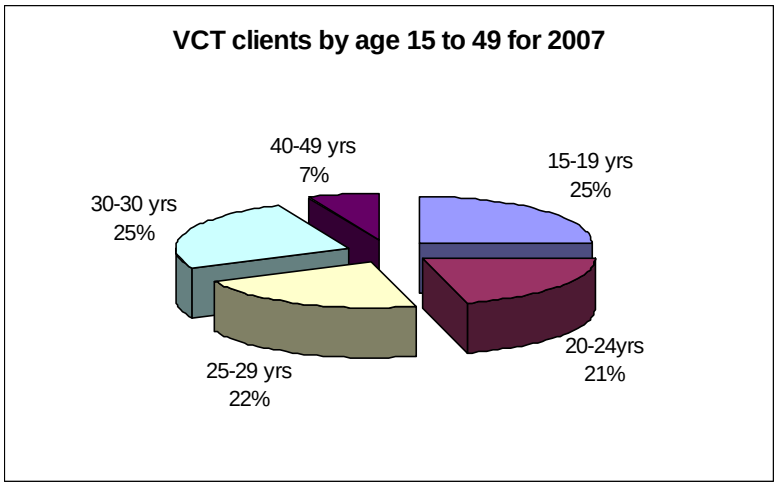
Table 2: HIV and Syphilis (RPR) prevalence in different population groups

Type of survey	Sample size	HIV reactive	HIV prevalence	Syphilis prevalence
HIV prevalence in TB patients	166	57	34.33%	Not done
HIV prevalence in long truck drivers	300	21	7.0%	3.0%
HIV prevalence in CSWin Asmara	272	22	8.08	0.73%
HIV prevalence in CSW in Massawa	252	37	14.68%	1.98%

Source: NATCoD (2006), Annual Report

HIV situation in VCT clients

The MOH also analyzes data collected on VCT clients. As shown in Table 3, the number of VCT clients continued to increase while the HIV positivity rate remained almost the same with 3.91% in 2004 and 3.21% in 2007. In 2007, the total number of VCT clients was 80,706 of which 46.7% were females and 53.7% were males, suggesting that both sexes have been accessing the services almost equally. However, in 2007, HIV positivity rate was higher in females (3.72%) than in males (2.76%).



The prevalence among VCT clients varied with age. Data for 2007 shows that the prevalence rate is high among the age bracket of 15 to 19 and lowest among 40 to 49 years. Further studies may have to be done to establish the mode of infection in the age bracket as shown in the above figure in order to develop targets for intervention.

Table 3: VCT clients and HIV positivity rate

Year	Total VCT clients	HIV positive	HIV positivity rate (%)
2004	47,663	1864	3.91
2005	69,121	2336	3.38
2006	75,795	2676	3.53
2007	80,706	2591	3.21

Source: NATCoD (2007), Annual Report

HIV situation in PMTCT Services

PMTCT services were opened as pilot project in 2002 in the Central Zone and in 2004 it expanded to the Southern Zone. By 2006, the PMTCT services were expanded covering all zones. Table 4 shows that the users of PMTCT services increased from 2,080 in 2004 to 34,884 in 2007 (an increase of 17 folds), while the positivity rate drastically decreased from 2.50% in 2004 to less than 1% in 2007. The HIV positivity rates, however, varied significantly between zones. In 2007, the highest positivity rate in PMTCT receiving clients was observed in Southern Red Sea Zone (3.33%), and the lowest rate was observed in the Southern Zone (0.56%).

Table 4: HIV positivity in PMTCT services giving sites 2004-2007

Year	Total PMTCT users	HIV positive	HIV positivity
2004	2,080	52	2.50%
2005	8,144	159	1.95%
2006	23,200	278	1.20%
2007	34,884	300	0.86%

Source: NATCoD (2007), Annual Report

Sexually Transmitted Infections (STI)

In Eritrea, HIV/AIDS is spread mainly through unprotected heterosexual relations. According to health facility-based reports, STI cases in Eritrea has shown either a declining or stabilizing trend at an average of 2500 cases per year as shown in figure 2. In the studies conducted on CSWs and truck drivers, syphilis prevalence rates were 0.98% and 3% respectively. Syphilis

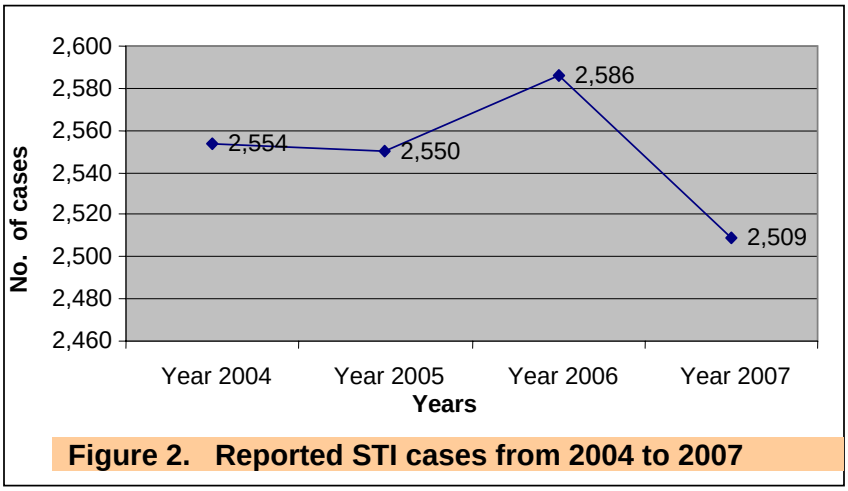


Figure 2. Reported STI cases from 2004 to 2007

prevalence rate in pregnant women in ANC SS in 2003 was 1.6%, while in 2005 the prevalence rate was 2.4%.

This suggests that the behavioral change among the sexually active population need more improvement. There is also a concern that the health facility-based reports might be underestimated as many people infected by STI could have remained undiagnosed in the health facilities and that more efforts would be required to raise and maintain the awareness and bring the desired behavioral change so that people with STI come and seek diagnosis in the health facilities as a pre-requite to the prevention of HIV/AIDS.

Experiences of other countries suggest that the epidemic has various negative impacts for any country in the world. Eritrea is no exception and that HIV/AIDS epidemic negatively impacts the country. However, to date, there is no nationwide study made on the impacts of HIV/AIDS at national, sectoral and household levels in Eritrea. This would imply that a study would be required to provide the necessary information on the impacts of the epidemic and its most likely future trajectory in the country.

Table 5: Summary of Studies Conducted in Eritrea, 2003-2007

Year	Sample	Study population	Prevalence (%)	Study place
2003	4559	ANC	2.40	National
2005	5033	ANC	2.38	National
2006	272	CSWs	8.08	Asmara
2006	252	CSWs	14.67	Massawa
2006	300	Truck drivers	7.00	National
2006	166	TB patients	34.33	One hospital in Asmara
2007	5033	ANC	Data in process	National

Source: NATCoD (2006 & 2007), Annual Reports

III. National Response to HIV/AIDS epidemic

3.1 Development of the National Response

The Government of Eritrea has continued its commitment to the national response of HIV/AIDS. To this end, the MOH has issued various policies and guidelines. The important milestones in the Government's response to the HIV/AIDS epidemic in the past years include the following:

- The establishment of the National AIDS Control Program (NACP) in 1992;
- The adoption in 1997 of the first 5-Year National Strategic Plan, which emphasized a multisectoral approach and decentralization of HIV/AIDS prevention and control program;
- The ratification in 1998 of the HIV/AIDS and STIs policy and policy guidelines. The key elements of the guidelines include individual and collective responsibility, voluntary counseling and testing, confidentiality, reduction of stigma and discrimination, equity in access to health services. ;
- The launching of the HAMSET Control Project in 2001;
- The approval in 2002 of a Second National Strategic Plan (NSP) for HIV/AIDS/ STIs for the period 2003 – 2007 ;
- The adoption of a set of HIV testing guidelines in 2002, which governs voluntary counseling and testing, testing for diagnostic purposes, testing of donated blood, and compulsory testing of army recruits prior to admission to the army;
- The adoption of a national BCC strategy in 2002 entitled "Winning through Caring: The BCC Strategy for prevention of HIV and control of AIDS in Eritrea";
- The restructuring of the Ministry of Health in 2003, and the creation of the National HIV/AIDS/STI and TB Control Division (NATCoD) within the Ministry of Health;
- Development of PMTCT guidelines and plan of action, 2003
- Development of Joint UN and Partners Implementation Support Plan to the National Strategic Plan, developed for 2003, 2004 and 2005;
- Development and implementation of Joint UN team program of support on AIDS, 2006, 2007 ;
- Development of home- based care and VCT training manuals in 2003;
- The formulation of National HIV/AIDS/ST Monitoring and Evaluation Plan in 2005;
- Development of a revised VCT guide line, 2006
- Development of antiretroviral policy and treatment guide lines, 2005
- Launching of antiretroviral therapy, September 2005
- Development of a revised Eritrean HIV/AIDS Care Manual in 2007 ;
- The setting of Universal Access Targets in 2007;
- Development of PMTCT Communication Strategy Manual, 2007 and
- Third 5-year national strategic plan 2008-2012 with its operational and M&E plans under development process, 2007.

3.2 National Strategic Plan on HIV/AIDS/STIs, 2003-2007

The National AIDS and Tuberculosis Control Division (NATCoD) of the Ministry of Health is the lead agency for the implementation of the National Strategic Plan, with significant support from the national and international partners. The National Strategic framework is inline with the UNGASS Declaration of Commitment on HIV/AIDS.

The National Strategic Plan focuses on the following nine priority areas:

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

(b) Scaling –up the activities to prevent the sexual transmission of HIV by implementing the behavior change communication strategy at a national level; promoting the use of male and female condoms ; introducing life-skills based education in schools; improving and expanding peer education and youth –friendly reproductive health services.

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

(d) Promoting early diagnosis and treatment of STIs by increasing the knowledge of MoH decision-makers on STI etiology and drug sensitivity; ensuring the availability of appropriate drugs for rational management of STIS; improving the availability and quality of STI clinical services , and promoting behavior change in STI patients to seek early and appropriate treatment.

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

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

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

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

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

3.3 National Commitment and Action

One of the major objectives of the health policy of the government of Eritrea is to provide adequate health services for the people, particularly in response to the HIV/AIDS epidemic. The government is committed to the International Declaration, including the UNGASS, MDG, and Universal Declaration on Human Rights. In addition, the government has set its targets for the Universal Access on prevention, treatment, care and support.

The National HIV/AIDS/STI and Tuberculosis Control Division (NATCoD) is responsible for managing Eritrea's response to the epidemic. The country's coordinating mechanism (CCM) is composed of the various line ministries, CSOs (Organizations of PLHAs, FBOs, private sectors), bilateral and multilateral development partners oversee the overall responses and mobilize resources. The Joint UN Team on AIDS and the HAMSET technical committee also gives support to the NATCoD. The government of Eritrea continues to put HIV and AIDS issue as a national priority of the country, recognizing the importance of proactively establishing appropriate programs and systems that will limit the spread of the epidemic.

The government of Eritrea has been committed to the national response to HIV/AIDS at the highest level. All its higher officials both at the national and regional levels have been addressing HIV/AIDS issues at different public occasions and gatherings, reiterating the government's commitment to the halting of the epidemic in the country. The Ministry of Information, on its part, has been disseminating sensational information on the prevention of HIV/AIDS through radio and television and other means on different occasions.

3.3.1 National Spending on the response to HIV/ AIDS

Indicator No.1: Domestic and Internationals AIDS spending by categories and financing

2006: 107,747,387.85 Nakfa
2007: 116,890,221.15 Nakfa

Source: Ministry of Health Annual Report, 2007; bilateral and multilateral development partners (see table 6).

Information on spending on HIV/AIDS was obtained from MOH, UN agencies and bilateral partners aggregated for each year, not disaggregated by various spending categories. Thus, it was not possible to present the annual spending by the various spending categories. The amount of financial resources indicated in table 6 as government contribution does not show the whole expenditure on HIV/AIDS activities because of the lack of national health accounting system. It is to be noted that these spending figures are actual spending not budget and were collected for the purpose of this reporting. The government will carry out NASA in 2008. Eritrea uses calendar year that is January 1 to December 31. The official exchange rate of $1USD is 15 Nakfa.

The political commitment of the Eritrean government has also been complemented by the allocation of resources on the national response to HIV/AIDS in the country. The spending covers broad area of intervention: prevention, treatment, care and support. Table 6 shows the spending on the national response to HIV/AIDS in Eritrea for the period 2006-2007. The resources mobilized and spent on the national response to HIV/AIDS come from several sources of funding such as Global fund, WB/ IDA, UNFPA, UNICEF, UNAIDS and Norwegian Church AID.

From all the sources, funding for 2007 seems to have increased as compared to 2006. The amount of spending for all HIV/AIDS related programmatic interventions was 107,747,387.85 Nakfa in 2006 and in 2007 it was 116,890,221.15 Nakfa, an increase of 8.5%. This is equivalent to 7,183,159.19 USD and 7,792,681.41 USD respectively.

Table 6: Spending on the national response to HIV/AIDS 2006-2007 in Nakfa

Source of funding	**Year**	
	2006	**2007**
Global Fund	71,513,670.00	59,189,520.00
WB/IDA	11,816,700.00	23,849,070.00
JUNP Program of Support on AIDS	10,046,312.85	18,087,081.15
Lutheran World Federation	3,000,000.00	3,300,000.00
Norwegian Church Aid	885,000.00	1,140,000.00
Government contribution/spending	10,485,705.00	11,324,550.00
Total	**107,747,387.85**	**116,890,221.15**

Source: MOH, JUNP program of support on AIDS, Norwegian church AID, Lutheran World Federation

3.3.2 National Composite Policy Index

Indicator no.2: National Composite Policy Index

2007: 80% (based on Questionnaire A);
72% (Based on Questioner B)

This indicator was derived from Questionnaire "A" administered to government officials and Questionnaire "B" administered to the CSO, bilateral and multilateral agencies. Data gathered have been analyzed and indicated that through multi-sectoral approach in line with the NSP of 2003-2007, the various partners which include government and non-government institutions, have been actively involved in the prevention of the epidemic.

The summary of the data collected and analyzed are presented here;

Questionnaire A
As to the national strategic plan, all respondents indicated that Eritrea has multi-sectoral strategic plan to combat HIV/AIDS. To date, the country has formulated two strategic plans covering the periods: 1997-2002 and 2003-2007 and its third strategic plan for the period 2008-2012 is underway. According to the respondents, the multi-sectoral national plan involves the line ministries such as the Ministry of Health (MoH), Ministry of Education (MoE), and Ministry of Labor and Human welfare (MoLHW), Ministry of Tourism (MoT), Ministry of Defense (MoD), Ministry of Transport and Communications (MoTC), Ministry of Information (MoI). The target population as per the respondents are women, youth in schools out of schools, orphans, most at-risk population , CSW, long distance truck drivers, TB patients, workers , military and PLHAs. The respondents also indicated that the main policy areas are HIV prevention, treatment of OI, antiretroviral therapy, care and support. The major program areas as per the respondents focus on behavioral change communication, HIV testing and counseling, STI services, Treatment and provision of care and support

As to the political support, almost all respondents responded that the national response to HIV/AIDS has the support of the government at the highest level, including the President of the country, His Excellency President Isaias Afewerki and other high ranking officials in all the zones of the country. In the 2007 World AIDS day, for example, the Ministry of Information organized a panel discussion by inviting people who have the knowledge on the epidemic. The panel discussion which mainly focused on methods of prevention of HIV was aired live to the public. The participation and response from the public was so encouraging that the people's awareness has reached to higher level. In sum, the collaborative efforts have raised the public awareness about the modes of HIV transmissions and prevention measures for the epidemic and more effort would be required to bring about a qualitatively better behavioral change that would lead to the complete halt of the epidemic in the country. The respondents also indicated that the county has national multisectoral HIV/AIDS coordination body, (NATCoD). According

to the respondents the partners of NATCoD provide information on priority needs and services; technical guidance/materials, Drugs/supplies procurement and distribution, coordination with other implementing partners and capacity-building. The data gathered from the respondents also indicated that the county has reviewed its laws related to HIV, particularly for HIV testing and ARV policies in 2005.

Virtually all respondents also indicated that Eritrea's main focus is on the prevention of the HIV/AIDS epidemic through IEC in order to encourage sexual abstinence, delay first sexual intercourse, encourage faithfulness , reduce the number of sexual partners , engage in safe sex, avoid commercial sex, promote acceptance and involvement of people living with HIV and to promote VCT so that people will be able to know their status . According to the respondents, the prevention policy strategy targets are CSWs, long distance truck drivers, youth and women worker in different organizations and the military. The information gathered from the respondents also indicated that the HIV prevention programs include blood safety, MTCT, and the prevention of HIV/AIDS at the work place.

As to treatment, care, and support, most respondents indicated Eritrea has a policy/ strategy to promote comprehensive HIV treatment, care and support which covers all zones of the country. The focus of HIV treatment, care and support services, according to the respondents are provision of antiretroviral therapy, psychological support for people living with HIV and their families, treatment of sexually transmitted infection management, HIV testing and counseling for TB patients, provision of Contrimoxazole prophylaxis in HIV infected people.

As to monitoring and evaluation, most of the respondents indicated that the country has monitoring and evaluation plan in place. However, to date, the budget for this particular activity has not been allocated. The monitoring and evaluation department is under the NATCOD, and it has permanent staff. NATCoD manages a National data base using different software such as excel, SPSS .As per the respondents, the country has mechanisms in place to ensure that all major implementing partners submit their M&E reports to the M&E Department for review and consideration in the country's national reports. However, the respondents indicated that the M&E committee does not meet regularly to coordinate the M&E activities.

As per the respondents, the overall value given for the NCPI was 80% for 2007, indicating the improvement in the national response to HIV/AIDS epidemic in Eritrea (see appendix1) for details.

Questionnaire B

Data were also gathered using questionnaire B and were analyzed and the summary of the findings is presented here.

As to the human right, most respondents indicated that the country has laws and regulations that protect people living with HIV and vulnerable sub-groups against discrimination in the area of education, employment and housing. The respondents also

responded on the existence of non-discriminatory health policy of the MOH. It was also noted by the respondents that PLHAs have been given support from the government, FBO, and the community. The respondents also indicated that a number of organizations have been developing their HIV/AIDS Policy in the work place, and in the view of the respondents this will address issues of non-discrimination on the ground of HIV status.

Also, there has been no court cases related to discrimination on the basis of HIV/AIDS. The cornerstone of the Eritrean government policies is the realization of social justices, particularly in the areas of access to health services and school enrollment. The provision of care and treatment in Eritrea is based on the principle of equity in line with Article 14 of the Constitution of Eritrea which contains broad equality provisions that prohibit discrimination on a range of listed grounds, as well as on the basis of " any other improper factors "The Democratic Principles in article 7 also states that " any act that violates the human rights of the women or limits or otherwise thwarts their role and participation is prohibited "Article 21 of the Constitution notes that every citizen has the right to equal access to publicly –funded social services and that the state shall endeavor to make available to citizens health , education , cultural and other social services (UNDP, 2006). In view of this, most respondents indicated that the HIV policy of the country provides free services in prevention, antiretroviral treatment, HIV-related care and support.

Moreover, the respondents noted that the government provides antiretrovirals for free; there are free VCT services, free distribution of condoms at the health facilities for both male and females. Furthermore, the respondents indicated that HIV screening for employment is not a requirement in the country. However, the respondents are of the opinion that they were not aware of the existence of independent institution for the protection of HIV/AIDS based discrimination in areas such as employment or housing. Furthermore, all respondents agreed that there are focal points within the government health and other departments which monitor HIV related human right abuse. The respondents also indicated that there are performance indicators for compliance with human rights standards in the context of HIV/AIDS efforts .

As to the civil society participation, the respondents indicated that civil society has moderate contribution in strengthening the political commitment of high ranking leaders and national policy formulation. The respondents also indicated that the representation of civil society in budgetary process/ current activity has been high. As to the services provided by the civil society in the areas of HIV prevention, treatment, care and support, the respondents value them as high. Moreover, the respondents indicated that civil society is included in the development of NSP. Furthermore, the respondents also responded that the representative of civil society in HIV- related efforts is high. The main organizations which represent civil society in Eritrea are NUEYS, NUEW, NCEW, FBOs, and BIDHO.

As to the treatment, care, and support, the respondents indicated that such services are given to HIV patients in all zones of the country. The treatment, care and support services according to the respondents include antiretroviral therapy, pediatrics AIDS treatment, and treatment of STIs, home-based care, support to PLHAs, and TB screening for HIV.

Respondents also indicated that the country has policy/ strategy that address HIV/AIDS related needs of orphans. The data analyzed using questionnaire B shows that the average valued given for the NCPI is 72% for 2007 (see annex1); a value not far from the valued respondents gave in questionnaire A. This would suggest that both respondents of questionnaire A and B have similar understanding and active participation to the national response on HIV/AIDS epidemic in the country.

Prevention through adopting Workplace Policy on HIV/AIDS

HIV/AIDS threatens the country's socio-economic development because it affects all sectors and especially the productive population. Implementing workplace based HIV/AIDS prevention programs in all sectors has a vital role in the prevention of the epidemic. HIV/AIDS at the workplace would also reduce stigmatization and discrimination on the basis of HIV infection in relation to employee recruitment, promotion and medical benefits. Therefore, the country will require developing workplace policy on HIV/AIDS as part of the national response to the epidemic. There are a lot of activities related to workplace interventions in HIV/AIDS but they are not yet institutionalized. The National Confederation of Eritrean Workers (NCEW) is one of the civil society organizations addressing the workplace interventions.

3.4 National program indicators

Since 1990s, the government of Eritrea has, in its capacity, been responding to halt the spread of HIV/AIDS, where many partners: public, private, religious and international partner organizations have been involved. The efforts have continued over 2006-2007 periods, and the comprehensive response to the HIV/AIDS epidemic has focused on prevention, treatment, care and support to those affected by the epidemic.

3.4.1. Prevention

The main mode of transmission of HIV among adults in Eritrea is through unprotected heterosexual contacts and the success on prevention of HV transmission depends mainly on the personal commitment. Faith-based and private sector organizations have been actively involved in providing education and information on the prevention of HIV/AIDS and the provision of care and support consonant with the Eritrean tradition of supporting each other. To date, different government organs such as the Ministry of Health, Ministry of Defense, Ministry of Information, Ministry of Education, Ministry of Labor and Human Welfare, Ministry of Tourism, Ministry of Transport and Communications and other partners such , NUEYS , NCEW, NUEW, EDE, FBOs, PLHA (BIDHO) and national and international NGOs have been involved in the dissemination of information , provision of education on HIV prevention through organized workshops , and mass media to targeted populations mainly the youth, in schools, military and at the work places. Youth is a specific focus area in the national response to HIV/AIDS epidemic because they are the most vulnerable to HIV infection. In addition, the youth are an important target group to protect against future HIV infection as they represent both the present and future economic powerhouse in the country.

The main methods of prevention to the spread of HIV/AIDS infection in the country include the following: Life skills education, IEC/BCC, Blood screening and safe transfusion, VCT, PMTCT, HIV/AIDS in work place, condom promotion, etc. Some of the above interventions are described and discussed in detail in this section.

3.4.1.1 Life skills- based HIV education in Schools

Indicator no.11: Percentage of schools that provided life skills-based HIV education in the last academic year
2006: 26%
2007: 26%

Year 2006:
Numerator: 274 (number of schools that provided life skill-based HIV education in the last academic year)
Denominator: 1046 (number of schools survey)

Year 2007:
Numerator: 274 (number of schools that provided life skill-based HIV education in the last academic year
Denominator: 1046 (number of schools survey)

The source of information for this indicator is the Statistical Office of the Ministry of Education Un published 2006/07 Annual Report. The school academic calendar of Eritrea is September to June.

As of 2006/07 academic year, there were 1046 schools in the country. Of these 274 junior and secondary schools (26%) provided life skills-based HIV education. Junior and high schools in Eritrea are those schools which give formal education in English to students of grade six up to grade 12. These schools have also continued providing life skill-based education in the current 2007/08 academic year (26%), while necessary preparation have been underway to introduce this program in all elementary schools in the country in the coming academic year.

In the 2006/07 academic year, all Junior and Senior secondary schools have been providing life skills-based education as a separate course in the country. During this academic year, of the 130,128 students enrolled from grade one up to grade twelve, 55% were studying life skills-based education as separate subject (MOE, 2007). The numbers of staff who taught life skills education during this academic period constituted 5% of the total academic staff in the country. In the coming years, it has been planned to introduce life-skill education at the elementary level and efforts are underway in preparing textbooks in mother languages for all elementary students. The expansion of life skill at all levels of education will require the training of more teachers for its effective implementation. Inline with this, in the first half of 2007, for instance, 353 facilitators and 1823 teachers and students were trained in life-skills (NATCoD, 2007).

It is universally accepted that life skill based education is an effective methodology that uses participatory exercise to teach behaviors to young people that help them deal with the challenges and demands of every day life . This has been recognized by the government of Eritrea, and the Ministry of Education is the one which has the authority

of designing and implementing curriculum at all levels of the Eritrean schools. The objective of introducing life skills-based education at schools is to teach young people how to cope with their emotions and causes of stress. As to HIV- related education, life skills- based education helps students understand and asses the individual , social and environmental factors that raise and lower the risk of HIV transmission with a positive effect on behavioral change , including delays in sexual debut or the use of safe sexual relations.

The education sector is the area where youth concentration is found, making it suitable to the provision of health related education among the youth. The Ministry of Education is actively engaged in life skill based health education in general and HIV/AIDS related activities to prevent the transmission of the HIV. In 2006-2007, the MoE was involved in the prevention of HIV through:

- The development of education sector HIV/AIDS Policy;
- Development of Strategic Plan of action for the implementation of School based HIV/AIDS life skills education;
- Awareness raising activities through dramas, cultural shows, musical concerts, general knowledge contests, news letters, brochures, training of influential peer leaders and educators in value and life skill education ;
- Formation of school Health Clubs;
- Development of guidelines for school health clubs;
- Formulation of radio program on health issues in 4 local languages and in English. The Ministry of education airs 52 health messages (topics) per year in each of the 4 languages. Health messages are aired for 30 minutes and repeated three times to help audience internalize the messages;
- Establishment of rural reading rooms for adult readers with HAMSET information materials; and
- Formation of peer educators among adult; learners in progress in collaboration with the MOH.

3.4.1.2. Prevention of HIV/AIDS through information, education, communication (IEC) program

Indicator no.8: percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results.

2006: 78.35 %
Numerator*:* 409 (Number of at most-risk-population respondents who have been tested for HIV during the last 12 months and who know their results)
Denominator: 522 (number of most-at-risk populations included in the sample)

2007: Another study to be conducted in 2008

The source of data for this indicator is NATCoD, (2006) Research Report for a study on HIV and Syphilis Prevalence and HIV risk Behavior Survey in Commercial Sex Workers in Asmara, Eritrea.

In the Eritrean context one of the most- at- risk population are CSWs. A survey was conducted in 2006 in CSWs who reside in two cities of Eritrea. The total number of CSWs included in the study was 522. Out of these CSWs 409 (78.35%) responded that they had ever tested for HIV. Since the HIV testing facility in Eritrea are the VCT where test results are given, then all those who tested received their results. The indicator presented here is not for testing in the last 12 months and the findings of this study is not representative for the whole country. It however suggest that expansion of VCT has made a substantial impact in making people voluntary test in order to know their HIV status as a part of the prevention measures in the general population.

3.4.1.3 Condom promotion

Indicator no. 9: percentage of most at-risk populations reached with HIV prevention programs (BCC)

2006: 45.8%
Numerator: 2199 (Number of most-at-risk population respondent who replied yes to questions 1 and 2)
Denominator: 4800 (Estimated number of respondents)

2007: 87.9
Numerator: **4218 (**Number of most-at-risk population respondent who replied yes to questions 1 and 2)
Denominator: 4800 (Total number of respondents surveyed)

Data source: NATCoD Annual Reports for 2006 and 2007

One of the strategies used to prevent HIV transmission in the country is the Behavioral Change Communication Strategy (BCC). There are a number of population groups addressed through this strategy all over the country. Among these population groups CSWs and long distance truck drivers are given high priority. The estimated national figures for the CSWs and truck drivers are 4000 and 800 respectively. In 2006 and 2007 the coverage of these high risk population groups reached through peer based education and condom promotion were 2199(45.8%) and 4218(87.9%), respectively.

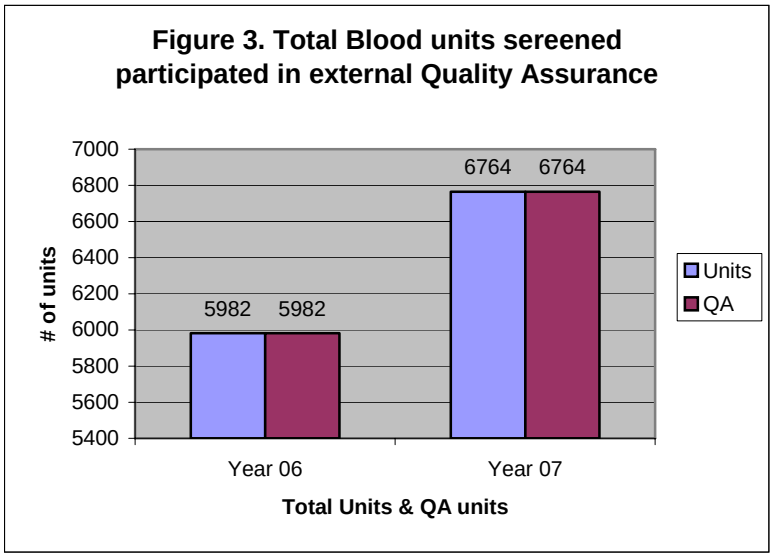
3.4.1.4 Blood Screening and Promotion of Safe Blood Transfusions

Indicator no.3: Percentage of donated blood units screened for HIV in a quality – assured manner

2006: 100%
Numerator: 5982 (Number of denoted blood units screened for HIV in blood center)
Denominator: 5982 (Total number of blood units denoted)

2007: 100%
Numerator: 6764 (Number of denoted blood units screened for HIV in blood center)
Denominator: 6764 (Total number of blood units denoted)

The source of data for this indicator is 2007 Annual Report of National Blood Bank and Transfusion Center, (MOH).



All blood transfusion services and blood units in Eritrea are managed and regulated by National Blood Bank and Transfusion Center, Ministry of Health. No private entities are allowed to independently collect, screen and store blood units. The NBTC receives blood both from volunteers and from family replacement donors and all the blood units received are screened for infection markers of HIV, Hepatitis B, Hepatitis C, and syphilis. The NBTC has also internal and external quality assurance procedures. It sends 1/20 of units tested (positive and negative) to the National Health Laboratory for external quality assurance.

In Eritrea, blood safety is recognized as a national public health priority. Policy guidelines on blood transfusion in Eritrea was released in 2002 in response to the increasing demand for safe and sufficient blood supply in the country. To this end, the National Blood Bank and Transfusion Center (NBTC), which became operational in 2002, is the major supplier of safe blood to all national and zonal referral hospitals and to build up Zonal Blood banks. All blood transfusion services and blood units in Eritrea are managed and regulated by the Blood Transfusion Services of the MOH.

The government of Eritrea is committed to provide safe and adequate quantities of blood and blood products for treatment of all patients' in public and private hospitals (GOE. 2006). The NBTC receives blood both from volunteers and from family

replacement donors. To minimize the risk of HIV transmission as a result of window period pre-donation counseling and risk assessment was done in all potential donors. Further more, the sources of blood donation are volunteer young secondary school students with HIV prevalence as low as 0.01%. In Eritrea, there is virtually no possibility of transmitting HIV through blood transfusions because all the units of blood are screened in quality assured manner. As shown in table 7, 100% of the blood units donated is screened in quality assured manners and only safe blood units are used for transfusion.

Table 7: Blood Transfusion donors tested for HIV and HIV positivity among blood Transfusion Donors 2005-2007

Year	**Voluntary donors**	**Annual HIV positivity in voluntary donors**	**Replacement donors**	**Annual positivity in Replacement donors**	**Total blood tested for HIV**	**Percentage of blood tested for HIV in quality assured manner**
2005	2832	0.16%	2020	0.18%	4852	100%
2006	4259	0.14%	1723	0.58%	5982	100%
2007	5392	0.16%	1372	0.43%	6764	100%

Source: NATCoD 2007, National Blood Bank, 2007: Annual Reports

3.4.1.5. HIV Counseling and Testing (HCT)

Indicator no.7: Percentage of men and women aged 15-49 who received an HIV test in the last 12 months and who know their results.
2006: 5.4%
Numerator: 72195 (number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results**)**
Denominator: 1,335,900 (Number of respondents aged 15-49)

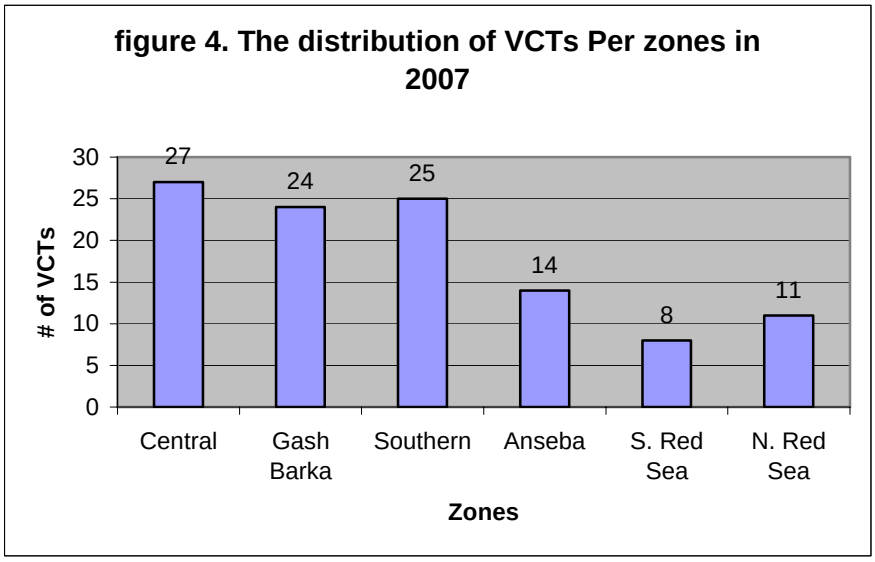
2007: 5.88%
Numerator: 80,706 (Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results)
Denominator: 1,371,969 (Number of respondents aged 15-49)

Source: NATCoD Annual Report 2006/ 2007, Extrapolated data based on estimated population and age dis-aggregation that is based on DHS 2002

Unlike the 2005 UNGASS report which was based on population based study in both sexually active men (15-54 years) and women (15-49 years), where the coverage of testing was 17% and 11% respectively, this year's indicator is extrapolated from the VCT attendees and the estimated sexually active population (15-49 years of age of both sexes) of the country. The denominator is the number of estimated population aged 15-49 which is 1,335,900 for 2006 and 1,371,969 for 2007. The numerator is the number of people aged 15-49 who has been tested for HIV and who know their results were 72,195(5.4%) in 2006, and 80,706(5.88%) in the 12 months of 2007.

Counseling and testing is a valuable component of comprehensive HIV/AIDS prevention in Eritrea as it helps individuals to protect themselves and to prevent infecting others by knowing their status. Client–initiated HCT has been the predominant approach to HIV testing in Eritrea since 1992. Increasing the number of people who are tested is an essential part of expanding access to AIDS care and treatment in the country.

Since the introduction of VCT in 1999, the number of sites providing VCT has increased. As of 2007, there are 109 nationwide network service delivery points for VCT: 10 freestanding sites and 99 "integrated" (e.g., VCT service delivery within a hospital, health centre or health station) sites. By the end of October 2007, 47% of the country's health facilities have been providing VCT services (see figure below). Trained counselors, mainly health workers and few non-health professionals have been involved in counseling activities on a regular basis. As shown in figure 4 the of VCT sites are distributed in all the zones of the country, reflecting the equity policy of the provision of health services



Expansion of VCT services will continue to provide Eritreans with the opportunity to now their HIV status. Recognizing the increased need for HIV testing in a varying settings , the MOH has developed broader policies to make VCT more accessible in all health facilities in the country.

In spite of the increase in the number of VCT in the country, DHS is not available for this report to evaluate on the population who had been tested for HIV. In 2008, the GOE has a plan to conduct DHS+ and in the 2010 report, the percentage of men and women who had been tested for HIV will be included.

3.4.1.6 Prevention of mother-to-child transmission (PMTCT)

Indicator no.5; percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother- to –child transmission

2006: 2.10%
Numerator: 73 (Number of HIV-infected pregnant women who received Antiretorvirals during the last 12 months to reduce mother-to-child Transmission)
Denominator: 3,484 (Estimated number of HIV-infected pregnant women in the Last 12 months)
2007: 3.72%
Numerator: 133 (Number of HIV-infected pregnant women who received Antiretorvirals during the last 12 months to reduce mother-to-child Transmission)
Denominator: 3,578 ((Estimated number of HIV-infected pregnant women in the Last 12 months)

Source: NATCoD (2006, 20070, Annual Reports

As part of its prevention measures, the MOH has started providing a complete course of ARV prophylaxis to HIV positive pregnant mothers to reduce the risk of PMTCT and the proportion has increased over the last four years. The estimated number of expected deliveries in Eritrea as of 2006 was 146,400, of which the estimated number of HIV infected deliveries was 3,484. Of the HIV infected pregnant women, 73 were receiving ARV prophylaxis, constituting 2.10%. In 2007, the estimated number of expected deliveries in the country was 150,352. The estimated number of HIV infected deliveries was 3,578. Of the total HIV infected pregnant women, 133 (3.72%) were receiving ARV prophylaxis.

It is well recognized that in the absence of any prevention, infants born to and breastfed by HIV-infected women have roughly a one-to three chance of acquiring infection themselves. This can happen during pregnancy, during labor and delivery or after delivering through breast feeding. This risk of mother-to-child transmission can be significantly reduced through the provision of PMTCT services. Effective prevention of mother-to-child HIV transmission involves a combination of strategies. These include primary HIV prevention for women , including integration of HIV preventive and sexual health services, prevention of unintended pregnancies in HIV-positive women , access to comprehensive antenatal care, promotion of voluntary HIV testing and counseling for pregnant women and their partners in antenatal and community-based settings, antiretroviral therapy for mother and new born and counseling on strategies to reduce the risk of HIV transmission via breast feeding (UNAIDS, 2006).

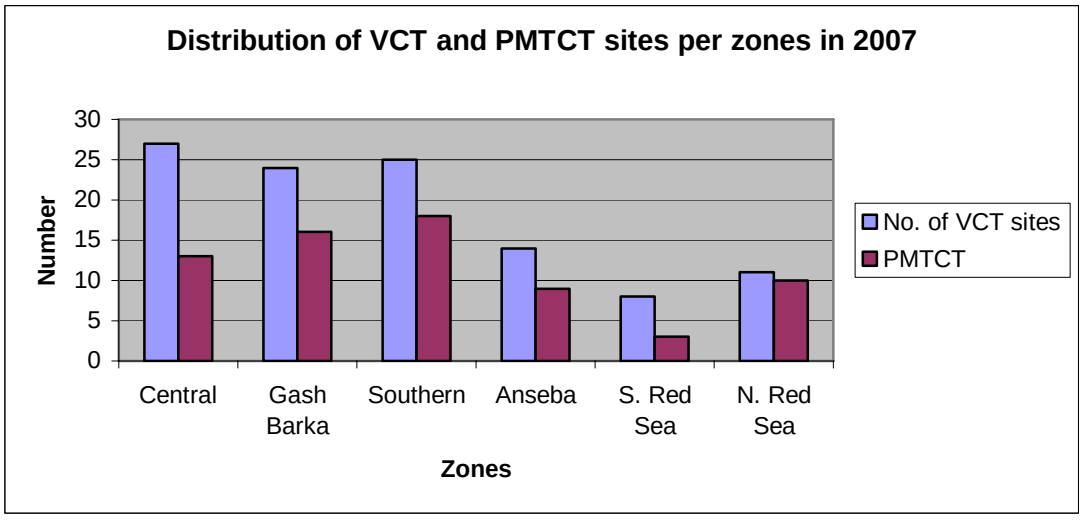
Eritrea recognizes very well the centrality of prevention of mother-to-child transmission as a major component of the national response to HIV/AIDS epidemic. In this spirit, the MOH started the provision PMTCT services in the Central Zone and Southern Zone in 2002 to enable pregnant mothers to come up for HIV testing. PMTCT interventions are being introduced into an already established network of antenatal care (ANC) sites. As of 2007, there were 66 PMTCT centers countrywide, which constitute 28% of the health

facilities in the country (see table 10). The situation is ripe for high uptake of PMTCT services due to high ANC coverage within the country. Knowledge about PMTCT has also been increasing in the communities. Thus, in terms of the way forward, there needs to be an emphasis on creating demand for PMTCT services in particular, and formal-sector ANC and delivery services in general in order to reduce the risk of mother-to-child transmission of HIV in the country.

Table 8: PMTCT Sites by Zone

Zone	**No. of PMTCT sites**
Central	13
Gash barka	16
Southern	18
Anseba	9
Southern Red Sea	3
Northern Red Sea	10
Total	69

Source: NATCoD 2007, Annual Report



3.4.2 Treatment, Care and Support

Indicator no. 4: Percentage of adults and children with advanced HIV receiving antiretroviral therapy

2006: 15%
Numerator: 1,884 (Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol).
Denominator: 12,600 (Estimated number of adults and children with advanced HIV infection).
2007: 24%
Numerator: 3,062 (Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol).
Denominator: 12940 (Estimated number of Adults and children with advanced HIV infection)
The source of data for this indicator is NATCOD 2007 Annual Report

In Eritrea, the estimated number of adults and children with advanced HIV in 2006 were 12,600. Of these only 1,884 were receiving antiretroviral therapy in accordance with the country's approved treatment protocol, constituting 15%. In 2007 the estimated number of adults and children with advanced HIV were 12940, of which 3,062 were receiving antiretroviral therapy, constituting 24%. It is worthy noting here that ART is provided freely to all who are medically eligible.

The estimated population infected with HIV in the country lies in the range of 70, 000-100,000. The National Strategic Framework has the provision of treatment, care and support as one of its major goals. In line with this, the MOH has recently finalized a series of national ARV and clinical care guidelines and implementation plans. In 2006, the MOH prepared Eritrean HIV/AIDS Care Manual. The government has acknowledged that with the increase in the number of HIV infected people , they will rely on conversant compassionate providers of care to help them understand a complicated illness , to assist them in coping with HIV-related diseases , and to provide them with comfort and treatment needed to improve the quality and length of their life. In order to meet these goals, it would be essential to mobilize all available health care providers and resources in the country (NATCoD, 2006).

Due to the relatively low prevalence and urban dominance of the epidemic, 63% of AIDS cases are reported from the hospitals in the capital city. Therefore, the antiretrovirals are provided in these hospitals and other hospitals located in the Zones. Officially ART was launched in the country in September 2005 in five designated sites in the capital city and other towns. Since its launching ART was expanded to the six Zones and by the end of 2007 at least one ART site exists in each Zone. As of 2007, 14 out of the 30 public, military and private hospitals are providing antiretrovirals, constituting 47% of these health facilities.

Indicator no.24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

2007: 93.3%)

Numerator: 1,096 (*Number* of Adults and Children who are still alive and on ART at 12 months after initiating treatment

Denominator: 1,175 (Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who died , those who have stopped ART and those lost follow-up)

Source of information NATCoD, Annual Reports of 2006 and 2007

The Documents of NATCoD indicate the total number of adults & children who initiated ART during the 12 months prior to the beginning of the reporting period were 709 in 2005 and 1,175 in 2006. The number of people who died after starting treatment in the years 2005 and 2006 was 13 and 79 respectively. Therefore, in 2007 the percentage of those who survived twelve months after initiation of antiretroviral treatment was 93.3%. However, this indicator was not based on cohort data making difficult to calculate the exact survival of patient twelve month after the initiation of treatment. As mentioned in previous sections antiretroviral therapy was introduced in late 2005 which made it impossible to generate data for 2006.

3.4.2.1 Home and community-based care

Home-bases care provides care outside of formal health care delivery system by faith-based organizations or community-based groups, families, etc. and it involves in providing assistance with chores, spiritual and psychological support, food parcels, some nursing care and palliative care. It also reduces the social stigma and discrimination so often associated with HIV/AIDS (Katabira and Stein, 20020). The delivery of organized basic medical and psychological support for patients in their homes may also help patients and their families to reduce hospital and transport cost and eliminate isolation from family and friends offer the opportunity to prove AIDS education for family members which is crucial in creating comfort home environment for the care seeking member of the family.

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In Eritrea, there has been a long-staying tradition of caring for those who are critically ill by keeping the home environment comfortable. With the provision of some basic training in caring, home-based care could play its role more not only in direct help and care but also in supporting the whole caring process of HIV patients in the country. At the present, such home-based services are being provided by (volunteer) lay providers affiliated with the various FBOs and BIDHO (the association of people living with and affected by HIV/AIDS) in the country. Table 11 shows that there are 1982 PLHA receiving home-based care by 289 different organizations in 2007. Predominantly, the home and community-based support have been highly concentrated in Asmara and

surrounding areas, although each of the six regions in the country has taken the initiative to pursue varying degrees of home-based care and support.

Table 9: Number of people receiving home-based care by different organizations

Organization	**Number of PLHA receiving home-based care by different organizations**	**Number of home an community-based care providers**
Orthodox church	210	52
Evangelical Church	100	19
Catholic Church	678	77
Mufti Office	33	11
MoLHW	26	15
NUEW	21	5
BIDHO	604	109
Total	*1672*	*288*

Source: NATCoD, 2007 Annual Report

As indicated in table 5, more than 36.12% of the PLHA receiving home and community -based care have been supported by the BIDHO. The BIDHO is also good resource for help and advice on HIV and AIDS education, counseling and support efforts as well as in eradicating stigma and discrimination towards people living with HIV/AIDS in the country. Yet, the involvement of the civil society in proving home and community-based care is still at its early stage. Thus, the integration of community-based HIV/AIDS support programs and national health systems would be required to ensure appropriate care, counseling and treatment, while avoiding duplication of efforts.

3.4.2.2 Support for the National Orphans and Vulnerable Children

Indicator no. 10: Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child

2006: 3.75%
Numerator: 3,935 (Number of orphaned and vulnerable children aged 0-17 who live in households that received at least one of the four types of support for the child).
Denominator: 105,000 (Total number of orphaned and vulnerable children aged 0-17)

2007: 3.91%
Numerator: 4,103 (Number of orphaned and vulnerable children aged 0-17 who live in households that received at least one of the four types of support for the child).
Denominator: 105,000 (Total number of orphaned and vulnerable children aged 0-17)

The source of information of this indicator is NATCoD, 2006 Annual report, MLHW Report 2006

According to the MLHW, there were 105, 000 OVC in Eritrea as of 2006 of which, 40, 000 are OVC related to HIV/AIDS. In 2006, NATCoD reports indicate that there were 3,935 and 4,103 OVC living in household receiving support, in 2006 and 2007, constituting 3.75% and 3.91%, respectively. It is noteworthy that the government of Eritrea and its partners have been supporting OVC in the countries in different forms and that the indicator presented here is not a representative whole support given to orphans in the country.

It is well recognized that orphans and vulnerable children remain a pressing challenge for many countries. The majority are caused by conflict, disease and accidents. However, in recent times, a new and significant cause of the increase in orphans and vulnerable children has been the impact of the HIV/AIDS epidemic. Orphans and vulnerable children have many different needs: for love, security, attention, health, shelter, nutrition, education and many others. Without the support of government, communities, and development partners, orphans would face a bleak future because their livelihood is immediately threatened with the death of their mothers /fathers or both.

In the Eritrean tradition, families cope with relatives' deaths by ensuring that orphans receive care from a substitute care giver. The extended family support network functions mainly through changes in household composition because children who survive their parents , or orphans move into households of one or more relatives. The extended family remains the predominant care giving unit for orphans. But this traditional safety net is weakening by a combination of two factors: a huge increase in the number of orphans, and a systematic change to the social structure that has occurred due to the ongoing urbanization and the growing tendency of individualistic behaviors.

Eritrea has a large number of orphans and vulnerable children because of its unique characteristics/history: protracted war for independence (1961-1991), the Ethiopian war of aggression on the pretext of boarder war (1998-2000), and HIV/AIDS epidemic (see table 12). The Government of Eritrea also recognizes its responsibility to ensure that most orphans and vulnerable children are protected and receive the support of the government and the Eritrean people.

Table 10: Number of HIV/AIDS orphans and vulnerable children receiving support by Zone

Zone	**Number of HIV/AIDS orphans and vulnerable children receiving support**	
	Year	
	2006	**2007**
Central	1620	1718
Southern	1200	1250
Anseba	350	350
Gash Barka	480	480
Northern Red Sea	165	180
Southern Red Sea	120	125
Total	3935	4103

Source: NATCoD, 2006, 2007 LQAS Survey Report; NATCoD, 2007 reports

It is underscored that in Eritrea, OVC are not denied access to schools and health services because these services are freely provided by the government. The government has also the policy of supporting OVC in its capacity through the provision financial support and income earring assets such as livestock and shops to the guardians of the orphans. However, information on the school enrolment of OVC is not available.

3.4.3. Knowledge and Behavioural Change

Indicator no 14: Percentage of most -at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

2006: 79.3**%**
Numerator: 653 (Number of most-at-risk population respondents who gave correct answers to all the five questions)
Denominator: 824. (Number of most-t-risk population respondents who gave answers, including "don't know" to all five questions)

2007: Next survey will be in 2008
The source of information of this indicator is NATCoD, 2006 Annual report

The report of this indicator is based on the study conducted in 2006 for both CSWs and long distance truck drivers. The total sample size for the two population groups is 824. Out of the total respondents 653 (79.25%) correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. However, it has to be noted that the study was limited to two cities. Note also that in Eritrea, there are no male sex workers in addition to this being illegal.

As already discussed, Eritrea has low HIV prevalence but it also has high rates of prevalence in the most-at-risk populations. Thus, knowledge levels and behavioral trend among the general population and the most risk groups are more appealing of intervention in the national response to HIV/AIDS. The government of Eritrea , together with its partners has strengthened its information , education and communication(IEC) programs including health promotion focusing on youth and adolescents to increase their knowledge about prevention of HIV/AIDS. The ultimate goal of these behavioral change interventions in HIV prevention is to reduce behaviors that increase the risk of HIV transmission and, thus reduce the incidence of HIV in the country, where the primary root of transmission is unprotected heterosexual practice.

There is thus a wide agreement that the most important tool for behavioral change is to strengthen the programs which would reduce unprotected sexual contact. The "ABC" (Abstinence, Being faithful, and condom use) are widely recognized as key behaviors that reduce the risk of HIV transmission in Eritrea. Abstinence includes delay of first sexual experience for adolescents. Being faithful is having one faithful sexual partner. In a situation where the two can not be strictly followed, for maximum effectiveness, male or female condoms must be used correctly and consistently. Promotion of condom use is more widely accepted in programs that target high risk group population such as commercial sex workers. In the Eritrean context, promotion of condom use might signal like encouraging individuals to engage in high-risk sexual behavior, and thus abstinence and faithfulness are widely accepted by the religious leaders and the general public to the prevention of the HIV epidemic.

Indicator no.18: percentage of female and male sex workers reporting the use of a condom with their most recent client

2006: 76%
Numerator: 395 (Number of respondents who reported that a condom was used with their last client).
Denominator: 520 (Number of respondents who reported having commercial sex in the last 12 months).
2007: Next survey will be done in 2008

The sources of information for this indicator are the two surveys conducted by NATCoD, (2006) on CSWs. That is Research Report for a study on HIV and Syphilis Prevalence and HIV risk Behavior survey in Commercial Sex Workers in Asmara and Massawa

For this indicator we used the two surveys on CSW conducted in 2006. The indicator presented here is on condom use in the last 12 months. A sample of 520 CSWs was studied in 2006 by NATCoD. Of these 395 responded that they made sex using condoms with clients/non-regular partners, constituting 76%.

It is underscored that unprotected sexual intercourse accounts for the vast majority of HIV infections in many countries. Effective protection of sexual transmission of HIV thus requires the correct and consistent use of condoms. As a complementary to the promotion of social norms that favor risk reduction behavior, the government of Eritrea has been encouraging use of condoms for all sexually active adults. To this end, the MOH has been providing male condoms free of charge at the health facilities. As shown in table 11, over 6 million condoms were distributed in 2006, while in 2007, close to 5 million condoms were distributed.

Table 11: Male condoms distributed by year, 2005-2007

Year	Number of condoms distributed
2005	6,012,220
2006	6,399,760
2007	4,777,654

Source: NATCoD (2007), Annual Report

The NUEYS, on its part , through its Social Marketing Group (ESMG) and as a partner of the Ministry of Health has been working to improve reproductive health by reducing transmission of sexually transmitted diseases (STDs), including HIV/AIDS, especially through the distribution of condom among sexually active population. The NUEYS also promotes the prevention of HIV and the benefits of voluntary counseling and testing through music and drama shows linked to HIV/AIDS in all Zones. In 2006-2007, alone a total of 16,584, of which 9326 males and 7,258 females participated in the music and drama shows, while 23 900 audiences from all Zones constituting 14,060 males and 9,840 females volunteered for HIV testing (ESMG, 2006; (ESMG, 2005).

3.4.4. National Impacts

Indicator no.23: percentage of most-at-risk populations who are HIV infected

2006: 9.7%
Numerator: 80 (Number of the members of the most-at-risk population who test positive for HIV).
Denominator: 824 (Number of the members of the most-at-risk population tested for HIV).

2007: Next survey will be done in 2008

Source NATCoD Annual Report, 2006

For this indicator we used the two surveys on CSWs in Asmara and Massawa and long distance truck drivers that were conducted in 2006. Of the 824 total sample (524 CSWs and 300 truck drivers) 80 (9.7%) were tested positive for HIV.

As already discussed in the previous sections, the extensive and comprehensive efforts underway by the government and partners in the national response to HIV/AIDS epidemic in Eritrea could be evaluated by the degree to which the program has resulted into noticeable impacts in the country. The HIV situation in Eritrea is characterized by low HIV prevalence at the national level and high rates of prevalence in the high risk groups. To date, there have been few studies made on this issue to give a conclusive evaluation. A study that was made in 2005 showed that the HIV prevalence rate on the young men and women aged 15-24 was 1.80%, much lower than the national prevalence rate (2.38%). This would suggest that the new infection rate has been reduced and more efforts would be required to drastically reduce the new infection rate among our young men and women. The study made in 2006 on high risk groups (CSW, truck drives) on sample of 572 indicates that the HIV prevalence was extremely high (7.5%, compared to the national level HIV prevalence. Thus, available evidence suggests that the national level impacts of the HIV program underway in Eritrea need to be studied more further to reach into a conclusive answer.

Indicator no. 22: Percentage of young women and men aged 15-24 who are HIV infected.
2006: NA
2007: NA

Although we could not report for this indicator, it has to be noted that the GOE will conduct DHS+ in 2008 and many of the indicators that we could not report this year will be reported in 2010.

IV. Best Practices

As already discussed, in previous sections Eritrea has been responding to halt the epidemic since 1992. In the Eritrean context, the supply of safe blood to all hospitals, the multi-sectoral response to HIV/AIDS and the stagnated prevalence of HIV are some examples of best practices. Moreover, the Ministry of Defense has mainstreamed HIV/AIDS in the defense sector and is one of the best practices in the prevention activities underway in the country.

With the objective to promote improved health seeking behavior and adoption of safe sex practices , the Ministry of Defense, for instance, has been using the military environment as a unique opportunity to provide HIV/AIDS prevention and education for large audience in a disciplined and highly organized setting . In this sense, the armed forces represent an ideal medium for instilling widespread awareness about HIV/AIDS and encountering safer behavior among a significant percentage of the sexually active population. The military structure is also well suited for providing information , knowledge and material resources such as condoms and therapeutic drugs , as well as to facilitate for voluntary counseling and testing , both for its own staff and for the general population. In the Eritrean context, the youth and the military are two priority population groups identified in the comprehensive HIV/AIDS Policy Guidelines established in 1998, as well as in the new five –year National Strategic Plan on HIV/AIDS/STIs for 2003-2007.

The Ministry of Defense has been aware of the threat posed by HIV since early 1990s, and the first concerted activities aimed at HIV prevention started in 1999, when a large number of young people were mobilized into the army to safeguard the sovereignty of the country from Ethiopian war of aggression. Since then, the Eritrean Defense Force has been involved in HIV/AIDS related activities: increasing awareness; promoting access to condoms; organizing advocacy seminars such as 'Seeing is believing'; care and support for people living with HIV/AIDS. The experience so far gained has been very encouraging that members of the armed forces have good understanding of the transmission of HIV and the methods of its protection (UNAIDS (2003) . Since 2003, one of the EDF 's major activities were on organizing mass information campaigns on HIV/AIDS for all military personnel and advocacy campaigns for all military officers, including testimonies by HIV-positive military staff. Moreover, the military has recruited and trained among its members to serve as 'change agents' within the Eritrean rural communities. The EDF aims at preventing the transmission of HIV and reducing the incidence and impact of HIV and STIs on its personnel. Judged on the increased demand for condoms and VCT services ,as well as the decreased incidence of STIs within the military , the EDF activities appear to have been effective in instilling behavioral change among its personnel . The 'seeing is believing' seminars have succeeded in breaking some of the conspiracy of silence around HIV/AIDS. The psycho-medical support the EDF is providing for PLHA has improved their well-being and it has encouraged more HIV positive people to speak openly about their status as well as to put into effect utmost ethical values so that the HIV/AIDS prevention efforts underway would be more effective.

The BIDHO association is also strongly involved in the ‘seeing is believing’ seminars and training on positive living. More people have been seeking voluntary counseling and testing and, in general, there is more openness about HIV.

V. Major challenges and remedial actions

Eritrea's declared health policy as the provision of high quality health services and the prevention of HIV/AIDS. Despite the encouraging outcome of the national HIV/AIDS response, Eritrea still faces strategic challenges which must be addressed in order to achieve the Universal Access Targets set for Eritrean HIV response, and subsequently achieve the goals set by NATCoD in 2007. Below are the main challenges identified and suggested actions that have to be carried out to overcome the obstacles.

(i) The current no-war no-peace environment in the post–border war because of Ethiopia's refusal to implement the Boundary Commission Decision has become one of the major challenges to the vigor implementation of the development programs in general and the HIV/AIDS programs in particular in the country. In this no war no peace climate, a large number of people are still internally displaced, and the country's infrastructure and economy have been hampered. The government has been forced to divert resources to support the internally displaced and deportees from Ethiopia competing with resources demands of the country needed for the safeguarding of the country's sovereignty. Competing demands for the limited resources might compromise the national response to HIV/AIDS.

(ii) Inadequate financial resources: Another major challenge facing the government is securing of adequate finance to ensure the fight against HIV/AIDS on sustainable basis. Notwithstanding with the political commitment and the resources allocated on the prevention of HIV/AIDS from the government, the various HIV/AIDS programs are expected to have a very high propensity of recurrent expenditures, particularly that of the care and treatment. The prevention of HIV/AIDS in the country is guided by the principle of equity considerations and that every affected citizen has equal right to prevention care and support. Shortage of finance would be a major obstacle to effectively implement all HIV/AIDS prevention programs. Mobilization of the Eritrean population in the fight against HIV/AIDS would to a greater extent alleviate the anticipated shortage of finance. The financing gap thus needs to be filled in order to unlock the existing financial constraint through increasing the financial inflow from the country bilateral and multilateral development partners for sustaining and expanding the various HIV/AIDS programs.

(iii) Inadequate Behavioural Change: Eritrea has a generalized epidemic with a prevalence rate of 2.38% in the general population and high prevalence rates of HIV in other high risk groups despite the fact that the awareness/knowledge about HIV and transmission is very high among the general population. This implies that the challenge ahead of the country in bringing behavioural change in the society that might lead to the reduction of risk behaviour and subsequently to the reduction of STI and HIV/AIDS. Thus, coordinated effort by all partners has to be strengthened, particularly in the area of IEC targeting this high-risk group. Side by side, a nationwide study on the high risk groups would be required in order to promote further strategies of reduction of risk behaviour based on the findings.

(iv) Insufficient M&E system: periodical activity reports and annual reports of the various interventions in the fight against HIV/AIDS in the country are limited. One of the reasons is because of the delays in sending reports/data from relevant and stakeholders to NATCoD and the time consuming data processing and compiling reports. It is underscored that delays in providing required information is major hindrance for a timely intervention for the prevention of the epidemic. Thus NATCoD should pay more importance to documentation by emphasising on intervention coverage , compiling all quantitative data over harmonized periods and producing all relevant information consistent to the demands of UNGASS . This would allow better visibility of the programs for national and development partners. Timely producing required reports are also helpful for close monitoring on the impact of the various programmatic activities and in getting more support from partners in the future. Thus, the institutional capacity of NATCoD need to be strengthened both in terms of human, financial and infrastructure so that it will have its branches well established in all Zones.

(vi) Slow progress in mainstreaming HIV in development plans:
Mainstreaming as an action is an essential approach for the expansion of and implementing multisectoral response to HIV and AIDS in Eritrea. It is underscored that the health sector remains key but non-health sectors are also major partners in the national response to HIV/AIDS in the country. Notwithstanding with their role in halting HIV/AIDS epidemic in the country, many focal persons of partner organizations were found to be slow in responding and providing the required information. This is tantamount to the lack of HIV/AIDS related policies in their strategic/ development plans and in their action plans as well. As multisectoral action to fight against HIV epidemic requires harmonization and coordination the articulation HIV policies in the sectoral plans and allocating resources to that end will enhance the effectiveness of the various programs on HIV/AIDS in the country. Thus those stakeholders/partners who have not yet mainstreamed HIV/AIDS policies would be urged to do so that the national response to the epidemic will be more effective. It is noteworthy that NATCoD is the lead organization not the only responsible organization in the fight against the epidemic.

VI. Support from the country's development partner

Implementing a strong national HIV prevention program involves more than the selection of an appropriate mix of programmatic actions. It also requires a strong national framework that encourages safe behaviors, reduce vulnerability , maximize the accessibility and effectiveness of HIV prevention services , promote gender equality and women's empowerment , and reduces stigma and discrimination. To mount to a comprehensive, sustained HIV prevention effort with the appropriate coverage and intensity, the required resources have to be in place. Eritrea appreciates the support of development partners in the fight against the epidemic with out which the resource gap: financial, material and technical would have been much wider. To date, our development partners are the key collaborators in our multi-sectoral national response to the epidemic. As discussed and illustrated elsewhere in this document , many of these partners made considerable financial inputs into the various aspects of the fight against the epidemic. However, for government and people of Eritrea in order to continue the fight against HIV/AIDS and to be able to reverse the spread of HIV/AIDS, the country would like development partners to provide support in the following areas:

1. Increase funding from development partners for HIV/AIDS prevention, treatment, care and support for the affected people

Eritrea needs more funding to sustain and expand its various HIV/AIDS programs in order to halt the epidemic and minimize its adverse impacts in the country. This will also ensure that other important national issues such as food security and poverty reduction do not suffer at the expense of HIV/AIDS. Development partners would be required to continue funding the various HIV/AIDS prevention programs so that Eritrea would be able to archive the sixth goal of Millennium Development Goal by 2015.

2. Alignment of development partners' intervention to the priorities set by the government

The alignment of development partners' intervention to the priorities set by the government of Eritrea would prevent a possible overlap of the partners' activities and that of the government. . It would also help in directing the scarce resources to where they are mostly needed and in achieving the Universal Access Targets that have been set to be achieved by 2010 regarding prevention, treatment , care and support.

3. Strengthen the institutional capacity of NATCoD

Capacity building is required to improve management skills, to enhance absorption capacity and to ensure efficient program implementation. There are several functions in the HIV/AIDS response, which need to be strengthened. This includes data collection on BCC, information management in terms of its storage, analysis, reports and its distribution. Since policy decisions are taken on the basis of the findings generated from these data, it is underscored that data/information provided must be of acceptable quality in order to be of use for decision making and monitoring impacts of HIV prevention programs. There is, therefore, a dire need for personnel to be trained and infrastructure

to be created in all Zones of the country. Capacity buildings of the organizations which involve in the fight against HIV/AIDS would also help to produce reports that could be easily monitored the outcome by the development partners of the country.

VII. Monitoring and Evaluation Systems

Monitoring and evaluation are essential to determine whether programs are reaching target populations accomplishing their objectives. This information is also needed to acquire additional resources by showing proof money well spent. It also helps in refining interventions for maximum impact, tracking increasing access to services and supporting the information needs of new partners.

In Eritrea, a number of surveys, research and/or routine data collection have or are being conducted to assess the spread of HIV, AIDS and STIs, to assess risk behaviors associated with an increased risk of HIV transmission, and to determine factors that would influence the implementation of activities under the HIV response. However, efforts are being made to integrate these systems so as to enable NATCoD have one M&E system that responds to all of its program needs.

In 2005 Eritrea has formulated a well articulated National HIV/AIDS/STI Monitoring and Evaluation Plan (GOE, 2005). The goal of the National HIV/AIDS Monitoring and Evaluation Framework is, therefore, to guide collection, analysis, use, and dissemination of information that enables the tracking of progress made in response to HIV/AIDS and enhances informed decision-making. The Framework provides an environment for inclusion of new fresh ideas on Monitoring and Evaluation and improvement of indicators in line with efforts done by experts and organizations working on Monitoring and Evaluation of HIV/AIDS. It is in line with and forms part of the National Strategic Plan. M&E has been designed according to a process incorporating contributions from various government organs, and development partners. It meets international-level requirements regarding monitoring-evaluation requirements for the indicators related to the United Nations' Declaration on HIV/AIDS. This plan includes a series of resources, process, product, and result and impact indicators. It also indicates the data collection tools, collection method, data sources and frequency. The Framework is guided by the "Three Ones" Principles: one agreed AIDS action framework that provides the basis for coordinating the work of all partners, one national AIDS Coordinating Authority with a Broad-based multisectoral mandate, and one agreed country level Monitoring and Evaluation system on HIV/AIDS.

The national monitoring-evaluation plan is now up but because of the relatively large data base needed on the one hand and the low institutional capacity of the Monitoring and Evaluation organization on the other hand, there is a still a major weaknesses in the M&E aspect of the prevention activities against the HIV/AIDS epidemic. The development partners, particularly the UNAIDS can play its role in providing the necessary technical support to this young system so that it will be able to conduct monitoring and evaluation activities regularly.

Annexes

SECTION A

I.STRATEGIC PLAN

1. Has the country developed a national multi-sectoral strategy/ action framework to combat HIV/AIDS?

Yes	Period covered **- 1997-2002; 2003-2007**

1.1.How long has the country had a multisectoral strategy/ framework?
Number of Years: **10 Years**

1.2 ***IF YES***, which sectors are included in the multisectoral strategy/action framework with a specific budget for their activities?

Sectors included	**Strategy/Action Framework**	**Earmarked Budget**
Health	**Yes**	**Yes**
Education	**Yes**	**Yes**
Labor	**Yes**	**Yes**
Transportation	**Yes**	**Yes**
Military (Police)	**Yes**	**Yes**
Women	**Yes**	**Yes**
Young people	**Yes**	**Yes**
Others: Defense, Information, FBO, CBO, CSO	**Yes**	**Yes**

1.3 ***IF YES***, does the national strategy/action framework address the following target populations, target population and cross cutting issues? (Yes/No)

Target populations	
a. Women and girls?	**Yes**
b. Youth	**Yes**
c. Most-at-risk populations	**Yes**
d. Orphans and other vulnerable children	**Yes**
Settings	
e. Workplace	**Yes**
f. Schools	**Yes**
g. Prisons	**Yes**
Cross-cutting issues	
h. HIV, AIDS and Poverty	**Yes**
i. Human rights protection	**Yes**

j. PLWHA	**Yes**
k. Addressing stigma and discrimination	**Yes**
l. Gender empowerment/or gender equality	**Yes**

1.4 Were target populations identified through a process of a needs assessment or needs analysis?

Yes	No
√	

IF YES, when was the needs assessment/analysis conducted? **2001, 2004, 2006**

1.5 What are the target populations in the country?

- Commercial sex workers
- PLWHA
- Women
- Workers
- Truck drivers
- Young people in school and out of school
- TB patients

1.6 ***IF YES***, does the multisectoral strategy include an operational plan?

Yes	No
√	

1.8 Has the country ensured "full involvement and participation" of civil society in the development of the multisectoral strategy/action framework?

Active involvement	Moderate involvement	No involvement
√		

IF active involvement, briefly explain how this was done:

A task force was established representing constituencies to guide the head consultant. This was followed by a series of consultative meetings. The consultant has made situation analysis to guide the strategic plan. The draft strategic plan was circulated to all stakeholders and after finalized it was disseminated.

1.9 Has the multisectoral strategy/action framework been endorsed by most external development partners (bi-laterals; multi-laterals)?

Yes	No
√	

1.10 Have external Development Partners (bi-laterals; multi-laterals) aligned and harmonized their HIV and AIDS programs to the national multisectoral strategy/action framework?

Yes, all partners	Yes, some partners	No
	√	

IF SOME or NO, briefly explain:
They are all guided by the National strategic plan and NATCoD –the body authorized to coordinate the fight against HIV and AIDS epidemic

2. Has the country integrated HIV/AIDS into its general development plans (such as: a) National Development Plans, b) United Nations Development Assistance Framework, c) Poverty reduction Strategy Papers, and d) Common country assessments) **Yes**

Yes	No	N/A
√		

2.**1 IF YES**, in which development plans is policy support for HIV and AIDS integrated?
a)_____ b)__√__ c__√__d)____ e) other

2.2 **IF YES**, which policy areas below are included in these development plans?

Policy Area	**Development Plans**				
	a)	**b)**	**c)**	**d)**	**e)**
HIV prevention		√	√		
Treatment for opportunistic infections		√			
Antiretroviral therapy		√			
Care and support (including social security and other schemes)		√	√		
AIDS impact alleviation		√			
Reduction of gender inequalities as they relate to HIV prevention/treatment, care or support		√	√		
Reduction of income inequalities as they relate to HIV prevention/treatment, care or support					
Reduction of stigma and discrimination		√	√		
Women's economic empowerment (access to credit, access to land, training)		√	√		

2. Has the country evaluated the impact of HIV/AIDS on its socio-economic development for planning purposes?

Yes	No	N/A
	√	

4. Does the country have a strategy/action framework for addressing HIV/AIDS issues among its national uninformed services, military, police, peacekeepers and prison staff?

Yes	No
√	

4.1 ***IF YES***, which of the following programmes have been implemented?

Programs	Yes	No
Behavioral change communication	√	
Condom provision	√	
HIV testing and counseling*	√	
STI services	√	
Treatment	√	
Care and support	√	
Others		

**** What is the approach taken to HIV testing and counseling?*** Is HIV testing voluntary or mandatory? Briefly explain:

It is mandatory for the military but voluntary for police, peacekeepers, and prison staff.

5. Has the country followed up on commitments toward universal access made during the High-Level AIDS review in June 2006?

Yes	No
√	

5.1 Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?

Yes	No
	√

Comment*: In the coming National strategic plan (2008-2012) Universal Access will be the guiding principle for National strategic Plan and operational plan.*

5.2 Have the estimates of the size of the main target population sub-groups been updated?

Yes	No
√	

5.3 Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?

Estimates and projected needs	Estimates only	No
	√	

5.4 Is HIV and AIDS coverage programme coverage being implemented?

Yes	No
√	

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes	No
	√

(b) ***IF YES***, is coverage monitored by population sub-groups?

Yes	No
	√

IF YES, which population sub-groups?
Population groups 15-49 and children under 15 years of age

(c) Is coverage monitored by geographical area?

Yes	No
√	

IF YES, at which level (provincial, district, other)
The country is divided into six zones (regions) and 57 sub zones (sub-regions) and HIV and AIDS is monitored at zonal and sub-zonal level.

5.5 Has the country developed a plan to strengthen health system, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes	No
√	

Overall, how would you rate the strategy panning effort in the HIV and AIDS programmes in 2007 and in 2005?

2007	Poor										Good
	0	1	2	3	4	5	6	7	**8**	9	10
2005	Poor										Good
	0	1	2	3	4	**5**	6	7	8	9	10

Comments on progress made since 2005:

I. POLITICAL SUPPORT

Strong political support include government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programs and effective use of government and civil society organizations and processes to support effective AIDS programmes.

1. Do high officials speak publicly and favorably about AIDS efforts in major domestic fora at least twice a year?

Yes	No
√	
√	
√	

- President/head of government
- Other high officials
- Other officials in regions and/or districts

2. Does the country have an officially recognized national multisectoral HIV/AIDS management/coordination body

Yes	No
√	

2.1 ***IF YES***, when it was created? Year
In 1992 which was soon after independence in 1991.

2.2 ***IF YES***, who is the chair?
Dr. Andebrehan Tesfazion Director of National HIV/AIDS/STI and TB Control Division in the Ministry of Health. There is also a National Steering Committee composed of ministries and zonal administrators which is chaired by the Minister of Health H.E. Mr. Saleh Meki.

2.3 ***IF YES***, does it?

Have terms of trade?	**Yes**	
Have active government leadership and participation?	**Yes**	
Have a defined membership? Include civil society participation? Include people living with HIV? Include the private sector?	**Yes**	 **No** **No** **No**
Have an action plan	**Yes**	
Have a functional secretariat	**Yes**	
Meet at least quarterly? Review actions on policy decisions regularly? Actively promote policy decisions? Provide opportunity for civil society to influence decision-making? Strengthen donor coordination to avoid parallel funding and duplication of efforts in programming and reporting?	**Yes** **Yes** **Yes** **Yes** **Yes**	

3. Does the country have a national HIV/AIDS body or other mechanism that promotes interaction between government, PLHA, the private sector and civil society for implementing HIV/AIDS strategies or programs

Yes	No
√	

3.1 **IF YES**, does it include

Terms of reference	**Yes**
Defined membership	**Yes**
Action plan	**Yes**
Functional secretariat	**Yes**
Regular meeting Frequency of meeting**:**	**Yes** **Quarterly**

IF YES, what are the main achievements?
Coordination and resource mobilization. It's also helpful to harmonize efforts and avoid duplication of work and misuse of resources.

IF YES, What are the main challenges for the work of this body?
Resources are limited and there is always competition for resources by implementers

4. What percentage of the national HIV/AIDS budget was spent on activities implemented by civil society in the past year?

Percentage: **15%**

5. What kind of support does the NAC (or Equivalent) provide to implementing partners of the national program, particularly to civil society organizations?

Information on priority needs and services	**Yes**
Technical guidance/materials	**Yes**
Drugs/supplies procurement and distribution	**Yes**
Coordination with other implementing partners	**Yes**
Capacity-building	**Yes**
Others	

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes	No
√	

6.1 **IF YES**, were policies and legislation amended to be consistent with the National AIDS Control policies?

Yes	No
√	

6.2 IF YES, which policies and legislation were amended and when?

Policy/Law :	**Year**:
• HIV testing	• 2005
• ARV policy	• 2005

Overall, how would you rate the strategy panning effort in the HIV and AIDS programmes in 2007 and in 2005?

2007 Poor Good

0 1 2 3 4 5 6 7 **8** 9 10

2005 Poor Good

0 1 2 3 **4** 5 6 7 8 9 10

Comments on progress made since 2005:

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education, and communication (IEC) on HIV/AIDS to the general population?

Yes	No	N/A
√		

1.1 ***IF YES***, what key messages are explicitly promoted?

Be sexually abstinent	√
Delay sexual debut	√
Be faithful	√
Reduce the number of sexual partners	√
Use condoms consistently	√
Engage in safe sex	√
Avoid commercial sex	√
Abstain from injecting drugs	N/A
Use clean needles and syringes	N/A
Fight violence against women	√
Greater acceptance and involvement of people living with HIV	√
Greater involvement of men in reproductive health programs	√
Others : Know your HIV status	√

1.2 In the last year, did the country implement an activity or program to promote accurate reporting on HIV by the media?

Yes	No
√	

2. Does the country have a policy or strategy promoting HIV/AIDS related reproductive and sexual health education for young people?

Yes	No
√	

2.1 Is HIV education part of the curriculum in:

	Yes	No
- primary schools?	√	
- secondary schools?	√	
- teacher training?	√	

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes	No
√	

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes	No
√	

3. Does the country have a policy or strategy to promote IEC and other preventive health interventions for most-at-risk populations?

Yes	No
√	

3.1 **IF YES,** which sub-populations and what elements of HIV prevention do the policy/strategy address?

	IDU	**MSM**	**Sex workers**	**Clients of sex workers**	**Prison inmates**	**Other sub-populations (truck drivers)**
Targeted information on risk reduction and HIV education	**N/A**	**N/A**	√	√	√	√
Stigma & discrimination reduction	**N/A**	**N/A**	√	√	√	√
Condom promotion	**N/A**	**N/A**	√	√	√	√
HIV testing and counseling	**N/A**	**N/A**	√	√	√	√
Reproductive health, including STI prevention and treatment	**N/A**	**N/A**	√	√	√	√
Vulnerability reduction (e.g. income generation)	**N/A**	**N/A**	√	**N/A**	**N/A**	
Drug substitution therapy	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	
Needle and syringe exchange	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	

Overall, how would you rate the policy efforts in support of HIV and AIDS programmes in 2007 and in 2005?

2007	Poor										Good
	0	1	2	3	4	5	6	7	**8**	9	10
2005	Poor										Good
	0	1	2	3	**4**	5	6	7	8	9	10

Comments on progress made since 2005:

Interventions were intensive, where HIV/AIDS at workplace have been developed in some sectors.

- *Prevention has been intensified since the government has declared that prevention is the priority of national response in its HIV/AIDS/STDS policy guidelines issued in 2005.*
- *Policy and Guidelines for managing HIV and AIDS at the Workplace that will enhance job safety of the workers and prevention of the spread of HIV/AIDS in the workplace have been finalized.*

4. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes?

Yes	No
√	

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?

HIV prevention programmes	The activity is available in		
	All districts in need	**Most districts in need**	**Some districts in need**
Blood safety	√		
Universal precautions in health care settings	√		
Prevention of mother-to-child transmission of HIV	√		
IEC on risk reduction	√		
IEC on stigma and discrimination reduction	√		
Condom promotion	√		
HIV testing and counseling	√		
Harm reduction for injecting drug users	N/A		
Risk reduction for men who have sex with men	N/A		
Risk reduction for sex workers	√		
Programmes for other vulnerable sub-populations	√		
Reproductive health services including STI prevention and treatment	√		
School-based AIDS education for young people	√		
Programmes for out-of-school young people	√		
HIV prevention in the work place	√		
Others			

- *Districts or equivalent de-centralized governmental level in urban and rural areas*

Overall, how would you rate the efforts in the implementation of HIV and AIDS prevention programmes in 2007 and in 2005?

2007	Poor										Good
	0	1	2	3	4	5	6	7	**8**	9	10
2005	Poor										Good
	0	1	2	3	4	**5**	6	7	8	9	10

Comments on progress made since 2005:

- ART sites which were only 5 in 2005 are raised to 14 sites in 2007.
- *Life skill education has been introduced in all junior and secondary schools since 2005.*
- *More VCT were opened*
- *More multisectoral participation in the prevention programme*

IV. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counseling, psychosocial care, and home and community-based care.)

Yes	No
√	

1.1 ***IF YES,*** does it give sufficient attention to barriers for women, children, and most-at-risk populations?

Yes	No
√	

2. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care, support and services?

Yes	No	N/A
√		

IF YES, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts *in need?

HIV treatment, care and support services	The service is available in		
	All districts in need	Most districts in need	Some districts in need
Antiretroviral therapy	√		
Nutrition care	√		
Pediatric AIDS treatment			√
Sexually transmitted infection management	√		
Psychological support for people living with HIV and their families	√		
Home-based care	√		
Palliative care and treatment of common HIV-related infections	√		
HIV testing and counseling for TB patients	√		
TB screening for HIV infected people		√	
TB preventive therapy for HIV infected people			√
TB infection control in HIV treatment and care facilities	√		
Contrimoxazole prophylaxis in HIV infected people	√		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	√		
HIV treatment services in the work place or treatment referral system through the work place			√
HIV care and support in the work place (including alternative working arrangements)	√		
Others			

** Districts or equivalent de-centralized governmental level in urban and rural areas*

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes	No
√	

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral **drugs**, condoms, and substitution drugs?

Yes	No
√	

4.1 ***IF YES,*** for which commodities?

Antiretroviral drugs, condom and medicines for opportunistic infections.

5. Does the country have a policy or strategy to address the additional HIV-or AIDS-related needs of orphans and other vulnerable children (OVC)?

Yes	No	N/A
√		

5.1 ***IF YES***, is there an operational definition for OVC in the country?

Yes	No
√	

5.2 ***IF YES***, does the country have a national action plan specifically for OVC?

Yes	No
√	

5.3 ***IF YES***, does the country have estimates of OVC being reached by existing interventions?

Yes	No
√	

IF YES, what percentage of OVC is being reached? N/A

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?

2007	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10
2005	Poor										Good
	0	1	2	3	4	**5**	6	7	8	9	10

Comments on progress made since 2005:

The government through the Ministry of Labour and Human Welfare is intensifying its efforts to support orphans and vulnerable children though households receiving support. The government has been using community rehabilitation of OVC.

V. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes	Years Covered	In progress	No
		√	

2. Does the M&E plan include?

a data collection and analysis strategy	**Yes**
behavioral surveillance	**Yes**
HIV surveillance	**Yes**
a well-defined standardized set of indicators	**Yes**
guidelines on tools for data collection	**Yes**
a strategy for assessing quality and accuracy of data	**No**
a data dissemination and use strategy	**Yes**

3. Is there a budget for the M & E plan?

Yes	Years Covered	In progress	No
		√	

4. Is there a functional M&E unit or Department?

Yes	In progress	No
√		

4.1 ***IF YES***, is the M&E Unit/Department based

in the NAC (or equivalent)?	**Yes**
in the Ministry of Health ?	**Yes**
Elsewhere	

4.2 IF YES, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Number of permanent staff		
Position: **Head of M & E unit**	**Full time**/part time	Since when? **2003**
Position:	Full time/part time	Since when?
Position:	Full time/part time	Since when?
Position:	Full time/part time	Since when?

Number of temporary staff	

4.3 ***IF YES,*** are there mechanisms in place to ensure that all major implementing partners submit their M&E reports to the M&E Unit/Department for review and consideration in the country's national reports?

Yes	No
√	

IF YES, does this mechanism work? What are the major challenges?

There is a monthly report format to collect data from most of the implementers specifically for VCT/PMTCT/HBC/BCC and ART

However, some implementers are not sending their reports regularly

4.4 ***IF YES***, to what degree do UN, bi-laterals, and other institutions share their M&E results?

Low High

0 1 2 3 4 **5**

5. Is there an M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	Yes, but meets irregularly	Yes, meets regularly
√		

5.1 Does it include representation from civil society, including people living with HIV?

Yes	No
	√

6. Does the M&E Unit/Department manage a central national database?

Yes	No	N/A
√		

6.1 IF YES, what type is it?

- Excel data base
- SPSS date base
- Soft ware based in access date base

6.2 IF YES, does it include information about the content, target populations and geographical coverage of programmatic activities as well as their implementing organizations?

Yes	No
√	

6.3 Is there a functional Health Information system?

National level	**Yes**
Sub-national level IF YES, at what level(s)? at Unit level	**Yes**

6.4 Does the country publish at least once a year an M&E reports on HIV, including HIV surveillance data?

Yes	**No**
	√

7. To what extent is M&E data used in planning and implementation?

Low					High
0	1	2	3	**4**	5

What are examples of data use?

- *Procurement of ARVs and HIV test kits*
- *Addressing high risk groups*
- *STI?HIV/AIDS data*
- *VCT/PMTCT data*

What are the challenges to data use?

- *Its reliability*
- *Completeness*
- *Timeliness*

8. In the last year, was training in M&E conducted

At national levels?	**Yes**
IF YES, Number of individuals trained	60
At sub-national levels?	**Yes**
IF YES, Number of individuals trained	200
Including civil society	**Yes**
IF YES, Number of individuals trained	30

Overall, how would you rate the M & E efforts of the HIV and AIDS programme in 2007 and in 2005vulnerable?

2007	Poor										Good
	0	1	2	3	4	5	6	7	**8**	9	10
2005	Poor										Good
	0	1	2	3	4	**5**	6	7	8	9	10

Comments on progress made since 2005:

- *The surveillance system of HIV/AIDS and STI has been strengthened*
- *The health management information system is strengthening*
- *Training is being given to members of the M&E*

SECTION B

CIVIL SOCIETIES AND NGO RESPONSES

I. HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV/AIDS against discrimination (such as general nondiscrimination provisions or those that specifically mention HIV, that focus on schooling, housing, employment, etc.)?

Yes	No
√	

1.1 **IF YES**, specify:

Comments: *The Constitution of Eritrea contains broad equality provisions that prohibit discrimination on a range of listed grounds as well as on the basis of " any other improper factors". Article 7 of the Constitution states that act that violates the human rights of the women or limits or otherwise thwarts their role and participation is prohibited. Article 21 notes that every citizen has the right to equal access to publicly funded social services and that the state shall Endeavour to make available to citizens health, education, cultural and other social services.*

2. Does the country have non-discrimination laws or regulations which specify protections for vulnerable sub-populations?

Yes	No
√	

2.1 IF YES, for which sub populations?

Women	**Yes**
Young people	**Yes**
IDU	**N/A**
MSM	**N/A**
Sex workers	**Yes**
Prison inmates	**Yes**
Migrants/mobile population	**Yes**
others	

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

- There is a policy on HIV/AIDS by the Ministry of Health
- People are not discriminated for recruitment because of their HIV status
- Adequate recognition and support is given to the association of people living with HIV/AIDS

IF YES, describe any system of redress put in place to redress the laws are having their desired effect:

- Through creating awareness on their right

3. Does the country have laws and regulations that present obstacles to effective HIV Prevention and care for most-at-risk populations?

Yes	No
	√

4. Is the promotion and protection of human rights explicitly mentioned in any HIV/AIDS policy/strategy?

Yes	No
√	

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations.

Yes	No
√	

IF YES, briefly describe the mechanism

- A number of studies have been conducted to streamline appropriate actions
- A number of organizations are now developing HIV/AIDS policy in the work place and this would give them a means of addressing cases, if any.

6. Has the Government, through political and financial support, involved most-at-risk population in governmental HIV-policy design and programme implementation?

Yes	No
√	

IF YES, describe some examples

- Formation BDHO Association- people living with HIV and their involvement in policy design and program implementation

7. Does the country have a policy of free service for the following?

HIV prevention services	**Yes**
Anti-retroviral treatment	**Yes**
HIV-related care and support interventions	**Yes**

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies:

- Anti-retroviral is freely distributed
- Testing and counseling is voluntary and free
- Condoms are sold at nominal price by ESMG

8. Does the country have a policy to ensure equal access formen and women, to prevention, care and support? In particular to ensure access for women out side the context of pregnancy and child birth?

Yes	**No**
√	

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support prevention and care for most-at-risk populations?

Yes	**No**
√	

9.1 Are there differences in approaches for different most-at-risk populations?

Yes	**No**
√	

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation appointment, promotion, termination)?

Yes	**No**
√	

11.Does the country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes	**No**
√	

11.1 ***IF YES***, does the ethical review committee include representatives of civil society and people living with HIV?

Yes	**No**
	√

Comments: The national Blood Bank is in charge of to all research related to blood in order to adhere to ethical issues

12. Does the country have the following human rights monitoring and enforcement mechanisms?

- Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions and ombudspersons which consider HIV/AIDS related issues within their work

Yes	No
	√

- Focal points within governmental health and other departments to monitor HIV-related human rights abuse and HIV related discrimination in areas such as housing and employment

Yes	No
√	

- Performance indicators or benchmarks for

a) compliance with human rights standards in the context of HIV/AIDS efforts

Yes	No
√	

b) reduction of HIV-related stigma and discrimination

Yes	No
√	

IF YES, on any of the above questions, describe some examples:

- Timely reports
- Evaluation and analysis
- Committees at different sectors and levels

13. Have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV/AIDS and human rights issues that may come up in the context of their work?

Yes	No
√	

Comments:

14. Are the following legal support services available in the country?

- Legal aid systems for HIV/AIDS casework

Yes	No
	√

-State support to private sector laws firms or university based centers to provide free pro bono legal services to people living with HIV/AIDS in areas such as discrimination

Yes	No
	√

- Programmes to educate, raise awareness among people living with HIV/AIDS concerning their rights

Yes	No
√	

15. Are there programmes designed to change **societal attitudes** of stigmatization associated with HIV/AIDS to understanding and acceptance?

Yes	No
√	

IF YES, what type of programmes?

Media	**Yes**
School education	**Yes**
Personalities regularly speaking out	**Yes**
Others	**Yes**

Overall, how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2007 and in 2005?

2007 Poor Good

0 1 2 3 4 5 6 **7** 8 9 10

2005 Poor Good

0 1 2 3 4 5 **6** 7 8 9 10

Comments on progress made since 2005:

- *BIDHO-the association of people living with HIV promotes and protects the rights of those PLHA*

Overall, how would you rate the efforts to enforce the existing policies, laws and regulations in 2007 and in 2005?

2007	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10
2005	Poor										Good
	0	1	2	3	4	5	**6**	7	8	9	10

Comments on progress made since 2005:

- *Intensive awareness raising campaigns on human rights were conducted since 2005.*

II. CIVIL SOCIETY PARTICIPATION

1. To what extent civil society contributed to strengthening the political commitment of top leaders and national policy formulation?

Low					High
0	1	2	**3**	4	5

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV/AIDS or for the current activity plan (attending planning meetings and reviewing drafts)?

Low					High
0	1	2	3	**4**	5

3. To what extent are the services provided by civil society in areas HIV of prevention, treatment, care and support included

a. in both the National Strategic plan and national reports?

Low					High
0	1	2	3	**4**	5

b. in the national budget?

Low					High
0	1	2	**3**	4	5

4 Has the country included civil society in a National Review of the **Strategic** Plan?

Yes	**No**
√	

Month/Year **2003**

5. To what extent is the civil society sector representation in HIV-related efforts inclusive of its diversity?

Low					High
0	1	2	3	**4**	5

List the type of organizations representing civil society in HIV and AIDS efforts:

- National Youth and Women's Association
- National Confederation of workers
- Faith based organizations
- Association of people living with HIV (BIDHO)

6. To what extent is the civil society able to access

a. adequate financial support to implement its HIV activities?

Low					High
0	1	2	**3**	**4**	5

b. adequate technical support to implement its HIV activities?

Low					High
0	1	2	**3**	4	5

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?

2007	Poor										Good
	0	1	2	3	4	5	6	7	**8**	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10

Comments on progress made since 2005:

- *HAMSET control project encourages the involvement of civil societies*
- *More NGOs and FBOs mostly local are involving in HIV and AIDS programme designing and implementation*

III. PREVENTION

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention prgrammes?

Yes	No
√	

IF YES, to what extent have the following HIV prevention progrmmes been implemented in identified districts in need?

HIV prevention programmes	The services is available in		
	All districts in need	Most districts in need	Some districts in need
Blood safety	√		
Universal precautions in health care settings	√		
Prevention of mother-to-child transmission of HIV	√		
IEC on risk reduction	√		
IEC on stigma and discrimination reduction	√		
Condom promotion	√		
HIV testing and counseling	√		
Harm reduction for injecting drug users	N/A		
Risk reduction for men who have sex with men	N/A		
Risk reduction for sex workers	√		
Programmes for other most-at-risk populations	√		
Reproductive health services including STI prevention and treatment	√		
School-based AIDS education for young people	√		
Programmes for out-of-school young people	√		
HIV prevention in the work place	√		
Others	√		

Overall, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?

2007	Poor										Good
	0	1	2	3	4	5	6	7	**8**	9	10
2005	Poor										Good
	0	1	2	3	4	5	6	**7**	8	9	10

Comments on progress made since 2005:

- *Civil society communication and participation has been strengthened*
- *Efforts to scale up programmes have been undertaken*
- *NGOs and the government have scaled up prevention efforts through the opening of VCT, PMTCT intervention with sex workers, truck drivers, school based life education*

IV. TREATMENT, CARE AND SUPPORT

1. Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV and AIDS treatment, care and support services?

Yes	No
√	

IF YES, to what extent have the following HIV prevention progrmmes been implemented in identified districts in need?

HIV treatment, care and support services	**The services available in**		
	All districts in need	Most districts in need	Some districts in need
Antiretroviral therapy		√	
Nutrition care	√		
Paediatric AIDS treatment		√	
Sexually transmitted infection management	√		
Psychological support for people living with HIV and their families	√		
Home-based care	√		
Palliative care and treatment of common HIV-related infections	√		
HIV testing and counseling for TB patients	√		
TB screening for HIV infected people	√		
TB preventive therapy for HIV infected people	√		
TB infection control in HIV treatment and care facilities	√		
Contrimoxazole prophylaxis in HIV infected people	√		
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)			√
HIV treatment services in the work place or treatment referral system through the work place			√
HIV care and support in the work place (including alternative working arrangements)			√
Others			

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2007 and in 2005?

2007 Poor Good

0	1	2	3	4	5	6	**7**	8	9	10

2005 Poor Good

0	1	2	3	4	**5**	6	7	8	9	10

Comments on progress made since 2005:

- *Ratification of ART policy in 2005*
- *Provision of ART for free reflects government commitment*
- *VCT and PMTCT are expanding at district level*
- *An assessment was conducted and this has helped to make an informed decision for scaling up activities.*

2. What percentage of the following HIV programmes or services is estimated to be provided by civil society?

Prevention for youth	<25%	25-50%	50-75%	**>75%**
Prevention for vulnerable sub-populations				
• IDU	<25%	25-50%	50-75%	>75%
• MSM	<25%	25-50%	50-75%	>75%
• Sex workers	<25%	**25-50%**	50-75%	>75%
Counseling and testing	<25%	25-50%	50-75%	>75%
Clinical services (OI/ART)*	<25%	25-50%	50-75%	>75%
Home-based care	<25%	25-50%	50-75%	>75%
Programmes for OVC**	<25%	25-50%	50-75%	>75%

3. Does the country have a policy or strategy to address the additional HIV/AIDS related needs of orphans and other vulnerable children (OVC)?

Yes	No	N/A
√		

3.1 IF YES, is there an operational definition for OVC in the country?

Yes	No
√	

3.2 IF YES, does the country have a national action plan specifically for OVC

Yes	No
√	

3.3 IF YES, does the country have an estimate of OVC being reached by existing interventions?

Yes	No
√	

3.4. IF YES, What percentage of OVC is being reached?

References

ESMG(2006) 2006 Annual Report
ESMG(2005) Consumer Profile Survey , 2004
Government of Eritrea (2005) National HIV/AIDS/STIs Monitoring and Evaluation Plan
Government of Eritrea , 2006 National Blood Transfusion Policy of Eritrea
Katabira, Elly T. and Stein, Zena (2002) Home-based Care. In: Essex et al (eds), AIDS in Africa Kluwer Academic Publishers, New York
Ministry of Education (20070 Statistical Office
Ministry of Health 2003, HIV Prevention Impact in Eritrea
Ministry of Health 2007, Financial report
NATCoD/MOH (2006) Eritrean HIV/AIDS Care Manual: Treatment and Prevention of Opportunistic. Infections
NATCoD/MOH (2006) Report of the 2005 Round HIV & Syphilis Sentinel Surveillance in ANC Attendee Women in Eritrea
NATCoD/MOH (2006) LQAS Survey Report
UNAIDS(2003) Fighting AIDS: HIV/AIDS Prevention and Care among armed forces and UN Peacekeepers: The Case of Eritrea
UNAIDS, (2006) , Report on the global AIDS epidemic
UNDP (2001) Human Development Report 2001: Making New Technologies Work for Human Development. Oxford University Press, Oxford.
UNDP (2006) A Review of Regional and National Human Rights Based HIV and AIDS Policies and Frameworks in Eastern and Southern Africa: UNDP-OHCHR Joint Initiative for Eastern and Southern Africa