

Five-Year Partnership Framework in Support of the
Ethiopian National Response to HIV/AIDS
2010 - 2014

Between

The Government of the Federal Democratic
Republic of Ethiopia and the
Government of the United States of America

Acronyms

ABC	Abstinence, Be faithful, Condom use
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Treatment
BCC	Behavior Change Communication
CHAI	Clinton Health Access Initiative
CSO	Civil Society Organizations
CT	Counseling and Testing
DFID	Department for International Development
EHNRI	Ethiopian Health and Nutrition Research Institute
EID	Early Infant Diagnosis
FBOs	Faith-Based Organizations
FGM	Female Genital Mutilation
GF(ATM)	Global Fund (to fight AIDS, Tuberculosis and Malaria)
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home-Based Care
HEW	Health Extension Worker
HSS	Health Systems Strengthening
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSDP IV	Health Sector Development Program (2010/11-2014/15)
IGAs	Income Generating Activities
IHP+	International Health Partnership
LMIS	Logistics Management Information System
MAP	Multi-Country HIV/AIDS Program
MARPs	Most At Risk Populations
MCP	Multiple Concurrent Partner
MDG	Millennium Development Goals
M & E	Monitoring and Evaluation
MNCH	Maternal Neonatal and Child Health
MOE	Ministry of Education
MOH	Ministry of Health
NASA	National AIDS Spending Assessment
NHA	National Health Account
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PBS	Population Based Survey
PEPFAR	United States President's Emergency Plan for AIDS Relief
PF	Partnership Framework
PFIP	Partnership Framework Implementation Plan
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care unit

PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PR	Principal Recipient
SI	Strategic Information
SNNPR	Southern Nations & Nationalities and Peoples Region
SOP	Standard Operating Procedure
SPM-I	Strategic Plan for Intensifying Multisectoral HIV and AIDS response in Ethiopia I (2004-08)
SPM-II	Strategic Plan for Intensifying Multisectoral HIV and AIDS response in Ethiopia II (2010-2014)
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
UHEW	Urban Health Extension Worker
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	The United Nations Children's Fund
VAT	Value Added Tax
WB	World Bank
WFP	World Food Program
WHO	World Health Organization

I. Purpose and Principles

This Partnership Framework reflects the outcome of joint discussions and respective contributions of the Government of Ethiopia (GOE) and the Government of the United States of America (U.S. Government) (hereinafter the Participants) to collaboratively expand, and sustain an effective response to the HIV/AIDS epidemic in Ethiopia over the next five years. The Partnership Framework goals and objectives are consistent with Ethiopia's Strategic Plan for Intensifying Multisectoral HIV/AIDS Response in Ethiopia 2010-2014 (SPM II) and the Health Sector Development Plan IV 2010/11-2014/15 (HSDP IV), the strategic plan of the President's Emergency Plan for AIDS Relief (PEPFAR), and the principles of the U.S. government's Global Health Initiative. The Partnership Framework also seeks to ensure that U.S. Government contributions towards the SPM II and broader health sector development programs complement and leverage other stakeholders.

Through the signing of this Partnership Framework, both governments acknowledge a shared desire to strengthen their relationship, and increase the effectiveness, efficiency and sustainability of the national response to the HIV/AIDS epidemic in Ethiopia. The Partnership Framework supports the Government of Ethiopia's unique leadership role in coordinating and mainstreaming efforts among many sectors to create an efficient, effective and sustainable response to HIV/AIDS in Ethiopia. The Partnership Framework is intended to work in close collaboration with other Ethiopian collaborative arrangements such as the International Health Partnership (IHP+) and other multilateral and bilateral relationships.

This Partnership Framework between the GOE and the U.S. Government also articulates the joint understanding and commitment to the following principles to guide how the two governments intend to combine efforts to combat HIV/AIDS in Ethiopia:

Country Leadership: The Partnership Framework supports Ethiopian national plans and priorities, is responsive to national planning processes, and seeks to uphold national high level leadership and continued ownership of the response by the Government and people of Ethiopia.

Cooperation and Partnership: The Partnership Framework outlines plans to strengthen the ongoing relationship between the GOE and U.S. Government and recognizes the need to increase the GOE's management and financial responsibility for the national HIV/AIDS response. The Framework also builds upon a foundation of an organized and concerted joint planning effort from all stakeholders, including multiple government sectors, private sector, civil society, faith-based organizations, donor organizations, people living with HIV/AIDS, and communities at large to enhance HIV/AIDS programs.

Evidence based and strategic decision making: The HIV/AIDS response should be led by planning for implementation of programs that have evidence supporting their effectiveness. Programs should be rigorously monitored and evaluated. Decision making should be data driven and be based on the most strategic investment of available resources in order to maximize program impact.

Accountability: The Partnership Framework assumes that the two Governments meet all Framework objectives and may be answerable to interested constituencies. The Partnership

Framework Implementation Plan should outline the schedule and method by which the governments expect to review progress toward Framework objectives.

Equitable, universally-accessible, quality care: The Framework is to be guided by the vision that systems and services related to HIV/AIDS should be equitable, move towards universal access, be of high quality, and support a family and community based approach. Gender inequalities should be addressed by all sectors to ensure more effective HIV/AIDS prevention care, treatment and mitigation programs. Programs should also take into account and work towards ensuring that all people with disabilities receive equitable and accessible standard quality services.

Integration: The Partnership Framework should further support, where possible, the progressive and bi-directional integration of HIV/AIDS interventions with other health services, as well as integration of other needed services into those for HIV/AIDS.

While the U.S. Government's main modality of delivering development assistance is to be project support, U.S. Government investments in Ethiopia should be based on a joint plan, include country leadership in decision-making on where investments are made, be transparent and support the principles of the "Three Ones."

Financial Principles

In addition to the above Principles, the two Governments affirm their understanding of the importance of the following financial principles:

Recognition that, as U.S. Government and GOE resources are limited, prioritization is necessary to achieve the most immediate and durable public health impact, and planned investments are subject to the availability of funds.

Recognition that achievement of national HIV/AIDS goals may require resource levels beyond the ability of any one partner, and that the constraints on availability of funding from either Government or from other key partners may lead to a review and revision of priorities.

Recognition that where U.S. Government assistance is to be provided directly to the GOE under this Partnership Framework, GOE contributions are expected to meet host country cost sharing needs under U.S. foreign assistance programs and progressively cover recurrent expenditures. Details regarding the GOE's financial and/or in-kind contributions to programs under this Partnership Framework are to be provided in the Partnership Framework Implementation Plan.

Recognition that transparency in HIV/AIDS-related resource allocation and expenditures is expected from both Participants.

Recognition that both Participants should continue to work in collaboration with other stakeholders to reduce redundancies and inefficiencies in allocation of HIV resources for HIV/AIDS interventions.



Recognition that both Participants should support full and open competition in the funding of non-governmental implementing partners.

II. Background/Context

Ethiopia has a population of 80 million¹ and is the second most populous country in Sub-Saharan Africa. It is a low-income country with a real per capita income is US \$232² and an estimated 39% of the population living below the international poverty line of \$1.25/day.³ It is also one of the least urbanized countries with 84% of the population living in rural areas.

Although improvements have been made, the health status of Ethiopia is still low, as in other Sub-Saharan countries. This is largely attributable to preventable infectious diseases and nutritional deficiencies associated with poor hygienic conditions, improper waste disposal practices, and insufficient access to clean water. Infectious and communicable diseases account for about 60-80% of the health problems in the country.⁴ Life expectancy is 53 years of age, the infant mortality rate is 77 per 1,000 live births and the child mortality rate is 123 per 1,000 live births. Neonatal mortality contributes 30% of the under 5 mortality, with pneumonia and diarrheal disease contributing an additional 22% and 17% respectively. Access to and use of maternity services is very weak. Ethiopia has a high maternal mortality rate at 673 per 100,000 births and only 20% of births are attended by a skilled attendant. Predictably, neonatal mortality is also high at 39 per 1000 births with asphyxia, sepsis and preterm birth the major contributors.⁵

Ethiopia's HIV/AIDS epidemic has placed substantial demand on the country's already strained resources. Although Ethiopia's 2009 HIV point prevalence estimate of 2.3% is lower than many other Sub-Saharan countries, there are still over 1.1 million people living with HIV in Ethiopia. Of Ethiopia's estimated 5.4 million orphans, 855,720 were orphaned due to AIDS. Prevalence is higher in women than in men (2.8% and 1.8%, respectively). Ethiopia represents a low level generalized epidemic with wide urban to rural differences in prevalence (7.7% and 0.9% respectively), with most at risk groups driving the epidemic.⁶ A National Prevention Summit attended by key stakeholders held in April 2009 reached consensus to strengthen prevention activities and also increase efforts to reach Most at Risk Populations (MARPs) with interventions. Population groups most at risk of HIV infection include female sex workers, migrant workers, long distance drivers, uniformed forces, discordant couples and men having sex with men. Common settings with MARPs include economic and infrastructure

¹ Based on the 2007 National Census (Central Statistical Agency) and extrapolated to include a 2.6% annual population growth rate.

² National 5 Year Growth Transformation Plan, Federal Ministry of Finance & Economic Development, August 2010

³ UN country level statistics, Federal HIV/AIDS Prevention & Control office, Federal Ministry of Health.

⁴ Health Sector Strategic Plan (HSDP III) 2005/06-2009/10. Federal Ministry of Health.

⁵ World Health Organization: The neonatal mortality breakdown is taken from the National child survival Strategy Document (which was based on the situation analysis document prepared before the development strategy).

⁶ Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia (SPM II) 2010-2014.

development schemes, brothels, high transport corridors, refugee camps and surrounding populations.⁷

The Government of Ethiopia has been innovative and has taken an active role in addressing the country's health challenges. This includes a doubling of the treasury budget for health over the past 5 years. Taking into account additional resources obtained through PEPFAR and the Global Fund, the annual per capita expenditure on health has increased from \$7.1 in 2004/5 to \$16.1 in 2007/8⁸, although this is still well below the World Health Organization's recommended \$34 per capita. The contribution of the GOE to HSDP IV is expected to increase from \$249 million in 2009/10 to \$298 million in 2014/15; the 2009/10 contribution is 4.4% of the total national budget. Ethiopia is the largest recipient of grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) which together with PEPFAR resources provided 90% of donor support for HIV/AIDS in 2009. Other donors include the UN Joint Program, the World Bank, UNITAID and other bilateral donors. Ethiopia was one of the first signatories to the International Health Partnership (IHP+).

With PEPFAR support, the GOE has demonstrated strong leadership and commitment to addressing the HIV/AIDS epidemic with significant achievements. This has resulted in increased social mobilization, an expansion of health facilities and services, improved access to antiretroviral treatment (ART), and enhanced efforts to build human capacity. The number of facilities offering counseling and testing has almost tripled from 658 in 2005 to 1596 in 2009; coupled with significant efforts being made in community mobilization through the Millennium AIDS Campaign; as a result, HIV testing increased from 436,854 (2004/5) to 5,800,248 (2008/09). Service expansion and service uptake significantly and consistently increased during the Strategic Plan for Multisectoral Response (SPM I) period (2004-2008). In 2005, only 3 facilities were offering ART; by 2009, these services were available in 481 facilities. From a baseline of 8,226 persons ever started on ART in 2005, over 241,250 were started on treatment by 2009.⁹ As of March 2010, there were 186,154 (62% of estimated need) persons still on ART. The dropout rate of those ever started and the current number of patients on ART is comprised of patients that have died, those that have transferred out, stopped treatment and the "true" lost to follow-up" which is estimated at around 7%. A significant lost to follow up is found among pre-ART patients.

Despite a three-fold increase in the number of sites providing PMTCT, only 8.2% of the estimated eligible number of HIV-infected pregnant women received prophylaxis. Due to limited access to quality ANC and maternity services, the challenges with reaching targets in PMTCT has been acknowledged by the GOE, partners and donors alike. Similarly, even with significant expansion of primary health care facilities, the health sector infrastructure falls well below the WHO recommended facility to population ratio. And, although the GOE has considerably expanded its number of health centers, a recent survey assessing health facilities illustrates that on average only 60% and 3.2%, respectively, had basic and high level supplies in place.¹⁰ It is anticipated that through the hiring, training and deployment of 30,000 Health

⁷ Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia (SPM II) 2010-2014.

⁸ 4th National Health Accounts; Federal Ministry of Health; April 2010 (2007/2008).

⁹ Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia (SPM II) 2010-2014.

¹⁰ Five-Year Evaluation of Global Fund Health Impact Evaluation: Health Facility Report. Federal Ministry of Health, Ethiopian Health & Nutrition Research Institute (2008).



Extension Workers (HEWs) focused on health promotion, disease prevention and provision of basic health care services and referrals, significant progress should be made at the community level to increase PMTCT services and the number of births managed by a skilled birth attendant.

Ethiopia is one of 57 countries recognized by WHO as having a health workforce crisis, marked by chronic under-production of trained personnel, especially at high and mid-levels, and poorly motivated underpaid staff with low retention. In addition, there are major rural:urban distribution disparities with health worker density ranging from 0.24 to 2.7 per 1,000 population, respectively. There are 2,151 physicians in the country, a ratio of 1 to 36,710 people which is far below WHO standards.¹¹ Ethiopia has been visionary in task-shifting HIV/AIDS services in order to compensate for the severe shortage of high and mid-level trained health workers to bring essential services to those in need.

The development of a Partnership Framework comes at a critical point. PEPFAR is moving from an emergency to a more sustainable response with greater emphasis on country ownership. This is outlined in the next 5-year PEPFAR strategy by which “PEPFAR will work through partner governments to support a sustainable, integrated, and country-led response to HIV/AIDS”.¹² Ethiopia is in the process of finalizing its Health Sector Development Plan 2010/11-2014/15 (HSDP IV) and has recently drafted the Second Strategic Plan for Intensified Multisectoral Response to HIV/AIDS 2010-2014 (SPM II). These strategic policy documents build upon the gains and lessons learned to date. Through this Partnership Framework, the U.S. Government and the GOE should consolidate the gains achieved through partnerships in the first five years and move forwards with an increased focus on country ownership and leadership, while strengthening health systems that integrate prevention, care and treatment services.

Policy Environment

The overarching health sector plan is outlined in the Health Sector Development Plan IV (HSDP IV) which is in final draft. This takes into account the Plan for Accelerated and Sustained Development to End Poverty (PASDEP 2007-2010) which is currently being updated. The Strategic Plan for Intensifying Multisectoral HIV/AIDS Response in Ethiopia 2010-2014 (SPM II) outlines in greater detail the country’s response to HIV/AIDS. In the development of this Partnership Framework and in the elaboration of the Partnership Framework Implementation Plan, policy issues have been identified. These include development of a National Condom Strategy, enforcement of free maternity services at primary health care level, ratification of policy on task shifting and broadening of the policy to allow urban health extension workers to distribute ARVs as part of PMTCT prophylaxis and revision of the social welfare policy. The status of the policy environment and how the policy agenda may be moved forwards should be further outlined in the PFIP.

The SPM II identifies selected strategies addressing gender inequality, including gender based violence. HIV programs should be encouraged to systematically mainstream gender, including

¹¹ Health Sector Development Program (2010/11-2014/15)

¹² PEPFAR Five-Year Strategy (2009)



integration into sectoral policies and programs. Awareness creation and punitive approaches should be implemented on perpetrators of Gender based violence (GBV), which includes abduction, wife battering and female genital mutilation (FGM). HIV post exposure prophylaxis should be available to survivors of sexual violence. The SPM II also promotes the education of girls and gender norms to facilitate gender equality. The SPM II plans to conduct a stigma index study, advocate against stigma and discrimination, promote respect for human rights, protect from gender-based violence and multimedia censorship for minors, early marriage and FGM.

III. Five-year strategic overview

The U.S. Government recognizes that the national response to the HIV/AIDS epidemic in Ethiopia is led and coordinated by the Government of Ethiopia (GOE). The health sector spearheads the National HIV/AIDS response. HIV/AIDS programs are coordinated through and led by the Federal HIV/AIDS Prevention and Control Office (HAPCO) and the National AIDS Council, and involve a range of institutions including but not limited to the Ministry of Health, other line Ministries, the Ethiopian Health and Nutrition Research Institute (EHNRI), the Pharmaceutical Fund and Supply Agency (PFSA), and the Drug Administration and Control Authority (DACA). Within Ethiopia's federal system, there are also regional HAPCOs, regional health bureaus, and emerging regional AIDS Councils.

This Partnership Framework represents the joint work with the GOE designated members of the HAPCO team and PEPFAR. It also incorporates comments and inputs from other multi-lateral and bilateral donors, other government sectors and civil society. In August 2009, the U.S. Government Deputy Chief of Mission communicated the concept of the Partnership Framework to the Ethiopian Minister of Health, who designated HAPCO as the U.S. Government's key contact. The Partnership Framework was developed by a design team comprised of members of the GOE and the U.S. Government, in consultation with multi and bilateral donors and civil society. The GOE and the U.S. Government held a number of joint design team meetings over the intervening period. There was some delay as the GOE finalized their new five year strategy, with the U.S. Government and other multilateral donors, working with the GOE to rationalize some of the ambitious targets. Based on the finalization of the SPM II document, within the Partnership Framework, the U.S. Government has clearly defined what is within its manageable interest and focus by specifying expected U.S. Government contributions towards achieving the goals and objectives. A number of consultation meetings with other development partners were held to elicit their input into both the policy agenda and their expected contributions towards the goals and objectives as identified within the Partnership Framework. The U.S. Government also consulted with its implementing partners. HAPCO also called a broader stakeholder consultation to bring in other sectoral ministries and partners. Drafts of the Partnership Framework document have been shared with the GOE and other development partners at various points in the process and comments elicited.

The first government Strategic Plan for intensifying the Multisectoral Response to HIV/AIDS (SPM I) covered the period from 2004-2008. The Partnership Framework builds upon the Strategic Plan for Intensifying Multisectoral HIV/AIDS Response in Ethiopia II: 2010-2014 (SPM II) and the HSDP IV. The SPM II places priority on the following thematic areas:

- Creating an enabling environment
- Intensifying HIV prevention

- Increasing access to and improving quality of HIV/AIDS care and treatment
- Intensifying mitigation efforts against the epidemic
- Strengthening the generation and use of strategic information

The Partnership Framework supports the SPM II, which also forms part of the HSDP IV. Health systems' strengthening is a broader goal which constitutes part of HSDP IV and is set forth within Goal 3 in the Partnership Framework. This Partnership Framework illustrates an enhanced coordination of resources and harmonization of goals and objectives between the GOE, PEPFAR and other key donors. Transitioning ownership of HIV/AIDS programs to Ethiopia's leadership is expected to require an organized, strategic approach that promotes sustainability of the programs. This Partnership Framework aims to create an enabling environment that ensures the active involvement and ownership across all sectors, enhances partnership under the "Three Ones Principles" and mobilizes appropriate use of resources.¹³

The Global Health Initiative (GHI) serves as the whole-of-U.S. Government approach to further coordinate and integrate the U.S. Government's global health efforts in partner countries and is intended to form the health component of future country development cooperation strategies. Through GHI, the U.S. Government intends to help partner countries improve health outcomes through strengthened health systems, with a particular focus on improving the health of women, adolescent girls, newborns and children through programs that address infectious disease, nutrition, maternal and child health, family planning, safe water, sanitation and hygiene. GHI should take into account and leverage the health and development efforts of partner countries, other bilateral donors, multilateral organizations, civil society, private sector, and faith-based and non-governmental organizations to achieve the greatest possible impact through U.S. Government investments. The GHI model has dual objectives of achieving significant health improvements and fostering effective, efficient and country-led platforms that deliver essential health care and public health programs sustainably. This Partnership Framework, although addressing primarily HIV/AIDS programs, also embodies the principles outlined in GHI.

The Partnership Framework aims to achieve the following four goals in support of the GOE's plan to address the HIV/AIDS epidemic:

Goal I: Reduce the national HIV incidence by 50% by 2014: Under this goal, the GOE, U.S. Government and other stakeholders recognize the importance of focusing efforts on evidence-based prevention and display their shared desire and commitment to increase comprehensive HIV knowledge and behavior change among the adult population, provide additional focus on intervention packages that are designed to reach MARPs, increase the availability of counseling and testing, and expand the availability of comprehensive youth focused ABC programs. Additionally, the two governments recognize the priority of putting into action efforts to significantly increase the availability and utilization of PMTCT services. As a result of increased efforts for combination prevention¹⁴ for the general population, and MARPs as well as higher

¹³ Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia (SPM II) 2010-2014.

¹⁴ Combination prevention can be considered as a multilevel approach that encompasses behavioral strategies integrated with biomedical and structural approaches, and treatment for HIV infection. Coates, T, Richter, L., Caceres, C., Lancet: 372:669-684 (2008).

uptake of PMTCT services, there should be an anticipated decrease in the incidence of new infections.

Goal II: To reduce morbidity and mortality and improve the quality of life for people living with HIV by expanding access to quality care, treatment and support by 2014: Under this goal, the U.S. Government plans to work jointly with the GOE and other stakeholders to ensure the continued provision of quality HIV/AIDS care, treatment and support services, including services to OVC with available resources. Emphasis should also continue to be given to enrolling more children into care and treatment and to ensuring, as with ARVs for adults, that available pediatric ARV formulations are available in an uninterrupted manner. As a result of investments in care, the increased detection and treatment of TB/HIV co-infection and other opportunistic infections, and improved treatment and follow-up services, it is anticipated that 12-months survival rate should increase. In addition, support for strengthening of psycho-social support for orphans and PLHAs, including improved access to livelihood options, should improve quality of life.

Goal III: Health systems necessary for universal access are functional by 2014. In partnership with the GOE, the U.S. Government and other stakeholders should work collaboratively to focus their activities and contributions towards creating a better-functioning health system. This is to include adequate human resources for health, expanded and improved physical infrastructure, increased capacity for planning, management, and finance of programs, especially at regional levels. This is to be based on functioning systems for health management information, surveillance, other sources of data and laboratory, all supported by adequate systems to ensure un-interrupted procurement and supply of essential HIV/AIDS commodities.

Goal IV: Multisectoral response in place to prevent the spread of HIV and mitigate its impacts by 2014. Under this goal, in partnership with the GOE, the U.S. Government and other stakeholders intend to promote the strengthening of leadership so that Ethiopia may coordinate and implement one multisectoral and strategic national response. Several GOE ministries have committed 2% of their budget to mainstreaming within their sector. The U.S. Government should engage with the GOE to strengthen coordinating bodies, accelerate implementation, enforce accountability of leadership, and intensify involvement of civil society and the private sector.

IV. OWNERSHIP

With the development of the SPM II and HSDP IV, the GOE demonstrates strong leadership and ownership in the proposed development of Ethiopia's health sector. The HSDP IV has applied the following principles:

1. Government leadership
2. Enhanced responsiveness to community health needs
3. Extensive consultation and consensus with stakeholders
4. Comprehensive coverage of priority health sector issues

5. Linkage between HSDP IV and sub-national HSDPs, strategies, programs on priorities and targets.¹⁵

The SPM II aspires to prevent and control Ethiopia's HIV/AIDS epidemic and to mitigate its impacts through intensified community mobilization and empowerment as well as through capacity building. The SPM II also aims to strengthen the active participation and involvement among all sectors. Creating an enabling environment is one of five strategic issues set forth by the GOE in the SPM II that helps to conceptualize the meaning of host country ownership for Ethiopia. Capacity building, community mobilization and empowerment, leadership and governance, mainstreaming, coordination and partnership are key components of Ethiopia's growing ability to create an enabling environment. Such an environment should strengthen the effective management, implementation and evaluation of Ethiopia's multisectoral and strategic response.

Specifically, the U.S. Government and the GOE intend to promote greater country ownership of programs and activities by the government, local organizations and other stakeholders through:

- Jointly deciding upon indicators that characterize ownership and outlining incremental and time-delineated steps to strengthen host country ownership.
- Increasing the proportion of local partners receiving PEPFAR funds in Ethiopia, including but not limited to the GOE.
- Increasing the proportion of PEPFAR funds that goes to local partners.
- Developing an appropriate plan to build local capacity that serves to enable transition from non-Ethiopian partners receiving PEPFAR funds.
- Ensuring that PEPFAR-funded activities are aligned and support other key GOE plans which include HSDP IV, SPM II, HMIS, HRH, Laboratory Master Plan, etc.
- Maintaining open, transparent, and regular communication between U.S. Government, the GOE, and other key partners such as primary recipients of GFATM and IHP+ partners.
- Aligning U.S. Government coordination for health activities with the MOH (federal and regional) and for multisectoral activities with the HAPCO (federal and regional).
- An evidence-based response, led by the GOE at all levels, with enhanced partnership of all stakeholders, including civil society and the private sector, under the principles of the "Three Ones" to institute the Partnership Framework principles and goals.

The U.S. Government anticipates ongoing discussions with the GOE to further define and progressively move toward greater country ownership.

¹⁵ Health Sector Development Program IV (2010/11-2014/15) Ministry of Health, Federal Democratic Republic of Ethiopia.



Goal 1: To reduce the national HIV incidence by 50% by 2014.

Under this goal, the GOE, U.S. Government and other stakeholders, recognize the importance of focusing efforts on prevention and display their shared desire and commitment to increase comprehensive HIV knowledge among the adult population, provide additional focus on combination prevention intervention packages that should reach Most at Risk Populations and vulnerable groups, increase the availability of counseling and testing and the availability of comprehensive youth focused abstinence, be faithful, and condom (ABC) programs resulting in behavior change. Additionally, the two governments recognize and should put into action significantly increasing the availability and utilization of PMTCT services.

Objectives	Expected Contributions			Expected steps for development of PFIP and identified policy issues
	GOE	PEPFAR	Other ¹⁶	
1.1: To increase HIV comprehensive knowledge among adult population aged 15-49 from 22.6% in 2005 to 80% by 2014.	<ul style="list-style-type: none"> Intensify social mobilization through community conversation Provide HIV prevention communication programs house to house to general population Ensure provision of comprehensive workplace HIV prevention communication programs 	<ul style="list-style-type: none"> Support outreach to the general population in high prevalence areas with comprehensive HIV prevention communication and behavior change programs Support evidence-based programs that provide effective one-to-one or small groups based BCC interventions including CT and the development and dissemination of materials and training 	<ul style="list-style-type: none"> Joint UN support for increasing knowledge among general population through integration of HIV into relevant sectoral interventions and community processes Global Fund: Support training of community conversation facilitators Support provision of comprehensive HIV prevention communication programs World Bank: Support for community conversations, 	<ul style="list-style-type: none"> Programmatic evaluation of effect of large scale general population activities on behavior change

¹⁶ World Bank contributions: The current MAP II program is likely to end June 2011. There are ongoing discussions as regards future WB support – all inputs here outside MAPII are illustrative.

<p>1.2: By 2014, increased percentage of MARPs are reached with HIV intervention programs.</p>	<ul style="list-style-type: none"> • Before end of 2010, lead study on MARPs identification, size estimation, distribution, HIV prevalence and mapping of hotspots • Develop comprehensive HIV prevention services packages of HIV services and communication strategy for MARPs • Organize, coordinate, and ensure provision of HIV prevention services to MARPs 	<ul style="list-style-type: none"> • Support in MARPs identification, size estimation, and mapping of hot spot areas • Generate evidence of the level of multiple concurrent partnerships and modes of transmission • Support development and implementation of specific intervention packages including condoms, HIV/AIDS and STI treatment in Urban and Peri-Urban hot spots • Support efforts to decrease stigmatization of MARPs and ensure increased access to services • Support efforts for greater involvement by NGOs, FBOs and CSOs 	<p>peer education groups under MAP II</p> <ul style="list-style-type: none"> • Joint UN technical support for development of MARPS surveillance and intervention packages • Joint UN team provides normative and M&E guidance and implementation support for MCP interventions • Netherlands support for MARPs programs • Global Fund: Support provision of HIV prevention programs to MARPs • Global Fund: Supports increased involvement of FBOs • World Bank: MARPs focused peer education and support groups and small community based grants for IGAs and to support above activities under MAPII 	<ul style="list-style-type: none"> • Identify size and mapping of MARPs population, behavioral characteristics and HIV prevalence among the identified MARPs • Develop comprehensive prevention packages of HIV services and communication strategy for MARPs, Policy decisions around new and most cost-effective interventions as they become available
<p>1.3: By 2014, the percentage of young people aged 15-24 who use condoms consistently while having sex with non-regular</p>	<ul style="list-style-type: none"> • Ensure health facility based distribution of condoms • Provide condoms to development schemes through outreach programs 	<ul style="list-style-type: none"> • Provide condoms on free and social marketing basis to Urban and Peri-Urban areas • Participate in National Condom Strategy development • Support the development and strengthening of Condom 	<ul style="list-style-type: none"> • Joint UN support to ensure supply and procurement of condoms and enhanced technical capacity for resource mobilization • DFID, IrishAid and Netherlands government support condom social 	<ul style="list-style-type: none"> • Develop national condom strategy • 100% of estimated national need and distribution of condoms is available by 2015

<p>partners should increase from < 50% (2005) to 80%.</p>	<ul style="list-style-type: none"> • Ensure provision of condoms to MARPs 	<p>Logistic management system</p> <ul style="list-style-type: none"> • Support BCC efforts (including CT), materials and training that promotes condoms 	<p>marketing programs</p> <ul style="list-style-type: none"> • UNICEF support in-school and out-of-school youth programs with MOE and MOYS • Global Fund Support provision of condoms to development schemes and youth centers • World Bank School based peer education programs, Anti-AIDS clubs, under MAP II 	
<p>1.4: By 2014, 85% of HIV positive pregnant women¹⁷ and their infants receive complete ARV prophylaxis or treatment.</p>	<ul style="list-style-type: none"> • Intensify social mobilization for prevention of mother-to-child transmission of HIV • Lead integration of PMTCT with MNCH services • Provide PMTCT at all PHCUs with outreach community services • Based on evidence, address barriers to access and utilization of PMTCT services 	<ul style="list-style-type: none"> • Support comprehensive ethnographic studies to better understand cultural and utilization barriers for PMTCT services in order to increase utilization of these services • Support HMIS to use PMTCT cascade for program improvement • Support integration of PMTCT services into other maternal and child health programming • Support community based PMTCT programs, focusing on HEW, UHEW, and mother support groups as appropriate • Focus on measures that increases the quality of PMTCT 	<ul style="list-style-type: none"> • WHO provides strategic advice, including adoption of new global guidelines, and UNICEF supports training in PMTCT settings • UNICEF support for integration of PMTCT services into MNCH • Global Fund: Support provision of PMTCT service provision at facility and community outreaches • CHAI: Strengthen/initiate comprehensive PMTCT services in 30 Primary Health Care Units and hospitals 	<ul style="list-style-type: none"> • Involvement of urban HEWs in appropriate aspects of PMTCT services including distribution of ARV prophylaxis • Plan for roll-out of new WHO guidelines related to PMTCT • Enforcement of free maternity services at primary health care level

¹⁷ 85% refers to total estimated number of HIV+ve pregnant women

<p>1.5: A cumulative total of 42 million people counseled and tested for HIV by 2014.</p>	<ul style="list-style-type: none"> Intensify social mobilization for counseling and testing among vulnerable and most at risk population groups Ensure provision of counseling & testing services at health facility and in community outreach activities Expand sites for provision of counseling and testing service Enhance targeting and quality assurance mechanisms 	<p>services to encourage utilization</p> <ul style="list-style-type: none"> Support increased private sector involvement in PMTCT Address gender issues in accessing PMTCT services Contribute to health facility and health worker skills Support infrastructure improvements to make sites more accessible and female-friendly 	<ul style="list-style-type: none"> Support targeted CT program in hot spots Increase CT to reach Most at Risk Populations and vulnerable groups Strengthen couples/family CT Evaluate home-based CT Strengthen referral linkages and post test clubs Support quality assurance mechanisms for CT Strengthen supply chain for test kits Support provider-initiated counseling and testing in clinical sites 	<ul style="list-style-type: none"> Joint UN support for normative guidelines, service delivery enhancement and CT and periodic M&E Global Fund: Support HCT services through supply of rapid test kits and expanding service delivery sites CHAI: Pilot HIV C&T at rural health Post level Strengthen HCT at hospital and HC level 	
<p>1.6: Reduce percentage of young people aged 15-19 with sexual debut < 15</p>	<ul style="list-style-type: none"> Ensure provision of age appropriate HIV/reproductive health services including BCC Expand school-based 	<ul style="list-style-type: none"> Support BCC efforts (including CT), materials and training that promote delay of sexual debut for youth Involve FBOs, CSOs and 	<ul style="list-style-type: none"> UNESCO, UNHCR and UNAIDS provide inputs to strategic planning, supportive supervision and enhanced management 	<ul style="list-style-type: none"> Evaluation of schools community conversations and anti-AIDS 	

<p>years from 8.4% in 2005 to 1.7%; 11.1% to 2.2% in females and male from 1.7% to 0.34% by 2014.</p>	<p>interventions</p> <ul style="list-style-type: none"> Encourage family-life education at schools and conversations at household level Ensure implementation of education sector policies and strategies Enforce policies prohibiting the access of minors to alcohol, illegal substances, etc 	<p>communities</p> <ul style="list-style-type: none"> Address Gender and Male Norms related behaviors Strengthen linkages with education programs – support in school and out of school programs which include training of teachers both in school and in TTIs, youth leadership development, mass media campaigns through school radio, TV, print serial dramas etc. Engage youth in constructive afterschool activities (Peace Corps) 	<p>capacities for supplies to schools</p> <ul style="list-style-type: none"> UNICEF and UNFPA HIV prevention work with young people in and out of schools and in tertiary education institutions Global Fund: Support BCC programs in school youth and out of school youth World Bank TA for school based programs 	<p>clubs</p>
<p>1.7 Increase availability of biomedical prevention measures:</p> <p>a) Universal precautions employed in all health facilities by 2014</p> <p>b) Ensure safe blood supplies are available throughout the country at hospital level</p> <p>c) Accelerate access to male circumcision</p>	<ul style="list-style-type: none"> Enforce universal precaution standards in all health facilities Implement quality assurance measures to screen all donated blood Provide leadership in providing a national blood transfusion service Ensure provision of male circumcision at major health centers and hospitals Conduct targeted promotion of male circumcision geographical areas with lower rates of male circumcision 	<ul style="list-style-type: none"> Support the provision of universal precautions in all health facilities Support production of local low cost locally customized IP supplies Support renovation of blood banks, and provide training and supplies Support the rollout of male circumcision in targeted areas 	<ul style="list-style-type: none"> Global Fund: Procure infection prevention materials and renovation of blood banks WHO provides PEPFAR funded TA for national blood transfusion service 	

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Goal 2: To reduce morbidity and mortality and improve the quality of life for people living with HIV by expanding access to quality care, treatment and support by 2014.			
Under this goal, the U.S. Government and other partners plan to work jointly with the GOE to ensure the continued provision of quality HIV/AIDS care, treatment and support services, including services to OVCs. This goal should focus on scaling up and sustaining treatment and care services with available resources.			
Objectives	Expected Contributions		Expected steps for development of PFIP and identified policy issues
	GOE	PEPFAR	Other ¹⁸
2.1: By 2014, 12-month survival among those receiving treatment is increased from 73% to 80%.	<ul style="list-style-type: none"> Strengthen adherence counseling and follow up Ensure uninterrupted supply of ARVs and OI drugs Adapt new WHO guidelines after considering cost implications and feasibility Ensure access to and quality of chronic care and treatment services, including adherence, follow-up, etc Provide leadership and coordination around program management 	<ul style="list-style-type: none"> Support GOE in considering implementing new WHO guidelines; emphasize strengthening mechanisms for follow-up Support efforts for earlier access and initiation to ART Enhance efforts to increase OI diagnosis and management Expand EID access Carry out efforts to better understand and address obstacles to optimal adherence Provide costing data to facilitate decision-making and planning for increasing access to ART Develop SOP to manage discordant couples 	<ul style="list-style-type: none"> WHO provides TA for new guideline implementation CHAI: Introduce new products to improve patient adherence UNICEF supports integrated IMNCI and Pediatric HIV services

¹⁸ World Bank contributions: The current MAP II program is likely to end June 2011. There are ongoing discussions as regards future WB support – all inputs here outside MAP II are illustrative.

<p>2.2: Increase ART enrolment from 73% to 95% of those eligible by 2014.</p>	<ul style="list-style-type: none"> Expand ART service by ensuring fulfillment of minimum standards for expansion of ART services Expand number of sites for ART services Deploy health personnel for HIV and comprehensive health care services Ensure uninterrupted supply of ARVs and OIs Adopt new guidelines after considering costing implications & feasibility 	<ul style="list-style-type: none"> Provide TA to support increased skills at service points and increase capacity for ART, including task shifting Provide costing data to facilitate decision-making and planning for increasing access to ART Support health facility infrastructure to improve ART accessibility Invest in pre- and in-service education to increase the number and quality of human resources for health Support case management to link positive persons to treatment 	<ul style="list-style-type: none"> WHO support to enhance technical skills for the scale-up of ART and health center support Global Fund: Support supply of 1st line ARVs, OI drugs, and reagents Support expansion of ART services CHAI: Supply pediatric and adult 2nd line ARVs until 2011 Decentralize ART services to lower tier of health system (in 4 regions at identified 30 woreda level (Amhara, Tigray, Oromia and SNNPR) Strengthen client referral and tracking system 	
<p>2.3: An increased number of individuals in all age groups access a continuum of quality comprehensive clinical HIV/AIDS care and treatment</p>	<ul style="list-style-type: none"> Strengthen service linkages and integration Develop guidelines, SOPs, and formats for service linkages and referral systems Ensure functional inter and intra facility community referrals to linkages 	<ul style="list-style-type: none"> Identify and support measures that strengthen linkages between counseling and testing and getting into care Support functional referral and follow up systems to ensure patients enter treatment early and remain in treatment Integrate HIV/AIDS services into other health programs Update guidelines, training 	<ul style="list-style-type: none"> Joint UN agencies to increase provision and utilization of treatment, care and support services for PLHIV and others (focus on quality assurance and strengthening referral/service integration and 	

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<p>services, including TB/HIV by 2014.</p>		<p>manuals and support pre and in-service training</p> <ul style="list-style-type: none"> • Support quality improvement processes at all levels • Support case management to better link clients to facility- and community-based services • Support increased range and quality of psychosocial services • Support basic care package (e.g. cotrimoxazole prophylaxis, Safe water) • Provision of therapeutic feeding for malnourished PLHIV 	<p>outcome monitoring) Global Fund: Support linkages of prevention and care services</p> <ul style="list-style-type: none"> • CHAI: Strengthen PHCU capacity to provide comprehensive services including TB/HIV in 4 regions at identified 30 woreda level (Amhara, Tigray, Oromia and SNNPR) 	
<p>2.4: Increase care and support to needy PLHIV from 20% in 2008 to 50% by 2014.</p>	<ul style="list-style-type: none"> • Ensure implementation of GIPA • Strengthen IGA activities • Ensure provision of care and support to needy PLHIV 	<ul style="list-style-type: none"> • Support increased access to sustainable livelihood programs • Collaborate with other partners to increase household food security • Support HIV case management provided by and for PLHIV to better link clients to facility- and community-based services 	<ul style="list-style-type: none"> • UNFPA to enhance access to care and support packages • UNICEF and WFP financial and food support to HIV – affected and food insecure HHs • Global Fund: Support PLHIV to engage in marketable IGA schemes • Support nutritional & HBC for PLHIV 	<ul style="list-style-type: none"> • Develop national standards for care and support service package

<p>2.5: Increase care and support to needy OVC from 30% in 2008 to 50% by 2014.</p>	<ul style="list-style-type: none"> • Ensure access to Education by OVC • Strengthen care & support to needy OVCs in their familial networks 	<ul style="list-style-type: none"> • Support increased range, age-appropriate and quality of psychosocial services • Support increased access to sustainable livelihood programs • Collaborate with other partners to increase household food security • Support basic care package (e.g. Safe water) • Support Implementation of OVC minimum standards • Support strengthening of community-based organizations 	<ul style="list-style-type: none"> • Joint UN support to increase provision of care and supportive supervision in delivering services to OVCs • UN supported social transfers to OVC HHs (e.g. cash transfers/vouchers child support grants, disability benefits, foster care grants, interest free micro-credit) • UNICEF support to training of para-professional social work cadre & strengthening of social protection programs • Global Fund: Support schooling to OVC • Support for basic needs for the needy OVCs • Support guardian and OVCs above 14 years to engage in vocational training & IGA • CHAI: Link HCVs with orphanages 	<ul style="list-style-type: none"> • Enforce implementation of national standards of OVC care and support • National OVC situational analysis is to be commenced • Operationalization of guidelines • Social welfare policy revision is to be commenced (including assessment of capacity and service provision.
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Goal 3: Health systems necessary for universal access are functional by 2014.

Under this goal, the U.S. Government plans to collaborate with the GOE and other donors to strengthen health systems, including the involvement of private sector and civil society at all levels. This goal focuses on recruiting, training and retaining human resources as well as supporting the GOE in its implementation of the HMIS and the Health Network Model. Through this goal, health insurance, supply chain mechanisms and laboratory services have been identified as key objectives that should be reached in order to offer a functional health system to the people of Ethiopia. Key aspects of this goal include investments in pre-service training and infrastructure, policy reform and performance-based management.

Objectives	Expected Contributions			Expected steps for development of PFIP and identified policy issues
	GOE	PEPFAR	OTHER	
<p>3.1: Increased availability of trained human resources for health to support accelerated scale up of comprehensive HIV/AIDS programs by 2014.</p>	<ul style="list-style-type: none"> Increase enrollment capacity of health professionals in training colleges and universities Ensure continuous education provision to health professionals Staffing health facilities is identified in GOE standards Enforce human resource strategy development Help strengthen and coordinate in-service and pre-service trainings Institute initiatives to improve retention and motivation from health workers Institute performance-based management 	<ul style="list-style-type: none"> Strengthen HR planning, leadership and management including task shifting, retention strategies, gender equity and HRIS. Support pre-service and in-service training including capacity building of public and private training institutions Support quality assurance through continued professional development, accreditation and licensing of health professionals. Support hospital management training for CEOs and other administrators to improve personnel management, facility maintenance and infrastructure, morale, and 	<ul style="list-style-type: none"> Joint UN efforts to scale up HR capacity through training and supportive supervision to ensure sustainable & effective response to HIV/AIDS Global Fund: Support the implementation human resource strategy and plan CHAI: Enhance capacity of PHCU (in 4 regions at identified 30 woreda level (Amhara, Tigray, Oromia and SNNPR) 	<ul style="list-style-type: none"> There is a need to develop costed implementation plan for the HRH strategy. Ratify policy on task shifting may be needed Plan for the transfer of personnel currently supported through PEPFAR resources to regular budget support.



	<ul style="list-style-type: none"> Scale up task shifting 	<ul style="list-style-type: none"> staff retention Support the development of the public health workforce (e.g. Masters programs FELTP, HIT etc) Support development of a public health workforce 		
<p>3.2: The health network model is improved by increased operational capacity at all levels—national, regional, zonal, woreda, facility and community by 2014.</p>	<ul style="list-style-type: none"> Strengthen referral system Strengthen service linkages and integration Scale up task shifting and mentoring 	<ul style="list-style-type: none"> Support the development of a standardized referral system Expand technical assistance provided at the regional level Focus on building the capacity of regional and sub-regional offices in planning and coordination of HIV/AIDS and health programs. Support select construction of health facilities 	<ul style="list-style-type: none"> UN support to system functioning ensuring effective service operations of regional coordination and functioning Governance Pool Fund (DFID, Irish, Italian Cooperation) with HAPCO to increase capacity and accountability at regional levels Global Fund: Support strengthening of referral system World Bank capacity building support at RHB and woreda levels under MAP II 	
<p>3.3: Planning at all levels is evidence based.</p>	<ul style="list-style-type: none"> Coordinate and lead evidence based multisectoral response planning at all levels 	<ul style="list-style-type: none"> Support, facilitate and participate in planning at all levels Support and participate in efforts to collect quality data and evaluate programs Support efforts to use data 	<ul style="list-style-type: none"> Joint UN support for enhanced sector management and strategic planning UNICEF, WHO and UNFPA support annual woredas based planning 	<ul style="list-style-type: none"> Prioritized planning at all levels takes into account evidence based information and available resources

<p>3.4: Health management information systems (HMIS) are functional throughout all regions by 2014.</p>	<ul style="list-style-type: none"> Implement HMIS at full scale Train workforce in HMIS and M and E (in service) 	<p>for decision-making</p> <ul style="list-style-type: none"> Support HMIS roll-out through technical assistance, training, and investments in HMIS and ICT infrastructure Support the development of a community based information system Support efforts to improve the HMIS to meet evolving information needs to support decision-making 	<ul style="list-style-type: none"> Governance Pool Fund (DFID, Irish, Italian Cooperation) with HAPCO to increase capacity and accountability at regional levels WHO technical support towards 9 key components of HMIS Support HMIS implementation CHAI targets HCs implement HMIS World Bank – TA support under MAP II 	<ul style="list-style-type: none"> Scale up staffing at the regional level for HMIS Staffing in place for HMIS at health centers and hospitals. Ongoing review and modification of HMIS to incorporate improvements
<p>3.5: Additional sources of strategic information provide timely inputs to evidence based planning for HIV/AIDS programs by 2014.</p>	<ul style="list-style-type: none"> Ensure five-year implementation of master plan strategy for strategic information and surveillance. Provide leadership and coordination to implement five year master plan 	<ul style="list-style-type: none"> Support the collection and generation of strategic information at the national and regional level Support the design and implementation of program evaluations as well as various surveys and surveillance 	<ul style="list-style-type: none"> Operational research from pooled fund UNICEF support operations research in using modern telecommunication for improved PMTCT uptake 	<ul style="list-style-type: none"> 5 year master plan for Surveillance and other SI information is to be finalized and implemented
<p>3.6: Expanded social and community health insurance schemes and improved utilization of</p>	<ul style="list-style-type: none"> Ensure implementation of social insurance 	<ul style="list-style-type: none"> Address key policy challenges in health insurance in Ethiopia Support the management of facility level user fees for effective utilization 	<ul style="list-style-type: none"> World Bank: TA to MOH for pilot community insurance schemes jointly working with PEPFAR funded partners under MAP II 	<ul style="list-style-type: none"> Ratify legal framework for community health insurance and social insurance

<p>user-fee revenue by 2014.</p>		<ul style="list-style-type: none"> • Support community based insurance schemes for PLHIV • Support the training of hospital/health system chief executive officers 		
<p>3.7: Primary health care infrastructure improved to support universal access to quality services by 2014.</p>	<ul style="list-style-type: none"> • Ensure the achievement of quality universal primary healthcare coverage • Provide leadership and coordination for improved infrastructure • Ensure expansion of infrastructure for Universal Access • Continue renovation to provide continued quality care • Ensure maintenance of facilities 	<ul style="list-style-type: none"> • Support functioning basic amenities in facilities • Support limited construction of new high-burden health facilities 	<ul style="list-style-type: none"> • UN support in the procurement of supplies & management of HFs • Strengthen the capacity of PHCUs • World Bank through PBS II procurement of medical equipment, supplies, drugs at all levels. • UNICEF support improving water supply and sanitation in health centers 	<ul style="list-style-type: none"> • Standardization of facilities and services may be required • Inclusion of maintenance budget for all facilities
<p>3.8: Chronic care sites covered with basic laboratory services by 2014.</p>	<ul style="list-style-type: none"> • Ensure availability of laboratory services • Ensure implementation of national laboratory plan • Provide leadership and coordination • Ensure maintenance of laboratories • Institute national quality assurance mechanisms 	<ul style="list-style-type: none"> • Focus on delivery of basic supplies and equipment • Focus on Lab quality assurance • Support national laboratory accreditation efforts • Support selected renovation or construction of laboratories • Support program for training of laboratory technicians and maintenance specialists 	<ul style="list-style-type: none"> • WHO and UNICEF to procure and supply lab commodities • World Bank through PBS II procurement of lab at all levels 	<ul style="list-style-type: none"> • National/regional Lab maintenance plan developed and implemented

<p>3.9: Supply chain system in place ensuring consistent availability of essential HIV – related drugs and commodities by 2014.</p>	<ul style="list-style-type: none"> • Ensure the availability of essential drugs and commodities • Strengthen drug supply management system • Ensure implementation of national logistic master plan • Lead and coordinate the supply chain system 	<ul style="list-style-type: none"> • Support the implementation of Pharmaceutical logistic management plan (PLMP) and logistics management information systems (LMIS) including the development of a handover plan 	<ul style="list-style-type: none"> • Joint UN Technical support for uninterrupted supply of drugs and commodities • DFID, through MDG Performance Fund, support for commodities • World Bank TA to PFSA to strengthen procurement and financial management 	<ul style="list-style-type: none"> • Plan developed for the GOE to subsume the distribution costs of all supplies and commodities which are currently covered through PEPFAR resources • Directives of the exemption of VAT for all health related commodities
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Goal 4: Multisectoral response in place to prevent the spread of HIV and mitigate its impacts by 2014.

Under this goal, the GOE, the U.S. Government along with other partners intend to promote the multisectoral and strategic national response. The U.S. Government should join efforts with the GOE and other partners to strengthen local leadership and coordination, enforce accountability of leadership, and intensify involvement of civil society and the private sector.

Objectives	Expected Contributions		Expected steps for development of PPIP and identified policy issues
<p>4.1- Ensure sustained commitment of leadership at all levels to take HIV/AIDS as strategic development issue and to enforce accountability</p>	<p>GOE</p> <ul style="list-style-type: none"> • Strengthen leadership and governance of HIV/AIDS programs at all levels • Ensure capacity building of leadership at all levels • Enforce accountability mechanisms to ensure responsiveness • Strengthen active multisectoral involvement at biannual program reviews 	<p>PEPFAR</p> <ul style="list-style-type: none"> • Focus on strengthening capacity at regional and sub regional levels • Aim for participatory governance of public health programs with the inclusion of the private sector, CSOs and other stakeholders • Identify and adapt best practices from other countries to enhance governance and leadership • Fund capacity building for 	<p>OTHER</p> <ul style="list-style-type: none"> • Concerted joint UN support to enhance institutions. Structures and coordination capacities at all levels (focus on emerging regions) • Governance Pool Fund (DFID, Irish, Italian Cooperation) with HAPCO to increase capacity and accountability at all levels • GF -Support capacity
			<ul style="list-style-type: none"> • Plan for activation of Regional AIDS Councils and coordinating bodies • Active multisectoral involvement at bi-annual program reviews • Strengthen Regional AIDS Councils and coordinating bodies through active multisectoral involvement

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<p>4.2: HIV programs are integrated into other sectoral budgets, work plans and review mechanisms by 2014.</p>	<ul style="list-style-type: none"> • Ensure mainstreaming of HIV/AIDS into key strategic sectors • Build capacity for mainstreaming • Ensure provision of workplace policies and strategies 	<p>planning, budgeting, management, accountability and technical oversight by regions, kebeles and woredas</p> <ul style="list-style-type: none"> • Fund and provide training on strategic leadership for HIV/AIDS response • Fund and conduct periodic review of multisectoral response and provision of feedback from governing bodies • Provide technical assistance in administrative and fiscal management 	<p>building for leadership and governance</p> <ul style="list-style-type: none"> • Joint UN efforts to facilitate multisectoral integration of HIV and strengthen M&E capacity GF Support mainstreaming of HIV/AIDS in key strategic sectors 	
<p>4.3: Increased participation of civil society in the national response by</p>	<ul style="list-style-type: none"> • Ensure civil society participation in multisectoral HIV/AIDS response at all levels • Strengthen partnership 	<ul style="list-style-type: none"> • Increase CSO participation in governance and delivery of public health services by building their capacities • Advocate for participation 	<ul style="list-style-type: none"> • Joint UN support to enhance multisectoral management and leadership capacity (focus on strengthening umbrella 	

2014.	forums and networking	and leadership from young people, women and PLHIV	<p>bodies, coordination, networking and advocacy capacities)</p> <p>Global Fund</p> <ul style="list-style-type: none"> • Support community system strengthening • Support CSOs to provide HIV services • Support in strengthening partnership • World Bank TA to assist with development of improved social accountability and transparency at community level 	
4.4: Increased participation of the private sector in the national response by 2014.	<ul style="list-style-type: none"> • Ensure private sector participation in multisectoral HIV/AIDS response at all levels • Develop standardized guidelines for provision of services • Ensure implementation of private-public partnership guidelines 	<ul style="list-style-type: none"> • Improve access and quality of health services by creating well regulated, competitive environment for the private health sector • Continue to expand and enhance public-private partnerships • Continue efforts to educate and engage professional societies in the national response (e.g. EPHA, EMA, ESOG, etc.) 	<p>Global Fund:</p> <ul style="list-style-type: none"> • Support community system strengthening • Support private sectors to provide HIV services • Support in strengthening partnership 	<ul style="list-style-type: none"> • Further define roles and responsibilities within GOE for private sector • Identify what workplace programs are in place • Draw up list of private sector health education institutions; define accreditation standards • Guidelines on standardization of private-public partnership • Guidelines on standardization of private sector services

V. Partners Roles and Objectives

The Partnership Framework builds on the GOE's high level of ownership and shared objectives with the U.S. Government and other partners to controlling the HIV/AIDS epidemic. At the federal level, HAPCO is the national coordinating body for ensuring that all HIV/AIDS interventions in Ethiopia are harmonized and aligned with national priorities and strategies. The Goals and Objectives table outlines the various stakeholder contributions within the four Partnership Framework Goals. The goal statements are aligned with and, in several instances, excerpted directly from the SPM II (2010-2014) and the HSDP IV. Each goal is associated with several objectives which contribute towards the achievement of that goal. Expected contributions from government and other groups overall reflect an integrated national response.

Ethiopia receives a substantial amount of Global Fund resources. Currently the U.S. Government and the GOE have a Memorandum of Understanding (MOU) which delineates the complementary roles of Global Fund and PEPFAR resources. As an essential step in the development of the Partnership Framework Implementation Plan, the GOE and PEPFAR intend to review and harmonize their investments, within a revised MOU. The U.S. Government is a member of the Country Coordinating Mechanism (CCM) of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). Technical assistance is provided to the GOE to develop proposals for HIV, malaria and TB.

The GOE receives health sector development aid from a wide array of donors. It is the function of the Federal Ministry of Health to coordinate this assistance. However it is also incumbent on multilateral and bilateral donors to clearly provide their assistance in support of the GOE's priorities moving towards the principle of the "Three Ones". Coordination of donor response towards HIV/AIDS programs falls within the mandate of FHAPCO.

VI. Plans for developing the Partnership Framework Implementation Plan

The Partnership Framework Implementation Plan is to provide the opportunity to operationalize the high level goals and objectives expressed in the Partnership Framework document. The development of the Implementation Plan should focus chiefly on the detailed plans that may be required to achieve the identified goals and objectives, with identified annual targets and benchmarks. The U.S. Government is committed to strengthening joint planning of activities with the GOE and other development partners to achieve these goals and targets. An important component of this effort should be harmonization with the Plan of Action for all resources obtained through the Global Fund for AIDS, Tuberculosis and Malaria and the regular sharing of information regarding programming of resources for both GFATM and PEPFAR funding. The Implementation Plan should also address a prioritization of key activities based on available resources, to be evaluated annually and adjustments made as may be required. The development of the Implementation Plan should be a highly consultative process similar to that adopted for the Partnership Framework document. The design team responsible for the Partnership Framework plans should guide the development of the Implementation Plan. Many of the details of the plan are already outlined within the SPM II and HSDP IV documents. In addition, U.S. Government and the GOE are committed to promoting the types of policy, strategies and guidelines that should foster success and maximize investments.

Estimated Timeline:

End of December Submit draft Implementation Plan to OGAC
January OGAC review Implementation Plan
End of January Implementation Plan signed

VII. Management and communications

On signature of the Partnership Framework and the subsequent Implementation Plan, responsibility for monitoring the implementation of the goals and objectives should be steered by FHAPCO. Review of progress should be conducted on a bi-annual basis at the GOE's bi-annual review of the implementation of the SPM II. This well-attended meeting is to include participation from government ministries, donors, implementation partners and civil society. This forum should also allow for review of the ongoing policy agenda which should support the successful implementation of the Partnership Framework. Interim reviews should be commenced through established regular meeting schedules between the PEPFAR /Ethiopia team and GOE. High level oversight should be provided through regular meetings held between the Minister of Health and the US Ambassador.

VIII. SIGNATURES

**For the Federal Democratic Republic
of Ethiopia**



H.E. Dr. Tedros Adhanom Ghebreyesus
Minister of Health

27 / 10 / 10

(Date)

**For the Government of the
United States of America**



H.E. Donald E. Booth
Ambassador

October 27, 2010

(Date)

