THE STATE OF ERITREA

MINISTRY OF HEALTH

UNGASS COUNTRY PROGRESS REPORT

NATCoD 2010

TABLE of CONTENTS

List of Acronyms:

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral (Drug)
BCC	Behaviour Change Communication
BIDHO	Association of People Living with HIV/AIDS
BSS	Behaviour Survey Surveillance
CBO	Community Based Organization
CCA	Community Change Agent
CCM	Country Coordinating Mechanism
CSO	Civil Society Organization
EDF	Eritrean Defense Force
EDHS	Eritrean Demographic & Health Survey
ENASP	Eritrean National Strategic Plan
EPHS+	Eritrean Population and Health Survey
ESMG	Eritrean Social Marketing Group
FSW	Female Sex Workers
FBO	Faith Based Organization
GFTAM	Global Fund, TB, Malaria and AIDS
GOE	Government of Eritrea
GSE	Government of the State of Eritrea
HAMSET	HIV/AIDS, Malaria, Sexually Transmitted Infections & TB
HBC	Home Based Care
HMIS	Health Management Information System
HSP	Health Sector Policy
HSDP	Health Sector Development Plan
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
I-PRSP	Interim – Poverty Reduction Strategy Paper
KAPB	Knowledge, Attitude, Practice & Behaviour
LQAS	Lots Quality Assurance Sampling
LSE	Life Skills Education

LWF	Lutheran World Federation
MOD	Ministry of Defense
MDG	Millennium Development Goals
M&E	Monitoring & Evaluation
MOE	Ministry of Education
MOH	Ministry of Health
MOI	Ministry of Information
MOLHW	Ministry of Labour & Human Welfare
MSM	Men who have sex with Men
MTCT	Mother to Child Transmission
NACP	National AIDS Control Programme
NATCoD	National AIDS and TB Control Division
NBTC	National Blood Transfusion Center
NCA	Norwegian Church Aid
NCEW	National Confederation of Eritrean Workers
NCPI	National Composite Policy Index
NUEW	National Union of Eritrean Women
NUEYS	National Union of Eritrean Youth and Students
OIs	Opportunistic Infections
PEP	Post Exposure Prophylaxis
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNDAF	United Nations Development Assistance Framework
UNJP	United Nations Joint Programme of Support on AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

Acknowledgment:

The National AIDS and TB Control Division (NATCoD) appreciate the different development partners, stake holders and individuals who participated in developing the Eritrean UNGASS report. Civil Society Organizations, the National Association of People Living with HIV & AIDS, faith based organizations, non government and government sectors gave their undivided support to the UNGASS Report 2010.

First and foremost, the National AIDS and TB Control Division acknowledges the roles played by the UNAIDS Country Office and the Country Programme Coordinator in commissioning and financing the entire process of the preparation of the UNGASS 2010. The Country Office organized a day for 'Consensus Building Workshop' and reviewed the entire document. Many invaluable comments, feed backs and recommendations were provided.

Stake holders and partners who gave their full support to the development of the Eritrean UNGASS report are acknowledged for the constructive contributions they made collectively and individually.

The faith based organizations, NGOs, CSOs, government sectors, the JUNP and the national association of people living with HIV & AIDS (BIDHO) participated and discussed in the formulation of the National Composite Index Report (NCIP), provided valuable information, identified major challenges, recognized opportunities and provided solutions and recommendations that is crucial to the report and to the future progress of the national response against HIV & AIDS.

The different departments and divisions of the MOH including the Project Management Unit (PMU) of HAMSET/GFTAM are specifically acknowledged for providing the financial information that is included in this report.

EXECUTIVE SUMMARY:

As a member of the world community of nations and a signatory to the UNGASS Declaration of Commitment on HIV and AIDS, Eritrea recognizes the need for a concerted multi sectoral action in response to the HIV & AIDS epidemic and offers political, technical, financial and material support to prevent the infection among its general public through well rounded preventive, treatment, care and support systems. During the last nine years of national commitment, Eritrea invoked upon extensive awareness campaign among the general population and specifically among most at risk groups; it institutionalized Life Skills based HIV education in middle, secondary and post secondary schools; introduced dependable blood safety mechanisms; scaled up voluntary HIV testing for all and integrated prevention of mother to child transmission of HIV and AIDS with antenatal care services in order to prevent infection, decrease morbidity and mortality caused by the AIDS related infections and to mitigate its negative effects.

Behaviour Change Communication (BCC) and peer group sessions held among different population groups including the military, sex workers, truck drivers, community youth and women proved to be tools of high value for reassuring that the basic facts about HIV and AIDS are reaching communities, groups and individuals both in urban and rural settings. Mid 2005 saw the introduction and free provision of ART at designated health facilities although treatment of opportunistic infections and Home Based Care (HBC) services started much earlier using trained volunteers from community and faith based organizations.

The declining trend in HIV prevalence among ANC attending pregnant women suggests that the country made successful strides in preventing HIV infection. In the area of impact reduction, Eritrea made profound efforts in improving the lives of individuals and households that are infected with or affected by AIDS. The effects of stigma and

discrimination around people who live with the infection are dealt with through public mobilization activities and advocacy programmes at every level of the administration. The challenges faced by stigma related issues negatively influence both the prevention and treatment services and call for serious attention of all concerned.

1. STATUS at a GLANCE:

a. The Report Writing Process:

Information for UNGASS 2010 Report demands the collaboration of stakeholders in both government & private sectors; the civil society and faith based organizations; military establishments; the Joint UN Programme of Support on AIDS, and the National Association of People Living with HIV & AIDS (BIDHO). Different departments and divisions of the Ministry of Health, the National Blood Transfusion Center (NBTC), the National Health Laboratory and the Project Management Unit (World Bank/HAMSET & GF) contributed and provided valuable comments and feedbacks. Desk reviews and personal interviews with concerned stake holders were applied to collect and compile the information that is included in this document. Twenty five organizations and offices representing government sectors, the UN Agencies, the civic society and faith based organizations took part in the final consensus building workshop and contributed to the document and nineteen organizations participated in the evaluation of the National Composite Policy Index (NCPI).

b. The Status of the AIDS Epidemic

The HIV epidemic in Eritrea is expressed as a generalized epidemic with a few pockets of population groups that are considered to be most at risk. The national HIV prevalence is monitored by the Sero-Prevalence Sentinel Surveys that are conducted every other year among pregnant women who attend antenatal care (ANC) services in selected sentinel health facilities located in both urban and rural areas. The results of the sentinel surveys indicate that HIV prevalence is decreasing from 2.41% to 1.33% between 2003, and 2007.

Disparity among urban and rural communities is observed in all sentinel surveys where HIV prevalence among urban population is proportionally higher than in rural

communities that showed 0.9%, 0.9% and 0.58% during the last three surveys while the same surveys showed HIV positive test results among urban based pregnant women at 3.5 %, 3.04% and 1.66% respectively.

c. Policy and Programme Response:

Programmes related to prevention and control of HIV and AIDS dates back to 1991 when the country finally emerged as a free and sovereign nation after 30 years of war that completely changed the country's social and economical landscape. After the national independence, the government's well structured and determined decision created the National AIDS Control Programme (NACP) and produced the policies, guidelines and strategies that shaped the correct socio-political environment for implementing comprehensive multi-sectoral programmes.

Eritrea subscribes to the "Three Ones Principles" and endorses the application of one agreed AIDS action framework, one national AIDS coordinating authority, and one agreed country level monitoring and evaluation system. To improve the quality of health services, the country adopted the National Health Sector Policy (HSP) and the Health Sector Development Plan (HSDP) which focused on the provision of health services at primary, secondary and tertiary level through out the country.

To strengthen and reorganize the national response, the Ministry of Health elevated the National AIDS Control Programme (NACP) which at the beginning, was only a unit under the Communicable Disease Control Division, to the National AIDS and TB Control Division (NATCoD) which rallies a huge number of partners and stake holders who take part and contribute to the prevention, treatment, care and support services. The involvement and participation of line ministries, national unions, professional associations, the Association of People Living with HIV & AIDS (BIDHO), civil society

organizations (CSOs), faith based organizations, and the private sectors had been fruitful.

Prevention programmes at workplaces is designed to fit both the formal and informal sectors and over the last nine years the participation of the national school system, the national youth and women associations and the military was intensified with the inception of the Government/World Bank HAMSET programme which brought more than US$64.0 million for the purpose of mainstreaming prevention and control of HIV/AIDS/STIs, Malaria and TB infections at different government sectors, CSOs and faith based organizations. In 2009, the Ministry of Health completed a *Policy Guide for Mainstreaming HIV and AIDS in Government and Private Sectors* and provided the essential training to increase the capacity of focal persons of ministries and organizations participating in the national response.

The gradual decrease in HIV prevalence shown in the national surveys, in HIV testing centers and PMTCT units is attributed to the careful, well designed and comprehensive national response programmes that enjoy political and administrative support and relishes the supporting policies and guidelines the Ministry of Health consistently advocated for and in association with line ministries and other sectors, developed through the years.

2. OVERVIEW OF THE EPIDEMIC:

The nation wide sentinel survey conducted every other year among pregnant women is still the base on which the national HIV prevalence is estimated. The most recent survey (2007) indicated a prevalence rate of 1.33% among the general population. The new estimate points at a stabilization of the epidemic although there are population groups that are considered most at risk who may present HIV positive test result that can be higher than the national average. Disparities along areas of residence; age groups; marital, occupational, and socio-economic variables are also observed.

Apart from the sentinel surveys, available indicators suggest that the overall HIV prevalence rate in Eritrea has decreased significantly. There is a general consensus that information and education on the modes of HIV transmission and the methods of prevention are disseminated through the activities of multi sectoral partners who periodically stage mass mobilization programmes which includes public debates, general knowledge contests, music and drama. A hot-line telephone counseling services exercised by the National Association of People living with HIV and AIDS (BIDHO) and the National Union of Eritrean Youth and Students (NUEYS) gained remarkable popularity among young people. BCC peer group education, life skills based HIV education in schools, and the EDF's *"know your self"* campaign for HIV testing held every other year in all bases the military establishment certainly increased public knowledge and promoted safe behaviour among the military and the general population. 'Community Change Agents' sponsored and operated by the EDF reach rural communities and the Home Based Care services have become important sources of knowledge in many neighbourhoods. These programmes are principally designed by the Ministry of Health and are adopted by the different supporting sectors, the Joint UN Programme of Support, and the faith based and civil society organizations. The lessons learned during the previous years elicited that special emphasis be made on populations considered to be most at risk.

The Declaration of Commitment on HIV and AIDS agreed upon by 189 Member States at the UN General Assembly Special Session on HIV and AIDS (UNGASS 2001) is monitored through a progress report which is submitted every two years using a set of UNGASS indicators that measure country level outputs and out comes as indicated in the Declaration of Commitments. The country developed the Interim - Poverty Reduction Strategy Paper (I-PRSP); adopted the United Nations Development Assistance Framework (UNDAF) and the HIV & AIDS National Strategic Plan which provide imputes to the quality of national responses and to the indicators presented in the UNGASS Report.

Efforts are made to capture the nature and diversity of the forces that drive the HIV epidemic in Eritrea through understanding of the entire landscape and history of the HIV epidemic. The greater part of the country situations and the dynamics of the epidemic are encompassed into the report through literature reviews and closer interactions with individuals, groups, and organizations that are closely associated with the national response. A few missing records and data caused by lack of periodic surveys and incompleteness of regular reports contributed to the incompleteness of some of the UNGASS indicators.

3. BACKGROUND:

Eritrea is located at the Horn of Africa and extends over 1,300 km from Ras Kassar in the north to Ras Dumeira in the south on the Red Sea coast. It is bounded on the east by the Red Sea, on its southeastern tip by Djibouti, on the south and southwest by Ethiopia and on the north and northwest by the Republic of the Sudan. With an area of 121,144 sq. km, Eritrea is home to an estimated 3.6 million population. Moreover, Eritrea owns the Dahlack Archipelago group of three islands and many rocky islets in the Red Sea whose surface area totals to over 751 sq.km. The mainland consists of a high plateau and a coastal plain ranging in altitude from Mt. Amba Soira at 3,010 meters to the Danakil Depression at 100 meters below the sea level.

The Eritrean society is ethnically heterogeneous with the nationalities of Afar, Bilen, Hedareb, Kunama, Nara, Rashaida, Saho, Tigre and Tigrigna making the list. Although all nationalities speak their oen languages and dialects, Tigrigna and Arabic are the working languages. About 80% of Eritreans live in rural communities and agriculture and

pastoralism are the main sources of their livelihood. The agricultural sector is mainly rain fed with less than 10% of arable land currently irrigated (EPHS 2002).

Before the national independence, the few urban centers that were under the Ethiopian administration were used as garrison towns for thousands of Ethiopian troops and their presence promoted a massive trade of sex work in Eritrea. After the advent of HIV and AIDS, the most notable places that became known for their transactional sex are the port town of Assab on the Southern Red Sea Coast and Asmara, the country's capital and its most populated city.

The first HIV infection was reported in 1988 at the port town of Assab, at such a time when a full scale war was in progress and when the port of Assab was the Ethiopian lifeline on which their massive war efforts depended. After the national independence, the MOH spent time and energy to develop national policies, guidelines and strategies to control of HIV epidemic, it also made efforts to closely understand the true magnitude of the epidemic and to determine the strategies for prevention. Behaviour surveillance Surveys (BSS), LQAS surveys and specific studies targeting most at risk groups had been regularly conducted. Country wide sentinel surveys that targeted ANC attending pregnant women started in 2001 and continued to provide proxy averages of HIV prevalence with reasonable accuracy and acceptability. Although disparities are observed between geographic locations, different age groups, occupational, educational and socio economic backgrounds among HIV positive individuals, the pictures shown by the results of the 2003, 2005 and 2007 sentinel surveys showed a stabilized HIV prevalence in Eritrea.

In more than 90% of the cases, HIV transmission route is heterosexual followed by mother to child transmission. HIV transmission through transfusion of donated blood is successfully curtailed with the establishment of a National Blood Transfusion Center (NBTC) and the introduction of a dependable system for blood screening since 2003.

Injecting drug use and men having sex with men (MSM) did not as yet pose as identified challenges although they are not ruled out altogether. The peak age for AIDS related infections is 29-34 for men and 20-29 for women.

No vulnerability study had been conducted in the recent past, but the following factors may represent some of the behavioural and economic situations that may propel the epidemic. NATCoD's annual report 2008 indicates that:

- Over 18.5% of the males and 19.6% of the females who live with the infection are in the age range of 15-24. A further 8.0% of males and 14.2% of females belong to the age group of 25 to 34;
- Rapid urbanization, especially among young people is believed to have contributed to the spread of HIV infection in urban and semi-urban communities;
- Women may be vulnerable because of their biological and cultural factors, inadequate negotiating skills and due to their economic dependency on their male partners who may not be faithful to them.

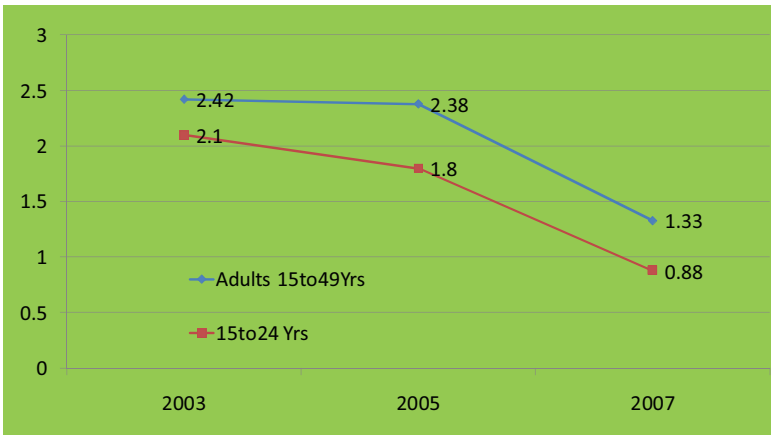
Based on the Sentinel Sero-Survey Prevalence Estimates of 1.33%, about 47,880 individuals of all ages and sex are currently estimated to be living with the infection.

4. CURRENT STATUS OF THE EPIDEMIC:

Of the estimated populations that are living with HIV and AIDS about 15% are estimated to be eligible for drug treatment. This estimation is, however, based on the former WHO Guidelines that recommend eligibility for ARV treatment at a CD4 count of 200/ml or less. With the new WHO Guidelines early treatment is recommended and the proportion of treatment eligible cases is expected to rise 2-3 times higher than the current estimate. By end of 2009, a total of 5,266 or 73.3% of the total ART eligible individuals started treatment. About 8.0% (428) of the total who started ART died and another 207 are lost to follow up during the years of treatment. Four hundred fifty

three cases shifted to other drugs during pregnancy and some due to drug failure. Free antiretroviral drug therapy started at the beginning of the third quarter of 2005 and ART is made available in 17 health facilities including at military medical centers. The result of the 2009 ANC based sentinel survey is not yet reported.

Eritrean HIV prevalence trend among ANC Sentinel sites 2003-2007



As indicated in graph 1 the current (2007) estimate of 1.33% prevalence among pregnant women attending ANC services is the lowest coming down from 2.42 % prevalence rate in 2003. Prevalence among pregnant women in the age group of 15-24 also showed a sharp decline from 2.1 % in 2003 to 0.88% in 2007. A proportionately similar reduction is observed in all administrative zones. A few urban centers including Asmara, Massawa, Tesseney and Keren continue to show HIV prevalence rates that are higher than the national average. Ironically, however, HIV prevalence at the port town of Assab dropped from 7.2% prevalence rate in 2003 to 0.7% during the 2007 survey probably because the of distance and limited mobility that kept the population size constant. Based on different epidemiological and socio economical factors and associated indicators, Massawa, Asmara and Tesseney can be taken as the geographical hot spots of HIV in Eritrea.

Urban / Rural Variation:

The current estimate of infection level among the urban population of Eritrea is 3.5% while the infection rate among rural residents is still less than 1.0% showing that the infection rate in urban setting is 2.85 times higher than it is among rural communities.

Marital Status:

Single women are the highest infected group of pregnant women with 4.94% prevalence rate. Although this figure is relatively lower than the proportion shown in 2003 (6.8%) or 2005 (7.2%) it is still 3.7 times higher than the national average.

Age Group:

The age group of pregnant women with the highest prevalence rate is that of 30-34 with 2.1% followed by 25-29 and 20-24 who presented 1.88% and 1.26% respectively. All other age groups, including young people aged 15-19 had an infection rate of less than 1.0%

Educational Level:

Despite the general belief that educated people receive more information and are inclined to learn quicker and apply preventive measures against HIV infection, the results of the sentinel survey of 2007 showed that women who attended elementary, junior secondary and senior secondary level education had at least two fold infection rates than the women who never attended any level of schooling.

Occupation:

In all sentinel sero prevalence surveys, pregnant women who work in bars and hotels showed a high infection rate of 7.69%. Women employed in private enterprises had 4.2% infection rate while the proportion of infected status among unemployed women is the fourth highest with 3.8%.

Occupation of Partners:

The survey showed disparity among women who are married to or are partners with men of different occupation. The 2007 survey report showed that women whose spouses are unemployed or are 'self employed' men showed 5.97% infection rate. The women who live with traveling merchants had 2.56% infection rate while daily laborers had 2.34%. Spouses or partners of truck drivers and the military showed 2.3% and 1.37% infection rate respectively.

5. NATIONAL COMMITMENT & ACTION:

Eritrea has a positive national commitment that stimulates policy decisions, political and government support, societal participation and support during the process of developing and implementing comprehensive multi sectoral programmes in fighting the HIV epidemic and in establishing a well-rounded national response that will also put more emphasis to mitigating the effects of the epidemic. With the increasing demand for the AIDS response in terms of the activities and projects indicated in the ENASP 2008 – 2012, tracking for funding that can be made available for all HIV and AIDS related programmes as shown in the different Thematic Areas and defining the sources of funding and other support was a measure of national commitment to the HIV & AIDS response.

Costing for the national AIDS response was included in the National AIDS Strategic Plan which estimated US$ 174 million figured to meet the set priorities, strategies and targets that are shown in the strategic plan and the Universal Access Targets. Understandably, the costing exercise was made to guide resource mobilization, allocation and utilization funds in accordance to the priorities set by the NATCoD and to identify the gaps for future proposals. Depending on the amount of funds that are to be made available during the next three years of the National Strategic Plan, a financial gap of over US$ 100 million is estimated. The indicated huge gap cannot be narrowed without the concerted efforts of the government, development partners, multilateral donors and supporting agencies to mobilize the amount of funds indicated above.

The tracking exercise for 2008 and 2009 showed a total spending on HIV and AIDS activities in Eritrea that amounts to **US$ 14,456,536.32** and **US$ 11,672,922.44** for 2008 and 2009 respectively.

a. UNGASS Financial Indicator Over- View Table in US Dollars

AIDS Spending Categories Thematic Area	2008	2009
1. Prevention of New Infection		
Prevention	1,323,420.84	1,265,602.48
Condom Promotion & Distribution	200,000.00	273,267.00
Diagnosis & Treatment of STIs	423,000.00	465,500.00
Prevention of Mother to Child Transmission	60,500.00	117,729.77
Behaviour Change Communication	540,000.00	680,499.00
Life Skills Based HIV Education in Schools	715,484.27	247,584.37
Blood Safety and Universal Precaution	423,000.00	465,500.00
Workplace HIV Prevention	82,100.00	5,702.00
Total	**3,767,505.11**	**3,521,384.62**
2. Improvement of Quality of Life (Care & Treatment		
Antiretroviral Treatment and Monitoring	408,168.22	763,264.21
Prophylaxis and Treatment of OIs	1,637,350.39	1,291,697.00
Care and Support for the Chronically Ill	348,988.00	688,731.67
Laboratory, including procurement of equipment	1,540,112.98	1,163,905.00
Total	**3,934,619.59**	**3,907,597.88**
3. Mitigation of Socio Economic Impact of HIV & AIDS		
Support for Orphans & Vulnerable Children	1,351,801.00	710,799.79
Skills Training for IGA	14,768.62	35,000.00
IGA for affected household	17,350.00	134,323.69
Total	**1,383,919.62**	**880,123.48**
4. Promoting Supportive Environment		
Multi-sectoral Capacity Development	137,896.47	740.065.00
Ensure Community Empowerment	1,467,049.00	1,505,500.00
Reduce Stigma & Discrimination	62,243,00	63,700.00
Address Gender and Gender Based Violence	51,726.00	100,000.00
Enhance Technologies for HIV Response	54,666.67	65,000.00
Promote Policy and Legal Framework	--	1,980.00
Total	**1,711,338.14**	**1,736,180.00**
5. Strengthening Supportive Health System		
Coordination & Planning System Management	256,799.72	279,207.24
Infrastructure /Institutional Support	1,972,658.02	1,250.202.21
Development of Human Resources	273,758.00	109,060.00
Monitoring & Evaluation	588,463.02	135,561.00
Procurement & Management of Supplies	326,968.00	991,202.00
Research and Surveillance	240,507.60	40,347.23
Budgeting and Resource Mobilization	--	72,258.98
Total	**3,659,154.36**	**1,627,636.45**
G. Total	**14,456,536.82**	**11,672,922.44**

b. Funding Source for HIV/AIDS During the UNGASS Reporting Period in US Dollars

Funding Source	2008	2009
Government Support	846,000.00	931,000.00
The Global Fund	6,756,054.12	3,313,423.00
The World Bank /IDA	3,655,972.00	3,846,375.00
JUNP of Support on AIDS	2,702,174.77	2,989,844.77
Sub Total	**13,960,200.89**	**11,080,642.77**
Norwegian Church Aid	262,708.00	332,638.00
Swiss Inter-Church Aid	44,955.47	59,215.65
OXFAM GB	--	29,795.00
Red Cross Society of Eri.	81,642.48	148,072.02
Sub Total	**389,305.95**	**569,720.67**
Lutheran W. Federation	107,030.00	23,559.00
Evangelical Church	--	--
Sub Total	**107,030.00**	**23,559.00**
Total	**14,456,536.84**	**11,672,922.44**

With a few exceptions, the financial resources raised by the government, funding agencies and the partners had taken care of most of the activities the country planned for implementation during the two years of UNGASS reporting period. At present, the Global Fund, the HAMSET II project, the Joint United Nation Programme of Support on AIDS and the few faith based organizations, associations and NGOs contributed to the national response of HIV and AIDS. Despite the resource constrained situations, the support made by the government during the last two years cannot be undermined. Of the USD 26,129,459.26 expended during the UNGASS reporting years of 2008 and 2009 disaggregated funding by Thematic Area is expressed as follows:

- Prevention USD 7,288,889.73 27.8%
- Treatment and Care USD 7,842,217.47 30.0%
- Mitigation of socioeconomic Impact USD 2,264,041.10 8.66%
- Promoting Supportive Environment USD 3,447,518.14 13.1%
- Strengthening Supportive Health System USD 5,286,790.81 20.2%

6. NATIONAL COMPOSITE POLICY INDEX (NCPI)

A number of government and non government organizations were involved and participated in the NCPI data collection and validation process. The main offices and officers who responded to NCPI and participated at the consensus building workshop are listed in annex

a. Part A:

I. Strategic Plan:

The Country has developed a national multi-sectoral strategy to respond to HIV since 1997. The current ENASP 2008-2012 is the third edition of the 5 year strategic plan that includes sectors such as the local administration, education, labour, transportation, the national defense, unions and associations of workers, youth, women and PLHA. The participation and involvement of faith based organizations and NGOs have been consistent in promoting issues of national response to HIV prevention and care services.

II. Political Support:

High officials including the President of the State of Eritrea use available forums to promote and support the efforts made in curbing the national epidemic of AIDS and in mitigating the effects of the global pandemic in Eritrea. Civil Society Organizations, the private sectors and faith based organizations are given opportunities and the resources needed to involve themselves in the implementation of the response package against HIV and AIDS including home based care services psychosocial and spiritual support, preventive programmes such as IEC/BCC activities. The national media is friendly to the ideals and principles of the national response against AIDS and provides ingenious and imaginative programmes that helps to enhance people's perception and knowledge about HIV and AIDS.

III. Prevention:

The National Strategic Plan (ENASP 2008-2012) is a highly comprehensive tool of planning and includes all aspects of prevention efforts that are essential in reaching the broad masses and specifically targets all young people in and out of schools, sex workers and their clients, long distance truck and bus drivers, travelling merchants, the military and all others that fall under the immediate concern of preventive programmes and projects.

HIV education is included in the National Schools Curriculum in junior and senior secondary and post secondary schools. Life skills based HIV education will be provided in grades 4 and 5 as soon as the text books and training materials designed for the level are printed in different ethnic languages.

BCC strategies are sufficiently spread in schools, the military camps, youth centers, among female sex workers, at workplaces and among women in rural communities. Although the public response in terms of behaviour change is not measured over all areas, knowledge about HIV infection in Eritrea can be safely expressed as universal.

IV. Treatment, Care & Support:

A comprehensive HIV treatment, care and support policy that addresses equal opportunity for women and other most at risk population is developed in 2005 and the specific needs for ART and care and support services are determined through situation and response analysis and data collected from service centers, the Health Management Information System (HMIS) and from the results of special surveys. Currently, more HIV cases are looking for physical examinations and counseling, in order to qualify their eligibility to ART. At present, more women than men are on treatment. There is an increased public awareness to care and treatment and community support systems are on the rise.

The challenges of faced in scaling up treatment, care and support services are constrained financial resources and shortage of skilled staff to support and attend to the needs of the infected and affected households including that of children.

V. Monitoring & Evaluation:

The monitoring and evaluation plan for all HIV related responses is incorporated in the 2008 – 2012 National Strategic Plan and the plan is endorsed by all partners and stake holders which in turn are able to align and harmonize their requirements according to the national M&E plan. The challenges faced in this effort is due to the lack of computerized data system and shortage of skilled human resources. Besides, the lack of an updated population census still play havoc on national indicators and the existing data bases.

b. Part B:

I. Human Rights:

Directives and regulations against all sorts of discrimination are underlined under the general law of health care and prevention programmes including the HIV/ AIDS and STIs Policy and Policy Guidelines. Discrimination around HIV in schools, workplaces, housing, employment and health care services is not tolerated. However, a few stigmatizing remarks and a few acts of discrimination taking place in poor and crowded neighbourhoods may have been noticed now and then without attracting official or legal measures. The legal and administrative directives help to clear away the obstacles to effective HIV prevention, treatment, care and support for population groups identified as most at risk and other vulnerable populations including women, the youth, sex workers, prison inmates, migrant and mobile populations, orphans and out of school children.

II. Civil Society Participation:

The National Unions of Eritrean Women (NUEW), the National Union of Eritrean Youth and Students, the National Confederation of Eritrean Workers, faith based organizations, the Association of People Living with HIV and AIDS, and community groups play significant roles in support of the national response to HIV infection. Prevention activities at work places, BCC peer groups among different population, home based care and support systems developed and matured within the civil society and faith based organizations force significant changes in the behaviour of the population and specifically among the young and the sexually active group.

III. Prevention:

Eritrea realized its specific needs for HIV prevention programmes since the development of the first National Strategic Plan (1997) and created linkages with the different HIV related communication strategies that were put forward over the years. HIV testing has become part of the integrated services in 135 health facilities and PMTCT programmes are available in 93 ANC units.

IV. Treatment, Care and Support:

Faith based organizations, the Ministry of Labour, the national unions, the Associations of PLHA and other support groups and volunteers established the Home Based Care (HBC) programmes since 2003. As explained above, ART was started by the Ministry of Health since 2005.

7. THE CURRENT NATIONAL STRATEGIC PLAN:

The National Strategic Plan on HIV and AIDS (ENASP 2008-2012) had its genesis on the results of the Situation and Response Analysis conducted at the end of the National Strategic Plan 2003 – 2007 and on the facts and the lessons learnt during the two preceding national strategic plans that were operational in 1997 through 2007.

The new National Strategic Plan puts the combined efforts of stakeholders, development partners, the government and the private sectors and is intended to be as participatory as possible. For all intents and purposes, the selected indicators are aligned with the UNGASS indicators and reflect targets 6A and 6B of the Millennium Development Goals (MDG) and the Universal Access Targets. ENASP 2008 -2012 captures the overall goals of Eritrea's national response which is built on Three Thematic Areas: Prevention of sexually transmitted HIV infection through targeted interventions; Improvement of the quality of life; and Mitigation of socio economic impact among people that are infected with and affected by HIV and AIDS. Besides, the three thematic areas are complemented by Strengthening *the Supportive Environment and Strengthening of Health Systems.* ENASP (2008-2012) also includes an *Operational Plan* and a *Monitoring and Evaluation (M&E) Framework and Plan.* Both are appropriately costed.

Thematic Area 1: Prevention of New HIV Infection: Aims at reducing incidence of HIV in the general population aged 15-19 and 15-24 by 2012. Key strategies include targeting identified high risk groups	
Service Delivery Areas & Objectives	**Selected Indicators**
1.1 Awareness, HIV testing, etc. • Increase % of adults (15-49) who test and received results from the current 12% (females) and 17% (males) to 30%	• % of men and women aged 15-49 who received HIV test in the last 12 months and who knew their result
1.2 Condom promotion and distribution. • Increase % of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom • Increase % of female sex workers reporting the use of a condom in most recent sexual encounter from the current 76% to 95% by 2012.	• % of women and men aged 15-49 who had more than one partner in the past 12 months reporting the use of condom during their last sexual intercourse
1.3 STI Diagnosis & Treatment • Reduce the national prevalence of syphilis infection among pregnant women from the current 1.12% to less than 1% by the end of 2012.	• National prevalence of syphilis among pregnant women; number of STI cases appropriately diagnosed and treated in accordance to national guidelines
1.4 Prevention of Mother to Child Transmission of HIV • Increase % of HIV infected pregnant women receiving complete course of antiretroviral prophylaxis to reduce the risk of MTCT from the current 25% to 50% by the end of 2012. • Increase % of HIV free infants who are born to HIV positive mothers from 70% to 90% by 2012.	• % of HIV free infants born to HIV positive women; number of PMTCT service sites in the country; • % of pregnant women tested for HIV and percentage of HIV positive pregnant women who received the full course of prophylactic ARV
1.5 Behaviour Change Communication • Increase % 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 from the current 35%to 10% by the end of 2012 • Increase BCC interventions nationally from 10% to at least 80% in high risk subgroups and vulnerable population (SWs, truck drivers, women, youth & students etc...) by 2012. • Increase the number of communities providing BCC peer group education among different population groups from 30 to 150 by 2012.	• % 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, • % of most at risk populations and vulnerable populations reached with HIV programs, • No. of communities that established BCC peer group education among different population groups.
1.6 Life Skills Based HIV Education • Expose children in primary and secondary schools to life skills education by 2012. • Enable all schools provide life-skills based HIV education by 2012.	• % of schools that provided life skills based HIV education in last academic year • No of students exposed to life skills education in the last academic year.

Thematic Area 1: Prevention of New HIV Infection: Cont. Aims at reducing incidence of HIV in the general population aged 15-19 and 15-24 by 2012. Key strategies include targeting identified high risk groups	
1.7 Blood safety, universal precaution & post exposure prophylaxis • **M**aintain 100% of donated blood screened for HIV in quality assured manner over the next five years. • **E**nsure 100% adherence to universal precautions by 2012. • Increase the number of health facilities with post exposure prophylaxis (PEP) services from 14 to 57 facilities by 2012.	• **%** donated blood units screened for HIV in a quality assured manner; number of health facilities with standard waste management system in place and number of health facilities providing PEP service.
1.8 HIV & AIDS at Workplace • **R**each at least 85% of public and private institutions/organizations implementing HIV/AIDS/STIs prevention, care and support within workplace programs by the end of 2012; • **B**uild capacity for integration of HIV & AIDS into private and informal sectors with defined policies, strategies and implementing guidelines.	• **N**o of public and private institutions and organizations implementing HIV/AIDS and STIs prevention, care and support services at the workplace and number of employee reached.
Thematic Area 2: **Improve the Quality of Life for Infected and Affected by HIV & AIDS.** Committed to address the well being of individuals and groups that are affected by and infected with HIVAIDS through multi sectoral approaches, the MOH developed policies on antiretroviral and treatment guidelines, training & reference manuals for the prevention and treatment of opportunistic infections and home based care and support. As a continuum of care and treatment, the following three service delivery areas are identified to improve the quality of life for the infected and affected.	
Service Delivery Areas & Objectives	**Selected Indicators**
2.1 Antiretroviral treatment and monitoring. • **I**ncrease the percentage of adults and children with advanced HIV infection receiving ARVs from the current 43% to 85% by end of 2012.	• **%** of adults and children with advanced HIV infection receiving ARV, • **%** of adults and children with HIV known to be on treatment 12 months after initiation of ARV, • **N**o of health facilities providing ART each year.
2.2 Prophylaxis & treatment of opportunistic infections • **I**ncrease number of adults and children with HIV infection receiving cotrimoxazole prophylaxis for opportunistic infections from the current number of 4,000 to 20,000 by the end of 2012. • **E**nsure that 100 percent of the adults and children diagnosed as HIV positive TB cases receive appropriate treatment by the end of 2012	• **N**o of adults and children with HIV receiving prophylaxis for opportunistic infections, • **N**o of staff trained in administration of prophylactic and OI treatment. • **N**o of adults and children who are HIV positive TB cases receiving appropriate treatment
2.3 Care and support for Chronically ill • **M**aintain at least 1,800 of chronically ill AIDS patients receiving home-based care every year.	• **N**o of people living with HIV and AIDS who received home-based care during the last 12 months.

Thematic Area 3: Mitigation of Social and Economic Impact of HIV/AIDS To protect and care for children orphaned and made vulnerable by HIV & AIDS and to mitigate the social and economic impact of the infection in families and communities, the government devised a mechanism to build and strengthen family and community capacities to provide care and support system and strongly advocated that care and support for AIDS orphans and vulnerable children be given due priority in all HIV & AIDS related policies and guidelines including in national strategic plans	
Service Delivery Areas & Objectives	**Selected Indicators**
4.1 Support for orphans & vulnerable children • Increase % of orphans and vulnerable children aged 0-17 who received free basic external support from the current 15% to 50% by end of 2012, • Promote external support for orphan and vulnerable children by extended family members and through organized community groups,	• % of orphans and vulnerable children aged 0-17 years who received free basic external support, • % of orphans who attend school as compared to non orphan children aged 10 - 14 years • Amount of financial resources allocated by all stake holders in support of orphans and child headed households per year
Thematic Area 4: Promoting Supportive Environment Aims to stand against all factors that disproportionately targets individuals to HIV infection, promotes awareness and information, economic security and empowerment of women; prevents sexual exploitation of women and girls, and stigma and discrimination.	
Service Delivery Areas & Objectives	**Selected Indicators**
4.1 Strengthen multi sectoral capacity development • Involve, by 2012, at least 60% of the multi-sectoral partners such as civic societies, faith based organizations (FBOs) the association of people living with HIV and AIDS (PLHA) and the private sectors in leadership, management, monitoring and reporting on HIV/AIDS/STIs related activities; • Promote at least 60% of multi-sectoral partners to adopt and use National Guidelines for mainstreaming HIV/AIDS and STIs into multi-sectoral activities across the country; • Enable at least 60% of multi-sectoral partners to adopt and apply standard formats for data collection and timely reporting systems pertaining to HIV & AIDS related activities within their areas of operations by end the of 2012.	• No of multi-sectoral partners (CSOs, FBOs and other community groups) trained on existing guidelines and issues related to monitoring and reporting; • No of line ministries, implementing agreed upon HIV/AIDS sectoral plans; • No of sectors in the multi sectoral partnership who regularly report using standard formats developed by the national authority.
4.2 Ensure community empowerment • Increase the number of BCC Peer education groups from the current 30 to 60 by the end of 2012. • Establish 150 income-generating schemes for individuals and households that are affected by HIV & AIDS by 2012; • To increase the annual number of community-based HIV/AIDS projects from the current 150 to 200 annually during the ENASP period.	• No of communities participating in BCC peer group education • No of HIV/AIDS affected people and households supported through IGAs annually. • No of communities using national guidelines for community participation

Thematic Area 4: Promoting Supportive Environment Cont. Aims to stand against all factors that disproportionately targets individuals to HIV infection, promotes awareness and information, economic security and empowerment of women; prevents sexual exploitation of women and girls, and stigma and discrimination.	
4.3 Reduce stigma and discrimination Reduce the effects of stigma, silence, discrimination, fear and denial around HIV and AIDS and to promote prevention, care, treatment and support services in the community and among PLHA from the __% (baseline to be determined from DHS+ 2008/2009) by 50% by 2012. • Enact, strengthen or enforce, as appropriate, legislation and regulation that eliminate all forms of discrimination against PLHAs and to ensure the full enjoyment of all human rights and fundamental freedoms by people living with HIV & AIDS and members of the vulnerable groups.	• No of stigma and discrimination related national, zonal and community campaigns undertaken each year; • No of life skills education and counseling to help HIV infected and affected children cope with stigma each year; • No of training sessions undertaken by the national association of People living with HIV and AIDS through ENASP's strategic support
4.4 Address gender issues and gender based violence • Identify existing resources and the potential channels for communication that can be mobilized to inform communities about prevention and response to sexual violence; • Support at least half of the women headed household who need support through income generating schemes by the end of 2012; • Reduce sexual violence reported from current level (to be determined in DHS+ 2008/09) by 25% by the end of 2012.	• No of social mobilization seminars and workshops focusing on gender and sexual violence against women; • No. of capacity building and training sessions conducted to empower women in management of IGAs. • Amount of investments allocated to support women-based IGAs.
4.5 Enhance new technologies for HIV & AIDS response • Introduce, test and evaluate the efficacy of new and emerging technologies & approaches for HIV/AIDS prevention and treatment through appropriate policies and programmatic guidelines;	• No of appropriate technologies & approaches for HIV/AIDS approved and implemented in the country; • No of national experts participating in regional and global research initiatives; • No of national experts attending international research network meetings.
4.6 Promote policy development & legal framework on HIV & AIDS • Develop appropriate policies and guidelines that addresses issues of stigma, discrimination, emergencies and humanitarian concerns and to incorporate them into sector planning and program activities by the end of 2012; • Establish and institutionalize the principles of "Three-ONES" in all government, non government and private sectors working on HIV/AIDS/STIs by the end of 2012; • Establish workplace policy and guidelines on HIV/AIDS interventions in public and private sectors by the end of 2012 • Ensure that all policies that are developed to support quality interventions are legally endorsed and in use by end of 2012	• No of institutions that adopt and applied the "Three-Ones" principles; • No of institutions adopting national policy for prevention of HIV/AIDS in work places; • No of training workshops conducted on mainstreaming of HIV/AIDS and STIs; • No of new policies and guidelines that address issues of stigma, discrimination, emergencies and humanitarian concerns into sector planning and national program activities.

Thematic Area 5: Strengthening Supportive Health System Aims to mitigate the burden that is inflicted by the HIV epidemic on the health care system in terms of bed occupancy and long in-patient care including of depletion of medical supplies, drugs and other consumable commodities.	
Service Delivery Areas & Objectives	**Selected Indicators**
5.1 Coordination and planning system management • Ensure the coordination and planning capacity of NATCoD, units and sections of the health care systems, structures and levels of service delivery, and establish clearly defined roles, functions and linkages by 2012;	• No of health staff trained on HIV/AIDS/STIs coordination and planning at all levels of the service delivery; • No of people from the multi-sectoral partnership and community groups trained in HIV/AIDS/STIs coordination planning and management at all levels of the service delivery.
5.2 Infrastructure support • Maintain & renovate 60% of health facilities integrating HIV/AIDS/STIs programs by end of 2012. • Institutionalize computerized information data systems into daily operations in at least 50% of the health facilities by 2012; • Ensure the continuity of power supply by installing solar systems in 60% of the existing health facilities by 2012; • Ensure storage capacity in 60% of health facilities by the end of 2012.	• No of health facilities that are renovated for effective integration and user friendly services each year; • No of health facilities that use computers for information and communication system; • No of health facilities that installed solar powered electric supply system each year; • No of health facilities that maintain appropriate storage system each year.
5.3 Development of Human Resources • Recruit and deploy adequate health staff in various programs of HIV/AIDS/STIs countrywide (baseline & quantity to be determined after human resources assessment has been conducted) by the end of 2012; • Increase involvement of non-medical personnel in the delivery of appropriate non-medical HIV/AIDS/STIs services(baseline & quantity to be determined after human resources assessment is conducted); • Train at least 60% of health workers and non-health workers in relevant aspects of HIV/AIDS/STIs responses;	• No of health learning institutions that incorporated HIV/AIDS/STI in their curriculum. • No of health workers who are trained in relevant aspects of HIV/AIDS/STIs responses; • No of skilled health staff and other professionals that are recruited and deployed in various programs of HIV/AIDS/STIs programs countrywide; • No of non-medical personnel that are involved in appropriate non-medical HIV/AIDS/STIs related services;
5.4 Monitoring & Evaluation • Ensure that all health institutions and partner organizations who are active in the HIV/AIDS response have trained M&E staff that are capable to apply standardized routine data collection and management system, analysis of facility level routine reports and reporting according to set timeliness by end of 2012; • Establish an efficient central data base system for access by decision makers and multi-sectoral partners to improve their response and to report for international indicators such as UNGASS, MDGs etc. during the ENASP period. • Ensure that all implementing partners have developed and use an elaborate Performance-Based Monitoring and Evaluation System (PBMES) as a facilitating tool to build on the culture of evidence-based planning and decision-making.	• No of institutions that have trained M&E staff and applied standardized routine data collection and data management system including data collection and analysis at facility level and reporting according to set timeliness. • No of staff at all levels that are trained to apply standardized data collection, data management system, data analysis at facility level and reporting according to set timeliness.

Thematic Area 5: Strengthening Supportive Health System. Cont.. Aims to mitigate the burden that is inflicted by the HIV epidemic on the health care system in terms of bed occupancy and long in-patient care including of depletion of medical supplies, drugs and other consumable commodities.	
5.5 Procurement of Appropriate Supply Management System • **S**trengthen systems of integrated procurement and logistics management by building the capacity of staff and through improving infrastructure support; • **M**ainstream procurement guidelines and logistics management aspects into program planning and implementation details of ENASP 2008-2012	• **N**o of staff trained on adherence of principles and practices of procurement and financial reporting systems; • **N**o of sector institutions adopting and applying procurement guidelines into programs planning and resource allocation; • **N**o of procurement undertakings delivered timely and completed in a required quantity and quality.
5.6 Promote Research and Surveillance System • **S**trengthen the national capacity for HIV and AIDS related research and surveillance activities at all levels. • **E**ngage multi-sectoral service delivery levels to undertake operational research in HIV. • **E**stablish a national HIV research strategy and research agenda that is connected to the key aspects of the ENASP's priorities and strategies; • Improve processes for disseminating HIV related research products; • **E**nhance regular epidemiological surveillance system;	• **N**o of new targeted research and surveillance surveys undertaken and disseminated per year; • **N**o of trainings undertaken for relevant staff on research and surveillance methodology and reporting; • **N**o of case-based operational research undertaken by multi-sectoral partners in their respective areas of operations;
5.7 Establish Proper Budgeting & Resource Mobilization Mechanism • **I**ncrease resource allocation for HIV/AIDS/STIs response by 61.0% from current level by the end of 2012; • **I**ncrease the number of institutions that can develop their sector plan and budget with sound financial management and reporting system per year;	• **A**mount of resources mobilized from MOH and multi-sectoral partnership; • **N**o of staff trained on Costing, budgeting, financial management and reporting system per year; • **N**o of multi-sectoral partners applying standard costing and using financial reporting formats.

8. PREVENTION:

Prevention of New HIV Infection:

The National HIV & AIDS Policy and the Eritrean National Strategic Plan (ENASP 2008-2012) are the two main launching pads for the national response. The military, as a single homogenous entity, the National Union of Eritrean Youth and Students (NUEYS), the National Union of Eritrean Women (NUEW), the national school system and the work places are engaged in the comprehensive HIV prevention programmes and activities that include voluntary counseling and testing (VCT), behaviour change communication (BCC), condom promotion and distribution and life skills based HIV education.

Prevention, according to the National Strategic Plan (ENASP 2008-2012) carries a host of activities that are significant to the National Response. Positive developments and bigger area coverage had been documented in many areas of the national response such as expansion of VCT centers and ART sites. A modest but constant yearly expansion is documented around HIV testing and counseling. Prevention of mother to child transmission is progressing and so is public education and awareness. Despite the efforts, however, the 2009 NATCoD report shows that number of pregnant women who got access to PMTCT service was 34.6% and the proportion of HIV positive women who received the complete course prophylactic ARV remains as low as 24.9%.

HIV Counseling and Testing in the General Population:

Based on the Eritrean Demographic and Health Survey (EDHS 2002) the age group of 15-49 makes about 36% or 1.3 million of the estimated total Eritrean population of 3.6 million. Ever since the VCT programme started, close to 50% of the said population is believed to have been tested for HIV at one time or the other but no mechanism has been set to filter repeated tests. In 2008 and 2009 the number of young people who tested for HIV and who received results was 91,032 and 86,285 respectively and the combined total is about 14.0% of the 15-49 population. The VCT figures indicated for

the two years do not include the men and women who are tested while in uniformed services.

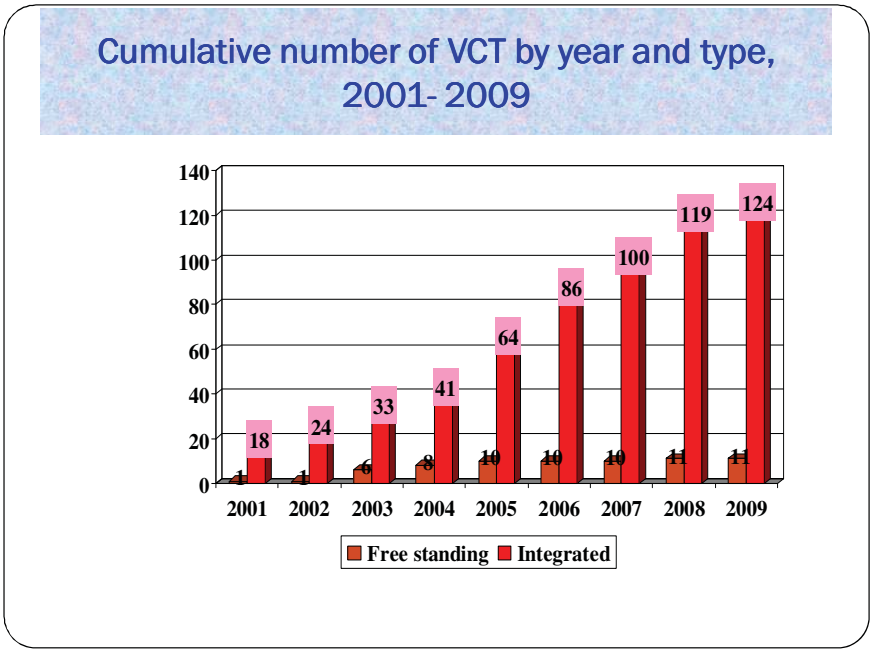
UNGASS Indicator 7: Percentage of young men and women who received an HIV test in the last 12 months and knew their results.				
Disaggregation				Remarks
	Numerator	Denominator	%	No population based
All 15- 49	NA	NA	NA	studies carried out.
Numerator: No of people aged 15 – 49 who have been tested for HIV during the last 12 months and who knew their result. **Denominator:** No of all people aged 15 – 49 including those who never heard about HIV and AIDS				

Population based study was not conducted during 2008/2009 and the number of males and females aged 15-49 who received an HIV test and who knew their results during the reporting period is not made available to validate UNGASS Indicator number 5.

However, VCT is presently provided in 124 integrated facilities and in 11 free standing units, the later being available in cities and towns only. Judging from the passive collection of VCT based HIV positive test results voluntary counseling and testing centers tend to present a higher proportion of infected individuals than the national prevalence indicated in the sentinel survey. The higher HIV positive rate documented in VCT units is said to be influenced by the characteristics of the people who attend the urban centered VCT centers. The numerical and geographical expansion of HIV testing sites is generally believed to have brought down the positive test results that went down from 4.34% in 2003 when it was exclusively urban based to 2.25% in 2009 when rural based facilities started providing VCT service.

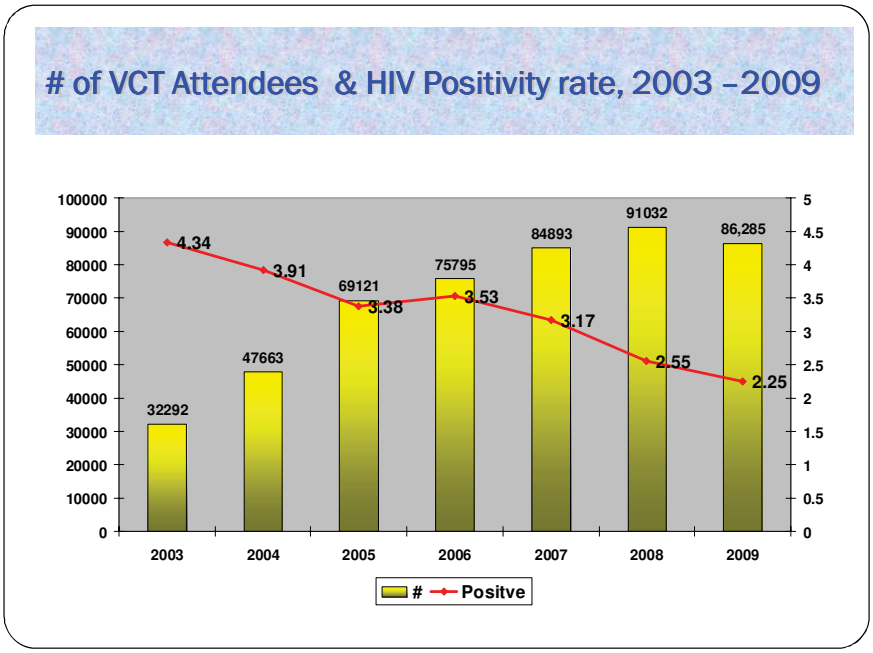
Peer education teams established among most at risk groups offered the opportunity to motivate a bigger number of young people to HIV testing and counseling. The BCC groups in rural communities and among sex workers routinely advocate for HIV testing in peer groups.

Graph 2 Cumulative numbers of VCT services and sites by year 2003– 2009



Media promotional programmes, awareness sessions staged in communities and in workplaces added up to the aggressive promotional activities sponsored by the Health Promotion Units of the Ministry of Health and other stake holders helped to increase the number of HIV tests every year. Moreover, the years of VCT services in Eritrea helped to stimulate a residual effect in improving risky behaviours. A decrease in unprotected sex with non primary partners is observed among individuals receiving VCT as compared to clients receiving information only and a significant decrease in gonorrhea incidence is indicated among women whose partners took the HIV test.[1]

[1] The World Bank Independent Evaluation Group – Project Performance Assessment (Denison et al 2006)



The Inter-Faith Group's determined promotion of premarital counseling and testing among couples increased the need for informed decisions among young people heading towards marital union. Pre-marital HIV counseling and testing is practiced in all parts of the country, is supported by all religions.

The National Union of Eritrean Youth and Students established youth friendly VCT units that are linked to sexuality and reproductive health education and BCC programmes carried out at their Youth Health and Recreation Centers established in different towns across the country.

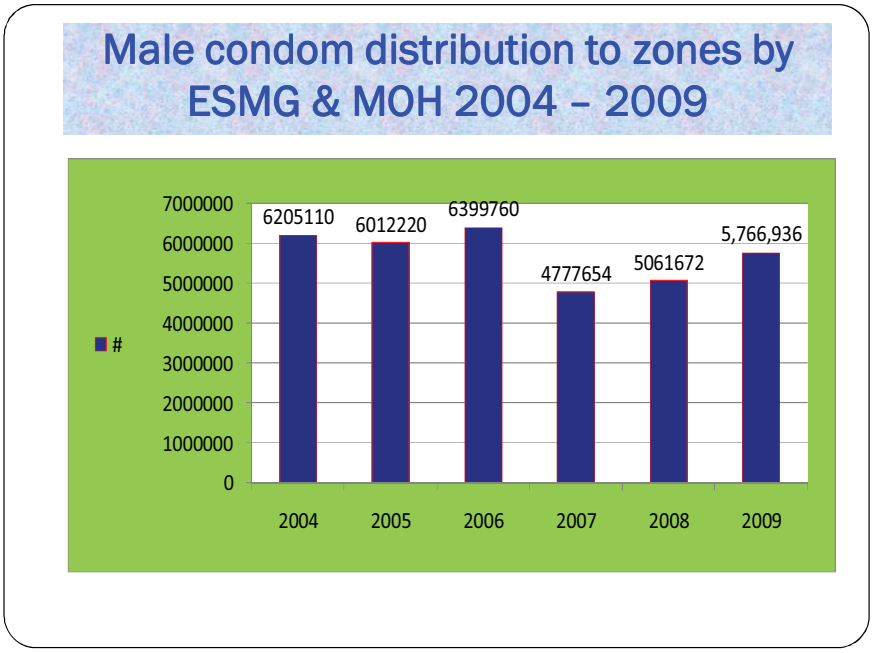
Condom Promotion and Distribution:

Condoms are distributed by health facilities of the Ministry of Health and by the Eritrean Social Marketing Group (ESMG). An average of 5.0 to 6.0 million male condoms is distributed every year during 2004 – 2009. Generic messages to promote condoms reached the general public through the ESMG's audio visual programmes and brochures, bill boards and the support from the national media services. ESMG created condom sales 'outlets' in bars, hotels, groceries, road side kiosks, and in pharmacies &

drug vendors and installed coin operated vending machines in night clubs, factories, and offices. In some areas like Massawa, the sex workers peer group often takes measures to ensure the availability of condoms at the time when other outlets are closed.

Both the Ministry of Health and the ESMG used IEC methodologies and the BCC peer discussion groups at all levels to smooth the feelings that developed among faith leaders and parents who perceived that teaching about condoms in schools and in communities is immoral. The importance of condom and its use is widely discussed in communities and schools.

An attempt was made to promote female condoms in the country since 2002 but its distribution was weak over the years even after female sex workers and other young women residing in Asmara and Massawa accepted is as women friendly preventive tool. BCC peer groups of community women and sex workers think that it was under utilized because of its high cost, unavailability and to some extent, because of the objection and suspicious reaction of male partners.

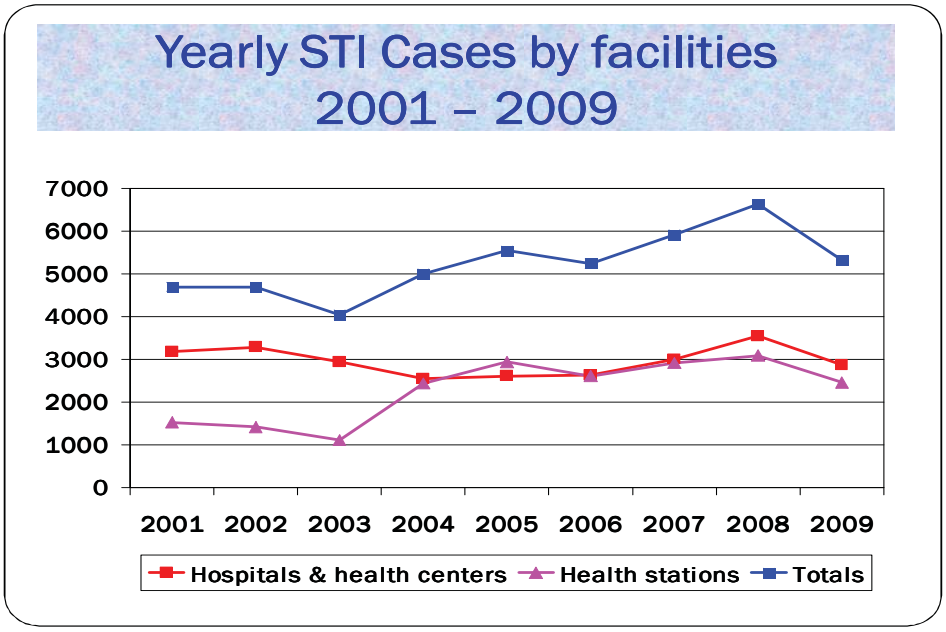


The mechanisms to condom promotion and its distribution applied among the Eritrean Defence Forces (EDF) became one of the Best Practices selected by UNAIDS in 2003. The EDF and the United Nations (Peace) Mission in Eritrea and Ethiopia (UNMEE) developed a strategy of condom promotion and distribution that was noted for its simplicity and practicality. The EDF's command structure, the existing health units, the trained human resources and its operational approaches added up to the enormity of the mission offered an opportunity to reach a high percentage of sexually active population and to promote condom use to all members. Consequently, condom is part and parcel of the military kit each member of the EDF ought to carry at all times.

Diagnosis and treatment of STIs:

The Sentinel Sero Prevalence Survey (2007) indicates a 1.1% of syphilis prevalence in the 4,898 pregnant women who took part in the study. The result proved to be less than the 2.4% reported earlier in 2005. Despite the lower rate, however, the relatively higher syphilis prevalence in particularly identified areas of the country is a cause for concern.

Gash Barka zone, with 3.29% syphilis prevalence among pregnant women, has become the most affected region and the zone's major towns and commercial centers such as Haykota, Barentu, and Tesseney showed higher rates of syphilis than the national average reported in all previous prevalence surveys including the last one. The results warrant for a highly charged comprehensive study, awareness programmes and treatment campaigns that need to focus on the general population of the area and beyond.



As demonstrated by the results of the HIV and Syphilis sentinel survey, syphilis infection is higher in rural Eritrea with a prevalence of 2.39% in 2007 than among urban dwellers that barely presented with 0.5% infection rate during the same survey. The disparity is believed to be caused by the lack of knowledge and information among women of the rural communities who consequently fail to identify early signs of STIs or who may lack the financial strength or transportation to seek proper medical diagnosis and treatment when the symptoms are finally felt. According to the 2007

sentinel survey, women with no education carry the highest syphilis prevalence with 2.35%.

Health facilities are still reporting an average of 5000 to 6000 STIs every year since 2004. Even then, the long practice of self treatment may have masked the true magnitude of the infections in the country. Given STI's intrinsic relationship with HIV and its role in speeding HIV transmission, the high prevalence of syphilis and other STIs among the rural communities may indicate that, despite the low prevalence of HIV, STIs may still carry some weight for concern in Eritrea. Another concern that emanates from the practice of self treatment may be the low quality of drugs and the insufficient dosage administered that may eventually create resistance strains.

MOH's policy demands that prevention of STIs is a priority public message and its proper diagnosis and treatment, including the establishment and practice of syndromic management of STIs in health facilities is carefully promoted.

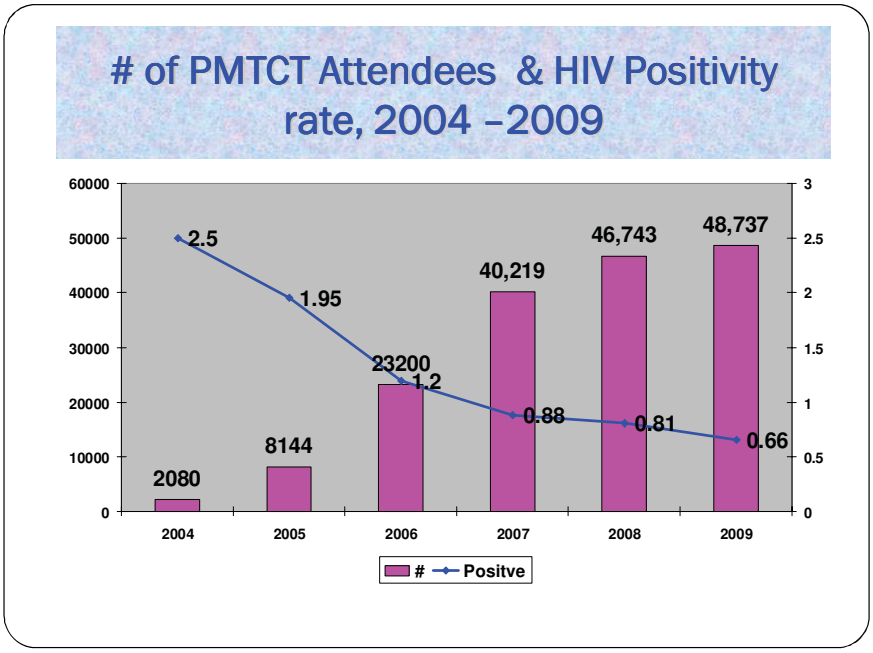
Prevention of Mother to Child Transmission of HIV

Prevention of mother to child transmission of HIV infection was first initiated in September 2001 and during 2002 – 2003 the programme went through a pilot phase at three Asmara hospitals. Actual expansion began in 2004 and by the end of 2009, the number of health facilities that integrate the service with the on going antenatal care (ANC) services are 93.

UNGASS Indicator 5: Percentage of HIV infected pregnant women who received ARV drugs to reduce the risk of mother to child transmission.				
HIV infected pregnant women receiving ARV to reduce the risk of MTCT.				
Disaggregation				Source
	Numerator	Denominator	%	
All	423	1,862	22.7	NATCoD, 2008
Single dose Nev. only	423	1,862	22.7	
All	464	1,862	24.9	NATCoD, 2009
Single dose Nev. only	464	1,862	24.9	
Numerator: No of HIV infected pregnant women who received ARV drugs to reduce the risk of mother to child transmission during the last 12 months of the year. **Denominator:** Estimated number of HIV infected pregnant women in the last 12 months of 2008 & 2009				

With only 34.6% coverage in 2009, the PMTCT service is relatively low as only 48,737 pregnant women attended services as compared to the number of pregnancies (0.04x3.6 m=144,000)[2] estimated to have taken place in 2009. The Health Management Information System (HMIS) report of 2007 showed that ANC service reached up to 75% of pregnant each year and the combined service of ANC/PMTCT service lingers far behind with about 35.0%. The PMTCT service is established in major towns where community hospitals and health centers are available while its distribution to rural based facilities is limited because of shortage of skilled human resources. Nationally, the HIV positive result among pregnant women showed a sharp decline from 2.5% in 2004 to 0.66% in 2009.

[2] NATCoD's estimate of pregnant women for 2009



Despite the constraining situations, the universal acceptability of PMTCT services among pregnant women attending ANC service is one of the most positive features of the national response in Eritrea. The programme introduced the 'Opt – Out' approach since 2005.

The opportunities that are offered by the influence and motivational activities of women in BCC groups and the developed personal initiations of the rural based pregnant women to seek PMTCT service enabled a significant number of rural based pregnant women to travel long distance to health facilities that can provide them the combined ANC and HIV testing service. The Ministry of Health trained over 700 health workers serving in ANC and maternal health units in PMTCT management with the objective of improving the quality of care and treatment for HIV positive women.

Behaviour Change Communication (BCC)

The strategies for community level BCC activities developed after the World Bank Project of HAMSET started in 2003 and fifteen model communities were identified, selected and initiated to start peer education activities among different population groups considered most at risk which included female sex workers, long distance truck drivers, women in communities, the workplaces. The same programme gradually involved farmers, fishermen, the military and students in schools. and later on involved the fishermen, farmers, military establishments and students in schools. In 2008 and 2009, 54 different communities and groups held weekly BCC sessions that involved 40,266 individual members, 1,546 peer facilitators and 61 supervisors[3].

The combined effort of the different BCC peer groups made 5,500 referrals to VCT centers in 2009. The peer group of sex workers distributed more than 32,000 condoms among its members in 2009. Presently, BCC peer group sessions include lessons and discussions on HIV/AIDS, tuberculosis, malaria and reproductive health.

A Peer Discussion Guide for all population groups was developed by the Health Promotion Unit of Ministry of Health. Other teaching aids such as posters and brochures were produced gradually. UNICEF's Sara Communication Initiative is introduced in a few selected school based BCC peer groups. Lack of proper supervision and refresher training for peer leaders and facilitators created a space for weak expansion. UNGASS Indicator 9 for percentage of most at risk populations reached with HIV prevention programmes is not available made available because of lack of a BSS or a special survey carried out during the reporting period.

[3] Source: Ministry of Health, Health Promotion Unit (HPU) 2009

Life Skills Based HIV Education in Schools:

UNGASS Indicator 11: Percentage of schools that provided life skills based HIV education in the last academic year				
Disaggregation				Source
	Numerator	Denominator	%	
All Schools	355	1145	31	Ministry of Education
Sec. School	80	80	100	
J. Sec. School	275	275	100	
Elementary School	0	790	0	
Numerator: No of schools that provided life skills based HIV education in the last academic year **Denominator**: Number of schools surveyed				

The GOE and its development partners embarked on HIV prevention programmes and mitigation of impact of the AIDS epidemic through life skills based HIV & AIDS education in schools since 2002/2003. The efforts made are significantly important and they successfully established HIV & AIDS related awareness as an integral part of the education system and education planning. The underlying causes of vulnerability to HIV infection and the longer term consequences of AIDS are addressed through intensive school based HIV education often complemented by debates, general knowledge contests, and group sessions that filter down to family members, out of school friends and relatives and to community members.

The UNDAF outcome objectives indicate that prevention measures for the sexual transmission of HIV are correctly identified by 90% of school girls and boys aged 12 – 18 by 2011. Likewise, the ENASP 2008-2012 is focused on two Life Skills related objectives:

1. Expose all children in primary and secondary schools to life skills education by 2012, and
2. Enable all schools to provide life skills based HIV education in all grades and classes.[4]

[4] UN Development Assistance Framework (UNDAF) 2007-2011GSE/JUNP November 2006

Life skills based HIV Education is used to reduce vulnerability of young people in or out of schools; to build students' understanding to the facts of life that is closely related to the present or future sexual curiosity and practices.

Assertive thinking and high self esteem make part of the messages that are always used to build positive behaviour of young students. The underlined objectives and the responsibilities that follow in successfully promoting HIV/AIDS and sexuality education among young people in schools are fully realized by the determined ownership and guidance of the Education Sector.

Since 2002, the Ministry of Education introduced Life Skills Based HIV & AIDS Education in all Junior and Senior secondary schools. Training manuals for elementary schools is in print in all languages of ethnic nationalities. Presently, all junior and senior secondary schools and the learning institutions beyond the secondary schools provide LS based HIV education in all classes as a component of the national school curriculum. The life skills based HIV education in schools went through an external evaluation process in 2008 and received encouraging results.

The Ministry of Education is self sufficient in terms of developing Life Skills related syllabus, training manuals and instructors' hand book. During the last two years, advocacy seminars were convened to close to 1,000 school directors, zonal and sub zonal education officers, supervisors, life skills educators and BCC peer leaders. Moreover, LS educators took part in the development of interactive methods and approaches to life skills education and text books for grades 4 and 5 of the elementary schools in the printing press.

Orphans and Vulnerable Children (UNGASS Indicator 10):

Based on the EDHS 2002, children under 17 years are estimated at 1.9 million of which 105,000 are orphans and vulnerable children who comes under the responsibility and

care of the Ministry of Labour and Human Welfare. As it currently stands 6.3% of the total households with orphans and vulnerable children receive free basic external support. The support provided is not disaggregated in to number receiving medical support, school materials, emotional and spiritual counseling, etc. No population based survey was carried out to support the services rendered by the Ministry of Labour and Human Welfare.

Blood Safety, Universal Precaution and PEP

UNGASS Indicator 3: Percentage of Blood Units Screened for HIV in a quality assured manner.					
2008			**2009**		
Total Screened Using Standard Operating Procedure for HIV at NBTC					
Numerator	**Denominator**	**%**	**Numerator**	**Denominator**	**%**
8,737	8,737	100	9,331	9,331	100
Total Screened Using Standard Operating Procedure for HIV in Zonal Hospitals					
899	899	100	660	660	100
Participated in External Quality Assessment Scheme for Screening at NBTC					
390	390	4.4	430	430	4.6
Participated in External Quality Assessment Scheme for HIV Screening at Zonal Hospitals					
44	44	4.8	33	33	5.0
Numerator: No of donated blood units screened for HIV in a quality assured manner in 2008 and 2009. **Denominator:** Total number of blood units donated during the same period.					

Qualifying the system of screening of donated blood and improving the capacity of staff both at the National Blood Transfusion Center (NBTC) and the National Health Laboratory became a priority of the Ministry of Health from the early period of the health system management. Investment is made to maintain a good system of blood safety and to introduce a strict adherence to the principles of universal precautions in health facilities.

During the last two years the NBTC collected and screened 8,737 and 9,331 units of donated blood in 2008 and 2009. The HIV positive result was 0.11% and 0.04% for volunteer donors and 0.33% and 0.23% positive result for replacement based donated blood collected during the two years.

Table 2: Number of blood units donated and screened for HIV, Hep.B, Hep C and syphilis

Year	No. of Blood Units		% Screened	% HIV + Test Result Among	
	Donated	Screened		Volunteer %	Replacement %
2004	4088	4088	100	0.2	0.3
2005	4852	4852	100	0.16	0.16
2006	5982	5982	100	0.14	0.58
2007	7681	7681	100	0.14	0.55
2008	8737	8737	100	0.11	0.33
*2009	9331	9331	100	0.04	0.23

The NBTC built an inventory of blood donors out of volunteers who regularly donate blood. Each year, over 82% of donated blood comes from volunteer donors and the aim is to close down emergency collection of blood from 'replacement donors' who often constitute family members and friends. Much of the advocacy and sensitizations programmes organized by the NBTC helped to remove misconceptions about blood donations and to increase public participation. Blood for transfusion is not a purchasable commodity in Eritrea both from the legal and cultural point of view.

Workplace HIV Prevention:

The importance of establishing HIV & AIDS programmes at workplaces is to provide knowledge about the epidemic and the challenges that may arise within the work place. Workplace based HIV & AIDS related programmes help to build an environment that is free of prejudices that are often expressed against individuals and groups that are known to be living with the infection or are affected by the epidemic. The goal is to create a workforce that is informed about the measures of protection from HIV infection and to build a functional support system that operates using openness, understanding, and adherence to policies that benefit both the management and staff. HIV & AIDS related activities at work places are monitored by the National Confederation of Eritrean Workers and is responsible, along with the Ministry of Labour and Human Welfare, for establishing study groups and support systems.

In 2009, the Ministry of Health developed a Workplace Policy Guide on HIV and AIDS for the purpose of piloting mainstreaming HIV among its own office staff by

establishing study groups and regularly scheduled sessions on HIV & AIDS, STIs and in all aspects of prevention, care and treatment. The draft document that went through a consensus building workshop is ready for implementation. The same Workplace Policy Guide is planned to be applied for the office staff working in other sectors.

A National Guideline on mainstreaming HIV and AIDS in all government and private sectors is recently completed with the support and participation of development partners and stake holders. The final document was presented to the Ministry of Health for a final review.

Prevention Programme to Most at Risk Population:

World Bank/HAMSET project gave rise to the prevention programmes for most at risk population which is implemented at national, zonal and community levels and among different population groups. In association with the Ministry of Labour and Human Welfare (MOLHW), the MOH promoted Behaviour Change Communications (BCC) programmes among female sex workers, truck drivers, and among workers in different workplaces. Similar programmes are also established among youth groups, students and among the military establishment.

UNGASS Indicator 9: Percentage of Most at Risk Population Reached with HIV prevention programmes.				
Disaggregation				
	Numerator	Denominator	%	Source/Remarks
Reached	NA	NA		No BSS or special survey carried out on most at risk group
Knowledge of location for HIV test	NA	NA		
Condom during the last 12 months	NA	NA		
Sterile needles and syringes during the last 12 months	NA	NA		
Numerator: No of most at risk population respondents who replied 'Yes' to both (3 for injecting drug users) questions **Denominator**: Total number of respondents surveyed.				

Country wide vulnerability study and proper identification of 'most at risk population' is not done. Female sex workers, truck drivers, travelling merchants, the uniformed services, daily laborers and students are generally considered most at risk on the basis of the collected data from sentinel survey.

As indicated, no BSS or specific survey was carried out to provide information for UNGASS Indicator 9 – percentage of most at risk population reached with HIV prevention programmes among female sex workers, truck drivers and the other most at risk population groups.

Female Sex Workers:

HIV Testing in Most at Risk Population:				
UNGASS Indicator 8: Percentage of Most at Risk Population who have received an HIV test in the last 12 months and who know their results in 2008/2009				
Disaggregation				
	Numerator	Denominator	%	Source
Sex workers (Female) <25 >25	 185 186	 200 200	 92.5 93.0	Special Survey, 2008
Bus/Truck Drivers (Male)	245	300	81.6	Special Survey, 2008
Numerator: No of most at risk population respondents who have been tested for HIV during the last 12 months and who knows the result. **Denominator:** No of most at risk population included in the sample				

Literature reviews indicate that sex work is a widely spread practice and sero prevalence surveys and special studies conducted in the past indicate that about 7.75 % of sex workers in Asmara (2007) [5] tested positive for HIV. Due to their high mobility sex workers are said to be the human bridges for the transmission and spread of HIV infection.

According to the Ministry of Labour and Human Welfare, there are 3,800 registered sex workers in Eritrea. However, many more young women are believed to be involved in sex work unofficially and cannot be reached for health related services because they are not official about it. Considering the growing number of sex workers and the roles they play to influence a higher infection rate of all STIs including HIV, farther studies may be needed to persuade policy makers and stake holders' decisions to aim for preventive interventions that will eventually focus on weaning out transactional sex and replace it by healthier and decent lifestyle. Many a time, sex workers voiced out that skills training and gradual income generating activities, provided individually or in groups, can provide a better future for each of them. BCC activities that are established

[5] Study report on HIV and Syphilis prevalence among Female Sex Workers in Asmara, 2008.

among sex workers continue to influence peer members to attend VCT and other comprehensive health care services and the increased use of condoms.

Long Distance Truck Drivers:

Researches conducted elsewhere indicate that illicit sexual relationships during long distance transport are responsible for many of the risk factors to HIV and other sexually transmitted infections. A bigger danger lies in the fact that transport work fuels HIV transmission and prevalence by increasing mobility and expanding the horizon in which HIV spreads. Trucks and buses make regular services in areas where different most at risk population groups meet and travel to areas of different prevalence rates and levels in commercial centers and across international border lines. Such movements may also involve transporting the AIDS virus from high to low prevalence zones.[6]

Of the 600 truck drivers that are registered under the Ministry of Transport and Communications (MTC) and different trucking associations for the purpose of spreading BCC services, half of them were included in the 2006 survey in which 245 or 81.6% were available for HIV test. The findings of the survey showed a prevalence of 2.33% for HIV and 3.66% for syphilis infections.

The Ministry of Transport and Communication (MTC) started mainstreaming HIV related programmes during the HAMSET I projects when awareness building exercises among truck drivers and office staff, promotion of condoms, and establishing of BCC peer study groups became a priority action. Undoubtedly, the effort made to enhance awareness helped to boost knowledge about the basic facts of HIV/AIDS among truck drivers, however, given the high HIV and syphilis prevalence among truck drivers, BCC programmes should be intensified to ensure lasting behaviour change.

[6] Lessons learned in mainstreaming HIV/AIDS in transport business.

The Military:

Everywhere, the military is regarded as a most at risk population group for HIV and other sexually transmitted infection and often a high prevalence rate is indicated among its members. Often, the uniformed service is staffed with young, single and adventurous people where the majority of its members live in camps and away from home and loved ones. Week-end leaves and off duty hours seem to be devoted to sexual adventures and alcoholic drinks that often alters their reasoning during their relationship with female sex partners who strategically dwell close to the camp.

In Eritrea, the EDF's medical unit broke the tie that links the military with HIV promoting behaviours by establishing active BCC groups in all camps, encouraging advocacy seminars that is based on personal testimony of HIV positive members through a programme known as "Seeing is Believing", and by organizing the "Know Your Self" campaign that invoke HIV testing for all personnel, rank and file, every two years. The EDF aims to:

- Reduce the incidence of HIV and STIs among the young men and women serving the military including the National Service Corps (NSC) in any capacity and
- Reduce the impact HIV & AIDS may cause on infected members.

The strategy is based on combining prevention activities such as peer education; promotion and distribution of condoms, personal testimonies of infected members; promotion of voluntary counseling and testing establishing care & support systems appropriate diagnosis and treatment of STIs including the syndromic management is operational in all military health facilities.

Tuberculosis Cases:

Tuberculosis may be in the brink of elimination in many of the developed countries but like everywhere else TB is still a chronic and debilitating infection in Eritrea with an estimated 4,500 TB cases. The NATCoD estimates 100 new TB cases per 100,000 populations each year. The 2005 national TB prevalence survey showed a smear

positive TB of 90 per 100,000 while incidence of smear positive TB is 50 per 100,000 populations. Another survey conducted to study the HIV prevalence in tuberculosis patients involved 166 TB cases of whom 57 or 34.3% were HIV positive. Variation is observed around the geographical area of living, situation of mobility, marital status, educational and occupational back ground.[7]

The National TB Control Programme which operates under the National AIDS and TB Control Division asserts that appropriate treatment of TB is established in almost all health facilities and general preventive measures are taken to reduce the spread of the infection. The Directly Observed Treatment of Short courses (DOTS) has become the cornerstone of TB treatment in Eritrea with a high cure rate of 88.0% documented in 2008.[8]

Injecting Drug Users and Men who have Sex with Men (MSM):

Injecting drug use and men who have sex with men (MSM) did not come into the limelight of Eritrean HIV epidemic because of a strict government policy against drug use and a culturally watchful society that stand against MSM and related sexual malpractices. However, an open mind is saved for both eventualities that may creep into the society a step at a time.

Prevention Programme among Refugee Population:

With the collaboration of the UNHCR Country Office, the Health Team of Northern Red Sea Zone and the Office of Refugee Affairs introduced HIV/AIDS and STIs related preventive activities and services among the 4,500 (2008) Somali refugee placed at Emkulu, on the Red Sea coast. Capacity building on HIV and AIDS and training of trainers for camp based learning sessions are implemented each year with financial support provided by UNHCR.

[7] HIV prevalence in TB patients

[8] NATCoD Report 2008.

Both the refugee and the host community at Emkulu used the MCH Center at Amatere in Massawa for HIV testing and prevention of mother to child transmission services. No HIV related infection had been reported among the refugee community. Steps are being taken to establish BCC Peer Study group in the refugee camp that also have an elementary school, a clinic and a whole range of office and technical staff.

9. CARE, TREATMENT AND SUPPORT:

Eritrea introduced the antiretroviral (ARV) treatment in September 2005 and the care and support component including community and home based care and support system started earlier. The country used an estimated US$ 7,842,217.47 or 30.0% of the financial resources for AIDS related care and treatment services including for treatment of opportunistic infections during 2008 and 2009.

TREATMENT: Anti Retroviral Therapy

UNGASS Indicator 4: Percentage of adults and children with advanced HIV infection receiving ARV Combination therapy						
	2008			**2009**		
	Numerator	**Denominator**	**%**	**Numerator**	**Denominator**	**%**
All	4299	7182	59.8	4631	7182	64.5
Females	2096	3939	53.2	2640	3939	67.0
Males	1935	3243	59.6	1991	3243	61.3
<15	268	503	53.2	324	503	64.4
15+	4031	6679	60.3	4307	6679	64.5
Numerator: No of adults and children with advanced HIV infection receiving ARV combination therapy **Denominator:** Estimated number of adults and children with advanced HIV infection						

The basis for estimating the number of people who might be eligible for treatment is the country wide sentinel sero prevalence survey that takes place every two years. Consequently, the number of total HIV cases for 2008/2009 is extrapolated from the 2007 survey that established the prevalence rate at 1.33% and the estimated number of people living with the infection at about 47,880. About 15% of this figure is generally taken as the number of infected individuals who are in advanced stage of AIDS and are eligible for treatment. In 2009 the number of HIV infected cases that were on treatment reached a cumulative total of 4631 or 64.5% of the women, men and children presently estimated as eligible for treatment. Currently ART is available in 17 public, mission and military health facilities. Fifty percent of the cases under

treatment are women while the men account for 43.0 %. Children cover just about 7.0%.

Table : New Patients on ARV by year

Year	Women	Men	Children	Cum. Total
2005	322	333	54	709
2006	523	567	85	1,884
2007	670	566	65	3,185
2008	581	469	64	4,296
2009	548	343	76	5266
Total	**2544**	**2278**	**344**	**5266**

Since the start of antiretroviral treatment in the country, 428 men, women and children have died and including the 83 cases who defaulted in 2009, the number of cases that are lost to follow up is 207. A total of 453 others shifted to second line therapy due to toxicity (69.5%), pregnancy (3.53%) treatment failure (3.3%) and due to other reasons (23.6).

Co-Management of TB and HIV Treatment

UNGASS Indicator 6: Percentage of HIV positive incident TB cases that received treatment for TB and HIV & AIDS in 2008/2009				
Disaggregation				Source/Remarks
	Numerator	Denominator	%	No data available
All	NA	NA	--	
Numerator: No of adults with advanced HIV infection who received ARV combination therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment **Denominator:** Estimated number of incident TB cases in people living with HIV				

Because of the intrinsic relationship between Mycobacterium tuberculosis and the AIDS virus, the reactivation of latent TB infection and/or the growing risk of developing new TB infection in people living with HIV infection become inevitable. Roughly, there are about 4,500 tuberculosis cases in Eritrea with an annual infection rate of about 2.0%. A 2006 special study conducted among 166 TB cases receiving care and treatment at one Asmara hospital had an HIV prevalence rate of 34.3%.

Service provider initiated HIV test is performed for TB cases and DOTS treatment is provided for all HIV positive TB cases who receive their ART in designated medical centers. However, the number of HIV positive incident TB cases that received treatment for both TB and HIV/AIDS in 2008 and 2009 is not available due to poor recording and reporting by health facilities.

Home Based Care and Support System:

There are 420 home based care providers supporting 2,314 AIDS cases. The trained HBC providers who are selected from different government sectors and CSOs including the National Association of People Living with HIV & AIDS provide palliative care, psychosocial and spiritual counseling and counseling on infant and child nutrition, positive living and ART. The HBC is introduced in all zones

The Home Based Care service was first introduced with the development of HAMSET I Project and many organizations including the faith based organizations institutionalized since provided both home based care and psychosocial support by training volunteers.

Table Distribution of HBC services by organization

No	Organization	HBC Providers
1	Mufti Office of Eritrea	13
2	Evangelical Church of Eritrea	25
3	Orthodox "Coptic" Church	52
4	Catholic Secretariat	78
5	Ministry of Labour	20
6	NUEW	58
7	BIDHO	174
	Total	**420**

Support is provided by the government, the Norwegian Church Aide (NCA) and other sources and seven organizations including the Ministry of Labour and Human Welfare,

the National Union of Eritrean Women, the National Association of People living with HIV and AIDS and the faith based organizations provide the service.

The Ministry of Labour and Human Welfare carry out HBC programmes along with its core mandates of promoting legislation of workplace policies related to health, education, pension and retirement and provide care and support and financial aid for orphans and vulnerable children under the Child Care Programme.

Pic. World AIDS Day Parade 2009 Mendefera, Zoba Debub. (Photo T. Araya)

10. KNOWLEDGE & BEHAVIOUR CHANGE:

The Ministry of Health of the State of Eritrea is consistent in its efforts to build HIV & AIDS related knowledge and to promote positive behaviour change in order to strengthen the on-going battle against the HIV & AIDS infection in the country. Information, Education and Communication (IEC) tools and materials were developed in mid 1990s and the National HIV & AIDS Communication Strategy 'Winning *Through Caring'* was developed in 2001. An exclusive strategy for PMTCT was developed in 2005 to strengthen the development and expansion of the PMTCT service.

Public education on abstinence, faithfulness and the use of condom had been consistent and vigorous at all levels of the health care and in all administrative zones. Educational and awareness messages are disseminated to all people in every language in ways that are culturally acceptable and user friendly. Bill boards on HIV and AIDS information were installed along major highways and in all towns of the country. Besides user friendly posters, leaflets and brochures are designed, produced and distributed under the watchful eyes of the Health Promotion Unit. BCC programmes in communities and among different population groups are used to increase the public education and knowledge. Mass media support is often exploited to maximum advantage with programmes such as drama, discussion panels and briefing sessions held with health professionals and programme managers receiving weekly airtime on both the radio and TV programmes during the most convenient days and hours of the week.

Life Skills Based HIV Education in schools and the Community Change Agents Programme sponsored by the military provide awareness and education in schools and communities that yields a spillover effect on individual households and the grass root communities.

Young People's Knowledge about HIV Prevention:

UNGASS Indicator 13: Percentage of Young Women and Men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconception about HIV Transmission				
Disaggregation	Numerator	Denominator	%	Source
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partner?				
All 15-24	1482	2700	54.89	KAPB Survey MOE 2008
Male	683	1350	50.59	
Female	799	1350	59.19	
Can a person reduce the risk of getting HIV by using a condom every time they have sex?				
All 15-24	1937	2700	71.74	KAPB Survey MOE 2008
Male	1004	1350	74.37	
Female	933	1350	69.11	
Can a healthy looking person have HIV?				
All 15-24	2359	2700	87.37	KAPB Survey MOE 2008
Male	1177	1350	87.19	
Female	1182	1350	87.56	
Can a person get HIV from mosquito bites?				
All 15-24	517	2700	80.85	KAPB Survey MOE 2008
Male	266	1350	80.30	
Female	251	1350	81.41	
Can a person get HIV by sharing food with someone who is infected?				
All 15-24	219	2700	91.89	KAPB Survey MOE 2008
Male	121	1350	91.04	
Female	98	1350	92.74	
Numerator: No of respondents aged 15-24 years who gave the correct answers to all five questions **Denominator:** No of all respondents aged 15-24				

Note: This indicator is not based on representative sampling but it is the result of school based KAPB Study which was conducted to evaluate the Life Skills based HIV education in Junior Secondary and Senior Secondary Schools. The result is extracted from the MOE/UNICEF KAPB Study 2008.

As indicated above, about 80% of the middle and secondary school male and female students do not consider the mosquito as vector that transmits HIV and not less than 90.0% do not possess the misconception that HIV is transmitted by sharing food with an infected person. Knowledge about prevention of sexual transmission of HIV and AIDS on the given indicators among students is low with 55.0% for faithfulness, 72.0% for condom use while 87.3% acknowledge that a health looking person can still be an HIV carrier. The same information indicated that close to 100% of the students who

participated in the KAPB survey ever heard about HIV & AIDS and between 82.7 and 91.0% received HIV education in school. Over 73% received HIV related information from the radio and 75.8% claimed to have received HIV information from the TV.

An effective Information, Education and Communication (IEC) mainly created during the development of the National HIV/AIDS Communication Strategy, guided the many efforts of prevention the Health Promotion Unit of the Ministry of Health has developed and implemented through the years with an objective of moving the level of public awareness beyond knowledge. It aimed for a solid behaviour change with special emphasis to reduction of stigma, promotion of preventive services including increased condom use and ensuring blood safety in all health facilities.

Orphans School Attendance:

The number of all orphans and those currently attending school is not studied as the UNGASS Indicator 12 would suggest. However, all orphans and vulnerable children who receive government support; or those living in the household of extended family or those entered in government run children's home go to schools in the area they live in.

Most at Risk Population's Knowledge about HIV Prevention:

UNGASS Indicator 14: Percentage of Most at Risk population who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconception about HIV Transmission				
Disaggregation				Source/Remarks
	Numerator	Denominator	%	
Female Sex Workers	241	400	60.25	NATCoD Special Study 2008
Truck Drivers	246	300	82	
Numerator: No of most at risk population respondents who gave the correct answers to all five questions **Denominator:** No of most at risk population respondents who gave answers, including do not know to all five questions.				

NATCoD conducted a survey in 2008 to determine the knowledge level of female sex workers and long distance truck drivers. Both samples were taken from different localities of Asmara

and its surroundings. Questions similar to those used in UNGASS Indicator 13 were used for both groups.

Two hundred forty one sex workers out of the 400 and 246 truck drivers out of the 300 included in the study came with the correct answers.

Sex Before the Age of 15:

UNGASS Indicator 15: Percentage of young men and women aged 15-24 who have had sexual intercourse before age of 15.				
Disaggregation	Numerator	Denominator	%	Source/Remarks
All 15 - 24	NA	NA	NA	No study done
Male	NA	NA	NA	
Female	NA	NA	NA	
Numerator: No of respondents (aged 15-24) who report the age at which they first had sexual intercourse as less than 15 years. **Denominator:** No of all respondents aged 15 - 24.				

Information is not made available to complete UNGASS Indicator 15 due to lack of population based or special surveys. It is generally agreed that the next Eritrean Population and Health Survey (EPHS) will include a lot of issues and concerns that are pertinent to HIV & AIDS and that can provide meaningful measurements to the national response. Issues of youth sexuality, condom use and testing for HIV will be included.

Higher - Risk Sex:

UNGASS Indicator 16: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.				
Disaggregation	Numerator	Denominator	%	Source/Remarks
All 15 - 24	NA	NA		No study done
Male	NA	NA		
Female	NA	NA		
Numerator: No of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months. **Denominator:** No of all respondents aged 15 - 49				

UNGASS Indicator 16 is not completed because no population based or any type of AIDS indicator survey is conducted to explore the degree of unprotected sex practiced among partners that are not married and are not faithful to each other. It will be included in the next EPHS

Condom Use During Higher – Risk Sex

UNGASS Indicator 17 : Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months who used a condom during their last sexual intercourse.				
Disaggregation				Source/Remarks
	Numerator	Denominator	%	
No of sexual partners.	NA	NA		
No who used condom the last time they had sex.	NA	NA		
Numerator: No of respondents (15-49) who reported having had more than one partner in the last 12 months who also reported that a condom was used the last time they had sex. **Denominator:** No of respondents who reported having had more than one sexual partner in the last 12 months.				

UNGASS Indicator 17 is not dealt with in this report due to the same reason that influenced the inhibition of the previous indicator.

Sex Worker: Condom Use:

UNGASS Indicator 18: Percentage of female sex workers reporting the use of condom with their most recent client.				
Disaggregation				Source
	Numerator	Denominator	%	NATCoD 2008 special survey
Female Sex Workers	179	400	44.8	
Numerator: No of respondents who reported that a condom was used with their last client **Denominator:** No of respondents who reported having commercial sex in the last 12 months.				

A 2009 NATCoD study conducted among 400 sex workers established that 44.8% of the total always use condom with any one of their clients. The previous (2006) study showed a much higher result with 76.0% usage rate. The discrepancy may have been caused by the constant mobility of sex workers.

11. HIGHLIGHTS OF BEHAVIOUR CHANGE ACTIVITIES:

The National Union of Eritrean Youth and Students (NUEYS) carried out prevention programmes including voluntary counseling and testing services at the Youth Health and Recreation Centers established in major towns. Music and drama programmes, hot line telephone counseling BCC peer group education, condom promotion and distribution often draw the attention of young people. The learning opportunities offered at post test clubs provided free discussion about HIV infection and its implications between all members.

The National Union of Eritrean Youth and Students (NUEYS)

Promotion and distribution of condoms: In collaboration with the MOH and the Social Marketing Group (ESMG), distributed an average of 6.0 million condoms every year through ESMG's outlets.

Youth Friendly Counseling and Testing: Four youth friendly VCT centers are opened by the NUEYS in Asmara, Keren, Sawa, and Tesseney to provide VCT, STI and maternal health services that are friendly to the needs of young people. The Youth Friendly Centers are components of the Youth Health and Recreation Centers which include, library services, in-door games; sports; computer training programmes and Computer Cyber Cafes for members of the youth group

Youth to Youth Discussion Forums: Radio and TV programmes air discussions on gender, reproductive health and sexuality issues each week. Young men and women take part in the highly popular discussion programme

Hotline Counseling Service: Telephone hot lines respond to queries of young people on sexuality and HIV/AIDS, gender related issues, and reproductive health, About 100-150 telephones calls are received each month.

MOI – The National Media Programmes:

Young people's knowledge about HIV and AIDS is also boosted by the media support provided by the MOI press/radio and TV programmes. Basic facts about HIV and AIDS are aired by the national radio program which presents twice a week health and HIV & AIDS sessions in 4 ethnic languages. News papers often include HIV columns and health and social problems including questions and answers for youth are carefully prepared and personal opinions of young people are included.

The National Union of Eritrean Women.

The National Union of Eritrean Women (NUEW) is organized to ensure the legal, social, and economic opportunity for women; prevention of gender based violence and sexual exploitation of females; protection of young girls from harmful practices and to increase the level of awareness about sexually related infections among women.

The NUEW integrated HIV prevention with access to comprehensive services of reproductive health; provided elements of Life Skills education for women and girls in communities; advocated against underage marriage and promoted BCC peer group education among women of the rural communities. The National Union of Eritrean Women trained lawyers, administrators and other government authorities at zonal and sub zonal levels on issues and dangers of female genital cutting, clandestine criminal abortions, and rape including deliberate transmission of HIV using violent or deceptive mechanisms.

National Confederation of Eritrean Workers:

The Confederation of Workers is mandated to oversee and direct prevention of HIV infection at workplaces by involving trade unions, workers and the employer's federations, peer leaders and organizers. The Confederation conducted training of trainers and established BCC peer study groups in formal and informal sectors of

work; advocated for and initiated zero tolerance against stigma and discrimination at work places and promoted workplace sponsored treatment against opportunistic infections. The Confederation aims to strengthen preventive activities by collaborating with the Eritrean Employers Federation, Ministries of Public Works, Transport and Communication and related organizations.

The National Association for People Living with HIV& AIDS (BIDHO)

BIDHO, Tigrigna for Challenge is an association for all people living with the HIV infection lead by a democratically elected executive board. The association plays important roles in the protection of rights of its members and spend considerable amount of time and energy to control the effects of stigma by providing lessons on positive living.

BIDHO is highly involved in organizing income generating activities that benefits such as weaving, dress making, animal husbandry , dairy and poultry farms and distribution of consumables such as butane gas. In 2008/2009 BIDHO opened a post test club in Mendefera, sponsored promotional and awareness posters on city buses and other transport systems, provided personal testimonies by different members during the annual National Festival in Asmara.

Line Ministries and Other Sectors

Ministries of Education, Information, Defense, Labour & Human Welfare, Transport and Communication, Tourism, included prevention activities for their staff and in cases of Education, Defense, Labour & Human Welfare and Information programmed activities that involve the general public in many ways. Efforts are in process to involve all other ministries in mainstreaming HIV and AIDS into their activities.

12. IMPACT INDICATORS:

Reduction of HIV Prevalence:

UNGASS Indicator 22: Percentage of young people aged 15-24 who are HIV infected.				
Disaggregation				
HIV tested (female)	Numerator	Denominator	%	Source
All	65	4895	1.32	ANC based Sentinel survey 2007
<25	19	2138	0.88	
>25	46	2757	1.66	
Numerator: No of antenatal clinic attendees aged 15-24 tested whose HIV test results are positive. **Denominator:** No of antenatal clinic attendees aged 15-24 tested for HIV infection status				

HIV prevalence among young women and men aged 15-24 is showing a declining trend from 2.1% in 2003 to the 2007 estimation of 0.88%, as shown in the sentinel sero prevalence survey.. The corresponding rate for all other women above 25 years of age is 1.66%.

Most at Risk Population: Reduction of HIV Prevalence

UNGASS Indicator 23: Percentage of most at risk populations who are HIV infected.				
Disaggregation				
Female sex workers	Numerator	Denominator	%	Source
<25	6	200	3.0	NATCoD Special Study among high risk group 2008
>25	25	200	12.5	
Male truck drivers	Numerator	Denominator	%	
<25	0	0	--	
>25	7	300	2.33	
Numerator: No of members of most at risk population who test positive for HIV **Denominator:** No of members of the most at risk population who tested for HIV				

Percentage of most at risk population who are HIV infected is not available for all groups identified as high risk. However, NATCoD's special study conducted in 2008 among female sex workers showed 3.0% among the younger group (15-24) and soared to 12.5% for female sex workers in the 25 and above age groups. A similar study conducted in 2006 registered a combined total prevalence of 8.08%. A study among

long distance truck drivers from the head quarter in Asmara showed a significant decrease from 7.0% in 2006 to 2.33% in 2008.

HIV Treatment: Survival after 12 Months on ART

UNGASS Indicator 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.				
Disaggregation				
Males/ Females	Numerator	Denominator	%	
Total	NA	NA	--	
<25	NA	NA	--	
>25	NA	NA	--	
Numerator: No of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment. **Denominator:** Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12 months outcomes within the reporting period, including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow up at month 12.				

Health Facility based sources indicated 91.32% survival rate among adults and children 12 months after having been initiated to the ARV treatment. However, antiretroviral therapy cohort analysis report for the reporting period of 12 months of treatment had not been collected as per the recommendation of the guideline on the construction of core indicators.

Reduction of Mother to Child Transmission

UNGASS Indicator 25: Percentage of infants born to HIV infected mothers who are not infected.						
Disaggregation	2008			2009		
	Numerator	Denominator	%	Numerator	Denominator	%
All Children	9	135	6.7	8	165	4.8
Numerator: No of infants born to HIV positive women who became HIV negative upon testing **Denominator:** No of pregnant women who are HIV positive and received the full course of prophylactic ARV during 2008 and 2009						

The percentage of infants born to HIV positive women who are themselves infected was 6.7% in 2008 and 4.8% in 2009. This estimate is made by projecting the number of HIV positive women who attended post natal care and who got their children tested at 18 months of age. The 165 women who brought their children to health facility for

testing were only 35.5% of the 464 pregnant women who tested HIV positive at the ANC/PMTCT centers. Distance to health facilities and fear or shame often influence the slow response to the post delivery check ups by HIV positive mothers who had already known their HIV positive status.

FAITH LEADERS AGAINST STIGMA:

A BIDHO Poster: the Minister of Health and Heads of different Religious Groups in Eritrea

Asmara 2009 (Courtesy BIDHO)

13. BEST PRACTICES

Introduction:

Community initiated activities and practices of support are solidly embedded in Eritrean concepts, values and tradition in which the village community or one identified group becomes one large family that are led and coordinated by the elderly, faith and opinion leaders. Since time immemorial, community initiated actions had ploughed the land of poor widows, fixed the houses of the elderly, raised orphans and supported the sick.

Initiatives to prevent HIV & AIDS; to mitigate the effects of stigma; to provide care and support are practices that are often practices which make part of the general concept of oneness; a motivated concerted action that is inherently part of the community actions. Community based "best practices" are simply normal events that do not attract attention or are not documented and many of them fail to meet the Best Practice criteria and remain unnoticed.

The following two practices involve faith based organization, NGOs, the MOH, the Association of People Living with HIV & AIDS and the common people. It drew the attention of concerned organizations and were recommended for closer analysis and documentation. The Good Samaritan programme of the Catholic Secretariat is involved with home based care and support for people living with HIV and AIDS.

The Income Generating Scheme among HIV positive women in Mendefera involved the MOH, the national and zonal offices of BIDHO and NGOs and qualified as a best practice. WHO Country Office in Eritrea supported their documentation.

Best Practices 1.

The Good Samaritan: A Home Based Care Initiative[9]

In the Catholic Church, the Good Samaritan programme developed from the home based care services that was promoted and established by the National AIDS and TB Control Division (NATCoD) to become an association support among people living with HIV and AIDS infection. The establishment of home based care (HBC) service was conceptually designed by the GOE/World Bank supported HAMSET Project and was introduced to partners in 2003 under the leadership of NATCoD and partners.

The Catholic Secretariat Eparchy of Asmara received 42 PLHA to care for under the home based care (HBC) programme. With great care and compassion, the Church added spiritual and psychosocial counseling by training 52 young men and women volunteers on HBC. As time went by, PLHA members grew to 301 and close to 64% are women. After distributing the members into five different groups, the Church created a monthly discussion forum that is coordinated by a board of Church members and the PLHA and called it the "Coffee Ceremony". The forum provides opportunities for in depth discussion and learning sessions on the basic facts about HIV and AIDS, how to live positively, and how to deal with stigma related situations. The HBC volunteers are highly devoted and spiritually focused young men and women who are guided and supported by the saintly nuns in all five churches. Their combined effort and determination gave the church an added imputes to move foreword and deal with personal problems of members and ease the new challenge in the lives of widows and orphans. The Church leadership helped to pave the way for women and men in the group to find hope and solace during their most difficult moments of their lives.

The 'Coffee Ceremony', offers important entry point to discuss health conditions, learn basic facts about HIV & AIDS; spiritual guidance that is commonly used for all religions

[9] Based on Best Practices document prepared by Temesghen Araya for MOH/WHO

and denominations; lectures by speakers and lots of personal testimonies by members. It is also a stage where money is raised to help needy friends. The activities related to the HBC and the Coffee Ceremony demands more than what it takes to run a plain home based care. Food is low in some of the affected households and both the children and their mothers are often the victims. To help such households, the Catholic nuns offer their full support to the project and often contribute part of their own less than sufficient budget to help with the food situation of households. During the 'Coffee Ceremony' employed members or members who can afford it contribute Nakfa 10.00 for all eventualities including for supporting a house hold when the mother is too sick to feed her children. A basket is placed in the middle for additional contribution by members and guests as necessary.

Goals and Principles

In short the goals of the "Coffee Ceremony" that is generally known as the Good Samaritan Programme is to:

- Develop the confidence of PLHA to stand against all threats of stigmatization and marginalization through spiritual and psychosocial counseling;
- Convert the negative attitudes of family members, friends, neighbours through Sunday School teachings, brochures and other IEC materials;
- Promote and encourage families to provide home based treatment & care for sick family members with love and compassion.

The principles are, that the right of persons infected or affected by HIV/AIDS is supported medically, emotionally, spiritually and socially without bias; that the people who are infected and affected by HIV/AIDS cultivate high self-esteem for themselves and compassion and care for their dependants; that people who live with the infection trust and depend on each other and develop a sense of companionship with each other.

Members of all faiths and religions are admitted in all church groups. Although the Church refrain from propagating for condom the question of promoting safe sexual behaviour and adherence to treatment is dealt with by constant reminders that members need to follow the advice of their physicians and counselors.

The five church groups and their membership are as follows:

No	Church Groups	Male	Female	Total
1	The Daughters of Charity	17	55	72
2	The Capuchin Nuns	24	30	54
3	The Orsollini Nuns	10	21	31
4	St. Antony Church & Clinic	21	42	63
5	Kidane Mihret Church	28	53	81
	Total	**100**	**201**	**301**

Moreover,

- 73.0 percent are on ART;
- Close to 64 percent of the total are females;
- Thirty two percent of both sexes are in marital relationship;
- About 22 percent are single;
- 38.5 percent lost their spouses to AIDS;
- 14 couples are united by marriage after having met at the Good Samaritan;
- 33 HIV positive children are supported;
- 16 orphans (both parents) and 116 children who lost one parent are cared for by the Church;
- There are 721 children (324 males and 397 females) receiving support at the five church groups their parents belong to. Members are encouraged to bring their children to the coffee ceremony and many bring them along;
- Of the 75 children born to members during the 2007/2008 period, 74 children or 98.6% of them tested HIV negative at 18+ months of age;

With only 8 deaths since starting ART (2005 – 2009) as compared to 10 deaths among the members of the Good Samaritan programme between 2003 and 2005, lower deaths are reported. Only 2 episodes of suicide are reported.

Case Study

Z A: She is a widow with two children and meets and receives home based service as a member of the Daughters of Charity group. Her 9 years old son is HIV positive and she often bring him to the monthly meeting, the 'Coffee Ceremony'. Her husband died because of AIDS related infection and she learned about her own positive status when she attended the PMTCT service in her neighbourhood when she became pregnant with her twin daughters who died soon after they were born.

ZA joined the Good Samaritan by the recommendation of the National Association of PLHA and became a member of the group known as the Daughters of Charity, a group that provides her with home based care and psychosocial support and the monthly 'Coffee Ceremony'. She loved it.

'As a Moslem, I was a bit apprehensive about joining the group; but as the days went by, I learned that religion is not an issue at any one of the Churches where the Good Samaritan programme is offered. My faith did not bother any one at the Daughters of Charity. The nuns are kind hearted, caring and loving; the counselors are dedicated and full of compassion. I do not want to miss any programme at the "Coffee Ceremony" and my son who is now taking ART is always with me. I am full of hope" ZA said.

Criteria of Best Practice

Relevance: The goal of the Good Samaritan is to mitigate the ill effects of Stigma around HIV and AIDS through spiritual and psychosocial counseling and provision of home based care. The achievement made so far can be expressed by what the Church managed to accomplish in the area of cultivating the spiritual, psychological and morale capacity of their cohort and brought them back to live positively and appreciate each day.

Effectiveness: The spiritual and psychosocial counseling and home care sessions helped members of the different Church groups to live in peace and to gracefully accept the

situation they are in. They found peace in knowing their problem is not worse or better than their friends in the group and sincerely offer their support when it is needed.

Efficiency: Despite its limited resources, the activities of the Good Samaritan tried to solve the problems faced by many of its members. The home based care and counseling and the monthly meetings over coffee utilizes hard fetched resources with great care.

Ethical Soundness: The Good Samaritan programme puts great emphasis in mitigating the effects of stigma and its success is measured by the determination, firmness and supportive attitudes members demonstrate when under pressure.

Sustainability: At present, the project is suffering by a dire financial problem and as the needs of members grow day by day the problem will be worse. But the programmes go on.

Best Practice 2. Income Generating Project:[10]

Women Living with HIV & AIDS in Mendefera Town, Zoba Debub

For households that are affected by HIV the negative effects emanate from loss of earnings increased expenditure for medical care. The need for income increases as the demand for medicine, food, and other expenses start adding up. Shortage of cash becomes more pronounced as the bread winners are sick and incapacitated.

A six months skills training on weaving opened a way to a cottage industry for 30 women. The Swiss Inter-Church Aid (HECKS) paid the thirty women with pocket money during the six months training period and upon graduation provided each of them with a modified weaving loom that fits into one nicely lighted corner of their homes. Their HIV status, family size, personal inclination and ability to learn were the criteria for selection.

Marriage presents one of the greatest risks for HIV infection among women in Africa and Eritrea cannot be different. Women are believed to be infected by the very people with whom they formed a long term and stable relationship and the paradox often defeats the existing methods to HIV prevention such as faithfulness and safe sex. In this particular scenario, abstinence in a married relationship is not an option available to women, unilateral fidelity does not work, and a determined request for condom can often ignite domestic violence.

Major Elements of the Project

With the support from HECKS, Switzerland, and a skills training partnership provided by ACCORD, the Health Management Team of Zoba Debub and the BIDHO leadership helped 30 women living with HIV and AIDS to produce national garments that they sell in the open markets. Currently only 23 of the 30 trained women are making use of the skills and

[10] Based on Best Practices document prepared by Temesghen Araya for MOH/WHO

the materials they were given by the Ministry of Labour and Human Welfare to start their weaving project. The major objects and goals of the project are:

- To enhance women's economical strength and independence, increase their financial earnings, improve the level of household consumption including food intake of children and adults;
- To provide women with opportunities to education, innovative thinking and participation in issues and concerns of the society.

The second most important goal of the project is to set HIV infected women out of the bondage of fear and stigma related feelings and to develop their confidence while dealing with their business affairs. According to the local PLHA association, the women, who once developed negative feelings, hopelessness, self pity and defeatism learned to plan and manage their affairs and began to look forward. Many testify that they found their life completely changed to the better and would like to develop it further.

Case Study

SB: Widowed when she was still in her teens, SB is the youngest and the only childless member of the income generating group. At the beginning, she had a problem of accepting the situation she was in and was emotionally stressed and disturbed during the period of her husband's death and her subsequent knowledge of her own positive status. Her dotting parents took her home to live with them and their understanding attitude and the support she received from her younger brothers, sisters and friends helped her to accept her situation and carry on with life. She joined the National Association of PLHA and started to got involved in every activity that came her way including advising and teaching other infected women about HIV and AIDS and how they should deal with the infection.

SB was selected for the skills training and after she was happy and grateful for the chance given to her to be active and focused towards something that is productive. After her weaving course was completed, she felt she finally got some thing she really wants to do.

Like her friends in the weaving industry, SB would like to have a retail shop for the group where selling their products would be much easier. SB is now married to a fellow member of the PLHA association and believes that despite her situations and uncertain future her life has become finally meaningful. SB receives psychosocial counseling and supports from her support group her counselor. She is on ART since 2005.

Monitoring and Evaluation

The Ministry of Health and the Association of People Living with HIV and AIDS are in touch with the tasks performed by the women and do the monitoring and evaluation of the project. Moreover, the activity is strengthened by the concurrent supervision of the Communicable Diseases Control Section of the Zonal Health Department and the branch office of BIDHO.

Best Practice Criteria

The Weaving Project provided vocational training to HIV positive women who head households started in 2006/2007. As it currently stands, the project benefits at least 23 women and their households by weaving, producing and selling l clothing materials at local level.

Relevance: The goals and objectives of the weaving project in Mendefera town created a change in the lives of AIDS affected and infected women. The skill they learned and the production of cotton based garments for both urban and rural communities opened their eyes to efforts that can be rewarding and sustainable while giving them the courage and the confidence to handle their own affairs

Effectiveness: Despite their conditions, the women involved in the weaving industry have succeeded in winning the respect of neighbours, friends, and business associates. They are supported by counselors and their friends at BIDHO branch office and the Communicable Disease Control (CDC) section of the Zonal Health Department provide the morale and material support.

Efficiency: The weaving women are a small fraction of the people that are living with the infection that come out and to do business. Their determined stand against stigma related problems made them powerful catalysts among communities that can be misguided by fear, shame and by self afflicted stigma and isolation.

Ethical Soundness: The weaving skill and the income it generates supported the women and their children and also gave a chance for all that people with HIV & AIDS are humans and that they need to take care of their children and other members of their family . It made it clear for people who think that people with the infection can carry on living and that they also have vision.

Sustainability: The main challenge is the continuity of the weaving project which has to depend on the availability and sustainability of row materials and friendly atmospheres to sell their product. Provided that the row materials for the weaving industry are made available, the garments these women make are popular and competitive,

Photo. 02: The young weaver, Mendefera, Zoba Debub. (Photo: T. Araya)

14. MAJOR CHALLENGES and REMEDIAL ACTIONS:

As the newest independent state in Africa, Eritrea is one of the poorest countries in the world with an annual gross national income per capita of about US$ 200.. After the long and protracted war of independence, Eritrea started from scratch and established an equitable system of health services; improved the quality of services; built referral hospitals and developed the capacity of health staff. For a country of limited resources, the challenges it encountered can not be undermined.

Limited access to HIV & AIDS related services:

Health centers, MCH centers and health stations are more adept to preventive services than hospitals at all levels. Of the 237 health centers and health stations close to 55% of them are currently providing counseling and testing services for the general population and 37.5% provide PMTCT services. Factors that inhibit rapid scaling up of preventive services are the limited number of trained human resources and the old health facility strictures that did not provide adequate space for privacy and confidentiality. The government renovated some and built some more to turn them into centers of preventive health services.

Data Management and Monitoring and Evaluation:

Data are important to measure impact around HIV and AIDS and to make a reasonable guess if the HIV epidemic is under control or if the plans, strategies and the objectives need to be revised and corrected. Ministry of Health took the need for more qualified data seriously and included an M&E unit at NATCoD to take care of HIV and TB related data and established a Monitoring and Evaluation Division under the Department of Regulatory Services to monitor health services and the impacts made. M&E training are regularly provided; reporting formats are created, M&E units are established in

Zonal Health Management Offices. UNGASS 2010 Report missed a few indicators because of lack population based and periodic surveys.

Stigma and Discrimination:

Stigma around HIV & AIDS is generally accepted as a stumbling block that impedes universal access to prevention, treatment and care and support. To confront these situations the MOH tried to reduce stigma and discrimination and mitigate its effects especially in the health care setting. Over 700 health staffs working in maternal health services are trained in the principles of PMTCT related services to make health services in general and maternal health and ANC services in particular free of all traces of HIV related. Moreover, efforts made by faith based organizations, the National Association of PLHA (BIDHO), established BCC groups and the advocacies and anti stigma messages aired through the mass media helped to mitigate the effects of stigma among individuals and groups living with HIV and AIDS. Activities undertaken by the Home Based Care Programmes and the support systems established by different units and organizations considerably reduced self inflicted stigma. Skills training for income generating schemes added to the positive living methods and lessons organized and delivered by the National Association of People Living with HIV & AIDS provided sufficient knowledge and exposure to PLHA.

Coordination:

The Eritrean response to HIV and AIDS is largely governed by a combination of different committee led by the National Steering Committee that is composed of four cabinet ministers, 6 zonal administrators, the Director General of Health Services, the National Union of Eritrean Women (NUEW) and the National Union of Eritrean Youth and Students (NUEYS). Its main function is to coordinate the multi sectoral approach to the national response against HIV and AIDS; oversee utilization of resources; monitor the development of policies and guidelines that are pertinent to the national

response and evaluate the achievements documented by the Country Coordinating Mechanism (CCM), the National Technical Committee and the Ministry of Health. The Committee is chaired by the Minister of Health.

The Country Coordinating Mechanism (CCM) is an overall guiding body for planning and utilization of resources from the GFTAM and the HAMSET/WB Project before it. It is composed of 16 members representing 6 Government Ministries, 4 Country Offices of the United Nations, a Bilateral Agency, the National Association of People Living with HIV & AIDS; the Interfaith Council against HIV & AIDS (the Orthodox 'Coptic' Church, Office of the Mufti, the Catholic Secretariat and the Evangelical Church); 2 Civil Society Organizations and a private sector.

The National Technical Committee provides the necessary technical support for the Steering Committee and the and is composed of the director generals, directors and programme coordinators involved in the GFTAM.

The National AIDS and TB Control Division (NATCoD) of the Ministry of Health is responsible for all programme related functions including problem identification, human resource development, policy formulation, planning and programming, implementation and monitoring and evaluation including periodic surveys and research activities.

Challenges Faced During the 2008/2009 Reporting:

Baseline Data

Absence of base line data from population based sero prevalence survey or a recently updated behaviour surveillance survey (BSS) are the challenges encountered by the UNGASS Report 2010.

Many of the studies and surveys including population based surveys needed to answer for most of the UNGASS Indicators were not done in time. While condom distribution is properly documented and known, no specific survey was conducted to assess its use among the young and sexually active population group. The number of young people who started sexual exercise at age 15 and below is not available.

Population based surveys to assess HIV testing among the 15-49 age group would have answered a lot of questions that is not presently available. Cohort or group tracking for patients starting antiretroviral therapy to increase survival and quality of life is not properly documented and the assessment of the treatment programme cannot be successfully done.

Likewise, the co-management of TB and HIV treatment became an example of poor recording, reporting and documentation at all levels. In this case, the combined treatment services are provided in treatment centers but the effort is not documented.

The delayed National Population and Health Survey + is designed to include many of the population based studies that are missing in the current reporting. The population based survey is rescheduled to start in 1010.

15. SUPPORT: COUNTRY DEVELOPMENT PARTNERS:

International and bilateral agencies, most notably the World Bank/GOE (HAMSET I and II), the Global Fund, the Joint United Nations Support on HIV & AIDS, the Norwegian Church Aid (NCA), the Lutheran World Federation (LWF) and a few others with specifically focused support are organizations that provide financial support to the national response.

The Government of the State of Eritrea and the World Bank (HAMSET PROJECT)

The HAMSET I Project, an IDA financed HIV/AIDS/STI, Malaria and Tuberculosis Control Project was a US$40 million credit that came into being to complement the Government's commitment to improve health services in general and prevention and control of the "HAMSET Diseases" in particular. HAMSET I, (2001-2006) was successfully terminated at the end of 2006 and is followed by the HAMSET II Project of a US$ 24 million grant that aimed to provide flexible funding to help the government's financing gap for HAMSET Diseases, support the implementation of the National Strategic Framework for all project related infections, promote a deeper community centered and community managed response including a more focused multi-sectoral approach and promote a collaborative spirit and integration of activities at all levels by supporting the "Three Ones" principles and approaches for all HAMSET diseases. By adding a reproductive health component into the already existing package, HAMSET II provided the opportunity to address MDG's Goal 4 (promotion of gender equality) and Goal 6 (improvement of maternal health).

The Global Fund

The overall goal of the HIV & AIDS component of the Global Fund is to reduce sexual, blood, and mother to child HIV transmission and mitigate the personal, social and economic impact of HIV and AIDS. The main objectives follow the five thematic areas

of the Eritrean National Strategic Plan (ENASP 2008 – 2012) and include prevention, improvement of quality of life,

The main activities are expressed in expansion of prevention services for vulnerable populations i.e. women in general, high risk groups such as truck drivers, female sex workers and the military; implementation of STIs early diagnosis and treatment related services including training of health workers in syndromic management of STIs; set up integrated and free standing counseling and testing centers across the health care system and expansion of the quality of PMTCT related services in the country. The Global Fund provided support to the Eritrean national response to HIV and AIDS in Round 3, 5, and 8 with considerable amount of financial grant.

The Joint United Nations Programme of Support for AIDS

Development partners continue to contribute to the national response of HIV & AIDS epidemic in Eritrea through technical and financial assistance that focused on prevention, treatment, care and support programmes and activities. Highly significant efforts are made to improve the capacity of staff and to enhance institutional capacity of service provision centers.

As indicated in the UNDAF 2007-2011 document, the UN System's assistance to Health heavily focus on HIV/AIDS and Sexually Transmitted Infections (STIs) in which UNDP, UNAIDS, UNICEF, UNFPA, WHO and the World Bank have roles to play.

UNDP operates in partnership with the Ministry of Health, Ministry of Labour and the National Confederation of Eritrean Workers (NCEW) to include HIV & AIDS awareness, education and AIDS related support system into the natural flow of events at different ministries and workplaces. The preparation and development of the national mainstreaming guideline in 2009 and ensuing training and consensus workshop was the product of the joint efforts made by the Ministry of Health and UNDP.

Programmes such as Life Skills based HIV & AIDS education in schools, BCC peer group education in communities and among different population groups draws the

attention of UNICEF as does services such as Prevention of Mother to Child Transmission (PMTCT), Treatment and Care of Pediatric AIDS and training of counselors. There is an extensive drive to establish support systems for infected and affected households with special consideration to orphans and vulnerable children.

The Joint UN Programme is supporting reproductive health programmes including HIV/AIDS/STIs issues of youth. Establishing Youth Health and Recreations Centers, BCC programmes, condom promotion and distribution with the National Union of Eritrean Youth and Students (NUEYS) and the Eritrean Defense Forces (EDF) are prime concerns of UNFPA while provision and management of ART including monitoring, prophylaxis and treatment for opportunistic infections among adults and children often call the attention of WHO's Country Programme. HIV & AIDS related awareness programme among refugees residing in camps is carried out by the UNHCR country office.

Non Governmental Organizations:

Prevention activities including awareness building in the general population and high risk groups, promotion and support Home Based Care (HBC) Services with the faith based organizations is handled by the Norwegian Church Aid (NCA) while peer group education and construction of resource centers for youth and women largely involved the Lutheran World Federation (LWF). Besides, production of IEC materials, establishing community based actions against HIV and AIDS and supporting the National Association of PLHA also received the attention of LWF. OXFAM and the Swiss Inter-Church Aid made significant contribution in aiding the National Association of People Living with HIV/AIDS (BIDHO) and in financing income generating activities (IGA) for affected households in Zoba Debub.

Faith Based Organizations:

The Inter-Faith Group, namely the Orthodox 'Coptic' Church, the Mufti's Office of Eritrea, the Catholic Secretariat and the Evangelical Church of Eritrea broke a new ground by designing a faster lane to VCT by promoting pre-marital counseling and testing, establishing HIV & AIDS education as a must in all religious classes designed for youth and making Home Based Care Services available in many communities.

16. MONITORING AND EVALUATION

Programmatic monitoring and evaluation activities had been carried in health sectors – collecting routine data of HIV related services from health facility level through routine reporting and periodic surveys and studies. Data is also collected from other sectors who participate in the national response mainly in the areas of awareness and capacity building of basic facts be it at workplaces or among certain population groups. The key data sources for evaluating and measuring the impact of the different services and activities are:

The Demographic and Health Survey:

The last population based survey was conducted in 2002 and a third edition of the EPHS was expected in 2008. Unfortunately it has been postponed for 2009 and again for 2010. Moreover, the new EPHS was planned to include population based prevalence survey for the first time.

Health Management Information System:

The Health Management Information System is an office that is established to collect and analyze incoming data for possible actions. The incoming reports include STI diagnosis and treatment, ARV, VCT, and PMTCT services among others.

Sentinel Sero-Prevalence Survey:

The Sentinel Sero Prevalence Survey conducted every two years takes care of most indicators that tell the story of the HIV situation in Eritrea. Since 1999, Eritrea monitored its HIV epidemic through anonymous unlinked sentinel survey of pregnant women attending ANC services in both urban and rural clusters. The survey targets pregnant women aged 15 – 49 years and identifies HIV prevalence from the perspective of geographic, socio-economic and demographic characteristics

associated with HIV prevalence of population groups. The survey includes syphilis prevalence data disaggregated the same way like HIV.

Special Studies among High Risk Groups:

Periodic special studies conducted among high risk group such as sex workers, truck drivers and TB and STI patients. The finding determines the degree of association their specific characteristics may suggest.

Joint Periodic Supportive Supervision & Assessment:

At least four quarterly supportive supervisions are held jointly between the MOH and the Joint UN Team to follow and monitor activities around prevention, treatment, care and support. Programme staff mostly from the NATCoD and the Health Promotion Unit and staffs from UNICEF, UNFPA, WHO and UNAIDS usually make the trip to different administrative zones.

17. ANNEXES

Annex I

PREVENTION

Blood Safety:

UNGASS Indicator 3: Percentage of Blood Units Screened for HIV in a quality assured manner.					
2008			2009		
Total Screened Using Standard Operating Procedure for HIV at NBTC					
Numerator	Denominator	%	Numerator	Denominator	%
8,737	8,737	100	9,331	9,331	100
Total Screened Using Standard Operating Procedure for HIV in Zonal Hospitals					
899	899	100	660	660	100
Participated in External Quality Assessment Scheme for Screening at NBTC					
390	390	4.4	430	430	4.6
Participated in External Quality Assessment Scheme for HIV Screening at Zonal Hospitals					
44	44	4.8	33	33	5.0
Numerator: No of donated blood units screened for HIV in a quality assured manner in 2008 and 2009. **Denominator:** Total number of blood units donated during the same period.					

HIV Treatment

UNGASS Indicator 4: Percentage of adults and children with advanced HIV infection receiving ARV Combination therapy						
2008				2009		
	Numerator	Denominator	%	Numerator	Denominator	%
All	4299	7182	59.8	4631	7182	64.5
Females	2096	3939	53.2	2640	3939	67.0
Males	1935	3243	59.6	1991	3243	61.3
<15	268	503	53.2	324	503	64.4
15+	4031	6679	60.3	4307	6679	64.5
Numerator: No of adults and children with advanced HIV infection receiving ARV combination therapy Denominator: Estimated number of adults and children with advanced HIV infection						

Prevention of Mother to Child Transmission of HIV:

UNGASS Indicator 5: Percentage of HIV infected pregnant women who received ARV drugs to reduce the risk of mother to child transmission.				
HIV infected pregnant women receiving ARV to reduce the risk of MTCT.				
Disaggregation				Source
	Numerator	Denominator	%	
All	423	1,862	22.7	NATCoD, 2008
Single dose Nev. only	423	1,862	22.7	
				NATCoD, 2009
All	464	1,862	24.9	
Single dose Nev. only	464	1,862	24.9	
Numerator: No of HIV infected pregnant women who received ARV drugs to reduce the risk of mother to child transmission during the last 12 months of the year. **Denominator:** Estimated number of HIV infected pregnant women in the last 12 months of 2008 & 2009				

Co-Management of TB and HIV Treatment

UNGASS Indicator 6: Percentage of HIV positive incident TB cases that received treatment for TB and HIV & AIDS in 2008/2009				
Disaggregation				Source/Remarks
	Numerator	Denominator	%	No data available
All	NA	NA	--	
Numerator: No of adults with advanced HIV infection who received ARV combination therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment **Denominator:** Estimated number of incident TB cases in people living with HIV				

HIV Testing in the General Population

UNGASS Indicator 7 Percentage of young men and women who received an HIV test in the last 12 months and who knew their result.				
UNGASS Indicator 7: Percentage of young men and women who received an HIV test in the last 12 months and knew their results in 2008				
Disaggregation				
	Numerator	Denominator	%	Source/Remarks
Numerator: No of people aged 15 – 49 who have been tested for HIV during in the last 12 months and who knew their result. **Denominator:** No of all people aged 15 – 49 including those who never heard about HIV and AIDS				

HIV Testing in Most at Risk Population:

UNGASS Indicator 8: Percentage of Most at Risk Population who have received an HIV test in the last 12 months and who know their results in 2008/2009				
Disaggregation				
	Numerator	Denominator	%	Source
Sex workers (Female)				
<25	185	200	92.5	Special Survey, 2008
>25	186	200	93.0	
Bus/Truck Drivers (Male)	245	300	81.6	Special Survey, 2008
Numerator: No of most at risk population respondents who have been tested for HIV during the last 12 months and who knows the result. **Denominator:** No of most at risk population included in the sample				

Most at Risk Population: Prevention Programme:

UNGASS Indicator 9: Percentage of Most at Risk Population Reached with HIV prevention programmes.				
Disaggregation	Numerator	Denominator	%	Source/Remarks
Reached	NA	NA		No BSS or other special survey carried out on most at risk group
Knowledge of location for HIV test	NA	NA		
Condom during the last 12 months	NA	NA		
Sterile needles and syringes during the last 12 months	NA	NA		
Numerator: No of most at risk population respondents who replied 'Yes' to both (3 for injecting drug users) questions **Denominator**: Total number of respondents surveyed.				

Support for Children Affected by HIV & AIDS:

UNGASS Indicator 10: Percentage of Orphans & Vulnerable Children 0 – 17 whose household received free basic external support in caring for the child				
Disaggregation Received	Numerator	Denominator	%	Source/Remarks
Medical support	NA	NA	--	
School materials	NA	NA	--	
Emotional/spiritual counseling	NA	NA	--	
Other social support	NA	NA	--	
Numerator: No of orphaned and vulnerable children who live in households that received at least one of the four types of support for each child. **Denominator**: No of orphaned and vulnerable children aged 0 – 17 who lost 1) one or both parents, 2) has chronically ill parents, 3) lived in a household where one adult died, or 4) one adult was seriously ill for the last three of 12 months.				

Life Skills Based HIV Education in Schools:

UNGASS Indicator 11 Percentage of schools that provided life skills based HIV education in the last academic year				
Disaggregation	Numerator	Denominator	%	Source
All Schools	355	1,145	31	Ministry of Education, Curriculum Department
Sec. School	80	80	100	
J. Sec. School	275	275	100	
Elem. School	0	790	0	
Numerator: No of schools that provided life skills based HIV education in the last academic year **Denominator**: Number of schools surveyed				

KNOWLEDGE and BEHAVIOUR INDICATORS:

Orphans School Attendance

UNGASS Indicator 12 :

- Current School Attendance Rate of aged 10 – 14
- Percentage of Schools that Provided life skills based HIV education

Disaggregation	Numerator	Denominator	%	Source
Mother alive & living in House H?	NA	NA	--	Ministry of Labour & Human Welfare
Father alive & living in House H?	NA	NA	--	
Did the child attend school	NA	NA	--	

Numerator: No of children who have lost both parents who attend school
Denominator: No of children who have lost both parents

Numerator: No of children both of whose parents are alive, who are living with at least one parent and who attend school.
Denominator: No of children both of whose parents are alive who are living with at least one parent

Young People: Knowledge about HIV Prevention

UNGASS Indicator 13: Percentage of Young Women and Men aged 15-24 who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconception about HIV Transmission

Disaggregation	Numerator	Denominator	%	Source
Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partner?				
All 15-24	1482	2700	54.89	KAPB Survey MOE 2008
Male	683	1350	50.59	
Female	799	1350	59.19	
Can a person reduce the risk of getting HIV by using a condom every time they have sex?				
All 15-24	1937	2700	71.74	KAPB Survey MOE 2008
Male	1004	1350	74.37	
Female	933	1350	69.11	
Can a healthy looking person have HIV?				
All 15-24	2359	2700	87.37	KAPB Survey MOE 2008
Male	1177	1350	87.19	
Female	1182	1350	87.56	
Can a person get HIV from mosquito bites?				
All 15-24	517	2700	80.85	KAPB Survey MOE 2008
Male	266	1350	80.30	
Female	251	1350	81.41	
Can a person get HIV by sharing food with someone who is infected?				
All 15-24	219	2700	91.89	KAPB Survey MOE 2008
Male	121	1350	91.04	
Female	98	1350	92.74	

Numerator: No of respondents aged 15-24 years who gave the correct answers to all five questions
Denominator: No of all respondents aged 15-24

Most at Risk Population: Knowledge about HIV

UNGASS Indicator 14: Percentage of Most at Risk population who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconception about HIV Transmission

Disaggregation	Numerator	Denominator	%	Source/Remarks
Female Sex Workers	241	400	60	NATCoD Special Study 2008
Truck Drivers	246	200	82	

Numerator: No of most at risk population respondents who gave the correct answers to all five questions
Denominator: No of most at risk population respondents who gave answers, including do not know to all five questions.

Sex before the age of 15:

UNGASS Indicator 15: Percentage of young men and women aged 15-24 who have had sexual intercourse before age of 15.

Disaggregation	Numerator	Denominator	%	Source/Remarks
All 15 - 24	NA	NA	NA	No study done
Male	NA	NA	NA	
Female	NA	NA	NA	

Numerator: No of respondents (aged 15-24) who report the age at which they first had sexual intercourse as less than 15 years.
Denominator: No of all respondents aged 15 - 24.

Higher - risk Sex:

UNGASS Indicator 16: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.

Disaggregation	Numerator	Denominator	%	Source/Remarks
All 15 - 24	NA	NA		No study done
Male	NA	NA		
Female	NA	NA		

Numerator: No of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.
Denominator: No of all respondents aged 15 - 49

Condom use during Higher – Risk Sex:				
UNGASS Indicator 17: Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months who used a condom during their last sexual intercourse.				
Disaggregation				Source/Remarks
	Numerator	Denominator	%	
All 15 – 24	NA	NA		No study done
Male	NA	NA		
Female	NA	NA		
Numerator: No of respondents aged 15-49 who have reported having had more than sexual partner in the last 12 months who also reported that a condom was used the last time they had sex. **Denominator:** No of respondents (15 – 49) who reported having had more than one sexual partner in the last 12 months				
Sex Worker: Condom use:				
UNGASS Indicator 18: Percentage of female sex workers reporting the use of condom with their most recent client.				
Disaggregation				Source/Remarks
	Numerator	Denominator	%	
All 15 – 24				NATCoD Special Study 2008
Female	179	400	44.8	
Numerator: No of respondents who reported that a condom was used with their last client **Denominator:** No of respondents who reported having commercial sex in the last 12 months.				

Indicator 19, 20 and 21 are not applicable in Eritrea

IMPACT INDICATORS

Reduction in HIV Prevalence

UNGASS Indicator 22: Percentage of young people aged 15-24 who are HIV infected.

Disaggregation				
HIV tested (female)	Numerator	Denominator	%	Source
<25	19	2138	0.88	ANC based Sentinel survey 2007
>25	46	2757	1.66	

Numerator: No of antenatal clinic attendees aged 15-24 tested whose HIV test results are positive.
Denominator: No of antenatal clinic attendees aged 15-24 tested for HIV infection status

Most at Risk Population: Reduction in HIV Prevalence

UNGASS Indicator 23: Percentage of most at risk populations who are HIV infected.

Disaggregation				
Female sex workers	Numerator	Denominator	%	Source
<25	6	200	3.0	NATCoD Special Study among high risk group 2008
>25	25	200	12.5	
Male truck drivers	Numerator	Denominator	%	
<25	0	0	--	
>25	7	300	2.33	

Numerator: No of members of most at risk population who test positive for HIV
Denominator: No of members of the most at risk population who tested for HIV

HIV Treatment: Survival After 12 Months on ART

UNGASS Indicator 24: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.

Disaggregation				
Males/ Females	Numerator	Denominator	%	
Total	1011	1107	91.32	
<25	NA	NA	NA	
>25	NA	NA	NA	

Numerator: No of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment.
Denominator: Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12 months outcomes within the reporting period, including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow up at month 12.

Reduction of Mother to Child Transmission

UNGASS Indicator 25: Percentage of infants born to HIV infected mothers who are not infected.

Disaggregation	2008			2009		
	Numerator	Denominator	%	Numerator	Denominator	%
All Children	9	135	6.7	8	165	4.8

Numerator: No of infants born to HIV positive women who became HIV negative upon testing
Denominator: No of pregnant women who are HIV positive and received the full course of prophylactic ARV during 2008 and 2009

Annex II

List of Participants interviewed during the NCPI –

No	Name	Organization	Designation					
A: Government Sectors								
1	Dr. Andeberhan T. Zion	MOH	Director, NATCoD					
2	Dr. Araia Berhane	MOH	Head Treatment/Care, NATCoD					
3	Sr. Nighisti Tesfamichael	MOH	Head, preventive Service					
4	Dr. Tesfazion Negash	MOH	Head, M&E					
5	Mr. Embaye Andom	MOH	Director, M&E Division					
6	Mr. Mahari Woldu	MOH	Legal Advisor, MOH					
6	Mr. Rezene Seyoum	MOJ	DG Research & H. Resources					
7	Dr. Haile Mihtsun	MOD	Surgeon General					
8	Mr. Mihretab	MOLHW	DG, Human Welfare					
9	Mr. Negusse Maekele	MOE	Head, HAMSET Projects					
10	Mr. Abraham G. Michael	MOI	Project Officer					
B. Non Government Sectors								
11	Sr. Akberet Fre	LWF	Head, Health Projects					
12	Sr. Saba Haddish	LWF	Project Officer					
13	Mr. Solomon G. Kidan	BIDHO	Chair Person					
14	Mr. Goitom Mehari	NUEYS	Project Officer					
15	Ms. Luz Joseph	NCA	Project Officer					
16	Sr. Yihdega A. Haimanot	NUEW	Project Officer, Health					
C. The Joint UN Programme of Support								
17	Mr. Michael T. Medhin	UNDP	Programme Officer					
18	Dr. Asefash Zehaie	WHO	Programme Officer					
19	Dr. Aye Aye Mon	UNICEF	Chief HIV & AIDS					
20	Ms. Yordanos Mehari	UNFPA	Programme Officer					

Annex. III

Participants at the National Stakeholders Consensus Building Meeting

	Name	Designation	Organization
1	Mr. Berhane Gebretensaie	MOH	D.G. Health Services
2	Dr. Mamadou P. Diallo	UNDP	Resident UN & Humanitarian Coordinator
1	Mr. Dawit Solomon	Admin & Finance	National Association of PLHA
2	Hadji Mohammed Ali	HIV Project Officer	Mufti Office of Eritrea
3	Mr. Michael T. Medhin	Programme Officer	UNDP
4	Dr. Araia Berhane	Head, Treatment/Care	NATCoD
5	Mr. Semere G. Giorghis	Programme Officer	WHO
6	Mr. Tajedin A. Aziz	Head, Health Promotion	MOH
7	Ms. Tsehai Afewerki	Programme Assistant	UNAIDS
8	Dr. David Wand	M&E Advisor	UNAIDS
9	Ms. Yordanos Mahari	Programme Officer	UNFPA
10	Sr. Miriam Daniel	Health Project Officer	Evangelical Church of Eritrea.
11	Mr. Yemane Kidane	Consultant	National Consultant (UNAIDS)
12	Sr. Saba Haddish	Health Project Officer	Lutheran World Federation
13	Dr. Tesfazion Negash	Head, M&E	NATCoD
14	Mr. Negusse Maekele	Head Project HAMSET	Ministry of Education
15	Ms. Verity M. Nyagah	Deputy RR	UNDP
16	Mr. Zersenay Joseph	HIV P. Coordinator	Min. of T. and Communication
17	Dr. Andeberhan T. Zion	Director, NATCoD	Ministry of Health
18	Mr. Robel Yemane	Project Training Officer	NCEW
19	Mr. Barnabas Yisa	Country Representative	UNFPA
20	Mr. Dan Odallo	Country Coordinator	UNAIDS
21	Dr. Asefash Zehaie	Programme Officer ATM	WHO
22	Mr. Yemane Negash	Expert, Child Right	Min. of Labour & H. Welfare
23	Mr. Zekiros A. Mariam	Project Officer	ESMG
24	Mr. Biniam Gebrehiwet	HIV/AIDS Officer	UNICEF
25	Ms. Luz Joseph	Programme Officer	Norwegian Church Aide
26	Mr. Eyob Frezghi	Coordinator HIV/AIDS	Red Cross Society of Eritrea.
27	Reverend Tsegay Aregay	HIV Programme	Orthodox Church
28	Mr. Temesghen Araya	Lead Consultant	National Consultant