1. Country and Sector Background

   **Background.** More than 50 million Africans have been infected by HIV since the start of the epidemic, and three million people are newly infected each year. Through its impact on human capital, productivity, public services, and social cohesion, the epidemic represents the paramount threat to development on the continent. Within the past decade, however, a powerful new tool has emerged: HIV treatment with highly active antiretroviral drugs (ARVs). In both developed and developing countries, the use of ARVs has reduced mortality by as much as 80 percent, prolonging the lives of persons living with HIV and keeping them active members of families, society, and the workforce. Yet despite these successes, the development of simpler drug regimens, and a dramatic reduction in cost - ARV drug prices have fallen more than 98 percent since 1996 - treatment coverage in Africa remains negligible. Of the roughly 26 million people living with HIV in Africa, an estimated four million have advanced to the stage where ARVs are necessary to forestall (or reverse) the onset of AIDS. Only 100,000 have access to treatment.

2. Most developing countries have been reluctant to begin scaling up treatment. Little of the money committed under IDA’s Multi-Country HIV/AIDS Program (MAP) for Africa, for instance, has been devoted to treatment thus far. To encourage greater attention to this issue, IDA, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria and major bilateral donors have recently committed to increasing treatment, and WHO has declared access to ARVs a global health emergency, setting a target of treating three million people in developing countries by the end of 2005. Ultimately, achieving universal coverage will require addressing the chronic weaknesses that beset health systems, particularly in Africa. But accelerating access to treatment needs to begin now to accumulate enough lessons of experience so that subsequent scaling up can proceed effectively and quickly. Deferring treatment expansion until all conditions are optimal would result in countless unnecessary deaths, and would also encourage the development of an unregulated market in contraband and counterfeit ARV drugs, which would have serious consequences on HIV drug resistance and public health.

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1 The “3 by 5” Initiative.
3. Three pilot countries (Burkina Faso, Ghana, and Mozambique) have agreed to participate in the proposed Treatment Acceleration Program (TAP) to test the feasibility of scaling up existing treatment initiatives. The countries were selected based on the existence of promising ongoing treatment activities and contain a variety of systems, epidemiologic conditions, and different contexts for assisting governments and NGO/private sector partners to refine national treatment policy and adapt WHO-approved treatment protocols to country situations. They also support decentralized, cost-effective, and equitable treatment activities managed by NGOs and other private sector partners and offer learning opportunities for scaling up treatment programs in other countries. Under TAP a flexible financing instrument to strengthen the institutional relationships for providing care and rapidly increase the numbers of patients being treated.

4. The Region originally explored using MAP operations directly to achieve these ends, but determined that a short-term, complementary and nested instrument would be necessary. Countries have thus far chosen to commit the vast majority of MAP resources to prevention, care, and support. As these foundations provide essential underpinnings for treatment and have been chronically underfunded, it would be counterproductive to divert resources away from them. In addition, countries remain hesitant to embark on widespread public sector treatment with MAP (and other donor) support until more is known about how programs can be safely scaled up. This underscored the importance of designing a learning-based initiative focused on treatment. The Region concluded that the public goods aspect of this work would best be achieved through an integrated, synchronized, inter-country program that could ensure consistent methods and simultaneous results, as well as facilitating regional learning by doing. This would also enable the formal, funded involvement of WHO in the program, which is essential to ensure technical standards and region-wide application of lessons learned. MAP resources will be used, however, to: (a) mobilize communities to reduce stigma around HIV counseling and testing, (b) create community awareness regarding treatment, and (c) develop support services for those tested for HIV and/or on treatment. Thus TAP would serve as a nested experimental initiative with some of its activities already integrated within MAP, while others would be progressively mainstreamed into MAPs as knowledge is gained.

5. Key strategic elements. Each of the proposed TAP countries has approved a Poverty Reduction Strategy Program (PRSP) acceptable to IDA and a Country Assistance Strategy (CAS) emphasizing the importance of preventing the spread of HIV/AIDS and expanding care and treatment for persons living with HIV/AIDS (PLWHA). Each of the countries: is currently implementing a national HIV/AIDS project supported by IDA under the MAP; has adopted a national HIV/AIDS policy or strategy to expand treatment of PLWHA and to assist households and communities affected by the pandemic; and has applied for or received funds from the Global Fund.

6. The TAP would be patient-centered, and meet the treatment needs of PLWHA and their families. By using nongovernmental, private and community-based support activities, it would complement public sector-based treatment activities and provide a continuum of care for the poor in urban and rural low-income settings. The program design has sought to help countries pilot various means of scaling up treatment and learn lessons from the process that would be widely disseminated. The TAP would be used as a vehicle for refining roles and responsibilities,
rapidly developing appropriate and scientifically sound tools and mechanisms for scaling up treatment, and sharing lessons and results across countries. Individual country treatment programs would differ but would be mutually reinforcing as each country learns from the others.

7. **Key issues.** Despite the positive clinical results of many treatment pilot programs, coverage remains low because of technical, political, and financial challenges due to:

- **Weaknesses of the health care delivery system.** Facilities are ill equipped and poorly staffed, diagnostic services are rudimentary and operating budgets are inadequate; Government efforts to address these weaknesses are hampered by an acute shortage of qualified health personnel and lack of financial resources.

- **Weaknesses in patient management and tracking.** As TAP countries are poised to increase the number of HIV/AIDS patients under treatment, clinical procedures and patient tracking systems need to be strengthened and improved to ensure proper monitoring for compliance. This is essential for identifying and dealing with potential resistance.

- **Inadequate attention to issues of inclusion and gender equity.** Although expansion of treatment requires building the capacity of additional partners to reach the affected families and communities, few countries have taken adequate advantage of potential partnerships with the private sector, NGOs, faith based organizations, and associations of people living with HIV/AIDS. In Africa, nearly 60% of PLWHA are women, and women aged 15-24 are 2.5 times more likely to be infected than men in the same age bracket.

- **Financial accessibility.** Despite the sharp declines in the costs of anti-retroviral drugs, per patient treatment costs still constitute a major barrier to scaling up. Only a small proportion of the patients in participating countries will be able to afford treatment for some time to come.

2. **Objectives**

8. The primary goal of the TAP is to strengthen each country's capacity to scale up comprehensive programs providing care and treatment, which is effective, affordable, and equitable. PLWHA and their immediate families would benefit from expanded care and treatment which has been demonstrated to: (a) enable infected persons to live longer, healthier and more productive lives and to care for their dependents; (b) be effective in preventing maternal to child HIV transmission and in decreasing the risk of sexual transmission; and (c) diminish the stigma of HIV/AIDS. Households would also benefit by prolonging income, education, and nutrition and reducing the number of orphans.

3. **Rationale for Bank Involvement**

9. As AIDS is the foremost threat to development in Africa, IDA support for treatment is an integral part of its efforts to promote long-term economic and social progress. Both IDA’s expertise in implementation and its experience in coordinating multiple partners are necessary to help countries address the systemic, structural, fiduciary, and logistical issues that proper treatment will require. IDA finance represents a crucial contribution to the global funding of
HIV/AIDS efforts, which will depend on external resources for years to come. Scaling up HIV treatment would help protect IDA’s extant portfolio in Africa, in which investments in multiple sectors are under threat from AIDS. The TAP would also strengthen MAP projects, by providing governments and others with the knowledge for effective use of MAP resources to increase treatment and sustain VCT activities.

4. Description

10. The proposed IDA Grant of $60.0 million would finance a three-year HIV/AIDS Treatment Acceleration Program (TAP) to support national-level implementing partners (IPs) in Burkina Faso, Ghana, Mozambique, and the international facilitating partners WHO and UNECA. At the country level, TAP would: (i) scale up ongoing treatment programs through agreements with existing NGO and private sector service providers; and (ii) strengthen the health system’s capacity for expanding treatment through support to Ministries of Health for improving infrastructural and logistical support and for managing the complex issues related to treatment in resource-limited settings. At the regional level, TAP would facilitate: (iii) in-country technical and clinical support through WHO to intensively monitor and evaluate country-level program experience and regional coordination and knowledge sharing through UNECA to rapidly exchange and disseminate the lessons and implementation tools to other African countries involved in treatment. The three components of the project are as follows.

11. **Component 1: Testing approaches for scaling-up service delivery for HIV/AIDS care and treatment ($38.82 million) (Burkina Faso $13.48 million; Ghana $9.86 million; and Mozambique $15.48 million).** This component would scale up existing care and treatment programs by NGO and private sector programs to ensure the delivery of the full continuum of care, and increase the number of patients at each stage of care and treatment. In particular, the TAP would finance improvements in Voluntary Counseling and Testing (VCT); Home-Based Care (HBC); Prevention of Opportunistic Infections (OI); Anti-Retroviral Treatment (ART); and Prevention of Mother to Child Transmission (PMTCT and PMTCT-Plus).

- **VCT:** expand and improve the quality of services for each of the entry points for HIV-infected people: VCT centers, pre-natal care sites, STI and TB clinics, and hospital in-patient services.

- **Home-based patient care and family support:** training of community counselors, home-based medical and psycho-social support, and nutritional education; where feasible, coordinate treatment sites with food aid programs to ensure nutritional supplementation where appropriate, and build the capacity of associations as first line providers of services in their communities.

- **Treatment of opportunistic infections:** prevention and treatment of opportunistic infections which would not rely solely on referral to secondary or tertiary health facilities, but would be expanded to community health centers and associations where trained nurses can manage the majority of cases under the supervision of a doctor/physician; strengthen the organization of appropriate ambulatory care and the referral of complicated cases; explore and test the feasibility of training and involving traditional healers in the referral system; and because the treatment of complex opportunistic infections would require heavy involvement of
doctors/physicians and secondary or tertiary health facilities, emphasize the establishment of formal relationships between these facilities and the associations and community health centers.

- **ART.** TAP-financed implementing partners would adhere to the current WHO treatment protocol, and strict patient monitoring would be instituted. In addition to periodic testing and counseling, diagnostic materials, pharmaceutical supplies, and the pertinent patient monitoring and quality assurance measures will be supported.

- **PMTCT and PMTCT-Plus:** training of birth attendants in simple practices to reduce PMTCT at birth, administration of ARV at birth to the mother and the new born baby, and the prevention of transmission of the virus through breastfeeding; and distribution of the needed drugs to prevent mother to child transmission.

12. TAP would promote the components of PMTCT-Plus, which include: (a) family centered care linked to the local community; (b) continuity of care drawing on a multi-disciplinary team of providers, and long term retention of patients; (c) psychosocial support, treatment of STDs and depression; and (d) interventions to integrate treatment adherence with other programs such as family planning and reproductive health.

13. **Component 2: Strengthening institutional capacity for HIV/AIDS care and treatment ($16.51 million) (Burkina Faso $4.63 million; Ghana $5.72 million; and Mozambique $6.16 million).** This component would ensure effective public oversight of the treatment scale-up process as follows: (i) strengthen the capacity of the National Treatment Committee, established in each country by the Ministry of Health, to provide technical guidance and quality control; (ii) coordinate program expansion through improved planning of infrastructure, human resource development, and drug procurement; and (iii) monitor the accessibility, quality, and results of treatment with particular attention to the poor.

- **Strengthening the capacity of the National Treatment Committee:** provide resources for the National Treatment Committee and working groups, and for the coordinating secretariats; finance selected activities related to national treatment policy, accreditation and approval of providers, and program reporting and monitoring, limited office equipment and transport as well as operational costs, including assistance for financial management, auditing, and monitoring and evaluation.

- **Coordination of program expansion:** MOH in each country would coordinate the implementation of treatment scale-up initiatives, both in terms of policy formulation and in the areas of physical infrastructure, training needs, drugs logistics, and IP initiatives. Implementing partners would be responsible for coordinating their activities per their approved action plan (sub-grant proposals) among their member associations and report to the MOH. The drugs procurement and distribution agency would ensure a regular supply of ARVs and related supplies by coordinating its planning, procurement and logistics activities with the TAP coordination unit. WHO would support technical coordination of program activities in and among the TAP countries, and UNECA would support regional coordination of treatment acceleration initiatives. To facilitate the TAP coordination unit in each country,
the project would support regular stakeholder meetings and annual meetings involving the development partners.

- **Monitor the quality and disseminate the results of treatment.** The TAP countries would carry out feasibility studies to determine the most appropriate measures for scaling up patient tracking among treatment sites. Funds have also been allocated for equipment and technical support to increase national capabilities for monitoring resistance. WHO would provide technical support in the areas of patient tracking and small-scale operations research with TAP financing. IDA would provide support in examining the distributional impact of the program, focusing on equity of access. In addition, at the country level, MOH and the IPs would: (a) meet regularly to review and evaluate progress and to address implementation difficulties and (b) periodically revise treatment guidelines and protocols.

14. **Component 3: Facilitating regional learning from the TAP country experiences** ($6.0 million) *(WHO $4.0 million and UNECA $2.0 million).* WHO, through its headquarters and regional offices, would be supported to provide assistance in: (i) refining and implementing treatment guidelines and protocols; (ii) developing national standards, criteria and assessment tools for accrediting laboratories and treatment sites; and (iii) setting up quality assurance systems for drug procurement and testing. WHO would also provide additional technical assistance in: (i) developing curricula and pedagogical methods for the training of medical and paramedical staff; (ii) strengthening program monitoring and evaluation; and (iii) establishing methods for managing patient compliance and evaluating treatment outcomes and potential disease resistance.

15. To support cross-country learning, the TAP would establish a regional multi-disciplinary advisory panel (RAP) to promote the rapid incorporation of lessons from the TAP into MAP, Global Fund and other donor-funded programs. ECA, in cooperation with WHO and the World Bank, will facilitate regular consultation and learning among TAP countries. As the regional secretariat for the United Nations system and a source of analysis, learning, and support for African implementation of socio-economic policies, and as the host of the Commission on HIV/AIDS and Governance in Africa (CHGA), ECA would provide support on HIV/AIDS issues, access to important regional development statutory bodies, and organization and hosting of regular multi-country expert meetings. A small TAP coordinating unit would be established within the CHGA to serve as the secretariat for the RAP and regional liaison for TAP activities in collaboration with WHO (HQ Geneva, Regional WHO/AFRO and WHO country offices) and the country TAP Coordinators with regard to learning activities.

16. The RAP would establish a regional clinical coordination sub-committee (RCCC) to work with the International Treatment Coalition (ITAC) and WHO to maintain regular review of treatment regimens and protocols as lessons from country treatment programs are gathered and shared at the regional level. The RCCC would comprise clinical experts recognized for their work in HIV/AIDS treatment, to enable African countries to share experiences, to review clinical results, and to recommend policy reforms in participating countries. WHO would serve as the rapporteur of the RCCC. The project would finance costs associated with the regular review and evaluation of country results as well as for periodic workshops to exchange information and coordinate strategies for implementing lessons learned.
5. Financing

Source: ($m.)
BORROWER/RECIPIENT 1.5
IDA GRANT FOR HIV/AIDS 60.0
Total 61.5

6. Implementation

17. TAP implementation would involve three partners: the Government (represented by the Ministry of Health), the implementing partners (IP), and international facilitators (IF – WHO and UNECA). In collaboration with MOH, the IPs would deliver HIV/AIDS treatment outreach programs. The IPs would be local and/or international NGOs, working with communities, associations of PLWHA, faith-based organizations, the private sector, and/or public/private partnerships. IFs have recognized competence in HIV/AIDS treatment coordination (WHO) and coordination of inter-country learning (UNECA). IFs would use IDA funds for in-country technical support and cross-country activities.

18. Partnerships have been established in each country with a range of organizations to improve and expand HIV/AIDS treatment, care, and support activities. In each country, IPs were selected for the first phase of the TAP on the basis of on-going treatment programs they manage. Additional IPs may be added in future, in accordance with the guidelines established by the National Treatment Committee and with a no objection from IDA. The National Treatment Committee would review and approve future IP sub-grant requests, review regular reports, and monitor and evaluate the performance of the IPs. Initially identified IPs include:

  o Burkina Faso: AIDSETI with 5 associations of PLWHA; CICDOC with 4 other NGOs; and St Camille
  o Ghana: PEF and PharmAccess in association with 10-15 private companies

19. Through the RAP-RCCC, TAP country experiences will be shared with partners supporting treatment expansion in other countries. Regular consultation with partners such as the Global Fund, the Gates Foundation, and the Clinton Foundation will complement ongoing exchange of lessons.

20. While the situation differs from country-to-country, certain features for each of the national programs are common:

  • MOH has the responsibility for overseeing all treatment programs. In collaboration with the National AIDS Council and National AIDS Secretariat, it has defined the institutional framework within which TAP activities would be carried out and would ensure full consistency with activities under the MAP;
  • All TAP-financed activities of the Ministry of Health would be consistent with the national health program and integrated into existing structures within MOH. No new public sector implementing organizations would be created, although additional funding to support a small TAP project unit may be provided;
  • IPs would receive funds under terms set forth in a contract between the IP and the Ministry of Health (or its coordination unit);
Monitoring and evaluation systems would be developed or strengthened with technical support from WHO and used to document data for decision-making, the learning process and the RAP meetings;
Regional learning and coordination will be supported by UNECA;
IDA supervision will be led by MAP task team leaders and coordinated with TAP countries, WHO and UNECA.

21. Each TAP country has established an advisory National Treatment Committee reporting to the MOH to oversee expansion of treatment programs, monitor TAP implementation, and rapidly disseminate useful information among countries in the region.

22. Project finance, disbursement, and procurement management would be the responsibility of existing project coordinating units within the ministries of health which already have experience with IDA fiduciary procedures. A TAP coordinator position would be created and funded by the TAP, as well as 2-3 designated staff specialists for operational support. The project coordination unit would serve as the secretariat of the National AIDS Treatment Committee.

23. WHO would be responsible for backstopping in-country technical capacity building, monitoring and evaluation, working in collaboration with IDA’s Global AIDS Monitoring and Evaluation Support Team (GAMET). At the global level, as part of the 3 by 5 initiative, WHO would assist TAP countries to build their capacity to provide ART and to adopt WHO generic guidelines to local realities for an effective ART program with appropriate monitoring and evaluation. WHO would take the lead in assisting TAP countries to adapt the tools used in other countries to local situations and to apply global experiences to strengthen implementation.

24. UNECA would be responsible for facilitating regional knowledge sharing among technical experts and policy makers. UNECA would establish a small coordinating unit at its headquarters, comprising two technical professionals and an administrative staff member to facilitate the knowledge sharing among TAP countries and throughout Africa. TAP would provide an operational budget for three years to permit the unit to organize intra and inter-country learning and knowledge sharing and operational research commissioned by the RAP. UNECA administrative procedures would be followed in the management of these resources with annual reporting, and audit reports provided to IDA.

7. Sustainability

25. TAP would be the first IDA project in Africa to focus primarily on treatment of HIV/AIDS. The TAP approach is fully consistent with national policies and programs, the MAP, and prevailing treatment guidelines although treatment responses in the pilot countries are at an early stage, and Governments are far from having the tools, resources, organizational set-up or experience to mount sustainable efforts. The project is designed to build both the institutional infrastructure for expanded treatment as well as the trust and partnership among Government, communities, NGOs, the private sector, and the international community that will be necessary to sustain treatment.
26. By expanding treatment through delivery mechanisms that are pro-poor, TAP contributions would enhance the effectiveness of other investments in prevention, counseling and testing, care and treatment, as well as effective systems for addressing safety net issues. While the targeted beneficiaries will not be able to cover the full costs of treatment for the foreseeable future, declining drug costs and technological developments augur well for reduced costs per patient. By identifying and testing promising approaches to effective treatment and related services, and by sharing information across countries and in different operational settings, the likelihood increases that such activities will be scaled up and attract additional funding from many sources including donors, the Government, and implementing partners. TAP would also lay the groundwork for the next phase of MAP support, enabling MAP projects to apply the lessons of TAP to scale up treatment in a wide range of countries—including the TAP pilot countries. This would ensure uninterrupted financing from IDA over the medium term, as TAP activities would be folded into MAPs at the program’s close. This would also provide adequate time for governments to mainstream treatment scale-up in their development plans and budgets.

8. Lessons Learned from Past Operations in the Country/Sector

27. Lessons learned both from previous pilot studies of care and treatment and from the implementation of MAP projects have been incorporated into the design of TAP, particularly with respect to ARV treatment, which has had a dramatic impact in reducing mortality in resource limited settings. There are impressive results from Brazil, where universal access to treatment has reduced HIV-related mortality by 50% since 1996. Improvements in survival rates have also been reported from Mozambique, Haiti, South Africa and India.

28. Brazil has used public and private sector partners within its national health security system to provide universal care to all HIV/AIDS patients. Benefits have been recorded in increased health services funding, improved health care, and cost savings for companies and their employees. In Uganda, strong political leadership and community mobilization led to a substantial increase in patients receiving ARV therapy, while in Ghana, a district-level pilot provided an empirical basis for a structured scale-up plan. Further, evidence from Cote d’Ivoire’s electricity corporation shows that the introduction of comprehensive care and therapy for employees increased VCT five-fold, reduced absenteeism by 94% and decreased HIV/AIDS-related hospitalization by 81%. Preliminary results from other African, Caribbean and Asian countries have achieved outcomes for patients that compare favorably with those achieved by patients in more developed countries. In all cases, these positive results highlight the importance of strengthening community-based adherence support systems. Careful and sustained patient monitoring has produced strong adherence and less drug resistance. Effective and careful preparation and counseling of patients prior to starting treatment, funding essential elements of treatment including the training of family members to support patients, and building up community support, assures good results.

29. TAP preparations reviewed lessons learned from MAP operations in the three countries with special focus on more efficient mechanisms for speeding up and tracking the use of TAP funds and correcting constraints which initially slowed MAP disbursements and using recent improved MAP implementation procedures.
30. TAP would strengthen the functioning of existing national treatment committees within MOH to build an effective institution for quality assurance, program supervision, monitoring and evaluation so that all complications and adherence problems are tackled early. To improve dialogue and collaboration between private and public sector service providers, association and community organization representatives would be formal members of this treatment committee. TAP would strengthen management procedures, and would support efforts by the local associations and organizations to keep civil society advocates involved during implementation.

9. Safeguard Policies (including public consultation)

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10. List of Factual Technical Documents

**Burkina Faso**

“Développement des prestations de PTMEplus du Centre Médical St. Camille de Ouagadougou, Burkina Faso », Centre Médical St. Camille de Ouagadougou.

« Présentation de la Structure de Coordination », 04/15/04.

« Programme Global de Lutte contre le SIDA – Liste des PVVIH inscrites à la prise en charge de la SEMUS du 9/2000 au 30/06/2003, Association Solidarité et Entraide Mutuelle au Sahel (SEMS).»

«Projet de Prise en Charge Antiretrovirale des PVVIH au Centre Médical de Pissy », Médecins Sans Frontières, Mars 2003.

“Projet Régional d’Accélération des Traitements VIH/SIDA – TAP; Composante avec des Associations à Base Communautaire au Burkina Faso », AIDSETI, 04/15/04.

«Proposition de financement au Programme TAP des activités de PTME plus au Centre Médical St. Camille de Ouagadougou», Centre Médical St. Camille, 22 mars 2004.


* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas


**Ghana**


**Mozambique**


Health Care Waste Management Plan.

Implementing Partners Project Proposals and Budgets for Sant’Egidio, Health Alliance International and Pathfinder International.


MOH Procurement Plan.


Strategic Plan for the Health Sector (PESS), 2001-2005.

Other


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