Project Name	Eritrea-HIV/AIDS, Malaria, STDs & TB (@)... (HAMSET) Control Project
Region	Africa Regional Office
Sector	Basic Health; Targeted Health
Project ID	ERPE65713
Borrower(s)	GOVERNMENT OF ERITREA
Implementing Agency	Address MINISTRY OF HEALTH Project Management Unit (PMU) based in the Ministry of Health (MOH), in coordination with the Ministry of Education (MOE), Medical Services of the Ministry of Defense, Ministry of Labour and Social Welfare (MOLSW), Ministry of Tourism, Ministry of Local Government, Ministry of Information, Ministry of Agriculture, Ministry of Finance, Ministry of Land, Water and Environment and Zoba Governments. PMU, Ministry of Health, Asmara, Eritrea Contact Person: Ministry of Health, Dr. Eyob Tekle Tel: (291) 112-4199 Fax: (291) 112-4357 Email: pmu@gemel.com.er
Environment Category	B
Date PID Prepared	November 3, 2000
Projected Appraisal Date	September 18, 2000
Projected Board Date	December 19, 2000

1. Country and Sector Background

BackgroundSince independence in May 1992, the Government of Eritrea (GOE) has made great strides in supporting development and improving the living conditions of its population. Basic social infrastructure has been rehabilitated and expanded. Gross primary school enrollment has changed from 36.3% to 64%. Overall access and use of health services has increased from 30% to 60%; EPI coverage has increased by 125%; attended deliveries have more than tripled; and antenatal care visit-coverage has more than doubled during the same period. Yet, Eritrea remains one of the poorest countries in the world (GDP/capita US$ 200). It is eminently rural (about 20% of the population lives in urban areas and 30% is semi-nomad). Its population pyramid follows an early development pattern with nearly 70% of the population composed of children and women of child-bearing age. The primary causes of morbidity and mortality among children under five are acute respiratory infections (ARI), malaria, and diarrhea. Life expectancy is 51 years (SSA 50); infant mortality is 72/1000 live births (SSA 72); under 5 mortality is estimated at 135/1000 (SSA 93) and maternal

mortality at 1000/100,000 live births (SSA 500/100,000). In the general population 62% of the burden of disease (BOD) is caused by perinatal/maternal causes, malaria, diarrhea, ARI, and tuberculosis (TB). Two thirds of the population live in malaria endemic areas. In 1997 and 1998 above average rainfall triggered a malaria epidemic, making this the leading cause of mortality (over 50% in all areas) and morbidity (60-80% depending on the area) across all ages. The reproductive health situation is very poor: first pregnancy occurs at an early age (21% of 17 year olds and over 50% for 19 year olds), the fertility rate is high (5.6), and female genital mutilation--discouraged by government -- is prevalent in certain regions. This situation is compounded by an increase in STDs and the emergence of HIV/AIDS (3,6% adult population). The number of AIDS cases is believed to be doubling each year. Nutritional status is poor: 10% of under-five children are wasted, 66% stunted, and 41% underweight; and 50% of the children have anemia. Diarrhea, anemia and malaria are interconnected and increase vulnerability to other HAMSET diseases.This situation has worsened in 1999 due to the May 2000 military conflict with Ethiopia and to the drought. About 20% of the population (men and women) has been mobilized; a third has been displaced and is without adequate shelter, sanitation, food and basic services. Although widespread famine and disease outbreaks have not occurred, partly owing to Government efforts to mitigate the related adverse impact by providing food and other assistance, there is a growing concern that the situation will deteriorate in the coming months; early warning signals, such as rising morbidity rates and falling livestock prices, are already evident. The Ministry of Health (MOH) is responsible for the state health system and regulates and controls the provision of private and NGO's health services. The public sector is virtually the only provider of health care. Private clinics and pharmacies exist only in larger cities and serve a limited proportion of the population. All hospital beds are in the public sector. At the village and district level, the PHC network consists of health posts and health centers staffed with one or several nurses. Health centers have a laboratory, in-patient, and delivery facilities. Many remote villages have no health facility. Every village or cluster of villages has teachers, extension, social workers and malaria agents. They often work in cooperation with health facilities, sometimes referring patients. At the regional level (zoba) the recently established zoba health team manages the PHC network. The Government is completing a network of referral hospitals (one in each zoba). With support from WHO, the MOH has approved an essential drug list and has developed treatment guidelines. Drug purchase and distribution follows two systems: the pharmaceutical department of the MOH and Pharmecor. The pharmaceutical department of the MOH supplies the public health facilities. It is well organized, has an adequate monitoring system, and is supplied almost exclusively by donations from bilateral and multilateral agencies. Pharmecor is a parastatal, for-profit organization that imports and produces pharmaceuticals. While there are other pharmaceutical importers in the country, Pharmecor is the only producer. Private sector pharmacies can purchase drugs from any importer and public sector facilities purchase from Pharmecor those items that are not available through the MOH.Issues Highly mobile and disperse population compounded by military conflict: Despite being a relatively small country, Eritrea has heterogeneous ethnic-cultural groups and economic cultures, varying geographic and climatic zones, various vector habitats, and remote areas that are traveled by nomadic groups (about 30% of the total population in Eritrea

is composed of semi-nomads agro-pastoralists). There are seasonal migrations to and from the breadbaskets of the country. This previously isolated country is now open to trade, Eritreans from the diaspora, and foreign investors who travel in and out of the country. In the last two years, armed conflict has displaced about 3.5% of the internal population added to the 200,000 (7%) returnees. The combination of varied geography, high mobility, and openness after isolation stimulates the spread of communicable diseases, and complicates MOH capacity to reach the population. In the aftermath of the recent conflict, there is an expected increase in morbidity and mortality due to malaria, water-born diseases, as well as an increase in the transmission of tuberculosis, STDs and HIV/AIDS.Changing epidemiological profile: The factors listed above, compounded with changes in social mores and climatic conditions, have changed Eritrea's traditional epidemiological profile. Eritrea has a high case-fatality rate of malaria. Malaria resistance to chloroquine has been documented in 40% of cases in certain areas, and cases of endemic malaria have been detected in previously malaria-free areas. In '97 and '98 malaria was the main killer in adults (65%)--especially pregnant women--and the main cause of morbidity among all ages (70%-90%). The prevalence of malnutrition increases the overall morbidity and mortality cases. Existing diseases, such as STDs and TB, are on the increase; however, it is difficult to estimate the exact numbers because of the social stigma attached to these pathologies. HIV is initiating its spread, and there is no reason to expect that the epidemic in Eritrea will--without significant, well planned and focused intervention--follow a different pattern from that in neighboring countries. In 1995, over 11% of commercial sex workers in Assab (the main harbor and a key base of Eritrean economic activity) were HIV positive. Moreover, demobilization and the openness of the country is changing mores and attitudes, especially those of young people in urban areas. TB is a major public health problem with an annual risk of infection (ARI) of about 2.3%, i.e about 4000 people are expected to develop new smear-positive, infectious, TB cases each year. A similar number of people will develop non-infectious, pulmonary and extra-pulmonary, tuberculosis every year. As a consequence of the HIV/AIDS epidemic, the incidence of TB is expected to continue to increase. The recent massive population movements due to the conflict with Ethiopia and the mobilization of about 20% of the population to the front can have repercussions on the transmission patterns of malaria, STD, HIV/AIDS and TB that are difficult to predict. Lack of information on the epidemiological situation and effectiveness of current interventions: Health policy is made incrementally, based on experience rather than on data-based evidence. Data are collected but not always shared across sectors, and analytical capacity is poor across the board. Systematic monitoring and evaluation of interventions is virtually non-existent across all sectors. Because of the conflict, it has been difficult to carry out country-wide surveys. While there are on-going entomological studies on the malaria vector, little is known about: a) population practices, behaviors, incentives, and motivations for health behavior change; b) the incidence of STD, TB and HIV/AIDS by different age, gender, and socio-economical groups and regions; c) insecticide and drug resistance to malaria, TB and STD; and d) the impact of education and communication activities on health behavior. Statistical data on TB case notification are incomplete and unreliable. Insufficient and inefficient use of resources: Despite Government commitment and efforts (social sector expenditure amounts to 60% of Government's expenditure), the

country can afford to spend only about US$5 per capita on health. As a result, certain programs known to be cost-effective, such as social marketing of condoms and directly observed treatment strategies (DOTS) for TB, cannot be expanded. Expenditure patterns are inefficient with most financial resources (70%) concentrated largely on curative rather than preventive measures. While there is a series of policies to deal with different issues, including PHC, malaria, TB, and HIV/AIDS-STD control, there is very little coordination among the different programs of the MOH. Skilled staff are very scarce particularly in the rural areas. Capacity building is a key element of the Government policy, but lack of a sector strategy results in ineffective training for staff. The military conflict has further undermined the capacity as young staff had been called to the front. However, with the cease fire, staff are getting back to their posts. Poor quality of health care and blood safety: Diagnostic capacity is limited. In the case of TB, the distribution of diagnosed patients indicates substantial underdiagnosis of new smear-positive and overdiagnosis of smear-negative pulmonary and extra-pulmonary tuberculosis. This may be due to poor quality of smear microscopy and/or poor diagnosis of patients based on clinical findings only. Treatment guidelines are used rarely, and inadequate treatment is common. Outreach activities are limited and so are preventive activities. Except for a Central Blood Bank being built in Asmara with IDA financing, there are no blood banks in the country. Most transfusions are done on a person to person basis without testing for HIV or other critical diseases. Unfortunately, during the heat of the conflict there was no other way to transfuse some of the wounded. Commitment to multisectoral disease control but lack of coordination across sectors: GOE has adopted a multisectoral approach to address the challenges of HAMSET diseases, but this approach is as yet uncoordinated across sectors. The Ministry of Health, as the lead agency in combating the diseases, has prepared a five year plan of action and strategies for each of them. While those strategies are technically sound overall, they need to be adapted to local situations. The Ministry of Education has begun a pilot program of HIV/AIDS clubs in senior secondary schools and recognizes the importance of malaria as a cause of absenteeism in primary schools in epidemic regions. The MOE adult education Mass Media Unit currently reaches 75% of the rural population with messages addressing malaria. The Ministry of Labor uses its labor organizations to promote health messages, as does the Ministry of Information with its highly organized community networks. The National Union of Eritrean Youth actively promotes HIV/AIDS awareness among adolescents, and the army's medical service performs the same function for conscripts. Effective coordination of these activities would strengthen an existing infrastructure that reaches all target groups within the population. Shortage of qualified health personnel: Training of health professionals is done at the Institute of Health Sciences in Asmara and at the College of Health Sciences at the University of Asmara. There is no training of medical doctors in the country. There are only 145 physicians and 391 nurses, working mainly in the urban areas. Other health professionals such as laboratory technicians, entomologists and health educators, are in critical shortage. Furthermore, there are no staffing patterns in relation to service delivery and the development of infrastructure.Poor communications capacity and ineffectiveness of past communication efforts: Professional communication skills and experience beyond the field of journalism are limited within government agencies as well as the private sector. HAMSET messages are often contradictory and

carry the potential to either extend or create negative socio-environmental impacts. Moreover, despite significant efforts regarding participation, community mobilization is still mostly limited to implementation of government programs. Participation mechanisms lack comprehensive involvement that reflects the rich traditional and cultural knowledge possessed by the communities. Insufficient knowledge of health practices and use of services by the population. For the most part, Eritreans have limited knowledge of how preventive health measures and social practices affect health outcomes. Despite public efforts, literacy is low in the country, particularly among women (70%). The country has a large share of orphans and female-headed households, which typically have a lower health status than that for the general population, and are less likely to seek health care by themselves. Nutritional practices are poor among adults and children who live in areas of the country with low intake of vegetables and proteins. Low population density in most rural areas limits access to primary health care services where health personnel (especially skilled staff) may not speak the local language. Finally, there is substantial stigma and societal exclusion against patients that have TB, AIDS, and STD. All those factors severely lower the use of preventive and basic health services. Environmental: The lack of adequate disposal for contaminated refuse from health facilities provides a serious source of contamination. Household tasks and social activities and behavior promote vulnerability to malaria. Several daily tasks and workplace hazards increase the vulnerability to infection by HIV-AIDS. After independence, GOE initiated major efforts to develop the country, such as construction of dams and terraces, expansion of surface irrigation, reforestation, and resettlement of displaced people and returnees. All those activities contribute to increase HAMSET disease transmissions. The epidemiological profile of malaria in Eritrea implies that, according to WHO Guidelines for malaria control, effective control of the disease requires the use of pesticides to reduce vector density and for personal protection. Government StrategyThe objective of the GOE overall Macro Policy is to eradicate poverty and to foster economic growth through, among others, national policies on human resources development and food security. The health policy supports this objective through activities that aim to: (a) minimize and eventually eliminate easily controlled diseases; and (b) enhance awareness of good health practices in order to improve workforce productivity. The education policy seeks to develop self-consciousness and self-motivation among the population in order to fight poverty and disease. Current state policy acknowledges the necessity of empowering vulnerable groups to enable them to become productive members of society. Finally, capacity building is a key strategy for fostering development as the GOE invests a large part of its resources in updating staff skills and in-service training. The following are key strategic priorities for the GOE:Development of human resources: The work on a human resources development policy is underway. It will be finalized during the year 2000 together with a plan for matching training programs and staffing needs. In addition to external training, there are efforts to improve the quality of in-country health programs. Curricula have recently been reviewed with a focus on competencies and on horizontal integration.Improvement in the information base for decision making: The GOE plans to develop a social sector integrated information system to monitor living conditions and effectiveness of interventions. The nation-wide integrated food security system will serve as a model. As most ministries have developed their own information systems, GOE is studying

how to connect and integrate the different databases, and enhance the capacity to analyze and use information at the zoba level. In the health sector, it intends to build on the MOH management information system (SEMISH) and develop an effective surveillance and epidemic preparedness system.Decentralization and inter- and intra-sectoral coordination: The decentralization law creates an environment conducive to coordination of planning, budgeting, and implementation activities. Intersectoral committees at national and zoba level are being re-activated. Recent projects supported by IDA stress coordination and have a strong multisectoral framework. For example, agricultural and fishery extension programs will be revised to include health promotion activities. The year 2001 marks the beginning of government budgeting. The GOE intends to use this instrument to boost coordination.Community education and empowerment: The government has a strong adult literacy campaign to increase awareness of specific diseases and mobilize community for vector control. GOE is also fully supportive of the social marketing of condoms and is studying similar strategy for insecticide treated materials (ITMs). In its effort to empower the community, the GOE supports the efforts of other key stakeholders such as the National Union of Eritrean Women (NUEW) and the National Union of Eritrean Youth (NUEY) in AIDS counseling and in providing malaria prophylaxis to students during their social service. In their effort to minimize the stigma associated with HIV/AIDS, the MOH and other agencies are recruiting well- respected, often war heroes to meet with students and other vulnerable groups. Minimizing environmental damage: The GOE recently adopted the "National Environmental Assessment Procedures and Guidelines" to be used in all projects, regardless of the funding source. The MOH is responsible for the related work and compliance in the health sector. The MOH is aware of the potential negative impacts of the current use of pesticide use for malaria control, and is committed to address the issue by establishing: a) full control of chemical application, including handling and disposal of leftovers, and monitoring of both effectiveness and negative impact; and b) introducing safer alternatives to pesticides currently used for public health purposes. At the same time, the MOH is preparing standards for bio-hazardous waste management for health facilities.Humanitarian crisis and reconstruction: The GOE has promptly reacted to the May 2000 humanitarian crisis on two fronts: (i) by providing emergency relief and assistance to the displaced and the hosting communities; and (ii) by organizing the available human and financial resources in order to start the process of reconstructing and rehabilitating the areas damaged by the recent conflict. The process of reconstruction and rehabilitation of the country will be tackled in two phases: (i) a first set of immediate needs will be met through the financing of the Eritrea Reconstruction Program; the activities financed will enable the country to restart some productive activities and repair the infrastructure necessary to allow this process; (ii) the remaining and less urgent needs will be addressed through individual sector programs prepared and financed in collaboration with the development community.

The HAMSET control project supports the above policies by adopting a coordinated intra- and inter-sectoral approach to tackling the diseases that impose a heavy disease burden on the Eritrean population, and that is based on environmentally sound disease management. While it does not answer directly to the humanitarian crisis, it is part of the sectoral efforts to minimize the impact of the recent conflict. It will ensure, among other things, that there are enough supplies to support the GOE's malaria and TB control efforts and will provide basic drugs for the

treatment of STDs and counseling and testing for conscripts that are demobilized. Social sector activities supported by financing partners With support of the USAID-funded Environmental Health Project, studies are being undertaken to help refine the malaria strategy, and social marketing of condoms is being implemented in selected areas. The Italian Cooperation, through WHO, is assisting in the design and implementation of an integrated disease surveillance system, the development of a human resource policy, and the control of Tuberculosis (TB). An ongoing IDA-financed social fund is supporting the expansion of education and health infrastructure. An IDA and NORAD-financed health project is, among other things, constructing a Central Blood Bank and two referral hospitals at the zoba level, equipping PHC health facilities, and supporting an in-depth analysis of the health sector. The recently launched IECD project focuses on nutrition, education and health issues of children under five and pregnant mothers, as well as on orphan protection. UNICEF is supporting community-based water and sanitation programs, school health and AIDS clubs, and malaria control through ITMs. WHO provides technical assistance on several technical issues including malaria and TB, and finances a pilot community-based program for the integration of individuals with disabilities in the community. Apart from that, an emergency program is being prepared to cope with the impact of the conflict and to reconstruct the country. Several donors (including EU and Italian cooperation) have pledged assistance. During appraisal, the Government has reiterated its interest in developing a comprehensive health sector strategy and a health investment program in collaboration with all the partners. The consultative process on the first phase, i.e. the sector review, has been initiated.

2. Objectives

To reduce the mortality and morbidity of the Eritrean population due to HIV/AIDS, malaria, sexual transmitted diseases and tuberculosis (HAMSET) through an increase in utilization of quality, effective and efficient health services for HAMSET prevention, diagnosis and treatment, supported by health practices.

3. Rationale for Bank's Involvement

The comparative advantage of IDA is the involvement and ability to work across sectors, which will facilitate the proposed multi-sectoral approach. Furthermore, there are clear links with other IDA-funded projects, such as the Community Development Project, the Early Childhood Development project, the Human Resource Development Project, and the proposed Nutrition Project. IDA involvement will help: (i) ensure coordination, (ii) prevent duplication of efforts, and (iii) exploit the complementary aspects of the different projects. As the Bank is a key partner in the global Roll Back Malaria partnership, STOP TB Initiative and UNAIDS, the ability to play a facilitating role in identifying expertise and possible partners is also an asset. Lastly, the Government of Eritrea has explicitly and urgently requested the Bank to support and extend the ongoing efforts to control malaria and HIV/AIDS. Multi-Country HIV/AIDS Program (MAP)Management has recommended that HAMSET be included as part of the Multi-Country HIV/AIDS Program (MAP) for Africa. The MAP, approved by the Board in September 2000, is a "horizontal" adaptable program lending (APL) instrument developed to strengthen the Regional response to HIV/AIDS. The MAP will support efforts to expand national prevention, care, support, and treatment programs, and to prepare

countries to cope with the unprecedented burdens they will face as the millions living with HIV today develop AIDS over the next decade. The first phase of the MAP will consist of individual lending operations up to an aggregate amount of US$500 million. Provided they meet specific eligibility criteria, including eligibility for IDA credits, the MAP will enable countries to more rapidly access resources needed for the expansion of national HIV/AIDS programs. It is proposed that HAMSET be included under Phase 1b of the MAP (Phase 1a was constituted by the first two countries approved for MAP funding). As detailed below, HAMSET meets the MAP eligibility criteria: Satisfactory evidence of a strategic approach to HIV/AIDS, developed in a participatory way: The GOE 's comprehensive five-year plan for HIV/AIDS is multisectoral and has been developed using a participatory approach. Establishment of a high-level HIV/AIDS coordinating body, with broad representation of key stakeholders from all sectors, including people living with HIV/AIDS: A National HAMSET Steering Committee will provide overall strategic and policy guidance to the implementation of the program. This Committee includes representation from the Ministries of Health, Local Government, Labor and Social Welfare, Education, in addition to all six Zoba Governors and representatives of people living with HIV/AIDS. Government commitment to quick implementation arrangements, including channeling grant funds for HIV/AIDS activities directly to communities, civil society, and the private sector: The GOE is committed to the rapid implementation of HAMSET, and has emphasized the need for mechanisms to strengthen community-based responses. Agreement by the government to use multiple implementation agencies, especially community-based and non-governmental organizations: HAMSET will be implemented through a partnership of several Ministries, the National Union of Eritrean Women, the National Union of Eritrean Youth, among others. The inclusion of malaria within the HAMSET MAP is highly unusual and is not intended to set a precedent for future MAP country projects. In brief, the integration of HIV/AIDS and malaria in this project was considered necessary for two major reasons: (i) as a means of achieving economies of scale, and (ii) disease-specific programs face a higher risk of failure when implemented in parallel. This rationale is further detailed in Annex 4 ("Adequacy of the Sector Policy Framework") of the PAD. It should also be noted that the malaria specific component of HAMSET constitutes only 7 percent of the credit.

4. Description

The majority (47.2%) of Bank financing is for component C, which supports the major health sector interventions: diagnosis, care and counseling for HAMSET diseases. These activities are strengthened by smaller components which help to target care, control transmission in the community and promote community-managed responses to HAMSET diseases. A. Collect and Analyze Information on HAMSET to Facilitate Evidence-Based Decision Making and Rapid Response This component will strengthen the GOE's capacity to collect comprehensive information on HAMSET diseases in a timely and efficient manner, to analyze it and to use the information for planning and to responding appropriately to changes in disease trends. That capacity would exist at the central, zoba, and sub-zoba levels and would allow a quick response to epidemics. Activities supported by the credit would contribute to: (i) improve HAMSET surveillance techniques; (ii) establish an epidemic forecasting and preparedness system; (iii) improve country's capacity to carry-out operational research for identifying

changes in HAMSET; (iv) introduce methods to link the results of research and M&E to policy formulation, annual planning and budgeting; and (v) strengthen management of communicable diseases at the MOH.B. Multi-Sectoral Control of HAMSET TransmissionB.1. Promote healthy behaviors through multi-level communication. The project will enable the MOH /IEC unit to coordinate the communication activities of all implementing partners and build capacity at zoba and sub-zoba levels. It will enable zoba level IEC staff to: (i) conduct formative research to gain a better understanding of target audience attitudes and beliefs about benefits and barriers to adoption of desirable behaviors; (ii) develop a communication strategy and conduct communication activities to support project objectives and promote healthy behavior among target populations; (iii) coordinate and supervise the work of partner agencies at the zoba and sub-zoba level; and (iv) develop a system to track changes in knowledge, attitudes, beliefs, and behavior among target audiences reached by communication campaigns. The project will also support orientation of leaders of NGOs, and senior officials of other line ministries as well as national advocacy efforts.B.2 Promote healthy lifestyle through the education system. . The framework of the FRESH partnership (Focusing Resources on Effective School Health - WHO, UNESCO, UNICEF & IDA) has been used to prioritize the most cost-effective actions, particularly for the poor and disadvantaged. The approach will be implemented through the Ministry of Education (MOE) school health program in both the formal and non-formal systems. The project will finance activities that aim to: (i) strengthen central and regional skills in school health programming; (ii) promote in students and teachers healthy practices and behavior change; (iii) establish school based support and health services; and (iv) promote healthy practices and behavior change in adults.B.3 Enhance access to preventive, diagnostic and treatment services for conscripts. The project will: (i) promote healthy behaviors through multiple channels of communication, (ii) strengthen health care services available to conscripts (including the availability of voluntary counseling and testing), (iii) promote the increased use of condoms and insecticide treated materials (ITMs), and (iv) establish a program to address HAMSET concerns in the context of demobilization. B.4 Promote environmentally sound and cost-effective techniques for Malaria vector control by implementing a pesticide management plan (PMP) that will: (i) identify, test, validate and introduce safe, cost-effective chemicals to replace DDT; (ii) test and validate malaria biological vector control; (iii) develop a strategy for pesticide use and control; (iv) test community acceptance of validated methods and techniques; and (v) replicate socio-environmentally validated malaria vector control methods. The testing of the alternative chemicals will provide a reliable method to replace the current residual DDT house-spraying by chemicals and methods safer to the environment and to human health.C. Strengthen HAMSET Diagnostic, Health Care and Counseling Services.C.1 Establish safe blood banks in zoba hospitals. The project will support the establishment of four blood banks for zoba hospitals. This will complement the current health project which is establishing two blood banks in the remaining zobas as well as a national blood bank in Asmara.C.2 Improve diagnostic, treatment and counseling of HAMSET diseases through integrated in-service and on the job-training on HAMSET prevention and detection, case management, syndromic and laboratory diagnosis of HAMSET disease, as well as pre- and post-HIV-voluntary counseling and testing (VCT). The primary strategies for HAMSET disease management include: directly observed

therapy, short-course (DOTS) for TB; rapid detection and treatment of malaria in health facilities and in the community, including IMCI for children < 5 years of age, with laboratory confirmation when available; management of severe malaria at referral facilities; voluntary counseling and testing for HIV; management of opportunistic infections in HIV-infected persons; syndromic management of STDs, with laboratory confirmation when available.C.3 Improve availability of basic medical materials and drugs required to diagnose and treat HAMSET diseases in health facilities. The project will support procurement and distribution of basic essential drugs and diagnostic materials to treat HAMSET diseases (only opportunistic infections in the case of HIV/AIDS), surveys to assess the availability of drugs and medical materials, in-service and on-the job resource management training for MOH staff specially at facility level, and transport for drugs, medical materials and to provide supervision. D. Community-Managed Response Program.The project will identify community-based affordable, effective mechanisms for minimizing the transmission and impact of HAMSET diseases and have them ready for replication nationwide. The component consist of two sub-components: (A) Community Counseling and Support Groups; (B) Community-Managed Response. Sub-component A will strengthen community support services provided by the MOLHW to provide counseling and establish support groups for AIDS patients. Sub-component B will test the capacity of the communities --under their own community structure and socio-cultural fabric to: (i) respond to technical information about the HAMSET diseases for their prevention, care and cure; (ii) organize their internal mobilization, discussion and decision mechanisms on the support they deem necessary to assess and otherwise manage the diseases; (iii) identify and input their grassroots and socio-cultural contribution to HAMSET messages, prevention, care and cure methods, and available support services; and (iv) identify, decide on and implement available methods to prevent or mitigate the diseases and related impacts in the community. Lessons learned during the initial phases will be incorporated into the plans for subsequent phases. The component will link with the IDA-financed Eritrean Integrated Early Childhood Development IECD as adequate. The component will cover all Zobas and sub-zobas two in each cultural area, including semi-nomads but one Kababi each in Year 1 and 2 and expand to other Kababis in Year 3 and 4. This phasing will allow for internalizing of community based processes among field staff and community based workers and the testing of a number of assumptions in the initial phases.E. Project Management and Evaluation. The project will strengthen the current PMU (located in the MOH) that is managing the Health Project, with an emphasis on evaluation and monitoring of activities.

A. Collect and analyze information on HAMSET to facilitate evidence-based decision making and rapid response.
B. Multi-sectoral control of HAMSET transmission.
C. Strengthen HAMSET diagnostic, health care and counseling services.
D. Community-managed response program.
E. Project Management and Evaluation.
F. PPF Refinancing

5. Financing

	Total (US$m)
GOVERNMENT	8.45
IBRD	
IDA	40

LOCAL COMMUNITIES	1.55
Total Project Cost	50

6. Implementation

Implementation Period: 5 yearsDetailed implementation arrangements are part of the PIP (project implementation plan). The Bank has received the revised draft of the PIP which will be discussed further during negotiations. The following are initial details for project arrangements.Executing Agencies. The Ministry of Health will serve as the overall coordinating agency, in addition to its existing responsibility as the lead executing agency. In addition, the following agencies will implement relevant aspects of the project in accordance with their existing sectoral aims and mission: the Ministries of Education, Local Government, Labor & Human Welfare, Agriculture, Information, and Defense Medical Services as well as the National Unions of Eritrean Women and Youth. Project Oversight and Policy Guidance. A National HAMSET Steering Committee will provide strategic directions and policy guidelines. It will be chaired by the Minister of Health and will include Ministers of Local Government, Labor and Social Welfare, and Education as well as the six Zoba Governors. The Director General of Health Services (DG HS) will be the Secretary. This Committee will meet at least quarterly.Management of Project Activities. Figure 1 illustrates the management structure of the project. It adopts the existing organizational structure of the MOLG, thus promoting coordination and cooperation at all administrative levels, in line with the Government decentralization policy. This is achieved through the following arrangements: At the central level, there will be a National HAMSET Technical Committee chaired by the DG HS. The Director, Communicable Diseases Control Division (CDC) will be the secretary. This committee will provide the technical guidance for all project activities. Technical experts designated by the Ministries of Health, Education, Labor and Human Welfare, Local Government, Tourism, Agriculture and the Medical Services of the Ministry of Defense as well as the associations of Women and Youth and the Confederation of Eritrean workers, will be members of this committee and will meet once a month or more often if necessary to review all technical aspects and progress of the project. The Technical Committee will report to the Steering Committee through the DG HS. The Coordination, planning, financial management, and procurement at National Level will be the responsibility of the Project Management Unit (PMU) set up for the present health sector project (credit 3023). The PMU will be strengthened with the addition of one Operations Manager exclusively for HAMSET, three Program Officers to coordinate different project components, finance/accounts and procurement personnel and minimum support staff. Its manager reports directly to the Minister of Health. Both the procurement and financial management capacity of the Unit have been evaluated and found satisfactory. The project will add a sub-unit to the PMU, staffed with a deputy-project manager, financial management officer, procurement specialist, and appropriate support staff and equipment. Special training in project management will be provided for the new staff with special emphasis on monitoring and evaluation of activities. The expanded PMU will be responsible for compiling and preparing budget and plans, disbursing funds to participating Ministries and agencies, and managing the special account, financial management and accounting, bulk procurement of goods and services, and management of the Credit. The PMU will also be responsible for ensuring compliance with the Development Credit Agreement (DCA) and project coordination across ministries and the regional

administration and agencies. At the Zoba level, the overall coordination will rest with the Zoba HAMSET Coordination Committee to be formed with the Zoba Governor as the Chairperson. The members will include all multi-sectoral implementing ministries and agencies at the Zoba. The Executive Director of Zoba Administration will be the Co-chairperson, the Director of Social Services the vice-chairperson, and the Zoba Medical Director the Secretary of this committee. The committee will meet every month. There will also be a Zoba HAMSET Technical Committee with the technical experts from the line departments and agencies as members. The technical committee will meet every two weeks to review all technical and implementation aspects. The Zoba Medical Director will chair the technical committee and the HAMSET program officer will be the Secretary. 39. The day-to-day management and coordination of the project at the zoba level will be handled by a small project Management Unit under the Zoba Medical Director. The Executive Director of Zoba Administration and the Zoba Medical Director will be co-signatories to the Project Account in the Zoba. One Project Officer and one Project Accountant will be full time project staff at the PMU. The workload in the initial two years may require an assistant project officer to support the Project Officer. The specific job responsibilities will be included in the Project Implementation Manual. Planning, accounting, financial, reporting, and auditing arrangements. The development of the financial management system will have two phases: interim and final. The interim phase will involve expanding and/or adapting the existing financial management and accounting structure, and will be in place when the project becomes effective. The final phase will involve piloting and ensuring that the existing system is ready to adopt PMR-based disbursements. During appraisal, the capacity of the implementing agencies and Zoba level structures were reviewed. Due to the limitations regarding accounting and finance management at decentralized levels, a number of steps have been agreed with the Government, as follows.As part of the PIP, a Financial Management Manual to document the operation of the project's financial management system will be finalized by credit effectiveness. The manual will inter alia contain a description of financial policies and procedures applicable to the project, channels and arrangements regarding the flow of funds, the Financial Management System and sub-systems (budgeting, accounting, and reporting), and internal controls. During negotiations, IDA will obtain confirmation of the recruitment of an additional financial officer, and reviewed and updated action plan for the upgrading and implementation of the financial management system. Effective implementation and operationality of those systems will be part of the conditions for credit effectiveness.An independent and qualified audit firm with staff experienced in similar audits will carry out an annual audit of the project accounts. During negotiations, a short list of firms acceptable to IDA will be agreed upon. A one-year contract, renewable year by year, subject to annual performance satisfactory to the Government and IDA, will be signed between the Borrower and the selected firm. Terms of reference for the annual audits will be agreed upon at negotiations, and will cover all requirements for audit of the project accounts and review of internal controls. Audit reports (consisting of the auditors opinion and a management letter) will be submitted within six months following the end of each fiscal year. The cost of such audits is incremental and is therefore included in the project cost.Monitoring, evaluation, and reporting arrangements. A detailed monitoring and evaluation system will be developed and included in the Project Implementation Manual. The

monitoring and evaluation of the project will be based on the indicators outlined in Annex I and the Development Credit Agreement. Studies carried out during the first year and a half of the project will establish base line data and subsequent studies, and results from the surveillance and effectiveness monitoring systems will support evaluation of project progress. Representation of the government agencies at the sub-regional and village (community) levels makes it possible to supervise the details of program implementation, follow up activities, and cross-sectoral coordination at all administrative levels. Project M & E will be undertaken through: (1) IDA supervision missions and annual progress reviews, (2) regular quarterly meetings of the Project Central Steering Committee, (3) semi-annual progress reports based on implementation targets defined in the Annual Work Plan and Budget, (4) mid-term review of the project no later than 30 months after effectiveness to identify project successes and issues to be addressed, and (5) baseline and follow-up surveys of beneficiaries. A project Implementation Completion Report will be prepared within six months of the project closing date.

7. Sustainability

Prevention of a full-blown HIV/AIDS epidemic will impact sustainability of all development efforts in Eritrea. The social and economic impact of a rapidly spreading epidemic is hard to quantify, but it is clear that the costs across all sectors would be very high. It is of no use to train, educate, or cure people if they will, subsequently, die of AIDS. Mitigating the epidemic will therefore reduce costs of treatment, mortality, and morbidity in the future.The project will increase the health sector's institutional capacity to develop policies, implement programs, collect and analyze data as well as monitor and evaluate effectiveness of interventions. HAMSET diseases require a long-term effort to be effectively controlled and contained. Therefore, this increased capacity will enhance sector sustainability by enabling a long-term, well-targeted, and multi-sectoral response as adequate. Inclusion of cost-recovery mechanisms in this project would hamper the immediate response necessary to strengthen the sector, and unacceptably delay project implementation. The potential cost-recovery mechanisms will be analyzed during the sector review. The analysis will provide a basis to ensure future sustainability in the sector.The project constructs minimal infrastructure. Instead it rehabilitates existing structures to make them more effective. Prior to consider construction of new social centers the local government will carry out an inventory survey of existing facilities at village and sub-zoba level to identify existing structures that could be used for social purposes and propose how to maximize their use. In war affected areas, there may be a need to replace destroyed infrastructure. This will be done through the emergency recovery project now under preparation. It is, therefore, expected that the incremental recurrent costs will be negligible. The cost tables of the project identify incremental recurrent costs. GOE , and specifically the Ministry of Finance, has indicated that it is ready to increase per capita allocation for activities related to HAMSET control. At negotiations, the GOE and IDA will agree on a plan indicating how incremental recurrent costs will be covered after project implementation.Drugs, condoms and laboratory reagents: Despite the fact that these can easily be considered recurrent costs, they have been considered investments costs in this project. The key reason is the very low GDP of Eritrea, and the limited possibility to increase health budget in the coming five years. During the project the

Government will carry out studies that will allow it to propose a plan for transferring the financing of those items progressively to the Government budget. However, it is reasonable to expect that no substantial contribution can be made from GOE funds and that external financing might have to be relied upon in the short to medium term. Strategies to ensure HAMSET program sustainability in the medium to long-term will be one of the important areas to focus on in the preparation of the health sector review.

8. Lessons learned from past operations in the country/sector
The proposed project would be the second IDA-financed health operation in Eritrea. Several relevant lessons learned from the first health project and IDA health projects in other countries include: (i) the need for flexibility to adapt approaches to better respond to local needs; (ii) government commitment and institutional capacity are needed to ensure efficient implementation of program activities and achievement of development objectives; (iii) overly centralized management structure of many health ministries have impeded the efficiency and effectiveness with which project activities are implemented; it also deters stakeholder/beneficiaries from participating in project implementation, leading to little project ownership and, in many instances, low sustainability of operations in the future; and (iv) adequate provision for recurrent costs is critical to ensure quality of services and to sustain operations, especially where hospital capacity is under expansion.Lessons learned from previous projects in Eritrea: The Eritrea Community Development Fund experience--rated as Highly Satisfactory--has shown that both a decentralized system and an emphasis on strengthening institutional capacity were important contributors to project success. Sector effectiveness was particularly high in health and education, and community satisfaction and participation high in both sectors. Two constraints on community participation were (1) lack of consultation and underutilization of local knowledge, and (2) cultural factors limiting access of women and girls to some benefits in some regions. The present project is based upon an implementing structure decentralized to the zoba level--with a specific component of institutional strengthening--and with a strong emphasis on strengthening the infrastructure of health and education in the communities. A strong communications component supports the enhanced transparency of governance, and there is a specific role of the community in monitoring inputs and outcomes.Lessond learned from HIV/AIDS program development /implementation in other countries show that despite the lack of a cure or a vaccine, preventive measures such as awareness programs to bring about behavior change, social marketing of condoms, treatment of sexually transmitted infections and opportunistic infections such as tuberculosis, voluntary counseling and testing, a safe blood supply, and preventing mother-to-child transmission have all proven highly effective in reducing HIV transmission. Community-based programs have been especially effective in enhancing prevention, care, support, and treatment for those infected and affected by HIV/AIDS. Lessons learned during the implementation of effective HIV/AIDS programs in various countries have been integrated into the project as appropriate. Lessons learned from previous cross-sectoral and sector-wide projects: In January 1999 the HNP Quality Group reviewed 21 PADs, including 5 SIPs. This review was used by the HAMSET project team to direct project preparation overall, but specifically with regard to 5 key questions of particular relevance to cross-cutting projects:Is there indication of support from key

politicians? This project has the support of the President's office, which indicates the importance of the adopted structure in which the MOH takes a lead coordinating role, and also has the support of the Minister or Secretary of each of the nine participating agencies.Is there a detailed, phased and flexible implementation schedule? The project is based around a process approach that is described and planned in detail for the first year, is phased thereafter, and is deliberately designed to allow rapid roll out with maximum subsequent flexibility.Has the project conditioned disbursement against prior adoption of agreed institutional reform? Appraisal was dependent upon the adoption of agreed coordination and collaboration mechanisms, and effectiveness upon their formal implementation.Are the agencies involved kept to a minimum? There are nine agencies which were each able to demonstrate clear, synergistic and non-duplicatory roles in implementing the project. These agencies cover: health, education, information, youth, women, demobilized conscripts, and the agricultural, industrial and construction work forces. Given the epidemiology of HIV/AIDS/STD, all of these activities and populations were considered priorities.Is implementation progress subject to an annual review plan? The project establishes two technical committees--one at the central and one at the zoba levels which meet regularly and monitor progress and direction. The approach to institutional coordination is also based around experience other than that in HNP. The new Guinea Quality Education for All Project builds on this approach to include the Ministry of Women and Social Affairs, and is the model for the institutional management of the Senegal Quality Education for All Project. In Nutrition the original Madagascar Food Security and Nutrition Project led to the 1998 Community Nutrition Project that links nutrition and health with the education sector. Lessons learned during the implementation of effective HIV/AIDS programs in various countries have also been integrated into HAMSET, as appropriate. Despite the lack of a cure or a vaccine, preventive measures such as awareness programs to bring about behavior change, social marketing of condoms, treatment of sexually transmitted infections and opportunistic infections such as tuberculosis, voluntary counseling and testing, a safe blood supply, and preventing mother-to-child transmission have all proven highly effective in reducing HIV transmission. Community-based programs have been especially effective in enhancing prevention, care, support, and treatment for those infected and affected by HIV/AIDS.

9. Program of Targeted Intervention (PTI) Y

10. Environment Aspects (including any public consultation)

Issues : An Environmental Analysis (EA) was undertaken to review the elements of the National Malaria Control Program that may lead to negative environmental impacts unless properly planned and managed, namely the use of chemicals. The EA reflects and responds to both the GOE's "National Environmental Assessment Procedures and Guidelines" for project preparation, and the IDA's requirement regarding OP4.09 (Operational Procedures 4.09-Pesticide Management). The EA was cleared by the Eritrean Department of Environment (DOE) on June 20, 2000. The EA has been made available to stakeholders, including the civil society, through distribution to the 6 zobas, national and bi- and multilateral agencies, NGOs and several civil society groups (see consultation in 5.4 below). The EA concluded that the main concern of the Malaria Control Program (MCP) is the use of DDT for residual house-spraying. The EA however concluded that:

a) only 16% of the houses at risk of malaria are sprayed with DDT; and b) as currently used, and as proposed in the HAMSET project, this use is consistent with WHO guidelines (WHOPES) and the POPS exemption (which determines "specific use in health when effective, and in high risk areas to prevent epidemic conditions"). The EA recommends improving surveillance and monitoring of malaria trends to improve efficacy of both vector control, and prevention of epidemics, as well as replacing DDT by safer chemicals. A Pesticide Management Plan (PMP) was prepared following the EA conclusions and recommendations. Accordingly, pesticide selection, distribution and use will follow the EA recommendations and will be done by fully trained health personnel. During negotiations, the Government will give assurances that : (i) the PMP will be implemented in a manner satisfactory to IDA.; (ii) procurement of chemicals for control of malaria epidemic, will fully abide by IDA standards which follow WHO guidelines. Procurement documents will clearly state that all chemicals to be procured will be manufactured, packaged, labeled, handled, stored, disposed of, and applied according to standards acceptable to the IDA; and (iii) MOH will present by the end of the second year, a program and schedule for substituting DDT residual house-spraying by chemicals or techniques that are safer to the environment and human health, as satisfactory to IDA.

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Note: This is information on an evolving project. Certain components may not be necessarily included in the final project.

This PID processed by the InfoShop during the week ending November 10, 2000.