For the use of the Global Fund Secretariat:
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ID No:

HIV/AIDS and Tuberculosis in Eritrea: Reducing the Threat and Providing Comprehensive Care and Support Services

SUBMITTED BY

THE ERITREAN PARTNERSHIP
AGAINST
HIV/AIDS, TUBERCULOSIS and MALARIA

List of abbreviations and acronyms

AIDS – Acquired Immune Deficiency Syndrome
ARI – Acute Respiratory Infections
ARV – Anti-Retro Viral therapy (or drugs)
BCC – Behavioural Change Communication
BIDHO – meaning "*challenge".* Association of people living with HIV/AIDS in Eritrea
CCA – Common Country Assessment
CDC – Communicable Diseases Control
CHL – Central Health Laboratory
CPA – Country Programme Adviser
CSO – Civil Society Organisation
CMS – Central Medical Stores
CSW – Commercial Sex Work(ers)
DHS – Demographic and Health Survey
DOTS – Directly Observed Treatment of Short courses
DPKO – Department of Peacekeeping Operations
ECE – Evangelical Church of Eritrea
ECS – Eritrean Catholic Secretariat
EDF – Eritrean Defence Force
EFE – Employers Federation of Eritrea
EMDA – Eritrean Medical Doctors Association
ENCC – Eritrean National Chamber of Commerce
ENLD – Eritrean National List of Drugs
EPA – Eritrean Pharmaceutical Association
ESMG – Eritrean Social Marketing Group
ETU – Eritrean Teachers Union
EU – European Union
FBO – Faith-Based Organisation
FGM – Female Genital Mutilation
FHI – Family Health International
FP – Family Planning
FRHAE – Family Reproductive Health Association of Eritrea
GDF – Global Drug Facility
GFATM – Global Fund on AIDS, Tuberculosis and Malaria
GIPA – Greater involvement of people living with HIV/AIDS
GNP – Gross National Product
GoE – Government of Eritrea
GWEP – Guinea Worm Eradication Program
HAMSET Control Project – HIV/AIDS, malaria, sexually transmitted infections, tuberculosis
HIMS – Health Information Management System
HIV – Human Immunodeficiency Virus
HC – Health Centre
HQ – Headquarter
HS – Health Station
HW – Health Worker
ICRC – International Red Cross Committee
ICT/ESA –Intercountry Team for Eastern and Southern Africa (UNAIDS)
IDSR – Integrated Disease Surveillance and Response
IEC – Information, Education & Communication
IFRC – International Federation of Red Cross and Red Crescent Societies
IMCI – Integrated Maternal and Child Illnesses
IMS – Information Management System
KAP – Knowledge, Attitudes and Practices (survey)
MHMH – Mekane Hiwet Maternity Hospital
MHPH – Mekane Hiwet Pediatrics Hospital
MoA – Ministry of Agriculture
MoD – Ministry of Defense
MoE – Ministry of Education
MoH – Ministry of Health
MoI – Ministry of Information
MoLG – Ministry of Local Government

MoLHW – Ministry of Labour and Human Welfare
MoT – Ministry of Tourism
MoTC – Ministry of Transport and Communication
MSF – Médecins Sans Frontières
MTCT – Mother-To-Child Transmission
NA – Not available
NACP – National AIDS Control Programme
NATC – National AIDS Technical Committee
NATCoD – National HIV/AIDS/STI and Tuberculosis Division
NBTC – National Blood and Transfusion Centre
NCA – Norwegian Church Aid
NCEW – National Confederation of Eritrean Workers
NFA – Nakfa
NGO – Non-Governmental Organization
NORAD – Norwegian Agency for Development
NRH – National Referral Hospitals
NRS – National Referral Services
NRS – Northern Red Sea zone (or zoba)
NSP – National Strategic Plan on HIV/AIDS/STIs
NTCP or N TB CP – National Tuberculosis Control Programme
NUEYS – National Union of Eritrean Youth and Students
NUEW – National Union of Eritrean Women
OI – Opportunistic Infection(s)
PEP – Post-Exposure Prophylaxis
PHC – Primary Health Care
PLHAs – People living with and affected by HIV/AIDS
PM – Programme Manager
PMTCT – Prevention of Mother-To-Child Transmission
PMU – Project Management Unit (for the HAMSET Control Project)
PTB – Pulmonary TB
R & HRD – Research and Human Resource Development
RCSE – Red Cross Society of Eritrea
SRS – Southern Red Sea zone (or zoba – region level)
STDs/STIs – Sexually Transmitted Diseases/Sexually Transmitted Infections
TASC – Technical Assistance and Support Contract (John Snow Institute/USAID project)
TB – Tuberculosis
TBA – Traditional Birth Attendant
TOT – Training of Trainers
TWG – Technical Working Group on HIV/AIDS (UN)
UN – United Nations
UNAIDS– Joint United Nations Programme on HIV/AIDS
UNDAF – United Nations Development Assistance Framework
UNDP – United Nations Development Programme
UNDP/BDP – United Nations Development Programme/Bureau of Development Policy
UNFPA – United Nations Population Fund
UNGASS – United Nations General Assembly Special Session on HIV/AIDS
UNHCR – United Nations High Commission for Refugees
UNICEF – United Nations Children's Fund
UNMEE – United Nations Mission in Ethiopia and Eritrea
UNTG – United Nations (UNDAF) Theme Group on HIV/AIDS
USAID – United States Agency for International Development
VCT – Voluntary Counselling and Testing
WB – World Bank
WFP – World Food Programme
WHO – World Health Organisation
ZCDCC – Zoba Communicable Disease Control Coordinators
Zoba or zonal is the regional level (6 zobas in Eritrea)

SECTION I: Executive summary of Proposal

Please note: The Executive Summary will be used to present an overview of the proposal to various members of the Secretariat, the Technical Review Panel and the Board of the Global Fund. The proposal once approved becomes public information.

General information: *Table I.a*

Proposal title: (Title should reflect scope of proposal)**:**	**HIV/AIDS and Tuberculosis in Eritrea: Reducing the Threat and Providing Comprehensive Care and Support Services**				
Country or region covered:	**ERITREA**				
Name of applicant:	**Eritrean Partnership against HIV/AIDS, Tuberculosis and Malaria (CCM)**				
Constituencies represented in CCM (write the number of members from each Category)**:**	**1**	**Government – Ministry of Health**	**6**	**UN/Multilateral agencies**
	6	**Government – Other ministries**	**1**	**Bilateral agency**
	9	**NGOs/CBOs**	**1**	**Academic/Educational Organisations**
	3	**Private Sector**	**1**	**Religious/FBOs**
	1	**People living with HIV/TB/Malaria***		**Other** (please specify):
If the proposal is NOT submitted through a CCM, briefly state why:				

Specify which component(s) this proposal is targeting and the amount requested from the Global Fund:**

Table I.b

			Amount requested from the GF (USD thousands)					
			Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Component(s) (mark with X)**:**	**X**	**HIV/AIDS**	4,139	3,986	3,415	3,046	2,768	**17,354**
	X	**Tuberculosis**	1,154	332	493	308	292	**2,579**
		Total	**5,293**	**4,318**	**3,908**	**3,354**	**3,060**	**19,933**
Total funds from other sources for activities related to proposal			**5,000**	**5,000**	**5,000**	**5,200**	**5,200**	**25,400**

Please specify how you would like your proposal to be evaluated***

The Proposal should be evaluated as a whole	
The Proposal should be evaluated as separate components	**X**

* According to national epidemiological profile/characteristics

** If the proposal is fully integrated, whereby one component cannot be separated from another, and where splitting budgets would not be realistic or feasible, only fill the "Total" row.

*** This will ensure the proposal is evaluated in the same spirit as it was written. If evaluated as a whole, all components will be considered as parts of an integrated proposal. If evaluated as separate components, each component will be considered as a stand-alone component.

PROPOSAL SUMMARY (1 page) (please include quantitative information where possible)**:**

Background and context

Eritrea is the youngest country on the African continent, as it achieved independence from Ethiopia in 1993 after 30 years of war. A border conflict erupted in 1998 and lasted 2 years. A peace agreement was signed in December 2000. Since then, UN peacekeeping forces are in both countries until demarcation is finalised in July 2003.

The population of Eritrea is 3.5 million, of which 43% are under the age of 15 and 60% of them live in rural areas. 250 000 people are currently in the military, either national service or regular army (50 000). 30% of the regular military are women. The ratio of men to women in national service is 6:1. Since 1994, almost all people in the 18-40 years age group have been mobilized (other than women with children).

In 2002 and 2003 the Government of Eritrea has declared a national drought emergency. Currently 70% of the population is suffering from the consequences of drought and insufficient crop production of 2002. International food aid does not cover all the needs.

Eritrea today continues to grapple with a complex emergency of poverty, drought, post-conflict situation with internal population displacement, refugees returning from Sudan, Eritreans expelled from Ethiopia and mobilization of the youth in the army – all driving forces in epidemics, particularly HIV/AIDS and TB. In addition, uniform forces, either regular military or UN peacekeepers, raise the demand for commercial sex work.

The epidemiology of HIV/AIDS and TB in Eritrea is described, as required, in section III. Although the prevalence of HIV infection in the general population is around 3%, it is increasing. The THREAT of dissemination of a RAPID AND SEVERE EPIDEMIC is very high in the context of this post-conflict situation, due to i) a very high proportion of the population being in the military (4.6 % HIV prevalence in 2001 and 250 000 recruits); ii) the high prevalence of HIV infection among female bartenders (22.8% HIV seroprevalence in 2001[9]); iii) 70% of the population living below the poverty line and iv) an illiteracy rate among women of over 50%, 80% of them being either illiterate or only attending primary school. Between 1988 and 2002, 15 698 cumulative AIDS cases were serologically confirmed and over the period 1996-2000, 87% of the cases were in the 15-49 age group, primarily devoted to work and childbearing. Regarding TB, WHO and the Royal Netherlands TB Association Hague in 1996 estimated that Eritrea, even though there are no recent tuberculin or prevalence surveys, has an annual risk of infection (ARI) of 2%. One hundred new smear-positive pulmonary tuberculosis cases/100,000 population i.e. 3,500 new smear-positives would therefore be expected per year.

- **Describe the overall goals, objectives and main activities per component, including expected results and timeframe for achieving these results:**

This proposal only includes HIV/AIDS and TB related activities because the Malaria component was approved during the second round of submission.

A. HIV/AIDS COMPONENT

A.1 Overall goal

The overall goal of the HIV/AIDS component is to reduce sexual, blood and mother-to-child- HIV transmission, and mitigate the personal, social and economic impact of HIV/AIDS.

[9] Refer to section III and IV.

A comprehensive, high quality and multisectoral situation and response analysis of the HIV/AIDS epidemic in Eritrea was conducted at national level in October and November 2002[10], involving all government and non-government institutions, national and international stakeholders. From this analysis 9 priority areas were identified in the fight against HIV/AIDS. This analysis was immediately followed by the elaboration of a 5-Year National Strategic Plan 2003-2007[11], including 9 main objectives drawn from all the priority areas. The National Strategic Plan (NSP) process was achieved by a national validation workshop of all stakeholders in March 2003. A National Monitoring and Evaluation is being currently developed. This Global Fund proposal is directly related to main priorities, objectives and activities of the NSP and requests complementary funds to those available through the Government and international organisations in the next five years. This will enable the country to expand/scale-up existing activities and start new initiatives.

A.2 Main objectives

Among the 9 main objectives of the NSP, the Global Fund financial resources are requested to implement activities related to the following 6 objectives:

(1) Scale-up and expand effective HIV prevention activities with target populations including vulnerable women, the military, commercial sex workers and STI clients.
(2) Increase the number of people who know their HIV status by improving availability and quality of voluntary counselling and testing (VCT).
(3) Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission (PMTCT).
(4) Improve the availability and the quality of health care and psychosocial and economic support for people with HIV/AIDS (PLHAs) and those affected by the epidemic.
(5) Expand blood transfusion safety (HIV, Hepatitis B and C and Syphilis) to regional blood banks, and establish procedures to ensure adherence to *Universal Precautions* in the health care setting.
(6) Strengthen and expand epidemiological and behavioural surveillance for evidence-based planning.

A.3 Main activities

- Expand prevention activities among vulnerable populations such as women, high risk groups, the military and commercial sex workers, based on the *Situational analysis of commercial sex work* done in Eritrea (March 2003) and on a case study written by UNAIDS and the Government of Eritrea on *HIV/AIDS prevention and care amongst armed forces and UN peacekeepers*.

- Implement the STI early diagnosis and treatment-related activities planned in the NSP (Aetiology study of STI diseases and drug sensitivity; training of health workers and pharmacists in the public and private sector, in all regions and at all levels on syndromic management of STI; monitor STI prevention and care strategy).

- Set-up freestanding VCT in the 6 regions of Eritrea and scale-up existing VCT facility-based activities, together with setting-up non health-sector based VCT centres, e.g. in youth centres, and in the PLHAs BIDHO association.

- Expand and improve the quality of PMTCT related activities in Asmara and gradually to all regions, starting with the highly populated areas of Zoba Debub, Anseba and Gash-Barka.

- Set-up at the Ministry of Health Central Health Laboratory in Asmara a National reference laboratory for the diagnosis and monitoring of treatment for STI, TB and HIV/AIDS-related diseases, including opportunistic infections (OI).

[10] Ministry of Health. HIV/AIDS National Strategic Planning Task Force. *Situation and response analysis of the HIV/AIDS epidemic in Eritrea*. 120p.
[11] The State of Eritrea. National Strategic Plan on HIV/AIDS/STIs 2003-2007. April 2003.

- Train health workers of 6 regional hospitals and all health centres on AIDS case management, early diagnosis and treatment of opportunistic infections, and help them establish networking relations between VCTs, health services and support civil society organisations, including BIDHO, and faith-based organisations (FBOs) who can be involved in home-based care, food distribution, psychosocial and economic support through expanding existing income-generating projects.

- Expand blood safety to all regional hospitals, and disseminate existing guidelines on universal precautions and prevention of HIV transmission in the health setting among all health workers, including procedures for post-exposure prophylaxis (PEP) of potentially contaminated health workers.

- Set-up a sentinel surveillance system, including in the military where incidence data of HIV infection could easily be available as troop mobility is restricted.

The monitoring and evaluation design for the implementation of the activities described in this proposal is found in section VII. A.

A.4 Expected results

- Reduction of HIV infection in the general population and specifically among at risk groups (CSWs and the military) and other vulnerable populations, e.g. STI patients, women and children observed, and thus significantly reducing the threat of a severe HIV epidemic in a country already affected by war, drought and poverty.

- Additional and complementary resources brought to a low-income country in order that the HIV/AIDS epidemic and related diseases do not add to the burden of a post-conflict context country, which is ready to resume development initiatives.

- Existing prevention, care and support related activities expanded, and new activities, such as offering specific laboratory-based diagnosis of OI to AIDS patients at central level, and ARV treatment with clinical and biological follow-up initiated, using existing National HIV/AIDS, STI and TB policies and NSP, as well as the Guidelines developed for VCT, PMTCT and care-related activities (AIDS case management).

- The impact of opportunistic infections and severe terminal illnesses reduced, so that people living with HIV/AIDS improve the quality of their lives, keep active and work in a lower-stigmatised environment, including reduction of health expenditures, due to early diagnosis and treatment of STI, TB and HIV.

- Human resources developed and capacity built, and thus the health system is strengthened and integrated.

- All sectors, private, and public, tourism, agriculture, education, defence, workers unions, youth and women's organisations involved in the fight against AIDS, empowering civil society organisations (CSOs) and religious groups, building on the HAMSET multisectoral and decentralised activities in the zobas.

B. TB COMPONENT

B.1 Overall goal

The project aims to reduce the morbidity and mortality due to TB and to reduce its spread till it is no longer a public health problem in Eritrea. It hopes to do this by increasing case detection among new smear positive pulmonary TB cases to 70% and successfully treating 85% of them by 2005 and sustaining this through 2006 to 2007.

B.2 Specific objectives

The main goal will be achieved through the following 6 specific objectives: (1) Raise access to and quality of TB diagnostic services; (2) Strengthen support supervision; (3) Improve TB data recording, reporting, analysis and use; (4) Expand DOTS to all hospitals and all health centres by 2004; (5) Carry out advocacy and (6) carry out relevant operational research to guide decisions and polices.

B.3 Main activities

- Procuring laboratory reagents.
- Procuring 40 binocular microscopes and 146 slide boxes.
- Training 50 Assistant Laboratory Technicians;
- Buying 6 motorcycles to enable the 6-zoba laboratory technicians to carry out QA of microscopy services.
- Providing 7 vehicles and meeting 80% of the bill needed to carry out regular support supervision from NTCP to ZCDCCs and ZCDCCs to the facility level.
- Printing standard TB forms and registers.
- Starting and maintaining 6 zoba TB registers and provide 7 computers to facilitate TB data analysis and provision of feedback.
- Training of additional health workers to expand DOTS to 6 and 34 more hospitals and HCs respectively.
- Printing of IEC materials.
- Supporting CBOs to advocate for DOTS.
- Supporting CBOs to support TB patients socially and economically.
- Holding consensus-building meetings with partners and leaders.
- A TB prevalence survey and other operational researches will also be supported.

B.4 Expected results

It is hoped that these interventions will contribute to the global targets of 70% case detection and 85% treatment success and sustain this level till 2007 through a number of results. Expected results include:

- Access to quality microscopy services improved by 2004.
- Support supervision strengthened.
- Quality of monitoring data improved to provide timely and accurate information for prompt action through the project period.
- Awareness among the leaders and their respective communities raised thereby facilitating increased TB service utilization and promoting sustained provision of resources for TB control.

- **Specify the beneficiaries of the proposal per component and the benefits expected to accrue to them** (including target populations and their estimated number):

A. HIV/AIDS COMPONENT

The people who will benefit from the activities planned in this proposal are the following: the general population of Eritrea, the 250 000 people in the military (both men and women, conscripts as well as regular military), risk groups (commercial sex workers and bartenders, vulnerable women and children, and also health professionals, CSOs, including FBOs, public institutions and ministries.

Especially PLHAs will benefit from this proposal, through increased and comprehensive access to care, including ARV, and socio and economic support services.

Pregnant women in all regions will benefit from prevention activities. PMTCT activities will be implemented in Asmara and gradually to all regions.

TB patients who are HIV positive will also benefit from all HIV-related activities.

B. TB COMPONENT

Beneficiaries range from the community to the health system as a whole. The whole community, 3.5 million Eritreans would benefit from increased participation, decreased burden of TB as targets are attained and the spread is curtailed, and a better socio-economic status.

Patients would also benefit from more accessible services leading to improved adherence, increased cure rates, less default and less chances of MDR-TB occurring.

The health system as a whole would benefit as trained Assistant Laboratory Technicians and supply of microscopes would strengthen the whole health system not just TB diagnosis. Improved data management would also strengthen the whole system improving decision making and strengthening the recently set up integrated disease surveillance. On the other hand, raised awareness among the leaders would lead to provision of adequate resources for the strategy on a sustainable basis.

Partners would also benefit from improved coordination and allocation of resources.

- **If there are several components, describe the synergies, if any, expected from the combination of different components** (By *synergies*, we mean the added value the different components bring to each other, or how the combination of these components may have effects beyond the effects of each component taken)

Working on HIV and TB as described allows integrated use of human and financial resources (for clinical, biological diagnosis and treatment follow-up) for HIV patients with TB disease, as well as their families. The cost-efficiency of activities increases and the expenditures both for patients and services decreases.

- **Indicate if the proposal is to scale up existing efforts or initiate new activities. Explain how lessons learned and best practices have been reflected in this proposal and describe innovative aspects to the proposal**

HIV/AIDS
The proposal aims to scale-up existing efforts and initiate new activities.

- Scale-up existing activities, such as prevention of sexual, blood and mother-to-child transmission of HIV, increasing efforts in the capital city, and also expanding the activities outside of Asmara, decentralising in urban and rural areas of all 5 other regions of the country.
- Initiate new activities mainly, with regard to care by i) providing STI, TB and OI biological diagnostic capacity, ii) setting-up a national reference laboratory in Asmara, iii) giving access to ARV drugs, good quality clinical and biological follow-up of patients and ARV and TB treatment resistance surveillance systems, as well as social and economic support to PLHAs, their families and orphans.
- An innovative scientific relationship between the Washington University Medical Centre and Laboratory and the Central Health Laboratory (CHL) of the MoH in Asmara will provide quality assurance and control.

All the activities planned here are part of the priorities identified while doing the situation analysis, and are consistent with national commitment and previous developments in the field of HIV/AIDS, TB and STI. The activities are based on international guidelines and best practices.

Tuberculosis
The proposal aims to scale up DOTS strategy and to fund gaps. So far DOTS is limited to just a few health facilities with laboratory services. Moreover, through this proposal, DOTS will be expanded not only to health facilities, but also through community health services, such as TBAs and community health agents.

SECTION II: Information about the applicant

Country Coordinating Mechanism (CCM)

Table IIb

Preliminary questions	(Yes/No)
a). Has the CCM applied to the Fund in previous rounds?	Yes
b). Has the composition of the CCM changed since the last submission?	
c). If composition of CCM has changed, briefly outline changes:	

1. Name of CCM (e.g., CCM Country name, National Committee to fight AIDS, TB and Malaria, etc):

Eritrean Partnership against HIV/AIDS, Tuberculosis and Malaria, thereafter "The Partnership".

2. Date of constitution of the current CCM (The date the CCM was formed for the purpose of the Global Fund application. If the CCM builds on or uses existing processes – which is encouraged – please explain this in Question 3)**:**

The Partnership was officially established in March 2002 (see Question 3 below for details).

3. Describe the background and the process of forming the CCM (including whether the CCM is an entirely new mechanism or building on existing bodies, how the other partners were contacted and chosen, etc.), (1 paragraph):

Until 1995 HIV/AIDS issues were not discussed outside health care facilities. Since then the Government moved quickly to address the epidemic. In 1997 a 5-Year National Strategic Plan was developed with an emphasis on a multisectoral approach and decentralization of the HIV/AIDS prevention and control program. In November 2000, following the approval by the World Bank of an IDA credit of 40 million USD for the HIV/AIDS, Malaria, STDs and Tuberculosis Control Project (HAMSET), the Ministry of Health has built partnerships with other Government sectors and civil-society organizations by forming the National HAMSET Steering Committee, consisting of four Ministers, the Director General of Health Services and six Zonal Governors. Taking the opportunity of the submission of proposals for the 1st round of GFATM, this body was expanded in March 2002 to include more partners from the private sector, civil society organisations (CSOs) – community-based, faith-based, the UN Theme Group on HIV/AIDS (established in 1996) as well as bilateral development agencies, in order to form The Partnership.

3.1. If the CCM is or includes an already existing body, briefly describe the work previously done, programmes implemented and results achieved (1 paragraph)**:**

Multisectoral and decentralised response through the Government HAMSET control project has been launched in 2001. HIV/AIDS, STI and TB activities are integrated in the health and other sectors activities. Since the launching of this project, multisectoral social mobilisation has increased significantly, through the involvement of CSOs (unions, NGOs, FBOs), because their human resources have benefited from capacity building and training on awareness, BCC, home-based care, etc. Please refer to section III.22.5.

4. Describe the organizational processes (e.g., secretariat, sub-committee, stand-alone; describe the decision-making mechanism. Provide Terms of Reference, operating rules or other relevant documents as attachments), (1 paragraph):

The Partnership is chaired by the Ministry of International Cooperation, Macro-Policy and Economic Coordination (ICMPEC). The Vice-Chair is the Chairperson of the UNDAF Theme Group on HIV/AIDS, which rotates every two years (currently UNFPA). The Executive Secretary is the Minister of Health.

The main functions of the **Secretariat of the Partnership** are to carry out the following functions on behalf of the The Partnership:

1) Review and approve workplans submitted by various implementing partners.
2) Instruct the Principal Recipient to disburse funds according to these workplans.
3) Review regularly the progress made towards the implementation of The Partnership programme.

The Secretariat is located in the Ministry of Health and is composed of the following members:

- Executive Secretary
- Deputy Executive Secretary
- Director General of Health Services
- Director General of Regulatory Services
- Director of National HIV/AIDS/STI and TB Division
- Director General of Research and Human Resources Development
- Director Project Management Unit (PMU)
- UNAIDS Country Programme Adviser

Existing **Technical Committees** will continue to provide necessary technical backstopping for The Partnership and its Secretariat. Such existing and operational committees include: *the National HAMSET Technical Committee* (NHTC), *the National AIDS Technical Committee* (NATC), *the UN Technical Working Group on HIV/AIDS* (TWG).

5. Describe the mode of operation of the CCM (e.g., frequency of meetings, functions and responsibilities of the CCM. Provide the minutes or records of previous meetings as attachments), (1 paragraph):

Major functions and responsibilities of The Partnership

1) Provide input for the preparation of national strategic plans for the three diseases
2) Review bi-annually progress made toward the implementation of national programmes on the three diseases, in line with indicators set in:
    a) The United Nations Declaration of Commitment on HIV/AIDS, New York, 27 June 2001
    b) The Abuja Declaration and Framework for Action for the Fight Against HIV/ AIDS, Tuberculosis and other Related Infectious Diseases in Africa, 27 April 2001
    c) The United Nations Millennium Declaration, New York, 8 September 2000;
3) Continue advocacy at all levels for implementation and resource mobilization with regards to the prevention of the three diseases in Eritrea
4) Review and recommend policies and guidelines related to the three diseases.

Frequency of meetings

Bi-annually and ad-hoc basis as required.

Previous meetings

Although The Partnership was officially established in March 2002 during the process leading to Eritrea's 1st submission to the Global Fund, the first meeting was held in Asmara on 26th August 2002. The main purpose of this meeting, chaired by the Minister of Health in his capacity as Executive Secretary of The Partnership, was to review the response from the Global Fund Secretariat to the 1st submission and to discuss the way forward. The main outcome of the meeting was the establishment of an *ad-hoc* task force to coordinate the preparation of Eritrea's second submission to the Global Fund.

The second meeting of The Partnership was held on 18th September 2002. Participants included both heads of The Partnership member organizations as well as their technical representatives. The main objectives of this second meeting were the following: (1) to orient and involve all members of The Partnership in the preparation of the second proposal to the GFATM; (2) to review Eritrea's first proposal and the response from the GFATM Secretariat; (3) to present the draft of Eritrea's second proposal to all members of the Partnership and (4) to review, discuss and provide feedback on the draft of the second proposal.

The third meeting of The Partnership took place on 23rd September 2002. Main purpose of this meeting was the endorsement and signature of Eritrea's second proposal by all member organisations of The Partnership. The recent meeting May 22 was aimed at the endorsement and signature of Eritrea´s third proposal for the Global Fund.

6. Describe plans to enhance the role and functions of the CCM in the next 12 months, including plans to promote partnerships and broader participation as well as communicating with wider stakeholders, if required (1 paragraph)**:**

1) Recruit the Deputy Executive Secretary and necessary support staff to strengthen the MOH to act as Principal Recipient (see Section VI).

2) Develop detailed terms of reference for The Partnership and its Secretariat and establish linkages among the technical committees for the three diseases.

7. Members of the CCM

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Table II.7

Agency/Organization	Name of representative	Title	Date	Signature
1. Ministry of International Cooperation and Macro-Policy	Hon. Dr. Woldai Futur	Minister		
Main role in CCM				
Chair				

Agency/Organization	Name of representative	Title	Date	Signature
2. Ministry of Health	Hon. Mr. Saleh Meky	Minister		
Main role in CCM				
Executive Secretary				

Agency/Organization	Name of representative	Title	Date	Signature
3. Ministry of Local Government	Hon. Mr. Kidane Tsighe	Minister		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
4. Ministry of Labor and Human Welfare	Hon. Ms. Askalu Menkorios	Minister		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
5. Ministry of Education	Hon. Mr. Osman Saleh	Minister		
Main role in CCM				
Member				

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Agency/Organization	Name of representative	Title	Date	Signature
6. Ministry of Defense	Hon. Gen. Sebhat Efriem	Minister		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
7. Ministry of Information	Hon. Mr. Ali Abdu	Minister		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
8. University of Asmara	Dr. Woldeab Yisak	President		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
9. UNDP	Mr. Simon R. Nhongo	UN Resident/ Humanitarian Coordinator		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
10. WHO	Dr. D.V. Nsue-Milang	Representative		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
11. UNICEF	Mr. Christian Balslev-Olesen	Representative		
Main role in CCM				
Member				

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Agency/Organization	Name of representative	Title	Date	Signature
12. UNFPA	Mr. Bruce Campbell	Representative		
Main role in CCM				

Agency/Organization	Name of representative	Title	Date	Signature
13. World Bank	Mr. Florian Fichtl	Country Manager		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
14. UNAIDS	Mr. Dominique Mathiot	Country Programme Adviser		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
15. USAID	Dr. J.K. Cheema	Director		
Main role in CCM				
Member				

Agency/Organization	Name of representative	Title	Date	Signature
16. EU	Mr. Carl Bertil Lostelius	Head of Delegation		
Main role in CCM				
Member				

Agency/Organization (Religious)	Name of representative	Title	Date	Signature
17. Inter-Faith Council	Rev. Asfaha Mehari	Assistant Chair		
Main role in CCM				
Member				

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Agency/Organization (International NGO)	**Name of representative**	**Title**	**Date**	**Signature**
18. Norwegian Church Aid	Ms. Estrid Hessellund	Country Office Coordinator		
Main role in CCM				
Member				

Agency/Organization (International NGO)	**Name of representative**	**Title**	**Date**	**Signature**
19. Population Services International	Mr. Robert Maroni	Country Representative		
Main role in CCM				
Member				

Agency/Organization (National NGO)	**Name of representative**	**Title**	**Date**	**Signature**
20. National Union of Eritrean Youth & Students (NUEYS)	Mr. Mohedien Mohammed Shengeb	Chairperson		
Main role in CCM				
Member				

Agency/Organization (National NGO)	**Name of representative**	**Title**	**Date**	**Signature**
21. National Union of Eritrean Women (NUEW)	Ms. Luul Gebreab	Chairperson		
Main role in CCM				
Member				

Agency/Organization (PLWA association)	**Name of representative**	**Title**	**Date**	**Signature**
22. BIDHO – Association of Persons Infected & Affected by HIV/AIDS	Corp. Hagos Ghirmay	Chairperson		
Main role in CCM				
Member				

Agency/Organization (Workers Union)	**Name of representative**	**Title**	**Date**	**Signature**
23. Eritrea National Chamber of Commerce (ENCC)	Mr. Akborom Tedla	Secretary		
Main role in CCM				
Member				

"We the undersigned hereby certify that we have participated throughout the CCM process and have had sufficient opportunities to influence the process and this application. We have reviewed the final proposal and are happy to support it. We further pledge to continue our involvement in the CCM if the proposal is approved and as it moves to implementation"

Agency/Organization (Workers Union)	**Name of representative**	**Title**	**Date**	**Signature**
24. National Council of Eritrean Workers (NCEW)	Mr. Tekeste Baire	General Secretary		
Main role in CCM				
Member				

Agency/Organization (Private Sector)	**Name of representative**	**Title**	**Date**	**Signature**
25. Eritrean Federation of Employers (EFE)	Mr. Mengisteab Tekletsion	Chairperson		
Main role in CCM				
Member				

Agency/Organization (National NGO)	**Name of representative**	**Title**	**Date**	**Signature**
26. Vision Eritrea	Dr. Tsegai Ghebregziabher	Director		
Main role in CCM				
Member				

Agency/Organization (National NGO)	**Name of representative**	**Title**	**Date**	**Signature**
27. Haben	Dr. Berhane W. Michael	Representative		
Main role in CCM				
Member				

Agency/Organization (Public Corporation)	**Name of representative**	**Title**	**Date**	**Signature**
28. Eritrean Pharmaceutical Corporation (PHARMECOR)	Mr. Misgna Tecleab	Director		
Main role in CCM				
Member				

Agency/Organization (Private Sector)	**Name of representative**	**Title**	**Date**	**Signature**
29. Consultancy Service in Chemical Technology Marine Resource, and Environment (CTMRE)	Dr. Tesfamariam Yosief	Director		
Main role in CCM				
Member				

7.1 Provide as attachment the following documentation for private sector and civil society CCM members:

- **Statutes of organization** (official registration papers)
- **A presentation of the organization, including background and history, scope of work, past and current activities**
- **Reference letter(s), if available**
- **Main sources of funding**

See Attachment #1.

7.2 If a CCM member is representing a broader constituency, please provide a list of other groups represented.

The Interfaith Council (IFC) represents the four major religious faiths in Eritrea, that is, the Catholic Church, the Mufti's Office (Islamic faith), the Orthodox Church and the Protestant and Evangelical churches.

8. Chair of the CCM and alternate Chair or Vice-Chair

Table II.8

	Chair of CCM	**Alternate Chair/Vice-Chair**
Name	Dr. Woldai Futur	Mr. Bruce Campbell
Title	Hon. Minister of International Cooperation and Macro-Policy	UNFPA Representative
Address	P.O. Box 257 Asmara, Eritrea	P.O. Box 5366 Asmara, Eritrea
Telephone	+291-1-124964 / 120905	+291-1-151852
Fax	+291-1-126422	+291-1-151648
E-mail	woldaif@eol.com.er	campbell@unfpa.org
Signature		

9. Contact persons for questions regarding this proposal

Table II.9

	Primary contact	**Second contact**
Name	Hon. Mr. Saleh Meky	Dr. Andeberhan Tesfazion
Title	Minister of Health	Director, NATCoD, Ministry of Health
Address	P.O. Box 212 Asmara, Eritrea	P.O. Box 212 Asmara, Eritrea
Telephone	+291-1-202917	+212-1-121562
Fax	+291-1-122899	+212-1-122899 / 125835
E-mail	smeky@gemel.com.er	erinacp@eol.com.er

SECTION III: General information about the country setting

18. Describe the burden or potential burden of HIV/AIDS, TB and /or Malaria:
(*Describe current epidemiological data on prevalence, incidence or magnitude of the diseases; its current status or stage of the diseases; major trends of the diseases disaggregated by geographical locations and population groups, where this data is available and/or relevant)*

1) <u>The burden of HIV/AIDS in Eritrea</u>

Owing to the latest war against Ethiopia, it has not been possible to set-up a sentinel surveillance system among the same groups in the same regions over the year. Nevertheless the following data is available:

HIV Seroprevalence
A national HIV serological and behavioural survey was carried out in 2001 among 5 population groups with the following results: HIV prevalence among the general population (15-49): 2.4%; secondary students: 0.1%; antenatal attendees: 2.87%; female bar tenders: 22.8%; military forces: 4.6%.

HIV prevalence among VCT clients are the following:

- In the year 2002, among 2547 clients screened at the freestanding Edaga clinic in Asmara over the period July to October 2002, HIV prevalence was 2.91%.
- In the first 3 months of the year 2003, among 7615 clients from all regions, 4.2% were HIV positive.
- In the first 3 months of 2003, among 171 volunteers from Alla military hospital, 8.2% tested positive.

Among blood donors HIV seroprevalence varies between 0.5% (high risk excluded) and 2.6% among family replacement donors (identified on the spot in absence of blood bank).

Previous studies carried out among commercial sex workers and STI patients in all regions in 1999 show respectively high levels of HIV prevalence: 35% and 14.6%.

HIV prevalence among TB patients has not been regularly assessed, but an observation shows that between 8.5% and 23% of hospitalised TB patients are HIV positive.

AIDS Cases
The first AIDS case was suspected in Assab city (on the Red Sea) and serologically confirmed by Elisa in 1988. In December 2002, 15 698 cumulative AIDS cases were reported through the Health Management Information System (HMIS) out of which 2223 cases were reported in the year 2002 alone. Underestimation is mainly due to lack of diagnosis, particularly among children.

In the year 2000, the distribution of AIDS cases by residential areas showed that the epidemic was dominant in urban areas: 49.4% of the cases come from Asmara, and 5.8% from Massawa. 22.7% of the cases had a lifetime history of any STI and 35.8% had a history of travel outside the country. Male to female sex ratio is 1.55 and 6% of the cases are children. During that year 2000, members of the Eritrean Defence Forces account for 26.4% of the cases.

Over the period of 1996-2000, 87% of the cases were in the 15-49 age group. Considering its small population of 3.5 million people, and the existing shortage of human resources, educated and qualified people for health care, education and job creation, the epidemic could have a devastating effect on the country's economic development. The burden is already very high (60 to 70 000 people infected), as families are already suffering from drought, malnutrition and poverty.

People living with HIV face severe stigma and discrimination, as well as widespread denial, all of which contribute to the conspiracy of silence around the disease. Few have agreed to do testimonies in public.

A study is being conducted by the Ministry of Labour and Social Welfare to identify the number of AIDS orphans. To date financial support is being provided to 719 AIDS orphans and foster families. AIDS orphans and war or other orphans are not discriminated. Eritrea identified 90 000 orphans in a study carried out in 1993 out of which 42 000 have been reunified with their next of kin.

STI Patients

Little is known about the exact magnitude of the sexually transmitted infection (STI) epidemic in the State of Eritrea.

Population-based STI data. There are limited population-based data in Eritrea for STIs. The general population data is represented by antenatal attendees and blood donors. Syphilis prevalence among antenatal attendees in 1998 was 1.7% nationwide. In 2002, among blood donors (who are mostly high school students and rigorously pre-screened to exclude high-risk individuals) positive syphilis serology was 2%, hepatitis B serology was 3.5% and hepatitis C serology was 1%. The high-risk population is represented by CSWs. Syphilis prevalence in two sentinel surveillance studies carried out in 1997 and 1999 were, respectively, 4.5% and 7.8%.

STI case reports. Most epidemiological data on STIs in Eritrea is based on case reports from public health facilities obtained through the State of Eritrea Management Information Systems for Health (SEMISH) in addition to occasional behavioural surveys. Data from health facility case reports are thought to be a poor representation of the real STI situation because of (a) incomplete reporting, (b) STI patients seeking care in the informal and private sectors, (c) diagnostic deficiencies, (d) reporting deficiencies and (e) inconsistencies in STI case definitions. Furthermore, (f) STIs are often asymptomatic or only mildly symptomatic, thereby eluding recognition. The SEMISH data is principally from civilian public health facilities and (g) does not capture completely data from the private, informal and military health sectors where most STI patients are believed to seek care.

Based on data from SEMISH, a total of 3,261 STI cases were reported from public health facilities in Eritrea in 2000, 3,183 STI cases in 2001, and 3,367 STI cases in 2002. STI case reports from 1998 and 1999 were higher than these figures but this was when SEMISH was just being put in place and there were many errors in the data due to high levels of duplicate reporting. These figures are probably not truly representative because conditions such as trichomoniasis, the STI syndromic diagnoses and STI complications (such as pelvic inflammatory diseases) are not routinely reported.

Inconsistencies in STI case definitions that are currently in use render it impossible to state with certainty the frequency of occurrence of specific STD syndromes or aetiologies from this data. However anecdotal data obtained from interviews with health care providers indicate that male genital discharge and genital ulceration are seen frequently. The fact that STI case data is not disaggregated by age and sex make it impossible to determine which population sub-groups are most affected by the STI epidemic.

Relationship between HIV prevalence and STIs. There are limited data available on the prevalence of HIV among STI patients. However, the trends in the data from Eritrea clearly demonstrate a close relationship between STIs and HIV infection, as has been shown in many other studies from around the world. Studies carried out in 1994, 1997 and 1999 showed that the HIV infection rates among STI patients were 9.5%, 13.2% and 14.6%, respectively. The 2001 population-based survey showed that HIV prevalence among respondents who reported an STD episode in the previous 12 months was 32% compared to 7% among those who did not report an STD episode.

2) The burden of Tuberculosis in Eritrea

WHO and the Royal Netherlands TB Association Hague in 1996 estimated that Eritrea, even though there are no recent tuberculin or prevalence surveys, has an annual risk of infection (ARI) of 2%. One hundred new smear-positive pulmonary tuberculosis cases/100,000 population i.e. 3,500 new smear-positives would therefore be expected per year. It is further presumed that the prevalence of TB is on the increase due to several interrelated factors. The malnutrition occasioned by the drought, the stress and overcrowding in internally displaced persons camps resulting from war with Ethiopia and the rising trend of HIV among others. A survey carried out in 2001 indicated an HIV sero-prevalence of 2.8% among the general population and 4.6% among army recruits (HIV/AIDS/STIS Risk Group and Risk Behaviour Identification Survey, 2001). By increasing the risk of latent TB progressing to active disease, HIV may dramatically increase the spread of TB in the country. Moreover HIV positive TB patients tend to have a higher risk of adverse drug reactions including MDR-TB occurring.

According to the relatively complete TB notification data available at the National Tuberculosis Control Program (NTCP) for the last 3 years, Eritrea is yet to attain the WHO targets of 70% new smear positive case detection and 85% treatment success. In both 2001 and 2002 only 20% of the expected cases were detected. Of the 2001 cohort 76% were successfully treated, 8% died, 11% defaulted while treatment failure occurred in 1% of them[12]. Surprisingly, nearly a third of the notified cases were extra-pulmonary most of them over 40 years old. Over the same period of time, 78% of sputum positives reportedly converted at 2 months.

There is little if any data on the prevalence of HIV among TB patients. However a study in Mekane-Hiwot hospital in the capital estimated that 60% of the hospitalised TB patients were HIV positive while observations from other hospitals suggest that between 6.8% and 23% of hospitalised TB patients are HIV positive.

19. **Describe the current economic and poverty situation** *(Referring to official indicators such as GNP per capita, Human Development Index (HDI), poverty indices, or other information on resource availability; highlight major trends and implications of the economic situation in the context of the targeted diseases).*

Eritrea remains one of the poorest countries in the world. The national per capita income is 200 USD (1998). Approximately 60-70% of the population live below the poverty line (1993-1998), excluding those working in the traditional farming sector. Over 70% of the population survives on subsistence agriculture, with only 16% of GDP in 1999 from agricultural production. The industrial sector only accounts for 27% of GDP.
The unemployment rate is estimated to be 15-20%.

Eritrea is currently in a post-conflict phase. Its initial promising growth was disrupted by the recent border conflict with Ethiopia (1998-2000). This conflict resulted not only in damage to physical infrastructure, but also considerable loss of life and the displacement of nearly one-third of the total population (approximately one million people). In addition, the conflict and post-conflict situation reversed the positive economic trends of the post-independence period, resulting in:

- Decline in real GDP growth from 3.9% in 1998 to 0.8% in 1999 and ultimiately to a negative growth of 8.2% in 2000;
- Increase in inflation from an average of 6% during 1994-97 to 27% in 2000;
- Decrease in international monetary reserves from 5 months of imports to less than one month in 2000; and
- Increase in the deficit from 6% of GDP in 1997 to 48% of GDP in 2000.

[12] These should however be interpreted with caution as the 2001 cohort was composed of 702 new smear positives cases but those evaluated were reportedly 804. The higher figure was therefore used as the denominator.

Despite Government commitment and efforts (social sector expenditure amounts to 60% of Government expenditure), the country can only afford to spend about 5 USD per capita on health. As a result, certain cost-effective preventive programs cannot be expanded, and 70% of health expenditure is largely spent on curative rather than preventive measures.

This economic situation is worsen by a severe drought affecting around 70% of Eritrean population mainly in rural areas depending on Food Aid.

At present the country faces two daunting development challenges:

1. Meeting immediate needs for humanitarian assistance, reconstructing infrastructure damaged during the war, assisting nearly one-third of the displaced population resume economic activities, demobilizing and reintegrating nearly 250,0000 combatants mobilized for the war, rebuilding the economy, restoring social services and completing the economic and political reforms initiated before the conflict.
2. Planning a medium to long-term development programme to attain rapid, sustainable, propoor economic growth and reduction of poverty in an environmental sound manner. Led by a dynamic private sector based on the founding principles of Eritrea's constitution (participatory development, equitable economic growth, social justice, and rule of law).

A Poverty reduction strategy preliminary study is underway in Eritrea, with the assistance of UNDP. There is not a sector wide approach programme in the country.

20. Describe the current political commitment in responding to the diseases
(indicators of political commitment include the existence of inter-sectoral committees, recent public pronouncements, appropriate legislations, etc.)

The Government of Eritrea views the AIDS pandemic as its first priority for action. TB is the third priority disease after HIV/AIDS and malaria. National commitment at high level was demonstrated through early recognition of these diseases in the country, establishing a National AIDS Control Programme (NACP) in 1992, a National Tuberculosis Control Programme (NTCP) in 1995, developing HIV, STI and TB national policies (1998) and Strategic Plans on HIV/AIDS/STIs (1997-2001 and 2003-2007). There is a multisectoral national HIV/AIDS technical committee, an interagency committee on TB, a national care and support committee, an ARV expert group, a PMTCT committee, and a joint government-UN agencies and CSOs theme group and technical working group.

Moreover, early in 2003, the Ministry of Health restructured itself in order to make optimal use of available resources and to improve the efficiency and effectiveness of its management units. Within the new structure of the Ministry, the National HIV/AIDS/STI Control Programme has been combined with the National Tuberculosis Control Programme and promoted to the status of Division. The new National HIV/AIDS/STI and Tuberculosis Control Division (NATCoD) reports directly to the Director General for Health Services.

A UN development assistance framework (UNDAF) was developed for the period 2002-2006 and Eritrea has adopted the Declaration of Commitment of the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS held in New-York in June 2001. The objectives of the National Strategic Plan 2003-2007 refer to the main UNGASS global goals and targets.

In addition, in 2000 a USD 40 million loan from the World Bank to address prevention and care of HIV/AIDS, STI, TB and Malaria (HAMSET control project) was agreed. The deadline of disbursement of this project is 2005.This project is funding multisectoral and decentralised activities and human resources through subcontractors, such as the Ministries of Labour and Human Welfare, Education, Local Government, Health, Defence, Information, Agriculture, Transport, Tourism and Macro-Policy, and through NGOs, FBOs, associations and Unions.[13]

[13] Refer to Situation and response analysis of the HIV/AIDS epidemic in Eritrea. December 2002.

Furthermore, Government entered into a bilateral agreement with the Italian government through which TB benefited USD 600,000 under PHARPE phase I, which ran from 1997-1999 in addition to USD 530,000 out of the expected USD 950,000 under phase II, 2000-2001. Though negotiations for PHARPE phase III are ongoing it is not clear whether TB will benefit, and if so how much and/or when.

The Government provides testing reagents for HIV, STI, TB, laboratory equipment and commodities, essential medicines and condoms (together with the social marketing project run by PSI), human resources devoted to prevention, social mobilisation and care activities, and monitoring and disease and behavioural surveillance capacity. Care services are free for HIV, STI and TB patients.

21. Countries classified as "Lower-Middle Income" or "Upper-Middle Income" by the World Bank are eligible to apply only if they meet additional requirement (Guidelines Para 8).

Eritrea is classified as a low-income country and is therefore fully eligible to apply for support from the Global Fund.

22. National context

22.1. Indicate the percentage of the total government budget allocated to health:

4.6%

22.2. Indicate national health spending for 2002, or latest year available, in the Table III.22.2

Table III.22.2

	Total national health spending in 2002 Specify year: (USD)	**Spending per capita** (USD)
Public	21.0	6
Private	Very small	Very small
Total	21.0	6
From total, how much is from external donors?	10.1	2.9

22.3. Specify in Table III.22.3, if possible, earmarked expenditures for HIV/AIDS, TB and/or Malaria (expenditures from the health, education, social services and other relevant sectors)**:**

Table III.22.3

Total earmarked expenditures from government, external donors, etc. Specify Year:	**In US dollars: (millions)**
HIV/AIDS	4.2
Tuberculosis	0.9
Malaria	3.1
Total	8.2

22.4. Does the country benefit from external budget support, Highly Indebted Poor Countries (HIPC) initiatives, Sector-Wide Approaches? If yes, how are these processes contributing to efforts against HIV/AIDS, TB and/or malaria?

None of these initiatives or approaches is implemented in Eritrea.

22.5. Describe the current national capacity (state of systems and services) that exist in response to HIV/AIDS, TB (e.g., level of human resources available, health and other relevant infrastructure, types of interventions provided, mechanisms to channel funds, existence of social funds, etc.)

Health infrastructure

Eritrea is divided into 6 administrative zobas (regions), 57 sub-zobas (sub-regions) and 2,564 adis (villages). It has an estimated population of 3.5 million growing at a rate of 3% per annum, a fertility rate of 6.1 and an IMR of 72.3/1000 live births but a high maternal mortality ratio of 998/100,000 live births. 80% of the population is rural based with a low literacy rate of 20% on average but lower among women.

Health service delivery is organized at four levels: national referral, zoba referral, sub-zoba health centre level and health station levels. One national referral-specialised hospital is under construction but its functions are currently being provided by 5 hospitals in the city. This level serves the whole country and is directly responsible to the Ministry of Health (MoH). Each zoba has a referral hospital that serves as a referral unit for the zoba. Each zoba is also served by one to 3 other hospitals. Sub-zobas are served by health centres while heath stations provide services to several surrounding villages. In all there are 22 hospitals, 51 HCs and 128 health stations. Some degree of decentralization is observed. Zoba health teams are now responsible for planning, implementing and coordinating health services in their respective areas. At community level community health agents and traditional birth attendants render informal health services. Though they are supervised by the nearest health facility they are responsible to and remunerated by their respective communities. The Government also pays incentives to TBAs and community health agents when the community is not able to afford these costs due consequences of the post-conflict situation, dought or other.

Qualified health personnel man all Eritrea health facilities, right from health station to hospital level, but there are only: 1-3 staff/health station, 5-10/health centres and 30-50/sub-zoba hospital, 50-100 per zoba referral hospital.

Multisectoral and decentralised response through the Government HAMSET control project

As HIV/AIDS, STI and TB activities are integrated in the health and other sectors activities, it is therefore difficult to give the exact number of human resources available on prevention and care activities. Multisectoral social mobilisation is increasing through all the unions and NGOs, including FBOs, as their human resources have been trained on awareness, home-based care and prevention activities.

Many workshops have been carried out among the military and UN peacekeeping forces. At least one focal point in each ministry and several people from the national unions (workers, youth, women) have been trained and are involved in awareness and prevention activities and condom distribution all over the country. The NSP 2003-2007 includes non-health sector's responses.

The health sector capacity to respond

Guidelines are available for STI syndromic management, VCT anonymous and confidential services, PMTCT services, AIDS case clinical diagnosis and management, and PEP. Universal precautions guidelines and procedures are available and have been disseminated through trainings at 9 out of 22 hospitals, where teams are trained and supervised, and equipment has been provided with the support of USAID.

VCT services are offered through 2 freestanding sites: 1 in Asmara and 1 in Mendefera. Facility-based VCT services are offered in 5 MCH clinics and health centres, and all 22 hospitals throughout the country over the 6 regions. Pre-test counselling, prevention services, condom distribution and STI counselling and services are provided, mainly in Asmara. Two rapid tests are performed and confidential results are given the same day. Around 150 nurses, including military personnel, have been trained as counsellors for HIV and about 30 of them are full time counsellors, either in the existing freestanding VCTs or in health facilities throughout the country, including the paediatrics and maternity hospitals in Asmara and the military hospitals.

The MoH started in April 2003 to train non-health workers as counsellors, mainly members of the PLHA association BIDHO, including HIV+ people from the military. 21 volunteers of the Evangelical Church of Eritrea (ECE), 40 of the Orthodox Church and 20 of the Catholic Church were trained in home-based care and counselling.

All laboratory technicians in regional and referral hospitals have been trained on HIV rapid tests procedures by the CHL in Asmara, where a team is devoted to HIV/STI and TB-related activities. Elisa machines have just been distributed to 2 military hospitals, but training is needed to start utilizing them. The Government plans to establish Elisa machines in all regional hospitals (funded by HAMSET), and establish quality control mechanisms.

All health workers of regional hospitals and some health centres at sub-region level, and those of national reference hospitals in Asmara, have been given information on HIV, but no real training on AIDS case management. The national essential drug list has been adjusted to treat basic opportunistic infections, including TB (but Fluconazole is not available), and to use a syndromic management strategy for STI diagnosis and treatment. Essential generic drugs are available in all facilities in the country, and procurement systems are well organised at central level for all HIV/AIDS, STI, TB and malaria-related supplies, drugs and commodities.

Very few patients benefit from prophylaxis of OI. PMTCT services are offered on pilot sites in Asmara only, but PMTCT guidelines are available. There are no social funds, as all prevention, care and support services for people living with HIV, STI and TB are free of charge.

Support activities to PLHAs, families and orphans have started, mainly through the MoLHW, BIDHO and the religious groups, but there is a need to expand the scope and the quality of interventions.

TB control

TB control is organised as follows. One officer, the Program Manager (PM), heads the NTCP at central level. The PM together with 5 other programs including NACP and IDSR form the Control of Communicable Diseases (CDC) Division[14] of MoH. Replica of CDC at zoba levels are headed by Zoba Communicable Disease Control Coordinators (ZCDCCs) previously called zoba tuberculosis leprosy coordinators. The 6 ZCDCCs, all from a nursing background and oriented to TB in country and at Arusha, manage and coordinate TB control in the respective zobas. There are no specialised TB personnel below the zoba level rather TB is implemented as an integral part of the health system. However two zobas are pilot-decentralizing TB care to the community through “Heath promoters” under the Youth Association.

The MOH/NTCP adopted the WHO/IUATLD DOTS strategy in 1997, successfully piloted unit based DOTS in Maekel zoba before extending it to the rest of the zobas in 1999. Thus attaining 100% geographical but a 20-25% population-based DOTS coverage according to MOH situation analysis (2001). At present 16 out of 22 hospitals and 17 out of 51 health centres implement DOTS. The rest primarily due to shortage of manpower especially qualified laboratory personnel are not. 85 health stations also support DOTS implementing HCs by providing the DOT component. Eritrea is in the process of trying out decentralized TB care in two zobas refer to section IV 28.

Below the PM are ZCDCCs responsible for the day to day running of TB control in their areas. They plan, budget for and monitor TB management in the hospitals and HCs that serve as TB diagnostic-treatment units as well as in communities. ZCDCCs are expected to supervise each unit once a quarter taking this opportunity to check on TB management, anti-TB drugs, reagents and other supplies as well as TB records. However with the exception of 2[15] ZCDCCs lack transport.

[14] This has just been changed with the creation early in 2003 of a fully-fledged National HIV/AIDS/STI and Tuberculosis Control Division – NATCoD (refer to section 20).

[15] Even the 2 use multipurpose ambulances that may not be available when needed for supervision

Treatment units submit data on case finding, treatment outcome and sputum conversion to ZCDCCs quarterly. ZCDCCs, in turn, submit these to the PM who until 2002 collated the National data quarterly. This responsibility with effect from 2002 shifted to IDSR to which reports are now directed with copies to PM. As exemplified by treatment outcome data - 78% of the 2000 smear positive cohort was evaluated as compared to only 52% the previous (1999) year but over 100% for 2001 cohort.

Anti-TB drugs are obtained from MoH. Each zoba Pharmacist's request endorsed by a ZCDCC is based on reported caseload. The National store supplies them, zoba Pharmacists, twice a year. They, in turn, supply treatment units quarterly basing the amounts on reported caseload and a 10% buffer stock.

The NTCP advocates for passive case finding prioritising sputum smear microscopy for identifying infectious cases, and for Medical Officers to augment this with chest x-ray to rule in smear negative PTB. MoH/NTCP policy is to provide anti-TB drugs and sputum smear services free of charge to the patients. Similarly the policy follows WHO guidelines on categorisation (CAT I, II and III) of patients for treatment using 2ERHZ/6EH for CAT I, 2SERHZ/1ERHZ/5RHE for CAT II and 2RHZ/6RH for CAT III and 2RHZ/6EH for adults. The program also recommends preventive isoniarzid for under-five-child contacts of infectious cases. DOT for most even re-treatment cases is on a daily ambulatory basis. Only the severely sick and the distant are admitted. Two zobas are however, piloting use of community laypersons, health promoters, to supervise DOT at home.

The NTCP is challenged by lack of trained laboratory personnel and lack of microscopes in some units to establish microscopy network throughout the country. The MoH has however initiated a 6-month Assistant Laboratory Technicians (ALTs) course as a short-term measure to the former problem. The first 30 are currently undergoing training though funds to sponsor more are lacking. A TB Reference Laboratory is being established at Central Health Laboratory in Asmara with the support of PHARPE project. It is hoped that once established the Reference Laboratory would reactivate quality assurance of sputum smear microscopy that had hitherto been abandoned. Culture and sensitivity is currently not being done therefore the prevalence of drug resistant TB in the country is not known though the moderate default and low treatment failure rates would seem to suggest that it is not high.

NTCP is supported by a number of partners. WHO provides technical assistance and funds that cover 10-20% of the training, support supervision and World TB Day needs. The Italian Cooperation through a bilateral grant, WHO/PHARPE, used to fund the whole drug bill, support both external and internal training, procure laboratory reagents, print TB stationary and fund operational research. PHARPE is putting aside US$ 420,000 to establish a TB reference laboratory but not for its recurrent costs. Unfortunately WHO/PHARPE fund has not been forthcoming for the last year or so. The program also benefits from the HAMSET project, which uses an intersectoral approach. Under HAMSET all Ministries and Civil society especially Women and Youth groups are involved in advocacy. Civil society advocates for DOTS through radio, television, drama, plays and seminars. There is also a positive indication that the Global Drug Facility (GDF) will cater for the country's anti-TB drugs needs for the next 3 or so years.

All funds for TB care whether from donors or government are channelled through the Finance section of MoH where two Financial Controllers, one responsible for donor the other for government funds oversee their expenditure. The same accounting procedures apply to both.

Funds are spent according to annual work plans prepared by ZCDCCs, PM and partners and are accessed through the PM. At the zoba level ZCDCCs request for funds from the Health Administrators based at zoba-headquarters.

The NTCP is in the process of finalising a 5 year strategic plan that identifies its needs, partners; spells out its goal, objectives and strategies. The plan also spells out the current gaps. Indeed the request for support from the fund is based on this plan.

22.6. Name the main national and international agencies involved in national responses to HIV/AIDS, TB and/or Malaria and their main programmes:

Table III. 22.6

Name of Agency	**Type of Agency** (e.g., Government, NGO, private, bilateral, multilateral, etc.)	**Main programs** (for example, comprehensive HIV/AIDS prevention; DOTS expansion over 3 years, etc.)	**Budget USD** (Specify time period)
NATIONAL			
- Ministry of Health - Ministry of Labour & Human Welfare - Ministry of Local Government, - Ministry of Education	Government of Eritrea	BCC related activities; care and support; health infrastructures, equipment, reagents, drugs, commodities; supervision and training; advocacy for DOTS by youth and women groups	USD 40 million over 5 years 2001-2005 for HIV/AIDS, STI, TB & Malaria
INTERNATIONAL			
USAID	BILATERAL	Social marketing of condoms, BCC related activities; STI and HIV surveillance related activities; technical assistance to the MOH	USD 2.3 million annually
WHO/PHARPE	BILATERAL	TB: Drugs & reagents supply, training, supervision, research, establishment of TB Reference Laboratory	USD 530,000 for 2000- 2001
WHO	UN Agency	TB: Technical assistance, financial support for supervision & training	USD 25,000 in 2003
UNDAF Theme Group on HIV/AIDS	UN Agencies	BCC, condom distribution, GIPA, care and support, technical assistance, socioeconomic impact surveys; food assistance; services for mobile and vulnerable populations; CSW; uniformed services, etc.	USD 7.9 million for 2002-2006

22.7. What is the total budget required for the different diseases, list the sources and amounts available and needed including amount requested from the Global Fund.

Table III. 22.7

Source/Agency	Amount In US dollars:						
	2002	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
HIV/AIDS							
USAID	1,900,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000	2,200,000
UNFPA	420,000	350,000	300,000	300,000	300,000	300,000	300,000
UNICEF	630,000	450,000	450,000	450,000	450,000	450,000	450,000
WHO	84,000	22,000	22,000	22,000	22,000	22,000	22,000
Italian Cooperation	170,000	-	-	**-**	**-**	**-**	**-**
Others	150,000	150,000	150,000	150,000	150,000	150,000	150,000
Global Fund request	**-**	**-**	4,139,280	3,985,630	3,414,806	3,046,307	2,768,012
Unmet need	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Total need	**3,354,000**	**3,172,000**	**7,311,280**	**7,157,630**	**6,586,806**	**6,218,307**	**5,940,012**

Tuberculosis							
WHO/AFRO	25,000	25,000	25,000	25,000	25,000	25,000	25,000
WHO/PHARPE	265,000	265,000	-	420,000	600,000	600,000	600,000
World Bank Loan	-	-	200,000	200,000	200,000	200,000	200,000
Global Fund request	-	-	-	-	1,153,878	332,302	493,417
Unmet need[16]	510,000	910,000	1,175,000	1,284,062	722,183	1,078,802	1,382,748
Total need	**800,000**	**1,200,000**	**1,400,000**	**1,929,062**	**2,701,136**	**2,236,105**	**2,701,166**

22.8. Describe the major programmatic intervention gaps and funding gaps that exist in the country's current response to HIV/AIDS, TB (2-3 Paragraphs)**:**

1) <u>Gaps in the response to HIV/AIDS</u>

The country's current multisectoral response to the HIV/AIDS epidemic is predominantly Asmara-based in terms of human resources trained. Nevertheless, involvement in BCC, blood safety, VCT, care and support activities though decentralised activities have started in 15 model communities throughout the regions.

The purpose of requesting supplementary funds is:

1) To expand existing activities outside Asmara, and from urban areas to rural areas, such as expanding blood safety and universal precautions, and increasing access to VCT, PMTCT, care and support services.
2) To provide new services such as national HIV sentinel surveillance system, a good tracking of STI, and access to ARV therapy, clinical and biological follow-up.

The current response in terms of funding focuses on IEC, BCC, and condom distribution, which at this stage are relevant and need to be continued, but gaps remain in terms of geographical scale and the extent to which the implementation is done, including greater accessibility of materials in local languages, especially Tigrinya. Gaps remain in addressing STI surveillance, early diagnosis and treatment for all, and particularly for at-risk groups, such as the CSWs and the military.

There is no funding other than from the Government for HIV+ people, whether symptomatic or asymptomatic. Voluntary testing is available. There is little microbiological capacity to diagnose OI and STIs (treatment failures), to measure CD4, or conduct TB resistance surveillance. ARVs are not available in the country. Nevertheless, a few patients access them in neighbouring countries. Waste disposal infrastructure is lacking in all facilities.

PMTCT activities were launched at 3 sites in Asmara, but on a very small scale. The demand is increasing both from women and health workers, to develop PMTCT activities at regional antenatal and hospitals levels.

Paediatric AIDS cases are increasing. There is one Paediatrician in the whole country who has been trained on case management. No trained counsellor for children is available.

Support services, whether public through the Ministry of Labour and Human Welfare, or run by FBOs, NGOs and unions (youth, women and PLHAs), are few and primarily in Asmara. The volunteers involved in BCC, HBC and counselling, food distribution, orphans follow-up, are overwhelmed. The PLHA association BIDHO, with 600 members and around 3000 beneficiaries, is helped by 35 active members. Existing micro-financing activities run by NUEW, FBOs or BIDHO could also be scaled-up.

The NSP for the period 2003-2007 takes into consideration coverage and programmatic gaps; thus, the current priority is to fill the funding gap.

[16] Unmet need for years 2004-06 is computed assuming that the GFATM will fund the request.

External donors involved in the fight against HIV/AIDS in Eritrea are few:

- The European Commission does not intend to finance any health activities.
- USAID is the only bilateral contributor. The Italian Cooperation has stopped its support in 2001.
- UN agencies are contributing to the fight against HIV/AIDS in Eritrea with technical assistance, but with very little financial support.

The activities to fight against HIV/AIDS in the country are mainly financed under the HAMSET control project. HAMSET/MoH implementation plan started in 2001 and will end in 2005. HAMSET/MoH expenditures are primarily on prevention and support activities. No care or surveillance activities have been financed by HAMSET. For condom promotion and behaviour change, only 32 model communities are targeted over the 5 years. Risk groups, especially military and their spouses, CSWs and STI clients need more attention.

The request to the Global Fund will fill major gaps: (1) in **time** over the period 2004-2008 (complementary to the 2001-2005 HAMSET implementation plan); (2) in **coverage** (towards decentralised prevention and care and support activities); and (3) in **thematic areas** to initiate new and innovative activities on STI and AIDS management, diagnosis and follow-up, surveillance, monitoring and evaluation. Human resource development is a crosscutting issue and is emphasised throughout the activities.

2) Gaps in the response to Tuberculosis

Though DOTS strategy was adopted, successfully piloted in the central zoba in 1997 and extended to all zobas in 1999, the country is yet to attain the WHO (70% and 85%) targets. This is largely because there are a number of intervention and funding gaps and challenges that the program must overcome if these targets are to be met. Major intervention gaps include the need to scale up DOTS to cover at least all hospitals and all health centers and to strengthen it in those already implementing. The need to improve on the quality and access to microscopy diagnostic services as well as to institute a Reference Laboratory to provide culture and sensitivity and periodic drug-resistance-monitoring services. Support supervision, currently irregular mainly due to lack of transport for both the ZCDCCs and the PM, also needs to be strengthened. Infrequent supervision constrains data management especially collation and timely recognition and correction of errors leading to such inconsistencies as referred to in section III 22.5 above. There is also a need for continued advocacy. On the funding side, uncertainty still surrounds the continuity or non-continuity of the PHARPE project.

The country also needs to document experiences gained in decentralising TB care especially DOTS through youth groups and community health agents so as to adopt a sustainable approach.

22.9. If a SWAp or a similar fund pooling mechanism exists in your country, briefly describe how it is functioning and if you anticipate using it to administer the Global Fund grant

There is no such fund pooling mechanism in the country.

SECTION IVA – Scope of proposal

23a. Identify the component that is detailed in this section (mark with X):

Table IVA.23

Component (mark with X)**:**		
	X	**HIV/AIDS**
		Tuberculosis
		Malaria
		HIV/TB

24a. Provide a brief summary of the component (*Specify the rationale, goal, objectives, activities, expected results, how these activities will be implemented and partners involved):*

Introduction and rationale. The HIV/AIDS epidemic is perhaps the gravest threat faced by Eritrea today. The post-conflict situation, the mass mobilisation of youth into national and military service (men and women) and their impending demobilisation create an ideal environment for the massive and rapid expansion of the HIV epidemic. The uncontrolled spread of HIV infection would have devastating effects on the fragile but recovering economic and social sectors. However, Eritrea is fortunate to enjoy a high-level of political commitment to HIV/AIDS coupled with an extraordinary organisational capability. This setting presents an ideal opportunity to scale up effective, targeted and well-coordinated HIV/AIDS prevention activities and to make a significant difference in the course of the epidemic at this critical time. In addition, the number of people known to be HIV infected and to have AIDS in Eritrea is growing rapidly. Therefore, in addition to the prevention efforts, we must rapidly expand access to and quality of care and support for Eritreans living with and affected by HIV/AIDS (PLHAs).

Current situation. Since the first case of AIDS was reported in 1988, 15 698 AIDS cases have been reported to the Ministry of Health. According to the 2001 biological and behavioural survey carried out by the Ministry of Health, the estimated HIV infection rate is between 2.4% and 2.8% in the adult general population, <1% in secondary school students, 4.6% among members of the military and 22.8% among female bar tenders[17]. The Ministry estimates that between 60,000 and 70,000 Eritreans are currently HIV infected – the overwhelming majority of these persons do not know that they are infected. In Eritrea, most HIV infection is transmitted by heterosexual sex; other means of acquiring HIV infection include transmission from mothers to child and transmission through traditional skin piercing and scarification practices and cutting instruments, both within and outside the medical setting.

Eritrea is on the verge of a generalised HIV/AIDS epidemic. The military population (250 000) that engages in higher risk behaviours and has higher rates of infection may bring these higher rates of infection back to their families and home communities when they are demobilised (gradually after border demarcation planned in July 2003). We have the chance to intervene in a significant way to prevent the spread of HIV infection by acting decisively and at a national scale to prevent HIV transmission through adoption of safer sexual behaviours, improved management of STIs, voluntary counselling and testing, prevention of mother-to-child transmission, and universal precautions.

At the same time, Eritrea must improve its capacity to care for and support people infected with and affected by HIV/AIDS, including orphans. Only by ensuring that there is a caring and open attitude towards people living with HIV/AIDS can we effectively prevent HIV transmission and provide access to care and support. In spite of high levels of knowledge about HIV/AIDS in Eritrea, there are also high levels of denial about the epidemic at both the personal and community level. This

[17] *HIV/AIDS Risk Groups and Risk Behaviors Identification Survey Eritrea*, October 2001.

denial and depersonalisation of the epidemic is complicated by high levels of stigma and shame that prevents people from confronting the issue of HIV/AIDS on a personal level, in their relationships, and in their demand for and access to services. People living with HIV/AIDS must play a leadership role in the struggle to overcome the denial, stigma and discrimination that hinder all our efforts to confront the HIV/AIDS epidemic.

Eritrea's Response to HIV/AIDS to date.[18] Eritrea has already mobilised an effective multisectoral response to HIV/AIDS, especially considering the size of the country, the level of the epidemic and the prevailing security situation. The strategic plan for HIV/AIDS in Eritrea emphasizes the importance of multi-sectoral and multilateral approaches to HIV/AIDS. The Ministry of Health has joined in partnership with other Government sectors as well as NGOs, CBOs and unions (women, workers, and youth), FBOs, the private sector and other elements of civil society to respond to the epidemic. Activities are integrated at several levels and, for example, those activities supported by the HIV/AIDS, Malaria, STI and Tuberculosis (HAMSET) Control Project are being implemented by a variety of partners from many sectors working at central, regional and community level under the leadership of the Ministry of Health. This kind of intersectoral cooperation is the model we propose for the implementation of the activities outlined in this current proposal.

Thus far, the national response to the HIV/AIDS epidemic has concentrated on the following broad areas of activity:

- Behaviour change communications focusing on personalising the epidemic and overcoming denial, stigma and discrimination in order to prevent HIV transmission as well as to care for and support PLHA.
- Male and female condom promotion and distribution with an emphasis on male condom social marketing.
- Life skills education in schools focusing on providing basic information about health, hygiene and reproductive health (including HIV/AIDS/STI education) for primary and secondary school children.
- Military and peacekeeping forces: prevention and VCT, support activities.
- Voluntary counselling and testing, mainly in Asmara and 5 other towns
- Commercial sex workers and their clients, focusing on making sex work safer for the CSW and the client, improving access to STI management and providing care and support services for PLHA.
- Sexually transmitted infection prevention and management for its own sake, recognising the role that STIs play in enhancing the transmission of HIV, as well as focusing prevention activities on this high-risk group, and at scale.
- Preventing HIV transmission through blood and in the health care setting (a National Blood Bank Centre was built in Asmara, providing blood throughout the country, blood is tested for HIV, Hepatitis B and C and Syphilis, at least at central level, because blood is insufficient and family donors at regional level are only tested for HIV).
- Preventing mother-to-child transmission of HIV through primary prevention and through screening of pregnant women for HIV in a pilot site in Asmara alone.
- Care and support for PLHA in the home, community and through the health care system mainly in Asmara.

Although the activities that are being carried out in these broad implementation areas provide a strong foundation for our fight against HIV/AIDS, not nearly enough is being done, **and not one of these activities is being implemented at a scale that matches the magnitude of the threat that the HIV/AIDS epidemic poses to the State of Eritrea**. In order to make a significant contribution to the prevention of HIV transmission and to increase the scope and speed of our response, we need additional resources in order to act more broadly and more rapidly to control the spread of HIV and to ensure that PLHA are cared for adequately. For this reason, we are submitting this application to the Global Fund.

Goal. The overall goal of Eritrea's response to the HIV/AIDS epidemic is to reduce HIV transmission and mitigate the personal, social and economic impact of HIV/AIDS.

[18] Refer to Situation and response analysis, April 2003.

Objectives.

1) Scale-up and expand effective HIV prevention activities in target populations, including the military, wives of the military, commercial sex workers and STI clients.

2) Increase the number of people who know their HIV status by improving availability and quality of voluntary HIV counselling and testing (VCT).

3) Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission (PMTCT).

4) Improve the availability and quality of health care and psychosocial and economic support for people living with and affected by the epidemic (PLHAs).

5) Expand blood transfusion safety (HIV, Syphilis, Hepatitis B and C) to regional blood banks and establish procedures for, and ensure adherence to, universal precautions in the health care setting.

6) Strengthen and expand epidemiological and behavioural surveillance for evidence-based planning.

Activities. Activities included in this proposal are designed:

- To build upon and scale up existing activities and experiences with i) prevention (BCC activities, STI, VCT and PMTCT; ii) care (AIDS case management and prevention of opportunistic infections), and iii) support for people living with and affected by HIV/AIDS (psychosocial, economic, food aid, etc.), and

- To facilitate the launching of new interventions by: i) targeting the military, the vulnerable women (military spouses), commercial sex workers (BCC and condom distribution), and STI clients; ii) setting up a sentinel surveillance system for HIV, TB and STI; iii) initiating a blood donor association and donor recruitment; iv) expanding and improving the quality of diagnosis and treatment for STIs; v) offering access to clinical and biological (at referral level) diagnosis capacity for OI, STI and TB and to ARV treatment and follow-up of adolescents, adults, women and children; vi) expanding support activities including orphans; vii) improving surveillance and monitoring and evaluation capacity of the MoH (refer to Section IV. 28). A better knowledge of the epidemiological situation of the HIV, STI and TB diseases is needed as well as improvement of the surveillance and reporting systems, and the use of data from improved decision-making.

Expected results. With these additional resources, we expect to achieve a reduction in the transmission of HIV infection, especially among youth, and to provide quality care and support to people living with HIV infection and affected by the epidemic, including orphans. By responding early and rapidly we intend to reduce both the spread of the epidemic and the social burden of the disease on an already heavily affected population, and thus keep people healthy, working and active in order to contribute to the reconstruction of the country.

Implementation partners. *The Eritrean Partnership Against HIV/AIDS, Tuberculosis and Malaria* (CCM) will coordinate the implementation of the activities included in this proposal, led by the Government of the State of Eritrea, with a number of implementing partners that include: the University of Asmara, parastatal organisations (such as Phamecor), local and international NGOs, FBOs, CBOs including BIDHO PLHA association, and the private sector.

Human resources gap. ***Eritrea is a young country with a limited number of educated and experienced professionals. The University of Asmara is the only university in the country; it has a limited number of faculties and a small student body. There is no medical school yet, but the MoH has set up a steering committee to start a medical school in Asmara. In the College of Health Sciences, there are programmes for nurses, pharmacists, laboratory workers and other paramedical staff, all trained on HIV/AIDS, STI and TB diseases, which are part of the curriculum for students. Social workers and students in biology and psychology can also be trained in the***

field of HIV/AIDS, to enable them run prevention and support related activities, or home-based care follow-up and supervision.

The demand for trained and experienced personnel in the military and civilian sectors far outstrips the supply. However, programmes and materials are in place for the training and supervision that is required in order to carry out the activities outlined in this proposal.

The country needs to strengthen and expand its human resource capacity by recruiting, training and deploying personnel at all levels to manage, implement, supervise, monitor and evaluate the various components of the national response. Hence, our strategy for implementing the activities in this proposal places a strong emphasis on building human resource capacity and broadening the national response to the HIV/AIDS epidemic.

25a. Indicate the estimated duration of the component:

Table IVA.25

From (month/year)**:**	**January 2004**	**To** (month/year)**:**	**December 2008**

26a. Detailed description of the component for its FULL LIFE-CYCLE:

26a.1. Goal and expected impact *(Describe overall goal of component and what impact, if applicable, is expected on the targeted populations, the burden of disease, etc*.)

The **overall goal** of Eritrea's national response to the HIV/AIDS epidemic is to reduce HIV transmission and mitigate the personal, social and economic impact of HIV/AIDS.

The **overall strategy** is to provide a comprehensive programme of prevention, care and support, building on existing community and governmental responses to create a response continuum of prevention, counselling and testing, care, support and impact mitigation activities, so that the synergy between the various activities emerges to achieve measurable national impact.

Activities planned under the 6 objectives described in the HIV/AIDS component intend to provide a comprehensive package of HIV/AIDS prevention and care that includes condom distribution, IEC and BCC activities particularly among the CSWs and the military, STI early diagnosis and treatment, VCT youth friendly services, PMTCT, care and home-based care and impact mitigation activities. The links between health services, TB and STI will be improved as they are now headed by one director.

Specific objectives, target populations and expected impact. The overall goal will be achieved by scaling up existing activities and initiating critical new activities in the following programmatic areas:

1) **Scale-up and expand effective HIV prevention activities in target populations, including the military, wives of the military, commercial sex workers and STI clients.**
   Target population: CSWs, military, wives of the military, STI clients.
   Expected impact: Reduce HIV transmission and HIV prevalence in Eritrea.

2) **Increase the number of people who know their HIV status by improving availability and quality of voluntary HIV counselling and testing (VCT).**
   Target population: Persons at risk of HIV infection, individuals and couples before initiating a sexual relationship, before reuniting, before marriage and before conception.

Expected impact: Reduce HIV transmission and HIV prevalence and improve the quality and length of life for people living with and affected by HIV/AIDS.

3) **Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission (PMTCT).**
Target population: Pregnant women and their children.
Expected impact: Reduce HIV transmission and HIV prevalence and improve the quality and length of life for people living with and affected by HIV/AIDS.

4) **Improve the availability and quality of health care and psychosocial and economic support for people living with and affected by the epidemic (PLHAs).**
Target population: Persons living with and affected by HIV/AIDS.
Expected impact: Improve the quality and length of life for people living with and affected by HIV/AIDS.

5) **Expand blood transfusion safety (HIV, Syphilis, Hepatitis B and C) to regional blood banks and establish procedures for, and ensure adherence to, *universal precautions* in the health care setting.**
Target population: Patients, health workers.
Expected impact: Reduce HIV transmission within the health sector.

6) **Strengthen and expand epidemiological and behavioural surveillance for evidence-based planning.**
Expected impact: Increase the ability to a) monitor epidemiological and behavioural trends, b) monitor Eritrea's response to the HIV/AIDS epidemic, and c) use data to improve HIV/AIDS programming and maximize desired outcomes.

Beneficiaries. Broadly speaking, the beneficiaries of the activities outlined in this proposal will be the entire population of the State of Eritrea, with special emphasis on the youth of the nation (80% of youth in the 18-40 year age group is in the military), commercial sex workers, the sexually active population and people who are living with HIV/AIDS and affected by the epidemic.

Expected Impact. The goals and objectives outlined in this proposal will help to reduce the incidence of HIV infection in Eritrea and improve the quality of life and length of life for people living with and affected by HIV/AIDS.

Table IVA.26.1

Goal:	***To reduce HIV transmission and mitigate the personal, social and economic impact of HIV/AIDS in Eritrea***		
	Impact indicators	***Baseline***	***Target*** *(last year of proposal)*
		Year: 2001	***Year: 2008***
Maintain current HIV prevalence rate at or below its current level	HIV prevalence among antenatal mothers in the age group (15-24)	2.4%[19]	Stabilized or lower
Observed reduced burden of HIV disease for PLHAs and their families and for the orphans	Percentage of children under age 18 in a household survey whose mother, father, or both parents have died		

[19] general population HIV seroprevalence rate.

	% of projected number of new TB cases identified			

Health delivery system in Eritrea: Summary

The country is divided into 6 zobas/regions: Maekel (where Asmara capital city is located), Anseba, Debub, Gash-Barka, Northern Red Sea and Southern Red Sea. Respective main towns in the regions are: Asmara, Keren, Mendefera, Barentu, Massawa, and Assab.

Each zoba is divided into sub-zobas and the regional medical officer is responsible for coordinating health activities at all levels of the zoba. At sub-zoba level, at least one health centre (mini-hospital with laboratory and 30 beds covering a 50 000 population with in patient care and MCH related activities) coordinates several health stations (outpatient only, covering 10 000 population). Gash-Barka, Debub and Maekel have the largest population, and thus the highest number of health facilities**.**

The Ministry of Health is the major health service provider. The Ministry owns all hospitals (national referral, zonal and mini-hospitals), 75% of the health centres and 80% of the health stations. The others are owned by different church missions, non-profit, NGOs, Industry and private for profit organizations (refer to table below). Out of the total registered health facilities, 29 (9.2%) are owned by Catholic Mission Church, 9 (2.9%) by NGOs including the mobile clinics, 26 (8.3%) by industry, 29 (9.2%) by private for profit and the other 4 (1.3%) by the Evangelical Church of Eritrea and the Ministry of Agriculture.

There is also one national referral hospital in Maekel, and two zonal referral hospitals in Debub (Mendefera) and Gash Barka (Barentu) are soon to be opened. The new Orota NRH in Asmara is finished, and will soon function, when human resources are identified.

Number of Health Facilities by Type and Zoba in 2002

Type of facilities	DKB	SKB	Anseba	Gash-Barka	Debub	Maekel	National Referral Hospitals	Total public/ other	*Total*
Hospitals	1	4	1	3	3	-	7 in Asmara + 1 Debub + 1 Gash Barka	**21**	***22***
							1 non public	**1**	
Mini-hospitals	1	-	-	-	2	1	-	**4**	***4***
Health centres public/other	-	10	6	11	7	7		**41**	***51***
	2	1	2	1	3	1	-	**10**	
MCH clinics	-	2	1	2	1	0	-	**6**	***6***
Health stations public/other	12	21	17	39	36	23	-	**148**	***179***
	4	3	5	4	12	3	-	**31**	
Private for profit	2	6	5	2	3	11	-	**29**	***29***
TOTAL	***22***	***47***	***37***	***62***	***67***	***46***	***10***	***291***	***291***

The distribution of health human resources in the public sector over the last 10 years is the following[20]:

Category		1991	1995	1999	2000	2001	2002
Physicians	**GP**	58	108	102	100	95	121
	Specialist	NA	NA	74	73	68	96
Nurses and midwives (regular nurses, surgical nurses, midwives, anaesthetists etc)		228	391	756	811	807	797
Health assistants (associate nurse)		-	539	1292	1333	1373	1379
Laboratory technicians and technologists		> 80	35	132	133	133	127
Pharmacists, pharmacy technicians and druggists		8	17	84	85	85	87
Sanitarians		-	15	21	21	21	21
X-ray technicians		18	18	40	40	40	40
Other Health Professionals				245	231	272	117

The main concern of the HR management unit at the MoH is related to the lack of physicians, both general practitioners and specialists. The opening of a medical school in Asmara is currently being discussed. Meanwhile, to alleviate the lack of physicians and particularly specialists, the country has developed bilateral cooperation allowing expatriate physicians to come from Cuba (30), Egypt (20), Russia (2), China, Uganda, and Sudan (1).

In addition, the College of Health and Sciences is training each year about 60 nurses, 80 associate nurses, 15 radiology technicians, 30 lab technicians and 20 physiotherapists. The nurses are trained on HIV/AIDS, STI, TB diseases, including clinical diagnosis, basic treatment and universal precautions.

As new hospitals open, needs for human resource increase. The training school intends to double the number of trainees in 2004-2005: 100 nurses, 200 associate nurses, 37 public health officers, 35 assistant lab technicians, 14 radiology technicians and 15 anaesthesia nurses will start training. All trainees are recruited after graduating to serve in the MOH. The nursing school needs supplementary funding to expand training activities in the zobas.

The projected numbers of people graduating and in post are the following[21]:

Health workers		**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Qualifying trainees	Basic nurse	52	48	52	100	50	50	50
	Associate nurse	74	44	200	200	200	200	200
Projected numbers in post	Advanced nurse	268	277	286	295	304	313	322
	Basic nurse	608	694	780	867	953	1039	1126
	Associate nurse	1180	1108	1121	1206	1066	1143	1113
Lab technicians		35	-	37	-	30	-	30

The military health delivery system: Summary

[20] Situation and response analysis HIV/AIDS, brief description of the health system of Eritrea.
[21] TASC/USAID project. Eritrean human resource Plan, 2001.

The military has a central referral hospital and 4 operational zones hospitals. Each division has a health centre at peripheral level, and up to 25 health centres. The human resource availability is 14 physicians, 90 nurses, 100 associate nurses and 300 health assistants, and 2 laboratory technicians. Initial training for health human resources is carried out at the nursing school integrated with other future MOH personnel.

OBJECTIVES AND OUTCOME/COVERAGE INDICATORS

26a.2. Objectives and expected outcomes (*Describe the specific objectives and expected outcomes that will contribute to realizing the stated goal*)

26a.2.1. Objective 1. Scale up and expand effective HIV prevention activities in target populations

A. The military - Eritrean Defence Force (EDF)

All young people attaining the age of 18 years are conscripted into National Service in the EDF. This comprises six months training and 12 months service. At the time of writing, there are 250,000 people aged 18-40 in the military, 80% of whom are in National Service. There are six males to each female soldier. Prevention activities in the military begin with mandatory HIV testing for all new recruits. Pre-test and post-test counselling is available. Those whose test results are negative are counselled in groups to maintain their negative status, while those found positive are counselled individually and assigned to appropriate levels of training regimen and work assignment. Peer group facilitators have been trained, most recently in BCC and interactive theatre, to continue awareness-raising efforts and behaviour change. EDF health services have produced IEC materials for the military in collaboration with MoH. Condom promotion activities are also ongoing with the participation of NUEYS and ESMG. These activities need to be updated, intensified and expanded.

The Gap – The enthusiastic prevention efforts in the military must be intensified and updated to present a comprehensive prevention package for this population group which, at one time or another, contains virtually all young people in the country.

B. Wives of the military

It is estimated that between 25 000 and 30 000 male soldiers are married or have a cohabiting partner. These female partners are clearly at high risk of HIV infection if the soldier is infected. The Ministry of Local Government (MoLG) has a support programme for wives of the military. It is proposed that a project to target this group of women with education in HIV prevention and care, including STI recognition, through this support structure. Couple counselling could be made available at local VCT centres when the man returns on leave. This counselling would encompass risk perception and pregnancy planning. The couples would be encouraged to take the test and receive post-test counselling and appropriate services. This would facilitate the long-term planning of family life. Because this group of women are already targeted and accessed for general support, the proposed intervention would be relatively inexpensive, in that the support network already exists and locally available facilities would be utilised.

The Gap – The support package offered by the Ministry of Local Government to soldiers' wives so far does not include any HIV prevention element. As male soldiers are at increased risk of HIV infection by nature of their mobility and isolation from family, their wives and partners have been identified as a priority group for HIV prevention activities, including the female condom.

C. Commercial sex workers

Sex work has long been recognised as a necessary target for health interventions in Eritrea, and municipalities register female sex workers for regular health visits to specialist MoH STI clinics. Peer education has been carried out at these sites. While this has met with some success, in the context of high child and maternal mortality, sex work has not received sufficient funds or human resources. Global fund assistance would help redress this. Sex worker interventions in Eritrea so far have been most active in the field of identifying women who have entered sex work due to economic and social factors, and assisting them to return to work in the general community. The best-practice strategies are proposed which aim to extend the options open to sex workers, in terms of safer sex and working conditions.

The gap – Female sex workers have not been targeted with a structured comprehensive package of HIV prevention activities up until this time. The active identification of women who sell sex, and their non-discriminatory enrolment into prevention programs, is an absolute national priority.

D. Individuals infected with STI

Although STI have been shown as a major factor facilitating HIV transmission, it has been said that STI early diagnosis, appropriate treatment and reporting is among the weakest links on the chain of prevention of the heterosexual transmission of HIV in Eritrea. This is true in all parts of the country and among various high-risk groups, such as the CSWs and the military. Awareness campaigns need to be increased on STIs to encourage early diagnosis and treatment seeking behaviour. The NACP team has conducted some STI activities in recent years, such as training health workers from different levels of the zonal health facilities, but the needs for training are still high.

The gap – Very little is known about the quality of management of STIs in Eritrea. While syndromic management guidelines exist, it is thought that very few clinicians have received quality training in their use, and very few use the STI provider-client interaction as a behaviour change and partner referral opportunity.

Table IVA.26.2.1

Objective 1:	***Scale-up and expand effective HIV prevention activities in target populations***				
Outcome/Coverage indicators	***Base line***	***Targets***			
	Year: 2002	***Year 2: 2005***	***Year 3: 2006***	***Year 4: 2007***	***Year 5: 2008***
Number of female condoms* distributed or sold	-	5,000	10,000	20,000	20,000
Number of sex workers reached with targeted HIV/AIDS interventions		1,000	4,000	8,000	12,000
Number of cases of STIs treated*		500	1,000	2,000	4,000
% of CSWs who reported condom use at last sex	**				
% of male soldiers aged 15-24 who reported condom use at last sex with a non regular partner	**				

* Refers to products or treatments financed by resources from the Global Fund

** Baseline data will be available after studies planned in 2004.

26a.2.2. Objective 2. Increase the number of people who know their HIV status by improving availability and quality of voluntary HIV counselling and testing (VCT)

VCT – The current situation. National guidelines for anonymous and confidential HIV VCT are available. Elisa HIV testing has been available at the CHL for the last 12 years. Rapid tests for HIV voluntary counselling and testing is now available in Eritrea on various sites: a) *Freestanding VCT centres* in Asmara (capital) and Mendefera (Zoba Debub); b) integrated VCT activities in health services of all hospitals in 6 zobas and on 5 sites in the military. Counsellors and laboratory technicians have been trained in all hospitals. Elisa machines have been provided to 2 military hospitals under HAMSET funds to start quality control for HIV testing throughout the country.

There is an incredibly high public demand for VCT services (as many clients came for VCT in the first months of 2003 as in the whole year of 2002) and the Global Fund resources would enable the Government of Eritrea and its stakeholders to meet that demand through expanded health infrastructure, improved quality of care and better referral mechanisms and integrated use of services.

The specific objectives are to:

a) **Increase the number of people who know their HIV status.**
b) **Establish/strengthen a highly accessible VCT system which offers anonymous and confidential VCT service to anyone who needs it, by increasing the number of freestanding VCT centres, improving the quality of VCT service provision and (either freestanding, NGO or facility-based), expanding affordable VCT services to other peripheral health facilities in non-public-health sector related sites: existing youth centres (8 youth centres provide reproductive health services in various towns of the country), military health services.**
c) **Develop non-health workers whole blood testing activities, with the PLHA BIDHO association and the National Eritrea Union of Youth and Students (NUEYS) and the military; train non-health workers on counselling and whole blood testing and set up a national quality control system with the CHL.**
d) **Create linkages and build networking capacity between VCT services and health and/or support services. These activities will increase the knowledge and motivation for utilizing Integrated Health Network services.**

Table IVA.26.2.2

Objective 2:	***Increase the number of people who know their HIV status by improving availability and quality of voluntary HIV counselling and testing (VCT)***				
Outcome/coverage indicators	***Base line***	***Targets***			
	Year: 2002	***Year 2: 2005***	***Year 3: 2006***	***Year 4: 2007***	***Year 5: 2008***
VCT OUTCOMES					
Number of clients receiving HIV testing in freestanding VCTs, facility-based voluntary testing settings, Youth centres, BIDHO and the military, and who know their HIV status	10 659	80 000 [22]	100000	120 000	150 000

26a.2.3. Objective 3. Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission (PMTCT)

PMTCT – The current situation. More than 2000 pregnant women are expected to be HIV positive, and a third of their children will be HIV positive without PMTCT intervention. National guidelines are available. A pilot project has started in Asmara on 3 pilot sites: Edagahamus hospital and the maternity and paediatrics wards of Mekane-Hiwot national referral hospital where respectively HIV positive mothers and children receive Nevirapine. Less than 10 mothers have actually received Nevirapine.

The specific objectives are to:
a) Integrate PMTCT activities in the safe motherhood package and primary prevention of HIV women of reproductive age, as antenatal visits provide an opportunity to promote VCT, identify STIs, encourage condom use and family planning, discuss post-natal feeding practices and safe delivery practices, both within and outside of health facilities,
b) Provide VCT service to antenatal clinic attendees and HIV positive mothers and newborns with short course of ARV therapy in regional referral services (6 regional hospitals). Counsel them on infant feeding options.
c) Develop linkages between PMTCT services and health care and/or support services, with special emphasis on involvement of people living with HIV and their families.

[22] In the first 3 months of year 2003 (year 1), more than 7 000 people came for voluntary testing nationwide, about 28 000 expected by the end of year 2003, so by the end of year 2, 80 000 expected individuals for VCT as VCT sites increase in numbers.

d) Train counsellors on children counselling and follow-up.

Estimates of target population for PMTCT programmes

Relying on the population distribution among regions/zobas in 1998 national figures, the distribution of the 3.5 million population of Eritrea among the zobas is the following:

Region/Zoba	Population
Anseba	**563 068**
Debub	**930 541**
Gash-Barka	**695 491**
Northern Red Sea	**565 505**
Southern Red Sea	**81 717**
Maekel (Asmara)	**663 677**

Expected pregnancies are 4.5% of the general population, therefore 157 500 nationwide in Eritrea.

- In Asmara-Maekel region, the population number is 663 677, so 29 866 expected pregnancies. According to the Demographic and Health Survey (DHS) 2002, 70% of pregnant women in this region attend antenatal care[23], so expected pregnant attendees are 20 906 in Asmara. If pre-test counselling is good, based on other countries experience, acceptance-rate for voluntary HIV testing will be around 75% (high estimate), so 15 680 women will be tested for HIV, among them 2.87% (HIV prevalence rate among pregnant women) are expected to be HIV+ = 450 HIV+ pregnant women Year 1.

- For all regions the expected estimates of HIV positive pregnant women and infants are as follows (if we apply 60% use of antenatal health services outside Asmara):

Region	Population	**Expected pregnancies 4.5%**	**Expected attendees** *if 60% use of antenatal services outside Asmara*	***Expected mothers to be tested*** *if 75% acceptance rate for voluntary testing:*	**Expected HIV+ attendees** ***x 2.87%***	**Expected HIV+ infants** *(MTC HIV transmission rate 30%)*
Anseba	563 068	25 338	15 203	11 403	328	99
Debub	930 541	41 875	25 125	18 844	541	163
Gash-Barka	**6 95 491**	31 298	18 779	14 085	405	122
Northern Red Sea	**5 65 505**	25 448	15 269	11 452	329	99
Southern Red Sea	**8 1 717**	3 678	2 207	1 656	48	15
Maekel Asmara	**6 63 678**	29 866	20 906	15 680	450	135
Total expectations	**3500 000**	**157 503**	**94 502**	**73 120**	**2 101**	**633**

Expectations for access to Nevirapine

The use of services for delivery is lower than for antenatal services. The DHS shows that 26% of births occur in health facilities nationwide. The expectation for mothers to receive Nevirapine is much higher in Asmara if we believe the data given by a preliminary study to the PMTCT pilot project, which showed that 90% of antenatal attendees deliver in hospitals.

[23] Final assessment report before PMTCT pilot sites implementation project.

The expectations for mothers to receive Nevirapine outside Asmara is low and should be improved by major interventions on maternal services, which are planned to be implemented nationwide with support of a USAID project.

Table IVA.26.2.3

Objective 3:	***Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission (PMTCT)***				
Outcome/coverage indicators	***Base line***	***Targets***			
	Year: 2002 [24]	***Year 2: 2005***	***Year 3: 2006***	***Year 4: 2007***	***Year 5: 2008***
PMTCT OUTCOMES					
Number of regions with at least one site offering PMTCT services (staff trained, equipment and drugs)	1 Asmara	3 (with Debub and Anseba)	4 Gash-Barka	5 Southern Red sea	6 Northern Red Sea
% of all antenatal attendees tested for HIV[25] / Absolute numbers	0	62% / 45 335[26]	81 % / 59 228	84% / 61 421	100% / 73 120
% of HIV+ women receiving ARV therapy to prevent mother to child transmission of HIV / Absolute numbers	8	70% / 1 471	80 % / 1 681	90% / 1 891	95% / 1 996
Numbers of babies born to HIV infected mothers who receive ARV therapy to prevention of MTCT	8	500	600	630	650

26a.2.4. Objective 4. Improve the availability and quality of health care and psychosocial and economic support for people living with and affected by the epidemic (PLHAs)

A. <u>Health care for HIV+ people – The current situation.</u> Guidelines for OI clinically based treatment are available and distributed in national and regional referral hospitals but not in other facilities; no clinical and biological follow-up is available for asymptomatic PLHAs. AIDS cases are not all diagnosed. AIDS cases from the military are not reported. Biological diagnosis for opportunistic infections at referral level is not available for major OI. Very few health workers have been trained in AIDS case management, mainly at national referral hospitals for adults and children. Prophylaxis treatment for OI is not prescribed. Several drugs for OI are not on the national essential drug list. ARV therapy is not available and biological follow-up (CD4 counts at least) is not available in the country. Care strategy and guidelines for ARV therapy are underway with a National Task force on access to ARV therapy set up. Integrated network use of services between VCTs, health services (STI and TB programmes and services) and support organisations is just starting in Asmara but the networks need to be strengthened and expanded outside Asmara.

[24] VCT baseline data is 2002 because VCT activities started being implemented in 2002.
[25] if 75% of acceptance rate and in Year 1.
[26] 75% of Asmara, Debub and Anseba pregnant attendees.

The specific objectives are to:

a) Develop a National Reference Lab at the CHL for STI, TB and HIV, including the biological diagnosis for common OI, ARV follow-up and resistance surveillance for TB, STI and HIV treatments. This is feasible in Eritrea because of a strong collaboration between the CHL in Asmara and the Retrovirology Laboratory of Washington University Medical Centre, St Louis, USA. Technical and scientific assistance is offered by the Washington University in the long run on all theses components;
b) Train health professionals of all adults and children services of regional hospitals, and of health centres, military personnel included, on EARLY diagnosis and treatment of OI of HIV including TB among HIV positive patients and at central level give access to diagnosis of severe OI, prophylaxis treatment for OI and ARV therapy and clinical and biological follow-up to 1800 patients by year 5. Integrate outpatient follow-up in referral health services at central and regional levels. There are no day-clinic *per se* but these services exist within the existing hospitals (outpatient clinics).
c) Provide community-based home care to complement traditional hospital care. Set up network referral services between health services and support organisations including in the military.

B. <u>Psychosocial and economic support for PLHAS – The current situation</u>. PLHA in Asmara benefit from support, including HBC and food distribution, mainly through NGOs, FBOs and the Ministry of Labour and Human Welfare (MoLHW). The BIDDHO association provides support to 3000 beneficiaries in Asmara. Income-generating projects have started at a small scale in Asmara (honey production, poultry). 719 AIDS orphans are supported by the MoLHW and for the majority living within their extended families.

The specific objectives are to:

a) Expand the capacity of BIDHO to respond to a rapidly increasing demand (in Asmara and in all regions) where it plans to open branches. Train members of BIDHO, NGOs and FBOs in HBC, food distribution, psychosocial support to PLHAs, including children.
b) Expand income-generating activities through BIDHO, NGOs, FBOs, and unions (youth, women, workers).
c) To create capacity at all levels to ensure the care and protection of the growing number of orphans and expand interventions to the 4 zobas not yet covered through existing funds.
d) Provide counselling and prevention services for PLHAs and their families.

Table IVA.26.2.4

Objective 4:	***Improve the availability and quality of health care and psychosocial and economic support for people living with and affected by the HIV epidemic***				
Outcome/coverage indicators	***Base line***	***Targets***			
	Year: 2003	***Year 2: 2005***	***Year 3: 2006***	***Year 4: 2007***	***Year 5: 2008***
HEALTH CARE					

National reference Lab for STI, TB and TB established in Asmara CHL with the technical and scientific assistance of the Retrovirology Laboratory of Washington University Medical centre	Quality control for HIV tests, (blood bank included) underway	Quality control for HIV tests, STI and TB; OI diagnosis and CD4 counts available	OI diagnosis; ARV biological follow-up at central level	HIV, TB & STI treatment resistance surveillance system set up	Viral load quality control
Number of people (adults and children) receiving treatment for OI, including in the military	12 to 15 per week	2000	3000	3500	4000
Number of people (adults and children) receiving prophylaxis for OI	400	3000	4500	6000	8000
Number of people receiving HIV/AIDS palliative care	100	1000	1500	2000	2500
Number of people receiving ARV therapy; adults and children	20 to 30	1200	1400	1600	1800
Number of referral hospitals with counsellors trained and specialized on children counselling	0	10	15	18	23
HOME-BASED CARE					
Number of people receiving HBC	3600	6 000	8 000	10 000	15 000
SUPPORT TO PLHAs					
Number of PLHAs receiving psychosocial support from BIDHO and FBO, or other	3500	5000	6000	7000	8000
Number of PLHAs enrolled in income-generating activities	0	1000	1500	2000	2500
Number of orphans receiving support	719	1500	2000	2500	3000

26a.2.5. Objective 5. Expand blood transfusion safety (HIV, Syphilis, Hepatitis B and C) to regional blood banks and establish procedures for, and ensure adherence to, universal precautions in the health care setting

A. <u>Blood transfusion safety – The current situation.</u> A National Blood and Transfusion Centre (NBTC) was built with the support of IDA funds and NORAD. National transfusion policy and guidelines are underway to avoid unnecessary transfusions. Paid donors are excluded and so are high-risk donors. Blood donor recruitment is difficult. There are very few regular donors. Blood is essentially drawn from low risk populations, such as students from Asmara's schools. 4000 units are distributed each year from the NBTC to referral hospitals. Blood provision is insufficient in regional MoH and military hospitals. Blood is screened at the NBTC for HIV, Syphilis, Hepatitis B and C. The prevalence for blood born diseases in 2002 are the following: HIV: 0.5%. Hep B : 3.5%, Hep C: 1.1% and Syphilis : 2.2%.

Regional hospitals have to rely on family donors to provide blood, which is tested only for HIV (rapid tests are available in all hospitals laboratories and laboratory technicians have been trained).

The specific objectives are to:

a) Create a regular blood donor pool and a donor association.
b) Screen blood units from regional and military hospitals blood banks for all blood borne infectious (HIV, Syphilis, HepB and HepC) before transfusion.

B. <u>Prevention of HIV transmission in health settings –The current situation.</u> The Ministry of Health has begun the process of developing universal precautions guidelines and procedures for use by health workers. Whole site trainings have been conducted among health teams in 9 out of 22 hospitals and is ongoing to target all hospitals, health centres and beyond. Infection committees are set up in the target hospitals.

A "*Health care wastes management assessment*" has just been done and recommendations are expected from a WB consultant report[27]. Guidelines for PEP and ARV prophylaxis for health workers are available but so far only 3 health workers have been exposed to accidental injury and have benefited from ARV therapy.

The specific objectives are to:

a) Protect the patients from getting HIV or TB infections in the health services, and to protect health workers from HIV, Hep B and C contaminated blood. A preliminary study on situation analysis of nosocomial infection by HIV and TB would be a start.
b) Train health workers on universal precautions and HIV PEP.
c) Improve availability of adequate waste disposal infrastructure in health facilities, including military hospitals, and follow recent recommendations made on health care wastes management, such as setting up one centralized incinerator in Asmara, equipping all zoba hospitals with pyrolytic incinerators, health centres and health stations with pits and other infrastructure health care wastes (expired drugs and sharps). The Global Fund could finance part of these infrastructure/equipment complementary to the HAMSET control project.
d) Provide all necessary commodities and gloves to enable staff to follow the recommended guidelines and procedures.

Table IVA.26.2.5

[27] Goitom Fitwi. Environmental health Unit/MOH. Highlight on the field trip report on health care wastes management and school sanitation assessment. April 24, 2003.

Objective 5:	Expand blood transfusion safety (HIV, Syphilis, Hepatitis B and C) to regional blood banks and establish procedures for, and ensure adherence to, universal precautions in the health care setting					
Outcome/coverage indicators	Base line	Targets				
	Year: 2003	Year 2: 2005	Year 3: 2006	Year 4: 2007	Year 5: 2008	
Number of units of blood screened for HIV	4 000	4 500	5 000	6 000	7 000	
% of health facilities with guidelines to prevent nosocomial transmission of HI, written protocols for PEP, adequate sterilization procedures and surgical gloves in stock	1 national referral hospital	23 MoH hospitals + 5 military hospitals	50 health centres + 25 military health centres	PEP can not be implemented at health station level		
Number of HIV exposed health workers who received counselling and PEP	4	150	100	100	100	

26a.2.6. Objective 6. Strengthen and expand epidemiological and behavioural surveillance for evidence-based planning

Monitoring and surveillance – Background. There is a strong foundation for carrying out routine monitoring and surveillance for clinical services in Eritrea. In addition, the Integrated Disease Surveillance and Response Unit is establishing training methodologies and procedures for monitoring the occurrence of notifiable and reportable diseases. NACP carried out sentinel surveillance for HIV in 17 antenatal clinics in 1999. Due to the conflict situation, this activity was not continued. However, a new system has been established with 12 sites – one urban centre and one rural centre in each of the six zobas. Specimen collection is ongoing in May 2003.

Monitoring and surveillance – Next steps. In order to meet the needs of second generation surveillance, Eritrea also needs to collect biological and behavioural data in addition to antenatal sentinel surveillance clinic surveys. Components for which Global fund assistance are requested include:

- ***HIV seroprevalence studies in TB patients and STI clients.***
- Number of adult AIDS cases and paediatric AIDS cases.
- ***STI: Gonorrhoea antibiotic sensitivity, and STI prevalence and aetiology studies in antenatal clinic women, CSWs and the military.***

Outline of Second Generation Surveillance[28]

Goals of second generation surveillance systems

Better understanding of trends over time – Better understanding of the behaviours driving the epidemic in a country – Surveillance more focused on sub-populations at highest risk of infection – Flexible surveillance that moves with the needs and state of the epidemic – Better use of surveillance data to increase understanding and to plan prevention and care

[28] from Second generation surveillance for HIV: The next decade (WHO/CDS/CSR/EDC/ 2000.5, UNAIDS / 00.03E)

Major indicators used in HIV surveillance

1) Biological indicators

HIV prevalence – STI prevalence – TB prevalence – Number of adult AIDS cases –Number of paediatric AIDS cases.

2) Behavioural indicators

Sex with a non-regular partner in the last 12 months – Condom use at last sex with a non-regular partner – Youth: age at first sex – Sex workers: Reported number of clients in the last week.

3) Socio-demographic indicators

Age – Sex – Socioeconomic and educational status – An indicator of residency or migration status – Parity (for antenatal sites) – Marital status.

Second generation surveillance systems should:

Be appropriate to the epidemic state – Be dynamic, changing with the epidemic – Use resources where they will generate most useful information – Compare biological and behavioural data for maximum explanatory power – Integrate information from other sources – Use data produced to increase and improve the national response.

Eritrea meets the criteria for a generalized HIV epidemic

• Principle: In generalized epidemics, HIV is firmly established in the general population.
Although sub-populations at high risk may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection.

• Numerical proxy: HIV prevalence consistently over one percent in pregnant women.

Surveillance in generalized epidemics

Key questions for surveillance in a generalized epidemic

• What are the trends in HIV infection?

• To what extent do trends in behaviour explain trends in prevalence?

• Which behaviours have changed following interventions and which continue to drive the epidemic?

• What impact is the epidemic likely to have on individual, family and national needs?

Recommendations for surveillance in generalized epidemics

• Sentinel HIV surveillance among pregnant women, urban and rural.
• Cross-sectional surveys of behaviour in the general population.
• Cross-sectional surveys of behaviour among young people.
• HIV and behavioural surveillance in sub-populations with high-risk behaviour.
• Data on morbidity and mortality.

The gap – Very little HIV prevalence, STI prevalence, sexual risk behaviour or STI surveillance data is available. There is an absolute need to gather this information in a replicable way, in order to monitor the epidemic and our prevention and mitigation activities.

Table IVA.26.2.6

Objective: 6	***Strengthen and expand epidemiological and behavioural surveillance for evidence-based planning***				
Outcome/coverage indicators	***Base line***	***Targets***			
	Year: 2002	***Year 2: 2005***	***Year 3: 2006***	***Year 4: 2007***	***Year 5: 2008***
Percentage of health facilities submitting complete and timely HMIS reports every month in the last 12 months	92%	94%	96%	98%	100%
Number of zobas conducting quarterly HIV review and planning meetings with health personnel	6	6	6	6	6
Number of HIV special studies (seroprevalence, biological, behavioural, or qualitative) conducted	1	5		5	

Percentage of health facilities offering HIV-related services that received at least one supervisory visit in the past three months to assess quality of care, including case management and drug/supply inventory	30%	40%	50%	60%	70%
Number of facilities that are included in the ANC sentinel surveillance	12	12	15	15	15
Number of zobas (zones) using a computerised system for monitoring & reporting surveillance data	6	6	6	6	6

ACTIVITIES AND PROCESS/OUTPUT INDICATORS

26a.3. Broad activities related to each specific objective and expected output (Describe the main activities to be undertaken, such as specific interventions, to achieve the stated objectives)

26a.3.1. Broad activities related to Objective 1. Scale up and expand effective HIV prevention activities in target populations

Prevention Strategies

- Prevention strategies employed in the military and CSW groups are principally: improved condom knowledge and access, peer education for BCC, and improved sexual health care.
- Prevention strategies for STI clients include improved sexual health care, condom access, partner referral and behaviour change communication.

A paragraph outlining the rationale for each of these approaches for HIV prevention among high-risk groups follows.

Behavior Change Communication (BCC) is an interactive, community-driven process to develop tailored messages and approaches using various communication channels to develop positive behaviors; promote and sustain individual, community and societal behavior change; and maintain appropriate behaviors. Before they can reduce their risk and vulnerability to HIV, individuals and communities must understand the urgency of the epidemic. They must be given basic facts about HIV/AIDS, taught a set of protective skills and offered access to appropriate services and products. They must also perceive their environment to be supportive of changing or maintaining safe behaviors. As HIV is primarily a sexually transmitted infection, this requires national and community discussions on sex and sexuality, risk, risk settings and risk behaviors. It also means dealing at the national and community levels with the resulting stigma, fear and discrimination. The HIV/AIDS epidemic forces societies to confront cultural ideals – and the practices that clash with them. BCC is vital to this process and can set the tone for compassionate, responsible interventions. It can also produce insights into the broader socio-economic impacts of the epidemic. BCC is most effective when integrated into an overall program.

Peer education. Peer education programs provide an ideal environment for the types of interactive learning environment for BCC outlined above. Combining peer education and service delivery interventions are synergistic and result in higher condom use and lower STI prevalence.

Control of STIs. More than 300 million new cases of curable sexually transmitted infection (STI) occur each year, with a global distribution much like that of HIV. There are a few large-scale interventions that demonstrate the potential impact of STI control on HIV transmission. In less than five years, Thailand reduced the incidence of curable STI by more than 80 percent through a comprehensive effort that included both improved STI treatment and targeted promotion of condom use in commercial sex establishments (100 percent condom policy). HIV prevalence, which had been increasing rapidly, began to fall during this period. Through sustained application of these interventions, Thailand stabilized HIV transmission early and averted a far more extensive epidemic. There is also evidence that more limited STI interventions can reduce HIV transmission.In rural Mwanza, Tanzania, improving the case management of STI through the syndromic approach in clinics reduced the incidence of new HIV infection by 40 percent. In contrast, the mass antibiotic treatment of the sexually active population at nine-month intervals in Rakai, Uganda, neither reduced most curable STI nor lowered the rate of HIV transmission. We

attribute these differences mainly to the stage of the epidemic and the underlying prevalence of curable STI and high-risk behaviour in the population. Experience in STI control programming teaches us that reducing high rates of STI requires a comprehensive strategy of both prevention and management. This includes such well-known aspects of STI control as ensuring effective diagnosis and treatment, encouraging treatment adherence and partner treatment and avoiding re-infection. But it is equally important to pay attention to who uses existing clinical services and who does not. Even the most technologically advanced services will have little impact on STI prevalence if there is poor access to those services. One of the greatest challenges in STI control is making sure that effective services reach the people most frequently exposed to infection and who have the most frequent opportunities to pass on infection to others.

Promotion and provision of condoms as the best protection against infection. The goal of 100% barrier protection is supported by improving access to male and female condoms and lubricants, and creating a supportive environment for their use. Peer educators can teach practical condom negotiation skills, and strategies to reduce accidental or deliberate condom breakage. Condoms can be made available through accessible outlets such as bars and brothels, by direct social marketing and through peer networks.

TableIVA.26.3.1

Objective 1:	***Scale up and expand HIV prevention activities in target populations***				
Main activities	***Process/Output indicators***	***Base line***	***Targets***		***Responsible/ Implementing***
	*(indicate one per activity; r*efer to Annex A)	***(Specify year)***	***Year 1 2004***	***Year 2 2005***	***agency or agencies***
Military					
Update BCC training literature for military	# of IEC brochures produced		60,000		EDF
Train and supervise male and female peer health educators in military	# of youth peer educators trained		300	300	EDF
Train youth in safer sex in the military	% of persons aged 15-24 with correct knowledge of two out of the three main methods of HIV prevention		40	100	EDF
Hold demobilisation planning for 15-24 year-olds in the military	# of demobilised youth receiving training		50 courses	50 courses	EDF
Improve condom access in the military	# of female condoms distributed		2,000	4,000	EDF
Conduct training for clinicians in the military on STI syndromic management	# of clinicians trained		50		EDF, MoH
Female partners of the military					
Prepare BCC training literature for female partners of military	# of IEC brochures produced		10,000		MoLG, MoH
Train and supervise MoLHW health educators	# of educators trained		100		MoLG, MoH
Educate women in HIV transmission risk and prevention	# of HIV prevention sessions held, including condom demonstrations, with female partners of the military		100	200	MoLG, MoH

Conduct VCT demobilisation preparation training	# of military couples accessing VCT		100	100	MoLG, MoH
CSWs					
Update BCC training literature for CSWs	# of IEC brochures produced		10,000		MoH, MoLHW, NUEYS, NUEW, NCEW, ESMG/PSI, MoE, NCEW
Train and supervise CSW peer health educators	# of CSW peer educators trained		50		MoH, NUEYS, NUEW, ESMG/PSI, MoLHW, NCEW, MoLG
CSW HIV prevention contacts, including condom demonstrations and distribution	# of HIV prevention sessions held, including condom demonstrations, with CSWs		100	200	MOH, NUEYS, NUEW, ESMG/PSI, MoLHW, NCEW, MoLG
Improve condom access	# of condoms distributed*		5,000	10,000	ESMG/PSI, MoH, MoLHW, Pharmecor
STI Clients					
Update BCC training literature for STI clients	# of IEC brochures produced		20,000		MoH, MoLHW, NUEYS, NUEW, NCEW, ESMG/PSI, MoE, NCEW
Carry out HIV prevention interventions, including condom demonstrations and partner referral	# of HIV prevention sessions held, including cCondom demonstrations, with STI clients		200	1,000	MoH, MoLHW, NUEW, NUEYS, ESMG/PSI, FRHAE, NCEW
Improve condom access	# of condoms distributed*		4,000		ESMG/PSI, MoH, NUEYS, Pharmecor
Train civilian clinicians on STI syndromic management	% of STI clients appropriately diagnosed and managed		20		MoH, MoLHW, NUEW, NUEYS, ESMG/PSI, FRHAE, NCEW

*With Global Fund sponsorship

26a.3.2. Broad activities related to Objective 2. Increase the number of people who know their HIV status by improving the availability and quality of voluntary counselling and testing (VCT)

The demand for VCT in Eritrea is rapidly increasing: in the first 3 months of 2003, there were almost as many clients coming to VCT sites countrywide (either freestanding or facility-based) than in the whole year 2002. As the VCT sites are going to be diversified, and the needs include the military (250 000 young men and women), the target numbers for VCT activities are rapidly increasing as can be seen in the table below.

As described earlier, human resource in the health sector are very limited, so existing health workers from all hospitals and health centres will be trained as counsellors (even if they are not appointed as full time counsellors). It is also relevant to train non-health workers from youth organisations (in the existing reproductive health youth centres) and PLHAs from BIDHO, as well people from the military, to run VCT activities under the supervision of the MoH and quality control for testing from the CHL.

Full time counsellors will then be trained for 6 weeks (3 weeks theory and 3 weeks practice on an existing VCT site). Current VCT data is compiled at NATCoD

level but should benefit from existing HIMS of IDSR reporting systems for HIV. Refer to activities (objective 6 cross-cutting).

It is essential that testing services remain voluntary and confidential. Staff training and supervision are key elements in ensuring quality of counselling and testing. As part of their training, all VCT staff will be sensitised in youth and gender issues, and STI early diagnosis and treatment services will be provided together with condom distribution.

HIV positive VCT clients will be referred to health services for follow-up and further counselling. All clients can be referred to PLHA and support organisations.

Table IVA.26.3.2

Objective 2:	***Increase the number of people who know their HIV status by improving the availability and quality of voluntary counselling and testing (VCT)***					
Main activities	**Process/Output indicators**	**Baseline**	**Targets**			**Responsible/ Implementing**
	(indicate one per activity; refer to Annex A)	**(Specify year) 2003**	**Year 1 2004**		**Year 2 2005**	**agency or agencies**
VCT						
1. Establish freestanding VCT centres in all regions	Number of freestanding VCTs in the country	2	3		4	NATCoD/MoH and MoH at regional levels
2- Set-up VCT facility based in the hospitals and health centres	Number of health services offering VCT services	23[29]	+ 20 health centers		+ 30 health centers	NATCoD/MoH and MoH at regional levels
3- Set-up VCT sites in the military	Number of military facilities offering VCT services	5	10		15	EDF
4- Set-up freestanding VCTs in youth centres and BIDHO	Number of VCT set-up in youth centres + BIDHO sites	0	4		7	NUEYS, BIDHO, NATCoD/MoH
5- Provide rapid tests to all VCT sites including confirmatory tests	HIV tests available on all sites	22 200 military non included	60 000 military included		80 000 military included	Pharmecor, MoH/Procurement unit, NATCoD, EDF
6- Provide Elisa tests to Zonal and referral hospitals for quality control of HIV tests	20% of rapid tests controlled by Elisa testing at CHL	4 440 Elisa tests	12 000 Elisa tests		16 000	Zonal and referral hospitals
7- Train health workers and non-health workers on counselling and testing, military included	Number of VCT counsellors trained among non-health workers, health workers, including the military	160	+ 75 235		+ 75 = 310	NATCoD/MoH CHL/MoH EDF
8- Train VCT supervisors	Number of supervisors trained	6	20		40	NATCoD/MoH and MoH regional level

[29] 22 public hospitals and 1 faith-based health center.

	9- Train laboratory technicians or health workers on HIV testing in all hospitals and MoH and EDF health centres labs	All lab technicians trained, out of nursing school lab training included	127	+ 40	+ 40	CHL/MoH EDF
	10. Recruit and hire non-health workers to run unions' nd association-based VCT centres	Non-health workers hired as counsellors	0	+ 60	+30	MoH

26.3.3. Broad activities related to Objective 3. Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission (PMTCT)

The activities in PMTCT pilot sites in Asmara are progressing slowly. Guidelines for PMTCT are available and should be widely distributed. Overall projections of HIV+ pregnant women and children are quite low (see tables under 26.2.3.) as the HIV prevalence among pregnant women baseline data is under 3%.

Nevertheless the demand is rising from both health workers and mothers in Keren regional hospital (Anseba region) and in Mendefera (Debub region) at the MCH clinic where VCT services are already offered. As these 2 regions have high numbers of population, PMTCT can be decentralised successfully and then be gradually implemented in all regions. As we can see 2101 HIV+ mothers are expected to give birth to around 600 children HIV+ in a year. Infant formula should be available year 1 under Global Fund requested funds and year 2 provided by UNICEF.

Care and support for HIV+ mothers and children is included in Objective 4 related activities. Counsellors trained and specialized in children counselling are needed.

Table IVA.26.3.3

	Objective 3:	***Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission (PMTCT)***				
	Main activities	***Process/Output indicators***	***Baseline***	***Targets***		***Responsible / Implementing***
		*(indicate one per activity; r*efer to Annex A)	***Year 2003***	***Year 1 2004***	***Year 2 2005***	***agency or agencies***
PMTCT	1. Integrate PMTCT to chosen antenatal sites and all regional hospitals	PMTCT services with trained staff, tests and ARV therapy in 6 regions	1 pilot site	2 Asmara + Debub	3 + Anseba	NATCoD, Region/MoH, Mekane Hiwot Maternity and Paediatrics referral hospitals

	2. Provide HIV test supplies and Syphilis tests to all PMTCT sites including HIV confirmatory rapid tests	Tests available on all PMTCT sites	10 000 HIV in Asmara pilot sites	HIV tests: 37 000[30] Syphilis tests= 35 000	HIV tests= 50 000 Syphilis tests= 46 000	Pharmecor, NATCoD, Region MoH
	3. Train health workers in antenatal and hospitals to PMTCT activities	250 health workers trained among 6 regions health facilities	20	100	150	NATCoD, Region/MOH, Mekane Hiwot Maternity and Paediatrics referral hospitals
	4. Provide ARV therapy to HIV pregnant women at delivery	% of HIV+ mothers receiving ARV therapy		50%[31] 500	70% 950[32]	Pharmecor, NATCoD and regional level of MoH
	5. Provide ARV therapy to newborns	Number of babies born from HIV infected mothers who receive ARV		500	950	NATCoD, regional MoH
	6. Provide infant formula	500 per year distributed		500	900	Pharmecor, MoH
	7. Developing and disseminating IEC and BCC materials for pregnant women and HWs	Guidelines and IEC materials distributed to health facilities and referral regional hospitals PMTCT sites		50% of health facilities covered	70% of health facilities covered	IEC/MoH, NATCoD, Private supplier
	8. Provide syphilis treatment for syphilis reactive pregnant women	Number of syphilis reactive pregnant women receiving treatment		500	1000	MoH, National referral hospitals, Regional hospitals
	9.Provide materials for safe obstetrics procedures	Number of PMTCT sites equipped with essential obstetric care materials		10 PMTCT	20	MoH, Zones
	10. Provide peer group support for HIV infected mothers	***This is planned under Objective 4 activities*** Care and Support				

26a.3.4. Broad activities related to Objective 4. Improve the availability and quality of care and psychosocial and economic support to people infected and affected by the epidemic (PLHAs)

The activities planned under this objective include the military population as a whole (national service recruits included) during year 1 and year 2. Even if border demarcation is successful, demobilization will be a slow and progressive process over several years.

Much work remains to be done in the field of AIDS case clinical management and follow-up. Guidelines for clinical AIDS management are available, but not widely distributed. Currently only a few patients are receiving treatment for OI. Few patients are receiving prophylaxis treatment in the public sector (400 patients) and in the military where they provide Cotrimoxazole prophylaxis to some HIV+ patients; health workers have been trained on a limited scale – mainly in Asmara – and no supervision has been implemented at regional levels.

The activities planned are divided into 3 components:

[30] 34 524 expected mothers to be tested in Asmara and Debub regions and 5% confirmatory tests= 36 250 tests + waste.
[31] Use of delivery services is very low in the country outside Asmara. Expected HIV+ mothers are 991 between Asmara and Debub year 1.
[32] with Anseba included year 3 and 70% of them receiving ARV therapy.

(1) **Establish a national reference laboratory for HIV, TB and STI at the CHL**, including OI diagnosis at central referral level, drug sensitivity, ARV biological follow-up and resistance surveillance for the 3 diseases (outcome Year 4). Setting-up a national reference laboratory for the 3 diseases is feasible because of the existing strong scientific collaboration between the CHL and the *Washington University Retrovirology Laboratory, St Louis, USA* committed to back-up the CHL HIV/AIDS, STI and TB related activities, and to an existing human resource capacity and infrastructure (Microbiology equipment and trained staff already in place):

a) Strengthening the existing Microbiology capacity of the CHL to perform aerobic and anaerobic bacteriology, to diagnose OI such as Pneumocystis carinii pneumonia (PCP), Cryptococcal meningitis, Toxoplasmosis or Campylobacter and Cryptosporidiosis diseases and to test drug susceptibility. Specific biological diagnosis for OI could be available at least at national referral level in Asmara to start when symptomatic treatment based on clinical guidelines fails or drug resistance occurs.
b) Establishing CD4 testing and HIV RNA viral load. FACScount equipment can be procured and quality control done attached to a neighbouring country reference laboratory, while viral load will be done at the US Virology Laboratory. Antigen p24 could be made available also for diagnostic purposes among children.
c) Setting up a quality control system with the *Retrovirology Laboratory in Washington University* with regard to HIV testing, CD4 counting, Microbiology and later on HIV RNA viral load.

These activities require remodelling and refurbishment of the current infrastructure of the CHL as a prerequisite to start expanding microbiology and virology activities. These infrastructure costs are covered by the HAMSET control project and will be implemented in 2003.

Preliminary studies like, the *In-country evaluation of HIV Rapid and Elisa tests* on a panel of samples, *Aetiology of STI infections and drug sensitivity*, and *Aetiology of OI infections and drug susceptibility,* can also be funded through the HAMSET control project.

(2) **Improve coverage and quality of care for AIDS patients, adults and children.**

a) Develop good quality clinical AIDS case management teams for OI in all hospitals – children and adults, military included (26) – and ambulatory care in hospitals and health centres (75) including HIV+ pregnant mothers after delivery and their infants; ambulatory care will be integrated to existing outpatients services – no creation of new day-care clinics. Since HIV/AIDS, STI and TB have been introduced in the curriculum of health care providers, the pool of trained personnel will increase in the coming years upon the graduation of the students presently in the professional training. Specialized children counsellors will be trained in existing health services among existing human resources in all hospitals.
b) Increase knowledge of health workers on prophylaxis treatment of OI and the number of HIV positive adults and children benefiting from these policies. Elaborating clear guidelines on OI prevention, TB included.
c) Offer access to ARV therapy for at least 1800 eligible patients over the 5 years. This will still leave a number of Eritreans out of ARV therapy, but the targets should be reasonable as human resource shortage is an impediment to ensure quality of follow-up. As the demand increases through VCT and PMTCT services, difficult decisions about allocation of expensive resources (though decreasing of prices is observed and will continue both on drugs and biological follow-up) may be necessary. A selection committee will be set up. Medical criteria will help the decision making process so that those in most and urgent need are served first. The members of the national ARV therapy task force have gone on a study tour to Uganda to learn from Uganda's experience in launching access to ARV therapy. Links between the 2 countries can be strengthened both on training and quality control. A *National Access to ARV Task Force* has been set up at central level, and is currently working on various issues such as eligibility criteria for patients and pilot sites identification; training tools and guidelines to be developed; cost-sharing mechanisms to sustain the activity (for those who can afford to pay), and the like (please refer to attachment). Provision of ARVs will be expanded in one or 2 other regions far from Asmara, as resources become available and expertise in their use grows. Quality control for CD4 counts can be established with a

reference laboratory in a neighbouring country at first and later on (by year 3 or 4) HIV RNA viral load assays performed at CHL with quality control by the *Washington University Retrovirology Laboratory.*

(3) **Provide home-based care and economic and social support to PLHAs, adults and children.**

a) Develop and disseminate guidelines and training tools for HBC.
b) Expand institutional capacity building for PLHAs organisations and regional branches.
c) Develop network relations between VCT sites, PMTCT sites, in and out patients health services, support organisations to provide a comprehensive care for PLHAs, including orphans. PLHA support groups will be offered in outpatients sites as experience has shown that patients attending health services appreciate the convenience and professional support associated with services offered at the health facility. PLHA s will be encouraged to be more involved in testing and counselling, PMTCT, HBC and support related activities as educators and counsellors.
d) Expand income-generating projects outside Asmara.
e) Support orphans, their foster families and existing group homes.

Table IVA.26.3.4

	Objective 4:	Improve the availability and quality of care and psychosocial and economic support for PLHAs				
	Main activities	**Process/ Output indicators**	**Baseline**	**Targets**		**Responsible/ Implementing**
		(indicate one per activity; refer to Annex A)	**(Specify year) 2003**	**Year 1 2004**	**Year 2 2005**	**agency or agencies**
Establish at CHL a national reference laboratory for STI, TB and HIV	1. Expand and improve quality control for HIV, Syphilis, TB and other opportunistic infections diagnosis	Quality control organised for India Ink stains and acid fast stain of stool, TB and syphilis biological diagnosis	Not available	QC done in all national referral hospitals And Military included	QC done at regional hospitals	CHL/MoH
	2. Provide reagents for biological diagnosis of HIV/AIDS related OI, TB and STIs	Lab diagnosis available for major OI in Eritrea at central referral level when clinical treatment fails	Not prescribed by hospital clinical teams	Biological diagnosis available for OI for Asmara National referral hospitals	Biological diagnosis available for OI in regional hospitals	Pharmecor, CHL, MoH/Zone
	3. Provide equipment to perform CD4 counts and viral load at CHL	Equipment available at CHL	0	Equipment available at CHL to perform CD4 counts	Equipment available at CHL to perform viral load	CHL, MoH, Pharmecor
	4. Provide reagents and other supplies to perform CD4 counts and viral load	Reagents available at CHL	0	CD4 counts performed for 400 patients follow-up	CD4 counts performed for 800 eligible patients	CHL, MoH, Pharmecor
	5. Provide basic biological check up for patients under ARV therapy at least 4 times a year	Number of people under ARV tested for liver and kidney functions, blood cells, etc.	0	1600 lab check up	3200 lab check up	CHL, MoH/Zones

6. Train Lab technicians from CHL to perform CD4 counts and viral load tests	Lab technicians at CHL trained	0	3 Lab technician trained on CD4 counts at CHL	3 Lab technicians trained to perform viral load tests	CHL, Pharmecor
7. Train Lab technicians at CHL, national and regional referral labs on OI and STI diagnosis	Diagnosis capacity for OI and STI available at CHL, national and regional hospitals labs	Diagnosis available for Cryptococcus, TB and STI	Lab technicians trained at CHL on other OI diagnosis methods	Lab technicians trained in regional hospitals	CHL, MoH/Zones
8. Establish external quality control for CD4 counts with a Reference lab neighbouring country and viral load with Washington University	Quality control system for CD4 counts established	0	80 samples sent	160 samples sent	CHL, Reference Lab in neighbouring country
9. Recruit and hire laboratory technicians	30 Lab technicians hired	127	+ 12	+ 20	MoH, CHL

Scale up clinical AIDS case management in hospitals and ambulatory health centres settings including the military	1. Train core teams of HWs in all hospitals and health centres on prevention, diagnosis, and AIDS case management	- 250 HWs trained in hospitals - 250 HWs trained in ambulatory care	- 30 HWs trained on clinical AIDS case management	60 HWs trained in national and referral hospitals	100 HWs trained including 20 health centers	NATCoD, NRH, Halibet hospital, Orota hospital
	2. Increase the capacity of HWs to give preventive treatment for OI and provide Cotrim and INH	% of children and adults receiving prophylaxis treatment for OI	-0 adult -600 children AIDS cases are under Cotrim	-2500 adults -800 children	-3000[33] adults 1000 childre n	NATCoD, NRH, Halibet hospital, Orota hospital
	3. Ensure availability of Drugs to treat OI	Fluconazole, Ketoconazol e, Pentamidine, etc. not available	15 to 20 per month in 1 national referral hospital	800 patients receivin g care for OI	2000	Pharmecor
	4. Ensure availability of ARV drugs for 1800 eligible patients children and the military included	1800 patients adults and children treated under ARV therapy and followed-up	- 0 adult - 0 child No ARV	800	1200	Pharmecor and Pharmaceutical services/MoH
	5. Train counsellors on Children counselling in all hospitals	One counsellor specialized in all hospitals on Children counselling	0	5	10	NATCoD/MoH, Region MoH, Mekane Hiwot referral Paediatric hospital
	6.Build up a continuum of care and support for HIV+ patients and their families	-% of VCT HIV + people referred to health services - % of VCT clients or facility patients referred to support organisation s	10% 700	25% nationwi de	50%	NATCoD/MoH, MoLHW, NGOs, BIDHO, FBOs
	7. Provide palliative care for AIDS patients	Number of patients receiving palliative care	NA	800	1000	MoH/Zones, National and regional referral hospitals

[33] By year 2 of the programme, 3% of 80 000 VCT clients and 1652 mothers will be HIV+, plus patients, around 3000 diagnosed people will need prophylaxis for OI.

	8. Train core trainers of health workers on palliative care		Number of palliative care teams in regional and national hospitals	0	10	20	MoH/Zones, NATCoD

Provide Home-based care to PLHAs adults and children	1. Provide Home-based kits to NGOs involved in HBC	Number of HBC kits provided in all zones	300 in 2 regions	500	800	NATCoD/MOH, MoLHW, BIDHO
	2. Train NGOs volunteers in HBC including BIDHO [34]	Number of volunteers trained and involved in HBC activities	80	300	300	NATCoD, MoLHW, BIDHO
	3. Provide funds to FBOs and NGOs and BIDHO to implement HBC activities	Percent of patients enrolled in HBC who have received at least 3 HBC visits in last month	NA	Grants provided to BIDHO & FBO	Grants provided to NGOs and Unions	MoLHW
	4. Train HBC nurse supervisors	MoH/Zones NATCoD	1	12	8	MoH, NATCoD
	5. Provide motorcycles to HBC supervisors	Number of motorcycles provided	0	12	24	MoH
Support to PLHAs	1. Foster the emergence of associations of PLHA outside Asmara in all regions	Number of BIDHO branches in the country	1	3	4	BIDHO, NATCoD/MoH, FHI
	2. Develop management capacity of PLHA associations (administration, HR development, transportation)	Technical assistance provided to BIDHO	-	Contract with private provider	Contract with private provider	BIDHO, NATCoD/MoH, FHI
	3. Develop service delivery capacity for PLHA association and branches	Number of PLHA trained and active in service delivery (HBC, support, counselling and advocacy)	15	50	100	BIDHO, NATCoD
	4. Train members of BIDHO, FBO, NUEYS, NUEW, NCEW, to provide psychosocial support and counselling to PLHA, their families and orphans	Number of PLHAs receiving support from an NGO; FBOs, MoLHW, or BIDHO	3500	4000	5000	BIDHO, NGOs, MoLHW, EDF

[34] Volunteers trained can be trainers year 2.

	5. Train service providers (school teachers, HWs) to better care for and protect orphans and vulnerable children	Service providers trained and equipped with required skills to care and support orphans (all orphans are integrated, war, other affected or infected)	NA	150	300	MoE, MoH, MoLHW
	6. Provide community with skills for income generating activities and facilitate links with microfinance institutions	Number of PLHAs enrolled into income generating projects	0	500	1000	BIDHO, MoLHW, MoH, FBOs, NGOs
	7. Provide small grants to NGOs working with children to ensure basic needs of orphans are met	Number of children supported	719	1000	1500	BIDHO, FBOs, NGOs, MoLHW
	8. Facilitate access of needy PLHAs adults and children and families to food	Number of beneficiaries of food distribution	3000	4000	5000	FBOs, BIDHO

26a.3.5. Broad activities related to Objective 5. Expand blood transfusion safety (HIV, Syphilis, Hepatitis B and C) to regional blood banks and establish procedures for, and ensure adherence to, universal precautions in the health care setting

Blood transfusion safety. Create a regular pool of blood donors and a blood donor association. Screen blood units from regional and military hospitals for HIV, Syphilis, Hepatitis B and C.

Universal precautions. Although National guidelines and procedures for universal precautions are available at national level, whole site trainings has been carried out in only 9 out of 23 hospitals. No training at all has been carried out in all the other health facilities. PEP guidelines, procedures and protocols can be disseminated and health workers trained. The MoH/Environmental Division assessed hospital waste management situation in April and recommendations have been made to equip the hospitals with incinerators.

Table IVA.26.3.5

Objective 5:	***Expand blood transfusion safety to regional blood banks and establish procedures for, and ensure adherence to, universal precautions in the health care setting***				
Main activities	***Process/ Output indicators*** *(indicate one per activity;* refer to Annex A)	***Base line (Specify year) 2003***	***Targets Year 1 2004***	***Year 2 2005***	***Responsible /Implementing agency or agencies***
Blood transfusion safety 1. Strengthen the blood donor recruitment program	Number of regular donors	NA	4 000	5 000	National Blood Banc Centre, Regional hospitals

			2. Train zonal hospitals laboratory technicians to test blood for HIV, Syphilis, Hepatitis B & C	Number of hospitals laboratories testing blood for the 4 diseases	5	10	20	NBTC, CHL, NATCoD
			3. Provide HIV, Syphilis, Hepatitis B & C test reagents, kits and supplies, to regional and military hospitals	Number of tests provided	0	2 000	2 000	Pharmecor, MoH/Zones
	Universal precautions		1. Carry out whole site trainings in hospitals and health centres throughout the country	Number of hospitals and health centres reached by the trainings	9	15 MoH hospitals + 3 military hospitals	22 MoH hospitals + 5 military hospitals	MoH/QA, NATCoD, MoH/Zones
			2. Carry out a needs assessment study in hospitals and health centres military included	Needs for implementation of universal precautions identified	No baseline data			MoH/QA, NATCoD
			3. Provide complementary gloves and commodities to health facilities	Number of health settings provided with posted guidelines and procedures and relevant commodities without stock-outs	9	22 Hospitals	22 health centres	Pharmecor, MoH/Zones
			4. Provide waste management equipment in all hospitals	Number of hospitals equipped	0	9	20	MOH/Environmental health, NATCoD
			5. Train core teams of trainers on universal precautions	Number of core teams trained	9	66	120	MoH/QA, MoH/Zones
	PEP		1. Provide health services with guidelines on accidental transmission of HIV and a written protocol for PEP	Number of facilities with posted guidelines on accidental transmission of HIV and a written protocol for post-exposure prophylaxis	1 site	17 hospitals, military included	23 MOH hospitals + 5 military hospitals	MoH/QA, NATCoD, EDF

	2. Train a core team for HIV-exposed health worker counselling, testing and ARV prophylaxis treatment in regional and military hospitals		Number of HIV exposed health workers who received counselling and Post-exposure prophylaxis ARV therapy	3 patients exposed	20	50	MoH/QA, NATCoD, EDF
	3. Provide ARV therapy for HIV-exposed health workers		Number of exposed health workers who received ARV therapy	3	50	100	MoH/QA, NATCoD, Pharmecor

26a.3.6. Broad activities related to Objective 6. Strengthen and expand epidemiological and behavioural surveillance for evidence based planning

Planned activities

HIV seroprevalence (WHO Protocols)

Periodicity : Annual

- Antenatal
- TB patients
- STI clients

Behavioural surveillance

- BSS (FHI/WHO/UNAIDS protocol) – 2004 and 2007*
- DHS (MACRO) – 2007*

*These studies will be funded by FHI/USAID and MACRO/USAID, respectively

HIV and STI Prevalence Surveillance (see appendices *-** for draft summaries)

2004 and 2007

- Gonorrhoea antibiotic sensitivity
- HIV prevalence and STI prevalence and aetiology studies
  - Antenatal
  - CSW
  - Military
- ***Institutional Infection Control Study***
  Quality assurance guidelines for infection control in health care facilities have been drawn up and disseminated. A study will be carried out to measure coverage of the recommended procedures in 2004, and repeated in 2007.

The gap – The above studies would give Eritrea a fuller picture of the HIV epidemic, and enable repeated measurement of outcome and impact indicators on standardised samples of high risk and vulnerable populations.

NB. It must be noted that while the special studies are budgeted and planned for 2004 and 2007, in order to give outcome and impact indicators during the life of the project, it is likely that some will be re-scheduled into 2005 and 2008.

Table IVA.26.3.6

Objective 6:	***Strengthen and expand epidemiological and behavioural surveillance for evidence- based planning***			
Main activities	***Process/Output indicators***	***Baseline***	***Targets***	***Responsible/ Implementing agency or agencies***
			Year 1 2004 / **Year 2 2005**	
Conduct sentinel surveillance for HIV in antenatal clinics	No. of facilities carrying out at least one round of sentinel surveillance in past 12 months	17 (1999)	12 / 12	MoH, EDF
Conduct sentinel surveillance for HIV in TB patients	No. of facilities carrying out at least one round of sentinel surveillance in past 12 months	--	6 / 6	MoH, EDF
Conduct sentinel surveillance for HIV in STI clients	No. of facilities carrying out at least one round of sentinel surveillance in past 12 months	--	6 / 6	MoH, EDF
Second Generation Surveillance Studies	# of surveys conducted	--	4 / 0	MoH, EDF, FHI, ESMG
Establish a computerised system for monitoring & reporting surveillance data at national & zonal levels	Computerised system installed & operating	--	7 / 7	MoH
Monitor # of adult AIDS cases	# of Zobas reporting	6	6 / 6	MoH
Monitor # of paediatric AIDS cases	# of Zobas reporting	6	6 / 6	MoH

27a. Describe how the component adds to or complements activities already undertaken by the government, external donors, the private sector or other relevant partner: (*e.g., does the component build on or scale-up existing programs; does the component aim to fill existing gaps in national programs; does the proposal fit within the National Plan; is there a clear link between the component and broader development policies and programmes such as Poverty Reduction Strategies or Sector-Wide Approaches, etc.) (2–3 paragraphs*):

As described in paragraph III.22.8, the Government of Eritrea is the biggest contributor to the fight against HIV/AIDS, TB and STI in the country. UN agencies (FAO, UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNMEE, WFP, WHO) have a 2003 workplan and funds to help the Government in the fight against AIDS, but available amounts are relatively small. USAID is the only bilateral donor currently contributing to the expenses in this field as the Italian cooperation has not resumed its cooperation and the EU does not intend to finance Health nor HIV/AIDS related activities in Eritrea in the next five years.

The fight against HIV/AIDS in Eritrea predominantly covers **prevention** related activities: BCC and condom promotion among the Youth, the military and CSWs, production of IEC materials, preliminary behavioural and epidemiological studies, VCT and PMTCT activities, blood transfusion safety, **all these activities being mainly implemented in Asmara**, and at a much lower scale, or not at all, in the regions. Also activities are run and coordinated essentially by the MoH. Very little has been done to expand early diagnosis and treatment of STI, care and support to PLHA is just starting to be implemented and at a very low scale leaving the vast majority of people living

with HIV suffering from stigma and lack of care and support. Blood transfusion safety is not covered outside Asmara. Universal precautions procedures are not implemented in all facilities and these lack waste adequate disposal infrastructure. Surveillance and monitoring activities are weak.

Therefore the proposal aims to fill both geographical gaps and qualitative gaps: set-up an HIV/AIDS sentinel surveillance system in all regions among various groups (CSW, STI patients, pregnant women, blood donors, students), increase coverage of prevention related activities (sexual, blood and mother-to-child transmission) to benefit to rural and urban populations outside Asmara; expand multisectoral component and involve other ministries and the private sector (Education, Macro Policy, Labour and Human Welfare, Transport, the work place, etc.); develop access to quality of care, diagnosis and treatment for opportunistic infections, and access to ARV at a reasonable and feasible scale, with back-up from a US-based *Retrovirology Laboratory* for quality control. Provide capacity building for health workers and civil society organisations to relate in networks between health and support services. Increase monitoring and evaluation capacity and integrate these activities to existing information systems in the country at regional and central levels.

This is a critical time for the country to take the national response to the epidemic to a nationally intensive scale so that every corner of the nation is reached with high-impact prevention activities as well as the means to care for and support people infected and affected by HIV/AIDS. Eritrea, who has already lost so many human resources during the wars, cannot afford to wait to implement these important interventions – the survival and the future of the nation depends upon defeating HIV/AIDS through an intensified response.

28a. Describe innovative aspects to the component:

We have adhered to international and recognised best practices, however the following aspects may be viewed as innovative in the Eritrean context.

- Strengthening the blood donor recruitment program.
- Creating a blood donors association.
- Training non-health workers on voluntary counselling and testing.
- Creating linkages between VCT, health services, support organisations, and community based BCC and condom promotion activities to provide a wide scope of activities, a comprehensive program on HIV/AIDS.
- Integrating TB prevention and treatment to HIV/AIDS prevention and follow-up at regional levels.
- Integrating PMTCT activities to safe-motherhood and care, follow-up and support of PLHA and their families.
- Providing support to orphans, and income-generating activities to their families, PLHAs and CSWs.
- Setting-up a sentinel surveillance system for HIV/TB and STI.
- Carrying out preliminary studies on aetiology of STIs and OI and drug susceptibility to validate or update algorithms and current guidelines.
- Setting-up a national referral laboratory at central level for HIV,TB, STI and building capacity for quality assurance and quality control
- Disseminating guidelines and procedures for universal precautions.
- Testing the blood to be transfused for Hepatitis B, Hepatitis C, Syphilis and HIV in hospitals blood banks outside Asmara.
- Providing access to diagnosis and treatment for OI and access to ARV therapy and clinical and biological follow-up, which is not yet available in the country.
- Providing waste disposal infrastructure.

29a. Briefly describe how the component addresses the following issues:

29a.1. The involvement of beneficiaries such as people living with HIV/AIDS

BIDHO, the only PLHA organisation in Eritrea, participated in the development of this proposal and is a key leader and participant in Eritrea's overall response to the HIV/AIDS

epidemic. Furthermore, BIDHO is a member of the *Eritrean Partnership Against HIV/AIDS, Tuberculosis and Malaria* (Eritrea's CCM) and members of BIDHO as well as other persons living with HIV will be trained as counsellors and are involved in all dimensions of the implementation of HIV/AIDS prevention and care programmes in Eritrea. On a practical level, openly acknowledge PLHAs, including in the military, have contributed enormously to the education and communication efforts carried out by the Ministry of Health, the Eritrean Defence Forces and NGOs such as ESMG/PSI. These activities will continue and expand under the activities proposed in this application.
PLHAs are also very much involved in HBC and support activities, as they are currently funded by a UNFPA "*Care and Support Project*". PLHAs have been trained on HBC to provide HBC in households in Asmara. BIDHO is organising a monthly food distribution to some 3 000 beneficiaries in Asmara, as subcontractor of a WFP supplementary program for PLHAs; BIDHO is willing to expand its activities in all regions. Some of its members are being trained to be able to participate in VCT activities. Finally, BIDHO is starting an income-generating pilot program for people living with and affected by HIV/AIDS in Asmara.

PLHAs will then gradually be involved in VCT, care and psychosocial and economic support activities funded under this Proposal.

29a.2. Community participation

Thousands of Women, Workers and Youth are involved in community-based activities throughout the country through their respective unions: NUEYS, NUEW, NCEW, FBOs from all religions: the Evangelical Church of Eritrea, the Orthodox Church, the Mufti and Muslim religious groups, and other NGOs are all involved in HIV/AIDS activities in the country and are members of "The Partnership". Their involvement is very important because they are like 200 000 or more in each of the Unions and they are represented in all regions.

29a.3. Gender equality issues

Prevention and care and support activities are available without regard to gender or social standing in Eritrea. The design and implementation of Eritrea's response to the HIV/AIDS epidemic takes into account the physical and social differences between men and women and provides appropriate access to services and opportunities to contribute to the response on an equivalent basis. Where appropriate, specific services and consideration is made available to groups of men and women. Examples are VCT screening for pregnant women, separate programmes for commercial sex workers (mainly women) and their clients (mainly men) and the recent introduction of the female condom as a female-controlled barrier method to prevent the sexual transmission of infection.

29a.4. Social equality issues

The Government of Eritrea, as a new country and leading a very poor population in the context of severe drought and post-conflict situation, is constantly concerned by equity issues. The Government is providing care at very low fees throughout the country and is the major contributor to the health sector. Use of services is high and essential generic drugs and commodities are widely available. Prevention and care related activities are free for HIV, TB and STI patients. A health sector review is underway to find ways of sustaining this policy designed in a very specific context compared to other countries.

Participation in Eritrea's response to the HIV/AIDS, as a provider or beneficiary, is open to all Eritreans regardless of social class, income or other factors. The services are targeted at the majority of Eritreans. The major focus of this proposal is scaling up existing prevention and care services so that they reach every community and, to the extent possible, every household in the country.

29a.5. Human resources development

Human resource development and capacity building is a major concern as the country has a small population and qualified human resource are few. In the field of HIV/AIDS,

activities are integrated and not only new people have been trained and appointed at central level, but all actors in the public sector have been sensitised. Multisectoral involvement will reduce the burden of the heath sector human resources both in prevention and support.

In the health sector the Nursing school has integrated the training on HIV/AIDS into the curricula to prepare future health personnel to diagnose HIV/AIDS, be involved in testing and counselling, care and support activities. Expatriates from different Southern countries work as physicians in the health services to help Eritrea deal with the lack of physicians.
In the field of HIV/AIDS, the objective is to train all HR and this is feasible over the five years as numbers are low (see introduction to objective 2). Supervision, refresher training, rational use of existing personnel, integration of care activities at regional and health facility levels, are major cross-cutting issues taken into consideration.

SECTION VA – Budget information

30a. Indicate the summary of the financial resources requested from the Global Fund by year and budget category

Table VA.30

Resources needed (USD)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**
Human Resources	316,400	138,000	151,800	151,800	166,980	924,980
Infrastructure/ Equipment	1,561000	1,591000	795,500	397,500	357,750	4,702,750
Training/ Planning	776,750	596,250	596,250	536,625	429,300	2,935,175
Commodities/ Products	637,750	684,000	684,000	684,000	547,200	3,236,950
Drugs	737,780	904,380	1,085,256	1,193,782	1,193,782	5,114,980
Monitoring and Evaluation	14,600	4,000	7,000	14,600	5,000	45,200
Administrative Costs	95,000	68,000	95,000	68,000	68,000	394,000
Total	**4,139,280**	**3,985,630**	**3,414,806**	**3,046,307**	**2,768,012**	**17,354,035**

The budget categories may include the following items:
Human Resources: *Consultants, recruitment, salaries, etc.*
Infrastructure/Equipment: *Building infrastructure, cars, microscopes, etc.*
Training/Planning: *Training, workshops, meetings, etc.*
Commodities/Products: *Bednets, condoms, syringes, educational material, etc.*
Drugs: *ARVs, drugs for opportunistic infections, TB drugs, anti-malaria drugs, etc.*
Monitoring & Evaluation: *Data collection, analysis, reporting, etc.*
Administrative: *Overhead, costs for Principal Recipients associated with managing the project, audit costs, etc*
Other (please specify):

31a. For drugs and commodities/products, specify in the table below the use of the commodity, unit costs, volumes and total costs, for the FIRST YEAR ONLY

*Unit prices for pharmaceutical products should be the **lowest** of: prices currently available locally; public offers from manufacturers; or price information for public information sources.[35] If prices from sources other than those specified above are used, a rationale must be included.*

[35] Sources and Prices of Selected Drugs and Diagnostics for People Living With HIV/AIDS. Copenhagen/Geneva, UNAIDS/UNICEF/WHO-HTP/MSF, 3rd edition, May 2002 (http://www.who.int/medicines/library/par/hivrelateddocs/prices-eng.pdf); Market News Service, Pharmaceutical starting materials and essential drugs, WTO/UNCTAD/International Trade Centre and WHO (http://www.intracen.org/mns/pharma.html); International Drug Price Indicator Guide on finished products of essential drugs, Management Sciences for Health in collaboration with WHO (published annually) (http://www.msh.org); First-line tuberculosis drugs, formulations and prices currently supplied/to be supplied by Global Drug Facility (http://www.stoptb.org/GDF/drugsupply/drugs.available.html)

Table VA.31

Item/unit	Purpose	Unit cost[36]** (USD)	Volume *Specify measure*	Total cost (USD)
ZDV/AZT 300mg	Treating eligible HIV+ adults	0.47	240,000	112,800
ZDV/AZT Oral solution 50 mg/ml	Treating HIV+ eligible children	4.0	1000	40,000
3TC LAMIVUDINE 150mg	Treating HIV+ adults and children and PEP therapy	0.23	120,000	27,600
3TC LAMIVUDINE10mg/ml				
NEVIRAPINE 200 mg	PMTCT	0.27	240000	64,800
NEVIRAPINE syrup 50mg/5ml		0.14	1000	140
D4T /STAVUDINE 40mg	Treating eligible HIV+ adults	0.10	240000	24,000
D4T /STAVUDINE 1mg/ml	Treating eligible HIV+ children		730000ml	
EFV/EFARVINEZ200mg	Treating HIV+ eligible adults	0.55	40000	22,000
DDI/DIDANOSIN/ 100mg tab		0.28	2000	
DDI/DIDANOSIN/ 10mg/ml	Treating eligible HIV+ children			
INDINAVIR /CXV/ 400mg	Second line treatment for HIV+ adults treatment failures	0.40	2000	800
Saquinavir/SQV/ 200mg		0.48	2000	960
Retonavir/RTV/			2000	
3TC/D4T/NVP 150/40/200mg		0.49	250000	122,500
ZDV/3TC300/150mg	PEP	0.69	6000	4140
Fluconazole 200 mg caps	Treating OI at referral hospitals levels	0.39	24000	10000
Ketoconazole 200mg		0.06	40000	2400
Pentamidine 200 mg powder		6.40	300	1920
Ceftriaxone 250 mg vial		0.98	20000	19,600
Amitriptyline 25mg tab		0.01	10000	100
HIV Rapid tests		2.4	100 000	240,000
Syphilis RPR		0.1	35 000	3,500
Female condoms		2	6000	12,000
TOTAL[37]				**709, 260**

- No of patients on ARV_____ 800
- No of clients visiting VCT centres_____ 100000
- No of patients on proper OI management at referral level_____ 200

31a.1. Budget justification: Please indicate assumptions or formulas used to calculate volume of drug/commodity necessary to achieve coverage targets specified in section 26.

It has been assumed that targets will be reached and recommended dosage schedules will be followed (Reference: *Scaling up antiretroviral therapy in resource-limited settings. Guidelines for a public-health approach. WHO. June 2002)*.

[36] Source of unit cost: *Sources and prices of selected drugs and diagnostics for people living with HIV/AIDS, May 2002, A joint UNICEF, UNAIDS Secretariat, WHO, MSF project.*

[37] This total can not match with total of commodities and drugs year 1 budget because we do not detail all universal precautions products and commodities that will be procured under these funds and commodities necessary to undertake the

32a. If you are receiving funding from other sources than the Global Fund for activities related to this component, indicate in the Table below overall funding received over the past three years as well as expected funding until 2005 in US dollars

Table VA.32

	1999	2000	2001	2002	2003	2004	2005
Domestic (public and private)	1,200,000	2,000,000	1,200,000	2,100,000	1,028,000	1,028,000	1,028,000
External	1,500,000	2,100,000	1,500,000	3,354,000	3,172,000	3,172,000	3,172,000
Total	**2,700,000**	**4,100,000**	**2,700,000**	**5,454,000**	**4,200.,000**	**4,200,000**	**4,200,000**

Please note: The sum of yearly totals of Table V.32 from each component should correspond to the yearly total in Table 1.b of the Executive Summary. For example, if Year 1 in the proposal is 2003, the column in Table 1.b labelled Year 1 should have in the last row the total of funding from other sources for 2003 for all components of the proposal.

33a. Provide a full and detailed budget as attachment, which should reflect the broad budget categories mentioned above as well as the component's activities. It should include unit costs and volumes, where appropriate

The full budget follows (Year 1 and Year 2).

HIV/AIDS BUDGET BREAKDOWN FOR EACH OBJECTIVE & ACTIVITY
YEAR 1

ACTIVITY	HUMAN RESOURCES 1	INFRASTRUCTURES EQUIPMENT 2	TRAINING 3	COMMODITIES 4	DRUGS 5	M&E 6	ADMI COSTS 7	TOTAL
Objective 1: Scale up and expand HIV prevention activities in target populations								
The military								
ACT 1	5,000							5,000
ACT 2				25,000				25,000
ACT 3			4,000			500		4,500
ACT 4			42,000			3,000		45,000
ACT 5			1,000					1,000
ACT 6			1,000					1,000
ACT 7			2,800			200		3,000
ACT 8			1,800	3,000		200		5,000
TOTAL	**5,000**		**52,600**	**28,000**		**3,900**		**89,500**
Wives of the military								
ACT 1	5,000							5,000
ACT 2				2,000				2,000
ACT 3			1,800			200		2,000
ACT 4			19,000			1,000		20,000
ACT 5			4,500			500		5,000
ACT 6			1,000					1,000
ACT 7				3,000				3,000
TOTAL	**5,000**		**26,300**	**5,000**		**1,700**		**38,000**
Commercial sex workers								
ACT 1	5,000							5,000
ACT 2				5,000				5,000
ACT 3			9,500			500		10,000
ACT 4			19,000			1,000		20,000
ACT 5			4,500			500		5,000
ACT 6				5,000				5,000
TOTAL	**5,000**		**33,000**	**10,000**		**2,000**		**50,000**
STI clients								
ACT 1	5,000							5,000
ACT 2				12,000				12,000
ACT 3			9,000			1,000		10,000
ACT 4				4,000				4,000
TOTAL	**5,000**		**9,000**	**16,000**		**1,000**		**31,000**
Objective 2: ***Increase the number of people who know their status by improving availability and quality of voluntary testing***								
ACTI 1		10,000		5,000		1,000		16,000
ACT 2		10,000		5,000		1,000		16,000
ACT3		10,000		5,000		1,000		16,000
ACT4		14,000		5,000		1,000		20,000
ACT5				134,340				134,340
ACT6				2,000				2,000
ACT 7			33,750					33,750
ACT 8			9,000					9,000
ACT 9			12,000					12,000
ACT 10	108,000							108,000
TOTAL	**108,000**	**44,000**	**54,750**	**156,340**		**4,000**		**367, 090**
Objective 3: ***Increase the number of infected mothers who ho receive effective counselling and medical intervention to decrease the likelihood of HIV transmission to children (PMTCT)***								
ACT 1		2,000		2,000		2,000		6,000
ACT2				144,410				144,410
ACT 3			45,000					45,000
ACT 4					10,000			10,000
ACT 5					10,000			10,000
ACT 6					144,000			144,000
ACT 7	3,000		2,000	5,000				10,000
ACT 8					3,500			3, 500
ACT 9				10,000				10,000
TOTAL	**3,000**	**2,000**	**47,000**	**161,410**	**167,500**	**2,000**		**382, 910**

Objective 4: ***Improve the availability and the quality of health care and psychosocial and economic support for PLHAs***								
Set up a national reference laboratory for HIV/AIDS, TB, STI at Central health Lab in Asmara								
	1	**2**	**3**	**4**	**5**	**6**	**7**	**TOTAL**
ACT 1	45,000	75,000	30,000					150,000
ACT 2				10,000				10,000
ACT 3		20,000						20,000
ACT 4				32,000				32,000
ACT 5		50,000		50,000				100,000
ACT 6			24,000					24,000
ACT 7			9,000					9,000
ACT 8							6,400	6,400
ACT 9	18,000							18,000
TOTAL	**63,000**	**145,000**	**63,000**	**92,000**			**6,400**	**369, 400**
Scale up clinical AIDS management in hospitals and ambulatory health settings military included								
ACT 1			27,500					27,500
ACT 2			90,000		19,800			109,800
ACT 3					128,400			128,400
ACT 4					330,000			330,000
ACT 5			18,000					18,000
ACT 6			10,000					10,000
ACT 7					48,000			48,000
ACT 8			33,000					33,000
TOTAL			**178,500**		**526,200**			**704, 700**
Provide home-based care to PLHA adults and children, military and families included								
ACT 1				30,000	20,000			50,000
ACT 2			90,000					90,000
ACT 3							10,000	10,000
ACT 4	14,400		3,600					18,000
ACT 5		120,000						120,000
TOTAL	**14,400**	**120,000**	**93,600**	**30,000**	**20,000**		**10,000**	**288, 000**
Support to people living with HIV and affected orphans included								
	1	**2**	**3**	**4**	**5**	**6**	**7**	**TOTAL**
ACT 1			3,000				6,000	9,000
ACT 2			4,000				10,000	14,000
ACT 3			36,000				3,600	39,600
ACT 4			3000				7000	10,000
ACT 5			6,000				14,000	20,000
ACT 6			10,000				10,000	20,000
ACT 7			3,000				7,000	10,000
ACT 8			5,000				15,000	20,000
TOTAL			**70,000**				**72,600**	**142, 600**
Objective 5: ***Expand blood transfusion safety to regional blood banks and establish procedures for, and ensure adherence to, universal precautions in the health care setting***								
Expand blood safety to regional hospitals blood banks								
ACT 1	5,000		5,000				5,000	15,000
ACT 2			4,500					4,500
ACT 3				24,000				24,000
TOTAL	**5,000**		**9,500**	**24,000**			**5,000**	**43, 500**
Universal precautions guidelines and procedures								
ACT 1			45,000					45,000
ACT 2	10,000						1000	11,000
ACT 3		800,000						800,000
ACT 4		450,000						450,000
ACT 5			60,000	10,000				70,000
TOTAL	**10,000**	**1,250,000**	**105,000**	**10,000**			**1,000**	**1,376, 000**
HIV PEP protocol implementation								
ACT 1			30,000	5,000				35,000
ACT 2			4,500					4,500
ACT 3					24,080			24,080
TOTAL			**34,500**	**5,000**	**24,080**			**63, 580**

Objective 6: ***Strengthen and expand epidemiological and behavioural surveillance for evidence based planning***								
ACT 1	4,000			10,000				14,000
ACT 2	4,000			5,000				9,000
ACT 3	10,000			10,000				20,000
ACT 4	2,500			2,500				5,000
ACT 5	2,500			2,500				5,000
ACT 6	15,000			15,000				30,000
ACT 7	20,000			20,000				40,000
ACT 8	15,000			15,000				30,000
ACT 9	10,000			10,000				20,000
ACT 10	10,000			10,000				20,000
TOTAL	**93,000**			**100,000**				**193,000**
TOTAL BUGET YEAR 1	**316,400**	**1,561,000**	**776,750**	**637,750**	**737,780**	**14,600**	**95,000**	**4,139,280**

HIV/AIDS BUDGET BREAKDOWN FOR EACH OBJECTIVE & ACTIVITY
YEAR 2

ACTIVITY	HUMAN RESOURCES 1	INFRASTRUCTURES EQUIPMENT 2	TRAINING 3	COMMODITIES 4	DRUGS 5	M&E 6	ADMI COSTS 7	TOTAL
Objective 1: Scale up and expand HIV prevention activities in target populations								
The military								
ACT 1								
ACT 2								
ACT 3								
ACT 4			45,000					45,000
ACT 5			3,000					3,000
ACT 6			1,500					1,500
ACT 7				4,000				4,000
ACT 8								
TOTAL			**49,500**	**4,000**				**53,500**
Wives of the military								
ACT 1								
ACT 2								
ACT 3								
ACT 4								
ACT 5			6,000					6,000
ACT 6			3,000					3,000
ACT 7				4,000				4,000
TOTAL			**9,000**	**4,000**				**13,000**
Commercial sex workers								
ACT 1								
ACT 2								
ACT 3								
ACT 4								
ACT 5			6,000					6,000
ACT 6			5,000				5,000	10,000
TOTAL			**11,000**				**5,000**	**16,000**
STI clients								
ACT 1								
ACT 2								
ACT 3								
ACT 4				4,000				4,000
TOTAL				**4,000**				**4,000**
Objective 2: ***Increase the number of people who know their status by improving availability and quality of voluntary testing***								
ACTI 1		15,000		5,000		1,000		21,000
ACT 2		15,000		5,000		1,000		21,000
ACT3		10,000		5,000		1,000		16,000
ACT4		10,000		5,000		1,000		16,000
ACT5				192,000				192,000
ACT6				3,000				3,000
ACT 7			33,750					33,750
ACT 8			18,000					18,000
ACT 9			12,000					12,000
ACT 10	65,000		7,000					72,000
TOTAL	**65,000**	**50,000**	**70,750**	**215,000**		**4,000**		**404,750**
Objective 3: ***Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission to children (PMTCT)***								
ACT 1		1,000		1,000				2,000
ACT2				163,000				163,000
ACT 3			67,500					67,500
ACT 4					19,000			19,000
ACT 5					15,000			15,000
ACT 6				UNICEF				
ACT 7			1,000	3,000				4,000
ACT 8					4,500			4,500
ACT 9				14,000				14,000
TOTAL		**1,000**	**68,500**	**181,000**	**38,500**			**289,000**

Objective 4: *Improve the availability and the quality of health care and psychosocial and economic support for PLHAs*								
Set up a national reference laboratory for HIV/AIDS, TB, STI at Central health Lab in Asmara								
	1	**2**	**3**	**4**	**5**	**6**	**7**	**TOTAL**
ACT 1	10,000		5,000	15,000				30,000
ACT 2				10,000				10,000
ACT 3								0
ACT 4				64,000				64,000
ACT 5		100,000		100,000				200,000
ACT 6			-					0
ACT 7			9,000					9,000
ACT 8							12,000	6,400
ACT 9	20,000							20,000
TOTAL	**30,000**	**100,000**	**14,000**	**189,000**			**12,000**	**345,000**
Scale up clinical AIDS management in hospitals and ambulatory health settings military included								
ACT 1			21,000					21,000
ACT 2			80,000		10,000			90,000
ACT 3					256,800			256,800
ACT 4					480,000			480,000
ACT 5			18,000					18,000
ACT 6								
ACT 7					60,000			60,000
ACT 8								
TOTAL			**119,000**		**806,800**			**925,800**
Provide home-based care to PLHA adults and children, military and families included								
ACT 1				30,000	30,000			60,000
ACT 2			90,000					90,000
ACT 3							5,000	5,000
ACT 4	10,000		4,000					14,000
ACT 5		240,000						240,000
TOTAL	**10,000**	**240,000**	**94,000**	**30,000**	**30,000**		**5,000**	**409,000**
Support to people living with HIV and affected orphans included								
	1	**2**	**3**	**4**	**5**	**6**	**7**	**TOTAL**
ACT 1			3,000				3,000	6,000
ACT 2			2,000				3,000	5,000
ACT 3			5,000				5,000	10,000
ACT 4			3,000				7,000	10,000
ACT 5								
ACT 6			5,000				5,000	10,000
ACT 7			3,000				7,000	10,000
ACT 8			5,000				15,000	20,000
TOTAL			**26,000**				**45,000**	**71,000**
Objective 5: ***Expand blood transfusion safety to regional blood banks and establish procedures for, and ensure adherence to, universal precautions in the health care setting***								
Expand blood safety to regional hospitals blood banks								
ACT 1								
ACT 2			4,500					4,500
ACT 3				24,000				24,000
TOTAL			**4,500**	**24,000**				**28,500**
Universal precautions guidelines and procedures								
ACT 1			70,000					70,000
ACT 2	10,000						1000	11,000
ACT 3		400,000						400,000
ACT 4		800,000						800,000
ACT 5			40,000	14,000				54,000
TOTAL	**10,000**	**1,200,0000**	**110,000**	**14,000**			**1,000**	**1,335,000**
HIV PEP protocol implementation								
ACT 1			16,000		5,000			21,000
ACT 2			4,000					4,500
ACT 3					24,080			24,080
TOTAL			**20,000**		**29,080**			**49,080**

Objective 6: *Strengthen and expand epidemiological and behavioural surveillance for evidence based planning*								
ACT 1	4,000			2,000				6,000
ACT 2	4,000			2,000				6,000
ACT 3	10,000			10,000				20,000
ACT 4	2,500			2,500				5,000
ACT 5	2,500			2,500				5,000
ACT 6								
ACT 7								
ACT 8								
ACT 9								
ACT 10								
TOTAL	**23,000**			**19,000**				**42,000**
TOTAL BUDGET YEAR 2	**138,000**	**1,591,000**	**596,250**	**684,000**	**904,380**	**4,000**	**68,000**	**3,985,630**

Detailed workplans for year 1 and 2 are on separated files.

34a. Indicate in the Table below how the requested resources will be allocated to the implementing partners, in <u>percentage</u>

Table VA.34

Resource allocation to implementing partners* (%)	**Year 1**	**Year 2**	**Year 3 (Estimate)**	**Year 4 (Estimate)**	**Year 5 (Estimate)**	**Total**	**%**
Government	2,483,568	2,391,378	2,048,884	1,827,784	1,660,807	**10,412,421**	**60%**
NGOs/ CBOs	620,892	597,844	512,221	456,946	415,202	**2,603,105**	**15%**
Private Sector	206,964	199,282	170,740	152,315	138,401	**867,702**	**5%**
People living with HIV/TB/ malaria	413,928	398,563	341,481	304,631	276,801	**1,735,404**	**10%**
Faith-based Organisations	413,928	398,563	341,481	304,631	276,801	**1,735,404**	**10%**
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Total in USD	**4,139,280**	**3,985,630**	**3,414,807**	**3,046,307**	**2,768,012**	**17,354,036**	

We recognise that the anticipated allocation to the Government is high, especially in the first years of implementation. This is due firstly to the allocation of resources to procurement (that will be carried out by Government), and secondly to the limited availability and capacity of implementing partners in Eritrea.

As a new country in the early stages of development, there are very few civil society partners in Eritrea with capacity to implement the activities that are vitally required for us to expand and accelerate the fight against HIV/AIDS. There are very few national or international NGOs or CBOs in Eritrea. The two largest organisations are the National Union of Eritrean Youth and Students (NUEYS) and the National Union of Eritrean Women (NUEW), both of which are broad community-based organisations. BIDHO, the first and only AIDS service organisation in Eritrea, became operational in early 2002 and has few members and limited capacity to implement activities. There are nearly no private organisations operating in Eritrea in any sector, and there is only one university with a small number of faculties and limited faculty with whom we can work.

At the moment, the greatest capacity for implementation outside of the Government is in the FBOs. However, the implementation capacity of the FBOs is limited due to the nature of the personnel available, the nature of the institutions and primarily the lack of financial resources. The religious organisations in Eritrea do not provide any significant amount of preventive or curative services unlike the situation in many African countries.

Our implementation strategy, therefore, focuses on Government implementation of activities and interventions in the first years of the project. We have attempted to increase the allocation of funding to our potential partners in order to build their capacity and to enable them to become more operational in the future.

Annex B: ***Principal Recipient Year 1 - Budget and Workplans for 2004***

Country:	**ERITREA**
Disease:	**HIV/AIDS**
Grant number:	
Principal Recipient:	**MOH**
Currency:	**USD**

Consolidated Budget & Indicators

		SEMESTER 1 (QUARTER 1 & QUARTER 2)		SEMESTER 2 (QUARTER 1 & QUARTER 2)		
Objectives/Broad activities	**Responsible**	Indicators -- Description	Budget[1)]	Indicators -- Description	Budget[1)]	**B**
OBJECTIVE 1: ***Scale up and expand effective HIV prevention activities in target populations***						
THE MILITARY						
Broad activity 1: Produce male & female prevention education brochures and posters	MoH HQ MoH zone ESMG EDF	Male & Female prevention education brochures and posters produced	5,000			
Broad activity 2: Print male & female brochures and posters	MoH HQ MoH zone ESMG EDF	50,000 Male & 10,000 Female brochures and 2,000 posters printed	25,000			
Broad activity 3: Train trainers for youth peer education	MoH HQ MoH zone ESMG EDF NUEYS			30 of Youth Peer Educator ToT training 30 x 5 days x $30	4,500	
Broad activity 4: Train youth peer educators	MoH HQ MoH zone ESMG EDF			300 of Youth Peer Educator trainings100 x 5 days x $30	45,000	
Broad activity 5: Hold HIV prevention sessions with condom demonstration	MoH zone ESMG	20 of HIV prevention sessions with condom demonstration	600	20 of HIV prevention sessions with condom demonstration	600	

	EDF NUEYS NUEW					

Broad activity 6: Train all military staff for demobilisation	ESMG EDF NUEYS			50 HIV prevention sessions with condom demonstration	1,500	
Broad activity 7: Train clinicians in STI syndromic management	MoH HQ MoH zone EDF	50 physicians receiving STI syndromic management trainings	7,500			
Broad activity 8: Distribute female condoms	MoH zone EDF NUEYS NUEW	1,000 female condoms distributed	2,000	1,000 female condoms distributed	2,000	
SPOUSES OF THE MILITARY						
Broad activity 1: Produce female prevention education brochures and posters	MoH HQ MoH zone ESMG EDF	# of Female prevention education brochures and posters produced	5,000			
Broad activity 2: Print female brochures	MoH HQ MoH zone ESMG EDF	10,000 Female brochures printed	15,000			
Broad activity 3: Train trainers in peer education	MoH HQ MoH zone ESMG EDF NUEYS			20 Peer Educator ToT trainings 20 x 5 days x $30	3000	
Broad activity 4: Train peer educators	MoH HQ MoH zone ESMG EDF			100 Peer Educator trainings 100 x 5 days x $30	15,000	
Broad activity 5: Hold HIV prevention sessions with condom demonstration	MoH zone ESMG EDF NUEYS NUEW	100 HIV prevention sessions with condom demonstration	3,000	100 HIV prevention sessions with condom demonstration	3,000	
Broad activity 6: Train all military staff about	ESMG	50 HIV prevention sessions with condom	1,500	50 HIV prevention sessions with condom	1,500	

spouses for demobilisation	EDF NUEYS	demonstration		demonstration		
Broad activity 7: Distribute female condoms	MoH HQ MoH zone EDF	1,000 female condoms distributed	2,000	1,000 female condoms distributed	2,000	
COMMERCIAL SEX WORKERS						
Broad activity 1: Produce CSW prevention education brochures	MoH HQ MoH zone ESMG MoLHW	CSW prevention education brochures produced	5,000			
Broad activity 2: Print CSW brochures	MoH HQ MoH zone ESMG MoLHW	10,000 CSW brochures printed	15,000			
Broad activity 4: Train trainers for CSW peer education	MoH HQ MoH zone ESMG			30 x 5 days x$30 CSW Peer Educator ToT training	4,500	
Broad activity 5: Train CSW peer educators	MoH HQ MoH zone ESMG MoLHW	50 CSW Peer Educator trainings50 x 5 days x $30	7,500	50 CSW Peer Educator trainings50 x 5 days x $30	7,500	
Broad activity 6: Hold HIV prevention sessions with condom demonstration	MoH zone ESMG MoLHW NUEYS NUEW	100 CSW HIV prevention sessions with condom demonstration	3,000	100 CSW HIV prevention sessions with condom demonstration	3,000	
Broad activity 7: Distribute female condoms	ESMG NUEYS NUEW			2,500 female condoms distributed	5,000	
STI CLIENTS						
Broad activity 1: Produce male & female prevention education brochures and posters	MoH HQ MoH zone EDF ESMG MoLHW	Male & Female prevention education brochures and posters produced	5,000			

	Vision Eritrea					
Broad activity 2: Print male & female brochures and posters	MoH HQ MoH zone ESMG MoLHW EDF Vision Eritrea	10,000 Male & 10,000 Female brochures and 2,000 posters printed	33,000			
Broad activity 3: Train clinicians in STI syndromic management	MoH HQ MoH zone EDF	20 Clinicians trained on STI syndromic management 20 x 5 days x $30	3,000	20 Clinicians trained on STI syndromic management 20 x 5 days x $30	3,000	
Broad activity 4: Distribute female condoms	MoH HQ MoH zone ESMG MoLHW EDF NUEYS NUEW	1,000 female condoms distributed	2,000	1,000 female condoms distributed	2,000	
OBJECTIVE 2: ***Increase the number of people who know their HIV status by improving availability and quality of voluntary counselling and testing***						
Broad activity 1: Establish 3 freestanding VCT run by MOH	NATCoD MoH zone	Identification of 3 sites and human resources to establish 3 Free-standing VCT development run by MOH in zones (1 in 3 different zone)	1,000	Development and running of 3 Free standing VCT run by MOH	15 000	
Broad activity 2: Set up facility-based VCT services in 20 health centres at zone level: development and running VCTs	NATCoD MOH zone	VCT facility-based in 10 health centres (2 in each zone): identification of sites and existing human resources to be trained on counselling and testing	1,000	VCT facility-based in 10 health centres (2 in each zone) : identification of sites and human resources to be trained on counselling and testing	15,000	1
Broad activity 3: Set up 5 facility-based VCT at health centre level in the military	MoH EDF	Identification of the health centres Development and running of 5 VCT-facility based in the divisions	1,000	Development and running of 5 other VCT health centre-based at Division level in the military	15,000	16
Broad activity 4: Establish youth centre-based VCT services and BIDHO association-based VCT services	BIDHO NUEYS	Contracts signed with BIDHO and NUEYS (development and running of 1 VCT each)	10,000	Contracts signed with BIDHO and NUEYS (development and running of 1 VCT each)	10,000	2

Broad activity 5: Provide rapid tests to all VCT sites for screening and confirmatory tests	Pharmecor NATCoD EDF	30 000 tests provided	67,170	30 000 tests provided	67,170	13
Broad activity 6: Carry out internal HIV quality control for 20% of tests performed at health facility level HIV whole blood testing included	CHL Zonal referral hospitals	6000 blood samples sent for QC HIV testing to CHL	1,000	6000 samples sent to CHL for QC HIV testing	1,000	2,(
Broad activity 7: Train health workers, non-health workers, in MOH and EDF health centres, as well as BIDHO and NUEYS associations, on counselling and whole blood testing	NATCoD CHL MoH region EDF	40 counsellors trained	16,875	35 counsellors trained	16,875	33
Broad activity 8: Train VCT supervisors at regional levels in 6 zones and in the military	NATCoD MoH zone EDF	10 VCT supervisors trained	4,500	10 VCT supervisors trained	4,500	9,(
Broad activity 9: Train Laboratory technicians or non health workers on HIV whole blood testing including the military and health centres human resources	CHL NATCoD EDF	20 Lab technicians trained	6,000	20 non health workers trained on whole blood testing	6,000	12
Broad activity 10: Recruit and hire non-health workers to run VCT	MoH	30 non-health workers hired	72,000	30 non-health workers hired	36,000	10
OBJECTIVE 3: ***Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission to children (PMTCT)***						
Broad activity 1: Integrate PMTCT services to antenatal services and regional hospitals in 2 regions	NATCoD MoH zones (Debub and Maekel)	Expanded integrated PMTCT services to antenatal sites in Asmara	2,000	Identify antenatal sites to deliver PMTCT services in Debub (Mendefera) and develop and run PMTCT integrated services with Mendefera referral hospital	4,000	6
Broad activity 2: Provide HIV and Syphilis tests for pregnant women screening and confirmatory tests for HIV+ mothers in Debub and Maekel antenatal sites	Pharmecor NATCoD MoH zones	20 000 HIV tests provided 20 000 Syphilis tests provided	79,400	17 000 HIV tests provided 15 000 Syphilis tests provided	65,010	14
Broad activity 3: Train health workers of antenatal and referral hospitals in Debub and Maekel	NATCoD MoH/Zone	50 health workers trained on PMTCT strategy and activities	15,000	50 health workers trained on PMTCT strategy and activities	15,000	30

Broad activity 4: Provide ARV therapy to mothers at delivery	Pharmecor MoH/Zones National referral hospitals	250 mothers receiving ARV therapy	5,000	250 mothers receiving ARV therapy	5,000	10
Broad activity 5: Provide ARV therapy to newborns from HIV positive mothers	Pharmecor	250 newborns receiving ARV	5,000	250 newborns receiving ARV therapy	5,000	10
Broad activity 6: Provide infant formula	Pharmecor Referral hospitals	200 infants receiving formula	72,000	200 infants receiving formula	72,000	14
Broad activity 7: Elaborate and disseminate IEC materials for pregnant women and health workers sensitisation on PMTCT services and guidelines	IEC/MoH NATCoD Private sector supplier	Contract with a Communication supplier	7,000	Dissemination of materials	3000	10
Broad activity 8: Provide syphilis treatment for syphilis reactive women	MoH/zones Pharmecor National referral hospitals	250 syphilis reactive pregnant women receiving syphilis treatment, counselling, follow-up	2,000	250 syphilis reactive pregnant women receiving syphilis treatment, counselling, follow-up	1, 500	3,
Broad activity 9: Provide materials for safe obstetric procedures	Pharmecor National and zonal referral hospitals	7 PMTCT sites equipped with essential obstetric care materials	5,000	3 PMTCT sites equipped with essential obstetric care materials	5,000	10
OBJECTIVE 4: ***Improve the availability and the quality of health care and psychosocial and economic support for PLHAs and orphans***						
SET UP A NATIONAL REFERENCE LABORATORY FOR HIV/AIDS, STI AND TB AT CHL IN ASMARA						
Broad activity 1: Expand and improve quality control for HIV, Syphilis, TB and other OI	CHL NATCoD MoH/Zones Washington University Retrovirology Lab	Development and running of a National referral Lab for HIV, STI and TB at CHL	100,000	Quality control started on biological diagnosis of OI including TB, and for STI in National referral hospitals in Asmara	50,000	1
Broad activity 2: Provide reagents and other supplies for biological diagnosis of HIV/AIDS related OI including culture anaerobic commodities and supplies	Pharmecor	Procurement of reagents to diagnose Cryptococcose, Pneumocystis carinii, Campylobacter, Cryptosporidiosis, Toxoplasmose, TB, STIs	5,000	Reagents supplied to National referral hospitals Laboratories in Asmara	5,000	1

Broad activity 3: Provide equipment for CD4 counts performance at CHL[30]	MoH Pharmecor CHL	Procurement of 1 FACSCount machine at CHL	20,000			20
Broad activity 4: Provide reagents and other supplies to perform CD4 counts	Pharmecor	Reagents available to perform 400 CD4 counts (1 at launching of treatment for 200 patients, 1 for follow-up)	16,000	Reagents available to perform 400 CD4 counts (1 at launching of treatment for 200 patients, 1 for follow-up)	16,000	32
Broad activity 5: Provide biological follow-up for patients under ARV drugs 4 times a year (blood cells, kidney function, liver function, etc.)	CHL	800 biological check up lab tests for 200 patients under ARV therapy	50,000	800 biological check up lab tests for 200 patients under ARV therapy	50,000	10
Broad activity 6: Train Lab technicians to perform CD4 counts[31]	CHL MoH/Zone Maekel	3 CHL Lab technicians trained abroad 1 month	24,000			24
Broad activity 7: Train Lab technicians to perform OI (+TB) & STI biological diagnosis at CHL, national referral hospitals and zonal referral hospitals	MoH/Zones CHL	20 Lab technicians trained at CHL and national referral hospitals	9,000	20 Lab technicians trained in zonal hospitals	9,000	9,
Broad activity 8: Establish external quality control with reference Lab in neighbouring country and back-up from University of Washington Retrovirology Lab	MoH CHL Washington University Retrovirology Laboratory	80 samples sent to neighbouring country for QC CD4 counts	3,200	80 samples sent to neighbouring country for QC CD4 counts	3,200	6,
Broad activity 9: Recruit and hire Lab technicians	MoH CHL	6 Lab technicians recruited and hired	9,000	6 Lab technicians recruited and hired	9,000	18
SCALE UP CLINICAL AIDS CASE MANAGEMENT IN HOSPITALS AND AMBULATORY HEALTH SETTINGS (OUTPATIENT WARDS), MILITARY INCLUDED						
Broad activity 1: Train core teams of health workers in national referral hospitals and regional hospitals (23 settings) on AIDS case management and diagnosis of OI, TB included	MoH NATCoD MoH/Zones	30 health workers trained from national referral hospitals in Asmara	13,500	30 health workers trained from regional referral hospitals in Asmara	13,500	27

[30] Viral load will not be performed year 1 but year 2.
[31] Lab technicians will be trained on viral load tests year 2.

Broad activity 2: Increase the capacity of health workers (including the military) to give OI preventive treatment to HIV positive clients, mothers, children and symptomatic patients and provide Cotrimoxazole and INH	NATCoD Pharmecor MoH/Zone Maekel	200 health workers trained 1000 adults HIV beneficiaries 400 children beneficiaries	38,400	400 health workers trained 1500 adults beneficiaries 400 children beneficiaries	71,400	10
Broad activity 3: Provide drugs to treat OI that are not on national essential drug list Fluconazole, Ketoconazole, Pentamidine, Ceftriaxone	Pharmecor	Drugs provided to treat 400 AIDS patients in national referral hospitals	64,200	Drugs provided to treat 400 AIDS patients in regional referral hospitals	64,200	12
Broad activity 4: Procure ARV Drugs to treat 600 eligible HIV positive patients	Pharmecor	ARV therapy available for 300 eligible patients in national referral hospitals	90,000	ARV therapy available to treat 300 eligible patients in national referral hospitals in Asmara and 1 national referral hospital in the military	240,000	33
Broad activity 5: Train health workers from medical wards and outpatient wards on counselling and nurses from paediatrics wards on children counselling including AIDS orphans	NATCoD National Referral hospitals in Asmara	30 nurses trained on counselling plus 3 children counsellors from national referral hospitals trained on children counselling	9,000	30 nurses trained on counselling plus 2 counsellors from regional referral hospitals trained on children counselling	9,000	18
Broad activity 6: Sensitise health workers and patients on integrated network utilization of services	NATCoD MoH	Contracts established between VCTs, BIDHO and referral outpatient services from referral hospitals	5,000	Contracts established between VCTs, BIDHO and referral outpatient services from referral hospitals	5,000	10
Broad activity 7: Provide palliative care to PLHAs	MoH/Zones National referral hospitals	400 PLHA receiving palliative care	24,000	400 PLHA receiving palliative care	24,000	48
Broad activity 8: Train core trainers of health workers on palliative care	MoH/Zones NATCoD	3 health workers from national referral hospitals trained in palliative care abroad	16,500	3 health workers from regional referral hospitals trained in palliative care abroad	16,500	33
PROVIDE HOME BASED CARE TO PLHA ADULTS AND CHILDREN						
Broad activity 1: Provide HBC kits to BIDHO, NGOs and FBOS	Pharmecor NATCoD	250 HBC kits distributed	25,000	250 HBC kits distributed	25,000	50
Broad activity 2: Train Volunteers from various civil society organisations on HBC	NATCoD BIDHO FBOs	150 volunteers trained (50 per month)	45,000	150 volunteers trained (50 per month)	45,000	90
Broad activity 3: Expand HBC activities in Asmara and other regions	BIDHO FBOs NATCoD	Contract with BIDHO and Faith-based organisations to undertake HBC activities in Asmara (150 beneficiaries)	5,000	Contract with FBO and other NGOs (NUEYS and NUEW) to undertake HBC activities outside Asmara (300 beneficiaries)	5,000	10

Broad activity 4: Train HBC nurse supervisors	NATCoD MoH/Zones	Recruit, hire and train 6 HBC supervisors within BIDHO and FBO in Asmara	9,000	Recruit and hire and train 6 HBC supervisors in 2 other regions	9,000	18
Broad activity 5: Provide motorcycles to HBC supervisors	MoH	6 HBC supervisors equipped with motorcycles	60,000	6 HBC supervisors equipped with motorcycles	60,000	12
SUPPORT TO PEOPLE LIVING WITH HIV AND AFFECTED						
Broad activity 1: Foster the emergence of PLHA associations outside Asmara	BIDHO NATCoD FBO	Contract with BIDHO to open Debub branch	3,000	Contract with BIDHO to open Anseba and Gash- Barka branches	6,000	9,(
Broad activity 2: Develop organisational and management capacity of PLHA associations throughout the country (administration, communication & Newsletter development, transportation and human resource development)	NATCoD BIDHO	Contract with private provider to build management capacity for BIDHO in Asmara	4,000	Contract with private provider to build management capacity for BIDHO Debub, Gash-Barka and Anseba branches	10,000	14
Broad activity 3: Develop service delivery capacity for BIDHO and branches (Advocacy, BCC, counselling and testing, condom and food distribution, HBC, psychosocial and economic support activities)	NATCoD Private service provider	Contract with private service provider to build service delivery capacity for BIDHO in Asmara including international study tours in neighbouring countries	19,800	Contract with service provider to build service delivery capacity for BIDHO Debub and Anseba branches	19,800	39
Broad activity 4: Train members of BIDHO, FBO, NUEYS, NUEW, NCEW, to provide psychosocial support and counselling to PLHA, their families and orphans	NATCoD Health services FBOs BIDHO	Contract with BIDHO, FBOs, to provide support and counselling to 2,000 patients and families including orphans	5,000	Contract with NUYES and NUEW to provide support and counselling to 2,000 patients and families including orphans	5,000	10
Broad activity 5: Train service providers (school teachers, social workers) to better care for and protect orphans and vulnerable children	MoE NATCoD MoLHW	Contract with Ministry of Education to train school teachers	10,000	Contract with Ministry of Labour and Social Welfare (MoLHW) to provide better care for orphans	10,000	20
Broad activity 6: Provide community with skills for income generating activities and links with micro-finance institutions	FBOs BIDHO ACCORD Eritrea	Contract with service provider to train FBOs and BIDHO on income-generating project management	10,000	Provide technical assistance to BIDHO and FBO to launch and monitor income generating projects	10,000	20
Broad activity 7: Provide small grants to NGOs working with children to ensure basic needs of orphans are met		Contract with MoLHW, FBOs and NGOs to provide support to 500 orphans and their foster families	5,000	Contract with FBO and NGO to provide support to 500 orphans and their foster families	5,000	10

Broad activity 8: Provide food to PLHA, children and orphans in need	WFP MoLHW BIDHO FBOs	Contract with NGO, FBOs, Unions and BIDHO to organise food distribution for PLHAs, families and orphans in Asmara (7 store rental)	10,000	Contract with NGO, Unions and FBO to organise food distribution for PLHA, families and orphans, in Debub, Gash-Barka and Anseba	10,000	20
OBJECTIVE 5: *Expand blood transfusion safety (HIV, Hep B, Hep C, and Syphilis) to regional blood banks to establish procedures for, and ensure adherence to, universal precautions in the health care setting*						
EXPAND BLOOD SAFETY TO REGIONAL BLOOD BANKS						
Broad activity 1: Create a regular pool of donors and encourage blood donor association	NATCoD NBTC	Contract with NBTC for regular pool of donor social mobilisation activities	10,000	Contract with NBTC for creation of a blood donors association	5,000	15
Broad activity 2: Train laboratory technicians from regional hospitals and military to perform HepB, HepC , HIV and Syphilis tests before transfusion	NBTC CHL MOH/Zone NATCoD	Train 5 lab technicians (4 regional MOH hospitals, 1 military hospital)	2,250	Train 5 lab technicians (4 regional MOH hospitals + 1 military hospital)	2,250	4,
Broad activity 3: Provide HIV, HepB, HepC, Syphilis test kits and other supplies to regional and military referral laboratories for blood transfusion safety purposes	Pharmecor CHL	1000 transfusions	12,000	1000 transfusions	12,000	24
UNIVERSAL PRECAUTIONS GUIDELINES AND PROCEDURES						
Broad activity 1: Carry-out whole site trainings on universal precautions guidelines and procedures in hospitals and health centres military included, (year 1 only hospitals are targeted)	MoH/QA EDF NATCoD	Undertake whole site trainings in 8 MOH hospitals and 2 military hospitals on *Universal precautions* guidelines and procedures	30,000	Undertake whole site trainings in 5 MOH hospitals and 2 military hospitals on *Universal precautions* guidelines and procedures	15,000	45
Broad activity 2: Conduct needs assessment study on universal precautions procedures in hospitals and health centres	MoH/QA NATCoD	Contract with private sector service provider to carry out an *Equipment, commodities needs assessment study*	11,000			11
Broad activity 3: Provide complementary commodities and gloves, sterilization equipment to hospitals and health centres in all regions	Pharmecor MoH/QA	Needs assessment underway		Procurement of complementary commodities, gloves and sterilization equipment for 22 hospitals	800,000	80

Broad activity 4: Provide waste management infrastructure in referral, regional and military hospitals (9 sites year 1)	MoH/Environment health EDF Procurement services	Procure waste management infrastructure and training on 6 sites	300,000	Provide waste management infrastructure and training on 3 sites	150,000	45
Broad activity 5: Train core team of trainers for universal precautions	MoH/Zone EDF MoH/QA	33 (3 from each hospital) trained in Universal precautions	35,000	33 (3 from each hospital) trained in Universal precautions	35,000	70
HIV PEP PROTOCOL IMPLEMENTATION						
Broad activity 1 Provide health services with guidelines on accidental transmission of HIV and a written protocol for PEP prophylaxis	MoH/QA NATCoD EDF	Guidelines distributed and training carried out in 8 regional MOH hospitals 2 military hospitals (1500 trainees)	17,500	Guidelines distributed and training carried out in 5 MOH hospitals and 2 military hospitals (1500 trainees)	17,500	35
Broad activity 2: Train a core team for HIV-exposed health worker counselling, testing and ARV prophylaxis treatment in regional and military hospitals	NATCoD EDF MoH/Zone MoH/QA	3 MOH regional hospitals core teams trained on HIV PEP and 1 core teams from military hospital	2,250	3 MOH regional hospitals core teams trained on HIV PEP and 1 core teams from military hospital	2,250	4,
Broad activity 3: Provide ARV therapy to HIV exposed health workers	Pharmecor	Procurement of ARV following PEP Protocol (50 receiving ARV)	12,040	Procurement of ARV following PEP Protocol (50 receiving ARV)	12,040	24
OBJECTIVE 6: ***Strengthen and expand epidemiological and behavioural surveillance and programme monitoring activities***						
Broad activity 1: Strengthen reporting of adult and paediatric AIDS cases	MoH zones HMIS HQ IDSR HQ EDF	30 of Health Care Facilities Reporting	7,000	30 of Health Care Facilities Reporting	7,000	
Broad activity 2: Collect and analyse STI service utilisation data	MoH zones HMIS HQ IDSR HQ EDF	30 of Health Care Facilities Reporting	7,000	# of Health Care Facilities Reporting	2,000	
Broad activity 3: Conduct survey of antenatal HIV seroprevalence	MoH HQ Contracting agencies	Survey conducted	20,000			
Broad activity 4: Conduct survey of TB patients HIV seroprevalence	MoH HQ EDF Contracting agencies	Survey conducted	5,000			

Broad activity 5: Conduct survey of STI clients HIV seroprevalence	MoH HQ EDF Contracting agencies	Survey conducted	5,000			
Broad activity 6: Conduct survey of antenatal HIV and STI prevalence	MoH HQ MoH zone	Survey conducted	30,000			
Broad activity 7: Conduct survey of HIV and STI prevalence in CSWs	MoH HQ MoH zone EDF ESMG Vision Eritrea	Survey conducted			40,000	
Broad activity 8: Conduct survey of military HIV and STI prevalence	MoH HQ EDF	Survey conducted			30,000	
Broad activity 9: Conduct infection control study	MoH HQ MoH zone EDF	Study conducted	20,000			
Total						

1) Budgets per indicator only if possible, otherwise total budget for semester

Annex B: ***Principal Recipient Year 2 - Budget and Workplans for 2005***

Country:	**ERITREA**
Disease:	**HIV/AIDS**
Grant number:	
Principal Recipient:	**MOH**
Currency:	**USD**

Consolidated Budget & Indicators

		SEMESTER 1 (QUARTER 1 & QUARTER 2)		SEMESTER 2 (QUARTER 1 & QUARTER 2)		
Objectives/Broad activities	**Responsible**	Indicators -- Description	Budget[1)]	Indicators -- Description	Budget[1)]	**B**
OBJECTIVE 1: ***Scale up and expand effective HIV prevention activities in target populations***						
THE MILITARY						
Broad activity 1: Produce male & female prevention education brochures and posters	MoH HQ MoH zone ESMG EDF					
Broad activity 2: Print male & female brochures and posters	MoH HQ MoH zone ESMG EDF					
Broad activity 3: Train trainers for youth peer education	MoH HQ MoH zone ESMG EDF NUEYS					
Broad activity 4: Train youth peer educators	MoH HQ MoH zone ESMG EDF			300 of Youth Peer Educator trainings 300x 5 days x $30	45,000	
Broad activity 5: Hold HIV prevention sessions with condom demonstration	MoH zone ESMG	50 of HIV prevention sessions with condom demonstration	1,500	50 of HIV prevention sessions with condom demonstration	1,500	

	EDF NUEYS NUEW					

Broad activity 6: Train all military staff for demobilisation	ESMG EDF NUEYS			50 HIV prevention sessions with condom demonstration	1,500	
Broad activity 7: Train clinicians in STI syndromic management	MoH HQ MoH zone EDF					
Broad activity 8: Distribute female condoms	MoH zone EDF NUEYS NUEW	1,000 female condoms distributed	2,000	1,000 female condoms distributed	2,000	
SPOUSES OF THE MILITARY						
Broad activity 1: Produce female prevention education brochures and posters	MoH HQ MoH zone ESMG EDF					
Broad activity 2: Print female brochures	MoH HQ MoH zone ESMG EDF					
Broad activity 3: Train trainers in peer education	MoH HQ MoH zone ESMG EDF NUEYS					
Broad activity 4: Train peer educators	MoH HQ MoH zone ESMG EDF					
Broad activity 5: Hold HIV prevention sessions with condom demonstration	MoH zone ESMG EDF NUEYS NUEW	100 HIV prevention sessions with condom demonstration	3,000	100 HIV prevention sessions with condom demonstration	3,000	
Broad activity 6: Train all military staff about	ESMG	50 HIV prevention sessions with condom	1500	50 HIV prevention sessions with condom	1500	

spouses for demobilisation	EDF NUEYS	demonstration		demonstration		
Broad activity 7: Distribute female condoms	MoH HQ MoH zone EDF	1,000 female condoms distributed	2,000	1,000 female condoms distributed	2,000	
COMMERCIAL SEX WORKERS						
Broad activity 1: Produce CSW prevention education brochures	MoH HQ MoH zone ESMG MoLHW					
Broad activity 2: Print CSW brochures	MoH HQ MoH zone ESMG MoLHW					
Broad activity 4: Train trainers for CSW peer education	MoH HQ MoH zone ESMG					
Broad activity 5: Train CSW peer educators	MoH HQ MoH zone ESMG MoLHW	100 CSW HIV prevention sessions with condom demonstration	3,000	100 CSW HIV prevention sessions with condom demonstration	3,000	
Broad activity 6: Hold HIV prevention sessions with condom demonstration	MoH zone ESMG MoLHW NUEYS NUEW	2,500 female condoms distributed	5,000	2,500 female condoms distributed	5,000	
Broad activity 7: Distribute female condoms	ESMG NUEYS NUEW					
STI CLIENTS						
Broad activity 1: Produce male & female prevention education brochures and posters	MoH HQ MoH zone EDF ESMG MoLHW					

	Vision Eritrea					
Broad activity 2: Print male & female brochures and posters	MoH HQ MoH zone ESMG MoLHW EDF Vision Eritrea					
Broad activity 3: Train clinicians in STI syndromic management	MoH HQ MoH zone EDF					
Broad activity 4: Distribute female condoms	MoH HQ MoH zone ESMG MoLHW EDF NUEYS NUEW	1,000 female condoms distributed	2,000	1,000 female condoms distributed	2,000	
OBJECTIVE 2: ***Increase the number of people who know their HIV status by improving availability and quality of voluntary counselling and testing***						
Broad activity 1: Establish 4 freestanding VCT run by MOH	NATCoD	Identification of 4 sites and human resources to establish 4 freestanding VCT development run by MOH in zones (1 in 4 different zone)	1,000	Development and running of 4 Free standing VCT run by MOH	20 000	
Broad activity 2: Set up facility-based VCT services in 30 health centres at zone level: development and running VCTs	NATCoD MoH zone	VCT facility-based in 15 health centres in 6 zones: identification of sites and existing human resources to be trained on counselling and testing	1,000	VCT facility-based in 15 health centres in 6 zones: identification of sites and human resources to be trained on counselling and testing	20,000	2
Broad activity 3: Set up 5 facility-based VCT at health centre level in the military	MoH EDF	Identification of the health centres Development and running of 5 VCT-facility based in the divisions	1,000	Development and running of 5 other VCT health centre-based at Division level in the military	15,000	16
Broad activity 4: Establish 3 youth centre-based VCT services and BIDHO association-based VCT services	BIDHO NUEYS	Contracts signed with BIDHO and NUEYS (development and running of 1 VCT each)	10,000	Contracts signed with NUEYS (development and running of 1 VCT)	6,000	1

Broad activity 5: Provide rapid tests to all VCT sites for screening and confirmatory tests military included	Pharmecor NATCoD EDF	40 000 tests provided	96,000	40 000 tests provided	96,000	19
Broad activity 6: Carry out internal HIV quality control for 20% of tests performed at health facility level HIV whole blood testing included	CHL Zonal referral hospitals	8000 blood samples sent for QC HIV testing to CHL	1,500	8000 samples sent to CHL for QC HIV testing	1,500	3,(
Broad activity 7: Train health workers, non-health workers, in MoH and EDF health centres, as well as BIDHO and NUEYS associations, on counselling and whole blood testing	NATCoD CHL MoH region EDF	40 counsellors trained	16,875	35 counsellors trained	16,875	33
Broad activity 8: Train VCT supervisors at regional levels in 6 zones and in the military	NATCoD MoH zone EDF	20 VCT supervisors trained	9,000	20 VCT supervisors trained	9,000	18
Broad activity 9: Train laboratory technicians or non-health workers on HIV whole blood testing including the military and health centres human resources	CHL NATCoD EDF	20 Lab technicians trained	6,000	20 non health workers trained on whole blood testing	6,000	12
Broad activity 10: Recruit and hire Non health workers to run VCT	MoH	15 non-health workers hired	36,000	15 non-health workers hired	36,000	72
OBJECTIVE 3: ***Increase the number of infected who receive effective counselling and medical intervention to decrease the likelihood of HIV transmission to children (PMTCT)***						
Broad activity 1: Integrate PMTCT services to antenatal services and regional hospitals in 2 regions	NATCoD MoH zones (Debub and Maekel)	Expanded integrated PMTCT services to antenatal sites in Anseba	2,000			2
Broad activity 2: Provide HIV and Syphilis tests for pregnant women screening and confirmatory tests for HIV+ mothers in Debub and Maekel antenatal sites	Pharmecor NATCoD MoH zones	25 000 HIV tests provided 30 000 Syphilis tests provided	85,000	25 000 HIV tests provided 16 000 Syphilis tests provided	78,000	16
Broad activity 3: Train health workers of antenatal and referral hospitals in Debub and Maekel	NATCoD MoH/Zone	75 health workers trained on PMTCT strategy and activities	33,750	75 health workers trained on PMTCT strategy and activities	33,750	67

Broad activity 4: Provide ARV therapy to mothers at delivery	Pharmecor MoH/Zones National referral hospitals	500 mothers receiving ARV therapy	10,000	450 mothers receiving ARV therapy	9,000	19
Broad activity 5: Provide ARV therapy to newborns from HIV positive mothers	Pharmecor	500 newborns receiving ARV	8,000	450 newborns receiving ARV therapy	7,000	15
Broad activity 6: Provide infant formula	Pharmecor Referral hospitals	500 infants receiving formula	Provided by UNICEF	400 infants receiving formula	Provided by UNICEF	
Broad activity 7: Elaborate and disseminate IEC materials for pregnant women and health workers sensitisation on PMTCT services and guidelines	IEC/MoH NATCoD Private sector supplier	Contract with a Communication supplier	3,000	Dissemination of materials	1000	4,(
Broad activity 8: Provide syphilis treatment for syphilis reactive women	MoH/zones Pharmecor National referral hospitals	500 syphilis reactive pregnant women receiving syphilis treatment, counselling and follow-up	3,000	500 syphilis reactive pregnant women receiving syphilis treatment, counselling and follow-up	1, 500	4,
Broad activity 9: Provide materials for safe obstetric procedures	Pharmecor National and zonal referral hospitals	10 PMTCT sites equipped with essential obstetric care materials	7,000	10 PMTCT sites equipped with essential obstetric care materials	7,000	14
OBJECTIVE 4: ***Improve the availability and the quality of health care and psychosocial and economic support for PLHAs and orphans***						
SET UP A NATIONAL REFERENCE LABORATORY FOR HIV/AIDS, STI AND TB AT CHL IN ASMARA						
Broad activity 1: Expand and improve quality control for HIV, Syphilis, TB and other OI	CHL NATCoD MoH/Zones Washington University Retrovirology Lab			Quality control started on biological diagnosis of OI including TB, and for STI in Regional referral hospitals in Asmara	30,000	3(
Broad activity 2: Provide reagents and other supplies for biological diagnosis of HIV/AIDS related OI including culture anaerobic commodities and supplies	Pharmecor	Procurement of reagents to diagnose Cryptococcose, Pneumocystis carinii, Campylobacter, Cryptosporidiosis, Toxoplasmose, TB, STIs	5,000	Reagents supplied to regional referral hospitals Laboratories in Asmara	5,000	1(

Broad activity 3: Provide equipment for CD4 counts performance at CHL[32]	MoH Pharmecor CHL	Procurement of 1 FACSCount machine at CHL				
Broad activity 4: Provide reagents and other supplies to perform CD4 counts	Pharmecor	Reagents available to perform 800 CD4 counts (1 at launching of treatment for 400 patients, 1 for follow-up)	32,000	Reagents available to perform 800 CD4 counts (1 at launching of treatment for 400 patients, 1 for follow-up)	32,000	64
Broad activity 5: Provide biological follow-up for patients under ARV drugs 4 times a year (blood cells, kidney function, liver function, etc.)	CHL	1600 biological check up lab tests for 400 patients under ARV therapy	100,000	1600 biological check up lab tests for 400 patients under ARV therapy	100,000	20
Broad activity 6: Train Lab technicians to perform CD4 counts[33]	CHL MoH/Zone Maekel	3 CHL Lab technicians trained abroad 1 month				
Broad activity 7: Train Lab technicians to perform OI (+TB) & STI biological diagnosis at CHL, national referral hospitals and zonal referral hospitals	MoH/Zones CHL	20 Lab technicians trained at CHL and regional referral hospitals	9,000	20 Lab technicians trained in zonal hospitals	9,000	9,
Broad activity 8: Establish external quality control with reference Lab in neighbouring country and back-up from University of Washington Retrovirology Lab	MoH CHL Washington University Retrovirology Laboratory	160 samples sent to neighbouring country for QC CD4 counts	6,000	160 samples sent to neighbouring country for QC CD4 counts	6,000	12
Broad activity 9: Recruit and hire Lab technicians	MoH CHL	10 Lab technicians recruited and hired	10,000	10 Lab technicians recruited and hired	10,000	20
SCALE UP CLINICAL AIDS CASE MANAGEMENT IN HOSPITALS AND AMBULATORY HEALTH SETTINGS (OUTPATIENT WARDS), MILITARY INCLUDED						
Broad activity 1: Train core teams of health workers in national referral hospitals and regional hospitals (23 settings) on AIDS case management and diagnosis of OI, TB included	MoH NATCoD MoH/Zones	50 health workers trained from regional referral hospitals in Asmara 7 days	10,500	50 health workers trained from regional referral hospitals 7 days	10,500	21

[32] Viral load will not be performed year 1 but year 2.
[33] Lab technicians will be trained on viral load tests year 2.

Broad activity 2: Increase the capacity of health workers (including the military) to give OI preventive treatment to HIV positive clients, mothers, children and symptomatic patients and provide Cotrimoxazole and INH	NATCoD Pharmecor MoH/Zone Maekel	200 health workers trained 1500 adults HIV beneficiaries 500 children beneficiaries	45,000	400 health workers trained 1500 adults beneficiaries 500 children beneficiaries	45,000	90
Broad activity 3: Provide drugs to treat OI that are not on national essential drug list Fluconazole, Ketoconazole, Pentamidine, Ceftriaxone	Pharmecor	Drugs provided to treat 1000 AIDS patients in national referral hospitals	128,400	Drugs provided to treat 1000 AIDS patients in regional referral hospitals	128,400	25
Broad activity 4: Procure ARV Drugs to treat 1200 eligible HIV positive patients	Pharmecor	ARV therapy available for 600 eligible patients in national referral hospitals	240,000	ARV therapy available to treat 600 eligible patients in national referral hospitals in Asmara and 1 national referral hospital in the military	240,000	48
Broad activity 5: Train health workers from medical wards and outpatient wards on counselling and nurses from paediatrics wards on children counselling including AIDS orphans	NATCoD National Referral hospitals in Asmara	30 nurses trained on counselling plus 3 children counsellors from national referral hospitals trained on children counselling	9,000	30 nurses trained on counselling plus 2 counsellors from regional referral hospitals trained on children counselling	9,000	18
Broad activity 6: Sensitise health workers and patients on integrated network utilization of services	NATCoD MoH	Contracts established between VCTs, BIDHO and referral outpatient services from referral hospitals		Contracts established between VCTs, BIDHO and referral outpatient services from referral hospitals		
Broad activity 7: Provide palliative care to PLHAs	MoH/Zones National referral hospitals	500 PLHA receiving palliative care	30,000	500 PLHA receiving palliative care	30,000	60
Broad activity 8: Train core trainers of health workers on palliative care	MoH/Zones NATCoD	3 health workers from national referral hospitals trained in palliative care abroad		3 health workers from regional referral hospitals trained in palliative care abroad		
PROVIDE HOME BASED CARE TO PLHA ADULTS AND CHILDREN						
Broad activity 1: Provide HBC kits to BIDHO, NGOs and FBOS	Pharmecor NATCoD	300 HBC kits distributed	30,000	300 HBC kits distributed	30,000	60
Broad activity 2: Train Volunteers from various civil society organisations on HBC	NATCoD BIDHO FBOs	150 volunteers trained (50 per month)	45,000	150 volunteers trained (50 per month)	45,000	90
Broad activity 3: Expand HBC activities in Asmara and other regions	BIDHO FBOs NATCoD			Contract with FBO and other NGOs (NUEYS and NUEW) to undertake HBC activities outside Asmara (300 beneficiaries)	5,000	5,(

Broad activity 4: Train HBC nurse supervisors	NATCoD MoH/Zones	Recruit, hire and train 4 HBC supervisors within BIDHO and FBO in Asmara	7,000	Recruit and hire and train 4 HBC supervisors in 2 other regions	7,000	14
Broad activity 5: Provide motorcycles to HBC supervisors	MoH	12 HBC supervisors equipped with motorcycles	120,000	24 HBC supervisors equipped with motorcycles	120,000	24
SUPPORT TO PEOPLE LIVING WITH HIV AND AFFECTED						
Broad activity 1: Foster the emergence of PLHA associations outside Asmara	BIDHO NATCoD FBO	Contract with BIDHO to open Southern Red Sea branch	3,000	Contract with BIDHO to open Northern Red Sea branch	3,000	6,
Broad activity 2: Develop organisational and management capacity of PLHA associations throughout the country (administration, communication & Newsletter development, transportation and human resource development)	NATCoD BIDHO			Contract with private provider to build management capacity for BIDHO Northern Red Sea and Southern Red Sea	5,000	5,
Broad activity 3: Develop service delivery capacity for BIDHO and branches (Advocacy, BCC, counselling and testing, condom and food distribution, HBC, psychosocial and economic support activities)	NATCoD Private service provider	Contract with private service provider to build service delivery capacity for BIDHO in Asmara and branches including international study tours in neighbouring countries	5,000	Contract with service provider to build service delivery capacity for BIDHO NRS and SRS branches	5,000	10
Broad activity 4: Train members of BIDHO, FBO, NUEYS, NUEW, NCEW, to provide psychosocial support and counselling to PLHA, their families and orphans	NATCoD Health services FBOs BIDHO	Contract with BIDHO, FBO, to provide support and counselling to 2,500 patients and families including orphans	5,000	Contract with NUYES and NUEW to provide support and counselling to 2,500 patients and families including orphans	5,000	10
Broad activity 5: Train service providers (school teachers, social workers) to better care for and protect orphans and vulnerable children	MoE NATCoD MoLHW	Contract with Ministry of Education to train school teachers		Contract with Ministry of Labour and Social Welfare (MoLSW) to provide better care for orphans		
Broad activity 6: Provide community with skills for income generating activities and links with micro-finance institutions	FBOs BIDHO ACCORD Eritrea	Contract with service provider to train FBO and BIDHO on Income generating project management	5,000	Provide technical assistance to BIDHO and FBO to launch and monitor income generating projects	5,000	10
Broad activity 7: Provide small grants to NGOs working with children to ensure basic needs of orphans are met		Contract with MoLHW, FBO and NGOs to provide support to 1000 orphans and their foster families	5,000	Contract with FBO and NGO to provide support to 1000 orphans and their foster families	5,000	10

Broad activity 8: Provide food to PLHA, children and orphans in need	WFP MoLHW BIDHO FBOs	Contract with NGO, FBO, Unions and BIDHO to organise food distribution for PLHA, families and orphans in Asmara (7 store rental)	10,000	Contract with NGO, Unions and FBO to organise food distribution for PLHA, families and orphans, in Debub, Gash-Barka and Anseba	10,000	20
OBJECTIVE 5: *Expand blood transfusion safety (HIV, Hep B, Hep C, and Syphilis) to regional blood banks to establish procedures for, and ensure adherence to, universal precautions in the health care setting*						
EXPAND BLOOD SAFETY TO REGIONAL BLOOD BANKS						
Broad activity 1: Create a regular pool of donors and encourage blood donor association	NATCoD NBTC	Contract with NBTC for regular pool of donor social mobilisation activities		Contract with NBTC for creation of a blood donors association		
Broad activity 2: Train laboratory technicians from regional hospitals and military to perform HepB, HepC , HIV and Syphilis tests before transfusion	NBTC CHL MOH/Zone NATCoD	Train 5 lab technicians (4 regional MOH hospitals, 1 military hospital)	2,250	Train 5 lab technicians (4 regional MOH hospitals + 1 military hospital)	2,250	4,
Broad activity 3: Provide HIV, HepB, HepC, Syphilis test kits and other supplies to regional and military referral laboratories for blood transfusion safety purposes	Pharmecor CHL	1000 transfusions	12,000	1000 transfusions	12,000	24
UNIVERSAL PRECAUTIONS GUIDELINES AND PROCEDURES						
Broad activity 1: Carry-out whole site trainings on universal precautions guidelines and procedures in hospitals and health centres military included, (year 1 only hospitals are targeted)	MoH/QA EDF NATCoD	Undertake whole site trainings in 12 MOH hospitals and 3 military hospitals on *Universal precautions* guidelines and procedures	40,000	Undertake whole site trainings in 10 MOH hospitals on *Universal precautions* guidelines and procedures	30,000	70
Broad activity 2: Conduct needs assessment study on universal precautions procedures in hospitals and health centres	MoH/QA NATCoD	Contract with private sector service provider to carry out an *Equipment, commodities needs assessment study*				
Broad activity 3: Provide complementary commodities and gloves, sterilization equipment to hospitals and health centres in all regions	Pharmecor MoH/QA	Needs assessment underway		Procurement of complementary commodities, gloves and sterilization equipment for 22 health centers	400,000	40

Broad activity 4: Provide waste management infrastructure in referral, regional and military hospitals (9 sites year 1)	MoH/Environment health EDF Procurement services	Procure waste management infrastructure and training on 10 sites	400,000	Provide waste management infrastructure and training on 10 sites	400,000	80
Broad activity 5: Train core team of trainers for universal precautions	MoH/Zone EDF MoH/QA	60 trained in Universal precautions	27,000	60 trained in Universal precautions	27,000	54
HIV PEP PROTOCOL IMPLEMENTATION						
Broad activity 1 Provide health services with guidelines on accidental transmission of HIV and a written protocol for PEP prophylaxis	MoH/QA NATCoD EDF	Guidelines distributed and training carried out in 5 regional MOH hospitals 5 military hospitals (1500 trainees)	21,000			21
Broad activity 2: Train a core team for HIV-exposed health worker counselling, testing and ARV prophylaxis treatment in regional and military hospitals	NATCoD EDF MoH/Zone MoH/QA	3 core teams x 10 people MOH hospitals trained on HIV PEP and 1 core teams from military hospital	3, 000	1 core teams x 10 people trained on HIV PEP and 1 from military hospital	1,000	4,
Broad activity 3: Provide ARV therapy to HIV exposed health workers	Pharmecor	Procurement of ARV following PEP Protocol (50 receiving ARV)	12,040	Procurement of ARV following PEP Protocol (50 receiving ARV)	12,040	24
OBJECTIVE 6: ***Strengthen and expand epidemiological and behavioural surveillance and programme monitoring activities***						
Broad activity 1: Strengthen reporting of adult and paediatric AIDS cases	MoH zones HMIS HQ IDSR HQ EDF	30 of Health Care Facilities Reporting	2,000 1,000	30 of Health Care Facilities Reporting	2,000 1,000	
Broad activity 2: Collect and analyse STI service utilisation data	MoH zones HMIS HQ IDSR HQ EDF	30 of Health Care Facilities Reporting	2,000 1,000	# of Health Care Facilities Reporting	2,000 1,000	
Broad activity 3: Conduct survey of antenatal HIV seroprevalence	MoH HQ Contracting agencies	Survey conducted	10,000 10,000			
Broad activity 4: Conduct survey of TB patients HIV seroprevalence	MoH HQ EDF Contracting agencies	Survey conducted	2,500 2,500			

Broad activity 5: Conduct survey of STI clients HIV seroprevalence	MoH HQ EDF Contracting agencies	Survey conducted	2,500 2,500			
Broad activity 6: Conduct survey of antenatal HIV and STI prevalence	MoH HQ MoH zone					
Broad activity 7: Conduct survey of HIV and STI prevalence in CSWs	MoH HQ MoH zone EDF ESMG Vision Eritrea	Survey conducted				
Broad activity 8: Conduct survey of military HIV and STI prevalence	MoH HQ EDF	Survey conducted				
Broad activity 9: Conduct infection control study	MoH HQ MoH zone EDF	Study conducted				
Total						

1) Budgets per indicator only if possible, otherwise total budget for semester

SECTION VI – Programmatic and Financial management information

Programmatic and financial arrangements are the same for the two components. The project will be implemented under the supervision and monitoring of the Eritrean Partnership against HIV/AIDS, TB and Malaria. The funds will be received from the Trustee by the Principal Recipient (PR), which will be the Ministry of Health and more specifically its Programme Management Unit (PMU), already in place for the management of the funds of the HAMSET Control Project, which is the World Bank sponsored project of USD 40 million.

The PR will have the responsibility to disburse funds to sub-recipients or implementers already identified in the project proposal. It will act as both the Treasury Agent and the Comptroller of the funds allocated by the Global Fund. As a treasurer, the PR will assure that the funds requested by the different implementers are disbursed on a timely manner and for the intended purposes as reflected in each semester workplans. As comptroller, it will ensure that the funds are spent in a transparent and efficient manner according to established accounting norms and financial control standards.

35. Identify your Principal Recipient(s) (PR)

Table VI.35

Name of PR	**Ministry of Health**	
Name of contact	Hon. Mr. Saleh Meky Minister of Health	
Address	P.O. Box 212 Asmara, Eritrea	
Telephone	+291-1-1202917	
Fax	+291-1-122899	
E-mail	smeky@gemel.com.er	

Please note: If you are suggesting having several Principal Recipients, please copy Table VI.35 below.

35.1. Briefly describe why you think this/these organisation(s) is/are best suited to undertake the role of a Principal Recipient for your proposal/component (e.g. previous experience in similar functions, capacity and systems in place, existing contacts with sub recipients etc) (1–2 paragraphs)

The Programme Management Unit of the Ministry of Health is already managing funds for the HAMSET Control Project. It has a good record of transparency and effective management of the funds. Its staff is already well acquainted with similar procedures for the HAMSET Control Project. Using such existing structure will need minimal strengthening and can be fully operational within a short time. Capacity building of the needed new staff will be done on the job by existing staff.

35.2. Briefly describe how your suggested Principal Recipient(s) will relate to the CCM and to other implementing partners (e.g., reporting back to the CCM, disbursing funds to sub-recipients, etc.) (1 paragraph)

The proposed PR will report to the Partnership and its Executive Secretariat, which will approve progress and financial reports, and implementation workplans before ordering disbursements and/or authorizing sending reports to the GFATM Secretariat through the Local Fund Agent. The Partnership as well as its Executive Secretariat include representatives of all the stakeholders involved in the national response to the three diseases.

36. Describe the proposed management arrangements (outline proposal implementation arrangements, roles and responsibilities of different partners and their relations) (1–2 paragraphs)

Each concerned implementer will prepare quarterly detailed implementation workplans at the beginning of each year. These quarterly workplans will present in a detailed fashion broad activities included in the approved proposal. Once approved by the Executive Secretariat of The Partnership, these workplans will be submitted to the CCM for endorsement, then sent to the PR office for the purpose of disbursing funds as well as monitoring and reporting progress in the execution of the programme activities.

The implementers will send their quarterly reports to the Executive Secretariat for approval before transmission to the PR. It will have the responsibility to compile the necessary information for the preparation of the reports to the Global Fund Secretariat in order to comply with the reporting procedures requested.

I. Implementation of activities

Upon approval by the Global Fund of the Eritrea HIV/AIDS/TB and Malaria (ATM) Proposal, the CCM through its Secretariat will invite and assist each implementing Organization concerned to prepare Quarterly detailed implementation workplans at the beginning of each year. These quarterly workplans will reproduce in a detailed way the activities in the approved Proposal. These workplans will be sent by the CCM Secretariat to the Principal Recipient (PR) office for the purpose of disbursing funds as well as monitoring and reporting progress in the execution of the programme activities.

a) Responsibilities of implementing organizations
In order to access funds, at the beginning of each quarter the implementing organizations will send an official request to the PR office accompanied by a copy of the quarterly detailed workplan as well as a status report on the execution of each activity in the previous quarter.

b) Responsibilities of the Principal Recipient (PR)
The PR will act as both the Treasury Agent and the Comptroller of the funds allocated by the Global Fund.

b.1) As a Treasurer, the PR will assume the following duties:

1. **Assure that the funds requested by the different implementers are disbursed on a timely manner and for the intended purposes as reflected in the quarterly workplans. In particular, the disbursements of funds should comply with the following norms:**

    a) Disbursements for personnel costs must be accompanied by:

- Staff: an official list of all Personnel appointed/ recruited with the corresponding Terms of reference;
- Consultants: a copy of the Contractual agreement for each consultant.

b) Disbursements for Equipment costs must be accompanied by references to the specific items in the List of equipment in the Proposal to the Global Fund. Any change in this list by the implementing organization must be first justified in agreement with the CCM Secretariat.

c) Disbursements for Supplies and Products costs must be accompanied by reference to the List as specified in the Proposal.

d) Any transfer of funds from one Budget category to another should be authorized by the Secretariat of the Global Fund or its Local Fund Agent.

2. In order to ensure further financial advances/replenishments from the Global Fund, submit a Statement of Expenditures to the Secretariat of the Global Fund or its Local Fund Agent by the end of the first week of each month.

b.2) As a Comptroller, will assume the following duties:

Ensure that the funds are spent in a transparent and efficient manner according to established accounting norms and financial control standards; in particular:

a) Ensure that the proper accounting and a common financial information system are in place which will provide for the Monitoring and financial reporting in a manner which reflects accurately the implementation of the Programme, by Component, Activities and Budget categories, as per annual approved workplans. A Summary of the Financial Situation of the programme on June 1 and December 1 must be presented.

b) Carry out bi-annual internal audits as well as an annual independent audit (in December) of the use of funds allocated by the Global Fund.

Given these responsibilities as well as the volume of financial and human resources to be managed, the PR will assign a Project Coordinator to attend the activities of the Programme. His/her main tasks will be:

- Receive and process the requests for disbursement from programme implementers;
- Relate with the Finance/ Accounting department of the PR to ensure that the financial reports are prepared according to the required format and submission dates.
- Act as a daily contact person for the implementing organizations and the CCM Secretariat.
- Submit copies of the above-mentioned quarterly reports (2B.1.2) to the CCM Secretariat for its quarterly meetings.

b.3) Procurement Management

1. Selection of Suppliers
   a) Equipments, Supplies, Commodities/Products (incl. Drugs) will be procured by open and competitive tenders consistent with applicable national and International Organizations (Specialized UN Agencies; World Bank.) procedures. Within the arrangements made in the HAMSET project, Procurement will be carried by the Project Management Unit (PMU) under the Ministry of Health on behalf of the participating organizations. The PMU has been assessed by the IDA/World Bank mission as procurement-capable under the HAMSET Project requirements). The procurement risk rating for this project is low. The PMU has implemented an IDA-assisted project (Eritrea Health), which has a very good track record in procurement

management. A Manual of procedures has been developed by IDA for the PMU's procurement management.

Procurement goods under Eritrea Proposal to the Global Fund consist mainly of Drugs (for HIV/AIDS and Malaria); and these have to be purchased in the international market under competitive bidding. Very few minor medical procurement actions at local level can be carried out.

2. Distribution mechanism
   The PMU will assume both the purchase and distribution of goods on behalf of the implementing organizations, under the same procedures applied by the IDA HAMSET project.

II. Monitoring and evaluation of the programme

a) Monitoring ATM activities

The monitoring of the programme activities as provided by the quarterly integrated implementation workplans only allows assessing the process indicators, not the quality and coverage of the activities. Therefore, the implementing organizations should provide to the CCM Secretariat an assessment of implementation progress for the outcome indicators as specified in the annual workplans. These activities progress Reports will be submitted no later than June 1 and December 1. The CCM Secretariat will submit these progress reports to the Secretariat of the Global Fund in Geneva or its Local Fund Agent.

b) Financial monitoring and Control

As specified in Section B above.

c) Programme Evaluation

A comprehensive evaluation of the progress in the implementation of the Programme will be undertaken jointly by the Secretariat of Global Fund and the Representatives of the CCM and the Implementing Organizations at the end of the second year of programme funding. Subsequent years funding is subject to this evaluation.

Programme administration

IDA has allocated around US$ 450,000 for administrative support to the PMU, mostly in human resources to strengthen its financial management and procurement capacity. However, as recommended in section B above, a local Project Coordinator, supported by a Procurement Officer and a Financial Officer at the PMU, as well as a Project Officer in each of the 6 Zobas, will be assigned for the administration and coordination of the activities of the ATM Programme and paid out of the Global funds for the duration of the Programme.

See a proposed Budget for the Programme Administration refer to 37.

36.1. Explain the rationale behind the proposed arrangements (e.g., explain why you have opted for that particular management arrangement) (1 paragraph)

Detailed implementation workplans will allow a greater respect of the approved project and a close monitoring of the activities. Disbursements will only be done according to clear plan and following appropriate reporting. Such arrangements are based on the procedures requested by the World Bank for the implementation of the HAMSET project. This is particularly appropriate for this project as the management Unit of the MoH is used to these management procedures.

37. Briefly indicate links between the overall implementation arrangements described above and other existing arrangements (including, for example, details on annual auditing and other related deadlines)**. If required, indicate areas where you require additional resources from the Global Fund to strengthen managerial and implementation capacity** (1–2 paragraphs)

Additional resources for a total amount of USD 258,345 are required to strengthen the Project Management Unit at the Ministry of Health as Principal Recipient, as in proposed budget.

ERITREA PARTNERSHIP AGAINST HIV/AIDS
TUBERCULOSIS AND MALARIA

FINANCIAL SUPPORT TO THE PMU (MOH) FOR PROGRAMME ADMINISTRATION

	Year 1 (Nakfa)	Year 2 (Nakfa)	Total (US$)
I. Staff			
I. Staff **I.1. National Staff** **Asmara** 1 Project Coordinator 1 Procurement Officer 1 Financial Officer **Zobas** 6 project officers	 60,000 60,000 60,000 216,000	 60,000 60,000 60,000 216,000	 58,700
I.2. International Staff 6 p/month			70,000

Sub-total for Staff			**128,700**
II. Operating Costs 2.1 Equipment (computers & accessories, office furniture) 2.2 Supplies + other office expenses			60,000 40,000
Sub-total for Operating Costs			**100,000**
III. External Audits			**3,000**
IV. Contingencies (15%)			**26,645**
TOTAL			**258,385**

LIST OF ATTACHMENTS

General documentation:	**Attachment #**
List of private and civil society organisations members of The Eritrean Partnership Against HIV/AIDS, Tuberculosis and Malaria	**1**
1. Poverty Reduction Strategy Paper (PRSP) 2. Medium Term Expenditure Framework (Sources of financial resources) 3. Sector strategic plans 4. Any reports on performance	
HIV/AIDS specific documentation:	**Attachment #**
5. HIV/AIDS/STI: Analysis of the current situation and response, April 2003	**2**
6. Baseline data for tracking progress (KAP survey)	
7. National Strategic Plan on HIV/AIDS/STI, 2003-2007, April 2003	**3**
8. Results-oriented plan, with budget and resource gap indication (where available)	
TB specific documentation:	**Attachment #**
9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control	
10. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents	
11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form)	
12. Most recent independent assessment/review of national TB control activities	
13. National Strategic Plan on Tuberculosis, 2003-2007, Draft, April 2003	**4**

Other documentation:

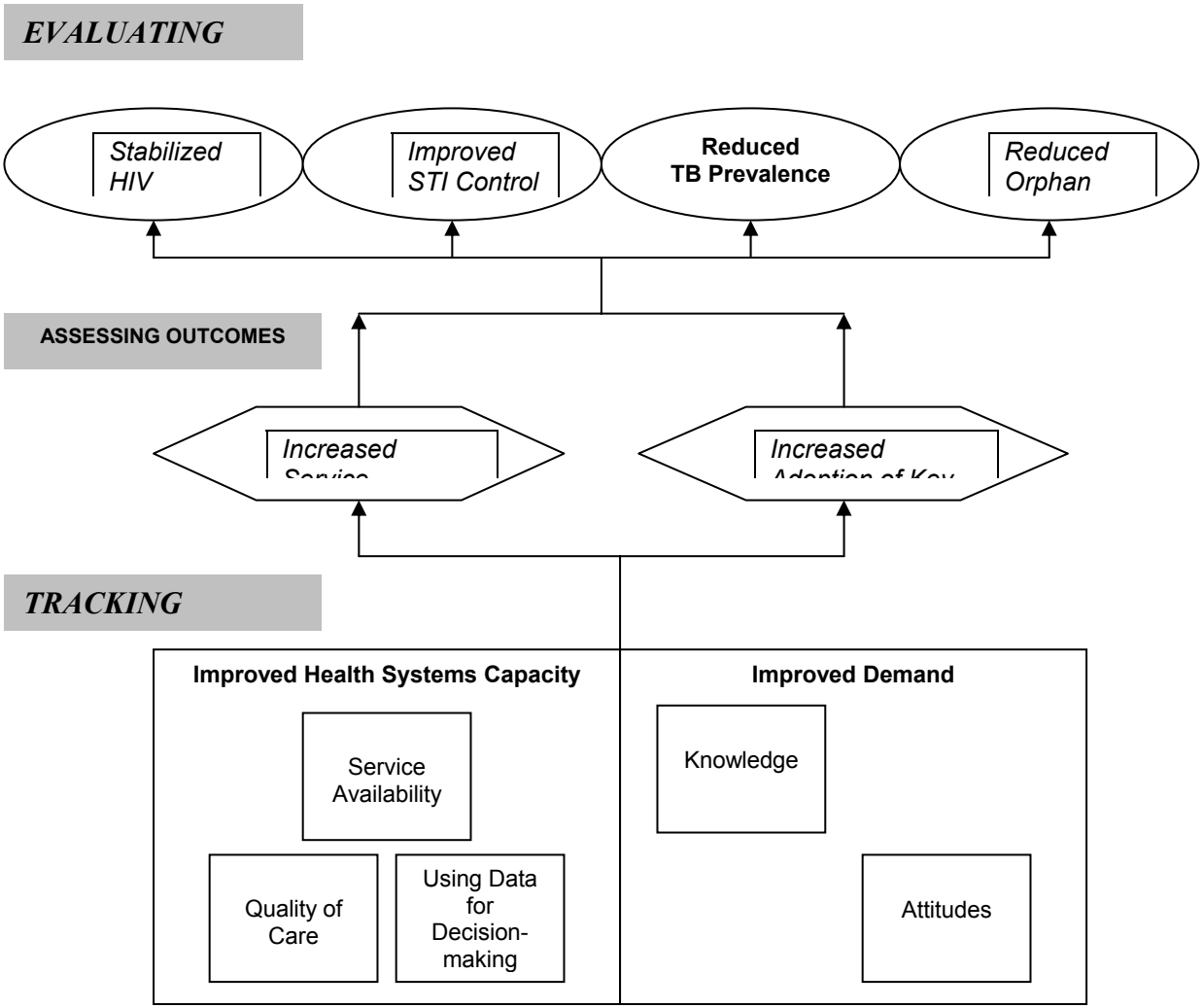
General documentation:	**Attachment #**
HIV/AIDS specific documentation:	**Attachment #**
National Guidelines for HIV Testing, June 2002	**5**
PMTCT Guidelines And Action Plan, July 2002	**6**
Situational Analysis of Commercial Work in Eritrea, March 2003	**7**
Eritrean Antiretroviral Therapy Guidelines, Draft, 25 March 2003	**8**
NACP Annual Report 2002	**9**
TB specific documentation:	**Attachment #**
Crosscutting documents/activities:	**Attachment #**

SECTION VIIA – Monitoring and Evaluation Information

38a.1. Overall M&E Approach

Eritrea is committed to a monitoring and evaluation (M&E) approach that links Global Fund resources and programme inputs to achievable and measurable results. The M&E plan described in this proposal is consistent with the M&E plan that is currently being developed for Eritrea's 2003–2007 National HIV/AIDS Strategy. The following three principles will guide Eritrea's Global Fund M&E efforts: 1) strengthening the M&E capacity of multiple stakeholders, 2) engaging in rigorous and programmatically meaningful data collection, and 3) maximizing the use of information to respond appropriately, efficiently, and effectively to any problems that are identified. As depicted in Figure VII.1, Eritrea's M&E plan involves the evaluation of impact, the periodic assessment of key outcomes, and the continuous tracking of programme progress (Specific indicators are summarized in section 38.5). Measures that will be used to evaluate impact correspond to two population-level results: transmission and impact of the disease. Lower-level outcomes relate to coverage/service utilization and the adoption of key behaviours in targeted population sub-groups (e.g., sex workers, military personnel). The CCM has also identified barometers of programme progress that will be assessed routinely using various data sources and approaches. These process measures have been grouped into two categories: a) those that relate to health systems capacity and b) those that relate to the demand for the services and/or behaviours being promoted.

Figure VII.1:
Monitoring and Evaluation Framework



38a.2. Involvement of beneficiaries in M&E

The Eritrean Partnership Against HIV/AIDS, Tuberculosis, and Malaria recognizes beneficiary involvement in programme planning, implementation, and M&E as a requirement, not an option for success. Persons living with HIV/AIDS (PLHA) will be engaged in M&E primarily through BIDHO, Eritrea's national PLHA association. People living with and affected by HIV/AIDS can play an advisory role in the design of data-collection instruments and approaches. When appropriate, they can also be involved in the collection of programme data. For example, BIDHO and FBOs – both of which have a presence at the grassroots level – can provide useful information on the coverage and quality of community-based care and support efforts, as well as promote the establishment of community-based monitoring systems such as home-based care or orphans registers in communities hardest hit by HIV/AIDS. This information can then be triangulated with information from other data sources to provide a more comprehensive view of progress towards objectives. The CCM is also committed to feeding information back to programme beneficiaries, and it plans to work closely with BIDHO and other local – stakeholders to ensure accurate interpretation of M&E data and participatory development of solutions. As indicated in earlier sections of this proposal, the military is a priority target group for HIV prevention. Thus, the Eritrean Defense Force (EDF) will play a focal role in Global Fund M&E efforts. The EDF is already engaged in various M&E and programme activities related to HIV/AIDS. However, the CCM aims to strengthen communication and collaboration between the EDF and other stakeholders in the future, with the hopes of building EDF capacity to use routinely collected information to track trends, identify priorities, and devise solutions with the assistance of local HIV expertise. Finally, the National Union of Eritrean Women (NUEW), which has a reach that extends from the national level to the community, will play a vital role in efforts aimed at mobilizing target groups in the community (e.g., spouses of the military, sex workers, pregnant women) and monitoring community-based activities.

38a.3. CCM and partner involvement in M&E

M&E efforts will be highly participatory, with multiple partners contributing to the process at different stages and at different levels. The Government of Eritrea will have the primary responsibility for M&E activities at the health-facility and health-systems levels. Local MoH staff and health workers will track information through various reporting formats maintained in health facilities and submitted monthly and quarterly to the zonal level. As part of Eritrea's on-going M&E capacity strengthening efforts, zonal medical officers will work closely with staff from the National AIDS and TB Control Division (NATCoD) in compiling the requisite M&E information and ensuring timely and complete reporting in the Health Management Information System (HMIS) and Integrated Disease Surveillance and Response (IDSR) system. The NATCoD will also carry out pertinent data analyses (e.g., using data from the recently instituted ANC sentinel surveillance or information from VCT reporting forms). Government ministries included in the CCM will work closely with non-governmental organizations (NGOs) to ensure that relevant programme data are incorporated into the M&E system. For example, the ministries of Defense, Health, and Labour and Human Welfare will collaborate with organizations that have global HIV/AIDS expertise (e.g., Family Health International). Through this collaboration, the CCM strives to support the MoH and local organizations such as the Eritrean Social Marketing Group (ESMG) to generate sound behavioural surveillance data on groups with high-risk behaviours, as well as relevant program data such as the number of condoms sold or distributed.

38a.4. Existing sources of M&E information

Despite being in the early stages of the HIV/AIDS epidemic, Eritrea is fortunate to have a wealth of HIV/AIDS-related information at its disposal. There are routine data-collection systems such as the HMIS (known as *SEMISH* [the State of Eritrea Management Information System for Health]) and an Integrated Disease Surveillance and Response (IDSR) system. Both of these systems entail routine reporting on different technical issues (not just HIV). The data flow from the health facilities, to zonal medical officers, to central-level MOH staff, and they will yield critical information on service availability, coverage, and HIV/AIDS-related diagnosis and case management in health units at all levels throughout the country. Although the current systems are generating potentially useful information, the CCM plans to refine them to more comprehensively reflect programme efforts related to HIV/AIDS, as well as track very specific aspects of quality of care (e.g., the availability of essential drugs for prophylaxis and treatment of opportunistic infections, or the availability of rapid HIV test kits at VCT service delivery points). The CCM also aims to reinforce mechanisms for ensuring that relevant information gets reported up to the central level, as well as establish mechanisms for feeding information back to the zonal and sub-zonal levels. In addition to these routine data-collection systems, there has been a spate of population-based and special studies (both quantitative and qualitative) in recent years. The following is an illustrative list:

1. USAID/Eritrea sponsored **Demographic and Health Surveys (DHS)** in 1995 and 2002. Although the most recent DHS was limited to women of reproductive age (due to the fact that an overwhelming number of men of reproductive age were conscripted in the military at the time of the survey), it yields critical information on topics such as knowledge of HIV transmission and prevention, signs of STI in men and women, stigma and fear, and the discussion of HIV with a husband or partner.
2. The Eritrean Social Marketing Group (ESMG) conducted a general population **Knowledge, Attitudes, and Practices (KAP) Survey** in 2001. The study yielded information on condom use with different types of sexual partners, number of sexual partners, and various attitudes related to HIV/STI prevention.
3. Under the HAMSET Control Project, the MOH carried out a combined HIV sero-survey and behavioural risk study (the "**HIV/AIDS Risk Groups & Risk Behaviors Identification Survey**") in early 2001. The study yielded prevalence and behavioural data on the general population, as well as the following population sub-groups: bar workers, the military, antenatal clinic attendees, and students.
4. In 2002, ESMG conducted a **qualitative research study on sex workers** ("Staying Safe on the Streets: 2002 Situational Analysis of Commercial Sex Work in Eritrea"). The CCM has used information gleaned from that study to inform the development of HIV prevention strategies targeting sex workers.

Finally, Eritrea has just re-instituted an Antenatal Care (ANC) Sentinel Surveillance. (The MOH had suspended surveillance activities since 1999 due to the conflict situation with Ethiopia.). Data from the ANC sentinel surveillance will yield important impact information, and will be triangulated with seroprevalence data from other sources (e.g., blood banks).

38a.5. Summary Matrix of impact, coverage, and process indicators

Table VII.38.5 depicts the set of indicators that the Eritrean Partnership Against AIDS, Tuberculosis, and Malaria will use to evaluate impact, assess outcomes, and track progress of the activities proposed in this application. As requested on page 25 of the Global Fund application form, the following information is presented in the table:

1. Source of data
2. Periodicity of data collection
3. How the quality of data will be determined/ensured
4. Who will be primarily responsible for each indicator
5. What indicators will be reported through partner organizations

Per the instructions on page 18 of the application form, information on baseline estimates and targets for impact, outcome, and process indicators are not presented in this table, but in Section IV under each objective.

Eritrea's CCM acknowledges that it is good M&E practice to identify a concise and manageable set of indicators for program monitoring purposes. Because the Global Fund expects each budget line item to be linked to a broad activity and corresponding indicator, the CCM has been responsive to this requirement and has identified a number of output indicators for the purposes of activity/financial tracking (e.g., numbers of individuals trained, numbers of IEC/BCC materials produced, number of essential commodities distributed). Those indicators are presented in a series of tables in Section IV, as well as in the budget (Section V). For the purposes of performance monitoring, however, a small number of process indicators have been identified that correspond to health systems capacity and demand (see framework depicted in Figure VII.1).

Table VII.38a.5: OVERVIEW OF ERITREA'S M&E INDICATORS, DATA COLLECTION, AND QUALITY ASSURANCE
(Global Fund core indicators are noted in bold.)

INDICATOR	SOURCE(S) OF DATA	PERIODICITY	DATA QUALITY ASSURANCE	RESPONS-IBLE ENTITIES	PARTNER ORGANISATION REPORTING?
I. Evaluating Impact					
Overall Goal, Part A: To reduce HIV transmission					
A1. % of blood samples taken from women age 15–24 that test positive for HIV during routine sentinel surveillance at selected antenatal clinics *(UNGASS indicator)*	ANC Sentinel Surveillance	Annual	• Specialized training for all surveillance personnel • Supervisory visits by national/zonal health officers during data-collection rounds • Written & disseminated protocols for handling/storing specimens & recording/ reporting surveillance information • Result verification on a 10% random sample of specimens by the Central Health Laboratory	MoH, NATCoD	No
A2. % of blood samples taken from women age 15–24 that test positive for syphilis by Rapid Plasma Reagin (RPR) testing during routine sentinel surveillance at selected antenatal clinics	ANC Sentinel Surveillance	Annual		MoH, NATCoD	No
Overall Goal, Part B: To mitigate the personal, social and economic impact of HIV/AIDS					
B1. No. of TB cases identified per 100,000 population	IDSR	Annual	• Specialized training of health facility staff on TB diagnosis • Quality assurance training of zonal medical officers for improved supervision • Tracking of timeliness and completeness of monthly HMIS reports (from facility to zones to central level)	MoH, IDSR	No
B2. % of children under age 18 in a household survey whose mother, father, or both parents have died	DHS	Every 5 years	• DHS standard tools, sampling methods, & data analysis programs are used. • ORC Macro provides technical assistance for all phases of the survey.	USAID	No

Table VII.38a.5 (continued): OVERVIEW OF ERITREA'S M&E INDICATORS, DATA COLLECTION, AND QUALITY ASSURANCE
(Global Fund core indicators are noted in bold.)

INDICATOR	SOURCE(S) OF DATA	PERIODICITY	DATA QUALITY ASSURANCE	RESPONS-IBLE ENTITIES	PARTNER ORGANISATION REPORTING?
II. Assessing Outcomes					
A. Increased Coverage and Service Utilization					
A1. (Obj. 1): No. of sex workers reached with targeted HIV/AIDS interventions	HMIS	Annual	• Training of health facility staff on register- and record-keeping • Quality assurance training of zonal medical officers and supervisors to ensure the use of supervision data for improved decision-making and quality improvement • Tracking of timeliness and completeness of monthly HMIS reports (from facility to zones to central level) • Periodic verification of the accuracy and completeness of HMIS data by selecting a small number of health facilities (e.g., one hospital, health center, and health station from each zone) and comparing aggregated HMIS statistics for those facilities with the information recorded in the records and registers	MoH, NATCoD	No
A2. (Obj. 1): No. of female condoms distributed or sold*	HMIS	Annual			
A3. (Obj. 1): No. of cases of STIs treated*	HMIS	Quarterly			
A4. (Obj. 2): No. of people receiving HIV testing, disaggregated by type of facility (e.g., military vs. non-military; freestanding vs. integrated)]	HMIS	Quarterly			
A5. (Obj. 3): No. of HIV+ women receiving antiretroviral therapy to prevent MTCT of HIV					
A6. (Obj. 3): % of all ANC attendees tested for HIV					
A7 (Obj. 3): No. of babies born to HIV-infected mothers who receive ARV therapy to prevention of MTCT					
A8. (Obj. 4): No. of people receiving HIV/AIDS home-based care*					
A9. (Obj. 4): No. of people receiving HIV/AIDS palliative care*					
A10. (Obj. 4): No. of people receiving treatment of OI*					

A11. (Obj. 4): No. of people receiving prophylaxis for OI*					
A12. (Obj. 4): No. of people receiving ARV therapy*					

***Commodity or service financed by the Global Fund**

Table VII.38a.5 (continued): OVERVIEW OF ERITREA'S M&E INDICATORS, DATA COLLECTION, AND QUALITY ASSURANCE
(Global Fund core indicators are noted in bold.)

INDICATOR	SOURCE(S) OF DATA	PERIODICITY	DATA QUALITY ASSURANCE	RESPONS-IBLE ENTITIES	PARTNER ORGANISATION REPORTING?
II. Assessing Outcomes ***(continued)***					
A. Increased Coverage and Service Utilization (continued)					
A13. (Obj. 4): No. of HIV/AIDS orphans receiving support	Program data	Annual	• Close partnership with BIDHO & other entities (e.g., NGOs, FBOs) to ensure coordination of efforts and documentation of progress in reporting systems • Capacity-building activities sponsored by NATCOD in the area of program monitoring tailored for BIDHO, NGOs, and FBOs	MoH, NATCoD, BIDHO	Yes
A14. (Obj. 4): No. of PLHAs receiving psychosocial support from BIDHO and other organizations					
A15. (Obj. 4): No. of PLHAs enrolled in income-generating activities					
B. Increased Adoption of Key Behaviours					
B1. (Population-based behaviour): % of sex workers who reported condom use at last sex	BSS	Every 2–3 years	• FHI has developed a rigorous methodology and standardized tools for behavioural surveillance among groups with high-risk behaviours. To the greatest extent possible, partner organizations will use or adapt what has already been developed, and they will consult colleagues in neighboring East African countries for guidance on dealing with special populations. FHI will provide technical assistance for all phases of the studies.	ESMG, FHI, USAID	Yes
B2. (Population-based behaviour): % of male military personnel age 15–24who report condom use at last sex with a non-regular partner	BSS	Every 2–3 years		ESMG, FHI, USAID, EDF	Yes

B3. No. of HIV-exposed health workers who received counselling & post-exposure prophylactic ARVs	NATCoD program data	Annual	• Tracking of timeliness and completeness of monthly HMIS reports (from facility to zones to central level) • Periodic verification of the accuracy and completeness of HMIS data		

Table VII.38a.5 (continued): OVERVIEW OF ERITREA'S M&E INDICATORS, DATA COLLECTION, AND QUALITY ASSURANCE
(Global Fund core indicators are noted in bold.)

INDICATOR	SOURCE(S) OF DATA	PERIODICITY	DATA QUALITY ASSURANCE	RESPONS-IBLE ENTITIES	PARTNER ORGANISATION REPORTING?
III. Tracking Progress					
Objective 1: Scale-up/expand effective HIV prevention activities in target populations including women, the military, CSWs and STI clients					
A. % of CSWs who can state at least two of three programmatically important ways to prevent HIV/STIs	*BSS*	Every 2–3 years	• FHI has developed a rigorous methodology and standardized tools for behavioural surveillance among groups with high-risk behaviours. To the greatest extent possible, partner organizations will use or adapt what has already been developed, and they will consult colleagues in neighboring East African countries for guidance on dealing with special populations. FHI will provide technical assistance in the design, implementation, and analysis phases of the studies.	ESMG, FHI, MoH, MoLHW, USAID	Yes
B. % of CSWs who believe they have little or no risk of contracting HIV/AIDS	*BSS*	Every 2–3 years		ESMG, FHI, MoH, MoLHW, USAID	Yes
C. % of military youth (age 15–24) who can state at least two of three programmatically important ways to prevent HIV/STIs	*BSS*	Every 2–3 years		EDF, ESMG, FHI, MoH, USAID	Yes
D. % of STI clients appropriately diagnosed, treated, and counselled *(UNGASS Indicator)*	STI manage-ment study (facility-based)	Every 2–3 years	• WHO/UNAIDS have developed a standardized methodology, training materials, and tools for STI management studies. Survey implementers will tap into in-country and regional nodes of expertise when implementing these studies to ensure that high-quality data are gleaned from the assessments.	EDF, MoH, NATCoD, USAID, FHI	No

E. No. of military clinicians undergoing STI syndromic management training	EDF program data	Annual	• NATCoD will work closely with the EDF to build its capacity to monitor and evaluate its HIV/AIDS activities in a systematic fashion (e.g., through simple reporting formats that can be compiled on a quarterly basis). Existing mechanisms of quality assurance will be refined to ensure that both program outputs and outcomes are being monitored appropriately and efficiently.	EDF, NATCoD	No

Table VII.38a.5 (continued): OVERVIEW OF ERITREA'S M&E INDICATORS, DATA COLLECTION, AND QUALITY ASSURANCE
(Global Fund core indicators are noted in bold.)

INDICATOR	SOURCE(S) OF DATA	PERIODICITY	DATA QUALITY ASSURANCE	RESPONS-IBLE ENTITIES	PARTNER ORGANISATION REPORTING?
III. Tracking Progress ***(continued)***					
Objective 2: Increase the number of people who know their HIV status by improving availability and quality of VCT					
A. No. of facility-based VCT sites, disaggregated by type (e.g., military versus non-military)	HMIS	Annual	• Training of health facility staff on register- and record-keeping • Quality assurance training of zonal medical officers and supervisors to ensure the use of supervision data for improved decision-making and quality improvement • Tracking of timeliness and completeness of monthly HMIS reports (from facility to zones to central level) • Periodic verification of the accuracy and completeness of HMIS data by selecting a small number of health facilities (e.g., one hospital, health center, and health station from each zone) and comparing aggregated HMIS statistics for those facilities with the information recorded in the records and registers	MoH, EDF	No
B. No. of freestanding VCT sites	HMIS	Annual		MoH, NATCoD	No
C. % of VCT sites reporting no stockouts of HIV rapid test kits in the last 12 months	HMIS	Annual		MoH, EDF	No
D. % of VCT sites that meet the following minimum conditions for quality: trained counselors, privacy for counseling, mechanisms for maintaining confidentiality, directory of services for referral, and quality-control measures for specimen collection, disaggregated by type of facility (e.g., military versus non-military; freestanding versus integrated)	Program data	Annual		MoH, NATCoD	No
E. % of VCT sites that have mechanisms for post-test support for both HIV+ and HIV-	VCT program data	Annual	• Close partnership with BIDHO & other entities (e.g., NGOs, FBOs) to ensure coordinated post-test support efforts that will be documented in reporting systems • Capacity-building activities sponsored by NATCOD in the area of program monitoring tailored for BIDHO, NGOs, and FBOs	MoH, EDF, NATCoD, BIDHO	Yes

Table VII.38a.5 (continued): OVERVIEW OF ERITREA'S M&E INDICATORS, DATA COLLECTION, AND QUALITY ASSURANCE
(Global Fund core indicators are noted in bold.)

INDICATOR	SOURCE(S) OF DATA	PERIODICITY	DATA QUALITY ASSURANCE	RESPONS-IBLE ENTITIES	PARTNER ORGANISATION REPORTING?
III. Tracking Progress ***(continued)***					
Objective 3: Increase the number of infected mothers who receive effective counselling and medical intervention to decrease the likelihood of HIV MTCT					
A. No. of regions with at least one site offering PMTCT services B. No. of PMTCT sites that reported no stockouts of rapid HIV test kits in the last 12 months C. No. of health workers based in antenatal care clinics and hospitals trained in comprehensive PMTCT	HMIS	Annual	• Training of health facility staff on register- and record-keeping • Quality assurance training of zonal medical officers and supervisors to ensure the use of supervision data for improved decision-making and quality improvement • Tracking of timeliness and completeness of monthly HMIS reports (from facility to zones to central level) • Periodic verification of the accuracy and completeness of HMIS data by selecting a small number of health facilities (e.g., one hospital, health center, and health station from each zone) and comparing aggregated HMIS statistics for those facilities with the information recorded in the records and registers	MoH	No
D. No. of PMTCT sites that have referral mechanisms for care and support of HIV+ women	HMIS, BIDHO program data	Annual	• Close partnership with BIDHO & other entities (e.g., NGOs, FBOs) to ensure coordinated post-test support efforts that will be documented in reporting systems • Capacity-building activities sponsored by NATCOD in the area of program monitoring tailored for BIDHO, NGOs, and FBOs	MoH, NATCoD, BIDHO	Yes

Table VII.38a.5 (continued): OVERVIEW OF ERITREA'S M&E INDICATORS, DATA COLLECTION, AND QUALITY ASSURANCE
(Global Fund core indicators are noted in bold.)

INDICATOR	SOURCE(S) OF DATA	PERIODICITY	DATA QUALITY ASSURANCE	RESPONS-IBLE ENTITIES	PARTNER ORGANISATION REPORTING?
III. Tracking Progress *(continued)*					
Objective 4: Improve the availability and quality of health care and psychosocial and economic support to PLHAs and affected by the epidemic					
A. % of health facilities, including VCT sites, with appropriate referral linkages to comprehensive care and support services for people with HIV	HMIS, supervision data	Annual	• Training of health facility staff on register- and record-keeping • Quality assurance training of zonal medical officers and supervisors to ensure the use of supervision data for improved decision-making and quality improvement • Tracking of timeliness and completeness of monthly HMIS reports (from facility to zones to central level) • Periodic verification of the accuracy and completeness of HMIS data by selecting a small number of health facilities (e.g., one hospital, health center, and health station from each zone) and comparing aggregated HMIS statistics for those facilities with the information recorded in the records and registers	MoH, NATCoD	No
B. % of health facilities offering PLHA care that report no stockouts of drugs used to prevent and treat opportunistic infections and drugs for palliative care in the last 12 months					
C. No. of referral hospitals with personnel with specialized training in working with children affected by HIV/AIDS					
D. No. of zobas (zones) with at least one service delivery point offering ARV therapy to PLHA					
E. % of faith-based or community-based organizations providing care and support to persons infected or affected by HIV/AIDS	Program monitoring data	Annual	• Close partnership with BIDHO & other entities (e.g., NGOs, FBOs) to ensure that information on community-based activities feed into formal reporting systems • Capacity-building activities sponsored by NATCOD in the area of program monitoring tailored for BIDHO, NGOs, and FBOs	NATCoD	Yes

Table VII.38a.5 (continued): OVERVIEW OF ERITREA'S M&E INDICATORS, DATA COLLECTION, AND QUALITY ASSURANCE
(Global Fund core indicators are noted in bold.)

INDICATOR	SOURCE(S) OF DATA	PERIODICITY	DATA QUALITY ASSURANCE	RESPONS-IBLE ENTITIES	PARTNER ORGANISATION REPORTING?
III. Tracking Progress *(continued)*					
Objective 5: Establish procedures for and ensure adherence to universal precautions in the health care setting					
A. No. of healthcare facilities offering safe clinical practices, including universal precautions and sterile needles for medical purposes	Infection control study	Every 2–3 years	• Training of health facility staff on register- and record-keeping • Quality assurance training of zonal medical officers and supervisors to ensure the use of supervision data for improved decision-making and quality improvement • Tracking of timeliness and completeness of monthly HMIS reports (from facility to zones to central level) • Periodic verification of the accuracy and completeness of HMIS data by selecting a small number of health facilities (e.g., one hospital, health center, and health station from each zone) and comparing aggregated HMIS statistics for those facilities with the information recorded in the records and registers	MoH	No
B. % of health facilities with guidelines to prevent nosocomial transmission of HIV, written protocols for post-exposure prophylaxis, adequate sterilization procedures, and surgical gloves in stock	Infection control study	Every 2–3 years	• Clear protocols and standards will developed for specially trained enumerators	MoH	No
C. No. of units of blood screened for HIV	NATCoD program data; CHL	Annual	• Quality Assurance training for CHL staff, including recordkeeping, reporting, and the use of data for improved decision-making.	NATCoD	No

Table VII.38a.5 (continued): OVERVIEW OF ERITREA'S M&E INDICATORS, DATA COLLECTION, AND QUALITY ASSURANCE
(Global Fund core indicators are noted in bold.)

INDICATOR	SOURCE(S) OF DATA	PERIODICITY	DATA QUALITY ASSURANCE	RESPONS-IBLE ENTITIES	PARTNER ORGANISATION REPORTING?
III. Tracking Progress *(continued)*					
Objective 6: Strengthen and expand epidemiological and behavioural surveillance and programme monitoring activities					
A. % of health facilities submitting complete and timely HMIS reports every month in the last 12 months	HMIS	Annual	• Training of health facility staff on register- and record-keeping • Quality assurance training of zonal medical officers and supervisors to ensure the use of supervision data for improved decision-making and quality improvement • Tracking of timeliness and completeness of monthly HMIS reports (from facility to zones to central level) • Periodic verification of the accuracy and completeness of HMIS data by selecting a small number of health facilities (e.g., one hospital, health center, and health station from each zone) and comparing aggregated HMIS statistics for those facilities with the information recorded in the records and registers	MoH	No
B. No. of zobas (zones) conducting quarterly HIV review and planning meetings with health personnel	HMIS	Quarterly		NATCoD	No
C. No. of HIV special studies (seroprevalence, biological, behavioural, or qualitative) conducted	NATCoD program data	Annual		NATCoD	Yes
E. No. of facilities that are included in the ANC sentinel surveillance	ANC Sentinel Surveillance	Annual			
D. % of health facilities offering HIV-related services that received at least one supervisory visit in the past three months to assess quality of care, including case management and drug/supply inventory	HMIS	Quarterly	• NATCOD will adapt/develop quality assurance tools and will train supervisors on aspects of quality of care to be assessed through supportive supervision.	NATCoD	No
F. No. of zobas (zones) using a computerised system for monitoring & reporting surveillance data	NATCoD program data			NATCoD	No

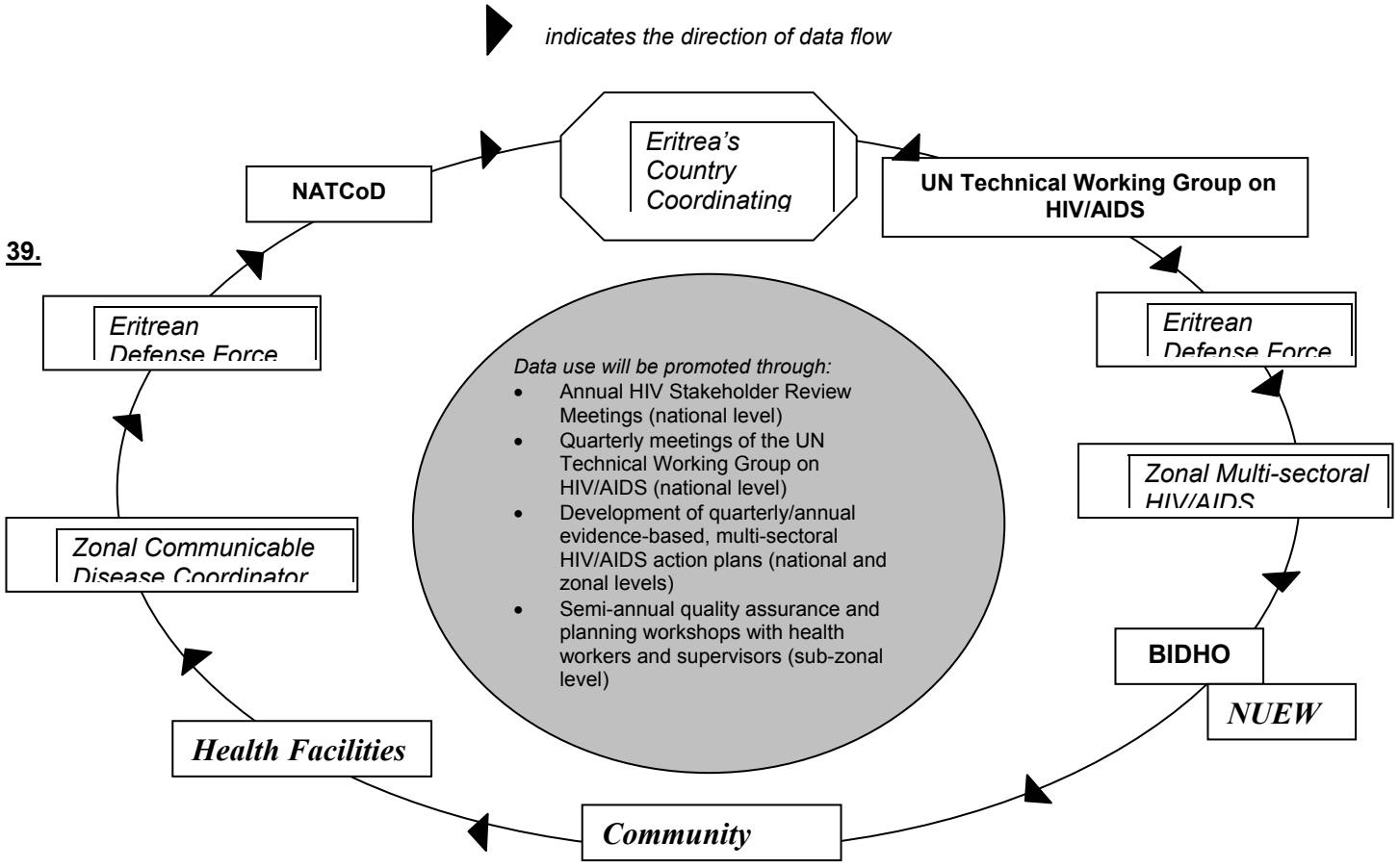
38a.6 Data analysis and data use

Eritrea's CCM acknowledges that data collection should not be burdensome or resource intensive. The emphasis should be on data use, and it should be tied to programmatic decisionmaking. M&E data will be used to calculate key impact, outcome, and process indicators related to the activities proposed in this application. As mentioned previously, findings will be documented and disseminated to all key stakeholders, including program beneficiaries. In addition to using data to track progress toward objectives, the CCM plans to use M&E data in the following specific ways:

1. To help focus **targeting** efforts (e.g., using biological surveillance data to highlight geographic areas or population subgroups that should receive more intensive program efforts, to re-allocate resources, etc.; using behavioural surveillance data to identify key precursors to behaviour change (e.g., self-efficacy in negotiating condom use or avoiding sex, risk perception, stigma/fear) in the Eritrean context
2. To **improve service delivery** (e.g., tracking stocks of essential drugs, equipment, and supplies and refining procurement/distribution systems; identifying areas for improvement in health-worker performance [e.g., by assessing the quality of pre- and post-test counseling, health workers' adherence to universal precautions] through quality-assurance approaches such as supportive supervision)
3. For **advocacy** (e.g., presenting data in user-friendly formats to raise awareness among policymakers, program planners, and key decisionmakers at the national, zonal, and community levels)

In sum, M&E will enable the CCM, and Eritrea's National AIDS and Tuberculosis Control Division (NATCOD) in particular, to plan future activities and strategies, to strengthen the positive aspects of the programme, to correct weaknesses, and to assist in the formulation and revision of policies through participatory approaches that engage all stakeholders. The following graphic depicts data flow and use.

Figure VII.2: M&E Data Flow and Use



39a. Strengthening M&E capacity

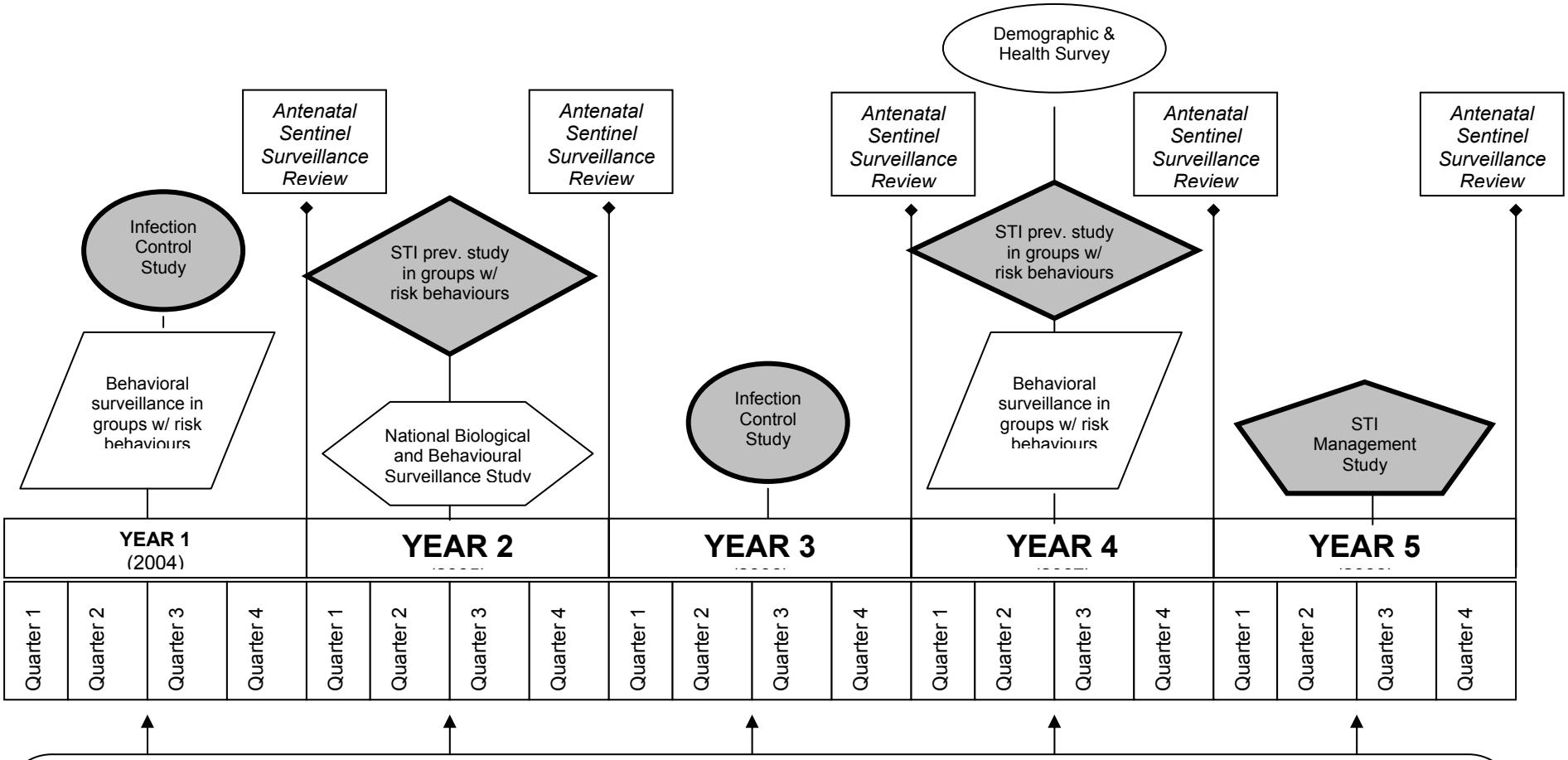
The Government/HAMSET project, WHO and USAID are currently supporting the Eritrean National Health information management reporting and monitoring systems countrywide.

Other surveillance and programme monitoring activities have been planned and integrated within Objectives 1 to 6 related activities, and specific funds requested are mentioned in detailed budgets year 1 and 2.

No additional funds are required.

TIMELINE OF ERITREA'S HIV M&E DATA COLLECTION ACTIVITIES

(Shaded items are activities for which Global Fund resources are requested)



Quarterly tracking of coverage and quality will be based primarily on routinely collected information that appears in the following two national-level monitoring systems:

1. The Integrated Disease Surveillance and Reporting (IDSR) system
2. The Health Management Information System (HMIS)

Illustrative indicators from the above systems that will be used to assess progress toward program objectives:

1. No. of people receiving VCT services
2. No. of people receiving HIV/AIDS home-based care
3. No. of people receiving HIV/AIDS palliative care
4. No. of people receiving treatment of OI
5. No. of people receiving prophylaxis for OI
6. No. of people receiving ARV therapy
7. No. of HIV/AIDS orphans receiving support

SECTION VIIIA – Procurement and supply-chain management information

40a. Describe your plans for procurement and supply chain management of health products

Fixed-term staff will be recruited only as management support to the PMU. Local consultants will be recruited as needed to assist the implementing organizations in such activities as workshops, training of community agents, etc. For both fixed-term staff and consultants, the recruitment will follow such procedures to be used by the PMU: submission by the implementing organisation of the Terms of reference of the qualified candidate(s); announcement of the posts in local newspapers; screening of the candidate(s) by a committee represented by the PMU, representatives of the implementing organization concerned and the Executive Secretariat of The Partnership.

The Programme will use the services of the Project Management Unit (PMU), Ministry of Health, for the procurement of goods and services as recommended by the IDA mission for the HAMSET project.

Component of procurement and supply chain management system	Existing arrangements and capacity (physical and human resources)
How are suppliers of products selected and pre-qualified? -Prequalification -Selected supplier list -Performance monitoring of selected supplies	For procurement of goods and services, the Project Management Unit (PMU) under the Ministry of Health has been assessed by IDA-World Bank as procurement-capable for the HAMSET project. For the procurement under the ATM programme funded by the Global Fund, PMU will be in charge and will comply with the same procedures and quality assurance required under the IDA/World Bank HAMSET Control Project
What procurement procedures are used to ensure open and competitive tenders, expedited product availability, and consistency with national and international intellectual property laws and obligations? According to size and urgency: - ICB: International competitive bidding - LIB: Limited international bidding - IS: International shopping	Actually, the PMU is using the World Bank procurement procedures. As recommended above, the same procedures will be used for procurements funded by the Global Fund. However, the Local Fund Agent of the GF should revise these procedures and, if necessary, propose another Manual for procurement.
What quality assurance mechanisms are in place to assure that all products procured and used are safe and effective? - Selection of reliable suppliers - GMP (Good manufacturing practice) Compliance certificate - Free sales certificate - Quality control testing on selected items	There is a Quality assurance laboratory for Drugs at the MOH central level in Asmara backed-up by WHO international QA system

	What distribution systems exist and how do they minimize product diversion and maximize broad and non-interrupted supply? - Direct to hospitals from PHARMECOR - To regional medical stores from which tertiary hospitals, health facilities obtain supplies - Strict control of delivery at regular intervals, trained manpower and efficient inventory control systems	Under the World Bank procurement procedures, drugs and other essential goods purchased in the international market should be ordered in a minimum bulk size to avoid non-interrupted supply. The PMU is using the services of a Public Corporation, PHARMECOR, as Agent to import Drugs on a competitive basis. This corporation is in charge of the storage and distribution to the clients across the country.