THE WORLD BANK OPERATIONS EVALUATION DEPARTMENT

Evaluation of the World Bank's Assistance in Responding to the AIDS Epidemic: Ethiopia Case Study

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Abbreviations and Acronyms

ACT Africa	AIDS Campaign Team for Africa
ADA	Amhara Development Association
ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
ANC	Anti-Natal Care
ART	anti-retroviral therapy
ARV	anti-retroviral
BDPP	Bureau for Disaster Prevention and Preparedness
BSS	Behavioral Surveillance Survey
CAS	Country Assistance Strategy
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
Civitas	Worldwide NGO for civic education
CRDA	Christian Relief and Development Association
DAC	Department of AIDS Control
DFID	Department for International Development
DHS	Demographic and Health Survey
DIDAC	Development and Interchurch AID Commission
DPPC	Disaster Prevention and Preparedness Commission
EAF	Emergency AIDS Fund
EECMY	Ethiopian Evangelical Mekane Yesus
ELISA	Blood test to detect antibodies to HIV
EMSAP	Ethiopia Multi-Sectoral HIV/AIDS Project
ENARP	Ethio-Netherlands AIDS Research Project
EOC	Ethiopian Orthodox Church
EU	European Union
FBO	faith-based organization
FP	family planning
GDP	gross domestic product
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GoE	Government of Ethiopia
GPA	Global Programme on AIDS
GTZ	Gesellschaft für Technische Zusammenarbeit
HAPCO	HIV/AIDS Prevention and Control Office
HIV	Human Immunodeficiency Virus
HSDP	Health Sector Development Program
IDA	International Development Association
IEC	information, education, and communication
MAP	Multi-Country HIV/AIDS Program
MCH	maternal and child health
MDG	Millennium Development Goal
MOFED	Ministry of Finance and Economic Development
MoH	Ministry of Health
NAC	National AIDS Prevention and Control Council

NAS	National HIV/AIDS Prevention and Control Secretariat Office
NGO	nongovernmental organization
OC	Operations Committee
ODA	Oromo Development Association
OED	Operations Evaluation Department
OSSA	Organization for Social Support for AIDS
PER	Public Expenditure Review
PHRD	Japanese Policy and Human Resources Fund
PMTCT	prevention of mother-to-child transmission
PPAR	Project Performance Assessment Report
PRSC	Poverty Reduction Support Credit
PSI	Population Services International
REST	Relief Society of Tigray
SEPDA	Southern Ethiopian Peoples' Development Association
SIDA	Swedish International Development Association
SNPPR	Southern Nation and Nationalities People's Region
SOE	statement of expenditure
STD	sexually transmitted disease
STI	sexually transmitted infection(s)
TB	tuberculosis
TDA	Tigrayan Development Association
UN	United Nations
UNAIDS	Joint United Nations Program for HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United Nations Agency for International Development
VCT	voluntary counseling and testing
WHO	World Health Organization

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Summary

The objective of this case study is to evaluate the impact of the World Bank's assistance – policy dialogue, analytic work, and lending – on Ethiopia's national response to HIV/AIDS, and to derive lessons from that experience. It is one of four country case studies conducted as part of OED's Evaluation of the Development Effectiveness of World Bank Assistance for Fighting the AIDS Epidemic. This case study is based on a review of published and unpublished documents on HIV/AIDS in Ethiopia; structured interviews with various stakeholders representing the government, civil society, World Bank, donors, and nongovernmental, community-based, and faith-based organizations; field visits to selected regions of Ethiopia in August 2003; and analysis of epidemiological and behavioral data. The current document was finalized as of early 2004 and covers events up to that date.

AIDS Epidemic

The first cases of HIV infection in Ethiopia were reported in 1984 and the first AIDS cases in 1986. Heterosexual transmission is the major mode of HIV infection. HIV spread rapidly among sex workers and other populations with high rates of sexual partner change. In its second phase, HIV spread to the sexual partners of high-risk populations, including monogamous partners and those with much lower rates of partner exchange. In rural Ethiopia, the epidemic began in the early 1990s. National adult HIV prevalence was estimated at 6.6 percent in 2002 – 13.7 percent in urban areas (15.6 percent in Addis Ababa) and 3.7 percent in rural areas. About 219,400 Ethiopians were estimated to be living with AIDS. The Ethiopian HIV/AIDS epidemic is now 'generalized,' with average HIV prevalence in the general population of 5 percent or higher. However, there is considerable geographic heterogeneity in the epidemic, with some regions at an earlier stage.

Ethiopia's Early Response

Ethiopia's initial response, launched in 1987, was one of the first in Africa. Under the Department of AIDS Control (DAC) within the Ministry of Health (MoH), the HIV/AIDS program centered on a strategic plan that emphasized the provision of public goods (surveillance, research, monitoring, evaluation, laboratory capacity) and prioritized prevention interventions both for high-risk groups and for the general population. In its earliest years, the program was decentralized to 14 regions, collaborated with key sectors, and financed NGO activities. The initial response was launched under the Derg government (1974-1991), when bilateral donor assistance for AIDS was limited, as many but not all bilateral donors withdrew support to the Marxist regime. Although the World Bank had been active in other sectors in Ethiopia since 1950, and the first health project was approved in 1985, it did not provide financial or technical support to these early HIV/AIDS program efforts. In addition to public budget allocations, the early program received technical and financial support from the World Health Organization's Global Program on AIDS (WHO/GPA).

In the early 1990s, with the ousting of the Derg, the new government had an overwhelming and pressing agenda of competing development and political priorities. The rapid

decentralization of resources and decision-making autonomy to new regions dramatically reduced the size and mandates of federal-level agencies. One consequence of this upheaval was a weakening of the national HIV/AIDS response. The government was facing an ambitious and under-funded agenda to improve and expand basic health care services. Although HIV infection was believed to be high at that point in time – especially in Addis Ababa and other urban areas – other diseases, such as malaria, caused more illness and death and predominated in rural areas, where over 80 percent of the population lives. In 1996, a new medium-term AIDS strategy was prepared and a national conference on "Breaking the Silence" was held, both a result of strong lobbying and support of UNAIDS and bilateral donors.

Initiation of World Bank HIV/AIDS Dialogue, 1996-99

In 1996, the World Bank launched a dialogue on the social sectors with the government, underpinned by a large and participatory social sector analysis published in 1998. This marked the initiation of the Bank's dialogue on HIV/AIDS. AIDS was one of many diseases subjected to a burden of disease analysis, and the study projected future HIV infections and AIDS cases. The Social Sector Report culminated in 10-year development plans for both the health and education sectors, provided the basis for the design of sector-wide approach (SWAp) operations, and significantly improved social sector donor coordination under the leadership of the Bank. It strengthened both the credibility of the Bank and its working relationship with the government and donors. The Health Sector Development Program (HSDP, $100 million, Credit No. 3140) was approved by the Board in 1998 and became effective in 1999. The control of sexually transmitted diseases (STD), including HIV/AIDS, is one of nine programs included in the 10-year health sector development program. The World Bank financial support to the HSDP focused on strengthening and expanding basic health services, which are critical for HIV/AIDS activities within the health sector. The Bank's Country Director and Resident Representative have persisted in raising the issue of HIV/AIDS at every opportunity.

In 1999, the World Bank prepared a new Africa regional AIDS strategy, *Intensifying Action Against HIV/AIDS in Africa*, and created an AIDS Campaign Team for Africa (*Act Africa*) to guide the region in implementing this strategy. Intensified dialogue in Ethiopia, with support from the Regional Vice President for Africa and the President of the World Bank, culminated in an agreement to undertake a rapid preparation of an HIV/AIDS operation, the Ethiopia Multi-Sectoral HIV/AIDS Project (EMSAP, $59.7 million, Credit No. 3416), one of the first two projects under the new Multi-country AIDS Program (MAP) for Africa. In addition, HIV/AIDS components were integrated into new or restructured projects in other (non-health) sectors.

Ethiopia Multi-Sectoral AIDS Project (EMSAP)

To satisfy the Bank's eligibility criteria for EMSAP, the government established in early 2000 a National AIDS Council (NAC) and a National AIDS Council Secretariat (NASC) placed within the Prime Minister's Office. The EMSAP channeled funds to four components: capacity building for government and civil society; expanding governmental multi-sectoral response; expanding the response of NGOs and communities; and project coordination and

management. Forty-four percent of project funds ($28.1 million) was allocated for NGO and community-based activities. The NASC assumed responsibility for coordination of HIV/AIDS programs, a responsibility previously assigned to the MoH. The project was prepared and negotiated in only six weeks because Bank management considered that the AIDS crisis warranted an emergency response and committed to seeking Board approval by the time of the annual meetings in September 2000. Preparation focused on setting up implementation arrangements that would accelerate the flow of funds and not on the content of the AIDS response that would be supported. It did not appraise the government's five-year strategic framework from technical, economic, financial, social, or institutional perspectives. Consultation with donors and NGOs during project preparation was extremely limited. A number of preparation tasks were postponed into the implementation phase of the project.

The EMSAP became effective in early 2001 and has now been active for three years. By the end of 2003 (six months short of the original closing date), less than half of the credit had been disbursed. The closing date of the project has been extended by 18 months, until December 2005. To date, the public sector multi-sectoral response has been weak, both in funds committed and spent and in the quality of the proposals submitted by ministries. The transfer of coordination of the HIV/AIDS program to the NASC initially resulted in the alienation of the MoH. The EMSAP has financed important health inputs (drugs for opportunistic infections, voluntary counseling and testing centers, new surveillance sites), but these have not yet translated into improved services and products. The civil society and community response component has stimulated action among these actors. NGOs have prepared and launched projects, many of them focused on information, education, and communication activities. Other prevention activities include the setting up and support of thousands of anti-AIDS clubs across the country for in-school and out-of-school youth. The number of local-level HIV/AIDS councils established and work programs prepared and financed have exceeded plans. The coordination of these activities and their coherence with the needs and demands of diverse regions and multiple target groups are not yet fully developed.

Impact of World Bank Assistance

Government commitment. The main impact of the World Bank's assistance has been to raise the profile of AIDS as a development issue and increase resources available to government and civil society to fight the epidemic. The 1998 Social Sector Report and accompanying dialogue was not successful in convincing the social sector leadership of the urgency of the HIV/AIDS epidemic. However, intensive work by high-level Bank officials in 1999-2000 succeeded in opening dialogue with the highest levels of government. Government spending on HIV/AIDS has since increased through project lending as well as counterpart financing of the new HIV/AIDS Prevention and Control Office (HAPCO). Regional budget allocations are financing regional-level HAPCO staff and operating costs.

Institutional response. The eligibility criteria for EMSAP leveraged the efforts of UNAIDS and other partners to create a multi-sectoral institution for HIV/AIDS coordination. EMSAP has supported the establishment and functioning of the federal and 11 regional HAPCOs. However, the new institutions were interpreted by the MoH as a lack of confidence in its leadership on HIV/AIDS and its capacity in health. The consequence had been a disengagement of the MoH – the key ministry in the fight against HIV/AIDS. This situation

is reported to have improved with the recent nomination of the Minister of Health as chair of NAC Board. HIV/AIDS components of non-health sector projects have supported more ownership and quality interventions than have public sector work programs in non-health ministries financed under EMSAP.

HIV/AIDS and the Health Sector. The two health projects have contributed to strengthening health system capacity for prevention and treatment of many conditions, including STDs, but with little direct support for HIV/AIDS activities. IDA financing made available for HIV/AIDS has not been fully exploited by MoH.

Strategic choices. The World Bank has not had significant impact on the content of national policy, adopted in 1998, or on the 2000-2004 strategy. The 1996-98 Social Sector Report did not review the HIV/AIDS medium-term plan and the EMSAP committed to support whatever activities were already in the national strategic plan without engaging in a discussion of priority activities for the public sector.

Civil society engagement. The EMSAP has supported a major shift in the environment of NGO and CBO participation in HIV/AIDS activities by supporting contracts between government and NGOs on an unprecedented scale. To date, there has been no systematic evaluation of NGO or community projects, so their impact is unknown. Cumbersome mechanisms for disbursement and replenishment of funds have affected the timeliness and reliability of financial flows to NGOs, causing stronger NGOs to turn to other financing sources and leaving the EMSAP resources to weaker NGOs. Civil society capacity has been utilized in part and modestly strengthened through applied experience and some training. However, capacity building remains a critical priority of the project.

Monitoring and evaluation. The Bank's collaboration with other partners to strengthen surveillance, monitoring and evaluation capacity has had modest impact to date. EMSAP has invested in expanding the number of ante-natal clinic surveillance sites, especially in rural areas. There is no systematic HIV surveillance of high-risk groups and data on pregnant women are not regular or reliable as of yet. There was no monitoring and evaluation framework at the project's outset, limited baseline data was available at the time EMSAP was developed, and efforts have been insufficient to develop a proper baseline. An M&E framework was not produced until the end of the third year of project implementation.

Impact on outcomes. Available data show that, while awareness of HIV/AIDS was already over 90 percent in 2000, knowledge of specific prevention methods in 2001-2002 was limited (50 percent of key target populations report knowing the three main ways to prevent HIV infection) and risky behaviors persist despite such knowledge. As there was no baseline measurement of many of the key outcome indicators, it is not possible to assess any changes that might have occurred during the course of the project to date, let alone evaluate the attribution of those changes to the project. The bulk of prevention interventions supported to date were for information, education, and communication, and not for targeted behavior change.

Findings and Lessons

The Bank was late in launching a dialogue and in providing support. It missed an opportunity to launch a dialogue on HIV/AIDS during the restructuring of the Family Health Project in 1993 ($33 million, Credit No. 1913), at which time enough information about the progression of the disease was available to warrant a stronger approach. When it did initiate a policy dialogue in 1998, the Bank succeeded in getting AIDS on the agenda on a par with other key infectious diseases. However, it did not succeed in convincing Government about the momentum and consequences of the infection and of the urgent need to halt further spread. Bank management was persistent and ultimately successful in opening up a dialogue with the highest levels of government. The two new channels of Bank support for HIV/AIDS – introduction of HIV/AIDS components in non-health projects and the EMSAP – were generated very recently as a result of the Africa Region's intensified strategy.

A number of lessons emanate from the World Bank's experience in Ethiopia that are relevant to other HIV/AIDS efforts.

- The adoption of HIV/AIDS coordinating institutions to satisfy eligibility criteria established by the Bank does not automatically ensure deep or sustained commitment by the multitude of actors necessary for an effective response.

- Project design and implementation that focus primarily on process rather than results undermine the effectiveness and efficiency of the Bank's financial support.

- The creation of a multi-sectoral institution does not necessarily foster a multi-sectoral approach and, if not founded on local institutional analysis, risks alienating key actors, like the Ministry of Health. Within the context of a multi-sectoral approach, the prominence of the health sector as a major leader and implementer in the fight against HIV/AIDS is unequivocal.

- Financial allocations and disbursements are necessary but insufficient conditions for successful NGO participation in the fight against HIV/AIDS. A number of factors can undermine NGO contributions, even when funding is accessible, including: the absence of a capacity building strategy based on in-depth assessments, the lack of baseline knowledge about the numbers and coverage of target populations, inadequate monitoring and evaluation of NGO activities, and the absence of viable mechanisms for coordination of public-private partnerships, in line with their comparative advantages.

- Failure to establish key baseline data and to design a monitoring and evaluation framework during project design is a missed opportunity for creating a targeted, results-based approach.

1. Introduction and Analytic Framework

1.1 **Background/Objective.** This case study is a contribution to OED's evaluation of World Bank assistance for HIV/AIDS. The main objective of the study is to evaluate the *development effectiveness* (measured in terms of relevance, efficiency, efficacy, and institutional development impact) of the Bank's support as well as the impact of the Bank's HIV/AIDS assistance relative to the counterfactual of no Bank HIV/AIDS assistance with respect to *outputs* of the assistance (government commitment and improved implementation) and, to the extent possible, *behavioral outcomes* and *epidemiological impacts*.

1.2 **Methodology.** The case study is based on the following sources of information: (i) a literature review of published and unpublished documents on HIV/AIDS in Ethiopia; (ii) structured interviews with various stakeholders representing the government, civil society, World Bank, donors, and nongovernmental, community-based, and faith-based organizations (see **Annex 1** for a complete list of persons interviewed); (iii) field visits to selected regions of Ethiopia in August 2003; and (iv) analysis of epidemiological and behavioral data.

1.3 **Organization of the Case Study.** The study begins by providing a chronological description of events related to the evolution of the HIV/AIDS epidemic in Ethiopia, and the response of the government, the World Bank, and other donors. Following an overview of the political and social context in Ethiopia (Chapter 2), the chronology of the epidemic and of the response is presented in three distinct phases. Chapter 3 documents the detection of the first HIV infection and AIDS cases in Ethiopia and the earliest responses to HIV/AIDS during the period 1984-1991. Chapter 4 describes the rapid evolution of the epidemic over the period 1992-98 and the response of a new government and its partners in the context of rapid decentralization. It includes the initiation of the World Bank's dialogue on HIV/AIDS. Chapter 5 documents events during the period 1996-present, notably the continued spread of the epidemic and the World Bank's intensified assistance to Ethiopia's HIV/AIDS efforts in the context of a new strategic and institutional framework.

1.4 The subsequent chapters assess the impact to date of the technical and financial assistance provided by the Bank to the HIV/AIDS effort in Ethiopia against the counterfactual of no assistance, draw lessons of experience to date, and provide perspectives for further enhancing Bank work in this regard. Specifically, Chapter 6 evaluates the impact and development effectiveness of the Bank's support in terms of program inputs and outputs, behavioral outcomes and, to the extent possible, epidemiological impact, in line with the Evaluation Conceptual Framework (attached as **Annex 2**). Chapter 7 concludes with key findings and lessons emanating from this case, notably those related to government commitment, strategic choices and prioritization, multi-sectoral approaches, the role of nongovernmental organizations (NGOs) and community-based organizations (CBOs), HIV/AIDS and the health sector, and monitoring and evaluation.

2. Background and Context

2.1 Ethiopia's political, social, and cultural context have shaped both the evolution of the HIV/AIDS epidemic and the response to it, including support provided by Ethiopia's partners. War, famine, poverty, and political turmoil have kept Ethiopia in an emergency state almost constantly since the 1970s, creating many competing urgencies. As a result, Ethiopia's population has been highly mobile, in terms of rural to urban migration, displacement of millions of people, the mobilization and demobilization of military personnel,[1] and migration associated with work (transport workers, sex workers, miners, merchants, traders). **Annex 3** provides a timeline of key historical events and landmarks in Ethiopia's fight against HIV/AIDS

2.2 Donors, including the World Bank, have had less influence on Ethiopia's strategic and policy decisions than in other African countries. Ethiopia was never colonized and places great importance on its sovereignty in making policy decisions. In addition, a Marxist regime, which held power from 1974 to 1991, isolated the country from financial support from the west and shielded Ethiopians from information and the opportunity to debate global and development issues. The media was tightly controlled under the Marxists and still is controlled largely by the public sector with only a few private news agencies. Thus, the ability of the media to bring dissenting views into the public arena has been limited.

A Highly Heterogeneous Society

2.3 **Society and Culture.** Ethiopia is an ancient civilization and Africa's oldest independent country. Except for a five-year occupation by Mussolini's Italy (1936-41), it has never been colonized. The country's cultural, historical, and linguistic identity are quite distinct from the rest of Africa largely because it has spent long periods of its history in virtual isolation. The Ethiopian people are ethnically heterogeneous, comprising more than 100 groups. The 84 languages and 200 dialects spoken in the country are divided into four major language groups. Amharic is the official national language of Ethiopia and the Oromo make up Ethiopia's largest ethnic group. Ethiopian society is complex and hierarchical. Ethnic tensions have shaped its history and continue to be a factor in the political and daily lives of citizens.

2.4 **Religion.** Approximately 40 to 45 percent of the population belongs to the Ethiopian Orthodox Church (EOC), which is made up of some 110,450 individual churches. Another 45 percent is Muslim. Evangelical and Pentecostal Protestantism are the fastest growing faiths adhered to by about 10 percent of the population. Oriental Rite and Latin Rite Roman Catholics, Jews, animists, and other practitioners of traditional indigenous religions make up most of the remaining population.

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1. According to UN Office for Coordination of Humanitairan Affairs, the war with Eritrea (1998-2000) displaced 1 million people, of which 76,000 still have not returned to their homes. Since the end of the war in 2000, 150,000 Ethiopian soldiers have been demobilized.

2.5 **Living Standards**.[2] Ethiopia's population, the second largest in Sub-Saharan Africa, was estimated at 67.3 million in 2003 and is growing at an estimated annual rate of 2.4 percent. Per capita GDP of $100 is among the lowest in the world. Forty-four percent of the population lives below the basic needs poverty line. Life expectancy is low at 42 years in 2000 and falling due to the HIV/AIDS epidemic. Infant and maternal mortality and child malnutrition rates are among the highest in the world and almost 60 percent of adults are illiterate. The gross enrollment ratio increased from 26 percent in 1991 to 71 percent in 1999, but poor quality and inefficiency are pervasive issues. Fertility is still high at 5.9 children per woman. While the health sector has succeeded in increasing service coverage, performance is undermined by human resources inadequacies (low skills, insufficient numbers, and inequitable distribution) and by severe under-financing. Only 20 percent of the rural population (which makes up 84 percent of total population) has access to clean water, whereas 80 percent of urban residents have such access. Despite progressive language in the Constitution protecting and promoting the rights and status of women, statistics show that women suffer greater poverty, are less educated, have lower health status and bear a heavier workload than men. Furthermore, they are more vulnerable to abuse, violence, and HIV/AIDS.

Thirty Years of Political Strife

2.6 **Marxist Regime.** In 1974 Emperor Haile Selassie I was overthrown and a Marxist regime (the Derg[3] regime) was established under Colonel Mengistu Haile Mariam. Mengistu continued his rule throughout the 1980s, proclaiming the People's Democratic Republic of Ethiopia in 1984 and winning the Presidential elections under a new Derg Constitution in 1987. In 1991, the Ethiopian People's Revolutionary Democratic Front captured Addis Ababa, forcing Mengistu to flee the country and putting an end to this regime.

2.7 Adding to the political turmoil of the late 1970s and 1980s were war, ethnic tensions, and famine. In 1977, Ethiopia went to war with Somalia over the Ogaden region. With the military and financial support of the Soviet Union and Cuba, it defeated Somalia and a peace treaty was signed in 1988. The late 1970s also witnessed the initiation of war for regional autonomy by the Tigrayan People's Liberation Front. In 1984-85 a severe and widespread famine affected 12 of 14 regions and caused the death of about 1 million of its 42 million population. National and international efforts rallied around the financing and management of food and other relief services, with very little attention to medium- and long-term food security.

2.8 Except for the provision of emergency famine assistance, the United States and Great Britain, which provided major support to Ethiopia during the 1960s and '70s, along with other western bilateral donors, scaled back considerably their development assistance during the Marxist regime. Soviet and Cuban support was more military than humanitarian in nature and did not fully or adequately substitute for withdrawn technical and financial assistance of major bilaterals. Social spending also suffered as a result of high domestic military

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2. Information and data for this section drawn from the World Bank's Country Assistance Strategy for the Federal Democratic Republic of Ethiopia, March 24, 2003.

3. The Derg (or "Dergue") was a Marxist junta established under Mengistu consisting of about 100 junior officers drawn from all regions of Ethiopia.

expenditure during the 1980s; military expenditure accounted for about one quarter of total government expenditure, compared to about 10 percent for social sectors.

2.9 **Transition to Federal Democratic Government.** Following the overthrow of the Derg government in 1991, the Transitional Government set about establishing a new Constitution, preparing for democratic elections, and putting the country on a path for economic and social reform and development. Legislation passed in 1992 provided a framework for a decentralized, democratic, federalist form of government through the creation of 14 states,[4] defined largely by linguistic and ethnic criteria. Regions (nine states and two municipalities) were given the money and the mandate to manage their own affairs with significant autonomy. Federal ministries, mandates, and programs were dramatically cut back, with the majority of human and financial resources slated for redeployment to the regions. While 90 percent of budgets did get reallocated to the regions, regional staffing did not increase significantly. Very few of the staff cut from federal programs took up posts at the decentralized levels. Except for those posted to places in and around Addis Ababa and other urban areas, highly skilled staff chose instead to leave the public service and found employment with the private sector, western bilateral agencies, or abroad.

2.10 A new Constitution was endorsed in December 1994 and became effective in August 1995. The Constitution provided for the right of self-determination and the possibility of secession by any region. It included, as well, progressive language guaranteeing equal economic and social rights to women. In 1995, a new elective government was installed.[5] Because of the relative peace that reigned during the 1990s, military spending fell dramatically (to 7 percent of government spending in 1995) and social sector spending increased from 9.8 percent in 1989 to 19 percent in 1996.

2.11 In 1998, border clashes erupted between Ethiopia and Eritrea and, in 1999, turned into a full-scale war, interrupting the momentum of economic and social reforms. Military expenditure as a share of total budget increased significantly again, to 29 percent in 1998. Intervention by the United Nations provided support and oversight of the peace process and culminated in the signing of a ceasefire agreement on June 18, 2000, and a peace agreement in December 2000, formally ending the conflict. Already in 2000, the government was quick to develop and implement programs to address postwar challenges, most particularly the demobilization of some 142,000 troops, emergency humanitarian needs, and reconstruction.

2.12 A second wave of decentralization launched in 2002 devolved authority from the regional level to the *woreda* (district of about 10,000 average population) level. As a part of this effort, *woreda* health bureaus were established and given the authority to hire, fire, and manage health personnel. *Woredas* are further divided into *kebeles*, the smallest administrative unit. The purpose of this second wave of decentralization was “to bring government even closer to the people, to give political representation and voice to the diverse ethnic groups, and to make governance and resource allocation sensitive to local needs and preferences” (World Bank 2003b).

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4. The subsequent amalgamation of five states in the southwest reduced the total number of states to nine. Together with two large municipalities, Ethiopia was administratively divided into a total of eleven regions.

5. Negasso Gidada was elected President and Meles Zenawi assumed the post of Prime Minister.

Civil Society

2.13 During the latter part of Haile Selassie's regime (1960-74) national and international nongovernmental organizations (NGOs) began to appear, and were recognized and codified by a law passed in 1960. Development of NGOs was slow during the Selassie regime, and the environment became hostile under the Derg regime. Nevertheless, both national and international NGOs played prominent roles in relief operations during the two catastrophic famines of 1973-74 and 1984-85.

2.14 NGOs became increasingly difficult for the government to control by the mid-1980s because of their growth in numbers and the limited capacity of government. During the ongoing civil war across Ethiopia under the Derg regime, international NGOs, sometimes in collaboration with local religious organizations, carried out relief operations within the government-controlled areas of Ethiopia, while local rebel movements provided food and other humanitarian support beyond these lines.[6] By the time the Mengistu regime collapsed, national NGOs were still mostly weak in their organizational capacity and were associated largely with emergency relief assistance.

2.15 In 1995, the government established Guidelines for NGO Operations, which updated procedures originally established in the law of 1960 and provided a framework for the classification of NGOs and for the definition of areas of programmatic activity. This law required their registration with the Ministry of Justice and their supervision by the Disaster Prevention and Preparedness Commission (DPPC) and Bureaus for Disaster Prevention and Preparedness (BDPP) at the regional level. Some interpreted these guidelines as a government attempt to control the activities of NGOs.

2.16 To demonstrate their relevance and effectiveness in taking on some of the tasks of the development agenda, NGOs sought to collaborate with government and to organize among themselves. In 1998, the Christian Relief and Development Association (CRDA), the oldest and largest NGO membership association dating back to 1973, officially registered as an NGO umbrella organization, with a membership of about 140 NGOs, the majority indigenous. CRDA has devoted considerable effort to building the capacity and self-reliance of its membership and promoting and enhancing their partnerships with government. CIVITAS constitutes a consortium of Ethiopian NGOs with the goal of mobilizing human rights activists and educating citizens on their rights and responsibilities in a democratic system. Many other networks of NGOs continue to emerge around a number of interests, including pastoralists, gender issues, environment, orphans, street children, microenterprise, education, family planning, religious charities (in complement to CRDA).

2.17 The adoption of the *Code of Conduct for NGOs* in March 1999 was another landmark. Prepared by and for the NGO sector, this document established consensus on the standards and guidelines for ensuring the quality and transparency of their work. Both the product and the consultative process (involving government officials, private sector leaders, professional associations, academics, the media, and international NGOs/partners) aimed to improve

6. The Relief Society of Tigray (REST) is the most prominent example of a group that was a humanitarian wing of the armed struggle against the Derg regime providing relief assistance to rebel areas.

prospects for public-private partnerships. Despite NGO efforts to legitimize and consolidate their ranks, government-NGO relations remain tense. Donors, on the other hand, are increasingly providing direct financial support to NGOs. A number of challenges have still to be addressed, most notably: inadequacy of resources for NGOs to finance operating costs; the continued need for capacity building; and their relatively small numbers (officially 310 as of 1999). Furthermore, NGOs are primarily clustered in and around Addis.

2.18 A number of other civil society actors have played critical roles in the development and democratization of Ethiopia. Self-help groups and networks have existed for generations at the community level, including: *debos* (which provide mutual aid to member farmers), *ekubs* (savings and credit associations), *ezens* (which provide assistance to families after the death of a member), and *idirs* (local neighborhood associations that organize and support the costs of funerals). There is an ongoing debate about whether these self-help groups should receive funding and other support from donors or whether they should be left alone as organs of social interaction and self-reliance.

2.19 Roughly 120 international NGOs were estimated to be operating in Ethiopia in 2000 and their efforts continue to evolve from relief to development work, with increasing partnerships with local NGOs. Regional development associations work with membership funds and with government financing to contribute on a large scale to the implementation of regional government development strategies.[7] Two other civil society organizations of note are the Relief Society of Tigray (REST), supporting environment and agriculture, micro-enterprise, water management, and emergency aid, and the Development and Interchurch Aid Commission (DIDAC), the development and relief arm of the Ethiopian Orthodox Church.[8]

History of World Bank Support

2.20 The first two World Bank projects in Ethiopia were approved in 1950 (highway and development bank projects). In the years leading up to the mid-1980s, 42 more projects were approved in support of infrastructure (highways, telecommunications, power, and water), agriculture, and education sector development. During the 1984-1991 period, the World Bank's project portfolio for Ethiopia remained active with an additional 16 projects approved over the entire period, or an average of two per year, despite the political turmoil. It was during this period that the World Bank initiated its dialogue with Ethiopia on the population, health, and nutrition sectors and developed the first health sector project.

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7. The more established regional development associations include the Amhara Development Association (ADA), Tigrayan Development Association (TDA), Southern Ethiopian Peoples' Development Association (SEPDA), and Oromo Development Association (ODA).

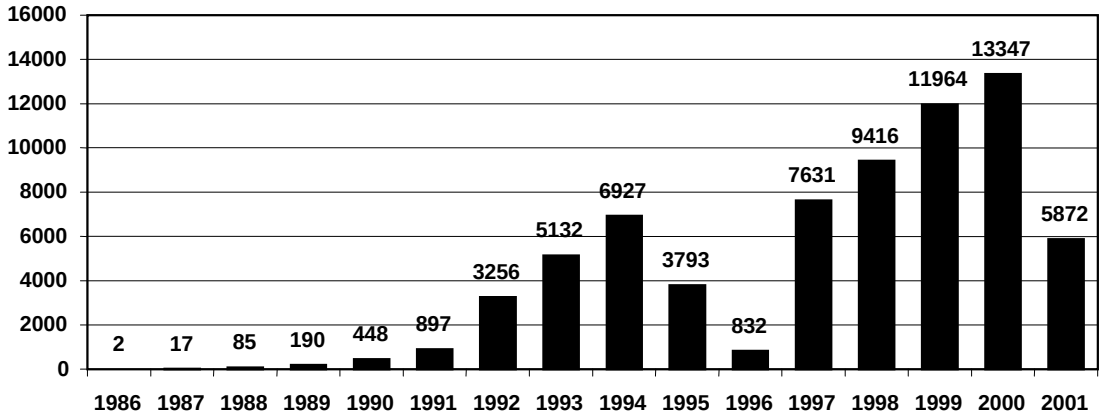
8. The Ethiopian Orthodox Church plays a prominent role in the daily lives of Ethiopians and has a long tradition of supporting community-based development and poverty alleviation. In 1974, the EOC established the Development and Inter-Church Commission as the development agency of the church. Since 1994, the Commission has developed and implemented five-year diocese-based community development programs focused on the goals of poverty alleviation, human development, gender equity, and emergency preparedness.

3. Ethiopia's Response to AIDS: 1984-91

Launch of an Early Response

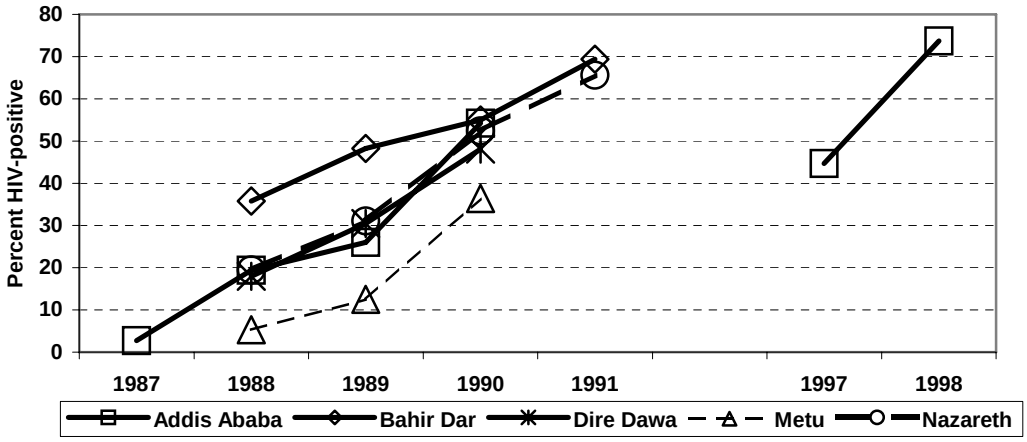
3.1 **Start of the Epidemic.** The first cases of HIV infection in Ethiopia were reported in 1984 and the first AIDS cases in 1986 (see Figure 1). In the 1980s and early 1990s, Addis Ababa was the center of the epidemic. Spread in rural areas began in the early 1990s. Earliest data indicate the concentration of the epidemic among commercial sex workers, mobile populations along Ethiopia's main trading corridors, sexually transmitted infection (STI) patients, and military recruits. While less than one percent of sex workers tested positive for HIV in 1985, HIV prevalence rose to 36 to 55 percent in five urban areas by 1990 (see Figure 2). HIV prevalence among the Ethiopian Freight Transport Corporation (EFTC) truck drivers

Figure 1. Reported AIDS Cases by Year of Reporting, 1986-2001



Source: MoH statistics, as reported in UNAIDS (2002).

Figure 2. Trends in HIV Prevalence among Sex Workers in Five Cities, 1987-98



and their assistants rose from 17 percent in 1989 to 33 percent in 1992. Among STI patients it increased from 8 percent in 1987 to 38 percent in 1992. In 1985-86 about 0.1 percent of military recruits were HIV-positive, increasing to 3 percent in 1991. By 1989, HIV prevalence among the general adult population was estimated at 2.7 percent (MoH statistics).[9]

3.2 **Strategic Orientation.** The Government of Ethiopia (GoE) mounted an early response to HIV/AIDS, one of the first in Sub-Saharan Africa to do so. Even before the first case was detected, the GoE established a National Task Force on the Prevention and Control of HIV Infection and AIDS to develop a strategic framework and a national HIV/AIDS program. With the technical and financial support of WHO's Global Programme on AIDS (GPA) the National Task Force developed short-term and medium-term plans for the prevention and control of AIDS in March and May 1987. The policy and strategic orientations developed by the Task Force were the product of a consultative process that involved other government agencies and the nongovernmental sector (see Box 1).

Box 1. Ethiopia's Strategic HIV/AIDS Priorities in 1987

Policy Objectives:

- To prevent HIV transmission
- To reduce morbidity and mortality associated with HIV infection

Strategic Framework for the Fight against HIV/AIDS:

- *Information, education, and communication:* target the general population and high-risk groups; establish links with community leaders, NGOs, inter-governmental agencies, and government offices; educate school children; develop optimal channels and content.
- *Epidemiological surveillance and research:* assess status of the epidemic through sero-surveys; define priorities for research; enhance research collaboration and coordination.
- *Clinical diagnosis and management of AIDS:* establish a case reporting system; strengthen the clinical diagnostic skills of health workers; improve patient management and quality of life.
- *Laboratory support and blood transfusion:* strengthen lab and diagnostic facilities and transfusion activities; provide effective HIV screening of blood; ensure safe, sterile injection.
- *STD control:* promote use of condoms; early effective treatment of other STDs.

Source: Zewdie et al., 1990.

3.3 **Institutional Structure.** In September 1987, the Department of AIDS Control (DAC) was established within the Ministry of Health (MoH). The office was staffed with more than 75 Ethiopians, 60 of whom were highly qualified professionals.[10] This staff was supplemented by three GPA-financed international experts, who provided technical and advisory assistance: a medical epidemiologist, a technical officer/administrator, and an information, education, and communication (IEC) officer. The DAC reported directly to the Vice-Minister of Health and was composed of six operational divisions that responded to priorities spelled out in the strategic framework: IEC; Surveillance and Research; Clinical Aspects of AIDS; Laboratory, Blood Transfusion and Sterilization; Control of Sexually

9. See Annex 4 for an overview of the epidemiology of HIV/AIDS in Ethiopia.

10. The qualification of these staff were confirmed in multiple interviews with national and international actors. They included very senior and experienced technicians from the MoH, some of whom had benefited from overseas training in AIDS-related and AIDS-relevant disciplines.

Transmitted Diseases (STD); and Administration. From the outset, the mandate of the DAC emphasized the importance of coordinating the implementation of multiple actors (rather than direct implementation) (see Box 2).

Box 2: Principal Functions of the Department of AIDS Control, 1987-91

- Mobilize internal and external resources
- Collaborate with international agencies
- Coordinate implementation of the program components with:
  - MoH departments
  - Regional health departments
  - International agencies
  - NGOs

Source: Zewdie et al., 1990

3.4 **Public Goods.** The earliest task of the DAC was to set up capacity for the provision of public goods. During the period 1987-90 the program set up an HIV screening laboratory network, including a National Referral Laboratory for AIDS, as well as screening capacity for all of Ethiopia's blood banks and regional hospitals. Under the surveillance division of the DAC, studies of HIV and behavior of high-risk groups (commercial sex workers, long-distance truck drivers, migrants, military groups, students, TB patients) were undertaken starting in the mid- to late-1980s. A sentinel surveillance system was also established in the late 1980s in five ante-natal clinics in different parts of the country to monitor HIV prevalence in the general population (clients of ante-natal clinics). Sentinel surveillance activities were carried out by local health personnel and ELISA testing[11] done in local screening laboratories with confirmation of tests by the National AIDS Reference Laboratory. The surveillance system for AIDS cases was introduced at the beginning of 1989, following the preparation of clinical surveillance guidelines and training for physicians at the national and regional levels. Both interviews and program documentation confirm that these data were actively used to stimulate and strengthen the commitment of political leaders and the health sector in the fight against HIV/AIDS as well as for strategic management of AIDS efforts.

3.5 **Initiatives to Decentralize and Integrate Activities in the Health System.** In 1990 under the Derg regime, efforts were undertaken by the DAC to decentralize management of the AIDS program and to integrate activities into health sector operations. Guidelines were developed, roles and responsibilities were defined, and training of regional and district staff was undertaken (see Box 3). Health personnel were trained in AIDS diagnosis, surveillance, and psychosocial support. By the end of 1990, three-quarters of regions had prepared and implemented AIDS action plans with financing from the DAC, and more

Box 3. Definition of HIV/AIDS Roles and Responsibilities at Decentralized Levels, 1990

Regional Health Office:

- Regional Health Manager: mobilize support, plan, implement, monitor, and evaluate regional-level activities
- Health Service Division Head: integrate and coordinate screening, and supervision of patient management
- Health Care Programming Division Head: training, coordination, IEC, research

Health District:

- Health Manager: mobilize, support, plan, implement, monitor and evaluate, organize training
- Other staff: incorporate AIDS control activities in existing activities
- Nurse educators or counselors: counseling for patients and families and encourage home care for AIDS patients

Source: Zewdie et al., 1990

11. A laboratory test used to detect the presence of antibodies in the serum. The ELISA is used to screen for HIV infection; a positive result indicates that antibodies are present.

regions were initiating the AIDS planning process. Regional- and district-level activities were centered primarily around prevention (IEC and condom distribution/ promotion), but also included surveillance, testing/diagnosis, counseling and care of patients and their families (at the facility and at home), social mobilization, and strategic program management.

3.6 **Collaboration with Other Sectors and NGOs.** Even though the DAC was housed in the MoH, there was full acknowledgement from the outset of the importance of involving other sectors and the non-public sector in the fight against AIDS. A Technical Advisory Committee to the DAC was made up of some 52 professionals drawn from the MoH, other public sector agencies, academia, and the NGO sector, providing technical input and guidance through seven topical subcommittees. Some of the early efforts of the DAC in eliciting partnerships with other actors are shown in Box 4. A significant outcome of the second national conference on AIDS, which took place in 1989, was the formation of the Organization for Social Support for AIDS (OSSA), a consortium of churches, religious groups, and NGOs that undertake and support community-level support for people with HIV/AIDS.[12] Most international NGOs operating in Ethiopia in the mid-1980s were involved with famine relief in drought-stricken areas. Information on NGO activities in support of HIV/AIDS control during the early years of the epidemic is incomplete.

Box 4. Early Efforts at Intersectoral Collaboration

- Targeting of men in bars, at sporting events, and in the workplace
- Sponsorship of two National Conferences on AIDS (1988, 1989) to share information, generate knowledge and commitment, establish common goals, develop plans, resolve differences and conflicts among partners, create partnerships
- Involvement of Addis Ababa University social scientists in research
- Training of youth leaders and communicators from government ministries, other public sector organizations, religious groups, and civil society
- Press briefings for local journalists
- Collaboration with Ministry of Education on secondary school pilot project
- Collaboration with Ministry of Culture and Sports on translation of IEC material
- Conducting (with CRDA) a 2-day seminar to foster cooperation between regional health officials and regional NGO workers.

3.7 **Stimulation of Government Awareness and Some Support.** While the AIDS epidemic was initially regarded with suspicion, fear, denial, and misconception,[13] there was a consensus among those interviewed that the DAC was successful in convincing the highest levels of government, including the Prime Minister and the President, of the importance of a robust, proactive HIV/AIDS program. Program staff both generated and disseminated

12. Founding members of the OSSA are: Christian Relief Development Agency (CRDA); Ethiopian Evangelical Mekane Yesus (EECMY); Ethiopian Catholic Church; Ethiopian Orthodox Church; Kale Hiwot Church; Radda Barnen; Save the Children (UK); Seventh-Day Adventist Church; Sudan Inerior Mission; and World Vision International, Ethiopia (Hadgu, et al.).

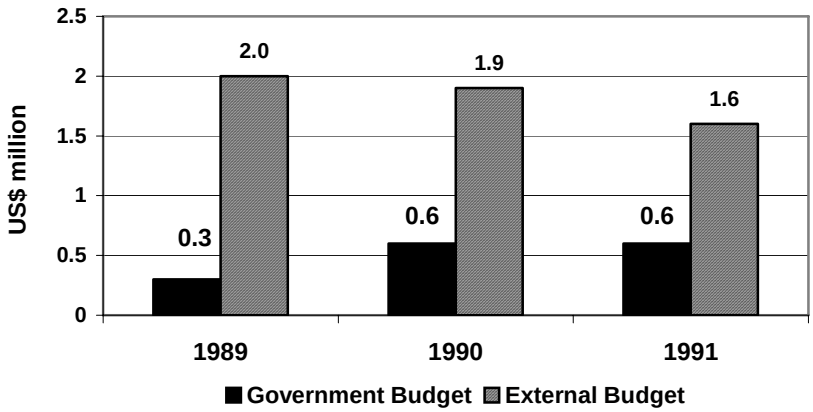
13. Many of those interviewed spoke of negative, discriminatory, dismissive attitudes of government officials and society at large at the earliest stages of the epidemic. Some denied that AIDS was a problem in Ethiopia and rather a disease of foreigners. Others said that it was a disease of prostitutes. Still others were fearful of the stigma. Many misunderstood its causes and consequences. False rumors ran rampant about the origins of the disease and modes of transmission. Some respondents spoke of government orders in the mid-1980s to suppress dissemination of information and the undertaking and sharing of research about the epidemic, especially in international conferences, fearing that it could hurt Ethiopia's tourism industry and even its coffee exports.

information on the progression of the HIV epidemic and made projections on the development of HIV/AIDS. Condoms were taboo at the start of the program's activities. However, DAC staff met in 1990 with the head of state, Colonel Mengistu, and his Cabinet to talk about the importance of condom promotion in curbing the epidemic. They agreed to the distribution of some 2 million condoms for public sector staff. DAC also brought Population Services International (PSI) into Ethiopia to launch the social marketing of condoms in 1991. According to senior international experts, this was one of the best condom social marketing programs of that era. Government support was also evident in its willingness to allocate public funds for program financing.

Financing and Donor Support

3.8 As shown in Figure 3, the National AIDS Program budget during the period 1989-1991 remained relatively stable, ranging from $2.2 million to $2.5 million annually. Government contribution doubled from $300,000 in 1989 to more than $600,000 in 1990 and 1991, while donor support declined.[14] Both program managers and GPA staff noted that this amount was inadequate for the level of effort needed at that time.

Figure 3. National AIDS Program Budgets in Ethiopia, 1989–1991



Source: Mann et al., 1992.

3.9 The DAC, with GPA support, began to intensify efforts to mobilize and coordinate the technical and financial inputs of donors. Because of the good performance and financial accountability of the program, donors were convinced to allocate financial resources to HIV/AIDS efforts. According to GPA experts working on Ethiopia and other East African countries, by 1993 the program's budget reached a level of about $11 million. They nevertheless considered this to be inadequate relative to the effort needed.[15] In addition, a

14. Weak and declining donor support was attributable to a number of factors, most notably: (a) withdrawal of bilateral support by the United States and Great Britain during the Derg regime; and (b) the reorganization and decentralization of GPA. Discretionary budgets previously used to support Ethiopia were being reduced as bilaterals increasingly chose to finance their own AIDS initiatives rather than channel their funds through the GPA.

15. Uganda's annual AIDS budget at the time was about $18 million, with about one quarter the population of Ethiopia.

thematic group was established under the leadership of the DAC to discuss issues of AIDS strategy and implementation.

World Bank Involvement

3.10 The World Bank attended these meetings, but no one interviewed could recall any financial or technical support to the HIV/AIDS efforts by the Bank during this period. On June 2, 1988, the first World Bank-financed health project in Ethiopia was approved. The objectives of the Family Health Project (total project cost of $43.9 million of which $33 million was financed by IDA Credit No. 1913) were to: (a) increase the quality, coverage, and cost-effectiveness of maternal and child health services; (b) increase the availability and use of family planning services; and (c) strengthen the institutional capacity of the MoH. The project was designed to reach these objectives through six components: maternal and child health/family planning (MCH/FP); manpower development; health education and IEC; institutional development; pharmaceuticals; and studies. Also in 1988, the World Bank sent a senior health sector expert to attend the first national AIDS conference, but there was no active follow-up.

Vision for the 1990s

3.11 By the end of 1990, just before the overthrow of the Derg regime, Ethiopia's AIDS Program was considered by GPA staff to be among the strongest in Africa. Ethiopia's program was already gaining a strong reputation with substantive contributions at international and regional meetings on HIV/AIDS. At the start of the 1990s the program articulated an agenda for the next decade: targeted IEC; more school interventions; social marketing of condoms beyond high-risk groups; generation of country-wide commitment; support to people living with HIV/AIDS; prevention of mother-to-child transmission; facilitating and expanding research and surveillance; continued efforts to mainstream AIDS into primary health care; resource mobilization; and intensification of inter-sectoral collaboration and collaboration with NGOs.

3.12 In 1989, the DAC estimated that there were 123,670 persons infected with HIV and projected that by 1993 this number would increase more than six fold to 810,550 (Khodakevich et al., 1990). Cumulative AIDS cases were projected to increase more than tenfold over that same period, from 3,340 to 45,458.

4. A Stalled National Response and the World Bank's Assistance: 1992-98

4.1 By 1992, the year after the Derg government was ousted and a new transitional government had been put in place, HIV prevalence had grown rapidly in two high-risk groups (commercial sex workers and transport workers) and was rising steadily in the general population in urban areas. Little was known about the situation in rural areas.

Change in Government and Its Aftermath

4.2 During the 1990s, implementation of the HIV/AIDS program stalled as a result of competing priorities of the new government, rapid decentralization and lack of conviction about the urgency to act.

4.3 **Competing Priorities.** The new government had an overwhelming and pressing agenda: to consolidate its political power; to (re)build infrastructure in the war-torn country; to improve food security and alleviate poverty; to achieve equity across the regions; and to put the country on a path for sound economic and social reform and development. While knowledge of AIDS was considerable, it was still regarded as a health issue and still perceived to affect only a small, marginal group (primarily commercial sex workers and, to a lesser extent, mobile populations). As such, investment in AIDS might have been perceived to be in conflict with the goal of equity, which was championed by the new regime. At this point, the government and many others had a poor understanding of the interlinkages between HIV/AIDS, on the one hand, and poverty alleviation and socio-economic development, on the other. As one respondent put it, there was no question at that time what the priority would be between rural electrification and condom provision in one region, or between roads and surgical gloves in another.

4.4 **Rapid Decentralization.** The new government's decentralization policy was aimed to establish a federalist form of government that would give resources and autonomy to regions defined largely by linguistic and ethnic criteria. The delegation of resources and decision-making responsibilities to the regions was rapid and applied to all federal-level ministries and public sector agencies. Federal-level mandates were scaled back[16] and 90 percent of human and financial resources were reallocated to the regions, which were given primary responsibility for policy implementation and autonomy of decision-making. Decentralization was implemented rapidly, without preparation for its success (e.g., capacity assessments and capacity development). Many national and international respondents confirmed that the speed with which this decision was implemented had serious, negative consequences on the capacity and effectiveness of sector ministries and other public sector agencies. The consequences for the MoH in general and for the HIV/AIDS program in particular were devastating.

16. Federal level ministries' new roles were limited essentially to policy formulation, establishment of technical norms and standards, and technical support and oversight.

4.5 In the space of two weeks, the federal MoH was reduced from more than 1,000 staff to about 100. The HIV/AIDS program staff was reduced from more than 75 to two professionals and one driver. MoH's most seasoned staff, who had already spent many years in the field and worked up to their current posts, were reallocated to posts all over the country and were expected to report within two weeks or be fired. Given that health infrastructure had been ravaged all over the country due to the war and its aftermath, many were assigned to locations lacking the minimum infrastructure needed to carry out the most basic health activities. Many, if not most, of these seasoned staff left the public service to seek other jobs in-country (NGOs and donors returning after the change of government) and abroad. This was the case for the majority of the HIV/AIDS staff. Furthermore, under the new decentralization scheme, the authority of the MoH relative to the regions was considerably undermined.[17]

4.6 **Lack of Conviction about the Urgency to Act.** The social sector leadership in the Prime Minister's office, throughout most of the 1990s, reportedly remained unconvinced by available statistics that the HIV/AIDS epidemic warranted higher priority or needed to be addressed with special urgency. The new health policy adopted in 1993 laid out an ambitious agenda to improve and expand basic health care services, a task made more challenging by inadequate and war-torn infrastructure, chronic shortages in skilled human resources, and chronic under-financing. Investment in primary health care was seen by the health sector leadership as a means to address in an integrated way a menu of priority diseases, including AIDS. Allocation of human and financial resources to AIDS (a single disease) was not considered the best use of scarce resources or in keeping with the principle of equity, highlighted in the 1993 health policy (see Box 5). Malaria, other diseases and health problems at the time caused more illness and death than HIV/AIDS: a 1996 burden of disease analysis found that perinatal and maternal complications accounted for 16.8 percent of all deaths, followed by acute respiratory infection (14.4 percent), malaria (10.0 percent), and nutritional deficiencies (7.8 percent). AIDS accounted for 7.7 percent of all deaths, followed closely by diarrhea (7.6 percent), and was thought to be mainly an urban phenomenon (World Bank 1998). Furthermore, government maintained that most of these conditions (not solely HIV/AIDS) were multi-sectoral in origin and required multi-sectoral solutions.

Box 5. 1993 Health Policy – Basic Principles for Health Sector Development

- Democratization and decentralization of the health system
- Prevention and promotion
- Equity
- Inter-sectoral activities
- Capacity development
- National self-reliance
- Participation of the private sector and non-governmental organizations

17. Under this new decentralization policy, the MoH is directly responsible to the Prime Minister's Office, which in turn manages the federal government's relationship with the regions. Within the Prime Minister's Office, the Regional Affairs Bureau has direct responsibility for regional matters and is the main contact point for the regional administrations. In short, under this new decentralized system MoH does not have direct administrative authority over the Regional Health Bureau.

Push for a New HIV/AIDS Policy and Strategy

4.7 Soon after the new government came to power, the MoH was given the mandate to develop a new medium-term HIV/AIDS implementation strategy, aligned with the decentralization policies of the government. It took the MoH almost five years to develop that strategy, which was finalized in 1996. Like its predecessor, the new strategy focused on surveillance among high-risk groups, prevention activities (IEC, behavior change, condom distribution), and care and support. The MoH was the key implementer, working with regional partners. However, the national implementation of this strategy was limited in scale and unmatched to the size of the problem of HIV/AIDS in the country.[18] In December 1996, a national conference on HIV/AIDS in Ethiopia took place, its objective captured in its title: "Breaking the Silence." This event, co-sponsored by USAID, UNAIDS, Ministry of Economic Development and Cooperation, and the Ministry of Finance, established a national coordinating body, under the overall responsibility of Ministry of Health, and called for the development and adoption of a national HIV/AIDS policy. This conference, an outcome of increasing lobbying of UNAIDS and bilateral donors, highlighted the importance of a multi-sectoral approach to the fight against HIV/AIDS.

World Bank Support to Health and HIV/AIDS

4.8 **Restructuring and Completion of the Family Health Project.** Following the overthrow of the Mengistu regime, the establishment of a transitional government in 1991, and the urgent business of formulating and launching policy for economic and social reform and decentralization, a review of this project's objectives found them still to be relevant. However, the project was restructured in 1994 with a view to: (a) expanding its initial coverage of one region to the whole country; (b) re-designing the components to be more aligned with the new (1993) health policy; and (c) revising implementation arrangements to respond more fully to the new decentralization policy. While these investments in health infrastructure and services are important inputs to HIV/AIDS activities, the addition of direct support for HIV/AIDS programs was not considered.

4.9 When it closed in 1997, the main achievements of the Family Health Project were improvement in geographical access of the population to health services through the construction and rehabilitation of health stations, the development of institutional capacity of the MoH to train health workers, and the establishment of the Drug Quality Control Laboratory to improve drug quality assurance. Drugs and essential medical equipment were provided to the newly built and rehabilitated health facilities. The implementation completion report rated the achievement of project objectives satisfactory. While primary health care facilities (stations and centers) were rehabilitated or constructed in underserved areas and equipped to deliver MCH/FP services, they were not fully functional at the project's end for lack of qualified manpower and recurrent financing. The project also built regional and zonal health bureaus and training schools. Key lessons learned included the importance of government's role in monitoring, the need to strengthen capacity (especially in the context of

18. Okubagzi and Singh, 2000.

decentralization), the need to balance facility expansion with quality measures, and the importance of supervision by the borrower and by the Bank (World Bank 1998b).

4.10 **HIV/AIDS Overlooked in Country Assistance Strategies (CAS).** While they are both centered around the objective of poverty alleviation and both support strategies and programs to improve and expand basic health services, neither the 1995 CAS nor the 1997 CAS mentions the rapid progression and consequences of the HIV/AIDS epidemic.

4.11 **Entry into an HIV/AIDS Dialogue through Social Sector Analysis.** In 1996, the Bank launched a social sector analysis with the main purpose of preparing sector-wide operations in the health and education sectors and to identify opportunities for World Bank support to population and nutrition.[19] The social sector analysis was based on a series of studies and surveys financed through a large grant from the Japanese Policy and Human Resources Fund (PHRD), carried out primarily by Ethiopian experts with technical reviews by the Bank and other partners. The studies were instrumental in helping the Bank deepen its policy dialogue with the government, as well as to shape its future support to social sector development. This work culminated in the publication of the Social Sector Note (Report No. 16860) in February 1998 and the Social Sector Report (Report No. 18482) in August 1998 (see Box 6). The scope of this work was broad, encompassing analyses of policies, performances, issues, and prospects of four major sectors (health, nutrition, population, and education).

Box 6. AIDS-Related Messages in World Bank Social Sector Report's Executive Summary

The executive summary cites AIDS as one of the top 10 killers in Ethiopia and proposes the following recommendations (directly or indirectly) relevant to HIV/AIDS:

Under health sector discussion: (i) increased access and quality of primary health care should be the main objective for the health sector; (ii) access should be increased to a minimal set of essential, cost-effective health services with the greatest impact on the disease burden, including reproductive health services and treatment of STDs.

Under population discussion: (i) reproductive health policies should be integrated with social policies that address poverty reduction and human development. Maternal and child health care, family planning and prevention, and treatment of STDs need to be integrated into a comprehensive reproductive health care package; (ii) strong public action (such as increased female education) should be undertaken to make changes in the roles and status of women, which should help reduce high rates of HIV/AIDS and other STDs.

4.12 By the time the report was published, 14 years had passed since the first HIV infection was identified and national prevalence among adults was estimated at 7.5 percent. In the health chapter, AIDS was cited in the burden of disease analysis as accounting for 7.7 percent of all life years lost nationwide in 1996, and an alarming 17.7 percent in Addis Ababa. However, the 1996 medium-term strategy for HIV/AIDS was not discussed. In the population chapter, STDs and HIV/AIDS were cited as major health concerns in Ethiopia. STD prevalence was estimated to be high and the national coverage rate for STD programs low. The study also reported 18,042 AIDS cases from January 1986 to first quarter of 1995 and estimated that in 1995 there were 171,000 new AIDS cases, 315,000 AIDS-related deaths, 76,000 children born HIV-positive, and 1.45 million people living with AIDS. The report projected continuing increases in adult HIV prevalence, new AIDS cases, and increasing numbers of HIV-positive births and AIDS deaths through 2020. The health, social, and economic consequences of the debilitation

19. The team could find no evidence of World Bank policy dialogue or analytic work on HIV/AIDS before 1996.

and ultimate loss of human lives were raised only briefly, along with the health sector costs and budgetary implications of care and treatment. The report estimated that in 1998 about 16 percent of all hospital beds in Ethiopia were occupied by AIDS patients, with a much higher rate in Addis (30 to 40 percent) (World Bank 1998).

4.13 The Social Sector Report was a success in that it culminated in the development of 10-year sector development plans both for health (HSDP) and for education (ESDP) sectors. These plans provided the basis for the development of sector-wide approaches (SWAps) around which all of Ethiopia's key partners coordinated their technical and financial support. Among Ethiopia's partners the Bank took a lead in supporting the government in the conception of the SWAp and in the coordination of technical and financial assistance. The Senior Minister for Social Administration in the Prime Minister's Office, who was the Bank's main counterpart for the social sector dialogue, was highly committed to the SWAp, recognizing the importance of coordinating all support around one vision and one program for health.[20] As a result of the Bank's leadership role in the mounting of the social sector SWAps, the Bank established strong credibility and a good working relationship both with the government and with donors. On May 26 and October 27, 1998, the Bank approved credits to support education and health SWAps,[21] each in the amount of $100 million equivalent.

4.14 The Bank was less successful in its efforts to engage the government more fully on HIV/AIDS and population issues through the vehicle of this analytic work. The data on HIV/AIDS and on population growth and dynamics generated through the study did not serve to convince government of the need to take urgent action. The validity of the data was questioned and it was maintained that external assistance was not needed on these fronts. In response, the Country Director and Resident Representative intensified their efforts to raise the HIV/AIDS issue at the highest levels of government. As will be shown in the following chapter, the dialogue further intensified and was raised to even a higher level in 1999.

4.15 **Modest Support for HIV/AIDS through the Health SWAp Operation.** The Health Sector Development Program (Credit No. 31400) became effective on March 11, 1999. It was conceived to support implementation of the first phase (1997-2002) of Ethiopia's 10-year Health Sector Development Program (HSDP), which aims to develop a health system that provides comprehensive and integrated primary care services, with a particular focus on community-level health facilities (see Box 7). The focus of this program is on communicable diseases, common nutritional disorders, environmental health and hygiene, reproductive health care, immunization, the treatment and control of basic infectious diseases, like upper respiratory tract infections, the control of epidemic diseases like malaria, and the control of sexually transmitted diseases, especially HIV/AIDS.

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20. Having been a champion of this approach, he was named Minister of Health in 1998, which gave him front-line responsibility to oversee its successful implementation.

21. Sector-wide adjustment programs (Cr. 31400 and Cr. 3077).

Box 7. Health Sector Development Program Components and HIV/AIDS-Specific Content

Components (indirect support to HIV/AIDS)	*HIV/AIDS-Specific Content*
▪ Expansion of primary health care access ▪ Improvements in the technical quality of primary health care service provision ▪ Human resource development ▪ Improvements to the pharmaceutical sector ▪ Information, education, and communication ▪ Health sector management and information systems ▪ Monitoring, evaluation, and applied research ▪ Improvements in the financial sustainability of health sector	▪ HIV/AIDS included as one of the STDs that will be brought under control through preventive care activities with particular emphasis on prevention and management of HIV/AIDS at the primary level ▪ Technical guidance to regions in the design and delivery of HIV/AIDS activities through the health system ▪ Strengthening of management information system to document disease patterns; HIV/AIDS monitoring system ▪ IEC for behavior change ▪ Appropriate budget allocations for HIV/AIDS ▪ Mobilization of other public sector agencies, and of the private sector, including NGOs

Source: World Bank (1998).

Activities of National and International Partners

4.16 **NGO Response.** In line with NGOs' own goals to shift their support from relief to development work, they increasingly forged partnerships with MoH in the provision of primary health care during the 1990s. In 1996, NGOs operated 8 (of a total of 89) hospitals, 13 (of 191) health centers, and just under 200 (of 2,515) health stations in the country. NGOs also ran 6 of the 159 pharmacies nationwide. In addition, they carried out drug distribution, family planning information and services, and provision of water and sanitation services. This was encouraged and facilitated under the 1993 national health policy, which acknowledged the value of partnerships with NGOs in the formulation, implementation, monitoring, and evaluation of primary health care activities, as well as the complementarity between governmental and nongovernmental support. NGOs are reported to have undertaken care and support of people living with HIV/AIDS since 1992.

4.17 **Donor Support and Collaboration**. In 1996, total health expenditures amounted to 988.2 million birr, or US$ 156.4 million equivalent[22], (compared with 357.2 million, or US$172.6 million equivalent,[23] in 1986), of which 171.1 million birr (or 17 percent) was external assistance (World Bank 1998). External financial support in 1996 represents a significant increase over 1986 levels (42.0 million birr of external assistance, or 11.8 percent of total health expenditure). No itemization of donor support to HIV/AIDS activities is available for the mid 1990s, but data collected and interviews indicate that such support was minimal.

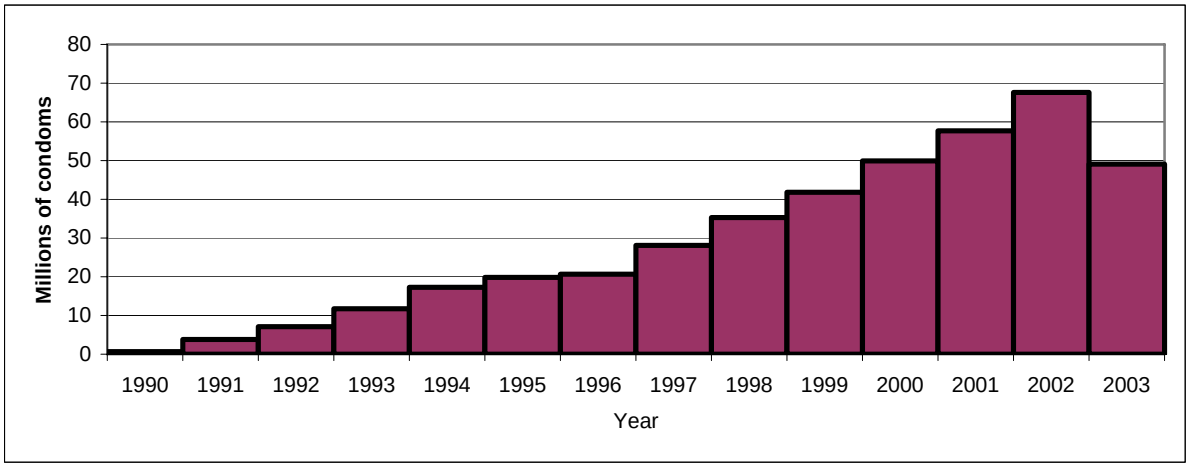
22. Source: National Bank of Ethiopia Report and Account 1995/96 (Ethiopian Fiscal Year 1988).

23. Source: National Bank of Ethiopia Annual Report 1985/86 (Ethiopian Fiscal Year 1978).

4.18 The joint government and donor Sector Investment Program workshop held in Debre Zeit, Ethiopia, in March 1997, following on the Consultative Group Meeting held in Addis in December 1996, mobilized technical and financial support for the Health and Education Sector Development Programs, each covering the period 1997-2001. Not only did this meeting succeed in covering entirely the funding gap for the HSDP, it also set the stage for enhanced dialogue and cooperation between the government and donors. In addition, it propelled donors into improving coordination and collaboration among themselves in support of the HSDP. The World Bank played and continues to play a lead role in donor coordination for the health sector. The main financial contributors to health sector development in 1998 were: UNICEF, UNDP, WHO, Germany, UNFPA, USAID, Norway, and SIDA (World Bank 1998).

4.19 USAID has made and continues to make a significant contribution to the fight against HIV/AIDS through its donations of condoms and other support to DKT/PSI, which runs a successful social marketing program in Ethiopia. Figure 4 shows dramatic growth in annual condom distribution carried out by this program since its launch in 1991.

Figure 4. Annual Condom Distribution in Ethiopia, 1990-2003



Source: DKT Ethiopia Program Statistics, 2004 Note: The drop in 2003 is attributable to the fact that the Ministry of Defense did not purchase condoms that year, due to internal reorganization of health services and a reassessment of condom needs.

Adoption of HIV/AIDS Policy

4.20 With the momentum created by the 1996 national conference and with the increasing lobbying of UNAIDS and bilateral donors such as USAID, the government finally approved in August 1998 a National HIV/AIDS policy (see Box 8).

Box 8. Objectives of the 1998 National HIV/AIDS Policy

- Establish effective HIV/AIDS prevention and mitigation strategies to curb the spread of the epidemic
- Promote a broad, multi-sectoral response to HIV/AIDS, including more effective coordination and resource mobilization, by government, NGOs, the private sector, and communities
- Encourage government sectors, NGOs, the private sector, and communities to take measures to alleviate the social and economic impact of HIV/AIDS
- Support an institutional, home and community-based health care and psychological environment for people living with HIV/AIDS and avoid discrimination against them
- Empower women, youth, and other vulnerable groups at risk to take action to protect themselves against HIV/AIDS
- Promote and encourage research activities targeted toward preventive, curative, and rehabilitative aspects of HIV/AIDS.

Source: World Bank October 2000.

5. The Bank's Intensified Assistance: 1999-2004

5.1 Based on sentinel surveillance in 2002 by the MoH, national adult HIV prevalence was estimated at 6.6 percent – 13.7 percent in urban areas (15.6 percent in Addis) and 3.7 percent in rural areas (DPCD/MoH 2002, see Annex 4.)

A New Strategic Framework for HIV/AIDS

5.2 Following the adoption in 1998 of the national HIV/AIDS policy, the MoH, with the strong support and encouragement of UNAIDS and other partners, including USAID,[24] coordinated a nationwide process of strategic planning and program development covering all 11 regions (9 states and the city administrations of Addis Ababa and Dire Dawa). This process followed the UNAIDS-recommended strategy of participatory situation analysis and involved multiple governmental and nongovernmental stakeholders at the national, regional, and local levels. It resulted in a five-year (2000-2004) Federal Level Multi-Sectoral HIV/AIDS Strategic Plan and accompanying Regional Multi-Sectoral HIV/AIDS Strategic Plans. Together, they constitute the Strategic Framework for the National Response to HIV/AIDS in Ethiopia for 2000-2004 (see Box 9).

Box 9. Strategic Framework for the National Response to HIV/AIDS in Ethiopia for 2000-2004

Objectives:

- To reduce the transmission of HIV, associated morbidity and mortality, and its impact on individuals, family, and society at large.

Pillars:

- Multi-sectoral approach; participation; leadership and efficient management (including monitoring and evaluation)

Areas of Intervention:

- *Prevention activities:* STI and TB control; IEC; increased condom accessibility and availability; poverty alleviation and employment opportunities, especially for youth and women; empowerment of women and girls; and prevention of HIV transmission in hospital settings.
- *Care and support activities:* clinical, home-based, and community-based care; increased social support to people living with HIV/AIDS and their families; human rights for people living with HIV/AIDS; sector-specific interventions to mitigate impact; and increased HIV/AIDS research and surveillance.

5.3 The 2000-2004 strategic plans were comprehensive and multisectoral in scope, but activities were not prioritized. The cost of implementing the first two years of these plans (2002-2003) was initially estimated at $96 million and subsequently reassessed at $245 million.[25] The plans did not take into account either financial or non-financial constraints (such as institutional capacity and weaknesses in health systems performance) that could affect implementation. Institutional mechanisms for expanding multisectoral HIV/AIDS activities were not identified. There was also no clear linkage between the orientation of the strategic plans and the very complex epidemiological context for HIV/AIDS in the country,

24. The USAID-financed Policy Project has been working in Ethiopia on projecting the HIV/AIDS epidemic and modeling the potential economic and social impacts. Regional studies have been completed in a few regions and a study for the entire country was completed in 1999 (see Bollinger, Stover and Seyoum, 1999).

25. The increase to the original estimate was largely attributable to adjustments to blood safety, universal precautions and prevention of mother-to-child transmission, which were considered to have been underestimated in light of the Resource Determination Model for Sub-Saharan Africa (Source: Government of Ethiopia 2002).

which is made up of multiple epidemics progressing at different rates in different regions and population groups.

World Bank Response

5.4 In 1999, the World Bank's Africa Region stepped up considerably its efforts to fight HIV/AIDS in Africa. It prepared a new regional strategy entitled *Intensifying Action Against HIV/AIDS in Africa* (World Bank 2000), which documented the alarming progression of the epidemic as well as its potential to undermine the social and economic development prospects of the entire continent. Noting that the Bank's response to date in supporting HIV/AIDS efforts in Africa had fallen far short of needs, the strategy focused on creating an enabling environment and mobilizing sufficient resources to "scale up" small initiatives. The regional strategy advocated: strengthening of political commitment; the mobilization of additional resources; support for HIV/AIDS prevention, care, and treatment; and expanding the knowledge base. It also advocated a decentralized, participatory, and multi-sectoral approach, maintaining that past efforts to address HIV/AIDS exclusively through health sector have "failed".

5.5 To enable the Africa Region to rise to the challenge of this intensified agenda, a new AIDS Campaign Team for Africa (*ACT Africa)* was created to provide technical support to country teams to "mainstream" HIV/AIDS activities in all sectors. *ACT Africa* undertook advocacy inside of the Bank, inciting a range of actors, from high-level managers to country teams, to intensify their efforts. Their approach had three elements:

- Strong ***advocacy*** within the countries at every opportunity, especially at the highest levels of government;
- The restructuring of projects in existing portfolios to add ***HIV/AIDS components*** wherever appropriate and feasible;
- The financing of ***stand-alone HIV/AIDS projects*** espousing a multi-sectoral approach.

5.6 **Advocacy.** In October/November 1999, the Vice-President of the World Bank's Africa Region visited Ethiopia and raised the HIV/AIDS issue with the Prime Minister. He indicated the Bank's readiness to support countries that adopt a multi-sectoral approach if the countries would: (a) establish a National HIV/AIDS Council consisting of representatives from the governmental and nongovernmental sectors, including religious groups, (b) establish an association of persons living with HIV/AIDS, and (c) identify a focal point for working with the Bank on project preparation. The Manager of *ACT Africa* also undertook missions to Ethiopia and was candid in highlighting the inadequacy of government commitment and effort and the urgency in addressing the epidemic. These messages were reinforced by the Bank's President, who maintained a close dialogue with the Prime Minister. These high-level exchanges, combined with the continued support and advocacy of the World Bank's Country Director for Ethiopia and the Resident Representative in Addis, culminated in an agreement to undertake rapid preparation of an HIV/AIDS operation for Ethiopia, as one of the first two projects to be negotiated and approved as part of the original Multi-country AIDS Program (MAP) package.

5.7 **HIV/AIDS Components.** As a result of *ACT Africa*'s advocacy for portfolio restructuring, a total of eight other World Bank operations in non-health sectors incorporated HIV/AIDS components (see Box 10).[26] In 2000, two ongoing projects were retrofitted to include HIV/AIDS activities: the Education Sector Development Program supported a modest set of activities (training, materials, and some student club support); and the Road Sector Development Program incorporated HIV/AIDS into their ongoing program. Three projects that were approved by the Board that same year included components with direct support to HIV/AIDS activities: the Women's Development Initiatives Project targets IEC messages to beneficiary women's groups that cover a range of issues, including HIV/AIDS. In the aftermath of the war, the Emergency Recovery Project supported HIV/AIDS interventions in 15 war-affected *woredas*, targeted at high-risk and vulnerable populations, and the Emergency Demobilization and Reintegration Project financed voluntary counseling and testing services for demobilized soldiers to complement ongoing IEC and condom distribution in the military.

Box 10. World Bank Projects with HIV/AIDS Components (Board Dates)

- Poverty Reduction Support Credit (02/17/04)
- Road Sector Development Support (06/17/03
- Energy Access (09/19/02)
- Emergency Demobilization and Reintegration (12/05/00)
- Emergency Recovery (12/05/00)
- Women's Development Initiatives (07/27/00)
- Health Sector Development Program (09/12/98
- Education Sector Development Program (05/26/98 – retrofitted)
- Road Sector Development Program Support (01/15/98 – retrofitted)

5.8 Since 2000, three other non-health operations have included support to HIV/AIDS. The Energy Access Project has supported awareness campaigns for workers and beneficiary communities. The follow-on Road Sector Development Support project has further intensified HIV/AIDS activities in the transport sector (see Box 11). The first Poverty Reduction Strategy Credit (PRSC) has also addressed a key bottleneck in HIV/AIDS work in Ethiopia: the lack of reliable information and of an operational monitoring and evaluation system. In its policy matrix, it calls for: (a) before PRSC I (February 2004), to establish a joint MoH and HAPCO committee to facilitate piloting of an HIV/AIDS epidemiological survey; (b) before PRSC II (early 2005)[27], to conduct HIV/AIDS pilot epidemiological survey; and (c) before PRSC III (early 2006) to report on the pilot survey and conduct of the

Box 11. HIV/AIDS and the Transport Sector

Two Road Sector Development projects provide IEC, AIDS care and support, and HIV capacity building for Ethiopian Roads Authority staff, project personnel, contractors, consultants, and local communities. As lessons were learned, the Bank's transport team has also supported the inclusion of HIV/AIDS clauses in work contracts and the recruitment of consultants to prepare an HIV/AIDS transport strategy and of an NGO to implement HIV/AIDS work. The Bank's team has also promoted and supported: a baseline study on risk behavior and needs assessment, continued dialogue during routine meetings with staff, the formation of HIV/AIDS committees among transport actors, and the incorporation of HIV/AIDS into monthly progress reports. It has also helped the Ethiopian Transport Authority gain access to technical and financial assistance through EMSAP.

26. These are in addition to the HIV/AIDS component in the Health Sector Development Program, discussed in Chapter 4.

27. Follow-on Poverty Reduction Strategy Credit. As a source of budgetary support, PRSCs are typically approved on an annual basis to be aligned with a country's budget cycle.

HIV/AIDS epidemiological survey (if feasible). The results and impact of these components have not been evaluated collectively or individually. Both government and Bank respondents reported that the design of these components were meaningful and well targeted to the sector actors and beneficiaries and that Bank's technical support served to enhance the quality and relevance of HIV/AIDS interventions, as well as their ownership by those sectors.

5.9 **Standalone HIV/AIDS Operation.** In late 1999/early 2000 the Africa Region launched the development of an emergency facility that would provide financial support to all countries in the region seeking to intensify their response to HIV/AIDS. In June 2000, the World Bank's Operations Committee supported the proposal, put forth by *ACT Africa*, to prepare an initial US$500 million Multi-Country AIDS Program (MAP) operation for Board consideration on two conditions: (i) that this "umbrella" operation would be prepared on an emergency basis (for Board approval by the time of the 2000 Annual Meetings, scheduled for September of that year); and (ii) that documentation to the Board would include two country projects already prepared and fully negotiated. The two projects that were prepared in tandem with the MAP were for Kenya and Ethiopia (see Box 12).

5.10 In April 2000, in anticipation of forthcoming support from the Bank, the National AIDS Prevention and Control Council (NAC) was established, with the President as its Chair, and members drawn from leaders of regional and federal ministries, civil society, faith-based organizations, and the private sector. The main role of this entity is to oversee the implementation of the strategic framework for HIV/AIDS, examine and approve plans and budgets, monitor performance, and evaluate impact. A National HIV/AIDS Prevention and Control Secretariat Office (NACS) was established in June 2000 to support NAC in its mission and to coordinate and facilitate HIV/AIDS activities in the country. The President also appointed a Board of Advisors to streamline the work of the NAC.[28] The year 2000 also saw the creation of the first regional AIDS councils in Tigray, Addis Ababa, and Dire Dawa.

5.11 ***Fast-Track Preparation.*** Project preparation and negotiation were carried out in a record six weeks.[29] A large (25-person) identification mission started its work in Ethiopia on June 26, 2000, collaborating with a rapidly assembled National Preparation Task Force. On July 12, with the team still in the field, a video-conferenced Decision Meeting approved the start of the appraisal process on July 17. Negotiations were completed in Washington on August 4, 2000. A $59.7 million credit was approved for Ethiopia (along with a $50.0 million credit for Kenya) by the Board of Executive Directors on September 12, 2000, as a part of the overall $500 million MAP operation.[30]

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28. This Board was originally chaired by the Minister of Youth, but recently (August 2003) the Minister of Health was given this role.

29. The Bank's historical coefficient for project preparation in non-AIDS projects in MAP countries is about 25 months (Source: Africa Region Program Statistics).

30. Thus, the goal set by the President of the World Bank and the Operations Committee of Board approval of the first MAP before the World Bank's Fall 2000 Annual Meetings was met.

Box 12. Multi-Country AIDS Program (MAP)

The emergency "Multi-Country AIDS Program" (MAP) was conceived as an Adaptable Program Loan (APL) that would rapidly provide financial support to governments in Africa seeking to mount and/or implement multi-sectoral HIV/AIDS programs.

To access MAP funding, each country would have to satisfy four "eligibility criteria" in terms of demonstrating: (a) satisfactory evidence of a strategic approach to HIV/AIDS (typically a multi-sectoral strategy and action plan); (b) a high-level HIV/AIDS coordinating body to oversee the implementation of the strategy and action plan; (c) agreement to use appropriate implementation arrangements to accelerate implementation, such as direct channeling of funds to multiple implementers; and (d) agreement to use and fund multiple implementation agencies. Processing of individual countries' requests for financial support under the MAP is expedited through an accelerated review process and approval by the Regional Vice-President. The Vice-President's approval is validated within two weeks on the basis of the Board's non-objection.

5.12 In line with the MAP approach, the EMSAP was conceived as a financial support to the implementation of national policy and strategy. Because Bank management considered that the AIDS crisis in Africa warranted an emergency response, and in respect of the Africa Region's commitment to the Operations Committee to seek Board approval by the time of the annual meetings, a number of preparation tasks were postponed into the implementation phase of the project. Technical, economic, social, financial, and institutional assessment of the national strategy was thus not undertaken in the brief course of project preparation. Baseline data were not established before the start of the project, nor was a monitoring and evaluation system developed. In-depth capacity assessments of the multiple coordinating and implementing institutions were not undertaken. The only exception was a rapid review of NGO capacity that provided an inventory of NGOs but insufficient analysis of their implementation capacity. There was no assessment of the amount and nature of donor assistance to ensure complementarity of Bank support. Bank consultation with donors during preparation was very limited. Donors and some Bank staff involved in the preparation noted that project content was deliberately not defined. Instead, project preparation, appraisal, and negotiation focused on the establishment of institutions and implementation arrangements that would permit the accelerated disbursement of funds to a multiplicity of implementers, with 44 percent of the credit amount allocated for grants to civil society and communities. Project objectives and components are shown in Box 13.

5.13 ***Slow Start-up, Management Bottlenecks, Low Disbursements.*** EMSAP, which became effective on January 2, 2001, was originally conceived as a three-year operation with a closing date of June 30, 2004. However, slow start-up and slow disbursement rates led the government and the Bank to agree in late 2003 to a new closing date of December 31, 2005, thus adding an additional 18 months to the project implementation phase and postponing the preparation of a follow-on operation. Start-up was slow because of the time taken to set up the institutional arrangements, including recruitment of essential procurement and financial management staff. Other factors that have contributed to slow project disbursements include lack of capacity to prepare and implement technically sound proposals, to undertake financial reporting and simple accounting of funds spent, and, with respect to the NACS, to evaluate and finance proposals in a timely manner.

Box 13. Ethiopia Multi-Sectoral HIV/AIDS Project (EMSAP): Purpose, Objectives, Components

Overarching purpose:

- To reduce the spread of the HIV/AIDS epidemic, alleviate its impact and increase access to treatment, care, and support for those infected and affected by HIV/AIDS.

Project development objective:

- To help accelerate implementation of the Federal and Regional Multi-Sectoral HIV/AIDS Strategic Plans, particularly through the provision of HIV/AIDS prevention, care, and treatment services at all levels and in a number of sectors. The project will prioritize support for community-driven initiatives.

Project components:

- *Capacity-building for Government and Civil Society ($8.8 million, 14 percent of project funds):* Enhance the institutional capacity of governmental agencies, civil society, and the private sector at the national, regional, zonal, *woreda*, and *kebele* levels to plan and execute multi-sectoral activities to combat the HIV/AIDS epidemic.
- *Expanding Governmental Multi-Sectoral Response ($19.7 million, 31 percent):* Support a major expansion of HIV/AIDS activities being implemented by government entities and other public sector agencies, including health and other development sectors. Activities eligible for financing encompass prevention, care and treatment and mitigation.
- *The Emergency HIV/AIDS Fund (EAF) ($28.1 million, 44 percent):* Expand the response of communities, NGOs, and the private sector to better manage the crisis related to the epidemic. This demand-driven fund channels funds directly to NGOs, religious organizations, the private sector, and local communities on a cost-sharing basis to finance multi-sectoral HIV/AIDS programs. The fund has two windows: (i) for NGOs and the private sector, and (ii) for local community initiatives in *woredas* and *kebeles*.
- *Project Coordination and Management ($6.8 million, 11 percent):* Supports for the project coordination unit (PCU), whose main responsibilities are coordination, liaison, supervision, monitoring and longer-term planning, and policy support.

5.14 Bottlenecks were particularly acute at the level of the NAS. NAS's management was weak and its legal status was not clear, having been so rapidly set up. Under the pressure of an extremely tight timeframe for project preparation the Bank nonetheless accepted the nomination of this candidate and the institutional setup during project negotiation.[31] In June 2002, 17 months after project effectiveness, the NAS was replaced by the HIV/AIDS Prevention and Control Office (HAPCO), created by government proclamation (see Box 14) and a new head was appointed. Regional HAPCOs were also created by government proclamation in all 11 regions. A project coordination unit (PCU) (originally attached to the NAS and subsequently attached to HAPCO) is responsible for fulfilling the Bank's fiduciary and reporting requirements, facilitating EMSAP implementation, and providing an interface between the Bank and HAPCO in project execution. During negotiation, the government rejected the Bank's suggestion to contract out financial management as a means of accelerating financial flows and ensuring transparency and efficiency in the management and utilization of financial resources.

31. Project documentation notes the Bank's intention to review the institutional arrangements, including structural and staffing needs for the NAS (World Bank August 2000).

Box 14. HIV/AIDS Prevention and Control Office (HAPCO)

HAPCO was established on June 11, 2002 as an autonomous federal government organ having its own legal status. Accountable to the Prime Minister, the main role of HAPCO is to coordinate and direct the implementation of Ethiopia's HIV/AIDS policy. Its main duties are to:

- Serve as the secretariat of the National AIDS Council;
- Submit for the approval of Government a national HIV/AIDS program prepared on the basis of the recommendations of the NAC and follow up and coordinate the implementation of the program;
- Coordinate federal and regional government activities and NGOs engaged in HIV/AIDS work and facilitate conditions for integration;
- Organize meetings and workshops for enhancing awareness of Ethiopian society;
- Participate in national and international conferences;
- Collect, compile and disseminate information on the general situation of HIV/AIDS in the country;
- Mobilize of donor support; and
- Ensure correct use of financial resources for HIV/AIDS.

5.15 ***Results to Date.*** **Annex 5** provides an overview of progress made to date with EMSAP support on each of the project indicators. EMSAP has supported the establishment and functioning of federal and 11 regional HAPCOs and of 240 *woreda*[32] and more than 6,000 *kebele*-level HIV/AIDS councils, including the recruitment of *woreda* and *kebele* facilitators. The functioning of the local councils has not been evaluated. Field visits and interviews revealed a significant turnover in *woreda* and *kebele* facilitators, given their very broad mandates, heavy workloads, and multiple accountabilities. Notwithstanding these challenges, the project has incited the preparation and financed HIV/AIDS work programs conceived by and for communities in these 240 *woreda* and 6,000 *kebeles.*

5.16 EMSAP has also supported massive IEC activities carried out by governmental and nongovernmental actors and contributed to an increase in condom distribution.[33] Condom distribution supported under the EMSAP is a complement to the long-established and robust DKT sales and distribution program supported by USAID, which has contributed to significant increases in the availability of condoms in five of Ethiopia's regions (see Figure 5). Other prevention activities supported include the setting up and support of thousands of anti-AIDS clubs across the country for in-school and out-of-school youth. Field visits confirmed the dynamism and strong ownership of these clubs. NGO initiatives supported under EMSAP have been primarily focused on IEC, but also included some care and mitigation activities (see Figure 6). In contrast with support provided by other donors channeled directly to NGOs, the EMSAP has channeled funds to NGOs through government, thus nurturing the establishment of contractual partnerships between government and NGOs.

5.17 Thirty federal government offices and 125 regional bureaus have accessed project funds to implement sectoral HIV/AIDS plans. Still, the public sector response has been very weak to date, both in the funds committed and spent, and in the quality of the proposals.

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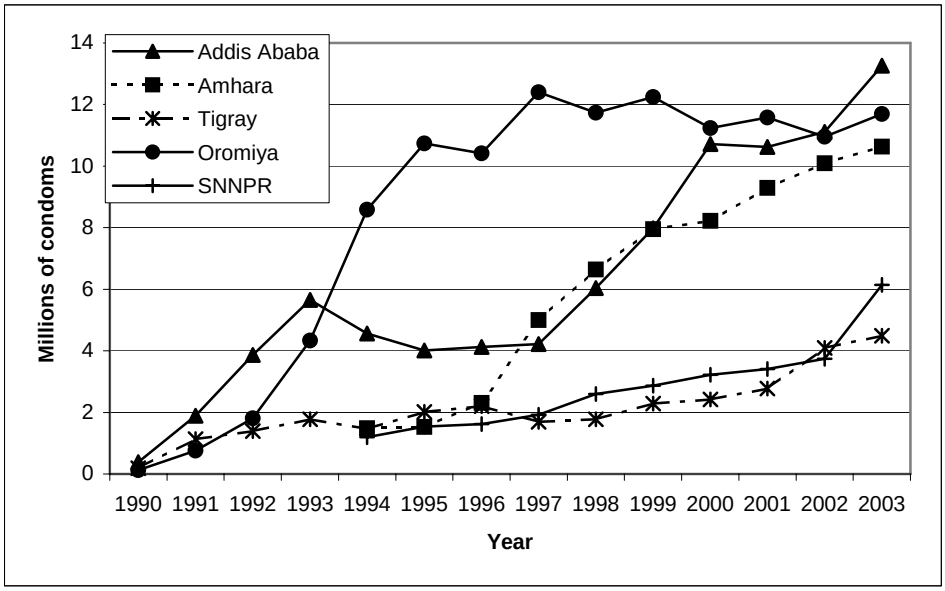
32. This represents a coverage rate of 43 percent of Ethiopia's 555 woredas.

33. Source: HAPCO reporting. According to HAPCO, EMSAP has contributed to an increase in condom distribution from about 4.1 million in 1999 to 67.6 million by the end of 2002. However, these data need to be clarified and reconciled with DKT data, both in terms of the overall amounts of condoms distributed, the breakdown of social marketed vs. freely distributed condoms and the financial contributions of all partners, including USAID and EMSAP.

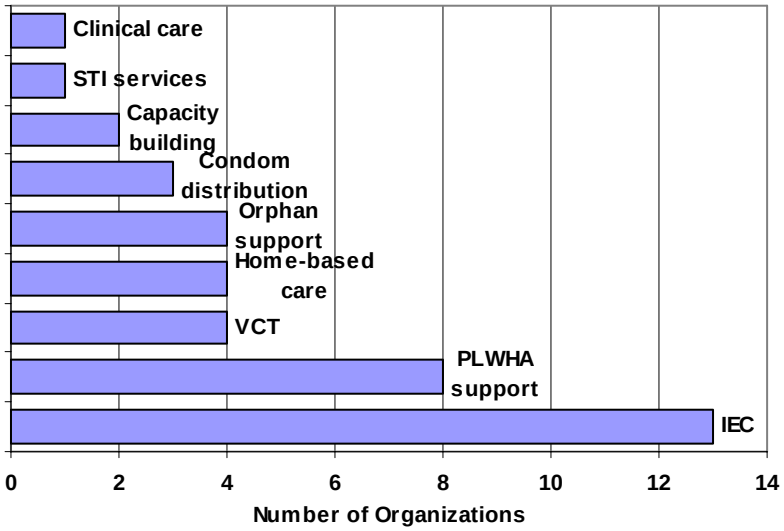
Most proposals have been limited primarily to AIDS in the workplace, following a prototype design, with very limited guidance and technical quality. There has been very little rigor in the review and approval of work program proposals from the public sector. Rather, their review is quick and their approval is almost automatic. Overall, EMSAP has stimulated considerable initiative and activity by governmental and nongovernmental actors. However, they are not coordinated and consequently pose a considerable risk of overlap and duplication of efforts carried out under these multiple proposals. Furthermore, these interventions have not always been conceived in response to the multiple and distinct priorities of groups in regions with different levels and rates of HIV prevalence and AIDS cases. Capacity has been utilized and further strengthened through applied experience accumulated by these different actors and some have benefited as well from formal training under the project. However, capacity building remains a critical priority of the project as much more remains to be done.

Figure 5. DKT/PSI: Annual Condom Distribution by Region, 1990-2003 (financed by USAID)



Source: DKT Statistics, 2004

Figure 6. : Number of NGOs Engaged in HIV/AIDS Prevention and Control Activities (Federal Level), 2001 - August 2003



Source: World Bank calculations based on HAPCO data

5.18 Difficulties in operationalizing the Emergency AIDS Fund (EAF), financial liquidity problems, and delays in the processing of proposals have generated skepticism among NGOs and the private sector and reduced the effectiveness of public-private partnerships. In one example, the delays in funding meant that AIDS orphans had not received their subsidies and had to stop going to school, affecting the credibility of the NGO in the community. Many large and capable NGOs that have alternative sources of financing are reluctant to apply to

the EAF because of the problems, while small NGOs that are largely dependent on EMSAP funds continue to apply. This has implications for the effectiveness of expanded activities supported through the EMSAP.

5.19 Health sector support provided under EMSAP has included the purchase of drugs for the treatment of opportunistic infections, the strengthening of blood safety measures, and the establishment of 170 voluntary counseling and testing centers. EMSAP has also supported the establishment of new surveillance sites increasing the total number of ante-natal clinic (ANC) sentinel sites in the country (especially in rural areas) from 15 in 2000 to 64 in 2003. Despite the early (1988) launch of Ethiopia's HIV/AIDS surveillance system, it is still very weak and there is no systematic reporting of data. Regular surveillance of high-risk groups, initiated in the late 1980s, has subsided since the mid-1990s. Until recently there was no surveillance of risky behaviors. The publication of the first Behavioral Surveillance Survey (BSS) in 2003 constitutes an important step in establishing key baseline data on behaviors of different target groups.

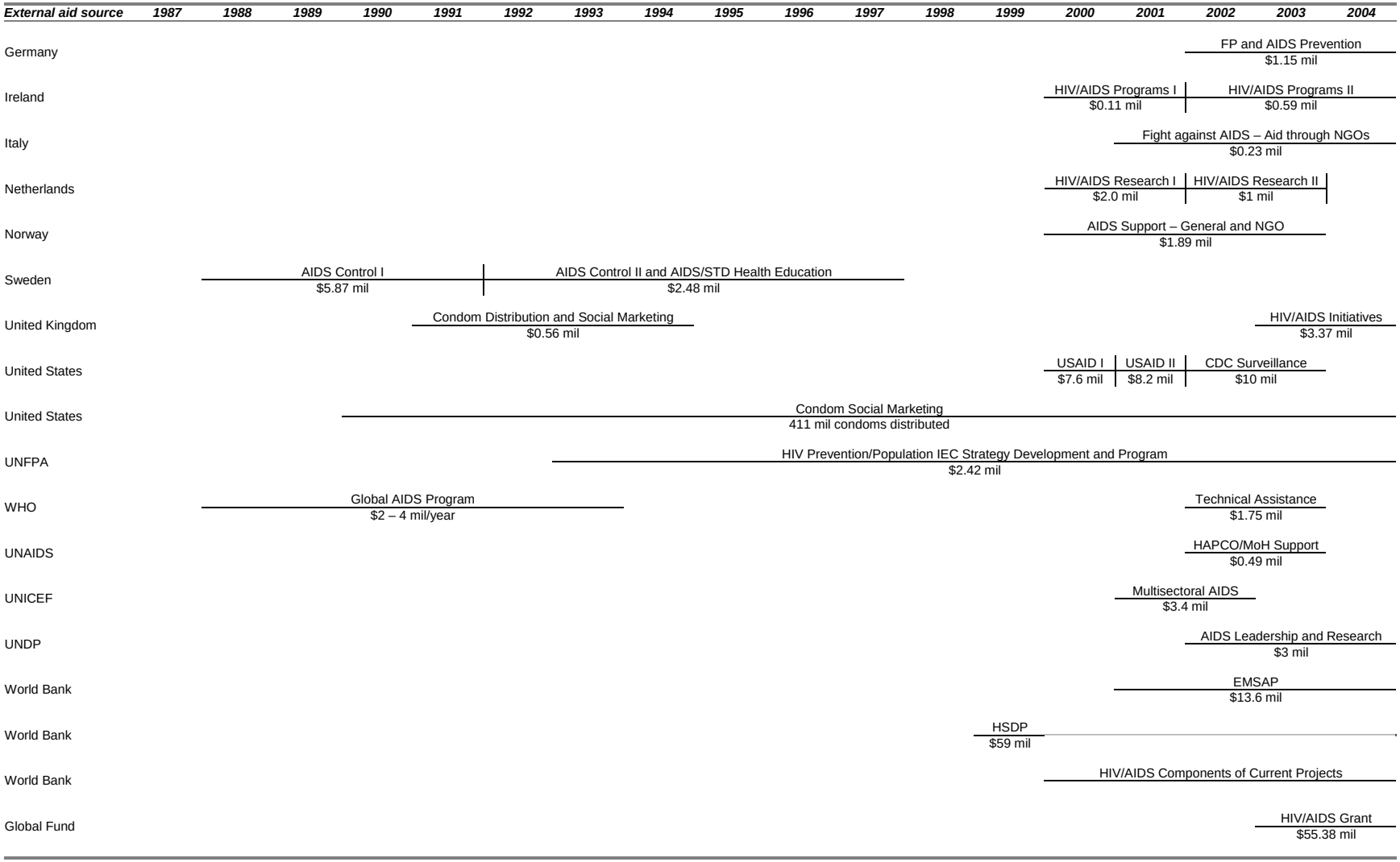
5.20 ***Mid-Term Adjustments.*** The government initiated a mid-term review of the EMSAP in February 2003. A Bank mission in May 2003, carried out jointly with other donors, highlighted the following bottlenecks: low implementation capacity at all levels; low disbursement and a weak financial management system; slow statement of expenditure (SOE) submission, leading to delays in replenishment of the Special Account and slow financial flows; lack of a detailed implementation and financing plan for anti-retroviral therapy (ART) in public and private facilities; weak planning, including inadequate targets and performance indicators; weak monitoring and evaluation; slow proposal review process; and overall weak coordination. By the end of 2003, the government had taken a number of steps to address these issues, including additional recruitment for federal and regional HAPCO positions; strengthened subproject approval process; capacity building for accelerated and accurate SOE submission; technical training of implementers of HIV/AIDS activities (for NGOs and government organizations); intensified efforts to expand programs for prevention of mother-to-child transmission (PMTCT), voluntary counseling and testing (VCT), and anti-retroviral therapy (ART); and the development of a monitoring and evaluation framework. The Bank, in turn, amended the Development Credit Agreement to: (i) extend the closing date by 18 months; (ii) raise the ceilings of the Special Accounts to improve financial liquidity; and (iii) adjusted procurement of small works to streamline processes in light of experience. As of March 25, 2004 (three months short of the original closing date), half of the total credit had been disbursed.

Support of Other Partners

5.21 The World Bank is not the only agency to have intensified its support to Ethiopia's HIV/AIDS efforts in recent years. Since the adoption of the 1998 HIV/AIDS policy, other multilateral and bilateral partners have also intensified their technical and financial support. The budget requirements for implementing the Strategic Framework during the two-year period January 2002 through December 2003 were estimated by the Government at $245 million, or $122.5 million annually (NACS 2002). Starting in late 1999, Ethiopia's partners, under the overall coordination of UNAIDS, have supported government in the participatory strategic planning process that produced the Strategic Framework for HIV/AIDS. They have also provided increased financing for implementation of this framework. Figure 7 illustrates the dramatic increase in donor support to HIV/AIDS efforts in Ethiopia in the past few years,

both in the number of donors contributing and in the amounts of their support. The total financial contribution of donors to the implementation of HIV/AIDS activities has not been calculated by HAPCO or UNAIDS.

Figure 7. Major Sources of External Assistance for Ethiopia's HIV/AIDS Efforts



Sources: AiDA, Ethiopia's application to the Global Fund, former GPA staff, and DKT statistics

6. Impact of the Bank's Assistance

6.1 This chapter assesses the impact of the totality of Bank's assistance to Ethiopia's fight against HIV/AIDS, encompassing policy dialogue, analytic work and all lending supporting HIV/AIDS activities. It attempts to define what actually happened as a result of Bank support, relative to the counterfactual of no Bank assistance. In doing so, it addresses several evaluation issues including: government commitment; multi-sectoral and institutional response; strategic priorities; the relation between the AIDS response and the health sector; civil society's response; monitoring and evaluation; and behavioral and epidemiological outcomes.

Government Commitment

6.2 ***Policy/Strategy.*** It is not evident that the adoption of the 1998 HIV/AIDS policy and the preparation of the 2000-2004 strategic framework reflected government commitment or that the Bank had influenced these heavily. Both were primarily the result of strong advocacy and intensive technical and financial support of UNAIDS, under the leadership of WHO, with relatively weak government ownership. According to UNAIDS members, the World Bank participated in UNAIDS meetings, but did not provide significant technical or financial support to the policy formulation and planning processes.

6.3 The 1998 Social Sector Report and accompanying dialogue did little to convince the social sector leadership in the Prime Minister's office of the urgency with which HIV/AIDS should be addressed. The sentiment expressed by the Prime Minister's office and by the MoH at that time was that there were other diseases, such as malaria, deserving equal if not higher priority. Questions about the priority of HIV/AIDS relative to other diseases and generic health sector constraints (insufficient human and financial resources and a crushing agenda to expand and improve basic health services) were not addressed by the burden of disease analysis. This is because the burden of disease analysis on which the Social Sector Report was based is not the optimal tool for demonstrating relative impact and priority of a rapidly spreading epidemic in which the "burden" is felt with a delay of many years. By the time a large burden of AIDS illness and mortality is detected by such analysis is it too late to prevent an epidemic.

6.4 Donors were unanimous in crediting the World Bank with opening up a frank dialogue about HIV/AIDS at the highest levels of government in 1999, particularly with the President, the Prime Minister, and the Minister of Economy and Finance. Three results of these efforts are the government's agreement to borrow IDA funds for HIV/AIDS, the willingness of the highest levels of government to raise the issue in public speeches, and the incorporation of HIV/AIDS in the government's Poverty Reduction Strategy Paper.

6.5 Still, commitment among decentralized authorities and among officials representing other development sectors varies. Many policymakers and implementers are not fully aware of the urgency in addressing HIV/AIDS. Not all in government have an appreciation of the relationship between HIV/AIDS and poverty and thus the role of HIV prevention as a critical intervention for achieving the Millennium Development Goals. Not all are aware of the current and potential

impact HIV/AIDS can have on their own sector development prospects or of what critical roles their sectors can play in fighting HIV/AIDS, in line with their core mandates, with and through their staff and clients. Many, instead, see HIV/AIDS activities as competing with other pressing priorities. There are notable exceptions. The Ministry of Defense has had a strong understanding of the risks and consequences of HIV infection and has launched early and strong preventive interventions. The Bank, through its transportation project component, seems to have had a positive impact on the commitment of the transport sector in taking on a proactive role in the fight against HIV/AIDS in line with its comparative advantage.

6.6 ***Public Spending.*** In 2001, total government spending for the health sector was $143 million, or about $1.38 per capita, of which about $8.5 million (6 percent) was allocated for HIV/AIDS.[34] Although exact data are not available, donor funding for HIV/AIDS (see Figure 7) falls far short of filling the financing gap for implementing Ethiopia's Strategic Framework for HIV/AIDS 2000-2004, estimated at about $122 million annually. World Bank financing through the EMSAP has helped ease the resource constraint for HIV/AIDS, boosting government spending on HIV/AIDS by around $15 million per year. HIV/AIDS components of other World Bank projects have made available small amounts of additional IDA financing for HIV/AIDS activities, although the exact amount of these has not been calculated. Table 2 provides a notional overview of the collective contributions of Ethiopia's partners in recent years. HAPCO is responsible for HIV/AIDS program coordination. While some is channeled to (or through) HAPCO, considerable technical and financial support is channeled directly to key implementers, including: federal MoH, regional health bureaus, other technical ministries (federal and regional), research institutions, and national and international NGOs.

34. This amount is net of the IDA credit for EMSAP and of government counterpart financing for this project.

Table 1. Recent Major External Aid Sources for Ethiopia's HIV/AIDS Programs

External aid source	*Amount (in mil of US$)*	*Start date*	*End date*	*Purpose*
Germany	1.2	2002	2004	Integrate HIV prevention in family planning services
Ireland	0.7	2000	2004	Various small-scale HIV/AIDS programs
Italy	0.2	2001	2004	Support for NGOs
Netherlands	3	2000	2003	Ethio-Netherlands AIDS Research Project, WHO support
Norway	1.9	2000	2003	Support channeled to UNICEF, UNFPA, and HAPCO
United Kingdom	3.4	2003	2004	Various HIV/AIDS initiatives
United States				
USAID	15.8	2000	2001	Behavioral surveillance, prevention, care, and support
CDC	10.0	2002	2003	Surveillance, STI and VCT services, and military outreach
UNFPA	2.4	1993	2004	Integrate HIV prevention in population IEC strategy
WHO	1.8	2002	2003	Technical support to health sector interventions
UNAIDS	0.5	2002	2003	Support to HAPCO and to MoH for VCT services
UNICEF	3.4	2001	2002	Multi-sectoral interventions, PMTCT, and youth programs
UNDP	3.0	2002	2004	Leadership, advocacy, communication, and planning
World Bank	60.0	2000	2005	HSDP and EMSAP
Global Fund	55.4	2003	2005	Scale-up HIV/AIDS interventions

Sources: AiDA, Ethiopia's application to the Global Fund (http://aida.developmentgateway.org/AidaHome.do)

6.7 Ethiopia's willingness to borrow on IDA terms for HIV/AIDS and its agreement to finance about $2 million in counterpart obligations for this project[35] are an indication of commitment at the highest levels of government. Additionally, in August 2000 (prior to EMSAP presentation to the Bank's Board of Directors), the government provided $1 million to the National AIDS Secretariat (NAS) to support its launch and running costs, including the recruitment of staff at the national, regional, and local levels. During visits to selected regions, regional and municipal governments have indicated that they are also allocating a portion of their budgets to support necessary recruitment and to assure the full functioning of coordinating entities at the local level. Exact data are not available.

6.8 While there are indications of increased public expenditure on HIV/AIDS, directly and indirectly attributable to World Bank support, the Bank has not as a matter of practice advocated domestic mobilization of public resources for HIV/AIDS within the public expenditure framework. Such advocacy is an integral part of the Bank's lending and non-lending assistance for other sectors. For example, under the HSDP, the federal government

35. An additional $1.7 million in counterpart funds is being provided by NGOs and the private-for-profit sectors.

agreed with its development partners, including the Bank, to allocate about $300 million over a five-year period for strengthening primary care. A basic principle of the MAP is the mobilization of resources for HIV/AIDS. However, increased allocation of public budget for HIV/AIDS and the monitoring of public expenditures have not been an integral part of the Bank's work, either in the macro or in the sector arenas.

Multi-sectoral and Institutional Response

6.9 ***Multi-sectoral Response.*** HIV/AIDS components under other World Bank sector projects in Ethiopia have stimulated and supported more in-depth response to HIV/AIDS challenges by public sector agencies in line with their comparative advantages and priority target groups: transport sector, education sector, women's development, emergency and relief assistance, demobilization and reintegration, poverty reduction. As a result of the strong conviction of the chief medical officer of the Ministry of Defense, this ministry carried out prevention activities targeted to soldiers during the war with Eritrea. It incorporated a robust HIV/AIDS component as a part of its demobilization activities, encompassing prevention, condom promotion and distribution and testing, with follow-up and care for all demobilized soldiers who seek such services. The Ethiopia Transport Authority, as well, has been proactive in incorporating HIV/AIDS activities into their work, targeting their staff, contractors, migrants, and villages in the areas of their interventions. For these sectors and (more recently) for the education sector, the World Bank technical support to design and implement appropriate HIV/AIDS interventions has enhanced public sector capacity.

6.10 In order to access financing under EMSAP, public sector agencies (federal, regional, and local levels, all development sectors) were required to establish HIV/AIDS task forces from within their ranks that are responsible for the preparation and implementation of HIV/AIDS sector work plans to target their staff and clients. With the few exceptions noted above, public sector agencies have not been proactive on this front. The majority of civil servants interviewed across a broad range of development sectors noted that (i) HIV/AIDS is not considered a priority within the respective ministries; (ii) ministries lack the technical support to design and implement such programs; (iii) there is little incentive or reward for HIV/AIDS work; and (iv) there is still stigma and consequently discomfort in addressing the issue of HIV/AIDS. Key ministries, such as Agriculture and Rural Development and (until 2003) Education,[36] have not incorporated HIV/AIDS issues fully into their work. HAPCO has not provided the technical staff needed to incite, guide, support, and monitor HIV/AIDS components. Neither the money available under EMSAP nor the institutional setups within these sectors seem to have had any impact on the response. The sectors that are benefiting from EMSAP funding are those whose convictions, capacity, and actions have benefited from Bank technical support through sector interventions.

6.11 ***Institutional Arrangements.*** Eligibility criteria, conditionality, and financial support under EMSAP have accelerated the establishment of the National HIV/AIDS Council (NAC), the NACS (which later was transformed into HAPCO), and regional HAPCOs. The

36. In 2003, the Bank sent a technical mission to Ethiopia to guide and support the design and implementation of HIV/AIDS interventions for the education sector. This mission seems to have enhanced both the commitment and the capacity of the education sector to address HIV/AIDS issues in line with its comparative advantage.

Bank's eligibility criteria not only influenced the *creation* of the institutional setup for a multi-sectoral response (HAPCO), but also the *nature* of that institution, which puts almost exclusive emphasis on the process of coordinating, implementing, and financing of HIV/AIDS activities. The responsibility and oversight for the technical components – the content – of the HIV/AIDS program have been ill-defined and have suffered as a consequence. Furthermore, no institutional or capacity assessment was undertaken before setting up these institutions to evaluate alternative institutional arrangements in light of the history and political economy of HIV/AIDS organizations in Ethiopia and elsewhere around the world. HAPCO is set up primarily as an agency to coordinate HIV/AIDS activities and to channel resources to multiple actors for a multi-sectoral, decentralized response. As a consequence, its main departments are organized around functions: information; audit; administration and finance; planning and programming; and advocacy, mobilization, and coordination. Staff consists primarily of administrators, including the head of HAPCO, and financial management experts. By contrast, Ethiopia's former institutional setup for HIV/AIDS in the late 1980s (the DAC) consisted of technical departments and technical staff, but they were also equipped to foster and support involvement of other sectors and NGOs (see Box 1 and para. 3.3).

Strategic Response

6.12 The World Bank has not had significant influence on national policies and strategies for HIV/AIDS. While the 1998 Social Sector Report did quantify the status and momentum of the epidemic, it neglected to assess the draft policy and the medium-term plan that was in effect at the time. Furthermore, the burden of disease exercise was not the most compelling tool for raising the awareness of government about the urgency of the epidemic since it focuses on AIDS morbidity and mortality rather than HIV infection. One respondent did note, however, that projections contained in this analysis may have contributed some momentum to the formulation and adoption of HIV/AIDS policy in 1998 and to the 2000 strategic planning process, along with the encouragement and support of UNAIDS and other partners.

6.13 Two years later, the EMSAP preparation did not include an assessment of the national HIV/AIDS policy that had since been adopted, nor did it assess the five-year strategic framework for HIV/AIDS, made up of the federal and regional five-year plans. Thus, very little dialogue was carried out on the content, cost-effectiveness, or prioritization of the multiple interventions included in the policy and strategic framework. The Bank did not take on its traditional role in preparing the EMSAP by evaluating the government's plans from a number of disciplines: technical, financial, economic, social, and institutional. A negative consequence of this departure from the Bank's rigor in project preparation is that there was insufficient emphasis and support of public goods, most notably surveillance, research, monitoring, and evaluation. No baseline data were established on the prevalence and behaviors of the general population in regions or on high-risk groups, which would have better informed the choice of strategic targets, interventions, and indicators and thus the cost-effectiveness of interventions. Furthermore, while a principle of the MAP is to "scale-up what works," there was no inventory or evaluation of ongoing HIV/AIDS activities and thus no basis on which to decide which of these were good candidates for widespread implementation.

HIV/AIDS and the Health Sector

6.14 World Bank support to the health sector has financed improvements in access and quality of primary health care services, through investments in infrastructure, human resources, drugs, and other essential inputs. It has also strengthened disease control interventions and developed sector management capacity, including donor coordination. Health sector investments have thus contributed to overall health system capacity, which is critical for HIV/AIDS work within the health sector. With World Bank support, the MoH has also benefited from direct HIV/AIDS assistance, most notably: expansion of VCT services; acquisition of drugs for opportunistic infections (OI); preparation of protocols for care of people living with HIV/AIDS; acquisition of equipment and supplies, and an increase in the number of surveillance sites by a factor of four. In addition, Bank support has contributed to: the preparation of an ARV policy and ART guidelines (although not yet applied); preparation of VCT guidelines and their translation into local languages; design of care and support guidelines; training in PMTCT in pilot areas; preparation of guidelines on home-based care and related training; a safer blood supply.

6.15 While IDA financing has been made available to support the health sector's fight against HIV/AIDS, it has been under-exploited. After HAPCO was established and assumed the oversight and coordination responsibilities for HIV/AIDS (which had been the responsibility of MoH) there was no redefinition of MoH's mandate and program priorities for HIV/AIDS, especially its complementarity with HAPCO, nor was there a reassessment and realignment of MoH's internal institutional structure. As a consequence, MoH's response to HIV/AIDS has not been very proactive. HIV/AIDS activities have been implemented largely with other donor support. The HSDP supported HIV/AIDS by definition, but very little direct support for HIV/AIDS activities was provided under this project, MoH preferring to use the funds for expansion of basic services. When the EMSAP became effective less than two years after HSDP effectiveness, all support to HIV/AIDS work within the health sector was shifted to EMSAP. The MoH was reportedly resentful in their perception that it was the Bank, which was behind the setting up of a multi-sectoral agency for coordination and oversight of HIV/AIDS policy implementation in Ethiopia, thus substituting for the traditional role and responsibility of that ministry. The consequence was a disengagement of the MoH in the fight against HIV/AIDS. Collaboration or even coordination with HAPCO was minimal, and MoH sought other sources of financing, directly channeled to them by other donors, as a preferred alternative.

Civil Society

6.16 The Bank has supported a major shift in the environment of private sector participation in HIV/AIDS activities. As opposed to other partners that channel money directly to NGOs, the Bank is supporting and nurturing contracts between the government and the private sector on a large, unprecedented scale. The impact of this initiative is not known because there has been no systematic evaluation of NGO or community projects. Nothing is known about: the effectiveness or coverage of sub-projects individually or collectively; their impact on intended beneficiaries; their complementarity with public sector interventions; or their coherence with the demands of beneficiaries and with local-level priorities as determined by the nature and growth of the epidemic.

6.17 The potential impact of the Bank's assistance in terms of the number and coverage of NGOs developing and implementing HIV/AIDS projects has been undermined by cumbersome mechanisms for disbursement and replenishment of funds, thus discouraging the capable NGOs from participating and financing by default the weaker, less experienced NGOs. The unreliability of financial flows to NGOs has undermined their credibility with their clients/beneficiaries. Attempts to rectify this situation include an increase in the amount of the special account to increase financial liquidity and intensified capacity building and technical assistance in accounting and financial management to improve the turnaround and accuracy in the submission of statements of expenditure.

6.18 However, the Bank has had little impact with regard to building the legitimacy and capacity of NGOs. A rapid (3-day) assessment of NGO capacity was carried out during the course of project preparation, but does not substitute for a more in-depth assessment of the opportunities and constraints (both existing and potential) of the legal, political, social, and historical environment within which civil society operates or of the technical, managerial, and financial capacities of NGOs. While some training and workshops were provided for NGOs, most of those interviewed highlighted the need for more intensive, better designed capacity building interventions tailored to the needs of this very diverse group. To date, HAPCO has not provided the needed support; and NGO proposals currently do not include capacity-building components. International NGOs such as ActionAID (supported by DFID) and PACT (supported by USAID) are working on these capacity-building issues.

Monitoring and Evaluation

6.19 The Bank has collaborated closely with bilateral and multilateral agencies in an effort to strengthen surveillance, monitoring, and evaluation capacity, most notably: UNDP, UNAIDS, USAID, CDC (for epidemiological surveillance), and Family Health International (for behavioral surveys). HSDP has a small HIV surveillance component, but has not directly supported HIV/AIDS surveillance. EMSAP did contribute to the expansion of the number of sentinel surveillance sites in ANC clinics, with an emphasis on rural sites. ANC data are not regular or reliable yet, though and there is still no regular surveillance of HIV in high-risk groups. Since the EMSAP became effective, an experienced and capable research institute, Ethio-Netherlands AIDS Research Project (ENARP)[37] has submitted 17 research proposals for funding under the EMSAP. Out of the 17 proposals, they have received funding for only two. One reason reported by respondents seems to be that HAPCO does not have technical staff to review the proposals and the proposals are rejected because the committee does not understand their value and how they fit into the priority areas for EMSAP support. The support of relevant HIV/AIDS research is a critical need.

6.20 Limited baseline data was available at the time EMSAP was developed, and efforts have been insufficient to develop a proper baseline for inputs, outputs, HIV, and behavior. An important advance in this regard is the financing of a national baseline behavioral survey, but

37. ENARP is an independent institute that is governed by a board of directors chaired by the Minister of Health. Established in 1994 it is extensively involved in pioneering research in HIV. As a policy and research resource, it has advised on ART policy development, prevention of mother-to-child transmission, and development of universal precautions. It has also been conducting HIV surveillance in Addis since 1995.

the need remains for a national baseline epidemiological survey that would provide regional-level data and analysis, as well as updates of prevalence rates for high-risk groups around the country. The Bank's internal report on the mid-term review highlighted the fact that there has been no systematic program activity monitoring since its launch and no readily available data to indicate how the EMSAP has been used to prevent HIV and mitigate the impact of AIDS. It went on to say that the total number and coverage of target populations was not known and that there was an urgent need to establish an effective M&E system, including recruitment of specialists and building capacity. HAPCO, with assistance from UNAIDS, including Bank inputs, issued a Framework for Monitoring and Evaluation of HIV/AIDS Activities in December 2003. Plans to implement this framework in 2004 include workshops and training to enable the multiplicity of actors to carry out M&E. Recruitment of M&E experts for federal and regional HAPCOs is underway. The lack of a baseline and the absence of an M&E framework at the project's outset have not supported the "learning by doing" philosophy of the MAP.

Outcomes

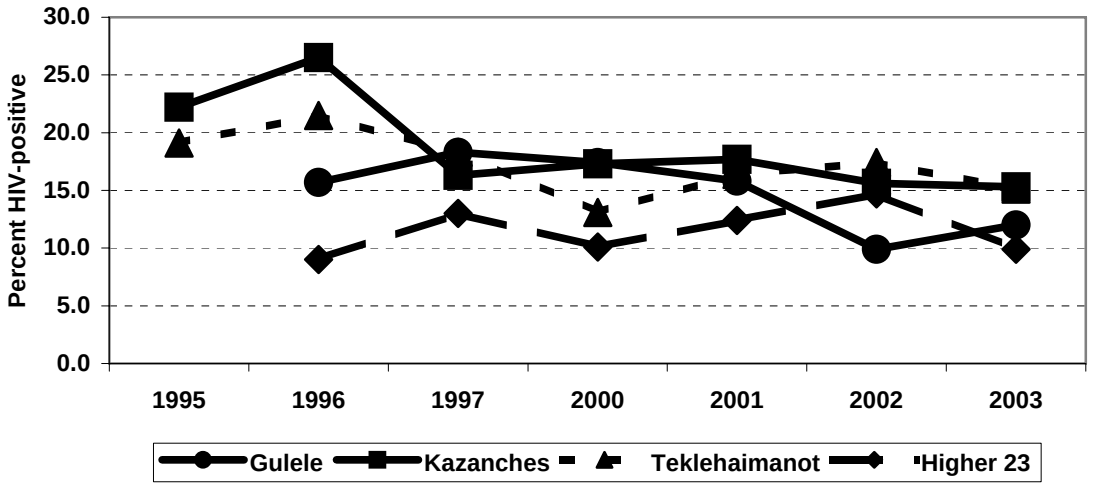
6.21 ***Knowledge.*** One impact indicator established under the EMSAP was that by the end of the project 80 percent in participating *woredas* of the population would have heard of HIV/AIDS and its prevention. HAPCO cites among its accomplishments awareness figures of 98 percent, but these must be qualified for two reasons. First, the 2000 DHS data (specifically citing 86 percent of women and 96 percent of men reporting that they know about HIV/AIDS) predates investment in IEC supported under the EMSAP and other Bank support. Second, the Behavioral Surveillance Survey (BSS) data (2001-2002) revealed that only half of respondents[38] had knowledge of the three main preventive methods (with rural respondents reporting lower knowledge than urban), and the perception of personal risk in contracting HIV/AIDS was low. DHS estimates (2000) reveal that 35 percent of all women and 68 percent of men have heard of condoms.

6.22 ***Behavior.*** The BSS also revealed that the behaviors of respondents did not always reflect the knowledge they had of risks. Many of those who had the knowledge of how condoms protect against HIV transmission did not apply that knowledge. This gap between knowledge and behavior was also documented in the behaviors of those who knew that sexual fidelity was yet another means of protection against the transmission of the HIV virus, yet still engaged in sex outside of marriage. BSS and DHS data show risky behaviors among these groups, including having more than one partner, extra-marital sex, and condom use with non-regular partners. Condom use among sex workers is found to be high at 92 percent (BSS 2001-2). Over and above these statistics, there was the overwhelming perception expressed through many interviews (spanning the full spectrum of actors and stakeholders) that behavior change was lagging significantly behind improved knowledge. There were some that provided anecdotal evidence that condom use was increasing. For example, condoms are available and visible in secondary schools and less taboo than previously.

38. Target groups included youth, ground forces, air force, truckers, inter-city bus drivers, minibus drivers, pastoralists, and factory workers.

6.23 ***Epidemiological impact.*** HIV prevalence appears to have stabilized in four ante-natal clinics in Addis Ababa over the period 1997-2003. The Bank's major support for HIV/AIDS interventions (through the EMSAP) became available in early 2001, so none of the earlier declines can be attributed to the Bank. Since HIV prevalence changes with a substantial lag, following behavior change, and HIV in low-risk populations tends to reflect this last, surveillance of ante-natal women is not likely to reflect any short-term policy changes or programs. HIV prevalence is likely to be affected first in high-risk populations, but unfortunately they are not being systematically monitored in Ethiopia.

Figure 8. Trends in HIV Prevalence at Four Ante-natal Clinics in Addis Ababa, 1995-2003



7. Findings and Lessons

Findings

7.1 ***The World Bank was late in launching a dialogue and in providing support.*** When the World Bank initiated a health sector dialogue with Ethiopia in 1985 it was before the first AIDS case had been identified in the country. It did not include HIV/AIDS in its first family health project (approved in 1988), which is understandable given that the epidemic was at its earliest stages. However, in subsequent years, there were missed opportunities to support HIV/AIDS earlier than it actually did. The first of these was the restructuring of the Family Health Project in 1993. Enough information had been generated by the DAC about the progression of the disease, including projections, to warrant an intervention. An HIV/AIDS intervention would have been consistent with some of the objectives and activities of the project, which emphasized information and services for reproductive health and family planning. The project would have provided a vehicle for implementing HIV/AIDS strategy within the health system and at that time the MoH was responsible for and committed to this strategy and the program was well-performing, but under-financed. The Bank attended meetings of donors organized by the DAC to mobilize technical and financial support from its partners, but made neither technical nor financial contributions in the late 1980s and early 1990s.

7.2 ***The Social Sector Analysis in 1996-98 succeeded in raising HIV/AIDS as an important health issue and in launching a dialogue with government, but was not followed up with needed analysis of the economic and social impacts of the epidemic.*** The disease burden of HIV/AIDS, especially in Addis, was assessed, and the analysis also made projections of HIV infections. The analysis did not, however, sufficiently assess the consequences of these infections, beyond those of health (it did project AIDS deaths) and the health sector (burden on hospitals and health sector costs associated with the care of AIDS patients). The Social Sector Report achieved its objective of preparing SWAps for health and education, but was unsuccessful in convincing the government about the urgency of addressing the epidemic. In retrospect, a standalone analysis of HIV/AIDS and its economic and social impact and deeper discussion could have highlighted how the control of the epidemic would contribute to many of the pressing priorities of the country, rather than compete with them. Experience in Thailand and India has shown that such analysis can be pivotal in developing a credible dialogue with governments and in influencing stronger government commitment. The social sector analysis also missed the opportunity to evaluate the adequacy of the 1996 medium-term plan for HIV/AIDS and capacity to implement it.

7.3 ***The Bank was persistent and ultimately successful in opening up a dialogue with the highest levels of government about the urgent need to address HIV/AIDS.*** The efforts of the Country Director and Resident Representative were supplemented in 1999 by the President of the World Bank, the Regional Vice President, and the Manager of Act Africa, thanks to a new momentum generated by the Africa Region's intensified HIV/AIDS strategy issued that year. But government commitment is still weak overall. The World Bank provided ample financial support for implementation of policy and strategy by a multiplicity of national actors, but did not assess the content of HIV/AIDS policy and strategy, or assist the government in setting of priorities within these frameworks.

7.4 ***Two new channels of Bank support for HIV/AIDS were generated by this new momentum in late 2000/early 2001: (a) the introduction of HIV/AIDS components through restructuring of ongoing operations; and (b) the development of the EMSAP.*** The former has been more successful than the latter in engaging key sectors to conceive and implement appropriate HIV/AIDS activities. The latter brought financing to NGOs and communities for grassroots activities; it also supported the setting up and functioning of a new institutional framework for the coordination of HIV/AIDS. The health sector did not take full advantage of either of these two channels. The health operation (HSDP), which was approved later in 1998 and became effective in 1999, could have been a vehicle for providing technical and financial support to the health sector in the fight against HIV/AIDS. However, in the face of continued resistance by high-level health authorities and the weak implementation capacity of the MoH, Bank efforts to promote and support HIV/AIDS activities under this operation culminated in only modest support, essentially the syndromic treatment of STDs.

Lessons on the Key Evaluation Issues

7.5 ***The adoption of HIV/AIDS policies and strategies and the setting up of institutions for their implementation do not ensure sustained commitment.*** Ethiopia's experience shows that government commitment cannot be strengthened through external pressure and inputs alone. Advocacy at the highest levels, financing, technical assistance, and project conditionality are not enough. Commitment to HIV/AIDS efforts is a function of the level of understanding of the progression and the consequences of the epidemic; its complex links with poverty and other human, social, and economic development issues; and the firm conviction that critical action can make a difference and must be taken. Given that the existence of national policy and strategy and of an institutional/organizational framework for a multisectoral approach were eligibility criteria for the EMSAP, it is misleading to interpret them as indicators of government commitment. These measures do not capture the more fundamental need for nurturing and fostering understanding, conviction, and commitment of multiple layers of leaders and officials. Those ministries and sectors that have been most successful in the fight against HIV/AIDS in Ethiopia have been those already convinced of the urgency of the issue, the impact of the epidemic on their own development objectives, and their ability and responsibility to take action.

7.6 The Social Sector Report highlighted AIDS as a major health concern and placed AIDS among Ethiopia's top 10 killers. Yet it failed to stimulate any enhanced action on AIDS. In retrospect, the Bank might have undertaken targeted, follow-up analytic work projecting the economic and poverty impacts of HIV/AIDS, with and for the various sectors and regions, as a vehicle for building the commitment and conviction of key actors in other sectors, particularly in the economic sectors. In short, high-level government speeches, the existence of a strategic framework, the establishment of an institution in support of a multi-sectoral approach and the availability of money have been important, but insufficient for demonstrating and further developing strong national commitment at all levels that is necessary for a vibrant national response.

7.7 ***Project design and implementation that focus on process (implementation arrangements and financial flows) rather than results will undermine the strategic choices,***

prioritization, and efficiency of the Bank's financial support. The EMSAP was designed to address what the Africa Region considered to be the most pressing impediments to building an effective national response: weak implementation arrangements and inadequate financial flows. As a consequence, there was little focus on the content of the HIV/AIDS program activities. [39] In support of the principles of "speed, flexibility, and coverage," a concerted effort was made to satisfy, and adjust as needed, requirements related to procurement, legal aspects, financial management and financial flows, and safeguards. Rigorous technical appraisal of the national HIV/AIDS strategic framework that would have been grounded in the analysis of existing data and in the commissioning of additional analytic work was not undertaken at the outset so as to accelerate the availability of financial resources for activities. A baseline would have documented prevalence of HIV/AIDS and risky behavior in high-risk groups and in the general population across regions and would have facilitated more precise targeting, prioritization, and monitoring of activities. Had this been done at the outset, there probably would have been less general IEC and more targeted behavior change from the start, to cite one example. The almost exclusive focus on implementation arrangements seems to have prevailed during implementation as well. With two exceptions,[40] supervision missions were carried out for the most part to monitor and adjust implementation arrangements and to address bottlenecks, most notably streamlined project approval processes and smoother and faster financial flows and accelerated disbursements. Very little dialogue was devoted to assessing and improving the cost-effectiveness or impact of activities. Despite the focus on implementation, capacity was not rigorously assessed during project preparation or implementation.

7.8 ***The creation of a multi-sectoral institution does not necessarily foster a multi-sectoral approach.*** The institutional and organizational framework for the HIV/AIDS program in Ethiopia was created in response to World Bank eligibility criteria on an accelerated timetable and without the benefit of institutional and political analysis. The functioning of this institutional/organizational framework is inadequate. There are good examples of multi-sectoral approaches that are different than the one the Bank advocated under the MAP, including the example of Ethiopia's own early program, which fell under the overall responsibility of MoH. Under the DAC in the late 1980s, the HIV/AIDS program practiced selective inter-sectoral collaboration, supporting key sectors in the documentation of the issue and in the development and measurement of interventions. An important example is the pilot testing of secondary school interventions for prevention in the late 1980s. The DAC also provided an enabling environment and an opportunity for civil society to network on the issue of HIV/AIDS, even allocating a portion of its budget for NGO activities.[41] At its own initiative, the Ethiopia Roads authority, through its HIV/AIDS activities at the local level, identified and developed collaborative arrangements with local-level health authorities and health service providers both to provide health education messages and to care for transport workers.

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39. Some members of the Bank's preparation team noted that they were discouraged in their efforts to define the content of the project, noting that the "what to do" aspect of the project design was missing.

40. Two missions conducted in 2003 aimed at guiding the design and implementation of HIV/AIDS interventions in the education and private for-profit sectors.

41. This being said, it is important to recall that more recent (1990s) performance of the MoH in the fight against HIV/AIDS (after the new government decentralized MoH and dramatically cut back staffing for the HIV/AIDS program) fell short of what was needed to mount and manage an effective response.

7.9 ***Financial allocations and disbursements are necessary but insufficient conditions for successful NGO participation in the fight against HIV/AIDS. A number of factors can undermine NGO contributions, even when funding is accessible, including: the absence of a capacity building strategy based on in-depth capacity assessments, the lack of baseline knowledge about target populations and of monitoring and evaluation of NGO activities, and the absence of mechanisms for coordination of public private partnerships, in line with their comparative advantages.*** Capacity needs to be assessed in order to strengthen it. Successes need to be identified and assessed in order to scale them up. With regard to the content of NGO interventions, the bulk of NGO/CBO activities supported to date have focused on IEC and, to a much lesser extent, on behavior change, treatment and care, and mitigation. Little or no advocacy has been supported, despite the position and potential of some NGOs to undertake such work. There has been no systematic monitoring of NGO performance or evaluation of their impact. Regarding which NGOs are benefiting, interviews and observations reveal that EMSAP has tended to fund the smaller, less experienced NGOs, with larger, more experienced ones reporting their preferences for other available financing sources, which are considered easier to access and more reliably available. Furthermore, there are NGOs with considerable capacity and potential to contribute to HIV/AIDS work that have not yet benefited from EMSAP (or any other) financing. While NGO/CBO capacity has been addressed through training and workshops, there has been no major effort to fully exploit the potential of stronger, more experienced NGOs to nurture, train, and support the weaker NGOs, both in the preparation of proposals and in their implementation. As is the case for the EMSAP overall, support to NGOs under this project placed almost exclusive emphasis on the "financial plumbing" and proposal approval process, and too little on the content and impact of NGO activities.

7.10 ***No matter the setup of the institutional/organizational framework for coordinating a multi-sectoral approach, the prominence of the health sector as a major leader and implementer in the fight against HIV/AIDS is unequivocal.*** Health sector policymakers were not receptive to messages about the growing threat of the epidemic, first raised by the Bank in the context of its 1998 social sector report. The Bank's support to the HSDP has contributed to improvements in quality of and access to basic services through the upgrading and expansion of infrastructure, human resource development, strengthening of communicable disease control, health prevention, recurrent financing, and capacity building in sector management. All of these are critical for facilitating the health sector's response to the HIV/AIDS epidemic. The specific HIV/AIDS content of the Bank's health sector operation was very modest, with actual support limited essentially to syndromic treatment of STDs. When EMSAP became effective in early 2001, there was opportunity for MoH, along with other public sector ministries, to apply for financial support under this operation. However, the MoH was resentful of the Bank's perceived role in taking away its leadership in the fight against HIV/AIDS in the context of EMSAP preparation and conditionality, and withdrew even further from World Bank dialogue and support to HIV/AIDS. *ACT Africa* has since acknowledged that insufficient emphasis on the role and importance of the MoH in the fight against HIV/AIDS and the bypassing of MoH in a number of MAP countries because of perceived lack of commitment and capacity had caused a backlash and that this lesson has been incorporated into the design of MAP II. The MoH has chosen to rely on financial and technical support provided by other sources, wherever possible, particularly that which is channeled directly to MoH without going through HAPCO.

7.11 Now that the MoH has been given chairmanship of the NAC Board in August 2003 (previously chaired by Minister of Youth), there is optimism that the MoH will fulfill its role and mandate more effectively. There is a need to ensure that HAPCO's mandate is restricted to coordination and that it does not assume the technical and policy-making responsibilities that should belong to MoH. There is also a need for the MoH mandate in the fight against HIV/AIDS to be more clearly and strategically articulated so that it is mainstreamed and owned rather than a sum of the various financial and technical contributions of donors. The lessons of this early experience should have been assessed and considered in the formulation of the new institutional arrangements.

7.12 In retrospect, the decision to support health sector HIV/AIDS activities under EMSAP rather than under HSDP was not fully commensurate with the spirit of retrofitting that encourages every sector to adopt HIV/AIDS as a part of its core mandate. It is noteworthy that, while the mission observed some tension between regional HAPCO and regional health bureaus, they are considerably less acute than those observed at the federal level and seem to be adequately managed.

7.13 ***Failure to establish key baseline data and to design a monitoring and evaluation framework during project design is a missed opportunity for creating a targeted, results-based approach.*** The opportunity cost of undertaking this work during project preparation was considered by the Bank to be too high as it was predicted to incur a postponement of the implementation phase by one to two years. However, experience has shown that fast preparation has not yielded the expected implementation gains: the first one to two years of project implementation were characterized by very slow disbursements as new institutions and mechanisms were being set up and actors were being apprised and their involvement prepared. On the other hand, the consequences of moving ahead without adequate baseline data and an M&E are the inability to measure progress and impact of efforts and expenditures to date, and the lost opportunity to adjust interventions for improved effectiveness and impact. Except for ante-natal clinic surveillance data, whose quality and reliability are uncertain, there is no systematic surveillance of HIV prevalence and behaviors among the general population and among high-risk groups across Ethiopia's regions. Some studies have been undertaken to assess prevalence and behaviors among high-risk groups (such as commercial sex workers, truck drivers, the military), but they encompass different timeframes, cohorts, and methodologies, making it difficult to document trends. The 2000 DHS has provided data on knowledge and behavior among the general population and the 2001-02 BSS, published in late 2003, has provided much needed baseline data on knowledge and behaviors of high-risk groups. The feasibility and timing of a first national HIV prevalence survey is only being explored now by the government through the design of pilots in the context of policy triggers of the PRSC. A monitoring and evaluation framework was issued in December 2003 on which basis training and workshops will be carried out in 2004 to launch M&E activities.

7.14 The lack of baseline data and absence of an M&E framework have undermined the "learning by doing" approach embedded in the MAP philosophy. Some "learning by doing" has occurred with regard to implementation arrangements, which have been adjusted as experience was gained. Very little "learning by doing," on the other hand, has occurred with regard to the cost-effectiveness and impact of program content. It should be noted that some regions have, on their own initiative, begun to establish baseline information and to prioritize

interventions and target groups through the collection and analysis of data and through the commissioning of research on the risks and behaviors of high-risk and vulnerable groups.[42] This is an encouraging trend that should be supported and nurtured in all regions.

42. The region of SNPPR is a good practice worth citing in this regard.

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Annex 1: List of Persons Interviewed

ADDIS ABABA/FEDERAL-LEVEL

National HIV/AIDS Prevention and Control Office (HAPCO)

Negatu Mereke, Head
Tibebe Shenie, Head, Project Coordination Unit
Shimeles Worku, Advisor
Shemsu Ali, Head, PPD (Monitoring and Evaluation)
Dr. Berhanu Demeke, Program, Training Officer, Project Coordination Unit
Hailegebrieal Ashagare, Finance Controller
Abebe Asrat, Senior Procurement Specialist
Asrat Kelemework, Assistant Project Coordinator
Dr. Teklu Belay, HAPCO Advocacy, Mobilization and Coordination Officer

Federal Ministry of Health

Dr. Kebede Tadesse, Minister of Health
Dr. Aseged Woldu, Acting Team Leader for HIV/AIDS
Fantahun Tesso, Focal Person for Counseling and Social Services for HIV/AIDS
Alemanhu Sefu, Department Head for Diseases Prevention and Control
Ahemed Amino, Department Head of Public Relations
Ato Abraham Giorgis, Head, Planning and Drug Information Department, Drug Administration and Control Authority of Ethiopia (DACA)

Federal-Level Sector Ministries

Ms. Netsanet Tako, State Minister, Information and Culture
Ato Dessalegne Bekele, Ministry of Justice
Ms. Gifty Abasiya, State Minister, Women's Affairs, Prime Minister's Office
Ato Mussie Tamar, Focal Point for HIV/AIDS, Ministry of Labor and Social Affairs
Ato Belete Tako, HIV/AIDS focal person, Ministry of Information and Culture
Dr. Abdulkadir Risku, Counsellor, International Organization and Economic Co-operation, General Directorate, Ministry of Foreign Affairs
Kassu Abdi, Ministry of Education
Sara Negussie, HIV/AIDS Focal Person, Ministry of Finance and Economic Development
Teshome Cheru, Ethiopian Road Authority (ERA)

Health Facilities

Dr. Zerou G. Mariam, Medical Director, Black Lion Hospital
Dr. Ermias Mulugeta, MD, MPH, General Manager, Bethzatha Health Services P.L.C.

Non-Governmental Organizations (NGOs) and Para-Public Organizations

Ethiopian Health and Nutrition Research Institute (EHNRI), Dr. Dawit Walday, Laboratory Manager
Ethio-Netherlands AIDS Research Project (ENARP), Dr. Tsehaynesh Messele, Programme Manager
University of Addis Ababa , Dr. Damem, Head Department of Community Health, Faculty of Medicine and President, Public Health Association of Ethiopia
Ethiopian Medical Association, Dr. Adem Ali Ahmed, President
Ethiopian Medical Association, Dr. A. Teka, General Secretary
Women's Lawyer's Association, Ms. Meaza Ashenafi, Executive Director
Agency for the Assistance of Refugees, Displaced and Returnees (AARDR), Amanuel Worque Ababe, Executive Director
ActionAid, Ato Jemal Ahmed, SIPAA Country Project Manager
Internist, Private Practitioner, Dr. Yigeremu Abebe, (formerly Head of Medical Services in the Ethiopian Army, and HAPCO Review Board Member)
Medecins Sans Frontieres Belgium, Isabelle Aubry
Christian Relief and Development Association (CRDA), Ato Hailu Nega, Head, Delegated Resources Management Department, (HAPCO Review Board Member)
Christian Relief and Development Association (CRDA), Ato Agonafer Tekalegne, M.D., MPH, Senior Advisor (HIV/AIDS Program Coordinator)
Ethiopian Employers Federation, Dr. Taye Berhanu, Executive Director
Organization for Social Services for AIDS (OSSA), Dr. Ibrahim Yusuf, Psychosocial Service Section Head
Mekdim HIV/AIDS Positive Persons and AIDS Orphans National Association, Ato Mengistu Zemene
Dawn of Hope Ethiopia, Association of PLWHA, Ato Tadesse Aynalem
DKT Ethiopia, Ms. Rahel Belete, Marketing and Communications
DKT Ethiopia, Girma Degfie, Senior Program Adviser
Ethiopian Development Association, Tilahun Guysa Salaesh
Mary-Joy , Serkalem Awulachew
CPAR – Ethiopia, Alemayehu Konde, Country Director
Family Association of Ethiopia, Amare Bedada
Ethiopian Employers Federation, Taye Berhanu
Ethiopian Teachers Association, Tenna Sivabezu
Ethiopian Aid, Serait H. Giorgis
The Confederation of Ethiopian Trade Unions, Muluwork Fantahun
Awareness through Entertainment, Teddy Studid
Ethiopian Muslims Development Agency, Mohammed Haji
Ethiopian Orthodox Church, Dr. Mesfin Tegcone
Ethiopia Nurses Association, Sister Lea Wolde Giorgis and Sister Tsegereda Yisa

Development Partners

Anne Nolan, Health and HIV/AIDS Specialist, Department for International Development (DIFID)

Holly Fluty Dempsey, HIV/AIDS Officer, HPN Office, United States Agency for International Development (USAID), Mission to Ethiopia
Getachew Demeke, Ph.D., Country Programme Adviser, UNAIDS
Emebet Admassu, National Programme Officer, UNAIDS
Dr. Tefera Wondie, World Health Organization (WHO) (formerly Minister of Health and deputy PM of Ethiopia in the 1980s)
Dr. Angela Benson, WHO
Lisa Bohmer, Chief, HIV/AIDS Section, UNICEF
Dr. Abebe Bekele, African Development Bank
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Kaori Nishiyama, Program Formulation Advisor in Health Sector, JICA
Abate Gudunffa, National Program Officer, UNFPA
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Zonal focal person
Woreda Facilitator
Leader of Kebele Council (Kebele #11), Nazareth
Shiffara Chairman, HIV/AIDS Committee Kebele #11

Kebele Committee Members of Kebele #19: Rosa Asafa, Clerk, Council, Tedesse, Vice-Leader, Kebela, Ato Abou, Head of Kebele Committee

Non-Governmental Organizations

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Dawn of Hope, Nazereth
Family Guidance Association, Nazareth

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Woreda Secretariat Facilitator, Awassa

Non-Governmental Organizations

Association of Women Living with HIV/AIDS, Awassa
Mary Joy, NGO, Awassa

REGION OF AMHARA

Dr. Sirak Solomon, Head, Amhara Regional HAPCO

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World Bank

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Jonathan Brown, Operations Adviser, *ACT Africa*
Marito Garcia, Lead Human Development Economist, Africa Region, formerly Task Manager of Ethiopia Social Sector Report, 1996-1998
Bachir Souhlal, Lead Social Development Specialist (formerly deputy of *ACT Africa)*
Debrework Zewdie, Director, Global HIV/AIDS Programme (formerly manager of *ACT Africa*)
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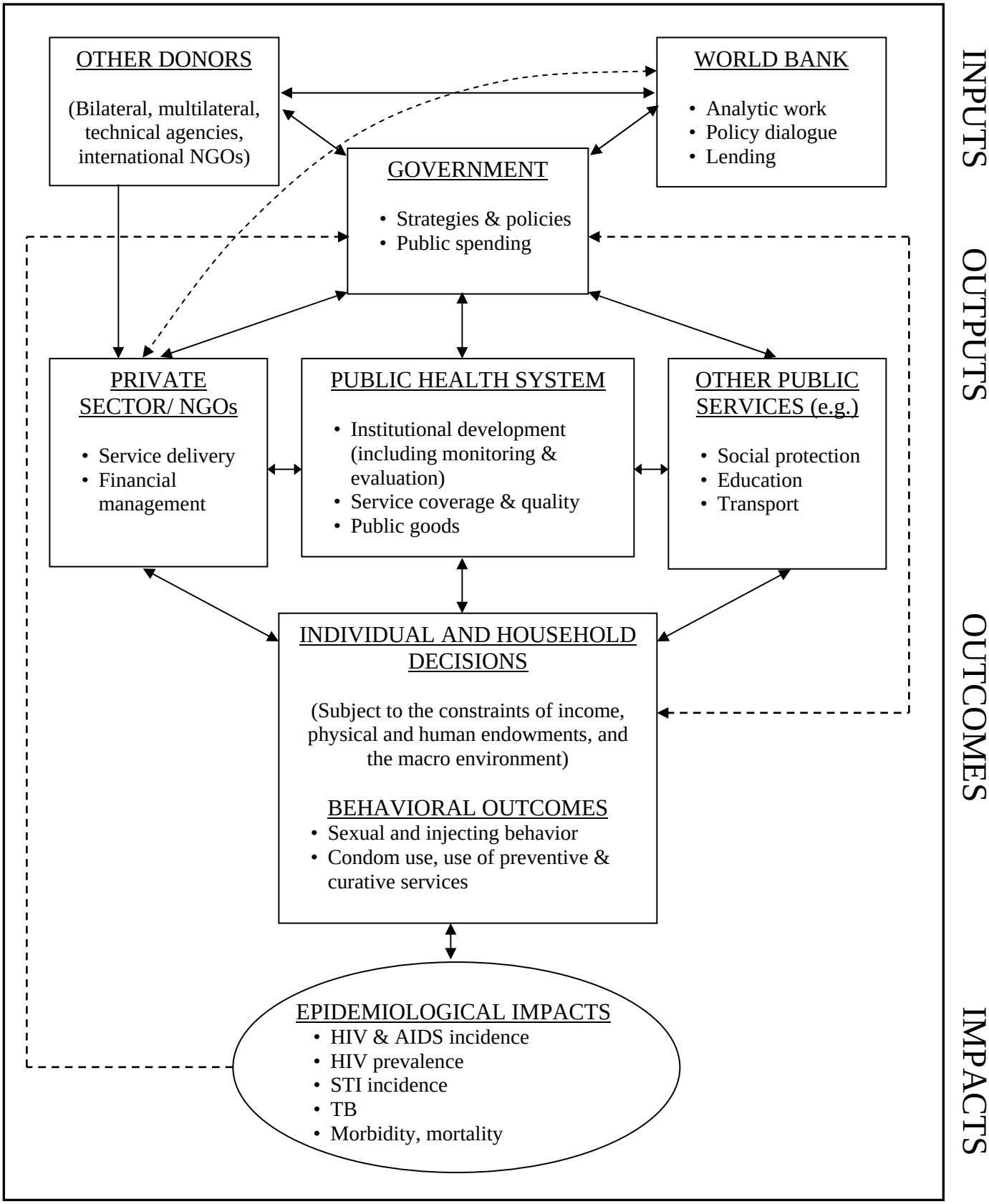
Dr. Michel Jancloes, Special Advisor to the Director General, WHO (formerly WHO representative in Ethiopia)
Dr. Jean-Louis Lamboray, Principal Coordinator, UNAIDS/UNITAR, AIDS Competence Program
Monica Wernette, Team Leader, Field Support Team, UNAIDS, formerly GPA-financed technical assistant to Ethiopia's HIV/AIDS Programme, 1988 – 1993

Annex 2: Evaluation Conceptual Framework



Annex 3: Timeline of Main Events

Date	Key Events in Ethiopia		Landmarks in World Bank Support to Health and HIV/AIDS in Ethiopia
	Historical Events	**Key Events in the Fight Against HIV/AIDS**	
1973	Famine strikes Welo and Tigray provinces; 200,000 die. NGOs become major players in relief operations; CRDA formed.		
1974	Haile Selassie overthrown; Derg reign commences.		
1977-1979	Thousands of government opponents die in “Red Terror” orchestrated by Marxist Regime/Mengistu.		
1977	Tigray People’s Liberation Front formed.		
1979	Ogaden war; Soviet bloc military assistance begins.		
1984	People’s Democratic Republic of Ethiopia proclaimed under Mengistu.	First HIV infection identified.	
1985	Worst famine in decades strikes; one million die. NGOs are pivotal in relief operations; REST and others carry out cross-border operations.	National Task Force on the Prevention and Control of HIV Infection and AIDS in Ethiopia established.	Publication of Ethiopia Population, Health and Nutrition Sector Review, Report No. 5299-ET (September 30), marking the initiation of the World Bank’s health sector dialogue.
1986		First case of AIDS identified.	
1987	Mengistu elected President under a new (Derg) Constitution.	Ethiopian Short-term plan for the Prevention and Control of AIDS issued (March). Medium-Term Plan for the Prevention and Control of AIDS issued (May). AIDS Control Program (ACP) established and put under the responsibility of a newly created Department of AIDS Control (DAC) within MoH (September).	
1988			Board approval of Family Health Project (Credit No. 1913 in the amount of $33.0 million), World Bank’s first operation supporting Ethiopia’s health sector.

Date	Key Events in Ethiopia		Landmarks in World Bank Support to Health and HIV/AIDS in Ethiopia
	Historical Events	**Key Events in the Fight Against HIV/AIDS**	
1989	Resistance movements gain momentum.	MoH drafted a four-point policy statement on AIDS prevention. MoH convened a 13-member policy drafting committee on HIV/AIDS to create a comprehensive national policy. Following training/mobilization of decentralized health personnel, AIDS Control Program decentralization launched with three-quarters of regions having received financing for implementation of their AIDS action plans and more preparing action plans for future financing.	Family Health Project becomes effective.
1990		PSI launches social marketing of condoms.	
1991	Ethiopian People's Revolutionary Democratic Front captures Addis Ababa, defeats Mengistu regime; transition government formed.	First draft of HIV/AIDS comprehensive national policy forwarded to MoH.	
1992		Second medium-term HIV/AIDS plan developed. Some NGOs already providing home-based care.	
1993	Eritrea becomes independent. Decentralization policy is implemented. Regional development associations are formed. Government requires NGOs to reregister.	Decentralization leads to drastic reduction in staffing and budget of MoH in general and the HIV/AIDS technical department, in particular. HIV/AIDS staffing reduced to 2 professionals.	
1994	New Constitution ratified; nine federated states and two autonomous municipalities created for a total of 11 regions.		Family Health Project restructured for nationwide (versus regional) coverage and to align project with new health and decentralization policies.
1995	Federal Democratic Republic of Ethiopia is created. Meles Zenowi elected Prime Minister. Constitution of the Second Republic is inaugurated. *Guidelines for NGO Operations* established by government.		
1996	*PACT* launches *Ethiopian NGO Sector Enhancement Initiative.*	National conference on "Breaking the Silence," co-sponsored by USAID and UNAIDS.	

Date	Key Events in Ethiopia		Landmarks in World Bank Support to Health and HIV/AIDS in Ethiopia
	Historical Events	**Key Events in the Fight Against HIV/AIDS**	
1998	Border war with Eritrea begins; hundreds die. CRDA officially registers as NGO umbrella organization.	Preparation/adoption of new HIV/AIDS policy.	Publication of Ethiopia Social Sector Report, Report No. 18482 (August), highlighting HIV/AIDS in burden of disease analysis and projecting growth in the epidemic. Family Health Project closing date (January 31). Approval of IDA-financed operation to support Ethiopia's Health Sector Development Program (HSDP) (Credit No. 3140 for $100 million), with modest support for HIV/AIDS.
1999	Ethiopian-Eritrean border clashes turn into a full-scale war. Peace negotiations between Ethiopia and Eritrea begin. *Code of Conduct for NGOs* adopted.	Patriarch of the Ethiopian Orthodox Church launched a major HIV prevention campaign stressing community-based information and action. President Negasso Gidada becomes an active spokesman in the fight against HIV/AIDS.	IDA-financed HSDP becomes effective (March 11). Visit of Vice-President of the Africa Region for high-level policy dialogue on the basis of *Intensifying Action Against HIV/AIDS in Africa*, published that same year. Creation of *ACT Africa* in Washington; visit to Ethiopia of Manager of *ACT Africa*. Initiation of a retrofitting exercise in Ethiopia, whereby HIV/AIDS components are developed within ongoing projects in IDA portfolio.
2000	Parliamentary elections lead to the success of the governing EPRDF under Prime Minister Meles. Ceasefire agreement signed by Ethiopia and Eritrea with UN oversight of peace process (June 18). Peace agreement ends two-year conflict between Ethiopia and Eritrea (December).	National Strategic Framework (2000-2004) developed, including a strategic framework for the federal level and one for each of the 11 regions. National AIDS Prevention and Control Council (NAC) established. National HIV/AIDS Prevention and Control Secretariat (NACS) established (later reorganized as HAPCO). National Task Force set up to prepare EMSAP (June 2000). Tigray, Addis Ababa, and Dire Dawa Regional AIDS Councils established. EMSAP implementation, administrative, fund management, and accounting manuals developed and EMSAP officially launched (December).	EMSAP identification mission (June 26 – July 15). EMSAP appraisal mission (July 17-27). EMSAP negotiations (August 1-4). EMSAP Board approval (September 12), as an annex to the MAP.

Date	Key Events in Ethiopia		Landmarks in World Bank Support to Health and HIV/AIDS in Ethiopia
	Historical Events	**Key Events in the Fight Against HIV/AIDS**	
2001		The last regional AIDS Council established in Oromia (March). At its fourth regular session, NAC declared HIV/AIDS a national emergency (June). National guidelines on home-based care developed.	EMSAP effectiveness (January 5). HIPC Decision Point: HIV/AIDS cited as top priority along with food and capacity building.
2002		HAPCO created (to replace NACS) by proclamation providing legal operational basis and rights (June). Regional proclamations followed to create regional HAPCOs. “Sex, Stigma and HIV/AIDS: African Women Challenging Religion, Culture and Social Practices” Conference held in Addis Ababa and opened by President Girma Wolde Giorgis (August). President Girma Wolde Giorgis opens Parliament with strong statements about HIV/AIDS undermining sustainable development and democratic order in Ethiopia (October). Proposal for Global Fund to Fight AIDS, Tuberculosis and Malaria prepared by Ethiopia’s Global Fund Coordinating Committee, chaired by Minister of Health (eventually approved for $139.4 million).	
2003	Physical demarcation of Ethiopia-Eritrea border delayed indefinitely.	Mid-Term Review of 2000-2004 Strategic Plan, and of EMSAP as an important component thereof. Twenty-two of 33 Federal HAPCO staff hired.	
2004	Nearly 200 killed in ethnic clashes in isolated western state of Gambella. Tens of thousands flee area.		PRSC II: Policy matrix on HIV/AIDS calls for a baseline epidemiological survey and improved monitoring and evaluation of HIV/AIDS activities. HSDP projected to close on June 30, 2004 after one 18-month extension.

Annex 4: Epidemiology of HIV/AIDS in Ethiopia

Early Evolution of the Epidemic

The first cases of HIV infection in Ethiopia were reported in 1984 and the first AIDS cases in 1986. The HIV/AIDS epidemic appears to have started in most of urban Ethiopia in the mid-1980s, reaching a peak in the mid-1990s and stabilizing thereafter. In rural Ethiopia, the epidemic began in the early 1990s; it is now progressing rapidly and is likely in its early stages. Data are highly inadequate to capture the epidemic's dynamics in rural areas, where 85 percent of the population lives. Although a trend of increase in reported cases over time is obvious, inadequacy of reporting due to weaknesses in the surveillance system is not unusual as in many developing countries (see Box 1).

Heterosexual transmission among adults is the major mode of HIV transmission in Ethiopia and perinatal transmission is the major mode of infection in children. Transmission by other modes, such as use of unsterile needles and traditional practices, is uncommon. The median incubation period of the disease among Ethiopians is about 8 years (Garbus, 2003) and HIV subtype C predominates (about 98 percent).

Early transmission among "core" groups. Populations with high rates of sexual partner exchange played a major role in HIV transmission at the start of the epidemic and continue to be a source of spread in many urban and rural communities. For example, soon after detection of the first AIDS cases, high HIV prevalence was detected along Ethiopia's main trading routes, signifying the concentration of commercial sex workers among mobile populations.

HIV initially spread extremely rapidly among sex workers and other populations with high rates of sexual partner change (see Figure 1). Infection rates rose from less than 1 percent in 1985 to between 36.4 percent and 55.0 percent in five urban areas by 1990 (see Appendix Table). Among sex workers from 19 sites outside of Addis Ababa, infection rates in

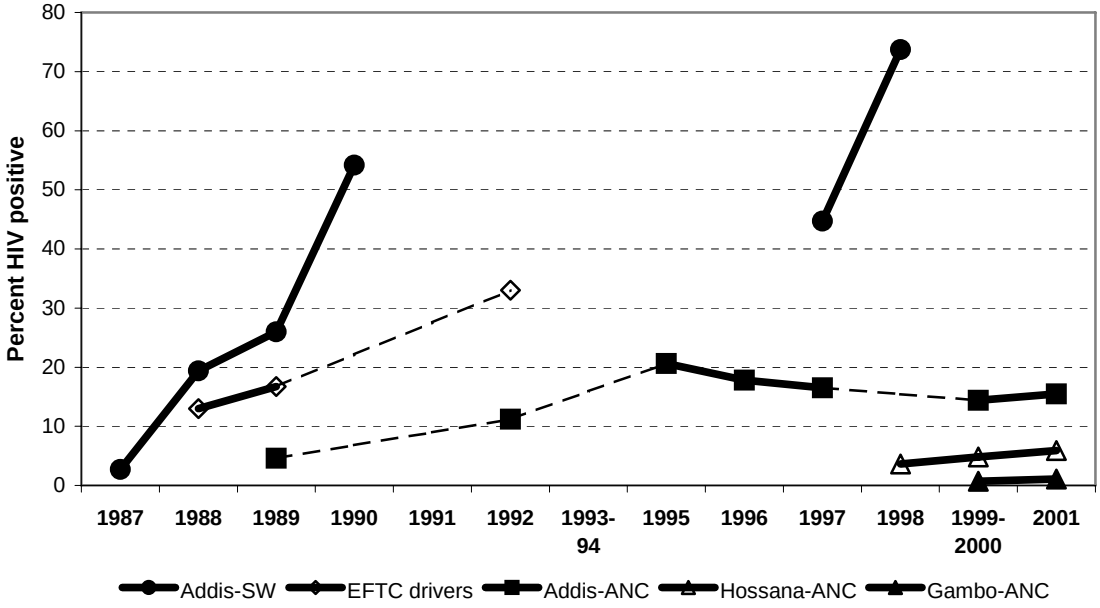
Box 1. HIV/AIDS Data Collection in Ethiopia

AIDS surveillance reports began soon after the establishment of the HIV/AIDS department within the MoH in 1987. The civil registration system is inadequate and underreporting is common when estimating AIDS morbidity and mortality for several reasons: the reporting system is inefficient; most Ethiopians never seek medical care for AIDS; some people with AIDS may die of opportunistic infections before they are diagnosed with AIDS; most rural hospitals and district health care facilities are unable to test for HIV; most private laboratories do not provide data to the MoH; most AIDS diagnoses are not confirmed via laboratory or autopsy procedures; and the laboratory infrastructure and technical expertise (trained personnel) are limited. The documentation and reporting systems for opportunistic infections and potential HIV/AIDS-related diseases are also inadequate in Ethiopia (Garbus 2003).

Caution should also be exercised in the interpretation of HIV surveillance data. Health care infrastructure and surveillance systems are weak in Ethiopia. There have been major gaps in HIV data collection in the 1990s, particularly in high-risk groups, limiting trend analyses. When trends are aggregated across sites for similar groups, they often represent different numbers of sites annually. Women who attend ante-natal care services are not necessarily representative of the rest of the population. In Ethiopia, only about a quarter (27 percent) of pregnant women consult ante-natal care (CSA/ORC Macro 2001). Lower fertility among women with HIV infection would lead fewer of them to seek ante-natal care, leading to underestimates of HIV prevalence (DPCD/MoH, 2002). HIV estimates based on population-based surveys and ante-natal clinic-based surveillance systems are often in disagreement. There are also concerns that inadequate laboratory quality control may affect the validity of HIV surveillance results

1988 ranged from 5 percent to 38 percent (UNAIDS, 2002). Other populations at high risk of infection and transmission included STD clinic attendees, members of the armed forces, truck drivers, and prisoners. HIV prevalence among STI patients in Addis Ababa increased from 8 percent in 1987 to 38 percent in 1992. Among military recruits infection rates rose from about 0.1 percent in 1985-86 to 3 percent in 1991. A 1989 survey among the Ethiopian Freight Transport Corporation (EFTC) truck drivers and their assistants found HIV prevalence of 17.3 percent, which increased to 33 percent by 1992 (UNAIDS, 2002). Among prisoners in Dire Dawa in 1990, HIV prevalence was 6.0 percent (Kebede et al., 2000).

Figure 1: Waves of the HIV/AIDS Epidemic in Ethiopia: Spread Among High-risk Populations and to Low-risk Partners

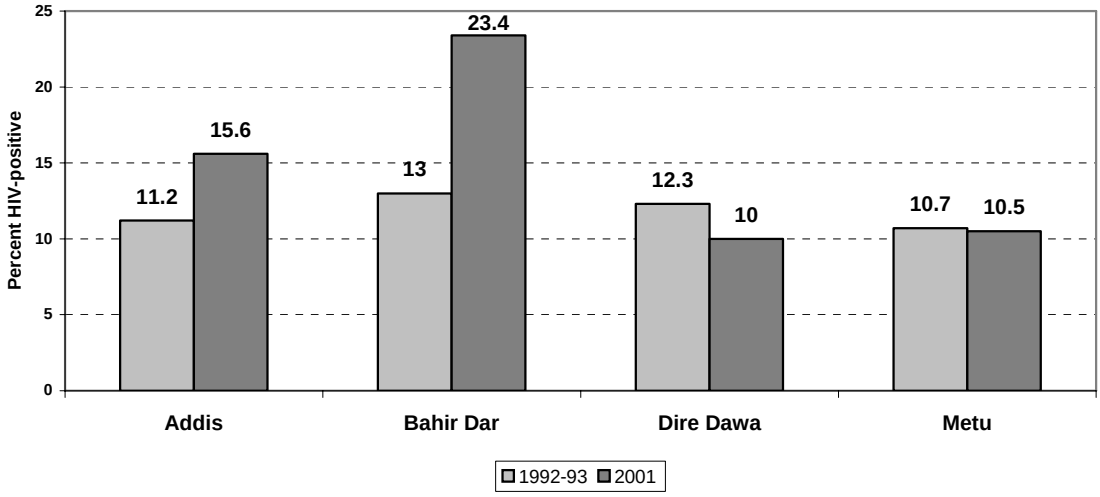


Source: Appendix. Dashed lines connect data points separated by more than one year.

Spread into the low-risk population. In its second phase, HIV spread to the sexual partners of high-risk populations, including monogamous partners and those with much lower rates of partner exchange. This was measured in terms of the rising rates of HIV among pregnant women attending ante-natal clinics (ANC), first in Addis Ababa and other cities and towns, and then in rural areas (Figure 1). In Addis Ababa, for example, the prevalence of HIV among women attending ANC steadily increased from zero in 1984 to 4.6 percent in 1989 to 20.6 percent in 1995. The Ethiopian Red Cross Society-Blood Transfusion Service (ERCS-BTS) has been collecting and reporting HIV prevalence data among blood donors since 1987. HIV prevalence initially rose among blood donors in Addis, from 2.3 percent in 1987 to 9.0 percent in 1995, before declining to 6.4 percent in 1999. In Dire Dawa, it has also declined since the early 1990s – from 14.9 percent in 1992 to 6.5 percent in 1998. It is difficult to determine, however, whether the decline reflects changes in HIV prevalence in the underlying population or is due to increasingly effective prescreening procedures in the transfusion services. The Addis Ababa Regional Health Bureau regularly collects, analyzes,

and reports HIV prevalence data among visa applicants, over 90 percent of whom are young women. HIV prevalence among visa applicants rose from 7.2 percent in 1993 to 9.1 percent in 1999. However, reports on visa applicants may underestimate prevalence by as much as 50 percent because of testing and reporting protocols (Garbus, 2003).

Figure 2. Trends in HIV Prevalence in Ante-natal Clinics, Four Urban Areas, 1992-2001



Factors Affecting HIV Transmission

Transport corridors and high population mobility. Because Ethiopia is landlocked, transportation corridors are especially important. For international trade, Ethiopia uses the seaports of Assab and Massawa in Eritrea and the port of Djibouti is connected to Addis Ababa by rail. In addition to commercial transport companies, humanitarian and relief workers also use these corridors; for example, the World Food Program (WFP) is employing more than 2,000 truck drivers to transport food aid from Djibouti to distribution points throughout Ethiopia.

The U.S. Centers for Disease Prevention and Control (CDC) undertook a small, rapid study of the Ethio-Djibouti corridor using focus group discussions, in-depth interviews, and key informant interviews with sex workers, truckers, their assistants, military personnel, construction workers, job-seeking women, and bar owners (Abbas, 2002). The study was conducted on the two main highways and 14 towns along the corridor. It found that mobility was very high. For example, many women gravitate to the area seeking work, including sex work. Sex workers had the most positive attitude toward use of condoms, whereas most men had a negative attitude. Although condoms are accessible to respondents, their use is low, especially among soldiers, young men, and truckers. The main places where high-risk activities occur are liquor-selling establishments, nightclubs, bars, hotels, and brothels (Garbus, 2003).

Conflict and displaced persons. War has contributed significantly to the spread of HIV/AIDS in Ethiopia. Many soldiers with multiple partners contracted HIV during the civil war in the 1980s. With the end of the war in 1991, thousands of infected soldiers and prostitutes returned to various parts of the country, spreading HIV in their villages and towns. Another wave of infections may be underway as Ethiopia has demobilized 150,000 soldiers

recently as the conflict with Eritrea has wound down (National Intelligence Council, 2002). More troops are returning as the border dispute is settled. As in the past, the movement of commercial sex workers may also be involved.

UNAIDS (2002) estimated that 90 percent of internally displaced populations (IDP) were displaced for more than 3 years for causes such as war, conflict, drought, and unemployment. More than 89 percent of the IDP are women and children and over 60 percent have families, many of which are headed by women. These populations are highly mobile, predisposing them to adverse situations such as pre-maritial and extra-marital sex, commercial sex, rape, STI, and alcohol and drug abuse. According to UNAIDS surveys, many IDP have heard of HIV/AIDS, and the majority would support testing and are eager to know their sero-status. Because of the prevailing insecurities, stigma, and discrimination, those who are HIV-positive tend to hide their status and continue to infect others knowingly or unknowingly.

Low status of women. The UNDP ranks Ethiopia 142 out of 146 countries on its Gender-Related Development Index (UNDP, 2002). Although the constitution of 1994 guarantees gender equality and permits affirmative action, implementation of the National Policy for Women is hindered by varying degrees of commitment across regions. Gender disparities in enrollment ratios and educational attainment levels are high. According to the 2000 Demographic and Health Survey (DHS), 75 percent of women age 14-49 years are illiterate compared to 47 percent of men age 15-59 years (CSA/ORC Macro, 2001). The country's high maternal mortality ratio (871 per 100,000 live births) is indicative not only of poor reproductive health but of women's low status and poor access to basic health services.

According to the 2000 DHS, fertility continues to be high in Ethiopia (about 5.9 children per woman). Early marriage, low literacy, and limited use of family planning methods contribute to this high fertility. For women, the median age at first marriage and at first sexual intercourse was 16 years, while for men the median age at first sexual intercourse was 20, three years younger than their median age at first marriage (age 23). Of the married women, 14 percent were in a polygamous union.

Many Ethiopian women have little power in sexual negotiation with their husbands. Female circumcision is widespread – 80 percent – and there is widespread support for it among Ethiopian women. Poverty and unemployment are leading to a dramatic increase in the trafficking of women. Other factors that render Ethiopian women vulnerable to HIV include rape, abduction, and early marriage (Garbus, 2003).

High prevalence of sexually transmitted infections (STI). Co-infection with another STI has been shown to raise the risk of HIV transmission when one partner is HIV-positive. Available evidence suggests that STI are common in Ethiopia. In two surveys in Addis Ababa in 1996 and 1997, the prevalence of syphilis among males was 16.7 percent in the community and 30.2 percent among factory workers and, among females, 13.6 percent in the community and 23.8 percent among factory workers (Mihret et al., 2002). In this same study, the prevalence of herpes simplex type 2 (HSV-2) was about 50 percent in both men and women. HSV-2, like syphilis, is an ulcerative STI that has been reported to increase the transmission of HIV infection in Africa. In the Afar Region in 2000, syphilis prevalence was 7.4 percent among police recruits (Zewde A, et al., 2001). Other indicators of STI, such as

reported genital discharge in the past five years of about 11 percent, have been described in cohort studies involving factory workers (Mekonnen et al., 2003). These discharges could be suggestive of gonococcal or chlamydial infections.

Trends in STI can be indicative of changes in behavior and/or treatment that are also likely to reduce the spread of HIV. Unfortunately, there are few data on serial prevalence of STI. An important exception is a study that monitored syphilis among ante-natal women in Addis Ababa that found that syphilis prevalence declined from 7.6 percent in 1995 to 1.3 percent in 2001. This decline was limited to young women (15-24 years) in the inner city (Tsegaye et al., 2002)

Current Situation

HIV prevalence. Based on sentinel surveillance in 2002 by the MoH, national adult HIV prevalence was estimated at 6.6 percent – 13.7 percent in urban areas (15.6 percent in Addis) and 3.7 percent in rural areas (DPCD/MoH, 2002) (see Table 1). These estimates are based on testing 12,689 pregnant women 15-49 years old at 34 sentinel surveillance sites (28 urban and 6 rural). A 1999/2000 survey among male army recruits found prevalence figures that were slightly lower than the national estimates among urban recruits (7.2 percent, ranging

Table 1: Recent HIV/AIDS Related Indicators

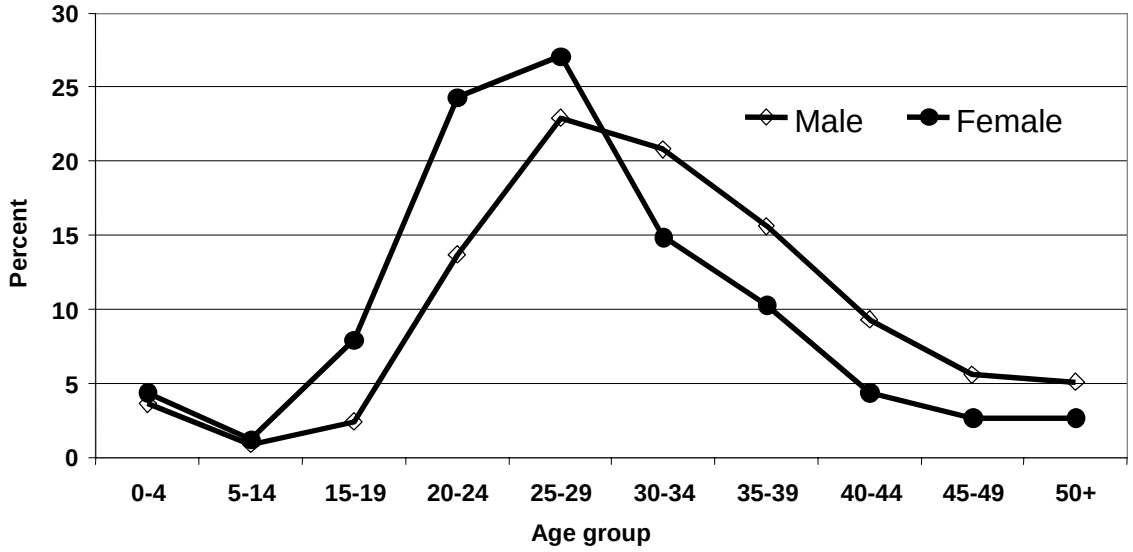
Indicator	Amount	Year
Total population	68 million	2002
Adult HIV prevalence	6.6%	2002
Urban	13.7%	2002
Rural	3.7%	2002
Low risk		
Pregnant women (Addis)	13.1%	2003
Blood donors (Addis)	6.4%	1999
Visa applicants	9.1%	1999
High risk		
CSW/STD clinic attendees (Addis)	73.7%	1998
Truck drivers	33.0%	1992
Army recruits urban (National)	7.2%	1999-2000
Army recruits rural (National)	3.8%	1999-2000
Police recruits (Afar Region)	6.4%	2000
HIV infected		
Living	2.2 million	2002
Adults	2.0 million	2002
Children	200,000	2002
AIDS cases	219,400	2002
AIDS deaths (cumulative)	1.2 million	2002
Rate of mother to child transmission	30-40% (estimate)	
Number of orphans	1.2 Million	2002
Life expectancy (with AIDS)	46 years	2001

Source: UNAIDS (2002a) and other sources cited in the text.

from 4.3 percent to 10.5 percent by region) and but roughly the same among rural recruits (3.8 percent, Abebe et al., 2003). The estimated number of infected people is 2.2 million, of which 2 million are adults and 200,000 children.

AIDS cases. As of 2001, about 219,400 Ethiopians were estimated to have full-blown AIDS. Men comprise about 60 percent of all reported AIDS cases. The majority of cases (male and female) are clustered in the productive age groups of 20-45 years and AIDS deaths for women occur, on average, at an earlier age than among men (see Figure 2). As in other parts of Africa, the gender differences in HIV infection at this early age are attributed to sexual activity among older males with younger females. The number of AIDS cases in the age groups 15-19 years is not small, especially among females. This suggests that the impact of HIV/AIDS is substantial even among these teenagers, and therefore intervention programs should target these groups.

Figure 2: Distribution of reported AIDS cases by age and gender, 2000-2001



Source: MOH data as cited in UNAIDS (2002).

Heterogeneity in the distribution of infection. Currently, the Ethiopian HIV/AIDS epidemic is 'generalized,' indicating that HIV prevalence in the general population – as measured among ANC attendees and other low-risk groups – is 5 percent or higher. However, there is considerable geographic heterogeneity in the epidemic in the overall population. The population is quite diverse and of many ethnic origins. Cultural and religious practices and the degree of mobility (in and out migration) are also variable in different regions. This heterogeneity can contribute to different levels of endemicity within the same population or geographic region. The risk factors that are unique to Ethiopia could still be driving the epidemic in segments of the population or regions.

In Addis Ababa and some urban areas the epidemic is now 'mature.' These areas have had a longstanding epidemic and HIV prevalence has reached a plateau or in some cases declined slightly. HIV prevalence among ANC in Addis, for example, has declined from

about 20 percent in the mid-1990s to 13 percent in 2003.[43] This indicates that the rate of acquisition of HIV (incidence) is roughly balanced with or exceeded by mortality. To the extent that preventive measures have been promoted for some time in mature epidemics, any impact that they have had on behavioral change should be reflected in lower HIV incidence than otherwise would have been the case. However, there is still very high heterogeneity in ANC prevalence rate across urban areas – ranging from 3.1 percent to 23.4 percent (see Appendix). Availability of time-trend data for most sites is still limited. In some urban areas ANC prevalence may still be on the rise, not yet at a plateau, while in others a "peak" may have been reached due to relatively recent and rapid spread of the infection.

Even less is known about the course or maturity of the HIV epidemic in rural areas. HIV surveillance was extended only recently to rural ANC – only six sites in 2001. In most of the rural areas surveyed, the infection rate among ANC is still below 5 percent and in some cases below 2 percent, highlighting the rural geographic heterogeneity in the current epidemic (Appendix).

High rates of transmission among populations with rapid rates of partner exchange and high HIV prevalence are still likely to be having an impact on the epidemic in all parts of the country. Currently, there is virtually no systematic collection of data on infection levels among sex workers and truck drivers, traders and merchants, or other high-risk groups. HIV surveillance was conducted in Addis Ababa and other major urban centers among core transmitter groups during the early stages of the HIV/AIDS epidemic, but after 1991 was discontinued for many years. The last systematic data collected on sex workers, in 1998, found nearly three-quarters of sex workers in Addis (73.7 percent) and 65-70 percent in Bahir Dar and Nazareth were HIV-positive (Appendix). But there was clearly some variation, since the average infection rate across 22 sites was 17 percent (UNAIDS, 2002). A census of sex workers in Addis Ababa showed that students were one of the client groups for sex workers and female night school and high school students worked as sex workers. The majority of sex workers were in the 20-24 years age range (FHI, 2002).

Data from ANC surveys and from blood donors indicate that individuals below age 24 account for a major proportion of HIV infections among the general population. The group with the highest HIV prevalence is women ages 15-24 (12.1 percent). Data from blood donors, visa applicants, and police and army recruits indicate that HIV prevalence among men peaks at ages 25-29.

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43. Most of this decline can be accounted for by steady declines in HIV prevalence among women 15-24 – from 23.7 percent in 1995 to 11.3 percent in 2003. No change was observed for older age groups or in the outer city health centers. The behavioral and other epidemiological factors that led to this decline remain to be identified. Data from the 2000 DHS on age at first sex and current rates of condom use do not suggest significant changes. In other countries, such as Uganda, where significant declines in HIV prevalence were observed, the onset of sexual intercourse among those 15-24 has increased (by two years), casual sex has decreased among men 15-24 (by 9 percent), and condom use rose (by 30-40 percent, Asiimwe-Okiror et al., 1997).

Behavioral Factors

The two main sources on current sexual and risk behavior levels are the 2000 Demographic and Health Survey (DHS), conducted in the entire adult population, and the 2001-2002 Behavioral Surveillance Survey (BSS), the first round of which was conducted in a representative sample of about 27,000 persons from ten specific populations: in-school youth (ISY) 15-19 years old; out-of-school youth (OSY) 15-24 years old, uniformed services (ground and air forces); transport workers (truckers, intercity bus drivers, minibus drivers and their assistants); farmers; pastoralists; factory workers; and female sex workers (Mitike et al., 2003).[44]

Systematic information on trends in risk behavior for HIV transmission over time is not available – for example, trends in HIV/AIDS awareness, the number of sexual partners, and condom use in different situations. An important exception is gleaned from longitudinal behavioral research conducted by the Ethio-Netherlands AIDS Research Project (ENARP) among workers at two factories (Akaki and Wonji) near Addis Ababa during the period February 1997 to December 1999 (Mekonnen et al., 2003).[45]

Trends in knowledge and behavior. At baseline in 1997 among 1,124 men included in the survey, 9.7 percent had had casual sex in the past year, 43.4 percent had had commercial sex, 38.8 percent used a condom with their last casual partner, and 10.7 percent had a history of genital discharge in the past 5 years. Among the men who remained in the cohort in 2000 (about 82 percent of those who started), the combined results for the two sites showed statistically significant declines between the first and fourth follow-up visits in three of these four factors: recent casual sex declined from 17.5 percent to 3.5 percent ($p<0.001$); commercial sex from 11.2 percent to 0.8 percent ($p<0.001$); and genital discharge from 2.1 percent to 0.6 percent ($p=0.004$). As reported by the investigators, part of these declines occurred independently of cohort interventions (Mekonnen et al., 2003).

Knowledge of HIV/AIDS and modes of transmission. The 2000 DHS found that 86 percent of women ages 15-49 and 96 percent of men ages 15-59 had heard of HIV/AIDS. Only 37 percent of women and 63 percent of men knew of at least two ways of preventing HIV. Roughly one-third of women (35 percent) and two-thirds of men (68 percent) knew about condoms. Only 12 percent of women knew a source for condoms and only 11 percent reported that they could obtain condoms for themselves. The urban-rural differential in knowledge of a source and availability of condoms was very wide: 7 percent versus 37 percent on source and 6 percent versus 34 percent on ability to obtain in urban and rural areas, respectively. As observed in field visits, a major knowledge gap exists in the area of mother-to-child transmission of HIV. Based on some estimates, only 58 percent of women and 72 percent of men know that HIV can be transmitted from mother to child (CSA/ORC Macro, 2001). Among the 10 groups surveyed by the BSS, about half of respondents did not have knowledge of three methods to prevent HIV. The knowledge gap among the rural

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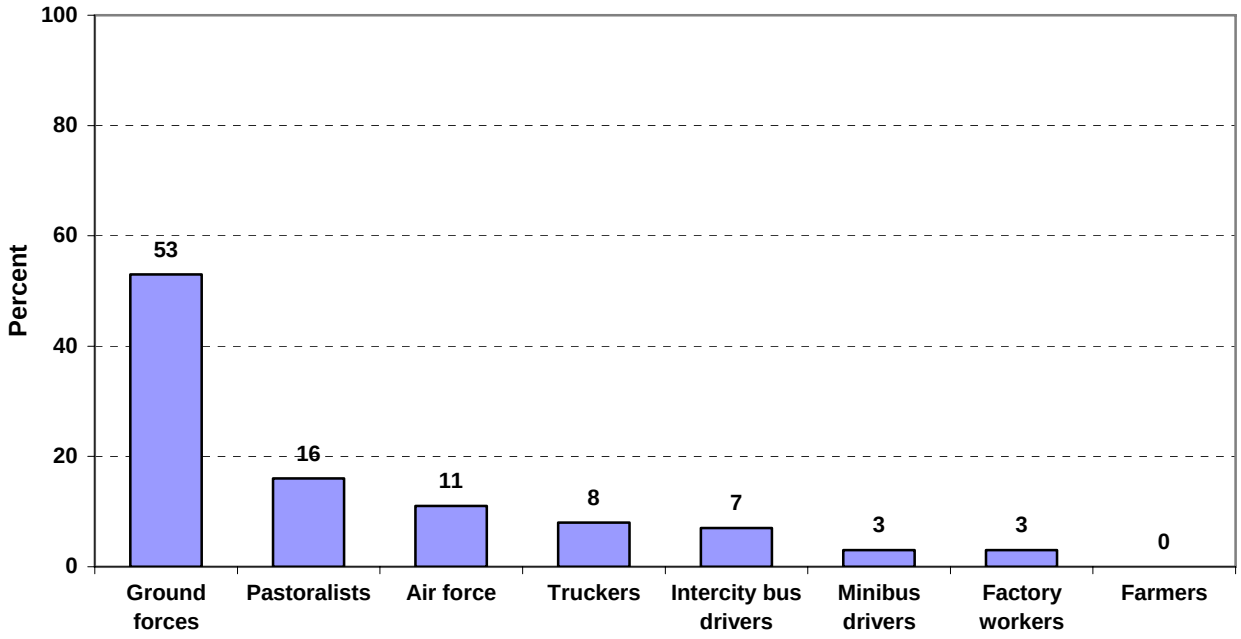
44. The BSS was a collaborative effort conducted by several groups. It started in 2001 and implemented the Second Generation HIV Surveillance that stressed the need to design a surveillance system appropriate for the stage of the HIV epidemic in the country. The survey emphasized the importance of using behavioral data to inform and explain trends of HIV infection among low- and high-risk populations from various geographic locations. The BSS methodology tracks trends in HIV/AIDS knowledge, attitude, and behaviors through repeated cross-sectional surveys.

45. The study used open cohorts of 1,124 males.

population was high. Misconceptions about HIV/AIDS existed among all population groups; the level of misconceptions was highest among farmers and pastoralists.

Sexual behavior. The 2000 DHS found that in the overall population 69.3 percent of women and 84.6 percent of men aged 15-19 report never having had sexual intercourse. According to the BSS 2002, roughly half of ground forces, 16 percent of pastoralists, and 11 percent of the air force had engaged in extramarital sex in the past 12 months (see Figure 3).

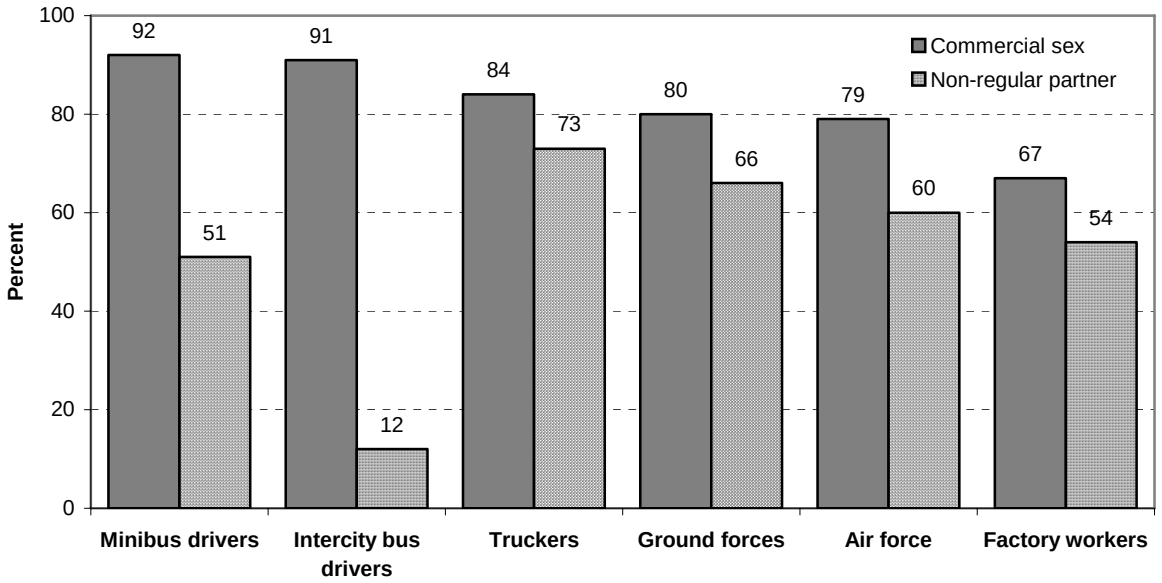
Figure 3: Percent of Men Who Engaged in Extramarital Sex in the Past 12 Months



Source: Mitike et al. (2003).

Condom use. Among the general population surveyed by the 2000 DHS, the use of condoms during last sexual intercourse with a spouse or cohabiting partner was negligible among both women and men. With a non-cohabiting partner, 13 percent of women and 30 percent of men reported condom use during last intercourse. In the BSS, reported condom use in commercial sex was relatively high. Ninety-one percent of female sex workers reported consistent condom use during sex with paying clients in the previous 30 days. The highest levels of consistent condom use in commercial sex among clients were among transport workers (minibus drivers, intercity bus drivers, and truck drivers, roughly 85-90 percent, see Figure 4). Consistent condom use in commercial sex was roughly 80 percent among air and ground forces, but only 67 percent among factory workers. Consistent condom use with non-regular partners was substantially lower than condom use with sex workers.

Figure 4: Condom Use by Men in Commercial and Non-regular Sex, Last 12 Months



Source: Mitike et al. (2003).

Voluntary counseling and testing (VCT). The BSS showed that the level of HIV testing was low among all 10 groups, despite a high expressed willingness to undergo VCT. Urban-rural differences in seeking VCT and gaps in knowledge and practice could have serious implications if the epidemic extends to the rural populations at a fast pace – a situation that seems possible at present.

Stigma and discrimination. Stigma of AIDS and potential discrimination by employers and community members are major barriers to the successful implementation of HIV/AIDS prevention programs. In the 2000 DHS, among those who have heard of AIDS, nearly twice as many women as men believed that the HIV-positive status of a family member should remain a secret. About 45 percent of women and 50 percent of men reported that they would be willing to care for relatives with HIV in their house. Based on a recent report, 61 percent of respondents reported that although they knew that HIV is not transmitted casually, they would not buy food from a vendor with HIV (Garbus, 2003).[46] Many would separate utensils, linens, and other household items used by people with HIV/AIDS from those used by other household members.

Much of the stigmatizing language and description of stigmatizing and discriminatory behavior centers on the sexual transmission of HIV. The belief that HIV is a divine punishment for sins committed is particularly strong. Nevertheless, many community members feel that people with HIV/AIDS deserve sympathy or support. Some stigmatizing

46. There was a high level of stigma and discrimination of HIV-positive people among all ten groups in the BSS. Eighty-five percent or more of farmers and pastoralists, over half of ground forces (56 percent) and 44 percent of female sex workers were unwilling to share a meal with an HIV-positive person.

behavior is caused by limited resources and fatigue. Although family and community members provide care, they often regard people with HIV/AIDS as a burden. Those who provide care to people with HIV/AIDS are often themselves stigmatized (Garbus, 2003). During field visits in Addis Ababa and other sites, examples of stigma and discrimination were consistently mentioned.

Mother-to-child transmission (MTCT) of HIV. Despite the high prevalence of HIV among pregnant women in Ethiopia, it appears that little research or intervention programs have been conducted on transmission of HIV from the mother to her child. A rate of 30-40 percent is generally quoted as an estimate of MTCT of HIV in Ethiopia (Dr Zerou, Black Lion Hospital, personal communication, 2003). However, no estimates are available for intra-uterine, intrapartum, or post-natal transmission. Breastfeeding is universal in Ethiopia: 96 percent of children have been breastfed at some time (CSA/ORC Macro, 2001). With the prevailing stigma and socioeconomic status it is unlikely that this trend will change through introduction of formula feeding in the near future. Only 58 percent of women (and 72 percent of men) know that HIV can be transmitted from mother to child (CSA/ORC Macro. 2001). Only one clinical trial of an extended antiretroviral drug regimen (nevirapine) to prevent transmission of HIV through breast milk is currently underway in the Black Lion Hospital in Addis Ababa and few other hospitals. Only 50 clients received prevention of MTCT services in Ethiopia during 2001 (Garbus, 2003). In 2002, national guidelines on prevention of MTCT were developed and a pilot program has been initiated by the MoH.

Impact

Hospital admissions. No reliable data are available to document hospitalization rates and the patterns of diseases associated with HIV/AIDS in Ethiopia. However, based on unpublished figures and anecdotal reports (Dr. Zerou, personal communication. 2003), more than half of hospitalizations are due to AIDS. Tuberculosis is the most common opportunistic infection (OI), but the clinical and laboratory capacities are inadequate to distinguish other specific OI of AIDS, such as pneumocystis carinii pneumonia (PCP) and bacterimias causing pneumonias, diarrheas, and other diseases (such as S. pneumoniae, non-typhoid salmonella, toxoplasmosis, cryptococcosis, cryptosporidiosis, and others). These conditions are often accompanied by wasting and nutritional deficiencies. TB in particular is a major public health problem and is endemic in Ethiopia (WHO, 2002). These infections are the main causes of morbidity and mortality.

Adult AIDS Mortality. AIDS is now the leading cause of adult morbidity and mortality in Ethiopia. The cumulative number of AIDS-related deaths from the beginning of the epidemic was estimated at about 1.2 million in 2000 (UN, 2003). In 2001, UNAIDS estimated that there were 160,000 adult and child AIDS deaths in the country**.** According to the U.N. Population Division, AIDS has already increased the number of deaths in Ethiopia by 6 percent. It projects that by 2015, 5.2 million Ethiopians will have died of AIDS; by 2050, the figure will reach 14.9 million (UN, 2003).

Infant and child mortality, orphans. The 2001 national estimate of infant mortality was 116 per 1000 live births and of under-five mortality 172 per 1000 (World Bank, 2002). No data are available to determine the impact of HIV/AIDS on these estimates. However, there is a large

database showing the adverse demographic consequences of HIV/AIDS on child survival in other African countries. For example, in Malawi, where the national infant mortality is comparable to that of Ethiopia, mortality among infected children who survive their first year of age is about seven times higher: 339 per 1000 person years among HIV-infected children compared to 46 per 1000 person years among uninfected children (Taha et al., 1999). The number of orphans (age 0-14 years) has been estimated to be 1.2 million.in Ethiopia.

Appendix to Annex 3. Trends in HIV prevalence among high- and low-risk groups in Ethiopia, 1987-2003

Population group	1987	1988	1989	1990	1991	1992-93	1993	1994	1995	1996	1997	1998	1999	1999-2000	2001	2002	2003
HIGH RISK																	
Sex workers																	
Addis Ababa	2.7	19.4	26	54.2							44.7	73.7					
Bahir Dar		35.8	48.2	55	69.4												
Dire Dawa		18	30.5	48.1													
Metu		5.3	12.5	36.4													
Nazareth		19.5	31.1	52.4	65.6												
Nekemte		15.3	31.3														
STI patients																	
Addis Ababa	8.3		36.8														
Transport																	
EFTC drivers		13.0	17.3			33.0											
LOW RISK: Ante-natal clinics																	
Addis Ababa																	
All sites			4.6			11.2			20.6	17.8	16.5			14.4	15.5	14.4	13.1
Guele HC										15.7	18.3			17.4	15.8	9.9	12.0
Kazanches HC									22.2	26.5	16.3			17.3	17.7	15.6	15.3
Teklehaimanot									19.1	21.5	18.3			13.1	16.4	17.4	15.1
Higher 23 HC										9.0	13.0			10.1	12.4	14.7	9.9
Other towns																	
Adigrat															16.2		
Asaita															12.4		
Awassa												14.4		11.5	10.1		
Bahir Dar HC						13								20.8	23.4		
Bahir Dar Hosp															19.9		
Dilla												14.5		11.7	9.8		
Dire Dawa HC						12.3								13.6	15.2		
Dire Dawa Hosp															8.5		
Estie														7.3	10.7		
Gambella											12.7			19.0	14.6		
Ginir															3.1		
Gondar HC															15.1		
Hossana												3.6		4.8	5.9		
Jijiga															19.0		
Jimma															8.6		
Maichew															16.8		
Mekele															17.2		
Metu						10.7									10.5		
Nazareth															18.7		

Population group	1987	1988	1989	1990	1991	1992-93	1993	1994	1995	1996	1997	1998	1999	1999-2000	2001	2002	2003
Nekemet															9.1		
Pawi															8.5		
Sashemene														14.3	13.1		
Soddo												9.2		10.7	11.6		
Rural																	
Ambo Toke															4.6		
Aira														2.0	2.6		
Attat												0.8		4.0	1.5		
Borena Dadim															1.7		
Borena Gosa															1.7		
Gambo														0.7	1.1		

Source: UNAIDS (2002) for sex worker data; EMJ (2003) for Addis ANC data by site and totals for 1995-2003; Ministry of Health 2002 for other ANC sites

Annex 5: EMSAP Indicators – Progress to Date

Key Indicators	Progress as of March 2004 (as reported by HAPCO and Bank team)
A. Output Indicators	
Access to treatment for opportunistic infections increased from 30* to 50 percent. *30 percent baseline is a very rough estimate made by the Bank's team at appraisal, based on existing information.	No reliable information, but large quantities of drugs for treatment of opportunistic infections have been procured and distributed to health institutions. OI drugs are among the drug lists planned for procurement this year.
The number of national surveillance sites will have increased by 2 in the first year and by 10 by the end of the project.	The number of sentinel surveillance sites has increased from 15 in 2000 to 64 in 2003. All sites are in ante-natal clinics, testing pregnant women.
The number of blood banks* will have increased by 25 percent by the end of the project. * There were five in 2000.	Six additional blood banks are in the process of being established.
At least 70 percent of the participating *woredas* have implemented their agreed action plans.	240 *woredas* (6709 *kebeles*) are implementing their agreed action plans.
Emergency AIDS Fund disbursements are at least 70 percent of plan level.	46.9% (and the rest is expected to be disbursed within the remaining 20 months before closing).
B. Process Indicators	
Functional HIV/AIDS councils will have increased as follows: regional from 1 to 11 by the end of year 1; zonal from 0 to 20 and *woredas* from 0 to 165 by the end of year 3 of the project.	All 11 regions have established functional HIV/AIDS Councils and 240 *woredas* have been reached. Zones are no longer active administrative units.
Councils at all levels (in participating *woredas*) have defined work programs in year 2 of the project.	Most *woredas* have received action plans from the *kebeles* and have been funded by HAPCO.
The number* of affordable VCT services incorporated into ANC, TB and STI clinics will have increased by 10 percent* by the end of the project. *Baseline not defined in PAD.	170 VCT centers have been established and 7 PMTCT centers are functional and an additional 47 PMTCT centers are expected to be operational by mid-March 2004.
Increase in the number* of anti-AIDS clubs in high schools: 25 percent increase in year 1 and 20 percent increase each in subsequent two years of the project. *Baseline not defined in PAD.	Recent study by the Ethiopian Public Health Association reported 7,600 elementary, 360 high school, and 400 out-of-school youth clubs are functioning and carrying out HIV/AIDS activities. A national workshop on accelerating education sector response to the HIV/AIDS epidemic was held the last week of February and this is expected to expand and strengthen anti-AIDS club activities in schools.
Funds distribution and financial management mechanisms will have been installed within three months of project effectiveness at the national level.	HAPCO has established a financial management system and a financial management manual.
C. Impact Indicators	
Eighty percent of the population* will be aware of HIV/AIDS and its prevention in participating *woredas* by the end of the project. *Baseline not defined in PAD.	Second generation BSS findings indicate 97% awareness on HIV/AIDS. (Data from 2000-2001)
Use of condoms at last sexual contact among young people (14-19 years)* will increase by 20 percent by the end of the project. *Baseline not defined in PAD.	Condom distribution by DKT increased from 4.1 million in 1999 to 67.6 million in 2003 and are reportedly used mostly by sexually active population groups.
Prevalence of HIV and STIs will be reduced.* *This target not quantified in PAD.	MoH reported prevalence of 7.3% for 2000 and 6.6% for 2001.* *This apparent decrease is due to a correction in the prevalence estimates, most notably a reclassification of a sentinel surveillance site from rural to urban, and is not reflective of an actual decrease.

Annex 6: World Bank Inputs to HIV/AIDS in Ethiopia: A Synopsis

Portfolio of World Bank Support to HIV/AIDS, 1995-Present			
	HIV/AIDS-Specific	**Health Sector**	**Non-Health Sector/Cross-Cutting (total credit amount shown; portion of credit allocated for HIV/AIDS activities not known)**
Lending (Board date) **(IDA credit amount)**	EMSAP (2000)	Family Health Project (1985) ($33 million) **indirect support only**	Road Sector Development Program Support (1998) ($309.2 million)
		Health Sector Development Program (1998) ($100 million)	Education Sector Development Program Support (1998) ($100 million)
			Women's Development Initiatives (2000) ($5 million)
			Emergency Recovery Project (2000) ($230 million)
			Emergency Demobilization and Reintegration (2000) ($170.6 million)
			Energy Access (2002) ($132.7 million)
			Road Sector Development Support (2003) ($126.8 million)
			PRSC I (2004) ($120 million)
Non-Lending Support **(publication date)**	*Intensifying Action Against HIV/AIDS in Africa* (1999)	*Ethiopia Population, Health and Nutrition Sector Review*, Report No. 5299-ET (September 30, 1985) **indirect treatment only**	
		Ethiopia Social Sector Note, Report #16860 (February 27, 1998), later published as *Ethiopia Social Sector Report*, Report No. 18482 (August 1998)	
Country Strategy Work			Country Assistance Strategy (1995)
			Country Assistance Strategy (1997)
			Interim Support Strategy (2000)
			PSRP
			Country Assistance Strategy (2003)
			HIPC

Annex 7: Inventory of HIV/AIDS Support Provided under World Bank's Active Portfolio of Projects in Ethiopia

Project	IDA Amount (US$ million)	Board Approval	HIV/AIDS components/activities
Poverty Reduction Support Credit	120.0	02/17/04	Actions to be completed (a) before PRSC I: establish joint MoH and HAPCO committee to facilitate piloting of an HIV/AIDS biological survey; (b) before PRSC II: conduct of HIV/AIDS pilot biological survey; (c) before PRSC III: report on the pilot survey and conduct of the HIV/AIDS biological survey (if feasible)
Road Sector Development Support	126.8	06/17/03	Continuation of HIV/AIDS activities initiated under previous roads project plus: (i) inclusion of HIV/AIDS clauses in work contracts; (ii) assistance in accessing EMSAP funds; (iii) recruitment of consultants to prepare strategy and an NGO to implement HIV/AIDS work under supervision of Environmental Monitoring Branch in collaboration with Medical Branch. In addition, Bank's team promoted and supported: baseline study on risk behavior and needs assessment; development of road HIV/AIDS strategy; continued dialogue during routine meetings with staff; HIV/AIDS committees; HIV/AIDS incorporated into monthly progress reports.
Pastoral Community Development	30.0	05/20/03	No specific component for HIV/AIDS. Given CDD nature of the operation, however, project resources could be made available if requested by beneficiary communities.
Emergency Drought Recovery	60.0	03/27/03	No specific component for HIV/AIDS. Given CDD nature of the operation, however, project resources could be made available if requested by beneficiary communities.
Social Rehabilitation and Development Fund – Supplemental Credit	28.3	12/17/02	At the outset, the Social Fund started to finance a few HIV/AIDS subprojects, but the government requested them to stop when funds under the MAP became available. Task team and CD tried to revert their decision but did not succeed.
Energy Access	132.7	09/19/02	The equivalent of $6,000 has been used for awareness campaigns for workers and communities.
Capacity Building for Decentralized Service Delivery	26.2	07/23/02	None
Food Security	85.0	05/30/02	None to date. New TTL intends to explore possibilities for more direct support to HIV/AIDS activities and better coordination with MAP.
Cultural Heritage	5.0	04/17/02	None
Distance Learning – LIL	4.9	04/17/01	No HIV/AIDS support to date. Opportunities are being pursued to target adolescents in future work in the context of extension of closing date of this project and in the development of a new (ICT) project.
Biodiversity (Global Environment Project)	1.8	02/13/01	None
Conservation and Sustainable Use of Medicinal Plants	2.6	02/13/01	None
Emergency Demobilization and Reintegration	170.6	12/05/00	Provision of VCT for demobilized soldiers to complement IEC and condom distribution already financed by other sources and institutionalized in the military.
Emergency Recovery	230.0	12/05/00	HIV/AIDS activities aim to reduce HIV/AIDS infection and spread by scaling up interventions in 15 war-affected *woredas* (8 in Tigray and 7 in Afar) for internally displaced people, deportees, demobilized soldiers, commercial sex workers, the military and host communities. The component is financed from the reallocated proceeds ($2.5 million) of the EMSAP. Component management and coordination is responsibility of regional HAPCOs and implementing bodies include: sector bureaus (health education, agriculture, trade, industry and transport, culture and information), the army, *kebele* AIDS committee, NGOs, and private sector.

Project	IDA Amount (US$ million)	Board Approval	HIV/AIDS components/activities
Multi-sectoral HIV/AIDS	59.7	09/12/00	Four components support proposals for: capacity building, public sector response, and NGO and community responses. Eligible activities encompass prevention, treatment, care, and mitigation.
Women's Development Initiatives	5.0	07/27/00	IEC messages to beneficiary women's groups and communities cover: harmful traditional practices, HIV/AIDS and reproductive health, nutrition, legal rights, gender and development, environment). Overall IEC budget is $720,000 of which $500,000 financed by IDA. IEC evaluation assessment being commissioned by the project, whose results expected around 4th Q of CY2004.
Health Sector Development Program	100	10/27/98	Program components support HIV/AIDS, most notably: service delivery/ quality of care; facility rehab and expansion; pharmaceuticals; IEC; health information; and M&E. PSR notes that EMSAP took over the financing of most of direct support of HIV/AIDS activities under the responsibility of the health sector when it became effective.
Agricultural Research and Training	60.0	06/09/98	None
Education Sector Development Program Support	100.0	05/26/98	Retrofitted to support development of instructional materials, training seminars, and support to student clubs. Bulk of support is now coming from EMSAP. This will be increasingly so when the Education project closes in June 2004 and education sector will in future be supported through PRSCs. Under a PRSC there will be no proposals, just general budget support, with the onus for implementation and planning at the *woreda* level. The knowledge base on HIV/AIDS at that level is very poor and there is the risk that other more "immediate" political priorities will win out in the competition for scarce funds.
Road Sector Development Program Support	309.2	01/15/98	Retrofitted to target Roads Authority staff, project personnel, contractors, consultants and local communities with (i) IEC; (ii) care and support; (iii) capacity building and policy development. Linkages with the MAP were forged for additional financial and technical assistance.
Energy Project	200.0	12/11/97	None
Social Rehabilitation and Development Fund	120.0	04/09/97	None

Source: TTLs of respective projects and Bank documentation on projects design and supervision. Status reported as of mid-March 2004.