



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

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Acknowledgements

The authors thank Jennifer Vollett-Krech for significant and valuable research assistance and William Hurlbut for editorial assistance. Comments on the first draft from members of the OED project evaluation team (Martha Ainsworth, Eric Jensen, Judy Hahn, Joan Nelson, Denise Vaillancourt, Heinz Vergin) and are gratefully acknowledged.

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
APL	Adaptable Program Loan
ARV	Anti-retroviral (treatment)
AZT	Azidothymidine
CBO	Community-based organization
CAS	Country Assistance Strategy
CDC	U.S. Centers for Disease Control and Prevention
CIDA	Canadian International Development Agency
CSW	Commercial sex workers
DFID	Department for International Development (UK)
DOTS	Directly observed treatment, short course
ECA	Europe and Central Asia
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB, and Malaria
GMP	Good Manufacturing Practices
HIV	Human Immunodeficiency Virus
IDU	Injecting drug use/users
MAP	Multi-country HIV/AIDS Program
MDR	Multidrug-resistant
MOE	Ministry of Education
MOH	Ministry of Health
MOJ	Ministry of Justice
MSF	Médecins Sans Frontières
MSM	Men who have sex with men
NGO	Non-governmental organization
OED	Operations Evaluation Department
OSI	Open Society Institute
PCD	Project Concept Document
PAD	Project Appraisal Document
PSI	Population Services International
RHCF	Russian Health Care Foundation
SIDA	Swedish International Development Cooperation Agency
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNESCO	United Nations Education, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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Executive Summary

The Operations Evaluation Department (OED) of the World Bank is evaluating the impact to date of the World Bank's work on HIV/AIDS. The Russian Federation has been selected for a case study because it has one of the fastest growing HIV/AIDS epidemics in the world and the Bank has invested heavily in non-lending HIV/AIDS assistance and project development. This study examines: whether or not the Bank did the "right thing" in its HIV/AIDS work with Russia; whether or not it did it "the right way"; and whether or not the Bank's work made any difference to the way Russia addresses HIV/AIDS, compared to what it would have done in the absence of the Bank's involvement.

This assessment was based on a review of literature on HIV/AIDS globally and in Russia, a review of the World Bank's files, and over forty interviews with an array of stakeholders from Russia, the Bank, development partners, academia, and NGOs. The report examines the context of the epidemic, the government response to HIV/AIDS, and the Bank's HIV/AIDS activities in support of Russia. It then assesses the impact of the World Bank's assistance on the Russian response to date relative to what might have happened if the Bank had not been involved. The information collected reflects the situation through the fall of 2003, shortly after the visit of the evaluation team.

HIV/AIDS Epidemic

The first reported case of AIDS in Russia was in 1987 and the first AIDS death in 1988. HIV initially spread primarily among men who have sex with men, with the exception of an outbreak of pediatric infections in health facilities in 1989. Profound and unprecedented social changes since the break-up of the Soviet Union, however, have rendered Russia fertile ground for an HIV/AIDS epidemic. From 1987 to 2002, syphilis rates, for example, rose from 4 to 144 per 100,000 and peaked at 278 per 100,000. New HIV cases began to increase rapidly in 1996, with the vast majority among injecting drug users (IDU). The rate of increase from 1999 to 2002 was among the highest in the world. As of October 2003, 255,350 HIV-positive persons had been officially reported in Russia since the beginning of the epidemic, of which 817 had AIDS, and 4,065 people had already died from AIDS-related causes. The true figure for HIV infection may be 3-5 times higher.

Government Response

During the Soviet period, there was no overarching national program to coordinate activity related to HIV/AIDS. In 1993, after the Soviet collapse, the Russian government developed the "Federal Program for the Prevention of the Spread of AIDS in the Russian Federation from 1993-1995." In practice, this program was overwhelmingly oriented toward a medical approach that stressed epidemiology and the biomedical sciences over prevention, education, social services, and legal support for HIV and AIDS patients. In August 1995, the legislature passed a Federal Anti-AIDS law that provides current federal guidelines for HIV/AIDS prevention, care, and support. It brought almost all activity in the country relating to HIV and AIDS under the authority and supervision of the federal government. The 1998 Federal Law on Narcotic and Psychoactive

Substances criminalized all drug consumption or possession not prescribed by physicians and prohibited substitution therapy of opiate addiction with methadone. Its provisions could easily be interpreted as defining needle or syringe exchange programs as illegal. The government has established a Federal AIDS Center, 86 Regional AIDS Centers, and 6 Territorial AIDS centers. In addition, there is a Federal Clinical AIDS Center in St. Petersburg. The system of regional AIDS centers includes over 1,000 screening laboratories and 500 offices for anonymous testing.

The highest levels of the government have been nearly silent on HIV. The government's early response, much like that to other STI, was dominated by mass testing and contact tracing. The approach to prevention is highly medicalized and not focused on those at greatest risk of contracting and spreading HIV. The federal government spends less than \$4 million a year on its earmarked federal HIV/AIDS program for a country of 144 million people. It continues to have great difficulty dealing with groups engaging in high-risk behaviors, and many government practices on both HIV and STI stigmatize people. There is very little treatment of AIDS patients with anti-retroviral therapy, and the approach that is taken is based on two drugs rather than three.

World Bank Response

From the early 1990s, the World Bank recognized the need to ensure that the government had appropriate safety nets and a health system that was effective and protected the poor. By the mid-1990s, an explicit part of the Bank's Country Assistance Strategy was to help Russia deal with its most pressing health problems and to address TB and HIV. In response to a government request, in 1999 the Bank began to develop a TB project with the Ministries of Health and Justice, to which HIV was added. WHO, DFID, CIDA, Soros/Open Society Institute, USAID, MSF, and local NGOs were already involved in helping Russia to pilot better approaches to HIV. The Bank initially worked closely with these groups in designing a project that would take their efforts to scale and raise the government's HIV/AIDS program to the level of international best practice. OSI was especially helpful to the Bank's work, by facilitating high-level interest in HIV and TB in Russia, by helping to get harm reduction on the agenda, and by encouraging Russia to consider new approaches to the difficult harm reduction issue. DFID was also particularly helpful in inspiring and financing a number of critical parts of project preparation, analytical work, and policy dialogue.

Over four years, the Bank engaged in high-level policy dialogue and co-sponsored training and analytic work in parallel with preparation of the TB and AIDS Control Project. In 2000-2001, project development ground to a halt due to government concerns about the DOTS approach to TB control being advocated by the Bank and the effect of international competitive bidding requirements on the domestic manufacturers of TB drugs. During the 9-month pause, the Bank sought, first, to restore its relationship with the government by reducing the perception of pressure to borrow and supporting public health seminars and, second, to maintain focus and raise commitment on HIV/AIDS by jointly producing with a Russian scientist a model of the economic impact of HIV and by planning a high-level meeting on vaccines that took place just after approval of the project by the Bank. In addition, the Bank worked with the government to keep the

project out of the media, as well as to take an approach to TB that acknowledged and built on Russia's own efforts and institutions.

The TB and HIV/AIDS Control Project was finally negotiated in December 2002, approved by the Board of Directors of the Bank in April 2003, and became effective in December 2003. The objectives of the HIV/AIDS component of this assistance were to help the government to: (i) improve its national strategy, policies and protocols on HIV and STI; (ii) promote public education on HIV and STI; (iii) improve surveillance, monitoring and evaluation; (iv) strengthen laboratories and blood safety; (v) prevent maternal to child transmission; and (vi) engage in targeted prevention programs for HIV and STI in both the civilian and prison population.

Development Effectiveness of the Bank's Assistance

In terms of development effectiveness, the Bank's HIV/AIDS assistance to Russia has been relevant to the epidemiological situation, Russia's institutions and the Bank's country and health strategies, although a better understanding of the borrower at the outset through institutional analysis would have improved the relevance of the early dialogue on project development. In addition, the Bank avoided the tendency to try to do too many things in the TB and HIV/AIDS Control Project and focused on those areas that would avert the maximum number of HIV cases if the project were implemented effectively. The Bank might have acted on HIV somewhat earlier, but to its credit, it did act as it became clear that Russia faced a rapidly growing epidemic.

The Bank's assistance tried to influence the Russian HIV/AIDS program in ways that would make it more effective, more efficient, and more in line with emerging global experience. Its policy dialogue, analytic work, and project preparation activities were most effective in three areas: (a) improving the efficiency and technical quality of the response; (b) working with government to create a vehicle – the project – for systematic expansion of coverage of interventions nationally; and (c) raising high-level government commitment to address HIV/AIDS.

Impact of the Bank's HIV/AIDS Assistance

The timeline of events related to HIV/AIDS in Russia reveals some temporal linkages between World Bank activities and government actions (Annex B). Correlation, however, does not prove causation, and therefore due caution must be exercised in drawing conclusions about the Bank's role. The evaluation team finds that the Bank has had an impact on the Russian government commitment to fighting HIV/AIDS along three critical dimensions:

- the quality and quantity of information government officials possess;
- the capacity and will of some constituencies to act on this information; and
- the way of thinking about HIV/AIDS.

In the absence of World Bank engagement on HIV/AIDS, the government's approach would have been less targeted to the main drivers of the epidemic and less in

tune with international best practice in key areas. It would also have paid less attention to capacity building, to laboratory strengthening, and to making the blood supply safe. In addition, the government would not be planning to take its HIV/AIDS efforts to scale in a timely way. Rather, many such efforts would remain small, local, and not in step with the imperative to move ahead forcefully against the epidemic. The World Bank has served as a facilitator to coordinate better and more expansive activities that were already taking place, and to catalyze thinking in new directions that bring the government program closer to international standards of prevention and treatment.

Lessons Learned

This case study highlights a number of lessons for the Bank.

- It underscores the importance of understanding the country context and embedding project development carefully in that context.
- It demonstrates how to build government commitment through reducing the pressure to borrow and engaging clients through highly relevant joint analytic work and selected high-level contacts with Bank policymakers.
- The approved project illustrates the important leverage of a small operation in large countries in potentially improving the effectiveness, efficiency and coverage of the response.
- The Bank's involvement on HIV/AIDS in Russia highlights the value of policy and project dialogue, analytical work, and technical assistance to help build country capacity for addressing key health issues in more effective and efficient ways.
- Finally, there were important lessons for the Bank concerning the need to match the skills of task managers with the variety of demands placed on staff in that position. The placement of senior staff in Moscow, in conjunction with the very able non-specialist already working on health there, might have reduced problems in the relationship and speeded project development. The placement of senior technical staff in Moscow during project implementation could also be very helpful.
- The AIDS epidemic is a long-run problem in Russia; effectively helping the government to address this issue will require flexibility by the Bank and a long time horizon.

1. Introduction and Analytic Framework

1.1 The World Bank has supported major efforts globally to prevent HIV/AIDS and reduce its social and economic impacts. The main tools of that Bank assistance have been analytic work, policy dialogue, and lending for country programs. The Operations Evaluation Department (OED) of the World Bank is undertaking the first evaluation of the Bank's assistance to HIV/AIDS country programs (World Bank/OED, 2003).

1.2 This case study examines the development effectiveness and lessons learned from the Bank's work on HIV/AIDS in the Russian Federation, chosen because it has experienced a steep rise in reported HIV infections in recent years, with one of the world's highest rates of new infections (UNAIDS/WHO, 2002); it is a large country in which effective action can have an impact on a significant number of infections; and the experience is illustrative of Bank assistance to raise government commitment and launch programs to fight a new and rapidly growing epidemic.

Objectives of this Review

1.3 The objective of this case study is to assess the development effectiveness of the Bank's assistance on Russia's response to HIV/AIDS. The review addresses the following questions: (1) What value has the Bank's assistance added to Russia's response to HIV/AIDS? (2) To what extent did the Bank collaborate with other counterparts in Russia, and how did that collaboration add value to Russia's response to HIV/AIDS? (3) What are the lessons learned from the Bank's work that can be applied to future Bank assistance for HIV/AIDS in Russia and other countries?

Evaluation Framework

1.4 The reviewers used the evaluation framework outlined in the design paper for the broader OED Evaluation of World Bank Assistance for HIV/AIDS (World Bank/OED, 2003). Development effectiveness of the Bank's HIV/AIDS assistance to Russia is defined by its *relevance, efficacy, efficiency, and institutional development impact*. In addition, the evaluation assesses the impact of the Bank's HIV/AIDS assistance against the counterfactual of no Bank involvement. Impact measures the difference that the Bank's analytic work, policy dialogue, and lending made for: *political commitment* to facing its HIV/AIDS epidemic, including strategies, policy action, and public spending; *implementation*, which includes institutional capacity and availability and quality of services; the extent to which Russia has been able to respond to HIV/AIDS *across sectoral lines*; and *donor collaboration* and the *involvement of NGOs* in Russia's HIV/AIDS program.

1.5 The Bank's work on HIV/AIDS can have indirect or direct effects on both government activities and other donor activities. Those activities will then have a "trickle-down" effect on HIV/AIDS outcomes in a variety of ways:

- The government's response to the Bank's assistance can be seen in new government strategies, policies, and public spending on HIV/AIDS;

- As the government implements new strategies and policies, this can influence the activities of other donors, NGOs, the private sector, the public health system, and other public sectors such as education or social protection; and
- As civil society and the public sector implement HIV/AIDS programs, individual and household decisions about sexual behavior and condom use will be affected.

1.6 This case study employs both quantitative and qualitative methods to assess the development effectiveness of Bank assistance to Russia on the national response to HIV/AIDS relative to the counterfactual of no World Bank involvement. These methods and results include: (i) a review of the nature of the HIV epidemic in Russia within its epidemiological, cultural, political, and institutional context; (ii) a review of the history of the Russian government's response to HIV/AIDS; (iii) an outline of the Bank's activities to date on HIV/AIDS in Russia; (iv) an analysis of the relevance, effectiveness, and efficacy of the Bank's assistance to Russia for HIV/AIDS; and (v) an analysis of the impact of the Bank's assistance on the Russian response to HIV/AIDS and the activities of donors.

1.7 The evaluation team reviewed literature and research, policy studies, and previous evaluations of the HIV/AIDS epidemic in Russia. It then assembled and analyzed epidemiological and behavioral data, surveys, information on government and donor expenditure, service delivery data, and information on World Bank and NGO activities in HIV/AIDS in Russia. The team carried out over 40 structured interviews with representatives from the government, World Bank, other donors, UN agencies, academia, NGOs, community-based organizations, and other parts of civil society in Washington, Russia, and other locations in the summer and fall of 2003. The team also developed an inventory of Bank assistance for HIV/AIDS in Russia, government policies and programs on HIV/AIDS, and the activities of other partners in HIV/AIDS in Russia. Finally, the team constructed a timeline of key events in Russia, Russian government actions and responses to HIV/AIDS, and Bank and other donor activities, some of which may have played a role in shaping the national response to AIDS (see Annex B).

Limitations

1.8 Although the World Bank has been active in analytic work and policy dialogue on HIV/AIDS in Russia since 1998, no Bank-assisted HIV/AIDS project has yet been implemented. This case study is therefore limited to the development impact of policy dialogue, analytic work, and project preparation activities.

1.9 Many actors are involved in Russia's fight against HIV/AIDS and many factors affect the formulation and implementation of national strategy. The conclusions noted in this report, while based as far as possible on evidence and facts, are therefore often subjective and reflect judgments drawn from a synthesis of the gathered information.

1.10 A wider interview list, including greater representation of officials outside of Moscow, would have improved the reviewers' understanding of the impacts of the Bank's work, especially at the sub-national level. Time and budget constraints prevented the team from collecting views from a wider range of informants.

2. Health and AIDS in the Soviet Era (1987-1991)

Early Spread of HIV/AIDS

2.1 The first incursion of HIV into Russia took place before 1982 through sexual contact between Russians and infected foreigners, most of those from HIV-endemic areas in Africa. In the mid-1980s, the predominant risk factor for HIV was unprotected sex with non-Russians, primarily male students from African countries (Vinokur et al., 2001). Students from Uganda and Rwanda studying in Leningrad, for example, exhibited seroprevalence rates of 5.5 percent and 1.3 percent respectively, and the majority of Russian seropositive female Leningraders during this time period had multiple sexual contacts with foreigners (Kozlov et al., 1993). An important exception to the prevailing transmission modes was an outbreak of HIV among children in a pediatric hospital, transmitted through inadequate precautions in health care procedures (see Box 2.1).

Box 2.1: An Early Outbreak of HIV in the Soviet Health Care System

Early in 1989, the small city of Elista (population 85,000), in the southern Russian republic of Kalmykia, witnessed an outbreak of HIV among about 250 children in a pediatric hospital. In November 1988, a baby born there tested HIV-positive, even though both of his parents were HIV-negative. By the end of the calendar year, more than 12,000 HIV tests were performed in the city, uncovering by May 1989 49 infected children and 9 mothers infected while nursing. One of the mothers' husbands, who had worked in the Congo for several years and received a blood transfusion during emergency surgery, was identified as the source of the infection. HIV then spread through routine reuse of syringes without proper sterilization (Medvedev, 1990; Pokrovsky and Eramova, 1989, abstract). Just a few weeks after the Elista epidemic was uncovered, other similar pediatric outbreaks were found in Volgograd (49 infected children) and in Rostov on Don (4 pediatric infections). As of 1996, 113 of Russia's 302 AIDS deaths were children under 15 years old. Since these initial pediatric incidents, infections in health care settings have only caused about one case per year of HIV (Vinokur et al., 2001).

2.2 During the late 1980s, however, the largest share of HIV-positive Russians was men having sex with men (MSM), and the vast majority of this group had no contacts with foreigners. From 1991 through 1995, about 40 percent of all new HIV cases in Russia could be attributed to homosexual transmission, and about 80 percent of new cases to homosexual or heterosexual contacts. Remarkably, this early phase of HIV in Russia did not appear to penetrate the injecting drug using (IDU) community at all. As of mid-1990, no HIV infection was reported among Soviet IDU (Savchenko and Pokrovsky, 1991, abstract). At the end of 1995, only seven out of a total of 1,062 reported cases of HIV were among IDU (Dehne et al., 1999).

2.3 Russia's first fully developed case of AIDS was a 35-year-old male diagnosed in Moscow in 1987. He had worked as a government official in East Africa in 1981, where it is believed he contracted HIV. In July 1982 he became ill, was treated for mononucleosis, and discharged in 1983. The Soviet medical system at that time was not familiar with HIV/AIDS, and therefore an HIV test was not conducted. This index case had 22 known homosexual partners between 1983 and 1987, of whom 5 were found to be HIV positive, and 24 traceable female sexual contacts, of whom 3 were infected. Of this

infected group, 3 were blood donors who passed HIV to 3 adults and 2 children through blood transfusions (Medvedev, 1990).

Political and Social Context for HIV in the Soviet Union

2.4 Early in the AIDS pandemic, the Soviet Union's response was determined largely by its status as the opposition superpower to the United States. Extensive media propaganda characterized HIV as a deliberately manufactured weapon of biological warfare, concocted during genetic engineering experiments conducted at Fort Detrick, Maryland, or at Atlanta's Centers for Disease Control and Prevention. A cartoon printed in *Pravda* in late 1986 depicted AIDS as "a terrible disease ... created in the laboratories of the Pentagon." (Williams, 1995) Before using this new weapon, according to the official view, the U.S. government first had to test it, using vulnerable groups such as drug users and homosexuals as its guinea pigs, which explained the high HIV prevalence among these groups (Powell, 2000).

2.5 On August 25, 1987, the Soviet legislature issued a decree "Concerning measures to prevent infection with the AIDS virus" that stipulated mandatory HIV testing of 15 population groups, including: all donors of blood, blood plasma, and other biological fluids and tissues; all Soviet citizens returning from international business trips that had lasted over one month; members of "high-risk groups," defined as recipients of multiple blood transfusions, drug users, gay men, and prostitutes; Soviet citizens who had contact with HIV-infected persons; and foreigners in the Soviet Union on long-term study, business, or diplomatic visits. The 1987 legislation also called for expulsion of non-Soviet citizens who refused to be tested, 8-year prison terms for anyone knowingly infecting others with HIV, and extensive national measures and international cooperation to combat the virus (Savchenko, 1999; Williams, 1995; Powell, 2000).

2.6 The Soviet authorities initially assigned institutional responsibility for HIV and AIDS to the sexually transmitted infection (STI) network of the health care system. At that time, testing for STIs was mandatory and treatment was coercive, but free. In early 1987 the Ministry of Health (MOH) attempted to develop a network of diagnostic laboratories to screen blood donors and conduct HIV tests, but the effort was constrained by resource shortages. In 1987 and 1988, a computer system for the registration and analysis of all HIV testing activities was established, and in the following year a centralized system of AIDS Centers and diagnostic laboratories was created. In the late 1980s, dispensaries, blood laboratories, research institutes, inpatient facilities, and staff were ostensibly reallocated to HIV and AIDS patients, but in reality the still-limited demand for services outstripped the supply.

2.7 Soviet commentary at the time admitted to significant infrastructure problems in the STI network: wide regional variation in the number and quality of STI facilities, inadequate methods for screening and treatment, and poor contact tracing (Williams, 1995). Ignorance and apprehension emerged in parallel with the spread of HIV in the late 1980s. Most physicians refused to treat HIV-positive patients in the epidemic's early years (Powell, 2000). Through the late 1980s, HIV/AIDS patients were isolated in special wards and forbidden to leave hospitals. As of 1989, 1,420 physicians had been trained in laboratory diagnosis of HIV/AIDS, and 1,600 in its clinical treatment. By late 1991, just

before it disintegrated, the Soviet Union had 1,015 HIV diagnostic laboratories, 110 prevention centers (of which 80 were in Russia), and 200 special consulting centers for anonymous blood testing (Williams, 1995).

2.8 The first Russian HIV/AIDS NGOs emerged in 1987-1988: the “Association for the Struggle Against AIDS” and “Ogonyok – AntiAIDS.” Immediately they began to provide medical and social assistance to Russian citizens affected by the epidemic, and “Ogonyok-AntiAIDS” continues to work with the families of the children infected in Elista (Savchenko, 1999).

2.9 Neither the Bank nor other donors were engaged with Russia on HIV/AIDS during the Soviet era.

3. AIDS in Post-Soviet Russia (1991-2003)

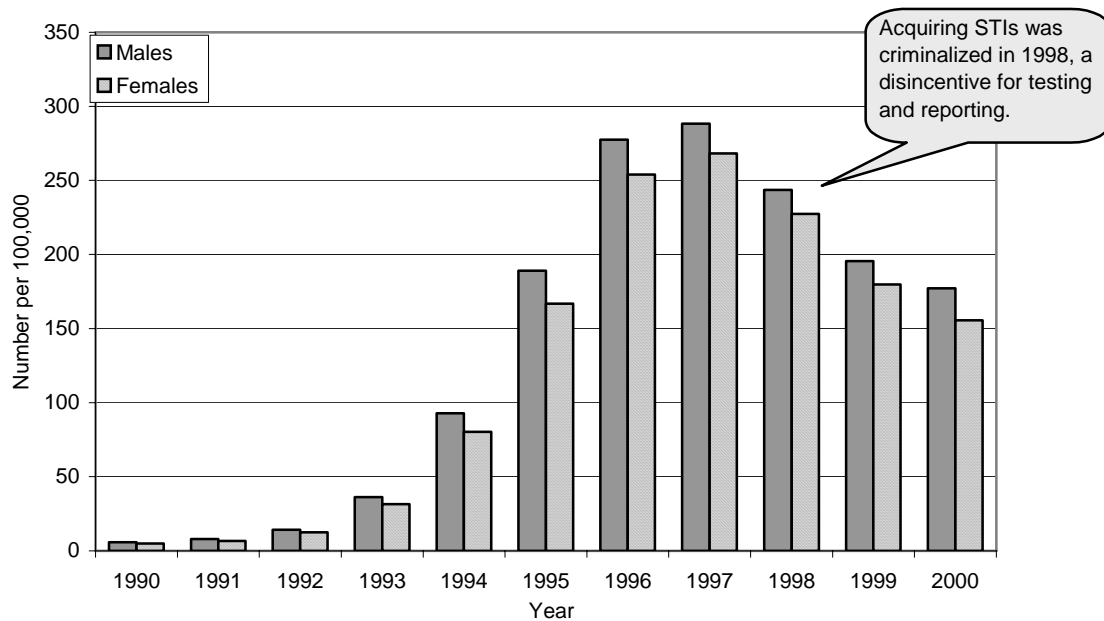
Political and Social Context

3.1 A wide variety of socioeconomic factors have contributed to Russia’s HIV epidemic. Throughout the 1990s, Russia and the other post-Soviet states experienced a prolonged economic crisis with severe social consequences that is without historical parallel. The rapidity and severity of the changes wrought by the transformation left most Russians with few adjustment strategies (Twigg, 2002). For some, family and community ties have served as coping mechanisms. Others, particularly those in the younger generations, have developed the capacity to survive or even thrive under the new economic and social rules. But many people remain alienated and fatalistic. Poverty and social alienation have affected vulnerable groups particularly severely: women, families with children, unmarried mothers, pensioners, the unemployed, and the disabled.

3.2 Health conditions in general have deteriorated (Feshbach, 2003; Field, 2000). Formerly controlled infectious diseases — cholera, diphtheria, and others — have re-emerged due to breakdowns in vaccination regimens and public works systems. Access to basic health services has declined, as more and more people are required to pay out-of-pocket for medical attention constitutionally guaranteed to be free of charge. Mortality, particularly among working-age men, has increased dramatically, driven primarily by cardiovascular disease and “external causes” — industrial and other accidents, suicide, and homicide. Increased alcohol consumption and binge drinking are among the fundamental drivers of this excess death. Life expectancy has decreased at a magnitude unprecedented for an industrial society not at war, from 69 to 1990 to 65 in 2002. Among men, life expectancy fell from 64 in 1990 to 58 in 2002. As a result, Russia’s population has been declining at a rate of about 750,000 people per year.

3.3 Following the break-up of the Soviet Union, Russia experienced a sharp increase in rates of non-HIV sexually transmitted infections. Syphilis rates rose from 4.2 to 144.1 per 100,000 population from 1987 to 2002 (see Figure 3.1), down from a peak of 277.6 in 1997, and there have been similar increases in gonorrhea, chlamydia, and trichomonas. Moreover, syphilis cases are under-reported (Vinokur et al., 2001), particularly since 1998 when a change in federal legislation required those contracting an STI or HIV through “socially aberrant behavior” (i.e., IDU or prostitution) to seek treatment through the penal system rather than in a medical institution. The recent stabilization in reported cases of syphilis may be due to under-reporting,¹ as those seeking treatment increasingly consult the unregulated, illegal private sector rather than state clinics (Hamers and Downs, 2003; Riedner et al., 2000; Dehne, 1999).

Figure 3.1: Syphilis Incidence Increased Sharply in Post-Soviet Russia



3.4 Russia and the other former Soviet states may represent a unique situation, where socioeconomic collapse and the deterioration of the health care system are occurring simultaneously with changes in social norms and moral values among many population groups (Atlani et al., 2000).² For many people, engaging in risk behaviors such as injecting drug use is an “escape” from the pressures of family disruption or socioeconomic instability and chaos. For others, a complicated psychological pattern has emerged in which society’s ideological shift — from collectivism to individualism and consumerism — has resulted in a marked collateral propensity for individual risk-taking (MAP, 1998). Other vulnerable populations include those that engage in risk behaviors as a means of survival, primarily commercial sex workers who may also use injecting drugs. Specific hypothesized

1. The increase is largely due to reductions in numbers of cases reported in urban areas, while those in rural areas continue to climb.

2. These environmental factors may play an equally powerful role in stifling the potential efficacy of interventions to prevent the spread of the virus (Rhodes et al., 1999).

linkages between rapid socioeconomic disruption and individual vulnerability to HIV are in Annex C.

Health Systems Context

3.5 The MOH is the cabinet-level department responsible for central health policy formulation and administration of the state-owned system of medical research, education, and health care. Other ministries — defense, interior, transportation, and more than 15 others — run parallel networks of health care for their employees. Large private enterprises may also house and subsidize health care providers. In recent years a small but growing network of private health providers, primarily at the outpatient level, has evolved. The vast majority of Russians, however, still receives health care through the MOH system, guaranteed by Article 41 of the Constitution to provide care that is universally accessible and free of charge.

3.6 In 1993, the legislature passed a law on local self-governance that devolved considerable authority and responsibility in many sectors of public life to the country's 89 regions (oblasts, krais, and other territories). Since then, a substantial degree of variation has emerged between regions; it would not be an exaggeration to describe Russia as containing 89 distinctly different systems of health care. Some still strongly resemble the Soviet-era, single-payer, single-provider system; others have developed impressive mechanisms for competition between providers through public/private health insurance. Although a 1993 federal law mandated a universal system of compulsory medical insurance, the regions vary in the extent to which current practice aligns with that law, and more broadly to which they mandate and implement publicly funded health and social entitlements (Twigg, 1998, 2002).

3.7 Russia has more than 12,000 state-owned hospitals, 21,000 outpatient establishments, and 3,000 emergency medical stations. First contact care is provided by municipal-level polyclinics, with polyclinic therapists assigned catchment areas based on place of employment or geographic residence. Although Russian citizens ostensibly enjoy the freedom to choose their therapists, in practice the vast majority seek care from the physician and clinic to which they are assigned within their neighborhoods. Secondary or tertiary care is by referral from the polyclinic, with patients adhering to a vertically organized system of local and regional general and specialized hospitals.

3.8 A combination of scarce and wasted resources results in a gross mismatch between the amount and quality of health care promised by Article 41 and the system's capacity to provide that care free of charge. Public spending on health care in Russia has totaled between 2 and 3 percent of GDP over the past decade. Inefficiencies created by incentives that lead to high use of specialists, long hospitalizations, and duplication of effort and services also constrain the health system. Patients routinely pay out of pocket for medical services. Side payments, both freely expressed on posted price lists and quietly passed under the table, are the norm in polyclinics. These payments may be expected for routine access to basic services, or they may buy the patient more comfortable surroundings, newer or more effective drugs, or diagnosis and/or treatment with more modern and sophisticated equipment.

3.9 Over the past two years, President Putin has placed in motion legislative and other initiatives designed to correct the health care system's perverse incentives and return some degree of order to the system at a federal level. These include attempts to bring all 89 regions' organizational, legal, and financial infrastructures for health in concordance with federal law, to improve and specify more comprehensively the financial flows and incentives inherent in the compulsory medical insurance system, and to construct a precise definition and set of funding requirements for the products and services that must be offered free of charge to all Russian citizens. To date, however, progress has been sluggish, primarily because health and health care remain a relatively low priority on the national agenda.

Accelerated Spread of HIV

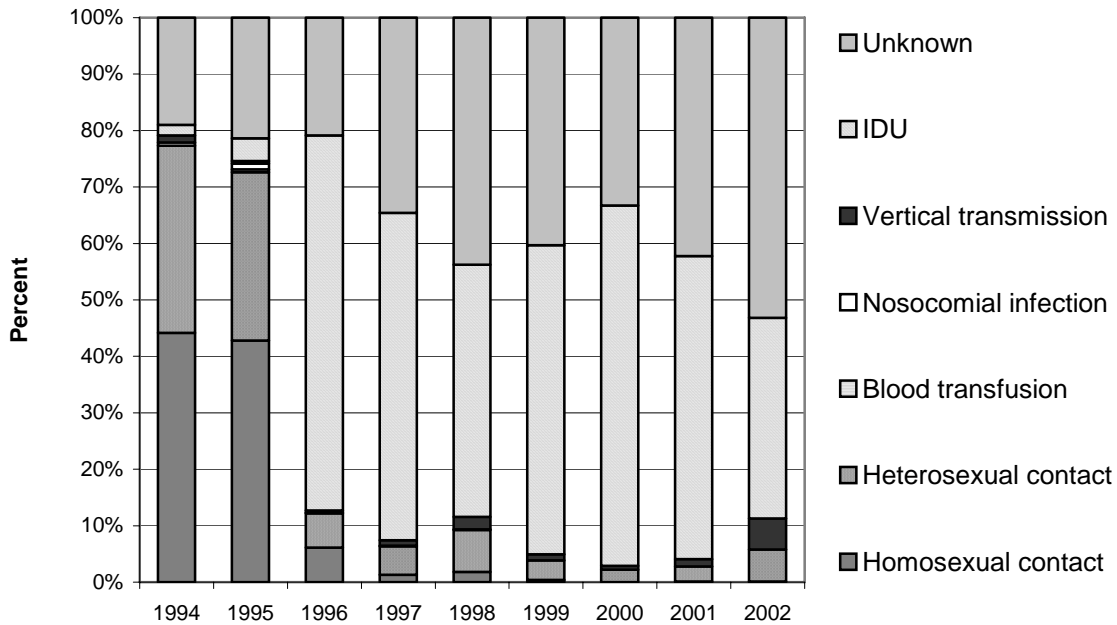
3.10 Russia's HIV surveillance system is based on systematic testing of large population groups, missing infections in smaller high-risk groups where they are most likely to occur (see Box 3.1). Official data on incidence and prevalence are therefore widely acknowledged to be understated by a factor of three to ten. With these caveats, HIV remained relatively rare until 1996. Prior to 1994, no HIV cases were detected among IDU. From 1994-1996, the share of new HIV cases attributed to IDU increased from zero to 66 percent (Figure 3.2); studies that include the military and prison populations suggest that 74-90 percent of HIV cases could be attributed to IDU (Rhodes et al., 1999). The share attributable to homosexual contact during this period declined from 44 to 6 percent, and to 2 percent by 1998 (Vinokur et al., 2001).

Box 3.1: Russia's Approach to HIV Surveillance

The Soviet government launched mandatory HIV screening and contact tracing of 15 population groups in 1987. This system offers the advantage of a well-organized reporting mechanism from the regional level to the federal and, while underestimating the total number of HIV cases, it has been "sufficiently uniform and stable in recent years for case reporting trends to at least roughly reflect the pace of spread and the geographic diffusion of the epidemic" (Dehne et al., 2000). However, 90 percent of those tested are from categories of the population that are the least likely to be infected with HIV — blood donors and recipients, pregnant women, and other low-risk groups (Vinokur et al., 2001). Only 10 percent of all tests are performed on groups most likely to contract and spread HIV, like STI patients, prison inmates, IDU, sex workers, MSM, contacts of persons with HIV/AIDS, and others, although this percentage has risen slightly in recent years. (Ainsworth, 1998). Furthermore, the program reports the names of those who test positive to a central registry, which likely inhibits voluntary counseling and testing, given the high level of stigmatization of HIV/AIDS, homophobia, prejudice against drug users, and the limited availability of HIV treatments (Kalichman et al, 2000).

The HIV surveillance system is also expensive and inefficient, producing little public health benefit and diverting resources from preventive efforts that could have greater impact. Between 1987 and 1992, over \$15 million was spent on more than 24 million tests, detecting only 85 positive results, while only \$3 million was spent on HIV prevention and education (Danziger, 1996). At the beginning of 1994, about 70 percent of all medical personnel working in AIDS Centers were engaged in serology diagnostics, 10 percent in medical care, 10 percent in administration, 5 percent in research, and only 5 percent in health promotion (Pokrovsky and Frolova, 1994, abstract).

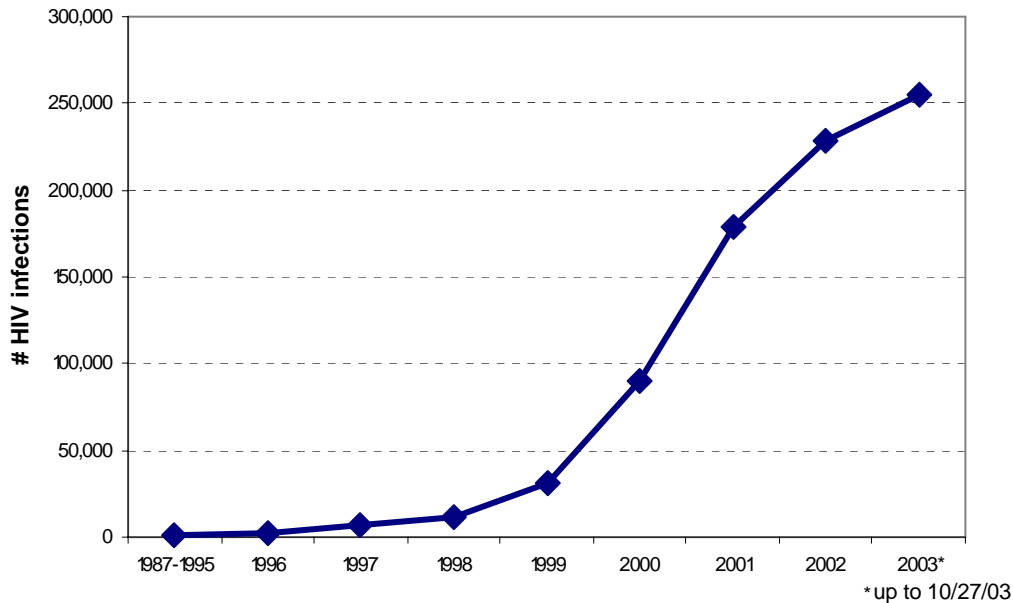
Since 1999, sentinel surveillance of HIV infection at sites or in groups with high-risk behavior — the international standard that is more cost-effective in tracking trends — has been slowly adopted in some parts of the country, in particular among IDU, prisoners, and STI patients. However, it is not yet part of the federal HIV/AIDS guidelines and systematic surveillance of behaviors in the population has not been adopted (Grund, 2002; WHO, 2001; Pisani et al., 2003).

Figure 3.2: Share of New Infections by Transmission Factor, 1994-2002

3.11 Beginning in 1996, the transmission of HIV cases among IDU accelerated against a backdrop of skyrocketing increases in injecting drug use and decreasing average age of first injection that began in the early 1990s (Kramer, 2003). Kaliningrad was the first city to report a rapid escalation of cases, followed in 1996 and 1997 by Krasnodar, Nizhny Novgorod, Rostov on Don, Saratov, Tula, Tyumen, and Tver (Pokrovsky et al., 1998, abstract). Moscow and St. Petersburg joined the list in 1999. HIV is spread among IDU due to needle sharing and practices related to the distribution and consumption of drugs (see Annex C).

3.12 Reported HIV infections rose dramatically in 1997-98 and accelerated in the years that followed (Figure 3.3).³ As of October 2003, there were 255,350 officially reported cases of HIV since the beginning of the epidemic. Of those, 817 have developed AIDS and 4,065 have died of AIDS-related causes. The relatively low numbers of reported AIDS cases and AIDS deaths reflect the long AIDS incubation period and the possibility that medical equipment and expertise, particularly in Russia's outlying regions, is not sufficient for accurate diagnosis of AIDS. In addition, Russian health authorities have traditionally considered HIV reporting to be more important than AIDS reporting (Hamers and Downs, 2003).

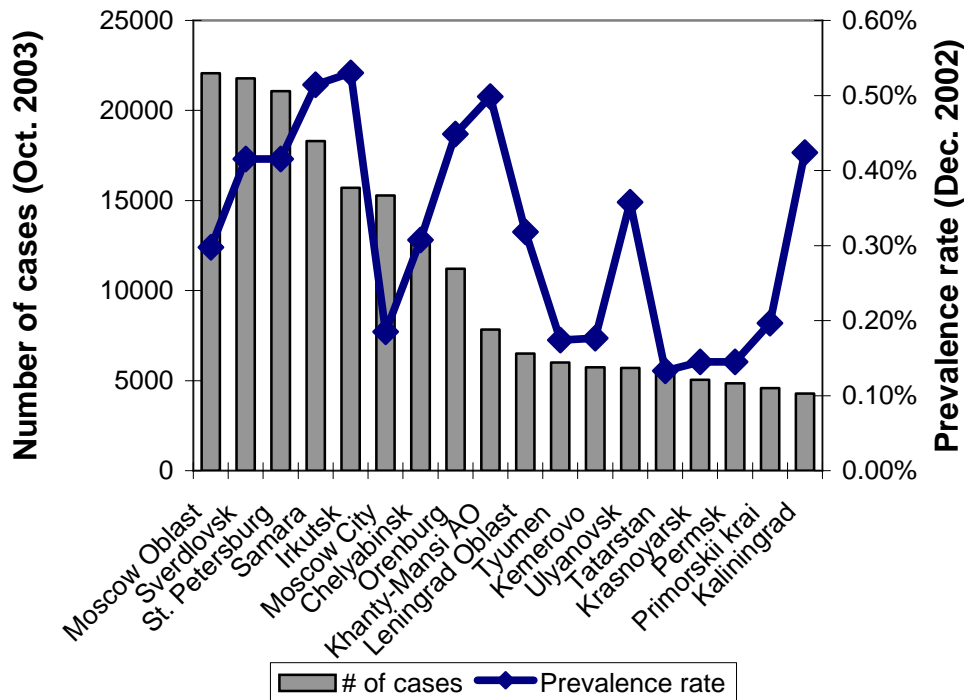
3. The number of reported new infections among IDU declined in 1998. This may have been due to the law requiring IDU to report for treatment to the criminal justice system, discouraging testing and increasing under-reporting. An alternative possibility is that the epidemic had reached a saturation point in the highest prevalence cities, where a significant majority of potentially HIV-infected IDU had already contracted the virus (Dehne, 1999).

Figure 3.3: Rapid Increase in Cumulative HIV Infections, 1987-2003

3.13 HIV has spread to all 89 regions (Annex D); only eight regions, however, account for over half of cumulative reported infections (Figure 3.4). One hypothesis for this pattern is that HIV has spread most rapidly in the economically more prosperous and industrially more developed regions because these markets are targeted by drug dealers (Sokolova et al, 2002, abstract).

3.14 Reliable data on risk behaviors and indicators on HIV prevention, including condom availability, condom use rates, STI incidence and prevalence, sexual mixing patterns, IDU behaviors, and general knowledge of HIV prevention practices, are sparse (Kalichman et al., 2000). The only nationally representative survey (n=5825), conducted in 2001, reveals that one third of 14–20 year olds are sexually active, with the age of first sexual experience having declined in recent years. Fewer than half of sexually active 14–20 year old respondents used a condom during their last sexual encounter (Vannappagari and Ryder, 2002). The relatively few published epidemiological and behavioral studies involving high-risk groups are highly geographically localized and involve either small or unreported sample sizes. Much can be discerned about HIV spread and the sources of vulnerability, however, through a review of the available literature on specific risk groups, transmission vectors, and contextual factors affecting the spread of HIV (see Annex C).

Figure 3.4: Cumulative HIV Cases by Region and Cumulative Prevalence Rate



Source: www.hivrussia.org, website of the Canada-Russia AIDS project.

Government Policy Response

HIV/AIDS-related Legislation

3.15 During the Soviet period, there was no overarching national program to coordinate activity related to HIV/AIDS. In 1993, the Russian government developed the “Federal Program for the Prevention of the Spread of AIDS in the Russian Federation from 1993-1995.” This program provided for: the introduction of a system of HIV/AIDS prevention; improvement in the capacity to diagnose, treat, and follow-up HIV/AIDS patients; a system of social support and legal protection for HIV-infected persons; improvement in epidemiological surveillance for HIV and AIDS; an increase in the scientific resources devoted to HIV/AIDS; and dissemination of AIDS information and educational materials both to the general public and to medical personnel (Williams, 1995). In practice, this program was overwhelmingly oriented toward a medical approach that stressed epidemiology and the biomedical sciences over prevention, education, social services, and legal support. The 1993 budget program was renewed in 1996 (the second Federal Program), and again in 2002 (the third Federal Program, adopted for 2002-2007). This program provides for the extensive vertically organized system of federal, regional, and local AIDS Centers, all run under the auspices of the MOH.

3.16 In August 1995, the Russian legislature passed a Federal Anti-AIDS law, which provides current federal guidelines for HIV/AIDS prevention, care, and support. It brought almost all activity relating to HIV/AIDS under the authority and supervision of the federal government. This legislation calls on the government for provision of public information about the status of the HIV epidemic, production and availability of

prevention and treatment resources, and availability of HIV testing including anonymous testing accompanied by pre- and post-test counseling. All government assistance to HIV-infected persons, including medical care and social support to them and their families, is guaranteed by the law to be free of charge. The law also protects the human rights of people living with HIV and AIDS (Savchenko, 1999). However, the law set no spending or programmatic priorities.

3.17 The 1998 Federal Law on Narcotic and Psychoactive Substances, an attempt to bring the IDU problem under control, states that all drug consumption, outside that prescribed by physicians, is illegal. It prohibits substitution therapy of opiate addiction with methadone, and its provisions could easily be interpreted as defining needle or syringe exchange programs as illegal abettors of drug use. The law defines as punishable by incarceration the possession of even miniscule amounts of heroin and some other drugs, leaving many IDU fearful of carrying used injection equipment that might contain even traces of drug solution.⁴ Needle exchange operations in Yaroslavl and St. Petersburg reported increased police harassment soon after President Yeltsin signed the legislation (Grund, 2002). This phenomenon is exacerbated by the occasional location of fixed-site exchange points within local narcology clinics; there is virtually always a police presence at the clinics, since police routinely refer suspected drug users there for testing or registration (Rhodes et al., 2003).

3.18 Criminal law related to sex workers does not prohibit a woman or man from exchanging sex for money or other valuables, instead focusing on protecting women and children from being involuntarily forced into sex work. However, article 164(2) of the Soviet Administrative Code, enacted in 1987, punishes prostitution with a warning or a fine in an amount up to one minimum monthly wage. Prostitution is therefore technically illegal, but the minimal penalties make it comparable to a traffic offense (Mariner, 2000). In practice, the low likelihood of punishment coupled with the small fines provides little legal incentive not to engage in sex work.⁵ The 1997 Criminal Code prohibits the organization or keeping of a den or brothel for prostitution, with penalties applied to the owners or administrators of the business, not to the sex workers themselves. The technicalities of the law limit its application to brothels that have fixed physical premises, thereby creating incentives for movement of sex workers that make it difficult to establish an ongoing and consistent relationship with social and health services.

3.19 Key Soviet and Russian legislation related to HIV/AIDS is summarized in Table 3.1.

4. In late 2003, The Duma passed legislation that would make possession of up to ten times the "average single dose" of an illegal substance an "administrative infraction" punishable by a small fine. The date on which that new law will take effect, however, has been delayed while government agencies argue over what precisely constitutes an "average single dose."

5. Only about five cases per year are brought against Moscow sex workers, all female.

Table 3.1: Chronology of Soviet and Russian HIV/AIDS-related legislation

Year	Legislation
1987	Soviet decree <i>Concerning Measures To Prevent Infection with the AIDS Virus</i> : stipulates mandatory HIV testing of 15 population groups, prison terms for anyone knowingly infecting others with HIV, and extensive national measures and international cooperation to combat the virus.
1987	Soviet <i>Administrative Code</i> : punishes commercial sex work with a warning or small fine. Establishes negligible legal deterrent to engaging in sex work.
1992	Russian Constitution: Article 41 stipulates that health care free of charge is a basic right of all Russian citizens.
1993	<i>Law on Self Governance</i> : devolves enormous amount of power and authority to Russia's 89 regions in most spheres of public life, including health care.
1993	<i>Law on Compulsory Medical Insurance</i> : establishes a nation-wide system of mandatory, employer-funded health coverage.
1995	<i>Federal Anti-AIDS Law</i> : brings virtually all HIV/AIDS activity in the country under federal jurisdiction; guarantees medical and social support free of charge to HIV-infected persons; protects the human rights of people living with HIV/AIDS.
1997	<i>Criminal Code</i> : prohibits the organization or keeping of a den or brothel for commercial sex work, with penalties applied to the owners or administrators of the business, not to the sex workers themselves.
1998	<i>Administrative Code</i> : amendment requires that people contracting an STI or HIV through "socially aberrant behavior" (i.e., IDU or prostitution) are provided with treatment through the penal system rather than in a medical institution.
1998	<i>Law on Narcotic and Addictive Substances</i> : all drug consumption outside that prescribed by a physician is illegal. Prohibits substitution therapy of opiate addiction with methadone. Has frequently been interpreted as defining needle or syringe exchange programs as illegal abettors of drug abuse.
2003	Amendment to the <i>Criminal Code</i> : frees from criminal liability a person who puts a partner at risk for HIV infection, provided that the partner is informed of the risk and consented to engage in the activities that create the risk.

Public Sector AIDS Institutions and Programs for Specific Groups

3.20 After Russia became independent in late 1991, the MOH was divided into preventive (the State Committee for Sanitary and Epidemiological Surveillance) and curative (the MOH of the Russian Federation) branches. Since then, separate structures for anti-AIDS work have co-existed in these two branches, although most action has occurred in the MOH branch.

3.21 At the federal level, the main HIV/AIDS institution is the Russian Federal Scientific and Methodological Center for AIDS Prevention in Moscow, attached to the MOH and headed by Vadim Pokrovsky. It is responsible for epidemiological surveillance, diagnostics, clinical treatment, and scientific research. It collects, collates, and publishes epidemiological data from 86 Regional AIDS Centers (oblast-level) and 6 Territorial AIDS Centers,⁶ including data on incidence and prevalence, transmission routes, and public knowledge and attitudes toward HIV and AIDS (Vinokur et al., 2001). The Regional AIDS Centers handle HIV screening, epidemiological investigation of HIV cases, and safety of medical procedures and the blood supply. They also train health care workers and, to varying degrees, are involved in HIV education and prevention work with the public. The

6. The six territorial centers, in St. Petersburg, Omsk, Yekaterinburg, Nizhny Novgorod, Rostov-on-Don, and Khabarovsk, conduct scientific research and analysis but provide no treatment.

Regional Centers are also the primary focal points for access to government HIV/AIDS services. They include more than 1,000 screening laboratories and 500 offices for anonymous testing; it is to them that individuals are referred after testing HIV positive elsewhere (Vinokur et al., 2001). They can provide a full array of medical services to HIV/AIDS patients, including dental care. For more complicated diagnostic and treatment services, patients are referred to central hospitals in Moscow and St. Petersburg. Hospice or rest home services for people with AIDS are currently virtually unavailable.

3.22 In addition, St. Petersburg is home to the Federal Clinical Center on AIDS Prevention, whose purpose is to provide treatment to HIV/AIDS patients from across the country. Until very recently, the MOH did not have a department specifically devoted to HIV/AIDS, and the department that deals with infectious disease was only recently given a portfolio to include work on HIV/AIDS. Even now, however, the MOH has only three staff members working on HIV.

3.23 Several government ministries other than health play a significant role in the battle against HIV/AIDS. The Ministry of Justice (MOJ) has jurisdiction over the penitentiary system,⁷ the law enforcement community, and the legality of harm reduction practices and appropriate treatment for IDU. The first prison facilities specifically for HIV-infected inmates were opened in Kaliningrad and Irkutsk oblasts in 1999 and 2000, two of the regions affected earliest in the epidemic. The Ministry of Education (MOE) is relevant due to the declining age of IDU populations and of sexual activity. Formal sex education in the schools remains controversial within the MOE. Although sex education does take place on an *ad hoc* basis, its quantity and quality are generally considered to be far from adequate, with the vast majority of students receives information on sexual health from peers rather than from teachers, health workers, or parents.

3.24 The Soviet Union bequeathed to Russia a tradition of horizontal separation of government agencies from one another, both geographically and institutionally. The Russian health care system is governed by a large and intricate organization chart whose branches tend to work in isolation. With health care budgets, never large, in steady decline in recent years, the country's health agencies (even within a single ministry) have increasingly competed with one another for resources, even when they are responsible for similar or identical areas. The practice of inter-agency cooperation, particularly that involving multidisciplinary teams with participants from different departments, remains underdeveloped (Burrows et al., 1999). On May 26, 2003, the MOH formed a Consultative Council on the Problem of HIV/AIDS, which includes representatives from several federal government agencies (MOH, MOJ, MOE, Ministries of Internal Affairs, Economic Development, Labor, and Defense, and the State Agency for Sanitary and Epidemiological Surveillance), regional AIDS Centers, and Moscow-based and regional NGOs (including people living with HIV and AIDS). On June 9, 2003, the MOH similarly formed a Coordinating Council that will focus on mother-to-child transmission.

3.25 The government's response to the IDU-driven acceleration of the HIV epidemic has been limited. Harm-reduction programs are rarely sponsored by the federal government; they are more often administered by regional or municipal governments,

7. Authority for prisons was shifted from the Ministry of the Interior in October of 1998.

funded by international donors. The first needle exchange center opened in Kaliningrad in July 1998, run by the oblast Center for Psychotherapy and a local foundation working against AIDS and drug addiction. Private clinics are banned from treating drug users who have agreed to receive treatment rather than face incarceration; only health care organizations licensed by the state can provide drug treatment and counseling services (Sergeyev et al., 1999). After the passage of the 1998 law, some physicians hesitated to teach addicts how to take drugs safely, for fear of prosecution, although others have reported that this did not present a legal challenge to their work (Clarke, 1996; Mariner, 2001). In essence, at least in some cases, the law severely restricts the ability of health professionals to work with drug users. MOH and MOJ officials at the federal and regional levels have discussed the legality of needle and syringe exchange and other harm-reduction measures, with inconclusive results (Burrows et al., 1999).

3.26 Screening procedures for the blood supply have remained effective, although numerous reports have called attention to the risk of blood donations from IDU⁸ (Hamers and Downs, 2003). In 1995, Moscow's public health director centralized blood supply to hospitals in a network of city blood-transfusion stations, in order to combat growth in underground trafficking in donor blood that was putting local supplies at risk for HIV (Powell, 2000).

3.27 As of late 2002, about 500 AIDS patients, mostly in the Moscow region, were being treated with antiretroviral therapy (Mainville, 2002). The standard treatment protocol for HIV approved by the MOH is monitoring only for the first four years after the discovery of infection, followed by two-drug therapy (AZT/3TC), rather than the triple-drug therapy that is the standard of care in the West. According to evaluation respondents, in reality, most patients do not receive even the prescribed two drugs. The government is currently paying \$4200-\$9000 per year for antiretroviral therapy, compared to some regimens available elsewhere in the world for \$850 annually for middle-income countries (Walgate, 2002). AZT is the only antiretroviral drug produced by Russia's pharmaceutical industry (Vinokur et al., 2001). Federal law bans HIV treatment for active drug users, closing off that option to the vast majority of HIV-infected Russians.

Trends in Public Expenditure

3.28 Real public spending on health has declined to as little as 30 percent of pre-transition levels, and much of the burden for payment for health services has shifted to individuals and families (Twigg, 2000). Government health workers have suffered from late or non-payment of declining real wages. Capital investment in government-owned health facilities has been slashed. Counterfeit and placebo drugs now comprise as much as 15 percent of the domestic pharmaceuticals market, with some estimates even higher (Rosen, 2001; McDonald, 2000).

3.29 Government spending on HIV/AIDS flows through many uncoordinated channels. There is no mechanism, individual, or institution inside or outside the government at any level that has assumed or been assigned responsibility to collect and

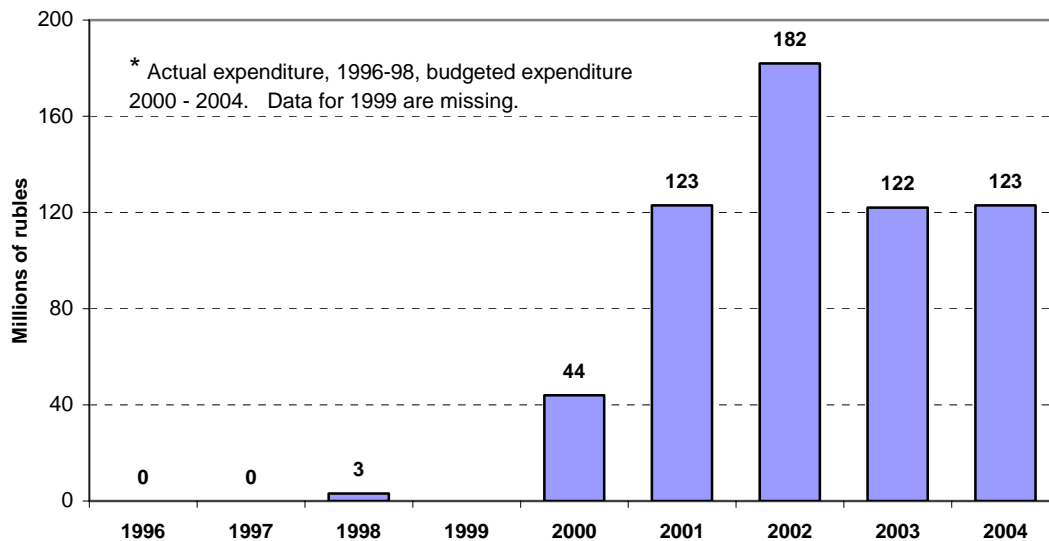
8. Blood donors are paid in Russia.

collate HIV/AIDS-related spending data, let alone coordinating the allocation and distribution of resources across institutions. Still, a few observations are possible.

3.30 The original budget for the Federal Anti-AIDS Program was 12.42 billion rubles, or \$20.35 million, for 1993-95. Over those three years, the program was funded at 42 percent of its authorized budget levels (Savchenko, 1999).⁹ The third Federal Program promises \$252 million over six years (2002-2007), roughly six times that allocated for 1996-2000, but less than one-tenth of the annual average of roughly \$40 million/year has actually been allocated over the program's first two years.

3.31 A compilation of Western and Russian press accounts reveals spending for the Federal Anti-AIDS Program over the last seven years as shown in Figure 3.5. The figures are not total federal spending on HIV/AIDS, but only that portion explicitly allocated to the earmarked Federal Anti-AIDS Program. The 2002-2007 Federal Program on HIV/AIDS includes 10 million rubles for the establishment of HIV prevention centers in schools, and 9 million rubles for training teachers and other school personnel in HIV prevention.¹⁰

Figure 3.5: Allocations* for Federal Anti-AIDS Program, 1996-2004



3.32 Of the 2003 budget, about 60 percent is allocated to medications for treatment (including ARV drugs and drugs to treat opportunistic infections and STI co-infection), 25 percent on testing, and the remainder on laboratory equipment, prevention, education, and other activities. The MOH has been criticized by international donors, domestic NGOs, and some within the domestic public health sector for spending the bulk of its resources on treatment and testing rather than prevention.

9. Throughout the mid-1990s, annual allocations in many federal budget categories were routinely sequestered and never disbursed.

10. It is difficult to assign dollar values to these multi-year programs because of exchange rate fluctuations. The mid-2002 exchange rate was about 31.5 rubles/dollar; it is currently 28.5 rubles/dollar.

3.33 The MOH budget also contains allocations outside the formal Federal AIDS program for the Federal AIDS Hospital in St. Petersburg, which pays for staff salaries, communal services, and some additional drugs. In some budget years, it also allocates resources to purchase test kits. Significant other spending is in other federal ministry budgets, particularly for scientific research, and in regional and local government spending. Many regional agencies have specific HIV-related programs or line items, and in some cases local AIDS centers are funded in part from regional health budgets. The low levels of funding for HIV/AIDS have left many of the regional anti-AIDS centers starved for resources. Funds for medications and equipment are often scarce, buildings are crumbling, and salaries of health workers are low and often paid late.

3.34 In total, about 500 million rubles (\$23 million) per year is spent on HIV/AIDS at the regional or local level, and 250 million (\$12 million) more at the federal level (for the Federal AIDS Program, other health ministry spending, and non-health ministry federal spending), meaning that about 750 million rubles (\$35 million, or 24 cents/capita) at all levels per year is devoted to HIV/AIDS at a time when high world oil prices have given the Russian treasury a reserve of over \$7 billion. There is no formal assessment of the degree to which spending corresponds to programmatic priorities. The lack of budget clarity has made it possible for scarce HIV/AIDS funds to be routinely diverted and misused, a fact confirmed by the government's Audit Chamber in a June 2001 report (Radio Free Europe/Radio Liberty Daily Report, 2001).

Political Commitment

3.35 To the present day, the highest levels of the Russian government have remained virtually silent about HIV/AIDS. For several years, a relatively small number of officials from the Russian HIV/AIDS community and the health ministry have criticized the government for failing to act to slow the rise of new HIV infections in the country. The health minister himself has been slow to comprehend the scope of Russia's potential HIV/AIDS problem. In early 2001, for example, he recommended a policy of a healthy way of life and harsh actions by law enforcement agencies, rather than substitution therapy and harm reduction programs, in order to curb the spread of IDU and HIV.

3.36 President Putin, who has been widely criticized by the Russian and international AIDS communities for his years of silence and inaction, first mentioned the epidemic in public only in the spring of 2003, when it received a passing mention in his annual address to the parliament:

During the last several years the mortality of the population has been increasing. It has grown 10 percent during the last three years. At the same time life expectancy has been decreasing. Sad statistics — from 67 years in 1999, to 64 in 2002. Among the reasons: the high level of diseases, and mortality from accidents, poisonings, and trauma. The situation has been aggravated by the spread of the so-called “new” epidemics, including drug abuse and AIDS (State of the Nation address, May 16, 2003).

3.37 Since then, the issue has not achieved higher status on Putin's agenda; in a three-hour news conference held in early August 2003, not a single question or comment dealt with HIV.

3.38 Some social and political factors resulting from the post-Soviet transition have created a supportive context for preventing and treating HIV and AIDS. For example, there is greater access to information on virtually all topics, including HIV and AIDS. The evolution of a community of nongovernmental organizations (NGOs) has both benefited from and contributed to this increase in information. And there is undeniably a movement toward greater tolerance for a variety of lifestyles and sexual orientations (Kon, 2000; Sperling, 2000).

3.39 At the same time, other forces have contributed to the government's reluctance to confront its HIV/AIDS situation. Russia faces so many other problems that appear to be more urgent — economic reform, the civil war in Chechnya, infrastructural decay — that HIV is not perceived to be an immediate threat to the general public. The government may also hesitate to identify as a top priority a problem for which the solution will most certainly prove to be expensive and intractable. Furthermore, discussions of HIV/AIDS would force top government officials to become vocal about issues — drug use, prostitution, homosexuality — that many Russians still consider culturally improper topics for public discussion. The government may also fear that discussion of AIDS might deter badly needed foreign investment and lead to regulation restricting the movement of Russians within Europe (Walsh, 2002).

3.40 Putin and his predecessors have been willing, however, to support the international battle against AIDS. Cooperation in health care, with a focus on AIDS and TB, was consistently on the agenda of the Russian-U.S. Commission on Economic and Technical Cooperation, also called the Gore-Chernomyrdin Commission, during the Clinton and Yeltsin administrations of the middle and late 1990s. In May 2001, Putin sent a letter to U.S. President George W. Bush expressing support for international efforts to combat AIDS and other infectious diseases, a position that was confirmed in the two presidents' joint statement following their May 2002 summit. The 2001 letter also called for the consolidation of international efforts to fight and find a cure for AIDS through the United Nations and the G-8 group of advanced industrialized countries. In July 2001, Putin signed off on Russia's support for the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), pledging US\$20 million. Many Russian commentators find irony in this commitment to international efforts when the domestic situation remains grave and resource-starved.

Response of NGOs and Civil Society

3.41 Private organizations (NGOs) and donor agencies have emerged to fill the gaps in government services. Other than routine licensing and registration requirements (for example, a license to perform medical diagnostic testing in general), no specific HIV/AIDS license is required for NGOs to offer services and programs (Mariner, 1999). In general, however, NGOs face an operational atmosphere that is, at best, ambivalent. Russia historically has little experience with the non-governmental sector, and in today's political climate, NGOs are frequently subject to harassment and attempts at control or

co-optation by the government. NGO registration and regulation are extremely complicated, and in the health sector, many state health facilities view NGOs as competitors rather than partners (Grund, 2002).

3.42 Currently about 300 Russian NGOs are active on HIV/AIDS, the vast majority having emerged after the Soviet collapse. Some are offshoots of Western organizations, while others are genuinely homegrown, grass-roots Russian institutions. Most are backed with international donor funding and expertise. They translate, publish, disseminate, and catalog HIV/AIDS-related information; provide treatment and social services to HIV/AIDS patients; establish and run prevention and education programs; and maintain links with experts in the West. Many provide services that state clinics do not, including psychological support and anonymous, client-friendly HIV and STI testing. They have provided outreach to some risk groups traditionally neglected by government programs, especially CSW, MSM, mobile populations (migrants, guest workers, and truck drivers), and IDU. Also, many NGOs working with HIV/AIDS in Russia are in reality very closely linked to government institutions, sharing physical sites and personnel with the government AIDS centers. This arrangement channels non-government money, including international donor funding, into programs that largely adhere to government priorities and procedures. It also permits AIDS Center personnel to supplement their otherwise meager salaries, and encourages them in some cases to experiment with innovative approaches outside the strictures of their government jobs (Burrows et al., 1999; Grund, 2002).

3.43 A political alliance of pro-life organizations, the communist party (for most of the 1990s the majority party in the legislature), and the Russian Orthodox Church has effectively opposed much of what the government has attempted in the areas of HIV education and prevention, as well as domestic and international NGO efforts. While the Church has begun to sponsor its own programs on HIV education for youth and HIV/AIDS care, these are conducted according to its own religious and philosophical principles; the Church's political activity continues to pressure the government to reject international best practices in the areas of education, prevention, and harm reduction.

3.44 In the mid-1990s, for example, this coalition won a reduction in public spending on family planning programs, the cancellation of a UNESCO project on sex education in schools, and the termination of an anti-AIDS campaign in the city of Moscow (organized by *Médecins sans frontières*, MSF). The coalition's arguments ranged from those commonly heard in the West — that public discussion of sexuality is immoral and encourages promiscuous behavior, which may then lead to drug use, violence, and pedophilia — to claims that HIV/AIDS education programs are plots by Western intelligence agencies and pharmaceutical companies aimed at depopulating Russia and jeopardizing its national security (Chervyakov and Kon, 1998; Powell, 2000). Some Russian psychiatrists and other educators have aligned themselves with these views (Torabi et al., 2000). Throughout the late 1990s, the people and institutions trying to raise voices and resources in favor of reproductive rights and sexual education were not as effectively and organized as those in the anti-education crusade.

3.45 Injecting drug use, homosexuality and bisexuality, and HIV/AIDS themselves remain highly impersonalized and stigmatized to the vast majority of the public, making

it difficult for HIV/AIDS programs to attract strong political support. Russia has not had a parallel experience, for example, to the United States, where relatively early in its epidemic a few highly popular public figures (Rock Hudson, Magic Johnson) revealed their HIV status, significantly changing public perceptions and attitudes toward HIV. There is also no effective political pressure from groups of people living with HIV/AIDS, which have been an important political force in increasing government commitment in other countries.

4. World Bank Engagement with Russia on HIV/AIDS

Early World Bank Health Efforts in Russia

4.1 The World Bank began its policy dialogue with Russia in 1991, and Russia joined the Bank in 1992. In the first few years the Bank concentrated on helping the government to build a market economy, develop a private sector, and mitigate the social costs of adjustment. By 1995, the Bank had lent Russia about \$4.6 billion, primarily investment lending that was concentrated in the oil and gas sectors. In 1996 there was a trend toward adjustment lending; from 1996 to 1998, the Bank lent Russia more than \$5 billion.

4.2 The World Bank prepared country strategies for Russia in 1997, 1999, and 2002 and a country assistance progress report in 2001.¹¹ The 1997 strategy suggested that the Bank position itself to work with Russia in the long term; focus more sharply on poverty reduction and targeted safety nets; manage the portfolio more intensely than in the past; and invest in the Bank's knowledge base on Russia. It proposed more systematic emphasis on institutional development, social protection, helping Russia to deal with the "TB/AIDS health crisis," and improving the delivery of services in health and education.

4.3 In the early years of engagement, there was no formal World Bank health sector strategy for Russia. The Bank aimed to help the country rehabilitate and reform the health sector and build an effective and efficient insurance scheme through three health-related projects in the mid-1990s:

- The **Community Social Infrastructure Project**, a \$288 million project funded by a \$200 million IBRD loan and approved in April 1996, was designed to reduce the deterioration of social infrastructure (including health facilities) and improve the efficiency of public resource management. It provided valuable lessons to the health sector on weaknesses in management and unclear governance relationships (World Bank, 1996a).
- The **Medical Equipment Project**, a \$304 million project supported by a \$270 million IBRD loan and approved in June 1996, provided medical equipment and

11. World Bank, Russia—Country Assistance Strategy, Report No. 19897, Washington, D.C. December 1, 1999; World Bank, Russia—Country Assistance Strategy, Report No. 24127, Washington, D.C. May 14, 2002; World Bank, Russia—Country Assistance Strategy: Progress Report, Report No. 19413, Washington, D.C. December 1, 1998; World Bank, Russian Federation—Country Assistance Strategy: Progress Report, Report No. 21709, Washington, D.C. January 11, 2001.

developed national health accounts in order to increase the availability and range of services provided in public health facilities and to improve cost-effectiveness in the delivery of health care. It offered an opportunity to establish a relationship with Russia in the health sector, and a chance to assist in the sector's rehabilitation. (World Bank, 1996b).

- The **Health Reform Pilot Project**, a \$98.4 million project supported by a \$66 million IBRD loan approved in June 1997, was to improve the quality and efficiency of health care and improve reproductive and cardiovascular health outcomes in two pilot regions, in a manner that would aid decisions about national adoption of health reform measures. (World Bank, 1997).

4.4 The Bank produced an internal "Health Sector Strategy Note" for the Russian Federation in September 1997.¹² The focus was on health reform. It proposed a seven-point program of action that would help the government to: revitalize the public health agenda; clarify governance; improve the financing system; update medical practices; accelerate the rationalization and integration of services; increase the autonomy and accountability of health providers; and involve stakeholders in the reform process. This program would be put in place through studies to review current programs and explore alternatives, through changes in legislation and regulation, and through investments in training, equipment, renovation of facilities, and other areas. Lending and non-lending services would be bundled to assist policy development at the federal level, implementation of the strategy at the federal and territorial levels, and donor coordination. In its aims to "revitalize the public health agenda," the strategy note anticipated attention to TB and HIV/AIDS. The strategic aim of updating medical practices also foresaw attention to helping Russia move to the best global practices for disease control.

4.5 In the meantime, worldwide attention to TB in Russia was growing, largely out of concern for MDR TB. Largely inspired by OSI, a meeting was called on this matter at the U.S. White House for Hillary Clinton, George Soros, and World Bank President James Wolfensohn, concluding that TB was a growing threat both to Russia and to the world and that the global community must put this problem high on its agenda for action and assistance. The first discussion of possible Bank assistance for TB or HIV/AIDS occurred when the Minister of Health visited Washington in 1998 and indicated that the government was very concerned about TB and would like Bank assistance in addressing it. The Bank was ready but indicated that assistance would have to be built around adoption of the directly-observed treatment, short-course (DOTS) approach to TB control, recognized as the international standard by the World Health Organization (WHO). HIV/AIDS did not enter into the discussions. The Bank's dialogue with Russia on TB was complicated from its inception because of concerns in the medical establishment about DOTS and concerns in the pharmaceutical industry about possible loss of markets.

12. The strategy was never formally issued, but it was discussed with some Russian counterparts. Neither at that time nor since has the Bank produced a strategy specifically for TB or HIV/AIDS in Russia, although in 2003 the Bank produced a strategy for HIV/AIDS for the Europe and Central Asia region.

The World Bank's Approach to HIV/AIDS in Russia

4.6 Among the first formal involvements of the Bank in HIV/AIDS in Russia was its participation in a 1998 regional conference on the socio-economic impact of HIV/AIDS, held in Kiev, Ukraine. Co-sponsored with UNAIDS and the British Council, it focused on recommendations for Russia, Belarus, Kazakhstan, and Ukraine about addressing the HIV/AIDS epidemic.¹³

4.7 The Bank began formal work with Russia on the development of a TB and HIV/AIDS Control Project in 1999, at which time the incidence of HIV/AIDS was growing dramatically and HIV was spreading rapidly among injecting drug users. The Bank's approach was premised on a number of considerations:

- The government's approach to HIV/AIDS was not consistent with international best practice and the administrative capacity for multi-sectoral action was very weak;
- The political economy of HIV/AIDS and related social issues made it difficult for the government to act in a manner consistent with the nature of the HIV/AIDS epidemic, which was spreading in groups with high-risk behavior;
- Russia was just emerging from a deep financial crisis and may not have the financial resources needed to address HIV/AIDS; and
- An important part of program implementation on HIV/AIDS in Russia should be done at the regional rather than the federal level.

4.8 From the inception of its work on HIV/AIDS in Russia, the Bank sought to help the government focus on the main drivers of the epidemic in a manner that would be effective and efficient and would raise Russia's HIV/AIDS program to the level of international best practice. The Bank also recognized that the HIV/AIDS epidemic was closely linked to explosive growth of TB and STI epidemics (see Box 4.1) and decided that it should try to develop a project that addressed TB, HIV/AIDS, and STIs together. This would have a major bearing on the opportunities and challenges for the lending operation that was under development. In addition, the fact that these epidemics were emerging in the Russian prison system meant that the Bank would need to work with both the MOH and the MOJ, posing additional challenges.

13. This workshop included a presentation of the main messages of the Bank's Policy Research Report, *Confronting AIDS: Public Priorities in a Global Epidemic* (World Bank, 1997). The book was translated into Russian and marketed in Moscow by a private firm in mid-1998. During its field visit, the evaluation team did not explicitly inquire about exposure to the Russian edition and no Russian respondent mentioned the book.

Box 4.1: The Dual Epidemics of Tuberculosis and HIV/AIDS

Many of the socioeconomic factors that have contributed to the spread of HIV — poverty, unemployment, substance abuse, and dwindling resources for public health — have also fueled Russia's TB epidemic. An estimated 26 million people, or one of every six individuals, are infected with TB. Particularly worrisome is the spread of multi-drug-resistant (MDR) TB and an increasingly high case/fatality ratio (Feshbach, 2003). TB is considered to be the most common opportunistic infection among Russian AIDS patients; HIV infection increases the risk of developing active TB from 10 percent over an entire lifetime to 10 percent annually (Kazionny et al., 2001; Reichman, 2002). Because of HIV-TB co-infection, the spread of HIV is likely to exacerbate an already severe TB epidemic.

Russia's scientific establishment traditionally has been reluctant to adopt modern international standards for TB treatment. The main TB institutes have preferred treatment with extensive hospitalization, an array of experimental drug therapies, and thoracic surgeries. The national TB infrastructure includes biannual X-rays of the entire population, more than 100 TB sanatoria, and thousands of TB doctors, much of which would be rendered obsolete with the adoption of DOTS (Reichman, 2002).

4.9 Bilateral donors and NGOs were already involved in HIV/AIDS work in Russia when the Bank entered the arena.¹⁴ The Bank saw that an important part of its efforts would be helping development partners work together and the government to scale-up small pilot operations being assisted by other organizations.

4.10 The Bank might have acted on HIV somewhat earlier. However, in mid-1998 Russia experienced a financial crash that led to significant debt default and a devaluation of the ruble. As a result, the attention both of the government and of the international financial institutions was focused for quite some time almost exclusively on urgent macroeconomic issues. To the Bank's credit, it did act relatively promptly as it became clear that Russia faced a rapidly growing epidemic.

Project Preparation

4.11 The Bank initially tried to build consensus among partners and other actors, including NGOs, to set out a clear policy context for project development. Project development moved forward considerably on HIV/AIDS, but difficult issues were encountered in the preparation of the TB component, which stalled discussions. This impasse was broken by the last task leader, who helped to overcome problems in the relationship with the government, solidify the project design, and provoke the government to think more seriously about HIV/AIDS. This task leader saw the project to approval and effectiveness.

Initial Preparation (February 1999-June 2001)

4.12 The Bank launched its dialogue on the TB and HIV/AIDS project in 1999 under the leadership of the team leader for the Bank's health work in Russia. A staff member was appointed to lead the project preparation in 1999. The new task leader was a medical doctor with public health training.

14. These included the Soros/Open Society Institute (OSI), CIDA, DFID, USAID, and international and national NGOs.

4.13 The Bank sought to work closely with UNICEF and WHO in project preparation, although largely on the TB side. The Bank also collaborated with agencies already in the field, particularly OSI, which funded a harm-reduction specialist. The Government of Brazil partly financed the participation of a monitoring and evaluation specialist from its Federal Ministry of Health, who worked to share experiences with Russia. The Bank also partnered closely with DFID and USAID. DFID was instrumental in inspiring and then financing a trust fund for project preparation and a modeling exercise on the economic impact of the HIV/AIDS epidemic on Russia.

4.14 The Bank engaged in policy and program dialogue with technical working groups and members of the Prime Minister's Cabinet, the State Duma, and the Ministries of Finance, Economy, and Science and Technology. In 1999 it assisted in the creation of an inter-ministerial committee (Coordinating Committee) to coordinate inputs into project development. From the inception it was clear that the proposed project would have two parts, one for the central government and the rest to be implemented by the regions. As part of project preparation, the Bank joined the Federal government in meeting with representatives from 30 regional governments to review the project, its development, and the role of the regions.

4.15 The Minister of Health visited the Bank in 1999 and met with the Vice President of the Eastern Europe and Central Asia (ECA) region to discuss the design of the project and its focus on prevention of HIV/AIDS. At an early stage of preparing the HIV component, the government requested a substantial amount of financing to support research and development of AIDS vaccines.¹⁵ The Bank was firm in its belief that assistance should be focused on the most critical causes of the epidemic and on prevention. It responded by helping Russia collaborate with key organizations working on vaccine development and suggested that the project could provide some seed money for ensuring that Russia's relationships with those organizations could be pursued effectively.

4.16 The government also requested financing for antiretroviral (ARV) therapy for children who had been infected with HIV through poor medical practices. At that time, ARV therapy was still very expensive, more than \$10,000 per patient per year. Agreement was reached that the project would finance ARV treatment for the affected children. It was also agreed that the project would contain an element to help prepare the institutional capacity it would need for an eventual comprehensive ARV program.

4.17 The initial design of the proposed TB and HIV/AIDS Control Project was issued in a project Concept Note in July 1999. The project's objectives with respect to AIDS were to reduce the incidence of HIV and enhance the effectiveness and efficiency of Russia's HIV/AIDS efforts with a long-term view.¹⁶ Specifically, the project's HIV/AIDS objectives focused on:

15. In November 1999, World Bank President James Wolfensohn accepted an invitation to meet with Dr. Andrei Kozlov, Director of St. Petersburg's Biomedical Center and one of Russia's leading HIV/AIDS researchers, to discuss HIV/AIDS in Russia and assistance that some Russian officials wanted to include in the project for AIDS vaccines.

16. The Bank originally proposed a Specific Investment Loan (SIL) for the project, but concluded on review that it should try to do an Adaptable Program Loan (APL)—an investment tool that embeds a series of operations within a long-term

- The development of a national strategy
- Policy development and public education
- Regional programs on prevention, outreach, and harm reduction, including prevention in the prison system
- Epidemiological surveillance of HIV and STI
- Training centers
- Prevention of mother-to-child transmission of HIV
- Regional laboratories
- Treatment for STI and (depending on results of modeling exercises) AIDS.

4.18 In 2000, regional management appointed a new task leader. He was not a physician but had considerable experience in the management of complex tasks in large countries and had worked on HIV and TB in Brazil. A number of relationships within Russia were complex and it was hoped that his skills could help propel project development forward.

A Pause in Project Preparation (July 2001-February 2002)

4.19 In June 2001, soon after the Bank's April invitation to the government to negotiate, project development stalled and communications with the government broke down, largely due to the concerns of some government officials and medical specialists about the project's approach to TB and the required procedures for purchasing TB drugs under Bank financing. Some of these concerns appeared in the press. To some observers, this appeared to be an orchestrated attempt to stop project development.

4.20 The Bank briefly considered the option of separating the AIDS and TB components into separate projects. This option was rejected because, although keeping the two together would delay the HIV/AIDS response, the project team felt that the rationale for linking AIDS and TB was strong and that separation would reduce the likelihood that a TB project would be developed at all.

4.21 The stalemate led the Bank to focus on trying to re-establish dialogue, create an environment in which the project might move ahead, and help the government enhance its HIV/AIDS work, even if the project itself did not develop further. This change in approach corresponded with appointment of a new health program team leader (PTL) for Russia in Washington in the fall of 2001, and his assignment as task leader for project development in early 2002. The third project task leader was a physician with public health training who had worked at the Bank and as a secondee at UNAIDS, and had managed complex tasks. He was not experienced in working with Russia. The Bank believed that he had the professional stature, credibility with the Russian medical establishment, and political savvy to take the project to the next step. The work of the

vision of objectives, aims, and the measures that would be necessary to achieve them. This was a significant development not only because there were few APLs in the Bank at the time but also because it demonstrated that those working on the HIV/AIDS problem in Russia understood the long-term nature of the situation and were willing to make a long-term commitment to working with Russia to address it. The idea of doing an APL was later dropped, although it was decided to frame the proposed operation explicitly in the context of a long-run approach.

team was also enhanced by the addition at headquarters of an operations officer whose skills were complementary to the team's Moscow-based operations officer.

4.22 In the summer and fall of 2001 the Bank tried to break the impasse on TB and maintain momentum on HIV/AIDS by obtaining support from the highest levels, keeping the project on the table but reducing the pressure to borrow, building commitment through a series of high-level public health policy seminars and modeling the economic impact of AIDS, framing the project as financing “local design of strategies that meet international standards”, and keeping the discussion of the project out of the press. One of the implications of the attempt to respect government sensibilities and keep the project out of the press was to scale back open dialogue with NGOs and regions, and with some partners. In September 2001, consistent with the strategy of reducing the pressure to borrow, a World Bank health sector mission to Moscow agreed to make technical resources available to the MOJ irrespective of the status of the project.

4.23 Beginning in August 2001, the Bank engaged in discussion with DFID and the Russian Federal AIDS Center about the possibility of modeling the HIV/AIDS epidemic in Russia and its potential economic impact in the short and long term. Ultimately, DFID financed the work, which was carried out jointly by the Federal AIDS Center and the Bank. This exercise followed work that had begun earlier in the modeling of the TB epidemic, which involved Bank staff, DFID, and technical assistance from WHO.

4.24 The Bank also sponsored the organization of a series of public health seminars to highlight key issues in public health and global best practice approaches to dealing with them. The first seminar, on monitoring and disease surveillance, took place in March 2002, the same month that project development was re-established. Subsequent seminars dealt with health promotion and the control of non-communicable disease (October 2002) and epidemiology and the control of infectious disease (April 2003). A planned fourth seminar on the role of the state in public health has not yet been held.

Box 4.2: The Economic Consequences of HIV in Russia

In early 2001, Bank staff together with partners from DFID identified the economic impact of HIV/AIDS as a potentially effective lever for increasing government attention to the epidemic in Russia. Working with funding from DFID, the Bank and the Federal AIDS Center developed and published a paper in May 2002 and accompanying computer model of the possible economic consequences of the epidemic.^a The results were subsequently updated twice.

The model allows the user to specify a range of parameters on 29 different medical and economic input variables. Based on those inputs, the model then projects the trajectory of the epidemic and its economic consequences. The authors ran illustrative optimistic, pessimistic, and baseline scenarios out to the year 2020. The most pessimistic scenarios forecast a 4 percent decline in GDP due to direct and indirect losses of labor supply and productivity by the year 2010, and a 10 percent decline by 2020.

The Bank disseminated the model and its findings widely throughout Russia, not only through standard Bank publications but also through news and op-ed pieces in the Russian broadcast and print media, letters to the editor, press conferences, and presentations to government meetings and seminars. The work attracted significant attention, including among top Russian government officials. It is now considered to be among the more significant steps the Bank has taken to help Russia fight HIV/AIDS.

a. C. Ruehl, V. Pokrovsky, and V. Vinogradov, "The Economic Consequences of HIV in Russia," May 15, 2002, <http://www.worldbank.org/ru/ECA/Russia.nsf/>, accessed February 13, 2004.

4.25 In June 2002, the Bank, the Russian Health Care Foundation (RHCF), and the Moscow Institute for Social Policy co-sponsored a one day workshop on "Health Financing and Delivery in Russia: Obstacles, Lessons, and Next Steps." The Bank and OSI funded this workshop. Senior government officials from the MOH, Ministry of Finance, the State Duma, and the Ministry of Economics and Trade attended.

4.26 The Bank also improved the environment through high-level dialogue. The Russia Country Director for the Bank was deeply involved in discussions over the delay in project processing and was cited by respondents to this study for having played an effective role in the dialogue on HIV/AIDS, continuously and repeatedly engaging Russian authorities at the highest levels. In April 2002, as the dialogue resumed, the President of the Bank and Vice Prime Minister met to discuss the project.

Renewed Project Preparation and Approval (March 2002-April 2003)

4.27 In February 2002, the government indicated a willingness to re-work the project, leading to two rounds of technical discussions, in March and June 2002. In addition to the Bank's efforts, WHO's work persuading the government to adopt WHO-recommended principles of TB control may have contributed to the renewed government interest in the project. When technical discussions resumed, the Bank sought to foster cross-sector communication within government. Collaboration between the Bank and OSI, DFID, and others was still apparent, but less emphasized. Collaboration with NGOs and other bilaterals was severely reduced.

4.28 The TB and AIDS Control Project (US\$286 million equivalent, financed through a \$150 million IBRD loan) was negotiated in December 2002, approved by the Bank's

Board of Directors on April 3, 2003, and became effective¹⁷ on December 11, 2003. In the interval between resumed project preparation (March 2002) and project effectiveness (December 2003), there were some important indications of increased commitment by the government to HIV/AIDS, though it would be hazardous to attribute them solely or primarily to the influence of the Bank's continued dialogue:

- In September 2002, the MOH issued Ordinance #28, "Intensified HIV Control Action in the Russian Federation", which recommended: (a) that MOH, MOJ and Ministry of Interior (MOI) launch efforts to prevent HIV among high-risk groups; (b) raising public awareness on HIV/AIDS; (c) increasing federal funding of HIV/AIDS; and (d) launching large-scale prevention in the regions on youth, IDU, and CSW, and expansion of harm reduction programs in cooperation with the MOI.
- In May 2003, one month following the government's acceptance of the project, President Putin mentioned HIV/AIDS in his annual address to parliament, his first (and up to now only) mention of AIDS to a domestic audience.
- Also in May, the MOH formed a Consultative Council on the Problem of HIV/AIDS, including representatives from several federal ministries, Regional AIDS Centers, and NGOs.

4.29 The project's original objectives were unchanged, but some of the components were modified. In the approved project, the TB component supports treatment approaches that are consistent with global best practice, but does not highlight DOTS and does not explicitly build on approaches used earlier by Russia. The original proposal to use loan funds to finance WHO technical assistance on TB was dropped from the final project document, as the government argued that WHO should finance this itself, and the Bank ultimately assisted in finding bilateral funding for WHO work on TB in Russia. With respect to HIV/AIDS, the final project design increased funding for serological and behavioral surveillance from \$2 million to \$3.74 million and for laboratories and blood safety from \$3 million to \$25.9 million. In addition, it supported the creation of coordination centers, rather than coordinating committees. The final design also gave more explicit support for the Federal AIDS Centers and may also have shifted the balance of activities slightly in favor of targeted interventions, although the original design was already quite focused. Lastly, the final design contained more explicit performance indicators for the HIV/AIDS component than did the original.

4.30 The overall project budget increased from \$169 million to \$286.2 million; the TB component rose from \$51.7 million to \$217 million and the HIV/AIDS component from \$52 million to \$65 million, about 23 percent of the project's total cost. The increased project budget was due to substantially increased counterpart contributions (rising from \$19 million to about \$136 million); the amount of the proposed Bank loan remained at \$150 million. The approved project is described in Box 4.3.

17. "Effectiveness" is a legal term that refers to the time when the borrower may begin to draw from World Bank loans. This follows the meeting of any standard conditions for country approval of the loan agreement and the meeting of any special conditions that have been set precedent to the time the Bank is willing to declare a loan to be "effective."

Box 4.3: The TB and AIDS Control Project

The \$286.18 million project supported by a \$150 million loan from the World Bank has two objectives: (i) to contain the growth of the epidemics of TB and HIV/AIDS in the short term and (ii) to halt and reverse the courses of these epidemics in the medium term. The project has three main components:

- Control of tuberculosis (\$217.3 million)
- Control of HIV/AIDS (\$65.3 million)
- Project management, monitoring, and evaluation (\$3.56 million)

The AIDS component of the project will: (i) improve policies, strategies and public information for HIV/AIDS control; (ii) strengthen surveillance and monitoring; (iii) improve lab service and blood safety; (iv) prevent and control STIs; (v) deliver preventive services against HIV/AIDS, with emphasis on high-risk groups; and (vi) prevent mother-to-child transmission of HIV. Project activities will also support institutional development through the establishment of coordination centers (for diagnosis, treatment, etc.), formulation of regulations, protocols, and workplans, and staff training. High-risk groups identified for specific prevention activities include IDU (harm reduction), CSW, MSM, vulnerable youth, the armed forces, health workers, and mobile populations. Surveillance strengthening activities will focus on “gaps in epidemiological surveillance, behavioral surveillance, and virological surveillance.”

The project will also seek to increase collaboration between the public sector and NGOs, particularly in working with high-risk groups, in undertaking systematic analysis of the needs and motivations of different groups, and in developing outreach and harm-reduction programs and targeted public information activities. TB and AIDS are linked in the project appraisal document on epidemiological grounds. There is little discussion, however, of project activities connecting the two epidemics.

Overall responsibility for project implementation will reside in MOH and MOJ. The responsibility for day-to-day management will rest with the Russian Health Care Foundation (RHCF), an autonomous non-commercial organization with experience in implementing other Bank health projects. Implementation at the regional and local levels will be carried out mainly by local MOH and MOJ staff.

4.31 A condition of effectiveness is that the RHCF must be fully operational with structures, functions and staffing necessary to start project implementation, satisfactory to the Bank. Other conditions (for Board presentation, disbursement, etc.) include: the management information system has been set up and is operational; the relevant parts of a federal strategy for TB control, acceptable to the Bank, have been developed in collaboration with WHO and officially approved by the government for country-wide implementation; and regions participating in the project will have met specified criteria including designating local staff to coordinate project activities. One of the covenants of the loan agreement stipulates that each region will have to undertake a needs assessment prior to disbursement of project funds.

Coordination with Other Donors

4.32 Soros/OSI, USAID, UNAIDS, DFID, CIDA, and a number of NGOs were working on HIV/AIDS in Russia when the Bank got involved. Each of them was operating on particular HIV/AIDS issues, usually in technical and geographical “pilot areas.” During the course of project preparation, the Bank worked jointly in *partnership* with some organizations, while with others it worked less closely, but still in *collaboration*.

4.33 During the early stages of project preparation, the Bank’s two key partners for the HIV/AIDS components were the Soros Foundation OSI and DFID. The Bank worked

with both in preparing the harm-reduction component of the project. It partnered with OSI in establishing public health seminars for Russian health officials and with DFID to produce the model of the economic consequences of the epidemic. WHO was a key partner with the Bank for the TB component, bringing technical expertise and an understanding of the context of TB from having assisted the government in reviewing the national TB control program and in preparing pilot/demonstration projects.

4.34 The Bank was able to use its position to help reconcile differences between donors, NGOs, and government. An example of this brokering role occurred when the Bank was able to facilitate broad consensus among all involved that high-risk groups, including CSW and IDU, should be a priority for the HIV/AIDS component of the loan. A number of NGOs and bilateral respondents reported that during the early stages of project preparation they enjoyed open and visible communications with the Bank, which actively sought their views on areas in which they had technical expertise and experience.

4.35 Collaboration in later project development was maintained with WHO and to some degree with OSI and DFID. The Bank also often exchanged views with USAID on program and project design. The role of UNAIDS in this phase also seemed to have increased, in part because of the UN agency's growing presence in Russia. Indeed, many respondents reported that some of their activities could not have been achieved without the help of the World Bank. For example, most respondents for this evaluation suggested that the Bank helped WHO and UNAIDS put the HIV/AIDS problem on the Russian government's agenda. The strategic approach taken during this time in project development, however, was one of focused collaboration with a select group of organizations that the Bank thought could add significant value to its support for Russia on HIV/AIDS.

4.36 After the June 2001 impasse in the loan discussions, partnership and collaboration with other stakeholders appears to have declined considerably. As the Bank may have shifted its approach to working with them, bilateral and NGO respondents reported not knowing the status of negotiations at that time, not being informed that the level of collaboration between the Bank and their organization would change, and not knowing when the negotiations for the proposed project had resumed. Speaking for many, one respondent said, "The World Bank loan process existed outside virtually all other processes going on."

Analysis and Stakeholder Views of the Process

4.37 Many of the respondents, especially those working on HIV, thought that the delay in processing the project, due primarily to problems with the TB component, caused important slippages in HIV/AIDS efforts that could have been avoided if the project had been split into two. In addition, while they appreciated the merits of keeping the project as one, they believed that Russian institutions, in any case, would continue for many years to work separately on HIV and TB and that little was to be gained by keeping the two linked in the project. Bank staff, however, were unanimous in believing that keeping HIV and TB linked in the project was imperative to the success of the fight against the dual epidemic. The lack of coordination and coherence in the Russian health care system and the difficulty that system will have in treating HIV/AIDS and TB as a "dual

epidemic” reinforced these concerns. Many Bank staff believed that an HIV project alone would have lacked credibility and that if they separated the project into two parts, the TB efforts might never move forward.

4.38 The project might also have been divided another way — into separate projects or components for the MOH and the MOJ – and the MOJ component might have been launched earlier. Throughout project preparation, the MOJ appeared to many development partners to be more willing than the MOH to move ahead. Bank staff believed that the MOH would not proceed with a project of this type, or that the MOH would agree to this approach only if the MOJ followed the MOH approach to TB control, which was not acceptable to the Bank. Bank staff also believed that raising this option would once again leave the impression that the Bank was “desperate to lend,” proving ultimately counterproductive.

4.39 It was suggested to the evaluation team that the Bank could have financed government HIV/AIDS efforts during the period of delay with funds from the ongoing Medical Equipment Project, for example, which were used to assist in the preparation of the TB and HIV project. In fact, it was intended that these funds be used to get a head start on specific HIV/AIDS activities that were included in the proposed project. It is not known, however, whether this effort was successful. The government simply would not discuss the project at all during the most intense period of delay, and all project-related activity slowed down or stopped.

4.40 The delay in project preparation precipitated only a few substantive changes in the content of the HIV/AIDS component. While the epidemic continued to spread rapidly among IDU and to their partners during this interval, the prices of ARV drugs declined dramatically compared to the time that the project was initially appraised. The government did not request greater funding for ARVs, however, and the Bank believed that a prerequisite for expansion of effective and efficient treatment was enhanced capacity, in terms of strengthening laboratories and helping Russian pharmaceutical firms get their manufacturing practices certified. The Bank also believed that money for ARVs in Russia would be available from the GFATM. The Bank’s position was that the priority for the relatively small amount of financing in this first project to address HIV/AIDS should be strengthening key institutions and ensuring the effective implementation of targeted and cost-effective prevention efforts. Finally, the Bank was concerned that some of the problems that had arisen over TB drugs would recur in any discussion of financing of ARVs.

4.41 The evaluation team believes that the measures taken during the lull in project preparation increased the likelihood that the project will be implemented, by raising government commitment. First, the government appears more supportive than before of the conceptual framework for implementation. It would have been difficult to implement the project if debate had continued about DOTS or TB drugs. Second, the Bank and government have improved their relationship in the health sector, with much better access of the Bank task leader to Russian policymakers. Third, senior Russian officials have been exposed to the nature of the epidemic in a more substantial manner, through the Bank’s dialogue, policy seminars, and the modeling of HIV’s economic impact, than they were earlier. Fourth, the Bank continued to work closely with those bilateral organizations that

were the most involved in HIV/AIDS in Russia and whose work would also be very important to the success of the Bank-assisted project. Even with steps in the above directions, however, it is important to note that the project implementation remains at a very early stage. There is no guarantee that the government units that are involved will continue to see the project in the same way, take the project as a high priority for government, and act on it accordingly.

4.42 There were both critics and supporters of the extent of collaboration and communication with NGOs during the phases of the project. On the one hand, many respondents were critical of what they thought was a unilateral reduction by the Bank in the degree of collaboration with NGOs after the impasse in the country dialogue. NGOs were frustrated with the lack of a clearly defined role for them to play in project design and implementation efforts. Some felt that the lack of collaboration has led to a less relevant project design than would have resulted if greater collaboration had been maintained throughout. They also thought that the Bank-supported project was now at risk of duplicating efforts that were being planned and implemented by others. On the other hand, other respondents criticized extensive engagement with NGOs at the outset of project preparation, suggesting that this collaboration did not sufficiently engage high-level officials or garner sufficient high-level support, which they thought was needed immediately if Russia was to be able to address HIV/AIDS more urgently.

4.43 The choice to pull back on collaboration appears to have been strategic, adopted in order to remove the loan from the media spotlight and to concentrate efforts on developing greater Russian government commitment to HIV/AIDS efforts. In the final analysis, despite the strategic withdrawal from public discussions mid-preparation, the Bank, through its collaboration efforts, does appear to have provided a forum for more coherent approaches to policy, and then through the vehicle of the project helped to provide a basis for going to scale through collaboration with the government and other partners.

5. The Impact of the Bank's HIV/AIDS Assistance

5.1 Attributing to the World Bank specific actions or general trends in any national government's response to HIV/AIDS presents a significant methodological challenge. The challenge is even more acute for Russia, where the loan negotiations and policy dialogue have been protracted and where the project itself has just become effective and implementation has not yet begun in earnest. The timeline of events related to HIV/AIDS in Russia does reveal temporal linkages between Bank activities and Russian government actions (see Annex B). Correlation, however, does not prove causation, and therefore due caution must be exercised in drawing conclusions about the Bank's role.

5.2 Sufficient evidence exists for the evaluation team to judge that the Bank has made an impact on the federal government's commitment to fighting its HIV/AIDS epidemic along three critical dimensions:

- Improving the quality and quantity of information government officials have about the epidemic;

- Raising the political will of some constituencies to act on this information; and
- Changing the way of thinking about HIV/AIDS.

5.3 In sum, the World Bank has helped Russia bring its HIV/AIDS program closer to international standards of prevention and treatment for HIV/AIDS than it would be otherwise. As one informant said, “the Bank has enabled the Russians to transition from a content-free or content-poor national program to a content-rich strategy that has international credibility.”

Political Commitment

5.4 Until very recently, virtually no officials at the highest levels of the government had acknowledged HIV/AIDS as a serious current or potential national problem. To a large extent, that reluctance persists, but World Bank efforts have made some inroads toward a change in that mindset. The persistence of Bank effort has been critical here, particularly since HIV prevalence was not high in the early stages of project preparation, and it was easy not to take the epidemic seriously. As noted earlier, since 1999, every meeting of high-level Bank staff (at the presidential, vice-presidential, and country director levels) with government officials included, at minimum, a mention of HIV/AIDS, and the current country director has held meetings directly with the minister of health and many other senior officials at which he stressed the critical nature of the HIV/AIDS threat.

5.5 By virtually all accounts, however, the most important milestone in the process of agenda-setting — bringing HIV/AIDS into the policy consciousness of some of Russia’s highest-level decision makers — was the Ruehl/Pokrovsky study on the potential economic impact of the epidemic. This study, done in collaboration with others, was the subject of a very deliberate dissemination strategy by Bank staff for advocacy and raising of public awareness about HIV/AIDS. According to many respondents, the strategy was quite effective and the study received considerable attention in the press. The study contributed to changing the nature of some of Russia’s conversations about HIV/AIDS from social and medical to economic and fiscal. It also helped to make the epidemic for the first time a topic worthy of attention for many politicians outside the health sector. In one informant’s words, it “shocked [the Russians] in fundamental ways,” surprising them by the extent to which they were vulnerable.¹⁸ There have been no public opinion polls to support this conclusion, but several respondents believed that the Bank’s success in getting mention of the impact of HIV/AIDS in print and over the airwaves created at least some degree of public pressure on the government.

5.6 By framing HIV as an economic issue, the Bank helped to place HIV squarely in the context of Russia’s long-term macroeconomic recovery and development. The economic model also took HIV out of the lower levels of the health ministry, placing it on the table of the health minister himself, and at the ministries of economics, finance, internal affairs, defense and others. It was only after the findings of this study were brought to

18. The Ruehl/Pokrovsky economic model, although updated with new data several times, has not been aggressively applied beyond the national level, engaging policy makers in the regions. This is an area in which some respondents felt that the Bank could capitalize further on this work.

President Putin's attention that he mentioned HIV/AIDS as a critical national challenge in his May 2003 address to the Duma.¹⁹

5.7 The government has not yet translated its recent increased public commitment to confronting HIV into a matching allocation of federal resources. Underfunding of government HIV/AIDS programs was understandable in the late 1990s, when the country was still reeling from the effects of its mid-1998 financial disaster. But several years of relative fiscal and budgetary stability have now passed. With Russia now holding significant hard-currency surpluses and continuing to reap the benefits of high world fossil fuel prices, it is difficult to interpret the *constant* federal allocations for HIV/AIDS (declining in real terms) as a product of financial scarcity. If the government fully funds the Bank-supported project, it will raise annual expenditure to \$13 million/year for HIV/AIDS. It is uncertain, however, whether the funds are included in the 2004 budget. High-level health and other government officials have pointed to the reduction in HIV incidence from 2001 to 2003 as evidence that the epidemic is under control, which may explain its continued low budgetary priority. No reliable studies, however, support this conclusion. Rather, the low budgets are a signal that at least some important elements of the government do not yet take HIV/AIDS as seriously as they should. It will be critical that the government adequately budget for the new TB and HIV/AIDS Control Project, which even until recently did not appear likely.

Strategic Choices and Prioritization

5.8 Several respondents felt that the Bank's persistence in policy dialogue and during the extended period of project negotiations, in promoting controversial but important activities and interventions for the project —harm reduction, the involvement of high-risk groups (particularly IDU and CSW), emphasis on HIV prevention, and to a lesser extent laboratory support and funding for ARV therapy and replacement of mass testing with behavioral and serological surveillance — demanded new and hard thinking on the part of national experts on HIV/AIDS. Respondents reported that MOH officials have privately credited the Bank's efforts in demonstrating the importance of these previously underplayed components of Russia's national HIV/AIDS strategy. In the words of one Moscow-based informant, "the World Bank was a good school for the Ministry of Health."

5.9 The project preparation team had access to a large amount of information about best global practice, some of which, such as *Confronting AIDS* (World Bank, 1997), was produced by the Bank itself, in addition, the team had an extensive network of contacts in the HIV/AIDS field that assisted it in thinking through the nature of the epidemic in Russia and how the Bank might best respond. With all of this in mind, the team believed that Russia's epidemic was still focal, that Russia had limited capacity to handle a broad spectrum of AIDS-related activities, and that the most cost-efficient way to stem the epidemic was to help Russia focus on a narrow range of prevention-related activities.

19. President Putin's public mention of HIV/AIDS occurred a full year after the Reuhl/Pokrovsky results were issued, in May 2002. However, the model was updated twice (including in May 2003), indicating the interest in the subject. Putin's speech also occurred one month after the government had agreed to the Bank-supported project.

A National Plan for Expanding the Response

5.10 The Bank's work with the government, resulting in the project design documents, has set the foundation for scaling up smaller pilot projects synergistically, rather than in wasteful duplication, to produce a nation-wide epidemiological impact. In the judgment of the review team and echoing the comments of numerous respondents, without the Bank's involvement these pilot projects would have continued on a relatively small (regional-level) scale, probably not coordinated at the national level and/or targeted effectively at the most needy or high-risk populations.

5.11 The Bank was also influential in insisting that all of Russia's regions be eligible for participation in the project. It had been government policy not to lend funds to regions that were fiscally insolvent. The Bank, in the judgment of the review team, appropriately observed that some of Russia's regions in the worst financial condition might be those with the greatest need for HIV intervention and programs. It encouraged the government to make HIV/AIDS project allocations to the regions in the form of grants rather than loans and to make each of the 89 regions eligible to apply for funds.

Multisectoral Approaches

5.12 It is the review team's judgment that the Bank's work brought together important Russian agencies that may have continued to operate in isolation from one another in the Bank's absence. In particular, several informants stressed that the MOH and MOJ might not have partnered outside the framework of the Bank project, and consequently that much-needed HIV-related efforts may not have developed within the penal system, if the Bank had not acted as an effective facilitator. Throughout the period of project development, the MOJ appeared to be more interested than the MOH in working with the Bank on both HIV and TB and developing the project in a manner that would take account of international best practice. The MOH appeared willing to work with the Bank but did not seem enthusiastic about developing this project, particularly in light of the tension related to TB and to TB drugs. Whereas the MOJ seems to have reached out to Bank staff, the MOH worked with the Bank in a way that suggested that it saw only limited value being added to its own efforts.

5.13 Many respondents also assigned partial credit to the Bank's influence for the May 2003 formation of the MOH's high-level Consultative Council on the Problem of HIV/AIDS. This body, bringing together ministerial-level officials with NGOs and representatives from the international donor community, is designed to promote intersectoral work, improve coordination of activities, and analyze and implement international best practice in combating HIV/AIDS.

Role of NGOs and CBOs

5.14 In every society in the world in which HIV has been effectively confronted, governments and NGOs have worked in close partnership, most often with NGOs carrying out programs financed through public resources. The Russian government, however, retains an impulse to control third-sector activity (not merely in the HIV arena, but in all areas) that hinders effective NGO development and program implementation.

The World Bank consulted and collaborated with NGOs in the development of the project, particularly in the early stages, but these efforts have not placed this issue squarely on the government's agenda, in terms either of government policy toward collaboration with NGOs or of mechanisms for incorporating NGOs into government-sponsored HIV/AIDS programs. Project documents indicate that a key criterion for selecting regions for project participation is the availability of HIV-related NGOs and their capacity for expansion. According to several NGO-based respondents, however, the project design essentially leaves the government to determine the degree to which NGOs will be involved in project implementation.

AIDS and the Health Sector

5.15 Russia's AIDS diagnostic and treatment infrastructure exists largely in isolation from the remainder of its public health system. The Bank's dialogue and project preparation activities have not demonstrated an impact here, nor was one planned. The Bank has encouraged the government to consider HIV, TB, and STIs as part of an interrelated challenge within the health sector, with the potential to facilitate addressing HIV/TB coinfection in the future. Several respondents believed, however, that project development for both HIV and TB have made Russian industry more conscious about the quality of its pharmaceutical production and has led to efforts to improve quality and competitiveness, potentially affecting the entire health sector.

Monitoring and Evaluation

5.16 The emphasis of the policy dialogue and project preparations on evidence-based programmatic decisions and cost-effectiveness highlight a key role for monitoring and evaluation in the project and in government AIDS programs. To date, the only evidence of the Bank's effectiveness is the government's acceptance *in principle* of more internationally accepted HIV and behavioral surveillance strategies. The project design also stipulates that no resources will be disbursed to regions until a baseline needs assessment has been conducted. There is no evidence of change in actual HIV/AIDS monitoring and evaluation activities of the government that could be attributed to the Bank during the extended period of project negotiations.

Institutional Development

5.17 One clear institutional impact of the Bank's efforts related to health in Russia has been the formation of the RHCF, the institutional mechanism formed explicitly for implementation of all World Bank-financed health project activity. Some informants believe that the RHCF has been successful in the management of Bank-assisted projects. Others, however, were skeptical of the effectiveness and longevity of the RHCF, citing the concern that it is an institutional pretense created to ameliorate Bank concerns about effectiveness of project implementation. The RHCF has already generated considerable negative media attention within Russia because of the high salaries paid to its staff (relative to other government salaries), high administrative costs, inappropriate purchases of expensive equipment, and missed project deadlines. Perhaps the most potent criticism relevant to this evaluation centers on its insufficient connection to the established Federal

AIDS program, creating concern that the Bank-financed activities will not be sustainable after the loan funds have been exhausted. Most respondents agreed, however, that a superior alternative to the RHCF is not readily apparent, and that implementation mechanisms are destined to be complicated in the current environment.

6. Conclusions

Development Effectiveness of the Bank's HIV/AIDS Assistance

6.1 The Bank's HIV/AIDS assistance to Russia to date has been in the form of intense policy dialogue and analytic work, leading to preparation of the TB and AIDS Control Project, which only become effective in December 2003. It is too soon to know the extent to which the project will be implemented and what the outcomes will be. The evaluation team can, however, comment on the relevance, efficacy, and efficiency of the Bank's assistance to date.

Relevance

6.2 Relevance is the extent to which the Bank's HIV/AIDS assistance: (a) has been consistent with the Russian government's current development priorities; (b) is consistent with current Bank country and sector assistance strategies and corporate goals; and (c) has taken into account the epidemiological and institutional context.

6.3 The Bank's policy dialogue built on the government's own HIV/AIDS strategy and has aimed to help it develop a project that is non-ideological, evidence-based and specific to local needs. Early project development involved the regions and NGOs, both of which would ultimately be responsible for service delivery. The dialogue on HIV/AIDS was consistent with and built on the ongoing dialogue on health reform and the government priority to reduce infectious disease.

6.4 The Bank's HIV/AIDS assistance has been consistent with its Country Assistance Strategy for Russia, the corporate priorities of poverty reduction and reducing the spread of HIV/AIDS, and the Bank's commitment to achieving the Millennium Development Goals by 2015. Given the weaknesses of the Russian health care system and its institutions more generally, the Bank encouraged prioritization around activities with the greatest impact for their cost, including controversial harm reduction programs with which some donors had already begun to do pioneering work. At the same time, the Bank tried explicitly in its project development work and in policy dialogue to help strengthen Russian institutions that deal with HIV/AIDS, by helping them to enhance the quality of their policies and programs. Consistent with the emphasis on evidence-based decisions and improved efficiency in the health care system, the project team provided an economic analysis of the cost-effectiveness of proposed project activities.

Efficacy

6.5 Efficacy is the extent to which the objectives of the Bank's HIV/AIDS assistance were achieved or are expected to be achieved, including the impact of the Bank's assistance to date relative to the counterfactual of no assistance.

6.6 Overall, the World Bank has had a positive impact on the design of the Russian government's approach to dealing with HIV/AIDS and on the commitment of government and civil society to addressing this problem. If the Bank had not been involved, the government's approach to HIV/AIDS would have been less targeted to the main drivers of the epidemic and less in tune with international best practice in key areas, such as harm reduction and sentinel surveillance. It would also have paid less attention to capacity building, laboratory strengthening, and making the blood supply safe. Without Bank involvement, it is unlikely that the government would be planning to take to scale in a timely way HIV/AIDS prevention efforts that emphasize behavior change and are consistent with international best practice. Rather, such efforts would remain small and local, and not in step with the imperative to move ahead forcefully against the epidemic.

6.7 The Bank's HIV/AIDS assistance to date has had greatest efficacy in three areas:

- ***Raising government commitment to fighting HIV/AIDS***, through the use of analytic work to demonstrate impact, reducing the pressure to lend, and the use of high-level Bank officials to promote the policy dialogue. Informants believed that the WB-DFID collaboration with the Federal AIDS Center on the projections of economic impact were a major factor behind President Putin's first mention of HIV/AIDS to a national audience. Assuming that the government fully finances its counterpart commitments to the new TB and HIV/AIDS Project, annual federal expenditures on HIV/AIDS will rise from roughly \$3-4 million to \$13 million over the next five years, a substantial increase.
- ***Improving the efficiency and technical quality of the response*** through an emphasis on: evidence-based programmatic decisions; prevention strategies that embrace behavior change in high-risk groups (the main drivers of the epidemic) and awareness-raising of the general population; and more efficient approaches to HIV surveillance. The emphasis of the approved project on building capacity in the health system to deal with AIDS diagnostic and treatment issues is likely to improve the efficiency of the response on care and treatment of AIDS patients.
- ***Solidifying the commitment to systematic expansion of program coverage***. The Bank's support in assisting the Russian government to develop the TB and HIV/AIDS Project has resulted in a vehicle—the project—for the planned implementation on a national scale of many of the highly effective smaller scale activities piloted by bilateral donors and NGOs. Efforts by the Bank to engage the federal ministries and encourage a national institutional framework for an expanded response were complementary to the activities of other donors in certain regions.

Efficiency

6.8 Efficiency is the extent to which the Bank's HIV/AIDS assistance achieved or is expected to achieve efficient resource use, as measured by cost-effectiveness and other indicators of best practice in HIV/AIDS.

6.9 During the policy dialogue, the Bank maintained an important focus on the efficiency of public expenditure on health in general, including HIV/AIDS. It aimed to help the government improve the effectiveness and efficiency of its HIV efforts and at helping the government move its AIDS program to international best practice. It focused attention on prevention, a sound decision at the early stage of Russia's epidemic. The Bank assisted the government in moving toward a much more selective approach to testing, and toward an approach that would focus on key drivers of the epidemic. If the project is implemented as designed, it will improve the efficiency of policy, the quality of HIV surveillance, and the institutional support for an effective program of prevention, treatment, and care.

6.10 Efficiency was also promoted, in theory, by the links in policy dialogue and design between the epidemics of HIV, STI and TB in both the civilian and prison populations. The link between HIV/AIDS and TB in project design, however, held up project approval and implementation. The delay provided an opportunity to engage in activities that would raise government commitment to HIV, but also delayed implementation of a scaled-up national response to HIV/AIDS that would have saved more lives.

6.11 Aside from the activities directly supported by the project, the Bank improved the efficiency of the government response to AIDS by bringing together the three main domestic research groups involved in HIV vaccine development, exposing both to best practice in the field, and by assisting the government to improve Russian manufacturers' ability to produce competitive and high-quality drugs. Many respondents believed that the Bank's continuous insistence on international competitive bidding during the preparation phase, coupled with helping the government work with WHO on good manufacturing practices (GMP), encouraged Russia to raise the quality of its own TB drugs, even if the Bank, in the end, was not to finance those drugs under the project.

Lessons for the World Bank's HIV/AIDS Assistance

The Importance of Understanding the Country Context

6.12 This case study demonstrates the importance of careful mapping of the political economy of any given issue, and of adjusting efforts to build commitment accordingly. The Bank's approach to helping the government to prepare a project, although it engaged the regions and NGOs, was not able to address adequately the weak commitment of key government institutions, particularly for TB. The Bank and some of its partners did not fully comprehend the political economy of DOTS, threatening the institutional and technical base of an important part of the TB control program. The Bank did correctly anticipate objections by drug manufacturers to international competitive bidding for TB drugs, and encouraging the government to work with WHO to improve GMP, it diffused

some of the political issues while simultaneously trying to improve the quality of pharmaceuticals at better prices. But this alone proved not enough. To try to move the project forward, the Bank appears to have assessed the political terrain more carefully than it had done earlier, carried out at least implicit stakeholder analysis, and then articulated a strategic approach for changing the nature of the dialogue and renewing an effective engagement with the government.²⁰

Reducing the Pressure to Borrow as a Catalyst to Policy Dialogue

6.13 This study highlights the extent to which pushing less on lending, as well as carrying out a well-placed piece of analytic work at an appropriate time, were very helpful to the government's thinking about HIV/AIDS and about the project that was under development. This study also highlights the importance of combining knowledge of the country context with substantive knowledge. The perception by the government of a Bank imperative to lend for HIV/AIDS and TB control had been clouding the atmosphere within which the operation was being developed.

Using Analytic Work to Generate Commitment and Ownership of HIV/AIDS as a Problem

6.14 The projections of the impact of AIDS were effective in raising commitment. They called attention to the impact of HIV/AIDS on something that the government outside of the MOH cared deeply about – economic growth. In addition, the product had greater credibility because it was partly domestically produced. The Bank used the report to lay groundwork for an enhanced dialogue with policymakers beyond the ministries of health and justice and at the highest levels of government.

Leverage from Small Operations in Large Countries

6.15 Although the project's allocation to HIV/AIDS is small (\$65 million) relative to the overall health budget and even relative to Russia's likely total needs in funding an adequate response, to the extent that the project goes forward, it will have leveraged a major change in the scale and quality of the government's national response to HIV/AIDS.

Continuity, Seniority, and Proximity of Task Management

6.16 The Bank had an Operations Officer of considerable experience in its Moscow Office who worked with the health team throughout the development of its HIV/AIDS work. Respondents believed that she added important value to the Bank's work. However, the presence of a more senior person in Moscow during critical times – either a senior technical specialist or the project preparation team leader—might have a sustained

20. This point is underscored by OED's April 2002 *Country Assistance Evaluation* on Russia (World Bank, 2002), which concluded that the Bank might have had a more valuable impact in its overall assistance if it had focused more on analytical and advisory services and less on lending, since much of the adjustment lending may actually have impeded needed reforms. It noted that the Bank lacked a sufficient understanding of context.

dialogue on HIV/AIDS and provided a basis for averting and/or permitted addressing earlier some of the problems that arose. Most respondents believed that the Bank would have been more effective if it had been able to keep a single person leading this task through the entire preparation and if the Bank, throughout preparation, had understood Russia better.

The Future

6.17 As of the writing of this report, the government continues to spend relatively little on HIV/AIDS and no one entity is leading the effort. The benefits of the planned project with respect to HIV/AIDS depend on adequate spending, continued commitment to the project design, and effective implementation. There are two areas, in particular, that require urgent and continued attention.

6.18 **First, many of the institutional arrangements necessary to achieve the project's objective have yet to be worked out.** In particular:

- **The mechanisms for engaging regions and NGOs, on which responsibility for program implementation rests, are not finalized.** This will by necessity involve re-engagement of the government with these two groups, which respondents to this case study felt were 'out of the loop' during finalization of the project. The PAD sets as a condition that no funds will be disbursed to any region until a baseline needs assessment has been conducted, but it does not provide guidance on how proposed regional strategies will be evaluated with respect to funding, how the federal government will prioritize across proposals from different regions, or the role of evaluation (as opposed to monitoring) in continued support. There is very little information in the PAD on how the regional governments will institutionally work with NGOs, the types of activities on which NGOs might best collaborate, the need for capacity development of NGOs to undertake priority interventions, or how NGO performance will be evaluated.
- **The project has yet to develop an implementation strategy that convincingly exploits the potential synergies between HIV/AIDS and TB or to show that the linking of the two was beneficial.** The PAD does not show many links in terms of implementation, with the exception of a coordinating committee for the overall project. While funding for TB is divided between the MOH and MOJ, HIV/AIDS remains entirely with MOH. Without explicit linkages between HIV/AIDS and TB that were realizable only with a combined approach, it is unlikely that the project will produce the positive externalities that justified the decision to hold up the AIDS component of the project.

6.19 **Second, there is a continued need for policy dialogue and analytic work in support of government commitment at the federal level and in regions where it may not exist.** The need for policy dialogue should not be overlooked simply because a project has been approved. Government commitment to HIV/AIDS at the federal level has grown but is fragile; commitment in the regions, which will be responsible for implementing most programs, is uneven. Even as the implementation details are worked

out, the Bank's experience in Russia and in HIV/AIDS to date indicates that a strategy in tandem continuously to promote commitment should not be overlooked.

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Annex A. Persons Interviewed

Olusoji Adeyi, Lead Health Specialist, Focal Point for HIV/AIDS, ECA Regional Department, Current Team Leader, Russian Federation TB and AIDS Control Project, The World Bank

Mr. Nikita Afanasyev, Country Representative, USAID/Moscow.

Natalia Vasilieva Antonova, Head of Infectious Diseases Unit, Department of Organization of Health Services.

Larissa Badrieva, Republic Center on AIDS Prevention, Kazan, Tatarstan

Andrew Ball, Department of HIV/AIDS World Health Organization.

Michael Borowitz, Senior Health Specialist, East Asia and Pacific Region, The World Bank, Senior Health and Population Advisor (on-leave), Lead Project Advisor for Russia HIV/AIDS, DFID

Dave Burrows, Independent Consultant on HIV/AIDS.

Nicolas Cantau, Head of Mission, Médecins Sans Frontières, Moscow

Vsevolod Chaplin, Archpriest, & Vice Chairman, Department for External Church Relations, Moscow Patriarchate, Russian Orthodox Church

Pedro Chequer, UNAIDS Representative, Russian Federation

Jean-Jacques de St. Antoine, Former Team Leader, Russian Federation TB and AIDS Control Project, The World Bank

Annette Dixon, Sector Director, Human Development, Europe and Central Asia Region, The World Bank

Murray Feshbach, Senior Scholar, Woodrow Wilson International Center for Scholars

Armin Fidler, Health Sector Manager, Europe and Central Asia Region, The World Bank

William Flanagan, Associate Professor, Director, International Law Spring Program. Queens University, Ontario

Olga Frolova, Research Institute for Phthisiopulmonology, Sechenov Moscow Medical Academy

Joana Godinho, Former Team Leader, Russian Federation TB and AIDS Control Project, Senior Health Specialist, Human Development, The World Bank

Alexander Golusov, Head of Prevention of HIV/AIDS, Ministry of Health of the Russian Federation

Theresa Ho, Senior Public Health Specialist, The World Bank

Wieslaw Jakubowiak, TB Programme Coordinator, WHO, Russian Federation

Wim Landman, Operations Director, AIDS Foundation East-West

Johannes Linn, Vice President for Europe and Central Asia Region, The World Bank

Tatyana Loginova, Operations Manager, Moscow, The World Bank

Kasia Malinowska-Sempruch, Director, International Harm Reduction Development program, Soros Foundation

Michael Merson, Dean, School of Public Health, Yale University, former director of WHO/Global Program on AIDS

Flavio Mirella, Representative, United Nations Office on Drugs and Crime, Regional Office for Russia and Belarus

Margarita Nelyubova, Coordinator, Russia Round Table, Department for External Church Relations, Moscow Patriarchate, Russian Orthodox Church

Igor Vladimirevich Pchelin, Editor, *Steps* (a journal for Russian medical professionals and PLWHA), AIDS-Infoshare

Mikhail Perelman, Professor of Surgery, Academician of the Russian Academy of Medical Sciences, Director and Chair of Research Institute of Phthisiopulmonology, Sechenov Moscow Medical Academy

Alena Peryshkina, Director, AIDS-Infoshare, Russian Federation

Peter Piot, Executive Director, UNAIDS

Vadim Pokrovsky, Director, Federal AIDS Center, Russian Federation

Elena Pushkareva, Health Policy Adviser, Development Section, British Embassy, Moscow

Lee Reichman, Executive Director, New Jersey Medical School National Tuberculosis Center

Signe Rotberga, Project Coordinator, United Nations Office on Drugs and Crime, Regional Office for Russia and Belarus

Christof Rühl, Chief Economist, Russia Country Department, The World Bank

Vinay Saldanha, Project Coordinator, Russian HIV Response Network, Canada AIDS Russia Project, CIDA

Alexey Savinykh, Project Management Specialist, Health Division, Office of Social Sector Restructuring, USAID

Nina Schwalbe, Director, Network Public Health Programs, Soros Foundation

Julian Schweitzer, Country Director, Russia, The World Bank

Sergey Selivanov, Head State Sanitary Physician, Ministry of Justice, Russian Federation

Elena Tkatchenko, Scientific Coordinator, International HIV/AIDS and STI Knowledge Programme, Imperial College School of Medicine, London, Former Project Officer, Sexually Transmitted Diseases, DFID

Natalia Vasilieva, Director, Open Health Institute, Russia

Mikko Vienonen, Special Representative of the Director-General in Russia, WHO

Michael Zeilinger, Chief, Bureau of Global Health and Nutrition, USAID

Annex B. Timeline of HIV/AIDS Events in Russia

Date	Russian event/activity/response	World Bank and other external activity
1987	<ul style="list-style-type: none"> ▪The Soviet Union's first documented case of HIV is detected in Leningrad. ▪The Soviet government passes the first HIV/AIDS legislation (August) ▪First HIV-related NGOs are formed. ▪The Soviet government creates a computer system for the registration and analysis of all HIV testing results. 	
1988	<ul style="list-style-type: none"> ▪First reported AIDS death. ▪ Centralized system of AIDS Centers and diagnostic laboratories established for registration and treatment of people infected with HIV. ▪An outbreak of HIV in medical institutions infects over 300 infants in the Kalmykia and Rostov regions. 	
1991	<ul style="list-style-type: none"> ▪The Soviet government collapses; Russia and 14 other Soviet republics become independent countries. 	<ul style="list-style-type: none"> ▪World Bank launches policy dialogue with Russian government.
1992	<ul style="list-style-type: none"> ▪Economic reform results in high inflation and other economic and social disruption. ▪Russia joins the World Bank. 	<ul style="list-style-type: none"> ▪1992-95, WB lends \$4.6 billion to Russia, primarily investment lending in oil and gas
1993	<ul style="list-style-type: none"> ▪The Russian government adopts its first post-Soviet AIDS legislation. ▪Russia's first post-Soviet HIV/AIDS NGOs emerge. 	
1995	<ul style="list-style-type: none"> ▪The first HIV case is detected in the military. ▪The government passes the Federal Anti-AIDS Law, with guidelines for HIV/AIDS prevention, care, and support (Aug). 	
1996	<ul style="list-style-type: none"> ▪Transmission of HIV among IDU begins to accelerate markedly. ▪The legislature passes a 1996-2000 HIV/AIDS budget. No federal funds are spent on these programs in 1996 or 1997. 	<ul style="list-style-type: none"> ▪Medcins Sans Frontières (MSF) initiates Harm Reduction Program. ▪1996-98, WB lends more than \$5 billion to Russia, mostly adjustment lending ▪Community Social Infrastructure Project (\$288 million) approved to reduce deterioration of social infrastructure, incl. health facilities. ▪Medical Equipment Project is approved (\$304 million) to initiate structural reform of the health care system (June)
1997		<ul style="list-style-type: none"> ▪ Health Reform Pilot Project is approved, (\$98 million) to improve the quality and efficiency of health care in two pilot oblasts (June). ▪<i>Country Assistance Strategy</i> proposes more systematic emphasis on institutional development, social protection, dealing with TB/AIDS crisis, improving delivery of health and education services. ▪Internal "Health Sector Strategy Note" for Russia prepared (September).
1998	<ul style="list-style-type: none"> ▪The government invites the WB to prepare a loan for the control of TB and HIV/AIDS epidemics (March) 	<ul style="list-style-type: none"> ▪USAID, CDC, and PSI/AIDSMark work with MOH to develop a multi-year strategy (1998-2000) to prevent HIV among high-risk groups

Date	Russian event/activity/response	World Bank and other external activity
1998 (cont)	<ul style="list-style-type: none"> ▪The government passes legislation requiring people who contract an STI or HIV through “socially aberrant behavior” (sex work or IDU) to receive medical care through the penal system rather than the public health care system. ▪The State Duma holds a hearing on HIV/AIDS (April) ▪First needle exchange center opens in Kaliningrad (July) ▪Financial crisis causes significant default on debt and devaluation of the ruble (August). ▪Jurisdiction over penitentiary system transferred from Ministry of Interior to Ministry of Justice (October). 	<p>(March).</p> <ul style="list-style-type: none"> ▪The WB, UNAIDS, and the British Council participate in a Regional Conference on the Socio-Economic Impact of HIV/AIDS, bringing together senior political figures from Russia, Belarus, Kazakhstan, and Ukraine. <p>▪Director-General of WHO informs the WB President of new WHO activity on HIV/AIDS in Russia, requests Bank assistance as the work progresses (December).</p>
1999	<ul style="list-style-type: none"> ▪Explosive outbreak of HIV among IDU in City of Moscow. ▪First prison facility for HIV-infected inmates is opened in Kaliningrad. ▪The government submits an official request for WB assistance to develop a TB/AIDS project, based on a proposal by the MOH for a \$150 million loan (February). <p>▪Government formally established inter-ministerial working group on HIV/AIDS to coordinate Bank-sponsored activities (September).</p> <p>▪City of St. Petersburg experiences outbreak of HIV among IDU (November)</p> <p>▪President Boris Yeltsin resigns on New Year’s Eve, appointing Vladimir Putin as acting president (December)</p>	<ul style="list-style-type: none"> ▪WB project identification mission for a TB/AIDS control project, to be prepared in the context of the development of a national AIDS strategy with assistance from UNAIDS (February). ▪WB mission further assists the government in the preparation of a TB/AIDS control project (May-June). ▪Project Concept Document completed (July). ▪WB mission to continue project preparation (September) <p>▪Minister of Health visits WB Vice President for the ECA Region to discuss proposed TB & HIV/AIDS project (November).</p>
2000	<ul style="list-style-type: none"> ▪Vladimir Putin is elected President (March). 	<ul style="list-style-type: none"> ▪WB mission continues policy dialogue with government and pre-appraises the project (Jan-Feb) ▪Change in WB task manager for the TB and HIV/AIDS project (February) ▪WB facilitates first Public Health Policy Seminar in Moscow on Health Monitoring and Disease Surveillance. ▪USAID proposes follow-on HIV/AIDS prevention strategy for 2001-2003 (March) ▪WB mission, including a donors’ meeting to inform them about progress of project development, and other project preparation

Date	Russian event/activity/response	World Bank and other external activity
2000 (cont)	<ul style="list-style-type: none"> ▪Officials advise MOH to reject the WB loan because it advocates DOTS therapy for TB and would force procurement of drugs from non-Russian companies (December) ▪The Federal AIDS Center detects a marked increase in the percentage of HIV cases due to heterosexual contact, although the extent of this shift varies considerably from region to region. 	<p>activities with government (May)</p> <ul style="list-style-type: none"> ▪Decision Review Meeting discusses financing treatment of HIV-infected children (June) ▪WB mission to continue project preparation (June). ▪Project Appraisal Document completed. Regional Operations Committee discusses project preparation (November) ▪WB mission to Russia to review and continue project preparation (December).
2001	<ul style="list-style-type: none"> ▪MOH publicly recommends “a healthy way of life and harsh actions by law enforcement agencies” in order to curb the spread of injecting drug use and HIV. ▪State Duma Speaker refers to the declining health of the population as a matter of national security (March) ▪The head of the presidential commission on women argues publicly that family planning efforts could help prevent the spread of HIV (April). ▪President Putin sends letter to U.S. President Bush expressing Russia’s support for international efforts to combat AIDS and other infectious diseases (May). ▪Prosecutor-general warns that the country’s prisons are becoming breeding grounds for HIV (June). ▪President Putin pledges \$20 million in support for the Global Fund (July). ▪MOH informs the Bank Country Office that the Ministry is not against the loan in principle, but the conditions for its provision are unacceptable (July). 	<ul style="list-style-type: none"> ▪USAID commits \$4.2 million to Russia’s HIV/AIDS activities for 2001. ▪WB Country Director sends letter to MOH inviting negotiation of the proposed loan (April) ▪ Breakdown of WB-government dialogue on TB and HIV/AIDS project preparation. WB Project Team Leader (PTL) summarizes government concerns about the project, indicating that there are no known objections to the AIDS component (June). ▪MSF and Russian NGO “Focus” launch media campaign to increase awareness about safe sex and condom use (June). ▪MSF promotes creation of AIDS Foundation East-West, to take over many of its AIDS programs in Russia (July). ▪Initial discussions on the analytic modeling of the economic impact of HIV/AIDS, to be developed jointly by the WB and the Federal AIDS Center (August) ▪New WB PTL (fall) ▪WB Health Sector mission offers to make technical resources and a specialist team available to the MOJ irrespective of the status of the loan (September).

Date	Russian event/activity/response	World Bank and other external activity
2001 (cont)		<ul style="list-style-type: none"> ▪Project Team Leader meets with Deputy Minister of Health with responsibility for HIV/AIDS (December).
2002	<ul style="list-style-type: none"> ▪Legislature passes a 2002-2007 Federal budgetary program for HIV/AIDS (January). ▪Chmn of Government, Kasyanov, instructs Ministries of Health, Justice, Economic Development, and Trade to undertake to re-work the project (February) ▪MOH indicates that it has submitted a Project Concept Document to other government agencies, that the Bank's project revision proposals are acceptable, and that MOH would like to move forward to finalize the project (April). ▪Deputy Prime Minister Valentina Matvienko expresses concern about IDU and the spread of HIV, indicating that the magnitude of these problems makes them political issues (spring). ▪Presidents Putin and Bush release a post-summit joint statement re-affirming their commitment to HIV prevention (May). ▪President Putin's wife, Lyudmila, hosts a large Live Aid-style concert in Kaliningrad to raise money and aware-ness in the struggle against HIV/AIDS (summer) ▪MOH Ordinance #28 "Intensified HIV Control Action in the Russian Federation" is issued recommending: a) MOH, MOJ and Ministry of Interior (MOI) efforts to prevent HIV among high-risk groups; b) raising public awareness; c) increasing federal funds; and d) large-scale prevention in regions on youth, IDU, CSW, and expansion of harm reduction in cooperation with the MOI (September) 	<ul style="list-style-type: none"> ▪New WB task manager for TB and HIV/AIDS Control Project (formerly the PTL) ▪CIDA launches HIV Network Project (February). ▪Dialogue on the project resumes: Initial round of technical discussions between WB mission and Inter-Ministerial Working Group to break the impasse on project preparation (March). ▪First Public Health Policy Seminar on Health Status and Disease Monitoring (March). ▪President of the WB and the Vice Prime Minister meet to discuss progress on the proposed TB/AIDS Control Project (April) ▪ Conference on Cooperation between the Government and Civil Society Organizations on National HIV/AIDS Control Strategies (Moscow, April). ▪WB releases <i>Economic Consequences of HIV/AIDS in Russia</i> (May). ▪WB Health Sector mission concludes technical discussions, ng the re-structuring and appraisal of the revised project, and sets project negotiations for September 2002, subject to updates of the operating manual, implementation & procurement plans, (June). ▪ Moscow workshop on Health Financing and Delivery in Russia (June). ▪WB sends official letter re-inviting loan negotiations for December (October). ▪Second Public Health Policy Seminar in Moscow on Non-Communicable Diseases and Health Promotion (October) ▪Economic impact study is upated (November) ▪WB President meets with President Putin, who expresses his commitment to the TB/AIDS

Date	Russian event/activity/response	World Bank and other external activity
2002 (cont)		Control Project (November). ▪Financial Management Assessment Report determines that Russian Health Care Foundation has sufficient financial management arrangements for the project to be implemented (November). ▪Draft loan agreed upon by government and the WB (December)
2003	<ul style="list-style-type: none"> ▪Government sends letter to WB President approving the outcomes of the loan negotiations (January?) ▪MOH approves a new strategy that includes a WHO-endorsed TB control protocol (March) ▪ Russia accepts the \$150 million loan (April). ▪President Putin mentions HIV/AIDS as contributing to the population's mortality in his annual address to parliament, his first (and still only) mention of HIV to a domestic audience (May). ▪MOH forms Consultative Council on the Problem of HIV/AIDS, including representatives from several federal ministries, regional AIDS centers, and NGOs (May). ▪MOH forms a Coordinating Council among domestic agencies and NGOs to deal with vertical transmission of HIV (June). ▪Duma passes legislation making it no longer a criminal act to put a partner in danger of infection with HIV, if that partner was informed of the HIV risk and consented to engage in the activities that created the risk of infection (November). 	<ul style="list-style-type: none"> ▪WB Health Reform Implementation Project is approved, (\$30 million) to enable the government to accelerate vital reforms of its health care system (March) ▪WB approves a \$150 million loan to support the \$286 million TB and HIV/AIDS Control Project (April) ▪Third Public Health Policy Seminar on Epidemiology and Control of Infectious Disease (in Moscow, April). ▪Economic impact study again updated (May). ▪First meetings of Transatlantic Partners against AIDS, a high-level, bilateral group formed by the East-West Institute, are held in Moscow and Washington (May-June). ▪TB and HIV/AIDS Control Project becomes effective (December).

Annex C. Risk factors and epidemiology of HIV/AIDS in Russia

Increase in Individual Vulnerability with Rapid Socioeconomic Change

1. Economic and social changes have raised the risk of HIV infection among certain populations in Russia, as evidenced by:
 - Growth in the number of street children at risk of sexual exploitation and drug use (Kulianov, 2003)
 - A drop in the age in onset of sexual activity (Chervyakov and Kon, 1998; Russia Longitudinal Monitoring Survey Results, 2001)
 - Deterioration in the status of women coupled with the high incidence of rape and domestic violence (Sperling, 2000)
 - Rise in resort to prostitution for economic survival (Twigg, 2002; Rhodes et al., 1999)
 - Heightened internal migration for economic reasons that separates workers from their families
 - Changes in sexual attitudes and behavior fed by access to Western media, which has not been accompanied by provision of reliable information about sexuality, contraception and STI prevention. (Atlani et al., 2000; MAP, 1998)
 - Greater tolerance of men who have sex with men, leading to greater public discussion and display of practices and lifestyles (Kon, 1995; 2000)
 - Increased accessibility and affordability of injecting drugs (Kramer, 2003)
 - A growing prison population at risk of transmission through sexual and injecting drug use routes

The Extent of Spread from IDU to the Low-Risk Population

2. Four behavioral and epidemiological factors will largely determine the extent to which HIV spreads outward from the high-risk IDU population through “bridge” groups to the general population: (1) HIV incidence and prevalence among IDU; (2) the extent and patterns of sexual contact between IDU and non-IDU; (3) risk behavior in these sexual contacts; and (4) STI type and prevalence in the IDU and non-IDU populations (Lowndes et al., 2003; Grassly et al., 2003; Kelly et al., 2001; Karapetyan et al., 2002).
3. With respect to the first factor, Kaliningrad provides an example of the rapidity of spread of HIV among IDU: HIV incidence in that region rose from less than one to more than 100 per month between August and September of 1996, and 80 percent of those cases were associated with IDU (Leinikki, 1997; Mashkilleyson and Leinikki, 1999; Rhodes et al., 1999; Meyers, 2002). Similar but more recent evidence of a rapid and explosive epidemic of HIV among IDU communities has emerged from Togliatti City in the Samara region (Meier, 2000; Rhodes et al., 2002; Rhodes et al., 2003).
4. With respect to the second and third factors, there is considerable interaction between sex workers and IDU and high levels of risk behavior that will enhance HIV

transmission between the two groups. Between 10- 30 percent of female IDU are involved in sex work (Aral and St. Lawrence, 2002). Sex is the primary source of money for female IDU to purchase drugs (Mainville, 2002). A local government study of female sex workers in Kaliningrad in the late 1990s (no sample size given) revealed that 65 percent were HIV-infected, and 30 percent of those aware of their HIV status still engaging in commercial sex – some with as many as 10 sexual encounters per day. Only 16 percent used condoms at all. Eighty-two percent of the HIV-positive CSW who injected drugs said that commercial sex was their only source of income (Mashkilleysen and Leinikki, 1999).

5. With respect to the fourth factor, the STI epidemics are roughly equally distributed between males and females, and they affect all sexually active age groups and socioeconomic strata (Dehne et al., 2000). The rise in STI incidence has occurred disproportionately among young people, with syphilis rates among 15- to 17-year-old girls increasing 120-fold between 1985 and 1997 (Amirkhanian et al., 2001). This points to a change in sexual risk behavior among young people and also creates a backdrop of untreated STI that could both enhance HIV transmission and increase susceptibility to HIV infection (Kelly et al., 2001; Lowndes et al., 2003). Several published reports have indicated higher syphilis rates among IDU than in the general population (Lowndes et al., 2003). Others have found syphilis prevalence rates as high as 34 percent among CSW in Moscow, while over 20 percent of CSW in other Russian cities reported having an STI episode in the last year (Lowndes et al., 2003).

6. Throughout the 1990s, heterosexual transmission accounted for at most 10 percent of new HIV cases. In 2000, the Federal AIDS Center began noting a marked increase in the incidence of HIV acquired through sexual contacts, possibly indicating the spread of HIV beyond the primary partners of drug users and therefore the risk of a major heterosexual epidemic. Studies performed in the mid-1990s demonstrated the emergence of HIV subtype A, previously found mainly in IDU, among heterosexuals with no history of drug use (Dehne et al., 2000). The number of HIV cases detected among pregnant women was 443 times greater in 2001 than in 1995 (Ladnaia et al., 2002, abstract).

7. In some cities where the IDU epidemic is “maturing,” the proportion of new cases of HIV infection attributable to heterosexual transmission is increasing markedly. In Kaliningrad, for example, the share of heterosexual transmission increased from 5-10 percent in 1996 to 30-35 percent in 2000 (Lowndes et al., 2003). Male-to-female ratios among new cases in Kaliningrad are similarly declining from 4:1 in 1997 to 2:1 in 2001. In the Tver region, one study found that IDU comprised 95 percent of new reported HIV cases in 1997, compared with just 72.8 percent in the first six months of 2001. A survey of over 400 IDU in the region found that over half had sexual contacts with non-IDU in the previous six months, and less than half of all IDU always used condoms (Ivanov, 2002, abstract).

8. Still, a country-wide explosion in the number and rate of new infections attributable to heterosexual transmission has not yet been detected. In other regions where the IDU epidemic first emerged in Russia, a spread to the heterosexual population has not been marked. In Krasnodar, for example, the percentage of new cases that had heterosexual contact as their only risk factor has increased much less significantly from

1.5 percent in 1996 to 2.1 percent in 2001 (Pokrovsky et al., 2002 abstract). Declines in the male-to-female sex ratios for HIV incidence have been interpreted as a sign that heterosexual transmission is becoming more important, since between 65 percent and 95 percent of IDU in Russia are reported to be male (Dehne et al., 2000). However, the change in sex ratio could also reflect an increase in IDU-associated transmission among women.

9. In recent years, a debate has emerged over whether available case reporting data are sufficient to demonstrate the spread of the epidemic significantly beyond primary risk groups. Official data on HIV transmission routes are frequently missing, with the gaps reaching as high as 40 percent of cases in some recent years. These holes in the data make it difficult to interpret and track movements involving small numbers, such as the possible beginning of a trend toward heterosexual transmission into the general population. Government statistics may also overstate the extent of IDU transmission, since all individuals with a history of drug use are recorded as having acquired HIV through the parenteral route even if other modes of transmission may have been involved (Lowndes et al., 2003).

HIV Prevalence and Risk Behavior in Key Groups

10. *Injecting drug users (IDU)*. According to President Putin, as of September 2002 there were 3 million Russians addicted to illegal drugs, although government officials routinely cite figures closer to 4-5 million (Kramer, 2003). IDU appear to remain fairly well integrated into social networks not constructed around drug-related activities. They lead “regular” lives, attend school, and socialize with non-IDU, including having sexual relationships with them (Veeken, 1998; Grund, 2002).

11. The most commonly injected opiates are kitchen-produced derivatives of opium poppies and poppy straw, including *chorniy* (“black”), *khimiya* (“chemistry”), and *hanka* (Rhodes et al., 1999). Also popular are liquid “amphetamine-like” drugs, known as *vint* (“screw”), *belie* (“white”), *jeff*, or *pervitin*, produced domestically from the ephedra shrub (which grows wild) or ephedrine (extracted from cough syrup or anti-asthmatic drugs) (Rhodes et al., 1999). All of these ingredients are readily available on the black market. Injecting heroin has grown in popularity in some parts of the country (Aral and St. Lawrence, 2002), as has injecting Ketamine, an anesthetic with strong psychedelic properties (Sergeyev et al., 1999; Dehne et al., 1999). The drug of choice varies geographically and by socioeconomic class. Relatively wealthy Muscovites in the late 1990s, for example, preferred heroin and cocaine, while the lower social strata in the suburbs chose less expensive home-made opiates and ephedrine-based stimulants (Dehne, et al., 1999).

12. Sharing of needles and syringes is believed to be the main mode of HIV transmission among IDU. Between 35-40% of IDU reported using a needle or syringe previously used by someone else in the past 30 days (Rhodes et al., 2003). In predominantly rural Orel region in 1999-2001, 59% of IDU shared needles at least occasionally (Sofronova et al., 2002). These methods may be considered necessary by IDU, who are reluctant to carry their own needles or syringes for fear of police detainment or arrest. IDU may therefore store their equipment at a dealer’s house, or use

whatever injecting equipment is available at the dealer's location. The 2001 Togliatti City survey showed that IDU who obtained their syringes from dealers, friends, and street contacts were twice as likely to be HIV positive as those who got their equipment from pharmacies, commercial shops, and the city syringe exchanges (Rhodes et al., 2002).

13. Drug distribution methods also enhance HIV spread. Solutions are often distributed at drug markets in ready-filled syringes or "front-loaded" from the needle or "backloaded" by removing the plunger, directly from a dealer's donor syringe. Users may re-fill their own syringes directly from a dealer's container. Nearly three-fourths of IDU interviewed in Togliatti City in 2001 reported that within the last week they had drawn up drug solutions from a container into which someone else had already put a used needle (Rhodes et al., 2003). The chances of HIV transmission between those sharing the drugs are significant when not all of the syringes are sterile (Grund, 2002; Dehne et al., 2000; Dehne et al., 1999; Burrows et al., 1999).

14. Finally, the social context of drug injecting has consequences for HIV spread. In contrast to some other cultures, in Russia drugs are usually prepared and injected among groups of friends, a practice that encourages sharing of drug paraphernalia as well as needles and syringes (Grund, 2002).

15. **Commercial sex workers (CSW).** There are no reliable studies that track HIV prevalence among CSW. Sex work in Russia is not a profession with clear boundaries.²¹ Although some women engage in sex work as a full-time profession, a significantly larger number engage in sex work intermittently and/or on a part-time basis, usually as a supplement to other employment. These women do not consider themselves to be prostitutes, and they encompass a broad range of the socioeconomic spectrum. Women who have been arrested in Moscow and who consistently work several times a month in the sex trade, for example, have identified themselves as students, sales clerks, and physicians (Aral et al., 2003). Sex workers are a potential bridge population for the spread of HIV into the general population.

16. **Blood donors.** Fewer than 50 infections contracted through donated blood were reported in the entire post-Soviet region during the 1990s, largely due to universal screening of donated blood and blood products (Savchenko, 1999; Dehne et al., 2000). Russian screening procedures have improved markedly over those during the Soviet era, when because of the expense and scarcity of diagnostic kits, blood from 10-15 different prospective donors was often pooled before testing (Powell, 2000). Since then, sensible and careful precaution has become the norm. Among blood donors the HIV-infection rate was 211 times higher in 2001 than in 1995, reflecting higher infection rates among IDU who donate blood (Ladnaia et al., 2002, abstract).

17. **Mother to child transmission.** As of the end of 2002, there were 4,682 cumulative HIV infections due to transmission from mother to child. Pregnant women continue to be HIV tested, often without their knowledge or consent. Most who test positive are encouraged to abort the pregnancies, not an unusual situation in a country where there are still two voluntary abortions performed for every live birth (Savelieva, 2000, abstract). In

21. Although sex work is dominated by women, there are male sex workers in larger cities.

2002, over 6,000 HIV-positive women in Russia became pregnant, and 2,700 of them gave birth. Prophylactic treatment is in theory offered to all HIV-positive pregnant women; in reality, however, it is rarely offered to pregnant IDU.

18. ***Men who have sex with men (MSM).*** MSM are young and sexually active, yet few studies have been conducted of their HIV risk behaviors, and few HIV/AIDS prevention campaigns have been targeted toward them. One of the few published studies surveyed attendees at all five gay nightclubs in St. Petersburg during June, 2000 (Kelly et al., 2001; Kelly et al., 2002; Amirkhanian et al., 2001). Nearly half of respondents reported engaging in unprotected anal sex in the prior three months and only 30 percent claimed to use condoms consistently. More than a third of the MSM (37 percent) had female partners in the previous three months and nearly a quarter of the men (23 percent) exchanged sex for money or other valuables. A study of 100 gay men in St. Petersburg found that only 40 reported regular condom use and almost half who engaged in casual sex did not feel that they were at risk of contracting HIV (Davydova et al., 2002, abstract).

19. ***The armed forces.*** HIV was first detected in the Russian military in 1995. Transmission was primarily through sexual contact until 1995, when it began to spread through IDU. At the end of 1997, the infection rate among military forces was 7 percent, with most having become infected prior to recruitment (Zmushko and Bolekhan, 1998, abstract). In 2001, military health officials reported that 1-2 soldiers were contracting HIV every day while in service, primarily through drug use.

20. ***Prisoners.*** Since the late 1990s, roughly 15 percent of reported HIV infections have been among prisoners (Frost and Tchertkov, 2002). Among more than one million people incarcerated in Russia, the number of HIV-positive inmates increased from 3,010 in late 1999 to 21,516 as of July 2001 and 37,000 by December 2002 (Grigoriev, 2002, abstract). As of mid-2001, in the correctional facilities of St. Petersburg alone, there were 400 IDU and 2500 HIV positive inmates (Bakuline, 2002, abstract). As recently as 2000, however, MOJ officials claimed that all HIV infected prisoners had acquired the virus before entering the penitentiary system, and that no one has actually been infected while incarcerated (Vinokur et al., 2001).

21. The scarcity of data makes it difficult to assess the risk environment within prisons. It is widely recognized, however, that health and living conditions are poor. A 1994 study of 1,100 male inmates in St. Petersburg found that 85-90 percent of prisoners engaged in sexual activity during incarceration, with 8-10 percent maintaining 30-50 concurrent partners for homosexual oral and anal sex. Condom use was extremely rare (Albov and Issaev, 1994, abstract). A 1999 study of 9,727 St. Petersburg prisoners revealed that 58 percent had injected drugs during the previous 12 months, with 46 percent of injectors HIV positive. Forty percent of all prisoners reported multiple sex partners over the previous twelve months, 61 percent of them never using a condom (Morozov and Fridman, 2000, abstract).

Annex D: HIV Prevalence by Region, 1997-2003

