

# **The Effectiveness of the World Bank's HIV/AIDS Assistance: Preliminary Findings from an Independent Evaluation**

Operations Evaluation Department, World Bank  
Martha Ainsworth, Team Leader

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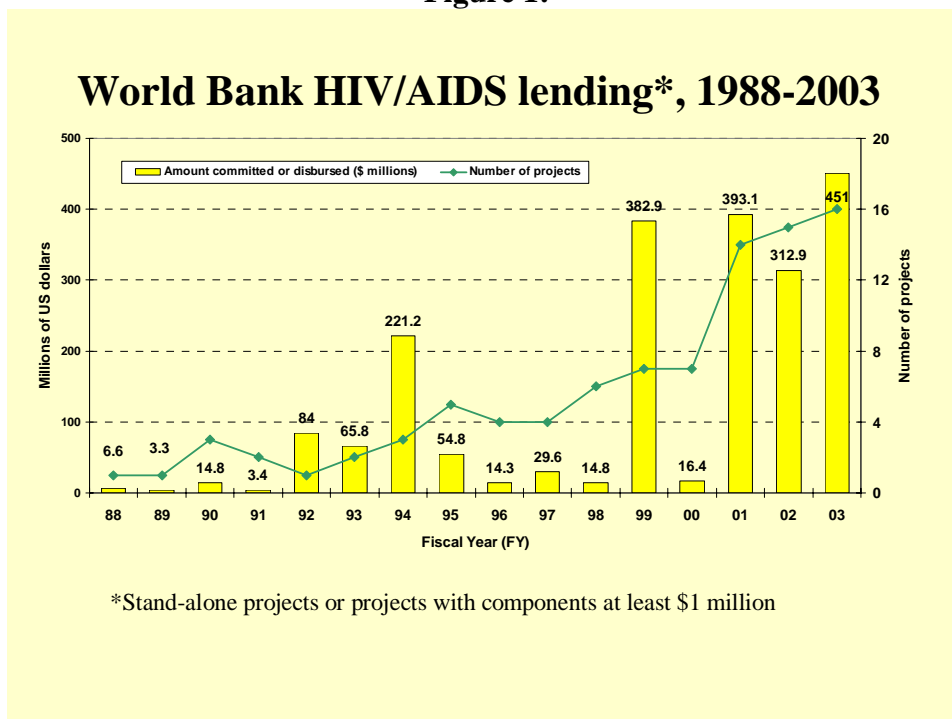
## Overview of the objectives and methodology of the OED evaluation

### Martha Ainsworth

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Since 1988 and through the end of 2003, the World Bank has financed or committed more than \$2.2 billion on 91 projects to prevent the spread of HIV/AIDS, provide treatment and care, and mitigate the impact of AIDS in developing countries (Figure 1). Of these projects, 29 have been completed and 62 are ongoing.

**Figure 1:**



The Bank also has conducted policy dialogue with government officials and sponsored analytic work on HIV/AIDS. These are more difficult to quantify but can also have an impact on the country response.

The fact that a sizeable number of projects have been completed and that a large, new wave of lending is underway, not only in Sub-Saharan Africa but in other developing regions, makes this an opportune time for stock-taking, to understand the impact of past activities and pull together the lessons from this experience across all developing regions.

The Operations Evaluation Department of the World Bank—or, OED—is in the process of concluding an evaluation of the effectiveness of the World Bank’s country-level assistance for fighting the AIDS epidemic. OED is an independent branch of the World Bank that reports directly to the Bank’s Board of Directors and is charged with evaluating the Bank’s assistance.

It is internal to the World Bank, but independent of the Bank's management in conducting its evaluations and making recommendations to the Board.

This evening, I and several members of the OED evaluation team will share with you preliminary results of the country case studies that have been conducted as part of the evaluation and hope to get your feedback on the bigger picture messages that are coming out of the study. This will serve as input to the final report, which is expected to be sent to our Board at the end of 2004.

Before handing the floor over to the presenters, I would like to review briefly the key evaluation questions and themes, the source of data, and the rationale for countries included in the case studies.

**Evaluation questions.** The key objective of the OED evaluation is to assess the impact of the Bank's country-level HIV/AIDS assistance relative to the counterfactual of no Bank assistance ( Figure 2). Thus, the evaluation will answer the question, "How are the HIV/AIDS response and outcomes of this country different than they would have been without World Bank assistance?" Assistance includes lending, policy dialogue, and analytic work.

**Figure 2:**

### **“Impact” relative to the counterfactual**

**How are the national response and key outcomes in country “x” different today than they would have been in the absence of the Bank’s HIV/AIDS assistance\*?**

**\*Assistance = policy dialogue + analytic work + lending**

**Evaluation issues.** In addition, the study will focus on lessons with respect to the Bank's experience on seven themes that are highly relevant to the design and implementation of the national HIV/AIDS responses supported by the Bank and other international donors ( Figure 3).

**Figure 3:**

### **Evaluation issues**

- Raising government commitment
- Strategic choices and prioritization
- Multi-sectoral response
- AIDS and the health system
- The role of NGOs and CBOs in the response
- Monitoring and evaluation
- Impact on outcomes

**Sources of data.** The OED evaluation will collect data from desk reviews of the portfolio of the Bank's HIV/AIDS lending and analytic work; project evaluations; country case studies; and in-depth interviews on the ongoing Multi-Country AIDS Program in Africa ( Figure 4).

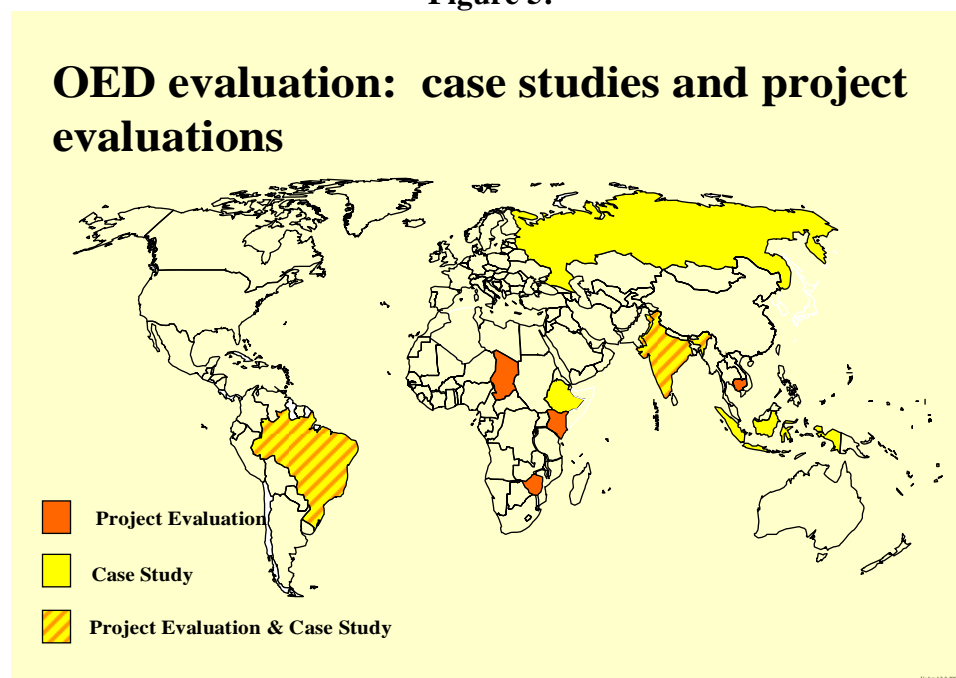
**Figure 4:**

### **Sources of data**

- **Inventory and review of country-level HIV/AIDS assistance to date**
  - Lending portfolio
  - Strategic documents
  - Analytic work
- **Ex-post evaluation**
  - Completed projects
  - Country case studies of WB assistance
- **Prospective evaluation of Africa-region Multi-country AIDS Project**

**Case study and project evaluation countries.** This evening, we will be presenting preliminary results from the five case study countries (Figure 5). Case studies provide a richer context than do project evaluations, as they consider the effectiveness of the totality of country-level HIV/AIDS assistance – including policy dialogue, analytic work, and related health lending – and go more deeply into the context and timing of the Bank’s involvement. The case study methodology includes establishing a detailed timeline of national, World Bank, and donor events and assistance, in-depth interviews with key informants, and assembly and analysis of available data concerning inputs, outputs, and outcomes.

**Figure 5:**



The five case study countries represent diverse stages of the HIV/AIDS epidemic, levels of national income per capita, and extent of World Bank engagement. All five are relatively large countries, with key issues in decentralization of service delivery.

- **Brazil and India** – the first an upper-middle income country and the second a low-income country – represent the largest and among the earliest borrowers from the Bank for HIV/AIDS, a combined total of \$700 million borrowed in five projects dating from the early 1990s. They both have concentrated AIDS epidemics, though the epidemic has become generalized in some states of India.
- In **Indonesia**, a low income country, the Bank persuaded the government to intervene early, before HIV had spread widely even among risk groups, to prevent an explosive epidemic like the one that occurred in Thailand. Yet, for a number of reasons, this effort was unsuccessful.
- In **Russia**, with a concentrated epidemic, the Bank engaged in many years of policy dialogue and analytic work to build government commitment before agreement was reached on the first lending operation, the AIDS and TB Project, which only recently became effective.

- Finally, **Ethiopia** was selected for a case study because it was one of the first two countries participating in the first African Multi-Country AIDS project, launched in 2000. Lessons about the Bank's engagement in HIV/AIDS or lack thereof since the early 1990s and more recently suggest some important lessons.

The case study results we will present today are preliminary and are not for citation. The objective of this session is to get new perspectives on them as a group, in a workshop format that will help in distilling messages for drafting the final evaluation report.

Copies of several of the case study drafts for Indonesia and Russia, as well as completed evaluations of AIDS projects in Brazil, Cambodia, Kenya and India are available on the tables outside the entrance to this hall.

The project evaluations and other intermediate outputs of the OED evaluation can be found at the evaluation website: [www.worldbank.org/oed/aids](http://www.worldbank.org/oed/aids). Posters on the India and Brazil project evaluations, as well as an oral presentation on monitoring and evaluation lessons from four countries will take place on Thursday, July 15<sup>th</sup>.

## **Brazil: Country Case Study**

Chris Beyrer, Johns Hopkins University  
Varun Gauri, World Bank  
Denise Vaillancourt, World Bank



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### **Brazil** **Varun Gauri**

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The first of three World Bank loans to Brazil for responding to AIDS became effective in 1994. Between 1994-2003, the Bank lent Brazil \$325 million, and another \$100 million will be lent between 2003-2008. Each loan has had a broadly similar strategy: prevention through NGOs and the government, services for AIDS patients<sup>1</sup>, and institutional development and monitoring and evaluation.

Let me start with the bottom line: I'll give you six impacts of the Bank's assistance to Brazil for its response to AIDS, relative to the counterfactual of no Bank involvement. Then I'll close with six lessons for future donor assistance.

#### **Impacts**

**1. Safeguarding prevention. The involvement of the World Bank likely helped safeguard prevention resources during a period in which there was a dramatic increase in demand for AIDS treatment and macroeconomic and financial instability.**

Prevention efforts go as far back as the outreach program in the Division of Leprosy and Dermatological Health in São Paulo in 1983. Brazil launched a nationwide prevention campaign,

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<sup>1</sup> Although the Bank financed lab construction to support HAART, it has not financed the purchase of anti-retroviral drugs (ARVs) in Brazil, and I can say more about if there are questions.

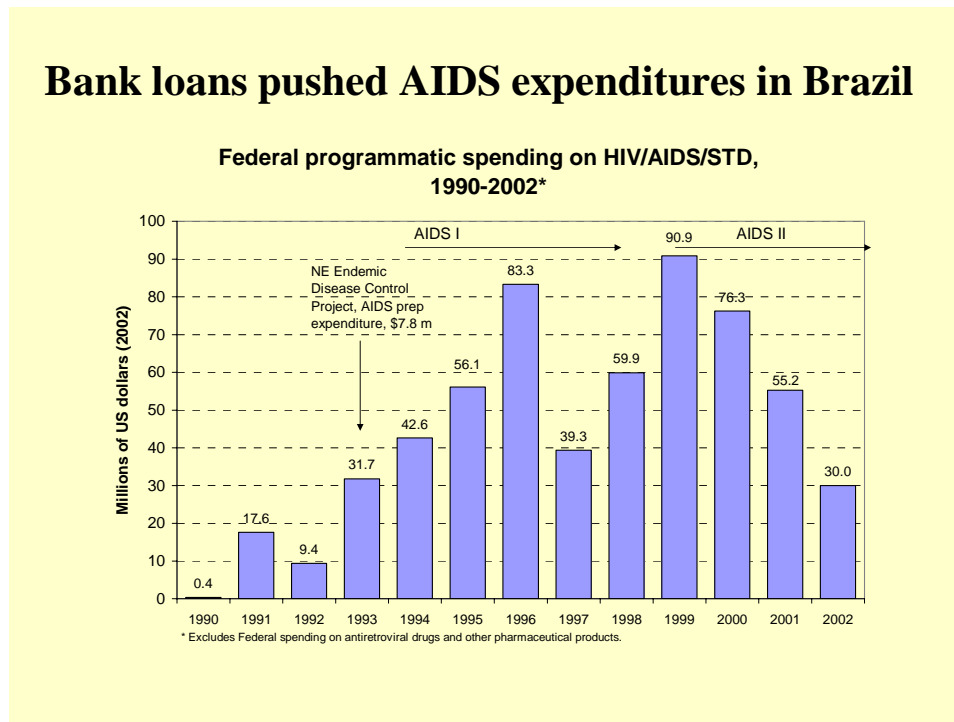
Previna, in 1989, that focused on groups engaging in high risk behaviors, including male and female sex workers. A harm reduction effort with needle exchange was attempted (though shut down by the police) in the port city of Santos in 1989.

But with the election of a new government in 1990, the national AIDS program was largely disarticulated, and Brazil was isolated from the international AIDS community.

When the previous National AIDS Program director returned in 1992, among the first important decisions she made was to pursue a loan with the Bank for the AIDS response. Given the previous instability in the program, the Bank emerged on the scene at an important moment.

Figure 6 shows federal programmatic expenditures in Brazil from 1990-2002: they averaged US\$9.3 million annually in 1990-92 and \$56 million annually in 1993-2002. The increase was probably due to the Bank loan. About half of Bank loan funds were spent on prevention activities. Note that there was no decline in AIDS expenditures during the financial crisis in 1998, when other government programs were cut.

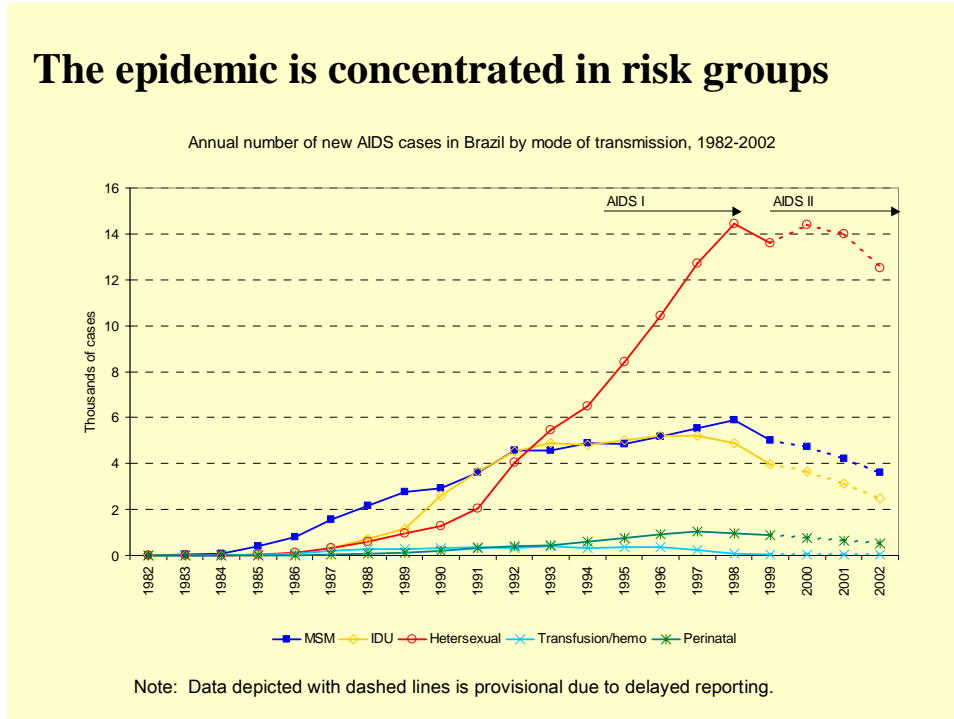
**Figure 6:**



**2. Focus on vulnerable groups.** The Brazilian national response has been more focused on HIV prevention among groups with high-risk behavior, including marginalized groups such as injecting drug users and sex workers, than might have been the case in the absence of the Bank's involvement. The Bank's presence lent legitimacy to some of these programs at a crucial time.

Brazil was already targeting groups with high-risk behaviors before the Bank got involved, but the Bank’s presence helped promote that work and lent an aura of credibility to controversial activities. The early focus was on marginalized groups because of data on AIDS cases ( Figure 7).

**Figure 7:**

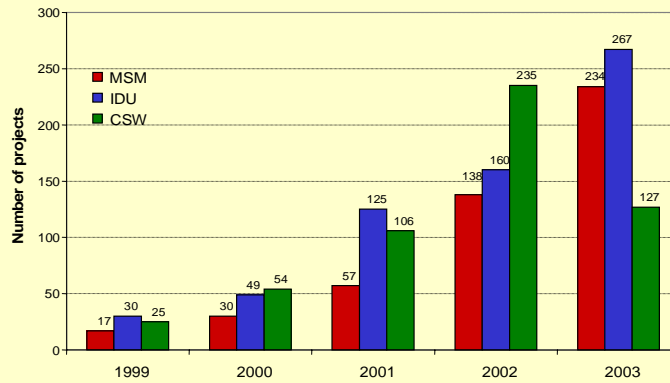


Between 1999 and 2003, there was a sharp increase in interventions targeted to men who have sex with men (MSM), injecting drug users (IDUs), and commercial sex workers (CSWs, Figure 8). To its credit, the Bank loan helped finance harm reduction programs that included needle exchange.

Figure 8:

## Bank-supported interventions focused on high-risk behaviors

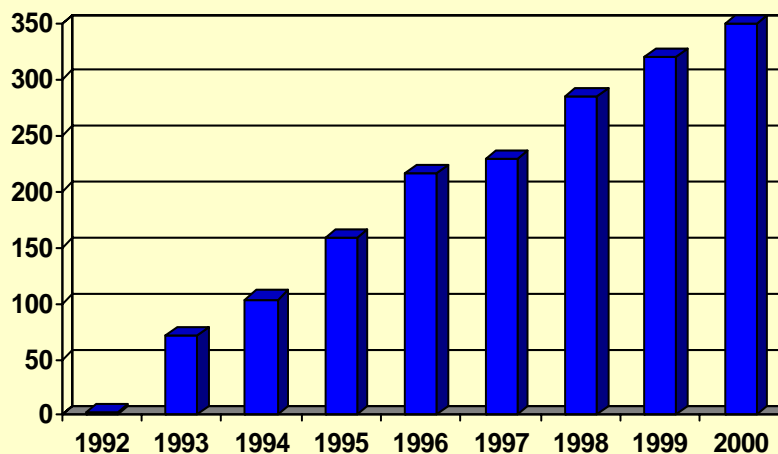
Growth in targeted interventions for high-risk groups during AIDS II, 1999-2003



There was also an increase in private condom sales (Figure 9), an associated increase in condom use, and an increase in government procured condoms as well.

Figure 9:

## Male condoms sold in Brazil (millions)



**3. Decentralization. The building of local institutions and the devolution of responsibility for planning and budgeting to states and municipalities was likely earlier than might have been the case without the Bank’s involvement.**

States were the original leaders in the AIDS response in Brazil – 11 states already had programs by the time the federal program was established in 1985, and São Paulo’s program (which began in 1983 under the first popularly elected governor in twenty years) had in some ways been the template for other state and federal programs (outreach, prevention, and support in collaboration with NGOs and vulnerable groups). But the Bank’s loan helped to make technical and financial resources available to states and municipalities that were not as advanced in their AIDS response.

The Bank loans required plans of action and funding from localities; this decentralization in AIDS began before the broader framework for health decentralization was established (NOB in 1996).

**4. NGO collaboration. The Bank encouraged early development of mechanisms by which government could finance NGOs as implementers of AIDS programs, improving the efficiency and effectiveness of the prevention program, empowering marginalized groups, and expanding the base of stakeholders to reinforce government commitment to the program.**

Before the Bank’s involvement, NGOs were already active – some were part of a working group with the National AIDS Program in 1986, 4 NGOs had formal positions on the inter-sectoral National AIDS Commission in 1988, many NGOs were pressure groups and activists – but after the Bank loan NGOs became implementers and service providers. The loans supported the work of some 800 NGOs involved in about 2800 different projects, and over \$25 million transferred.

**5. Treatment. While many of the project activities financed likely improved the efficiency and effectiveness of treatment and care, the team cannot dismiss the strong likelihood that they would have been undertaken by the government even in the absence of the Bank’s involvement.**

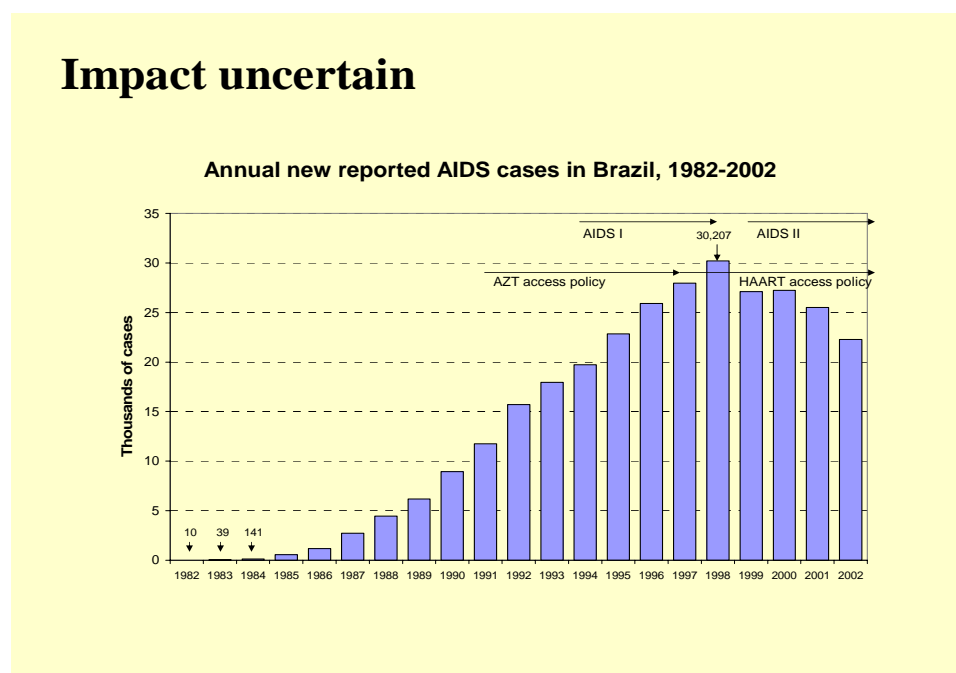
Brazil began providing AZT monotherapy for free in the public system in 1991, and by 1995-6 an effort to secure and build laboratories to monitor HAART was already underway. The effort was based on the 1988 constitution – health care is a “right of all and the duty of the state,” interpreted to mean that health care should be provided without charge by the state. The Sistema Unico da Saude (SUS) was established in 1990. In Brazil, the same strong human rights orientation that led to non-discrimination protections, such as a 1988 law that guaranteed workers with HIV the same rights as workers with other disabilities, supported the treatment effort. The Bank’s loans did finance laboratory construction, but this probably would have happened anyway.

**6. Uncertain impact on prevalence, incidence, and behaviors. Due largely to the failure of government to adopt systematic surveillance of HIV infection and risk behavior in both high-risk and general populations – and the failure of the Bank to ensure that these planned**

activities in the two projects were implemented – it is not possible to assess the impact of either the Brazilian government’s prevention efforts or the Bank’s contribution to them on the epidemic or behaviors that spread it, relative to the counterfactual.

The only methodologically comparable, nationally representative data for assessing the impact of the AIDS response on the epidemic over the last two decades are AIDS cases; here are new AIDS cases by year ( Figure 10). This slide shows that they went down in 1998, but the data are being continuously updated (data collected a year ago showed the decline began in 1997). AIDS case incidence lags HIV incidence by anywhere from 6-10 years; AIDS case incidence is affected by HAART as well as by prevention programs. For these reasons, we just can’t say what impact the prevention effort, though substantial in its own right, had on the epidemic.

**Figure 10:**



## Lessons

The evaluation team also offers six lessons from its review of the Bank’s assistance to Brazil for AIDS.

**1. Government commitment to fighting AIDS is important at all levels of policy formulation and implementation – federal, state, municipal, local – and is a moving target that fluctuates.**

It is important for external actors to be aware of this; financing is not enough; coalition building is important. The Bank’s financing for NGOs strengthened their position in the country.

**2. The Bank’s involvement can lend legitimacy to controversial prevention activities, such as harm reduction, work with prisoners, and programs for commercial sex workers.**

***3. NGO involvement in public HIV/AIDS programs can be critical in terms of reaching high-risk groups that are not easily reached by government, and in empowering those groups to become key stakeholders. But even in countries with a strong civil society, the Bank and other donors should not take for granted the existence of implementation capacity when it comes to AIDS programs.***

***4. Simply isolating M&E as a separate component in project design is not sufficient to ensure that it will become a reality.***

***5. Absence of systematic surveillance of HIV prevalence and behavior of high-risk groups and of the general population will undermine a program's ability to assess its prevention impact and document and disseminate its successes.***

***6. In concentrated epidemics, prevention aimed at specific risk groups is feasible and can be highly effective when developed by and with communities at risk and when done in a manner that respects their human rights.***

## India: National AIDS Control Project

Timothy Johnston, World Bank

Martha Ainsworth, World Bank

Sheila Dutta, World Bank



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### India Sheila Dutta

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This presentation will discuss the results of an ex-post evaluation of the first India National AIDS Control Project. The project was approximately US\$113 million in size, including counterpart and multilateral co-financing, and was implemented between 1992-1999. This project was notable in that it was not only the Bank's *first* AIDS project in India, but also the Bank's *second* free-standing AIDS project world-wide.

#### **Context of World Bank engagement** (Figure 11)

Since the discovery of the first Indian AIDS cases in 1986, HIV has spread to all states and union territories. The most recent UNAIDS estimates indicate a national adult prevalence rate of up to 1.3 percent. Given India's vast population, this results in its possessing the world's *second largest* number of people living with HIV/AIDS.

In 1991, at the time the India National AIDS Control Project was developed, far less was known about the epidemic, in terms of both its epidemiology and social context. There was a cumulative total of only 96 reported AIDS cases in India, as of September 1991. Although some Government officials recognized the potential seriousness of the epidemic, the initial response was largely characterized by complacency, denial, and a resort to detrimental legal measures.

The Bank initiated a dialogue with the government, during this period, regarding support for a series of disease control programs—including tuberculosis and AIDS.

**Figure 12:**

### **Context of World Bank engagement**

- First AIDS case reported in 1986
- Strong denial, discrimination, low commitment
- Bank dialogue on infectious diseases in 1991 led government to request blood safety project
- First Bank AIDS project in India (the second Bank stand-alone AIDS project globally)
- Health is a state matter in India (not federal)

Reflecting the widespread denial of national risk factors for the epidemic characterizing this early period, the government initially requested Bank support primarily for blood safety—even though the majority of known infections could actually be attributed to heterosexual transmission.

### **Project Development & Design (Figure 12)**

Following an intensive dialogue with the Bank and WHO, the Government of India prepared a comprehensive National Strategic Plan for the Prevention and Control of HIV/AIDS for 1992-1997, on which the Bank project was based. The final project design represented a compromise: although blood safety still constituted more than one-third of planned expenditures, the scope of the project was broadened.

In terms of its design, the six major objectives of the Indian National AIDS Control Project included the following:

- First, involving states and union territories in the national response. State involvement was critical since health is a state, versus federal, issue in India.
- Second, increasing public awareness. Specific attention was given to the development of interventions among groups at higher risk of infection.
- Third, improving blood safety. This included the supporting regulatory policies for blood donations.
- Fourth, training health care professionals. In the early 1990's, most providers had little to no familiarity with the clinical manifestations or case management of AIDS

- Fifth, strengthening the control of STDs. At the time of project appraisal, STDs were among the top five causes of morbidity in India.
- Sixth, monitoring the progression of the national epidemic.

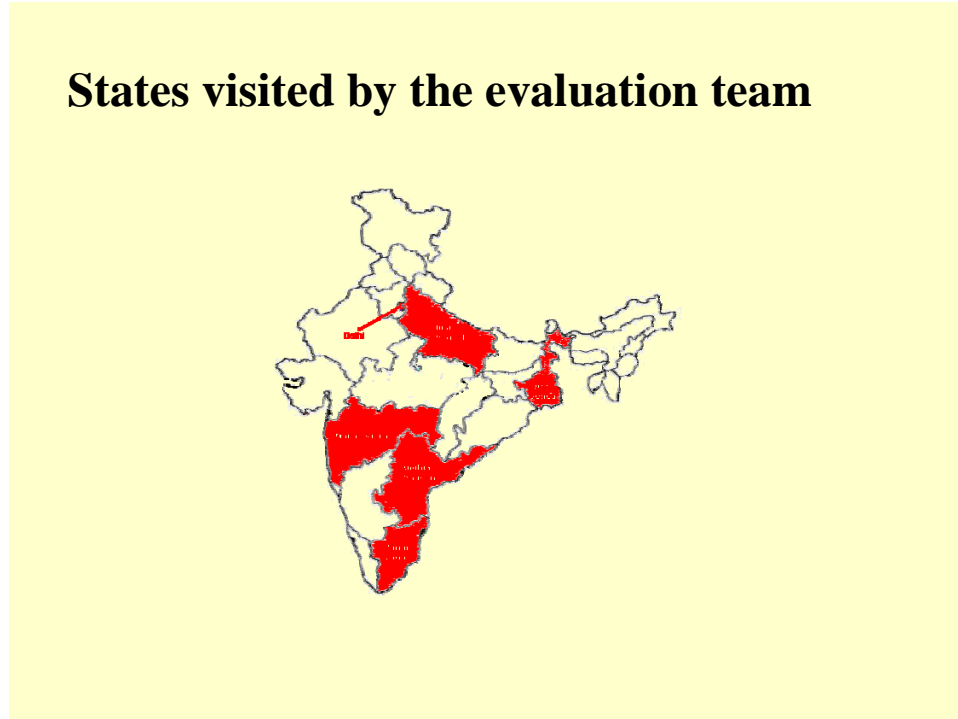
**Figure 12:**

## **World Bank inputs**

- National AIDS Control project (US\$99.6 million) funded by \$84 million IDA credit (1992-99)
  - Involve states in developing HIV prevention
  - Public awareness
  - Health promotion interventions among risk groups
  - Blood safety (screening and donor policies)
  - Train health professionals in AIDS clinical management, health education, counseling
  - Strengthen STD control in the general population
  - Monitor the epidemic
- Second National AIDS Control project (\$230 million) funded by \$191 million IDA credit (1999-present)

The OED Evaluation Report, completed in 2003, presents the overall performance of this project. This report is based on findings from an evaluation team, which conducted both extensive desk-based reviews and field-based interviews. The states highlighted on the above map (Figure 13) were visited by the team for in-depth consultation with stakeholders at various levels.

**Figure 13:**



### **Impact Relative to the Counterfactual**

The India AIDS Control Project likely advanced the government response to HIV/AIDS by several years, relative to the counterfactual of no project (Figure 14).

- The project largely put into place the institutional mechanisms at the national and state level on which a broader response could be launched. The strong institutional base built by the end of the project helped mobilize additional financial and technical support from international partners.
- The project extensively involved the mass media and civil society to increase public awareness of HIV/AIDS. OED found to be a positive correlation between state expenditures for IEC and improvements in AIDS awareness. This project was the major source of financing for behavior change communication programs during this period, when declines in risk behavior were measured in specific states (Figure 15).

**Figure 14:**

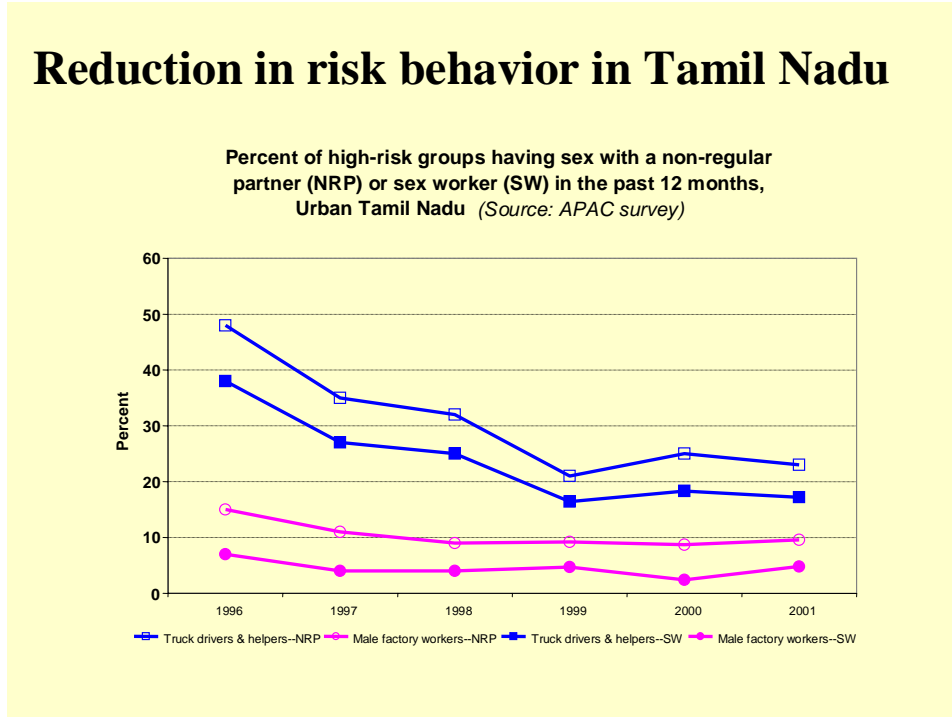
### **Impact of India First National AIDS Project**

- Likely advanced by several years the government response
- Put in place institutions (NACO, SACS) on which broader response could be launched
- Improved blood safety
- Established national HIV surveillance, although effectiveness was limited
- Correlation between project expenditures and awareness of HIV/AIDS at state level

- The project also supported the successful implementation of nation-wide epidemiological surveillance of HIV in the final year of the project.
- In addition, the project greatly increased blood safety.

However, a major shortfall of the project involves monitoring and evaluation - performance with respect to this critical area was limited. The design and ultimate effectiveness of IEC campaigns and pilot interventions might have been greatly enhanced had the project invested in collecting the planned baseline data on key biological and behavioral indicators at the beginning of the project.

Figure 15:



## Lessons

Lessons from the first India AIDS Control Project have been operationalized in the Second India AIDS Control Project, which is currently under implementation. The experience of this project suggests a number of lessons that may be relevant in other countries (Figure 16).

- **First**, building robust institutions for a national response requires substantial innovation and flexibility in implementation. Much of this project's effectiveness depended on the fact that its institutional design evolved over time to reflect both the political and operational realities. For example, when the project was developed, it specified the creation of an independent National AIDS Control Authority, which would function as an independent parastatal. However, when it became clear that this would not be politically viable, the National AIDS Control Organization was established as a semi-autonomous entity under the Ministry of Health and Family Welfare. The gradual transformation of the State AIDS Cells into State AIDS Societies, provides another such example.
- **Second**, epidemiological and behavioral surveillance provide key information to build support for the response where denial is high and the epidemic is otherwise "invisible." The availability of information on nationwide patterns of HIV prevalence and risk behaviors earlier in the project's life would have been helpful in generating stronger political commitment and earlier action.

- **Third**, projects that involve civil society organizations in implementing interventions need to carefully assess NGO capacity in light of what is expected, and to ensure requisite training and technical support. The impact of the project could have been enhanced with greater focus on these issues, and also more attention to the fact that such capacity and partnership development should be treated as a continuous, versus a once-off, process.
- **Fourth**, targeted awareness and interventions for high-risk groups can be successful only to the extent that complementary efforts are launched to improve the environment for prevention among these groups. For example, this project involved extensive support for NGOs to develop interventions for commercial sex workers. However, police harassment sometimes caused severe difficulty in reaching this marginalized population. Sensitization campaigns, including specific programs for law enforcement officials, were subsequently developed to address this challenge.

**Figure 16:**

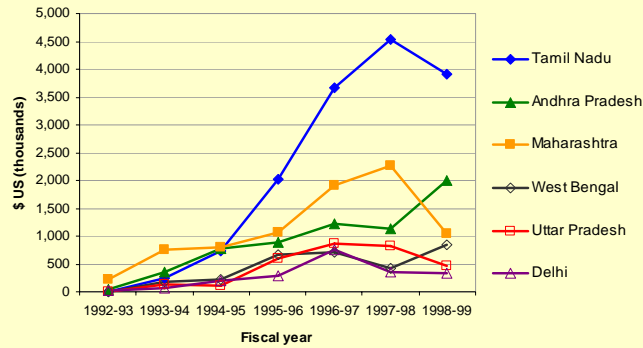
### **Lessons from India**

- Institutional impact of World Bank project nationally and at state level, leveraging of blood safety to support adoption of more relevant prevention
  - Surveillance helps build political commitment where denial is high and epidemic is ‘invisible’
  - NGO capacity building and training, monitoring and evaluation of activities need to be built into project design
  - Targeted interventions require complementary actions to improve the legal environment for prevention
  - Channeling resources to states with higher commitment demonstrates local feasibility,
- **Fifth and finally**, when political commitment is uneven in a decentralized system, channeling more resources to effective programs in areas with higher commitment can serve as a powerful means of mobilizing other states. Figure 17 shows the disproportionate disbursements to the state of Tamil Nadu, which expanded its response ahead of other states. Such a performance-based system enables the development of a positive form of “peer pressure,” which can stimulate the development and implementation of stronger programs.

Figure 17:

## Annual expenditure by State

Reported Annual Expenditure from the First India National AIDS Control Project, Five States and Delhi, 1992-99 (\$US)



Note: Rupee values were converted to US dollars using the average exchange rate for each period.

## **Indonesia: Country Case Study**

A. Edward Elmendorf, Johns Hopkins University  
Eric R. Jensen, College of William and Mary  
Elizabeth Pisani, Family Health International



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### **Indonesia**

A. Edward Elmendorf

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#### **The course of the HIV/AIDS epidemic**

In the early 1990s, researchers from the US Centers for Disease Prevention and Control – influenced by the experiences in Thailand and in African countries – projected dramatic increases in HIV in Indonesia, focusing on commercial sex (Figure 18). The donor community, the Indonesia Planning Agency (Bapenas), and Bank staff were in frequent contact with these researchers and their ideas.

Contrary to the projections, the HIV epidemic actually took off first, and roughly five years later, among injection drug users (Figure 19).

Figure 18:

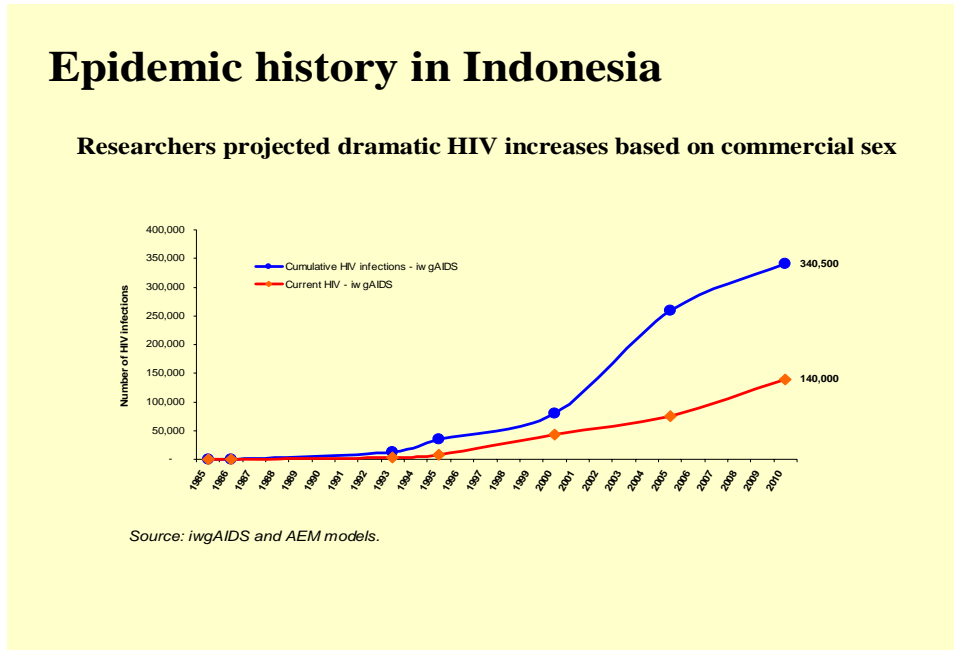
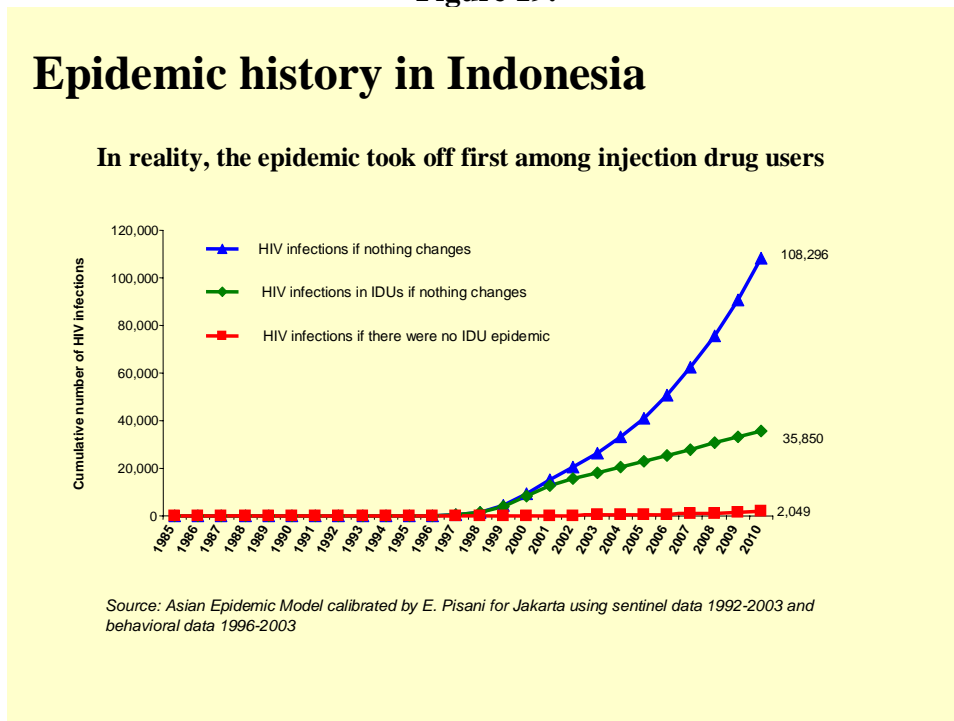


Figure 19:



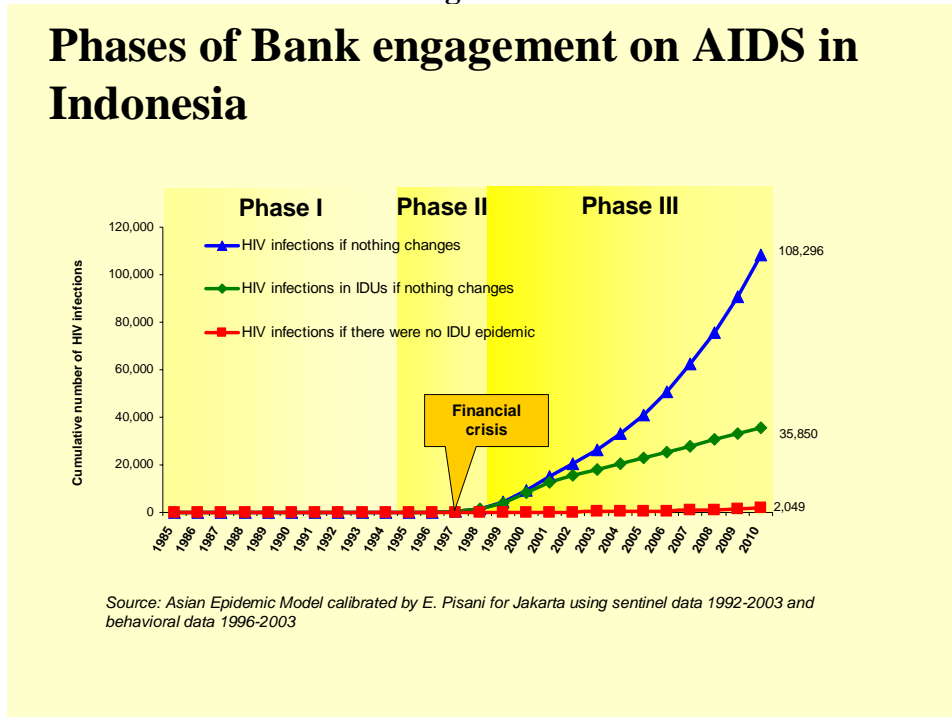
## Phases of the Bank’s engagement

Turning now to the Bank’s role, let me begin with a few words of context on the Bank’s engagement in the health sector in Indonesia. Starting with a loan for family planning in the early 1970s, the Bank has had a long and generally very successful involvement in population, nutrition, and health services development in the country. \$1.2 billion dollars have been committed, for projects costing nearly \$3 billion dollars.

In 1992, the Bank first entered dialogue with the Indonesian authorities on HIV – when HIV prevalence was very low (Figure 20, Phase I). Drawing on the work of the CDC researchers, the Bank included a brief boxed essay on AIDS in a country economic report completed in 1993. The discussions at that time were based on the faulty projections of an early epidemic based on commercial sex. These programmatic discussions were largely held with Bapenas, and the Bank was clearly pleased when Bapenas decided in 1994 to move forward with a project. The Bank staff and their Indonesian counterparts moved quickly into project preparation in 1995, and a \$24.8 million loan was negotiated in early 1996.

An initial AIDS strategy was adopted by the Government in 1994, and the National AIDS Committee (NAC) was created but did not meet. With Bapenas, the Bank focused on the Ministry of Health (MOH), although commitment to action in the Directorate responsible for HIV was low. The Bank-financed project was a large pilot, supporting services in Jakarta and Riau provinces, and central activities of the MOH. Services included behavior change, STD service delivery, surveillance, lab strengthening, NGO capacity building, and monitoring and evaluation. NGOs were expected to play a central role in service delivery for behavior change.

Figure 20:



The second phase of Bank involvement in HIV in Indonesia began with the start-up of execution of the AIDS and STDs Management Project in 1996 (Figure 20, Phase II). Problems arose quickly. The NGO implementation arrangements were incomplete, and took more than two years of unanticipated time to work out among the Indonesian agencies concerned. The Project Management Unit was poorly designed, and found itself in frequent conflict with other MOH agencies.

By the time the financial crisis hit in 1997, it was becoming clear to many that the projections which had served to justify early intervention were not being realized. Whatever commitment to the project existed among Indonesian stakeholders eroded rapidly as policymakers' attention was devoted to other issues at a time of crisis. The Bank's loan portfolio was restructured in 1998, and 80 percent of the AIDS and STD Management loan was cancelled. Other health projects survived the storm of the financial crisis, but the Bank's effort to assist Indonesia on HIV at a very early stage of the epidemic failed with a project that was labeled a pilot, was relatively small for IBRD loans to Indonesia, but was large in introducing new approaches and outreach to new high-risk groups. It should, however, be added that other donor efforts on HIV in Indonesia have hardly been noteworthy for success.

In the third phase of Bank engagement on HIV (Figure 20, Phase III), following closure of the failed project in 1999, HIV has emerged – rapidly in the past few years – as an epidemic driven by injecting drug use (IDU) in Indonesia. With this change and with the passage of time, HIV has gradually worked its way back into the Bank's agenda in Indonesia. The October 2003 Country Assistance Strategy (CAS) addressed HIV for the first time. It stated that the Bank would help elevate the policy dialogue and awareness on HIV and address analytical and funding gaps, as required. Discussions are under way on possibilities for including AIDS components in education and transport projects, and collaboration with other donors in Jakarta has grown.

## **Impact**

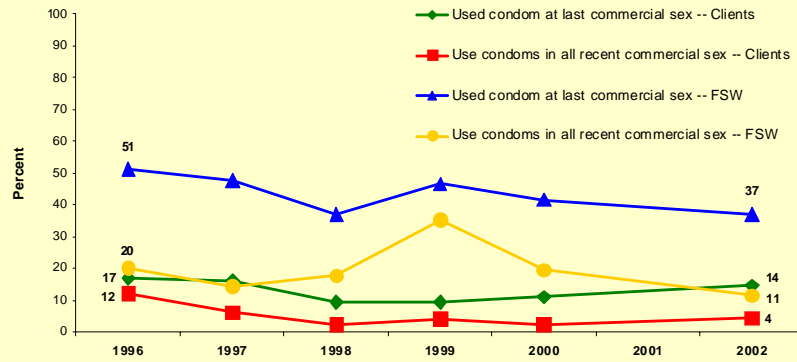
Now let me turn to the impact of the Bank. As we can see from this slide on condom use in commercial sex in Jakarta (Figure 21), the Bank has had no impact on AIDS-related behavior.

The failure of the Bank to have an impact on condom use and STD prevalence, seen in Figure 22, is hardly surprising, since the Bank-financed project was hardly executed.

Figure 21:

## Impact: None on behaviors

### Flat or declining condom use in commercial sex in Jakarta

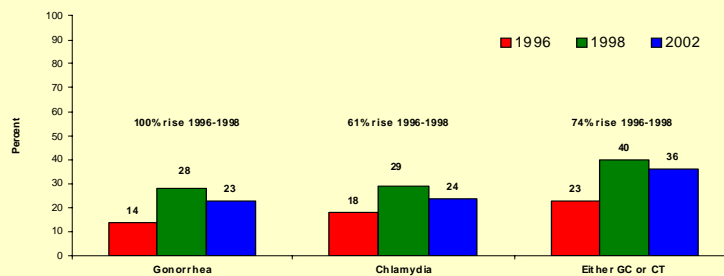


Source: BSS data

Figure 22:

## Impact: None on STD prevalence

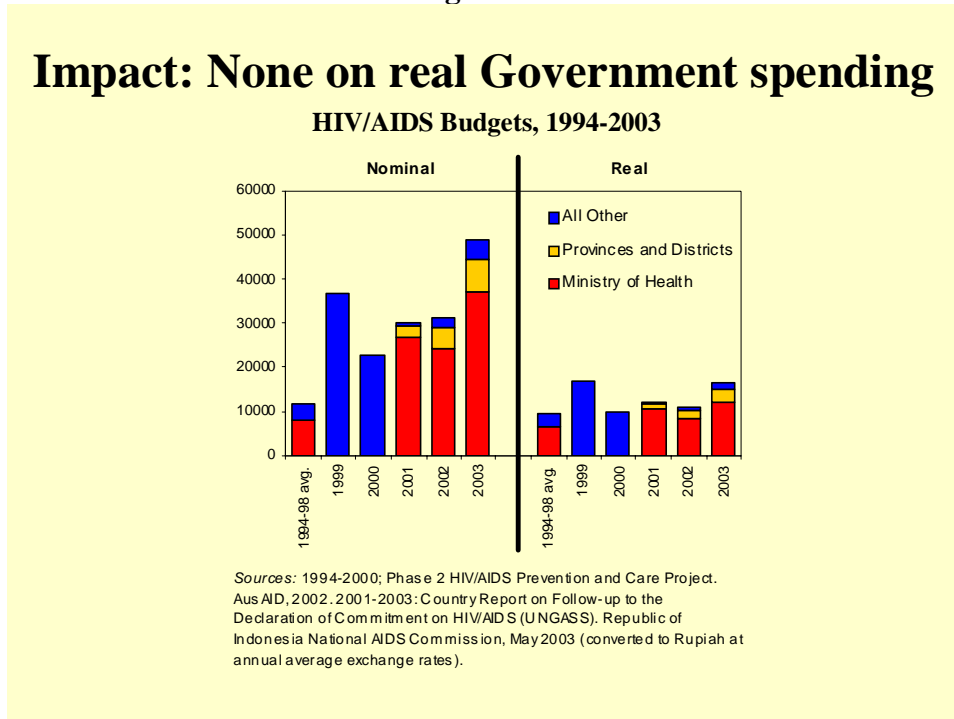
### Significant Increase in STI Prevalence Among Sex Workers in Jakarta



Source: Pisani et al (2004), Sedyangingsih-Mamabit et al (2000)

The Bank had no impact on government budgets to fight HIV, as can be seen from Figure 23, which shows in the right column that real budgets for HIV/AIDS remained substantially unchanged in level from 1994-2003.

**Figure 23:**



The Bank has had some institutional development impact through its work on arrangements for government financing of AIDS-related services by NGOs (Figure 24). However, since the procedures were only adopted by decree shortly before execution of the Bank-financed project ended, they have had relatively little use and their lasting impact is only potential. It is important that the Bank and other partners making funds available through the government encourage use of these arrangements.

**Figure 24:**

### **Impact: Some institutional development**

Though it took two years longer than expected to complete, the most important and *potentially* lasting impact was the establishment of procedures for government funding of NGOs.

#### **Lessons**

I would like to summarize five lessons from the Bank's engagement on HIV/AIDS in Indonesia (Figure 25)

First, to facilitate an early response in a nascent epidemic, a conscious strategy is needed to build commitment among stakeholders. In the Indonesia case, the early commitment of key stakeholders stimulated by the dramatic epidemiological projections dissipated over time: Continuous efforts for commitment building were needed, and could have been built into the Bank-financed AIDS project.

Second, it is important not to underestimate the difficulty of promoting an effective rapid response to a nascent epidemic. The figures on infections are small, and the populations affected often tend to be marginal, socially and politically, and thus with little voice in the debates on resource allocation. Furthermore, they are difficult to reach with services. In the Indonesia case, to the extent that it was executed, the Bank-financed project found the emphasis on high-risk groups built in at the initial design stage diluted in practice.

Third, institutional analysis and capacity building are critical. In the Indonesia case detailed project preparation studies were undertaken on technical aspects of the Bank-financed project, but the planned NGO capacity assessment was not carried out, and no institutional analysis was planned. Yet, the weaknesses in these areas contributed in important ways to the failure of the AIDS and STDs Management Project. While NGO capacity building was important, the Bank-financed Project in Indonesia had little impact on the NGOs themselves.

Fourth, in a nascent epidemic, the country's needs may lie more in the realm of policy and institutional change and dialogue than in widespread expansion of service provision, and donors may more effectively promote this work through non-lending activities than through project financing. In Indonesia, an early sector study might have contributed to a common understanding among stakeholders on the nature and importance of the epidemic, and could have paved the way

for the policy and institutional changes required to buttress public health services. Strengthening public health surveillance, and especially its financing, has become a particularly important issue in the management of HIV in Indonesia, as the country's health services have undergone rapid decentralization in the wake of the profound social and political changes of the late 1990s.

Fifth, where the financial requirements for expanded service provision are relatively small in a nascent epidemic, donors risk making available financial resources beyond the capacity of the country to make effective use of them. In the mid-late 1990s Indonesia did not need large donor financial resources for direct HIV services on the terms of the IBRD loan. Fashions in development assistance created pressures on the Bank and other donors to make substantial volumes of money available, and the potential for complementarity among donors was not realized in Indonesia. The corporate priority of the Bank on HIV/AIDS should not necessarily imply an IBRD lending posture in countries such as Indonesia with a concentrated epidemic and relatively easy availability of donor grants.

**Figure 25:**

### **Lessons from Indonesia**

- In a nascent epidemic, a conscious strategy is needed to build commitment continuously among key stakeholders, to launch an early response
- Difficulty of promoting a rapid response to a nascent epidemic
- Institutional analysis and NGO capacity building are critical
- Engagement through non-lending activities may be more effective
- Donors risk funding beyond absorptive capacity in a nascent epidemic

## **Russia: Country Case Study**

Judyth Twigg, Virginia Commonwealth  
University

Richard Skolnik, George Washington University



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### **Russia** Judyth Twigg

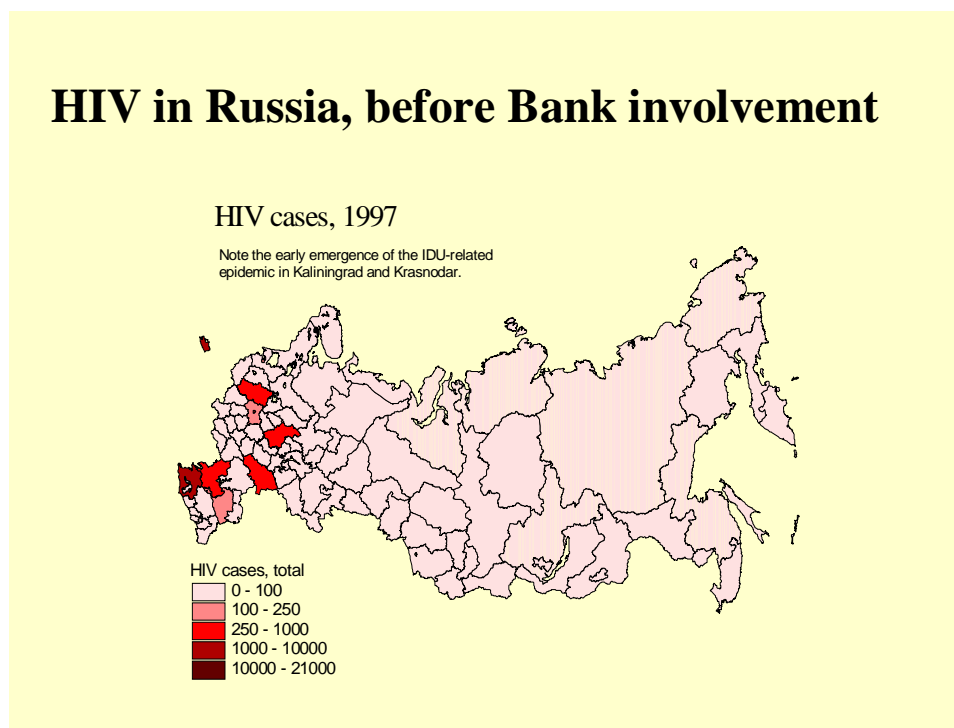
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The Tuberculosis and HIV/AIDS Control Project, being implemented by the Russian government with the assistance of a loan from the World Bank, was approved by the Bank's Board of Directors in April of 2003 and became effective in December of 2003. This case study is therefore rather unique. It evaluates the impact not of an approved project in which funds have been transferred over a multi-year period, but instead the impact of a process of protracted project preparation, which included a significant amount of policy dialogue and jointly prepared analytic work.

#### **Evolution of the epidemic and the response**

Until 1996, HIV rates in Russia were relatively low. In from 1996 through 1998, the number of new cases escalated dramatically among injecting drug users in just a few regions, many of those mirroring the drug trafficking routes from Central Asia into Western Europe (Figure 26).

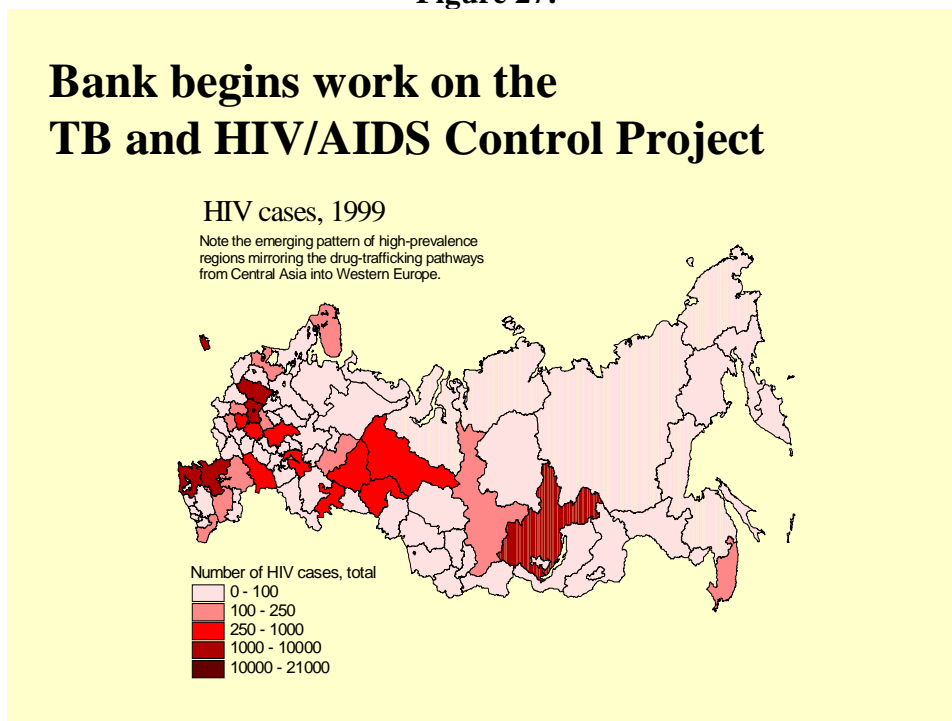
**Figure 26:**



From 1999 through 2002, the rate of increase of new infections in Russia was among the highest in the world (Figure 27). During this time period, and to a large extent continuing until the present day, the Russian government's response to HIV was overwhelmingly oriented toward a medical approach that stressed epidemiology and biological sciences over prevention, education, social services, and legal support for HIV and AIDS patients. As of June of this year, almost 282,000 HIV-infected persons had been officially reported since the beginning of the epidemic. Many factors contribute to underreporting, and this official figure should be multiplied by a factor of three to five in order to get the true prevalence.

In response to a government request, in 1999 the World Bank began to develop a tuberculosis project with the Russian ministries of health and justice. HIV was promptly added. WHO, DFID, CIDA, the Open Society Institute, USAID, Medecins sans Frontieres (MSF), and local NGOs were already involved at this time 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 work to scale and change the government's HIV/AIDS programs to conform with international best practice.

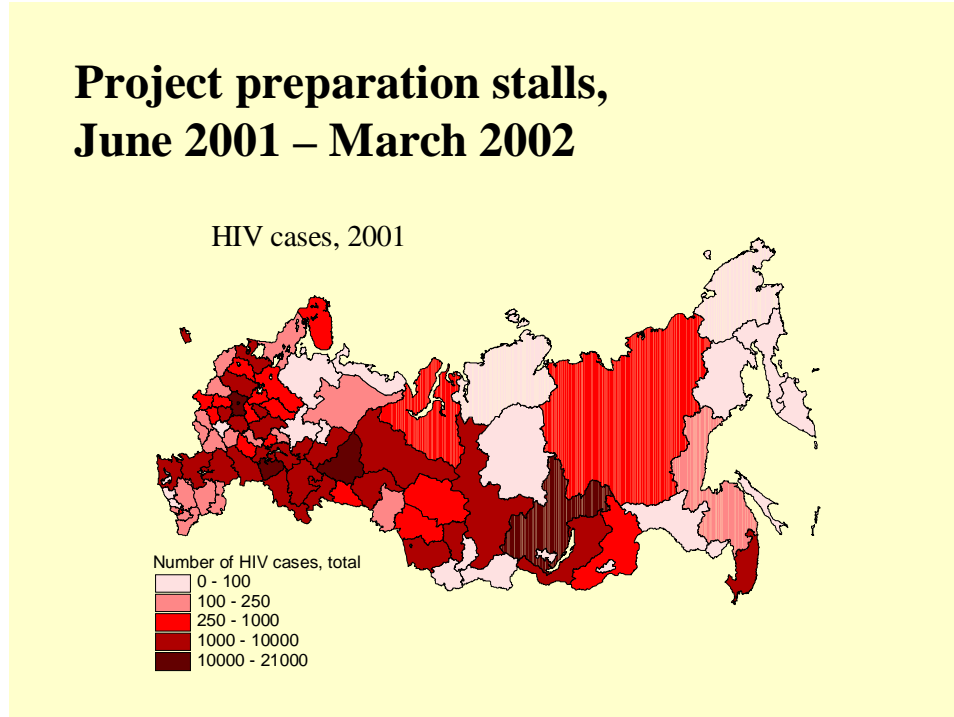
Figure 27:



In 2000 and 2001, project preparation ground to a halt due to government concerns about the DOTS approach to TB control being advocated by WHO and the Bank, and also due to concerns about the effect of international competitive bidding requirements on the Russian domestic manufacture of tuberculosis drugs (Figure 28). During the nine-month pause in project preparation, the Bank sought 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 the appointment of a new health program team leader for Russia in Washington in the fall of 2001, and his assignment as task leader for project development in early 2002. This project task leader -- the third assigned to the project -- was a physician with public health training and managerial experience who had worked at the Bank and with UNAIDS. 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.

Throughout the delay, the Bank tried to break the impasse on TB and maintain momentum on HIV/AIDS by obtaining support from the highest levels of the Bank, and by keeping the project on the table but deliberately reducing the perception of the pressure to borrow. The Bank consciously, during the stall in project preparation, worked to keep the project out of the Russian and international media. It worked with the Russian government on a modified approach to tuberculosis that acknowledged and built on Russia's own TB efforts and institutions. The Bank also supported a series of well-received public health seminars during this time period, on such topics as monitoring and disease surveillance, and health promotion and the control of non-communicable disease.

Figure 28:



Also critical during the pause in project preparation was the Bank's joint production with Russia's Federal AIDS Center of a model of the potential future economic impact of HIV. DFID financed this work. With its most pessimistic scenarios forecasting a 4 percent decline in GDP by 2010, and a 10 percent decline by 2020, due to direct and indirect losses of labor supply and productivity, the work attracted significant attention, including among top Russian government officials.

During the delay, the Bank briefly considered the option of separating the AIDS and TB components into separate projects. This option was rejected, even though keeping the two together delayed the HIV/AIDS response, because the project team felt that the rationale for linking AIDS and TB was strong, and that separation would have reduced the likelihood that a TB project would have been developed at all.

In February of 2002, the Russian government indicated a willingness to re-work the project, leading to two rounds of technical discussions in March and June of that year. In the interval between resumed project preparation and project effectiveness, there were some important indications of increased government commitment to HIV/AIDS. These include a Ministry of Health ordinance in September of 2002 on intensified HIV control action, a mention of HIV/AIDS by President Vladimir Putin in his annual address to the parliament in May 2003 -- still his only mention of HIV to a domestic audience -- and the formation in May 2003 by the Russian Ministry of Health of a Consultative Council on the Problem of HIV/AIDS that includes representatives of several federal ministries, regional AIDS centers, and NGOs. Of course, it

would be hazardous to attribute these solely or even primarily to the influence of the Bank's continued dialogue and analytic work, but the persons in Russia we interviewed during our evaluation believe that the Bank's efforts did make a significant difference.

## **Impact**

Our evaluation of the Bank's assistance to and engagement with Russia concludes that the Bank has had an impact on the Russian government capability and commitment to fighting HIV/AIDS along three critical dimensions. First, Bank actions have increased the quantity and quality of information available to Russian government officials. Second, some constituencies in Russia have become more able and willing to act on this information. Third, in general, the Bank's efforts have changed the way important elements of the Russian government think about HIV/AIDS. In the absence of World Bank involvement, the Russian 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. The government would also be paying 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; its efforts would remain small and localized, at the level of pilot projects. The World Bank has served as a facilitator to coordinate better and make more expansive those 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.

**Figure 29:**

### **Impact of Bank's HIV/AIDS assistance to Russia**

- Enhanced quality and quantity of information available to Russian government officials
- Increased capacity and will of significant (but not all) constituencies to act on this information
- Changed government mode of thinking about HIV/AIDS, scaling up local pilot programs, moving toward international best practice on HIV/AIDS and TB

## Lessons

This case study highlights a number of lessons for the Bank itself (Figure 30). First, it underscores the importance of understanding the country context and embedding project development carefully in that context. This was of particular importance for the tuberculosis part of the project, where Russia's legacy of TB treatment modalities and institutions had to be well understood. Second, this case study 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 policy makers. Third, the approved project demonstrates the important leverage of a small operation in a large country in potentially improving the effectiveness, efficiency, and coverage of the response to HIV. 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 might have reduced problems in the relationship and speeded project development.

Despite the efforts and impact of the Bank, other donors, and many others inside and outside of Russia, the Russian federal government's political and financial commitment to fighting HIV remains problematic. 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.

**Figure 30:**

### **Lessons from Russia**

- Importance of understanding country context
- Utility of reducing the pressure to borrow as a catalyst to policy dialogue
- Utility of analytic work to generate government commitment and ownership of HIV/AIDS as a problem
- Possibility of leverage from small operations in large countries
- Importance of task manager skills and placement

# Ethiopia: Country Case Study

Denise Vaillancourt, World Bank  
Sarbani Chakraborty, World Bank  
Taha Taha, Johns Hopkins University



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## Ethiopia

### Denise Vaillancourt

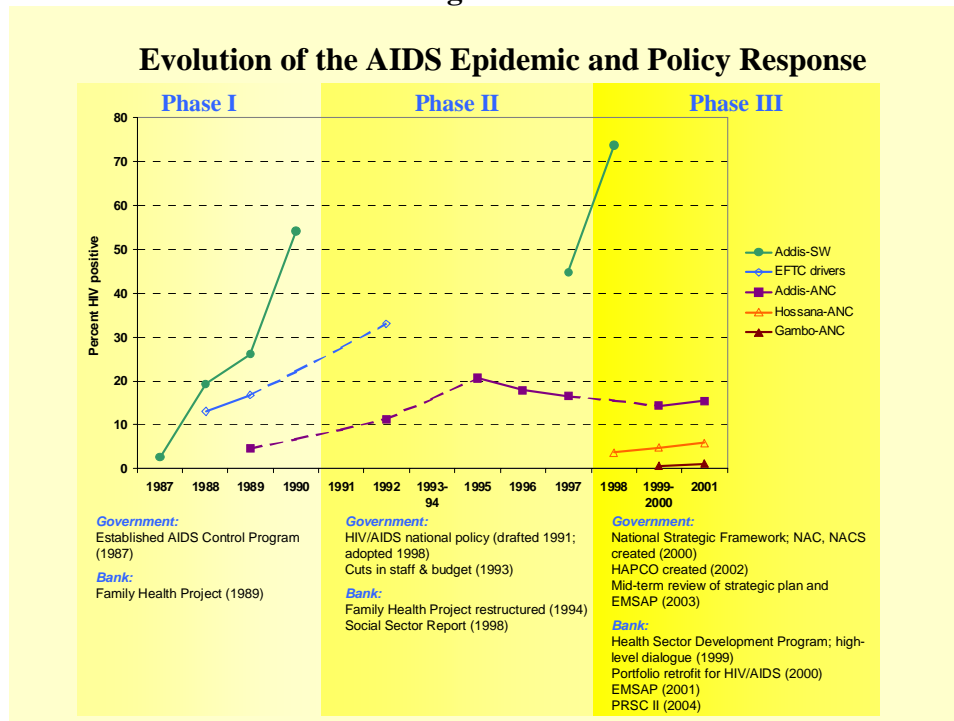
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In presenting the highlights of the Ethiopia case study, I will first provide a quick overview of the AIDS epidemic in the country. Next I will summarize the response of Government and the support of the World Bank over three distinct timeframes. I will then highlight the impacts of the World Bank's assistance; and, in conclusion, will outline some lessons drawn from this experience.

### **AIDS Epidemic in Ethiopia**

Starting in the mid-1980s, HIV initially spread rapidly in urban areas among sex workers and other populations with high numbers of sexual partners (Figure 31). HIV then spread to the sexual partners of high-risk populations, including monogamous partners and those with much lower rates of partner exchange. In rural Ethiopia the epidemic began in the early 1990s. National adult HIV prevalence was estimated at 6.6 percent in 2002 – 13.7 percent in urban areas (15.6 percent in Addis Ababa) and 3.7 percent in rural areas. The Ethiopian HIV/AIDS epidemic is now generalized, but there is considerable geographic heterogeneity in the epidemic.

Figure 31:



## The Policy Response

**Phase I.** The first phase of the policy response covers the period from 1984, when the first HIV infections were identified, to 1991, the year that marked the end of the Marxist regime (Figure 31, Phase I). Ethiopia was quick to launch an HIV/AIDS program in 1987, one of the first in Africa. Activities centered around surveillance, prevention, care, decentralization, collaboration with other sectors and with NGOs. The program was funded in part by the public budget and also received technical and financial support from WHO/GPA and modest bilateral assistance. The First IDA-financed Family Health Project (US\$33 million) was approved in 1985, but did not provide direct support to early program efforts.

**Phase II.** The second phase of the policy response covers the period from 1992, when a new (post-Marxist) transitional government took power, to 1998 when the Government of Ethiopia adopted a national HIV/AIDS policy (Figure 31, Phase II). During this period HIV/AIDS program efforts were stalled considerably. The new government had an overwhelming agenda of competing development and political priorities. The rapid decentralization of resources and decision-making autonomy to regions dramatically reduced the size, mandates and resources of all federal-level agencies and, as a consequence, significantly weakened the national HIV/AIDS response.

The World Bank-financed Family Health Project was restructured in 1993, but still did not incorporate direct support to HIV/AIDS, even though enough information about the progression of the epidemic was available to warrant a stronger approach. In the mid- to late-1990s the World Bank joined other development partners and began to raise HIV/AIDS as a development issue, both through social sector analytic work and in the context of overall macroeconomic

discussions. These efforts were persistent, but did not convince government of the urgency with which HIV/AIDS should be addressed, especially its priority vis-à-vis other diseases. Nevertheless, with the support and encouragement of development partners, an HIV/AIDS policy was adopted by Government in 1998. In that same year a US\$100 million IDA credit was approved to support Ethiopia's health sector development program.

**Phase III.** The third and most recent phase covers the period 1999 – present (Figure 31, Phase III). In late 1999 into early 2000 the World Bank intensified its efforts in Ethiopia on three fronts. First it stepped up high-level advocacy with support from the President and the Regional Vice-President for Africa of the World Bank. Second, the ongoing portfolio of projects was retrofitted to incorporate HIV/AIDS activities in a wide range of sectors. Third, a standalone HIV/AIDS operation in the amount of US\$59.7 million was rapidly prepared as one of the first two projects supported under the Multi-Country AIDS Program (MAP) for Africa. Looking across the three phases, it can be said that the World Bank was late in launching a dialogue with Government; it was persistent, but unsuccessful, in its initial attempts to convince Government of the urgency of addressing the issue; and it was late in providing financial support. It is significant to note that this was also the case for most other development partners.

#### **Impact** (Figure 32)

- With the support of its high-level officials, the World Bank raised the profile of AIDS as a development issue at the highest levels of government; it also increased resources available for HIV/AIDS activities through lending for health, HIV/AIDS and HIV/AIDS components, and extended the access to these funds to a multiplicity of actors, all the way to the community level.
- Social sector analytic work supported and nurtured the development of a 10-year health sector development plan, thus strengthening MoH capacity in coordination and strategic management; and it financed an expansion in basic health services coverage.
- The World Bank nurtured, strengthened and supported government responses in selected sectors, most notably: defense, transport and education sectors.
- The World Bank created mechanisms for public-private partnerships that financed NGO and community-based efforts on an unprecedented scale.

However:

- The Bank had no significant impact on the content of national policy/strategy.
- Creation and support of a new multi-sectoral institutional structure for HIV/AIDS served to alienate MoH, which had previously been responsible for HIV/AIDS program coordination. The funding made available under the health and HIV/AIDS operations was underutilized by the health sector, as a result.
- Finally, because of the emergency nature of the MAP operation, no baseline data were established at the project's outset and an M&E framework was only developed at the end of Year 3 of the project. Consequently, the impact of program efforts, in general, and of the Bank's support, specifically, is unknown.

**Figure 32.**

## **Impact of Bank's HIV Assistance to Ethiopia**

- Raised profile of AIDS as development issue and increased resources available to Government and civil society
- Supported establishment of a multi-sectoral institution for HIV/AIDS coordination, but:
  - initially alienated MoH in process, and
  - has not elicited robust response of key non-health public sector agencies.  
Important exceptions: transport, defense and education
- Strengthened health system capacity and coverage; direct support to strengthen health sector response has not been fully exploited.
- Provided support to NGO and community efforts on an unprecedented scale and fostered partnerships with government.
- Has not had significant impact on content of national policy/strategy
- Postponed focus on M&E due to emergency nature of assistance (no baseline, no regular surveillance, no M&E framework until very recently).

### **Lessons (Figure 33):**

- A multi-sectoral institutional framework does not necessarily foster a multi-sectoral approach, even when funds are available.
- Health sector leadership and full involvement, in line with its comparative advantage, is unequivocal.
- The Ethiopia case shows that the response of sectors is stronger when (a) the sector is highly impacted; (b) the impact is appreciated; and (c) technical support is provided. This points to the need for more sector-specific analytic work and design.
- Financing is essential for expanding NGO involvement. Also needed are: major capacity building efforts, an enabling environment, and mechanisms for coordination and evaluation.
- A final lesson is that the absence of baseline data and of a M&E framework undermines learning by doing.

**Figure 33:**

## **Lessons**

- Bank conditionality does not ensure sustained commitment/effective response.
- Project design w/ primary focus on process vs. results will undermine effectiveness and efficiency of Bank's investments.
- Without proper analysis, a multi-sectoral institution may not necessarily foster a multi-sectoral approach and risks alienating key actors like the MoH.
- Within context of multi-sectoral approach, health sector leadership and full involvement is unequivocal.
- Financing is a necessary, but insufficient condition for NGO involvement. Also needed: capacity strengthening, enabling environment, coordination.
- Absence of baseline data and monitoring and evaluation framework during design stage is missed opportunity for targeted, results-based response.