
APPENDIX G: CASE STUDY SUMMARIES

Brazil

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The objectives of this study are to: (a) assess the impact of the World Bank's HIV/AIDS assistance to Brazil relative to the counterfactual of no Bank assistance; and (b) distill lessons for future HIV/AIDS activities.

Previous experience in campaigns against the military government and for expanded access to health care inspired civil society in Brazil to mobilize aggressively against AIDS when domestic cases first appeared in 1982. The epidemic first spread rapidly among men who have sex with men (MSM) and then among injecting drug users (IDUs), after which a wave of heterosexual transmission took off. Several states, particularly São Paulo, led the response. By 1989, the federal government had established a national program, regulated the blood supply, and established a national AIDS commission composed of government and nongovernmental representatives.

The World Bank provided important assistance to Brazil's response in the form of two projects totaling \$550 million (funded in part by \$325 million in loans from the Bank) that were in operation from 1993 to 2003. A third, \$200 million project was approved in June 2003. In addition, the Northeast Endemic Disease Control Project financed \$7.4 million toward media campaigns on HIV/AIDS, the establishment of the National AIDS and STD Control Program (NASCP), and the preparation of the first AIDS project. It was Brazil that approached the Bank about an interest in borrowing to support its HIV/AIDS program in the early 1990s, a time when the Bank did not have an explicit AIDS strategy for Brazil,

nor was it already engaged in AIDS policy dialogue with the government. In 1993, when the first AIDS project began, prevention was not yet active outside selected major metropolitan areas, nor among certain high-risk groups. Brazil had not developed the laboratory network that would facilitate its testing and (especially) its treatment programs. The National Coordination on HIV/AIDS/STDs was reconstituting after a difficult period from 1990 to 1992, and many states and municipalities did not have HIV/AIDS programs at all. The Bank's implicit assistance strategy focused on preventive efforts, institutional strengthening (especially surveillance, monitoring, and evaluation), and public goods to promote cost-effectiveness in treatment. These emphases were, and remain, relevant.

The efficacy of the World Bank's assistance was high in some areas. The partnerships with NGOs and community service organizations (CSOs) mobilized effort in prevention at a critical time and expanded the geographic and functional coverage of the program significantly. Bank financial and technical assistance also supported the local design and implementation of 27 state and 150 municipal HIV/AIDS action plans, under the supervision of local STD/HIV/AIDS coordination units, many of which had been established with project assistance. The Bank's efforts to assist Brazil in development of HIV epidemiological surveillance were less successful—eventually, a substantial amount of data on HIV prevalence and risk behavior on some key populations (pregnant women and military recruits) did become available, but not until after 1997. Systematic HIV surveillance remains a challenge. Similarly, a comprehensive strategy for the monitoring and evaluation of program impact was not developed until well into the second project, in

preparation for the third. The capacity to use epidemiologic, behavioral, and program data for program decision making and coordinating prevention activities remains weak in Brazil, particularly outside of key metropolitan areas. Brazil failed to undertake cost-effectiveness analyses planned under Bank support, with the consequence that there is little empirical basis for the prioritization of program activities and for the allocation of human and financial resources. Although the projects did develop a system for promoting local initiatives, the latter (like many health initiatives in the country) were not integrated with other local health sector programs. The absence of an effective framework for health sector decentralization in Brazil until late in the 1990s hampered that effort.

As of the end of 2003, a total of 310,310 AIDS cases had been reported in Brazil since the beginning of the epidemic and an estimated 0.65 percent of the adult population was thought to be living with HIV/AIDS. A 2002 study of MSM in 10 state capitals found that 70 percent reported always using condoms with every sex partner in the previous six months. By that year, there were 160 needle and syringe exchange programs in operation in Brazil. A study of 3,000 sex workers in five cities in 2001 found that 74 percent consistently used condoms with clients. Coverage of prisoners with a basic set of educational and condom promotion efforts was reportedly 65 percent nationwide. Annual sales of male condoms have increased from 5 million in 1985 to 395 million in 2001. Brazil passed a law guaranteeing universal access to antiretroviral drugs to AIDS patients free of charge in 1996. In 2004, some 175,000 AIDS patients were under care: 135,000 in treatment with ARV drugs and 40,000 in other care. Brazil has built a national laboratory network for HIV viral load and CD4/CD8 immunologic monitoring to guide therapy. The impact on mortality, morbidity, survival after AIDS diagnosis, hospitalizations, opportunistic infection rates, and quality of life has been substantial.

Government commitment to fighting HIV/AIDS preceded Bank involvement, and general prevention programs almost certainly would have occurred even without the projects. The evaluation team nevertheless found four critical

areas in which the Bank likely had an impact relative to the counterfactual of no involvement:

- The projects helped safeguard prevention resources during a period of macroeconomic and financial instability in which there was a dramatic increase in demand for AIDS treatment and protected HIV/AIDS funds from political interference at the local level.
- The national response has been more focused on HIV prevention among groups with high-risk behavior, including very marginalized groups such as IDUs and sex workers, because of the legitimacy conveyed by the Bank's support.
- The creation and support of state and municipality-level HIV/AIDS and STD coordination units (in all 27 states and 150 municipalities), the development and implementation of local-level work program proposals that would be the subject of formal agreements (contracts) between these units and the NASCP, the financing of staff costs and cofinancing of other costs by local government, and the training of local-level program staff all are likely to have happened earlier than would have been the case without Bank assistance. The Bank's support helped to create local program capacity and propelled local government involvement that would ultimately facilitate program decentralization.
- The Bank's engagement encouraged early development of mechanisms for government to finance NGOs as implementers of AIDS programs, improving the efficiency and effectiveness of the prevention program, empowering marginalized groups that are key to success, and expanding the base of stakeholders to reinforce government commitment.

While many of the activities financed by the two projects 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. Unfortunately, due largely to the failure of government to adopt systematic surveillance of HIV and risk behavior—and the in-

ability 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 government’s prevention efforts or the Bank’s contribution to them on the epidemic or the behaviors that spread it. There has been very little evaluation of the cost-effectiveness of any of the innovative prevention interventions sponsored by these projects. The attempt to encourage monitoring and evaluation in the Brazilian AIDS program is arguably one of the areas in which the Bank’s assistance has had the least impact.

The evaluation has also highlighted numerous lessons from the Bank’s engagement with Brazil on AIDS: the need to foster political commitment at all levels of policy formulation and implementation; the Bank’s role in lending legitimacy to controversial prevention programs; the need to address constraints in the health system that are critical to the AIDS response; opportunities for the Bank to invest in public goods that improve the efficiency of treatment; the critical contribution of NGO involvement in reaching high-risk groups, but the need to invest in implementation capacity to make sure this happens; concerns about the long-run sustainability of the NGO response that is dependent on Bank-sponsored projects; the need to incorporate adequate preparation and incentives for M&E into projects; and the feasibility of working with high-risk groups in a concentrated epidemic when interventions are developed by and with communities at risk and respecting their human rights.

Ethiopia

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The objective of this case study is to evaluate the impact of the World Bank’s assistance—policy dialogue, analytic work, and lending—on Ethiopia’s national response to HIV/AIDS, and to derive lessons from that experience. This case study is based on a review of published and unpublished documents on HIV/AIDS in Ethiopia; structured interviews with various stakeholders representing

the government, civil society, World Bank, donors, and nongovernmental, community-based, and faith-based organizations; field visits to selected regions of Ethiopia in August 2003; and analysis of epidemiological and behavioral data.

AIDS Epidemic

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

Ethiopia’s Early Response

Ethiopia’s initial response, launched in 1987, was one of the first in Africa. Under the Department of AIDS Control (DAC) within the Ministry of Health (MOH), the HIV/AIDS program centered on a strategic plan that emphasized the provision of public goods (surveillance, research, monitoring, evaluation, laboratory capacity) and prioritized prevention interventions both for high-risk groups and for the general population. In its earliest years, the program was decentralized to 14 regions, collaborated with key sectors, and financed NGO activities. The initial response was launched under the Derg government (1974–91), when bilateral donor assistance for AIDS was limited, as many but not all bilateral donors withdrew support to the Marxist regime. Although the World Bank had been active in other sectors in Ethiopia since 1950, and the first health project was approved in 1985, it did

not provide financial or technical support to these early HIV/AIDS program efforts. In addition to public budget allocations, the early program received technical and financial support from the World Health Organization's Global Program on AIDS (WHO/GPA).

In the early 1990s, with the ousting of the Derg, the new government had an overwhelming and pressing agenda of competing development and political priorities. The rapid decentralization of resources and decision-making autonomy to new regions dramatically reduced the size and mandates of federal-level agencies. One consequence of this upheaval was a weakening of the national HIV/AIDS response. The government was facing an ambitious and under-funded agenda to improve and expand basic health care services. Although HIV infection was believed to be high at that point in time—especially in Addis Ababa and other urban areas—other diseases, such as malaria, caused more illness and death and predominated in rural areas, where over 80 percent of the population lives. In 1996, a new medium-term AIDS strategy was prepared and a national conference on “Breaking the Silence” was held, both a result of strong lobbying and support of UNAIDS and bilateral donors.

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

In 1996 the World Bank launched a dialogue on the social sectors with the government, underpinned by a large and participatory social sector analysis published in 1998. This marked the initiation of the Bank's dialogue on HIV/AIDS. AIDS was one of many diseases subjected to a burden of disease analysis, and the study projected future HIV infections and AIDS cases. The Social Sector Report culminated in 10-year development plans for both the health and education sectors, provided the basis for the design of sector-wide approach (SWAp) operations, and significantly improved social sector donor coordination under the leadership of the Bank. It strengthened both the credibility of the Bank and its working relationship with the government and donors. The Health Sector Development Program (HSDP, \$100 million, Credit No. 3140) was approved by

the Board in 1998 and became effective in 1999. The control of sexually transmitted diseases (STDs), including HIV/AIDS, is one of 9 programs included in the 10-year health sector development program. The World Bank financial support to the HSDP focused on strengthening and expanding basic health services, which are critical for HIV/AIDS activities within the health sector. The Bank's country director and resident representative have persisted in raising the issue of HIV/AIDS at every opportunity.

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

Ethiopia Multisectoral AIDS Project

To satisfy the Bank's eligibility criteria for the Ethiopia Multisectoral AIDS Project (EMSAP), the government established in early 2000 a National AIDS Council (NAC) and a National AIDS Council Secretariat (NASC) placed within the Prime Minister's Office. The EMSAP channeled funds to four components: capacity building for government and civil society; expanding governmental multisectoral response; expanding the response of NGOs and communities; and project coordination and management. Forty-four percent of project funds (\$28.1 million) were allocated for NGO and community-based activities. The NASC assumed responsibility for coordination of HIV/AIDS programs, a responsibility previously assigned to the MOH. The project was prepared and negotiated in only six weeks because Bank management considered that the AIDS crisis warranted an emergency response and committed to seeking Board ap-

proval by the time of the annual meetings in September 2000. Preparation focused on setting up implementation arrangements that would accelerate the flow of funds and not on the content of the AIDS response that would be supported. It did not appraise the government's five-year strategic framework from technical, economic, financial, social, or institutional perspectives. Consultation with donors and NGOs during project preparation was extremely limited. A number of preparation tasks were postponed until the implementation phase of the project.

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

Impact of World Bank Assistance

Government commitment. The main impact of the World Bank's assistance has been to raise the profile of AIDS as a development issue and increase

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

Institutional response. The eligibility criteria for EMSAP leveraged the efforts of UNAIDS and other partners to create a multisectoral institution for HIV/AIDS coordination. EMSAP has supported the establishment and functioning of the federal and 11 regional HAPCOs. However, the new institutions were interpreted by the MOH as a lack of confidence in its leadership on HIV/AIDS and its capacity in health. The consequence had been a disengagement of the MOH—the key ministry in the fight against HIV/AIDS. This situation is reported to have improved with the recent nomination of the Minister of Health as chair of NAC Board. HIV/AIDS components of non-health sector projects have supported more ownership and quality interventions than have public sector work programs in non-health ministries financed under EMSAP.

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

Strategic choices. The World Bank has not had significant impact on the content of national policy, adopted in 1998, or on the 2000–04 strategy. The 1996–98 Social Sector Report did not review the HIV/AIDS medium-term plan and the EMSAP committed to support whatever activities were already in the national strategic plan without

engaging in a discussion of priority activities for the public sector.

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

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

Impact on outcomes. Available data show that, while awareness of HIV/AIDS was already over 90 percent in 2000, knowledge of specific prevention methods in 2001–02 was limited (50 percent of key target populations report knowing the three main ways to prevent HIV infection), and risky behaviors persist despite such knowledge. As there was no baseline measurement of many of the key outcome indicators, it is not possible to assess any changes that might have occurred during the course of the project to date, let alone evaluate the attribution of those changes

to the project. The bulk of prevention interventions supported to date were for information, education, and communication, and not for targeted behavior change.

Findings and Lessons

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

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

- The adoption of HIV/AIDS coordinating institutions to satisfy eligibility criteria established by the Bank does not automatically ensure deep or sustained commitment by the multitude of actors necessary for an effective response.
- Project design and implementation that focus primarily on process rather than results undermine the effectiveness and efficiency of the Bank's financial support.
- The creation of a multisectoral institution does not necessarily foster a multisectoral approach and, if not founded on local institutional analysis, risks alienating key actors, like the Ministry of Health. Within the context of a multisectoral approach, the prominence of the health sector as a major leader and implementer in the fight against HIV/AIDS is unequivocal.

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

Indonesia

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The HIV/AIDS epidemic, until recently, was at very low levels in Indonesia. The first case of HIV was identified in a foreign homosexual tourist in Bali in 1987. Systematic sentinel surveillance of sex workers in Jakarta and Surabaya began in 1988. In 1993/1994, sentinel surveillance reported the first positive sample among sex workers and the first positive blood samples were identified among blood donors. HIV prevalence was still sufficiently low in 1997 that MOH statistics refer specifically to a small number of cases in Irian Jaya as “Thai fishermen, who have since left the country,” and this relatively small adjustment accounted for a significant share of all AIDS cases in the country at the time.

Projections of the possible course of the HIV/AIDS epidemic were generated by expatriate consultants and researchers beginning in the early 1990s. They did not take existing surveillance data as their starting point, were largely based on the Sub-Saharan African and Thai experiences of the late 1980s and early 1990s, and showed rapid acceleration of the epidemic. In hindsight, the projection models were ill suited to the purpose to which they were put in In-

donesia. HIV cases were projected to rise to roughly 500,000 in 2000 and to 700,000 in 2005, assuming that effective prevention efforts were launched during the mid-1990s. If prevention efforts were less successful, the model predicted that the number of cases would increase to an estimated 700,000 in 2000 and 1.2 million in 2005. This turned out to be dramatically wrong, as HIV prevalence barely increased through most of the 1990s. Since 1999, the HIV epidemic has emerged concurrently with an epidemic of intravenous drug use (IDU). IDU was rare before 1997 and has made a significant contribution to the HIV/AIDS epidemic. Without its contribution, more current projection models show virtually no epidemic taking place in Indonesia.

Before the AIDS epidemic and since its advent, the World Bank has had a long, active, and largely successful engagement in health in Indonesia. Starting with a population project in 1972, the Bank financed 13 health, nutrition, and population projects previous to its engagement on HIV/AIDS in the country in 1996. Nonetheless, much remains to be done to improve health services and outcomes. Compared to neighboring countries, Indonesia showed high infant and maternal mortality levels throughout the 1990s (including the period prior to the financial crisis), and UNDP data suggest that health indicators in Indonesia improved at a slower rate than would be consistent with Indonesia’s per capita economic growth.

A \$24.8 million IBRD loan for the Bank-financed HIV/AIDS and STDs Prevention and Management Project was negotiated in January 1996. The project was designed to support behavioral interventions and to finance laboratory and testing support. Some of this was accomplished—more HIV screening among sex workers is one example. However, project execution was problematic from the outset. The Project Appraisal Document (PAD) sometimes budgeted substantial funds for expenditures that were unnecessary for Indonesia’s situation. Clients at antenatal clinics were counseled about HIV/AIDS, even though HIV prevalence among married women was (and remains) virtually zero. Labs were equipped to speed processing, under the faulty assumption that supply bot-

tlenecks were the cause of testing delays. About 20 percent of the loan was programmed for test kits already in the possession of the government at appraisal. Many of the problems stemmed from a weak project management unit. Many also sprang from inappropriate project design, but these issues could have been handled by a more effective project management unit through reprogramming of the use of Bank funds. The projections should have been subjected to more searching scrutiny by specialists on HIV modeling. The failure of dire outcomes to materialize may have hurt political commitment as the project unfolded. The weaknesses in design and especially in project management led the project to be designated a problem project in the Bank's Indonesia portfolio only two years into its three-year planned execution. At the time of the East Asia financial crisis in 1997 and 1998, when the Bank's portfolio was restructured, 80 percent of the loan was cancelled. The HIV/AIDS project failed to achieve its development objectives, and was correctly judged by Regional staff as unsatisfactory in the implementation completion report.

The behavioral interventions of the Bank-financed project were to be implemented largely by NGOs. This required granting them tax-free status. The collapse of an agreement with the Ministry of Finance (MOF) to facilitate NGO involvement in turn made this a lengthy process. Eventually, some NGOs did work on the project, but we found little evidence that NGOs new to HIV/AIDS work before working with the project have continued to work in this area. To a number of observers, a meaningful contribution of the project was finally to gain acceptance of the idea and practice of government funding of NGOs for the provision of health services. The project may have helped to raise HIV/AIDS awareness at an early stage of the epidemic. However, it did so in alarmist fashion, and there appears to have been a period of complacency, perhaps backlash, during project implementation.

Except for the cancelled loan, there has been little HIV/AIDS-specific activity by the World Bank in Indonesia. Since 1999, the epidemic among intravenous drug users (spreading to their sexual

partners) has helped fuel a growing sense of urgency regarding HIV/AIDS. Little if any of this increase can be attributed to Bank activities, as until very recently the Bank has hardly been involved in AIDS-related dialogue or programs since the close of the HIV/AIDS loan.

On net, the impact of the Bank on the progress of the HIV/AIDS epidemic in Indonesia has been minimal. The most direct intervention, the HIV/AIDS and STDs Prevention and Management Project, accomplished little before most of the loan was cancelled. Outside of that loan, there have been some informal high-level contacts between Bank staff and government officials that may have helped to raise awareness. However, given the nature of the epidemic at that time, the lack of information about its course, and the demonstrated lack of response by the government, it is difficult to attribute any impact to the Bank on this score. The funding mechanisms for NGOs are in place, and one lasting result may be the relative ease of incorporating civil society in future Bank-funded health and AIDS work in Indonesia.

The Indonesian case underscores the essential tension between early (and cost-effective) intervention and intensity of commitment. This tension was heightened by the unwillingness of the Government of Indonesia to focus resources on the social periphery, at appraisal, during the early stages of project implementation, and especially as health resources were stretched to the breaking point by the financial crisis. Commitment also may have been diminished by the nature of the project relative to needs perceived by stakeholders. In a context where little is known about the extent of the epidemic and the behaviors that spread HIV, as was the case in Indonesia in the early to mid-1990s, more appropriate interventions would have aimed at increasing public health monitoring and surveillance capabilities and behavioral studies. As understanding of the nature of the epidemic and the behaviors that spread it increased, this information could have been used for evidence-based advocacy and policy dialogue to create an environment that would support effective work with groups at risk for HIV.

Russian Federation

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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 was 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.

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 (IDUs). 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 1993-95." 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 STIs, 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 antiretroviral 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 (OSI), USAID, Médecins sans Frontières, 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 2000–01, 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 to 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 mother-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. 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
- 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 policy makers.
- 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.