

**WORLD BANK LENDING AND SECTOR WORK FOR HIV/AIDS IN EAST
ASIA AND PACIFIC**
Review of Current and Past Activities and Strategies for the Future

*Vivian Lin, School of Public Health, La Trobe University, and
Alison Heywood, Heywood Public Health Group*

1. Introduction

The World Bank is one of the leading financiers of HIV/AIDS prevention and control activities in the world. The Bank has committed US\$1774.6 million (and disbursed nearly US\$800 million) for more than 70 current and future projects around the world. Although cumulative lending in the East Asia and Pacific Region (EAP) is a small portion of global commitment, the Bank is the largest single financier for HIV/AIDS in the Region.

The Bank has formulated its strategic thinking on HIV/AIDS at the global level, but there is a need to develop a more customized position in relation to EAP countries. Some of the most significant impact of the HIV/AIDS epidemics that the world may face may occur in the populous nations in the EAP Region – China and Indonesia - if effective preventive action is not taken. That is to say, given the huge population in many EAP countries, even a small increase in HIV/AIDS prevalence will translate into millions of infections. There is an opportunity, and an imperative, for the Bank to assist countries to develop and implement effective strategies and programs in the Region before the problem gets out of control.

This paper is one of six working papers providing background for a major report on how the World Bank would contribute to policy formulation, advocacy and programming related to the HIV epidemic in EAP. The objective of this paper is to review past and current activities that the Bank has undertaken in order to consider what future contributions the Bank could make. The paper seeks to assess the scope, focus, and strategy adopted by the Bank thus far in its HIV/AIDS work in EAP. By drawing on lessons learned, the paper aims to recommend directions for the Bank in furthering the HIV/AIDS prevention and care agenda in EAP.

The paper is organised as follows. After setting out how the review is done, the epidemic and the donor response are briefly described in order to provide the context for examining the Bank's activities. The Bank's specific lending activities and its sector work are then discussed, including the key lessons learned. Based on these experiences and in relation to expected challenges in the near future, the strategic issues are then set out, along with a discussion of the Bank's unique positioning. The paper concludes with recommendations about what further contribution to EAP countries the Bank could be making.

2. Methodology

A desk review was conducted during June 2002. This covered the Project Appraisal Documents (PADs) and Implementation Completion Reports (ICRs) for HIV-related

projects in EAP countries and where relevant, aide memoires for mid-term reviews of these projects and others that have been “retro-fitted” with activities directed at the HIV epidemic. Additional Bank policy and technical documents, such as background papers and speeches on HIV/AIDS, country assistance strategies (CAS) and comments on draft poverty reduction strategy papers (PRSPs), were also examined to provide context for World Bank thinking.

A mapping of projects from donor agencies was done for EAP countries. Policy documents from other donors – Asian Development Bank (ADB), AusAID, UK Department for International Development (DfID), World Health Organisation (WHO), UNAIDS, US CDC (Centers for Disease Control and Prevention), UNDP - were also reviewed in order to consider the relative contributions of all key agencies.

Interviews were conducted with Bank Task Team Leaders (TTLs) within EAP, covering China, Cambodia, Laos, Philippines, Vietnam, Mongolia, Papua New Guinea (PNG), Solomon Islands, Samoa and other Pacific Islands. Meetings were also held with the Global AIDS Advisor and with OED about its impending evaluation of the Bank’s HIV/AIDS Assistance. Discussions were further held with staff of AusAID, ASEAN Secretariat, and DfID.

The interviews were designed to understand better the context of past and current WB lending and sector work, along with how Bank staff viewed future development. Key questions explored include: use of mainstream tools (eg CAS, PRSP), rationale behind various projects, history and nature of policy dialogue, role of the Bank in relation to other donors, needs in various countries, barriers to addressing HIV/AIDS, challenges for project design and implementation, needs and opportunities for the future.

The Bank’s activities include both lending activities (for projects) and sector work/policy dialogue. For each of these activities, questions can be asked about the adequacy and appropriateness of the technical input (including design in relation to problem definition), along with how well the activity was executed. A general framework for evaluation can be described in the table below (drawing from, but not limited to, the assessment/evaluation criteria used by Dayton in 1998).

TABLE 1: A FRAMEWORK FOR REVIEWING HIV LENDING AND SECTOR WORK

	LENDING/PROJECTS	SECTOR WORK
TECHNICAL INPUT/DESIGN	<p>Was the design appropriate for the stage of the epidemic?</p> <p>Does project design reflect best public health practice?</p> <p>Are interventions cost-effective?</p> <p>Was the design suitably tailored to local circumstances?</p> <p>Is there effective targeting and effective coverage?</p>	<p>Is there a coherent strategy in sector work and dialogue?</p> <p>Has the Bank done enough at country and regional levels?</p> <p>Was the role Bank played based on its comparative advantage?</p> <p>Was the dialogue based on sound analyses (economic and epidemiological)?</p>
IMPLEMENTATION	Has appropriate consideration been	Has the Bank helped build

	<p>given to the implementation capacity?</p> <p>Have key stakeholders been mobilized?</p> <p>Is the monitoring and evaluation effort adequate?</p>	<p>government and other commitment?</p> <p>Have HIV issues been brought into the mainstream development agenda?</p>
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In addition, these activities do not occur only at a single point in time, or in a vacuum. It is therefore crucial to understand and assess the context for lending and sector work. In this respect, the key questions are:

- Was the Bank’s involvement timely and appropriate to the epidemic?
- What role could and did the Bank play vis-à-vis other donors and development partners?
- What role could the Bank play in HIV, given its broader relationship (ie beyond the health sector) with each country?

This paper is necessarily constrained by the brief time frame and the methodology (ie desk review and limited interviews) used for the task. A thorough assessment of the impact of the Bank's lending and sector work, leading to more definitive and precise conclusions about critical success factors (as well as problems), would require both field investigations and collection of primary data from a range of sources.

3. Context: The Epidemic and International Responses

3.1 Extent of problem

The HIV epidemic in EAP varies substantially between and within countries. Although HIV was relatively late in its introduction to the Region, the trend is one of increasing prevalence. The epidemic is also distinctive in the importance of intravenous drug use as a mode of transmission, as well as the importance of heterosexual transmission. Table 2 provides an overview of the current state of the epidemic.

TABLE 2: OVERVIEW OF HIV EPIDEMIC IN EAP COUNTRIES

Prevalence	Country	1 st Report of HIV	Prevalence Trend	Largest Group affected by HIV/AIDS or main mode of transmission	Estimated Cases 2000 (age 15-49)
Nascent	Brunei Darussalem	1986	Reported no. of new HIV/AIDS cases has decreased since 1994	Immigrant workers, men (96%), heterosexuals	521 cases up to 2000
	Mongolia	1992	Has remained virtually HIV-free over last two decades		3 cases reported as of July 2001
	Republic of Korea	1985	Stable	Men (87%); sexual contact (93%)	3800
	Lao People's Democratic Republic	1990	Has been stable but may be increasing	Borders with Thailand and China. Men & women equally affected	1400 projected
	Philippines	1984	Slow expansion - not expected to increase significantly over next few years	Men, sexual contact (90%)	10,000
	East Timor	2001	Although prevalence is low, inadequate testing and insufficient research indicates problem could be more serious than it appears		6 confirmed cases to date (3 AIDS & 3 HIV+)
Concentrated	Singapore	1992	Prevalence of HIV infection in sex	Men, heterosexual	3,000

			workers has decreased from 0.8% in 1992 to 0.5% in 1998		
	Indonesia	1995	HIV infections slowly increased since 1990, but rapidly since 1998	Rates increasing dramatically among IDUs, sex workers & blood donors	120,000
	China	1985	Expanding. Reported HIV infections rose by 67.4% in 1 st 6 months of 2001	IDUs, rural villagers in Henan Province (unsafe blood selling)	500,000
	Papua New Guinea	1987	HIV increased annually throughout early 1990s and continues to expand	Capital of Port Moresby. Heterosexual - men & women equally affected.	14,000
	Vietnam	1990	HIV & AIDS cases have grown rapidly in all provinces	IDUs, male, 20-29 year olds, sex workers	100,000
	Malaysia	1986	Appears to have stabilised, other than among IDUs	IDUs, men, ethnic Malays	50,000
Generalised	Myanmar	mid- to late-1980s	HIV prevalence has increased for sex workers by 22% & male STD clinic patients by 10%	IDUs, sex workers	510,000
	Thailand	Late 1980's	Annual new infection rates of HIV have decreased from 140,000 in early 1990s to 30,000 at end of decade	Affects 15-57% of sex workers in the northern provinces. IDUs, 20-44 year olds.	671,000
	Cambodia	1991	HIV transmission has rapidly increased since 1991 but stabilizing	Heterosexual; female sex workers, women of child-bearing age	170,000

Source: - UNAIDS: Epidemiological Fact Sheets by Country – 2002 Updates (UNAIDS & WHO)

Website: www.unaids.org/hivaidinfo/statistics/fact_sheets/index_en.htm

- WHO: HIV/AIDS in Asia and the Pacific Region (WHO, 2001)

Website: www.who.org.ph/pdf/sti/aids2001/complete.pdf

It should be noted that the adequacy of surveillance systems in many of these countries - such as the Pacific islands and Mongolia - cast some doubt on the accuracy of the estimates. Nonetheless, it can be seen that HIV is a serious problem in Cambodia, Myanmar, and Thailand. Indeed, Southeast Asia has become one of the most severely affected sites, outside sub-Saharan Africa. There are signs of increased risk in China, Indonesia, PNG, and some Pacific Islands. Concerns are also beginning to be voiced in the community sector about trends in the Philippines. It is estimated that there are more than 1 million new adult infections in Asia per year and the number of deaths from AIDS in the Region is projected to increase by almost 90 percent between 2000 and 2010.

3.2 Overview of major donor responses in EAP

The World Bank and other donors have been important sources of financial and technical assistance in EAP countries. Table 3 provides an overview of the Bank's lending in EAP countries, alongside the contributions of other major donors.

TABLE 3: DONOR SUPPORT FOR HIV IN EAP COUNTRIES

Prevalence	Country	HIV/AIDS related projects financed by WB*	Total WB project cost (US \$)**	Direct WB contribution for HIV/AIDS (US \$) ***	Other Donors+ (US\$ mil)
Nascent	Lao People's Democratic Republic				USAID (2002-06) - 2.00 UNDP (1998-2000) - 0.26 NORA (2000-02) - 0.007 Global Fund - 0.72
	Mongolia				UNDP (1997-2000) - 0.30
	Philippines				USAID (1992-2004) - 7.9 JICA (1996-2001) - 0.51

					UNDP (2000)	- 0.42
Concentrated	Malaysia	Health (1994)	50 mil	16 mil		
	Indonesia	HIV/AIDS & STD prevention & management project (1996-1999)	24.8 mil	24.8 mil	AusAID (2002-07)	- 26.16
		Safe Motherhood Project (1998)	42.5 mil	0.2 mil	KFWI (2000-03)	- 9.42
					UNDP (1997-2000)	- 0.87
					Global Fund	- 2.58
	Papua New Guinea	Pop. & Family Planning (1993)	6.9 mil	0.66 mil	AusAID (2000-05)	- 30.78
	China	Infectious Disease Control (1991)	129.6 mil	0.48 mil	AusAID (2002-07)	- 7.54
Maternal & Child Health (1994)		90 mil	0.4 mil	DFID (2001-02)	- 0.18	
Disease Prevention Project (1995)		100 mil	4.95 mil	DFID (2001-06)	- 0.22	
Health Nine Project (1999)		60 mil	25.6 mil	DFID (2001-06)	- 21.87	
				UNDP (1997-2000)	- 1.90	
Vietnam	Blood safety project (2002)	38 mil	38 mil	AusAID(2002-05)	- 1.53	
				JICA (1999-2000)	- 0.06	
				UNDP (1994-2001)	- 2.42	
				DFID (2001-02)	- 24.59	
				Global Fund	- 4.00	
Generalised	Cambodia	Disease control & health Development Project (1997)	30.4 mil	6.1 mil	USAID (1998-02)	- 4.55
		Home-based care for PLWHA (JSDF grant for KHANA)	0.45 mil	0.45 mil	DFID (2001-06)	- 14.16
	Myanmar				UNDP (1996-2000)	- 0.95
	Thailand	Social Investment Project (1998)	300 mil	2.6 mil	ADB (2001-02)	- 0.71
					Global Fund	- 7.15
					DFID (2001-04)	- 0.34
Regional					AusAID (2000-01)	- 0.51
					JICA (1998-03)	- 0.03
					UNDP (1989-2000)	- 1.69
					Global Fund	- 13.99
					AusAID (2002-07)	- 10.92
					USAID(1995-2006)	- 14.77
					ADB (2000-03)	- 10.00
					UNDP (1997-2001)	- 8.42
					Global Fund	- 0.55

* denotes projects considered by the Bank to be related to HIV/AIDS

** is the total size of the project

*** is the portion of the project deemed by the Bank to be related to HIV/AIDS

+ detailed listing of other donors' projects are found in Appendix 1

Source: Development Gateway, UNICEF, AusAID, USAID, ADB, WB sites.

Although the Bank has had few HIV-specific projects in the EAP Region, and the HIV proportion of broader health sector projects is relatively small, the Bank is an early and large financial contributor in China, an early contributor to Cambodia and would have been a major contributor to Indonesia had the project not been cancelled. The Bank's role has also been shaped by the 1997 Asian economic crisis. In Thailand, for instance, the HIV/AIDS budget was reduced by 24.7% in 1998 (Macfarlane Burnet Centre, 2000) and prevention accounted for only 8% of the national AIDS program budget by 2000 (Social Monitor V). The Bank has lent US\$30 million to ensure public health programs, including AIDS prevention, have sufficient funding during the crisis.

AusAID is the most significant donor for HIV/AIDS in PNG, and PNG is the most significant recipient of Australian development assistance related to HIV, committing over one quarter of its international HIV/AIDS resources to PNG. USAID is an

important contributor in Laos, Vietnam, and Cambodia while the CDC has cooperation programs in Vietnam, Thailand and China. The UK (DfID) has an increasingly strong presence in China, Vietnam, and Cambodia.

The ADB and UNDP are the major donors that have adopted a regional approach (ie extending beyond individual countries), with ADB's Mekong Regional projects (in Vietnam, Laos and Cambodia) and UNDP providing assistance to northeast Asia, southeast Asia, and Pacific. AusAID has also adopted a regional approach in the Mekong region, supplementing country-specific projects, and is developing a regional approach for the Pacific. At a regional level, ASEAN also provides a forum for cooperation, with their work program focused on joint action to increase access to affordable drugs and testing reagents, inter-country activities on mobile population, inter-sectoral collaboration, and capacity-building in support of national programs.

International non-government organisations are also involved in supporting community-based efforts to prevent and control HIV/AIDS. The Ford Foundation's offices in Hanoi, Manila, and Beijing have been active in supporting a range of small, focused, efforts, particularly in the non-government sector and for social research.

In looking to the future, there are a number of countries of particular concern. The sheer population size of China and Indonesia means that a small increase in prevalence should be of global concern. If the epidemic is not curbed in China and Indonesia, the potential for a rapid increase in numbers of HIV cases is very real. PNG has also recently reached high-risk status. Myanmar has one of the highest prevalence rates in Asia and is experiencing a generalised epidemic; assistance as a humanitarian effort is warranted. Other countries where HIV is an emergent problem (or where a watchful eye should be adopted) include Pacific Islands and Mongolia. These countries are of concern for a variety of reasons, ranging from poor health system capacity, conflict and population mobility, and social and economic change.

The situation in the PNG is illustrative. While PNG had been seen as a low prevalence country for some years, changing incidence rates in some population groups and indicators of high-risk behaviours suggest that the disease could spread rapidly. There is, thus, a high risk of PNG moving to a generalised epidemic state (Centre for International Economics, 2002). Initial incidence appears higher in high skilled groups and in urban areas, but there is evidence that the virus is not geographically isolated, and as in other countries HIV/AIDS will be a disease that impacts predominantly on the poor.

Consideration needs to be given as to how the Bank can contribute to minimizing the emerging risks in these countries.

4. Review of lending

4.1 Overview of HIV-related lending

Between 1992 and 2002, the World Bank has financed eleven health projects with HIV/AIDS related components in nine EAP countries. The cumulative lending in the Region for HIV/AIDS stands at US \$119 million. This figure is inclusive of resources dedicated to activities indirectly related to HIV/AIDS, ie activities initiated

for reasons beyond HIV/AIDS prevention and control although they do make a contribution to the objective. This figure does not, however, include the "retro-fitting" of other projects with HIV activities, as has occurred in the Vietnam Population and Family Health Project or is currently planned for China Health VIII (Basic Health Services).

Of the eleven projects, the only HIV-specific project was the Indonesia HIV/AIDS and STD Prevention and Management Project, begun in 1996 and cancelled in 1999. Although the new Blood Supply Management Project in Vietnam can be seen as a project contributing fully to HIV prevention, the impetus for this US\$38 million arose from general concern about the integrity of the blood supply system, rather than HIV prevention per se. The most significant financial support has been in China, with HIV occupying a small portion of Health V (Infectious and Endemic Disease Control), VI (Maternal and Child Health), and VII (Health Promotion) Projects, culminating in US\$ 24.8 million for HIV/AIDS prevention and control in Health IX.

The World Bank has held a sizeable portfolio of health lending in EAP countries, with a cumulative investment of US\$2.685 billion, and the health sector has been, and continues to be, an important aspect of the Bank's country assistance strategies in the Region. Consistent with the Bank's HNP strategy, these projects have evolved from population-oriented projects of the 1970s, to lending for primary health care in the 1980s, to health system reform projects in the 1990s. Within that context, the proportion of funding for HIV (at 3.92%, or \$119 million out of \$3.044 billion) is relatively limited, as can be seen in Table 4. (See Appendix 2 for full listing of all WB health projects in EAP countries and their HIV-related components.) Recognising that HIV/AIDS did not emerge as a serious concern until the early 1990s, Bank lending for HIV as a proportion of 1990s health projects is 5.7% (\$119 million out of approximately \$2.097 billion). If project "retro-fitting" were accounted for, that percentage would increase marginally again.

TABLE 4: THE PLACE OF HIV IN WORLD BANK STRATEGY AND LENDING

Prevalence	Country	Total Health Lending	HIV-relevant lending*	HIV-specific component of lending**	HIV component as % of Total Health Lending
Nascent	Mongolia				
	Laos	\$19 mil			
	Philippines	\$242 mil			
Concentrated	Malaysia	\$72 mil	\$50.0 mil	\$16 mil	22.22%
	Indonesia	\$995.9 mil	\$67.3 mil	\$24.8 mil	2.51%
	PNG	\$6.9 mil	\$6.9 mil	\$0.66 mil	9.56%
	China	\$1.072 bil	\$379.6 mil	\$31.43 mil	2.93%
	Vietnam	\$249 mil	\$38 mil	\$38 mil	15.26%
Generalized	Myanmar				
	Thailand	\$33 mil (+ \$300 social lending)	\$300.0 mil	\$2.6 mil	0.78%
	Cambodia	\$55 mil	\$30.4 mil	\$6.1 mil	11.09%

* is the total size of the project that has been deemed to be related to HIV prevention and control
 **is the portion of the project that is specifically dedicated to HIV prevention and control activities
 Source: www.worldbank.org

Most of the activities within eleven health projects that contain HIV-related activities are relatively limited – indeed many are indirectly relevant to HIV prevention. In the 1991 China Health V (Infectious Disease Control), US\$480,000 was allocated to STD training and HIV surveillance within a larger project that focused on tuberculosis and schistosomiasis. A 1993 Population and Family Planning Project in PNG contained US\$660,000 for STD drugs. The 1994 Malaysia Health Project included US\$16 million for blood transfusion services. In 1994, the China Health VI (MCH) Project included STD and other infections in its obstetrics and gynecology training package. In the 1998 Safe Motherhood Project in Indonesia, US\$200,000 was made available for STD survey and operations research.

Given the limited focus on HIV prevention per se in these broadly-based health projects, the only World Bank projects to date designed with a focus on HIV prevention in EAP are listed in Table 5 below and these projects will be examined more closely in this paper:

TABLE 5: MAJOR EAP PROJECTS DESIGNED TO ADDRESS HIV/AIDS PREVENTIONS AND CONTROL

Country	Project	Amount (US \$ mil)	Time period
Indonesia	HIV/AIDS and STD Prevention and Management	24.8	1996 - 1999
China	Health VII (Health Promotion)	4.95	1996 - present
China	Health IX (HIV/AIDS Prevention and Control)	25.6	1999 - present
Cambodia	Disease Control and Health Development	6.1	1997 - present

Given one project closed prematurely and three of these projects are still under implementation, it is not possible to discuss outcome or impact. Rather, the discussion would necessarily focus on key issues in project design, inputs, and implementation processes.

4.2 Assessment of HIV-specific lending

From an economics perspective, the prevention of HIV/AIDS, which is an infectious disease with high externalities, deserves public financing. Based on a public economics perspective, Dayton (1998) suggests that government HIV/AIDS interventions could be broadly grouped into two categories:

TABLE 6: PRIORITY INTERVENTIONS ACCORDING TO PUBLIC ECONOMICS

PRIORITY INTERVENTIONS	Health-specific interventions <ul style="list-style-type: none"> • Finance operational research and disease surveillance • Treatment of STDs, particularly for high risk groups • Promote/subsidize condom for high risk groups
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	<p>Broad public policy interventions</p> <ul style="list-style-type: none"> • Improve status of women by expanding educational and employment opportunities and more legal protection • Enforce laws against rape and exploitation of minors • Support anti-poverty programs that help reduce the vulnerability of poor households to the loss of prime age adults
OTHER INTERVENTIONS	<ul style="list-style-type: none"> • Broad-based mass-media information campaign • Subsidy for HIV testing for individuals • Provision of safe blood

The public economics framework can assist governments in assessing the extent to which any intervention is a “public good”, as well as setting priority within the confines of limited public resources.

The proposals by Dayton have now been overtaken by evolving successes in reducing the spread of HIV/AIDS. It is now generally accepted that a core set of cost-effective interventions that can be financed by governments include (World Bank Group 2002):

- Promoting behavior change through communication programs (IEC/BCC), peer education, and voluntary counselling and testing
- Increasing condom use through condom promotion and distribution
- Diagnosing and treating sexually transmitted infections (STIs)
- Ensuring safe blood supply
- Preventing mother-to-child transmission through short courses of anti-retrovirals and infant feeding options
- Harm minimization among injecting drug users (IDUs), which includes providing clean injecting equipment, counselling, and drug abuse treatment

From the viewpoint of public health practice, as captured by the consensus reached in the Ottawa Charter (1986) and the Jakarta Declaration (1997), these interventions should not be implemented as singular activities but should be part of a strategic and coordinated package, which includes the following objectives:

- Develop healthy public policy
- Create supportive environment
- Strengthen community action
- Develop personal skills
- Re-orient health services

To be effective, these interventions need to be implemented with sufficiently large scale and appropriate targeting. As importantly, they need to be supported by:

- adequate funding,
- favorable policy environments,
- strong political leadership,
- multi-sectoral cooperation, and
- popular support.

Increasingly, best practice public health also incorporates consideration of evidence from systematic reviews, such as those undertaken as part of the Cochrane Collaboration. Merson et al (2000) found that the evidence on effectiveness of

voluntary counselling and testing was mixed while behavior change interventions are effective when targeted to high-risk population groups. Structural and environmental interventions appear to show great promise, but there is limited evaluation of harm reduction interventions for IDUs.

Effectiveness of interventions may be context-specific, as Wilkinson and Rutherford (2002) suggest in examining the extent to which STI control is an effective HIV prevention strategy. It appears that improved STI treatment services could reduce HIV incidence in an emerging HIV epidemic, where STI treatment services were poor, and where STIs were highly prevalent. From this perspective, health system and civil society infrastructure and their capacity for implementing cost-effective priority interventions for HIV prevention and control should be major considerations in project design.

Based on the above considerations, Table 7 below summarises the key features of the Bank's four major HIV/AIDS projects in EAP in relation to their technical design.

TABLE 7: COST-EFFECTIVE INTERVENTIONS WITHIN PROJECT DESIGN FOR FOUR MAJOR PROJECTS IN EAP

	INDONESIA (1996)	CHINA HEALTH VII (1996)	CHINA HEALTH IX (1999)	CAMBODIA (1997)
Policy development		Specified list	Specified list	
Multi-sectoral cooperation	NGO involvement	As part of project leading group	X (including NGOs and private sector)	x (include NGO small grants)
Institutional capacity building	National and provincial; laboratory system	National and provincial	National and provincial, and NGOs	National and provincial
Surveillance and operational studies	x	x	X	x
Blood supply management			X	x
STI management	x	x	X	x
IEC/BCC, including outreach programs	x	x	X	x
Condom promotion		As part of STI management	X	x
IDUs		As part of IEC/BCC	X	
Patient care			X	

It can be seen from the above that the designs of these projects generally included the key dimensions considered to be essential for HIV prevention, although they were not highly targeted efforts. As projects were initiated at different stages of the epidemic in these countries, the emphases varied accordingly. National and provincial-level institutions and surveillance systems have been central features across all projects. All projects also offered a mix of IEC activities for the general population and high-risk groups, although earlier projects gave less emphasis to high-risk groups and more on health services capacity. The later projects tended to be more comprehensive in design, with patient care addressed only in China Health IX, approved in 1999. All

projects attempted to build in multi-sectoral involvement, including NGOs, although involvement in implementation activities remained unclear (unless an NGO funding program was specified).

The PADs (or Staff Appraisal Reports, for earlier projects) generally offer limited detail about specific interventions or the breadth vs the intensity of their coverage. If operations research was included, there were few details about the specific issues to be addressed. Project costs for specific activities are not documented for China Health VII and the Cambodia project, as HIV programming constituted 21% of the Cambodia project while it was only one aspect of the health promotion component, which was in turn 14%, of China Health VII. Nonetheless, Table 8 below offers a picture of the costs for, and contrasts between, specific activities in China Health IX (HIV component) and the Indonesia project.

TABLE 8: PROJECT COSTS FOR HIV-SPECIFIC PROJECTS

(**bold** denotes key subcomponents)

INDONESIA			CHINA HEALTH IX (HIV COMPONENT)		
	Total Costs	Costs as % of Total		Total Costs	Costs as % of Total
IEC/Behavioral interventions*	10.0	28.41%	Improved and expanded policy environment	3.49	10.76%
High risk groups	1.7		Improved HIV/STD interventions and support	11.00	33.89%
workplace	0.9				
school/university	1.5				
community and general public	1.4				
health providers	2.7				
other support activities	1.8				
Biomedical services	18.2	51.70%	Improved blood transfusion service	7.32	22.56%
blood supply protection	0.5				
STD/HIV services	7.1				
STD/HIV surveillance	4.0		Improved HIV/STD surveillance system	5.35	16.49%
Laboratory services	6.6				
Management and support	3.0	8.52%	Project coordination and support (includes national reference laboratory)	5.28	16.27%
STD/AIDS management	0.8				
Future project preparation	0.2				
Project management	2.0				
Total base costs	31.2	88.64%	Total base costs	32.45	100%
Contingencies	4.0	11.36%			
Total project costs	35.2	100%			

It is still premature to judge the extent to which they will help arrest the spread of the epidemic or at least bring about sustainable improvements in public health practice. The achievements to date have not been uniform, and each project needs to be considered in context, although some general lessons can also be drawn about the successes and problems.

Indonesia

The ICR for the Indonesia project documents clearly that although quality at entry was satisfactory, along with performance of both the Bank and the borrower, only the laboratory system to support testing and surveillance was successfully implemented. The key issues raised in the ICR include: was the design overly ambitious? Was the project too early in the stage of the epidemic to secure government commitment? Was there insufficient attention to implementation capacity and implementation readiness? Were there too many donor projects being implemented at the same time? To what extent were problems related to insufficient counterpart funding and instability in project personnel? To what extent was Bank supervision insufficient and too late in picking up the implementation problems? To what extent was the 1997 economic crisis a problem, as the country's HIV/AIDS budget was cut by 50% in 1999 (Macfarlane Burnet Centre 2000)?

Although these questions are (and have been) responded to differently by different participants in the process, it is likely that all these factors combined to contribute to the early closure of the project. If an ambitious project was designed and did not take into account the potential problems of absorptive capacity, political awareness and commitment to action, and personnel instability, then there is a mismatch between technical design and implementation readiness. Fuller assessment of institutional capacity for implementation would have been beneficial.

These issues from the ICR echo the findings of Johnston and Stout (1999) in their review of HNP lending by the Bank. Although that review focused on health system reform projects, it also highlighted the importance of realism in setting project objectives, strong country presence, need for institutional and stakeholder analysis, resources for supervision and for analytic and advisory work, routine quality assurance mechanisms, and more learning and sharing of experiences within the Bank and with clients and partners.

China

The China portfolio of projects, like Indonesia, follows from a relatively lengthy period of lending and policy dialogue in the health sector. It is worth noting that by the time the HIV component of Health IX was designed, there had been several incremental steps, both financially and conceptually. Beginning with US\$480,000 in 1991, the financing had grown to US\$4.95 million in 1995 and to US\$24.5 million in 1999. Similarly, from the relatively safe entry point of "infectious and endemic disease control", the projects have evolved to the relatively novel "health promotion" framework and finally to the specifically identified "HIV prevention control" component. Along with project size, the comprehensiveness of the projects had also grown. The use of the "safe entry point" approach may well be suited for other

countries that are reluctant, for reasons of social and political sensitivity, to address their emerging HIV problem.

An additional distinctive feature of the China projects is having identified policy reform sub-components and to specify key areas for policy reform. Although it is still too early to assess the impact of policy reform under Health IX, Health VII required and achieved reforms to STD services in the eight participating cities. For example, STD clinics now provide anonymous and confidential services and serve as a distribution point for condoms. In Kunming, a community-based drug rehabilitation program has been trialed. The policy engagement within the project, at the city level, has been based on a partnership between the Bank and UNAIDS and has placed HIV onto the local policy agenda in China.

In both China Health VII and Health IX, weaknesses in technical capacity have been partially addressed through co-financing from AusAID to provide a package of training and technical assistance. The additional input appears to have played a crucial role in ensuring contemporary public health practice is adopted. For instance, health education for CSWs has shifted from didactic lectures in "women's re-education centres" to outreach programs in karaoke bars.

Nonetheless, there remain problems of implementation delays in the "software" items within the projects, as spending on civil works and equipment tend to outpace other components of the projects. The implementation delays in China may also relate to the particular on-lending arrangements instituted by the Ministry of Finance, which pose particular barriers for community outreach programs and organizations working with high risk groups. This phenomenon may hold lessons for other countries attempting to implement national priority programs on-lending, such as Vietnam and Indonesia.

Given the spread of HIV within China during the life of these projects, questions could be raised about whether project supervision resources are sufficient to ensure the projects are not only progressing on schedule but also able to respond in a proactive manner to the ever-increasing challenge. Given China's geography, population size, and decentralized administration, there is an argument for having more resources in-country to enhance the policy dialogues that must take place at both national and provincial levels and to provide technical guidance to the projects. Closer monitoring of project progress - from the viewpoint of balance across components as well as disbursement - is also likely to require additional resources in-country.

Cambodia

In Cambodia, as in China, the Bank has played a strongly influential role in the health sector, and not limited to HIV. Working with partners in the UN system and the ADB, the Bank has been involved with both the reconstruction and expansion of the health system as well as supporting the strengthening of national, vertical, public health programs. The TTL believes that the Bank's access to the highest level of government may have assisted in securing political commitment to addressing the HIV epidemic.

The HIV/AIDS component of the 1997 projects has supported the operationalization of the national strategy and contributed to institutional strengthening at national and provincial levels. Challenges in program management, multi-sectoral collaboration, and decentralization have been key concerns throughout project implementation, suggesting similar experiences as Bank projects elsewhere.

Despite a wide donor presence in Cambodia, including the advent of the Global Fund, the Bank's lending program will continue to pay attention to HIV/AIDS. The Health Sector Support Project, appraised in April 2002, will include HIV/AIDS control activities, including behavior change, condom promotion, HIV testing and counselling, prevention of opportunistic infections, and development of guiding ethical principles. Such a project design points to a new model whereby targeted public health priorities can be situated within projects designed to support health sector reform. The Provincial and Rural Infrastructure Project, appraised in April 2002 and to be implemented by the Ministry of Public Works and Transport and Ministry of Rural Development, will be the first non-health sector project in EAP to include specific HIV/AIDS prevention activities.

Summary

Although the above four projects have constituted the major lending program in EAP Region, the Bank's health lending portfolio has been adaptive and dynamic. As projects evolve, for instance, HIV-related activities may be picked up as appropriate to the project and as the urgency of the issue becomes obvious. For instance, the Vietnam Population and Family Health Project has recently been "retro-fitted" with HIV/AIDS prevention activities in seven provinces. Additional activities supported by the project include: training and orientation of local leaders using information from surveillance and operations research, mobile IEC teams, and strengthening STD diagnosis and treatment. Similarly, China Health VIII (Basic Health Services) has also included HIV awareness as part of one of its core health promotion activities during Phase II of the Project.

Each of the Bank's projects has been developed within the context of the evolving epidemic, the Bank's country assistance strategy, lessons learnt from the Bank's previous health sector projects and HIV projects, and the presence and activities of other donors. At the same time, it is possible to draw across them some common conclusions. In general, the projects are stronger on technical design and input than on implementation. The consistent problem in implementation appears to relate to insufficient attention to analysis of institutional capacity within country as well as to insufficient resourcing of project monitoring and supervision within the Bank. Furthermore, countries would appear to prefer to borrow for "hardware" and in that sense, their commitment to tackling the HIV epidemic at an early stage would appear to be limited. Countries' awareness of non-lending product lines may also be limited.

Project activity reporting is oriented towards outputs, and the monitoring and evaluation framework does not necessarily facilitate assessment of the extent to which coverage and targeting have been appropriate, including for men and women, and for the poor who are at greater risk. Information about project impact depends on the adequacy of the surveillance components of the project, while more detailed analysis about impact of the epidemic and appropriate intervention models depends on the

extent to which research and operational studies are included in the project. Limited attention to project communication, however, means little information is available beyond those most closely involved with the projects. The most significant challenges appear to be in effecting genuine multi-sectoral partnerships and tackling harm minimization for IDUs.

4.3 *Lessons learned and implications*

Some of the lessons learned from the Bank's lending activities can be suggested:

- Good design does not ensure successful implementation – resources are required, along with more institutional analysis and attention to implementation readiness.
- Finding safe entry points for raising awareness and developing capacity may be a good way to secure commitment in the longer-term.
- An explicit policy framework or sub-component offers a ready, ongoing channel for policy dialogue. (With decentralisation, the policy dialogue needs to occur at both national and provincial levels.)
- Project designs should remain sufficiently flexible to allow for "retro-fitting", as new needs and information emerge.
- Partnerships with other development partners can improve implementation in offering greater and earlier technical support for “software” development as well as joint policy advocacy.
- Bank is uniquely placed to work across the health sector and place a focus on key health problems within the context of health system development.
- Bank has the capacity to work across sectors and incorporate HIV into infrastructure development projects.

Perhaps the single most surprising element is that, given the size of the Bank's health portfolio in EAP and the scope of the Bank's activities in general, there has been relatively limited lending in EAP for HIV prevention and control (in terms of number of dedicated projects). With HIV as a corporate priority and one of the Millennium Development Goals, along with the evolving nature of the epidemic, this picture may change.

The Bank's strengths have been seen by borrowers and other donors as: quantum of funds, capacity to work across geographical location and whole of the sector, strong analytical and advisory inputs, links with finance ministries, and bringing potential discipline associated with borrowing. Looking at the trend in the HIV epidemic in EAP Region, the Bank could play a stronger role in supporting the prevention agenda, by building on its capacity to work across sectors as well as working systematically across the health system.

Some of the issues for development of the future lending portfolio in EAP countries are:

- How to ensure HIV could be part of new health projects under preparation (eg Philippines)?
- How does the Bank assist countries to manage risks to national public health programs that may be brought by health sector reform, including through Bank support (eg decentralisation, revenue-raising by health providers)?

- How should infrastructure development (such as transportation and mining) and other human development (ie education and social protection) address HIV?
- Should the Bank increase its attention on HIV issues and its level of effort in countries with relatively little current activity in HIV prevention (eg PNG, Pacific Islands, Laos, Mongolia)?
- What should be the Bank's next set of interventions in the populous countries with a rising epidemic (eg China and Indonesia)?
- Given population mobility as a key issue in the region, should the Bank consider extending beyond country projects to regional approaches?

To some extent, the World Bank lending portfolio cannot be considered separately from the role played by other donors (multilateral, bilateral, and NGO) in each EAP country, plus the presence of the Global Fund. For instance, in 1998 there were 179 ongoing overseas development assistance projects in the health sector in Vietnam, with a total ODA commitment of US\$668 million (World Bank 2001). In this situation, the key is building on the Bank's comparative advantage and ensuring appropriate partnerships to meet the needs of the borrower by addressing weaknesses in the Bank's arrangements.

5. Review of sector work and policy dialogue

Most donors and borrowers consider that the World Bank has a particular contribution to make in terms of its capacity to access government leaders at the highest level and its analytical and advisory services, particularly in social, economic, and epidemiological analyses. Increasing the level of sector work and policy dialogue would be both consistent with the Bank's comparative advantage as well as appreciated by the international community. The Bank's current and potential activities in sector work are considered from three main areas of work: analytical and advisory services, mainstreaming, and capacity-building.

Analysis and Advisory Work

In the early and mid-1990s, prior to the establishment of UNAIDS, the Bank had an "AIDS in Asia Unit" within the Asia Technical Division and financed an economist in an AIDS group in Thailand. From the perspective of documented evidence, it would appear that the Bank's sector work on HIV in EAP countries has been relatively limited, although the earlier input may have been significant in agenda-setting and in assisting with project design. Two health sector studies have raised concerns about STDs and HIV – briefly in the 1992 health sector study in China and more extensively in the recent health sector study in Vietnam. The Bank has been involved with studies in Thailand more extensively – such as: “Thailand social monitor: Thailand's response to AIDS – building on success, confronting the future” (2000) and “The epidemiological impact of an HIV/AIDS vaccine in developing countries” (Stover J et al, 2002).

The nature and extent of policy dialogue varies across countries, depending in part on the Bank's lending portfolio and priorities. Where HIV-related projects are being developed or are under implementation, such as China and Cambodia, there is clearly greater scope for policy dialogue, although it is not evident the extent to which a coherent strategy exists. Without the lending and in the absence of other HIV-specific

analytical and advisory services, the Bank's capacity for effective advocacy is more limited.

As with other donors, representatives of the Bank participate in country-based UNAIDS Theme Groups. The level of participation, however, has been constrained by the Bank's more limited in-country presence. The Country Director is seldom in attendance and the Bank does not normally participate in the rotation for the Theme Group chair role. The Bank's engagement with other regional bodies, such as ASEAN, appears to be minimal in the health sector, although HIV/AIDS has been adopted as one of the priorities for functional cooperation by ASEAN health ministers.

At the global level, the economic analysis offered in the Bank's publication Confronting AIDS has been important in drawing attention to the problem as one of development. Although it has been distributed in EAP countries (indeed, translated into Vietnamese and Chinese, distributed to various ministries and extracts put on different websites in China), there is not yet more focused, detailed empirical work for specific countries.

Mainstreaming tools

There is a range of mainstream policy tools that can be used to ensure HIV is a recognised part of the national development agenda. Through country assistance strategies and PRSPs, the Bank could ensure that development projects are "AIDS-proofed", encourage governments to prevent discriminatory attitudes and measures being adopted against people who have HIV, advocate for a proportion of their budgets to priority health programs and to subsidize condoms and treatments, strengthen analytical and financial planning capacity to address the impact of AIDS, build links between poverty alleviation programs and HIV prevention, and ensure that poverty programs address mitigation issues. In the EAP context, recognition of the gender dimensions of the epidemic is particularly important in order to link with appropriately gendered approaches to development, eg micro-credit and local economic development for women, job skills development programs for young men, etc.

At present, Country Assistance Strategies for EAP countries are highly variable in their coverage of health issues, including HIV, as can be seen in Table 9 below. It can be seen that even in countries with generalised epidemic, HIV/AIDS has not been seen as a central aspect of the development agenda. In most CAS, there is cursory mention of the problem, or of Bank's current lending activities.

TABLE 9: OVERVIEW OF COUNTRY ASSISTANCE STRATEGIES

Prevalence	Country	Foci for Country Assistance Strategy
Nascent	Mongolia	Macroeconomic stabilisation, private sector development, infrastructure, poverty alleviation & equity.
	Laos	Poverty reduction, stabilisation of economy, investment in health (MCH, nutrition), education, and rural development [HIV/AIDS awareness mentioned]
	Philippines	Macroeconomic stability, rural development, human development & social services (health, education, housing), urban development & poverty, governance & rule of law, provincial infrastructure, private sector expansion
Concentrated	Malaysia	Mitigate social consequences of the economic crisis and prevent erosion of social sector achievements [brief reference to increase in HIV]
	Indonesia	Poverty reduction in democratic and decentralised environment - economic recovery, institutional development for accountable government, better public services, decentralisation, human resources development, basic services access & quality. [no mention of HIV/AIDS]
	PNG	Governance framework, rural development [mention of need to contain incidence of AIDS]
	China	Macroeconomic stability, infrastructure, human development (health education, social protection, poverty, alleviation), agriculture & rural development, environment protection. [reference made to HIV project lending]
	Vietnam	Economic management, finance system, SOE reform, infrastructure, rural development, social equity, public administration [need to improve awareness of HIV/AIDS mentioned]
Generalised	Myanmar	
	Thailand	Competitiveness of productive capacity, governance of public institutions, equitable distribution of benefits of growth [no mention of HIV/AIDS]
	Cambodia	Governance, access to basic services/economic opportunities (human & social capital), private sector investments; priority sectors – health, education, agriculture, energy/transport [HIV/AIDS mentioned in relation to women and as part of health sector development]

Country assistance strategies are meant to be informed by PRSPs, which set out each country's poverty reduction strategy and the priority public actions it expects to achieve its goals. PRSPs, therefore, represents one vehicle for providing assessment of the country's social, structural and key sectoral development policies. The use of PRSPs as a mainstreaming tool for HIV/AIDS is still in its early days. Hecht, Adeyi and Semini (2002) report that in a review of 25 PRSPs from African countries, the analysis of the relationship between AIDS and poverty was generally weak, even in countries where studies have been done on the social and economic impact of the epidemic. The elaboration of short-term actions and medium-term goals on AIDS were also weak.

In EAP, interim PRSPs have been drafted for Vietnam, Laos, Mongolia, and Cambodia. STD, HIV, and AIDS are mentioned in them all. Review of these documents suggests that the level of specificity and action-orientation can be improved in nearly all countries, as appropriate to their level of the epidemic. Comments from the Bank's review of the interim-PRSPS are provided below.

TABLE 10: WB COMMENTS ON ADEQUACY OF I-PRSPs IN ADDRESSING HIV/AIDS

Country	Comments on PRSP
Cambodia	<ul style="list-style-type: none"> • Should include more concrete action on HIV/AIDS and its links to poverty reduction • Effective implementation of National Strategic Plan on AIDS prevention, particularly through public education and outreach to rural areas and women, will be critical
Laos	<ul style="list-style-type: none"> • Early preventive action could avert a potential major threat
Mongolia	<ul style="list-style-type: none"> • Continued effort on prevention through public education
Vietnam	<ul style="list-style-type: none"> • Coverage is limited and action is urgently needed in a range of areas to reduce the risk of an epidemic

It is apparent from the above that HIV has yet to be considered from the level of public spending or making the health system function better, and only limited attention has been given to adopting targeted interventions that work. Indeed, the inter-relationship between AIDS and poverty is probably still not well understood or appreciated and greater promotion and assistance with use of the Toolkit for Mainstreaming HIV/AIDS Programs into Development Instruments (Adeyi et al 2001) is required.

Capacity-building

The World Bank Institute has contributed to the global effort through its capacity-building activities over the last ten years. In the mid-1990s, it funded training courses and seminars in Asia, including in China and Malaysia, aimed at country leadership. A new Leadership Program on AIDS is targeted at high level policy-makers and is designed to equip them with the knowledge, skills, and tools required for effective multi-sectoral AIDS responses. At the same time, gender and HIV/AIDS has been brought into the training on Integrating Gender and Health in Poverty Reduction, although greater application in EAP would be desirable. Furthermore, the Global Development Learning Network (GDLN) facility has also been used to implement seminars and hold electronic discussion forums. During the first half of 2002, videoconferences for the EAP have included such topics as: cross-border transmission of HIV/AIDS, prevention of mother-to-child transmission, access to care and treatment, involvement of business sector in HIV/AIDS, and HIV/AIDS and the uniformed services. The extent to which these high-level training resources are linked into policy dialogue efforts or coordinated with lending activities is not clear.

The decentralized nature of the World Bank, along with its complex organizational arrangements, means that the extent to which sectoral analyses and policy dialogue occur is somewhat dependent on country directors, sector chiefs, country economists, and task team leaders. Yet the Bank occupies a unique position amongst donors in its capacity to hold policy dialogue with planning and finance sectors. The question is: to what extent do country directors and task team leaders need and want greater technical support? (And should Country Directors attend Theme Group meetings?) At the Regional level, should there be a specific budget allocation for sectoral analyses (such as modelling the epidemic and analyzing the social and economic impact) and to support high-level, multi-sectoral, regional and national policy conferences? Given the importance of multi-sectoral cooperation for an effective AIDS response, should more effort be put towards bringing together task team leaders from various sectors together for discussion about mainstreaming of HIV prevention in all sectors? If the

Bank is going to contribute effectively to policy dialogue and capacity-building at the country level, then the above questions are answered in the affirmative.

6. Key Issues for Strategy Development

While HIV has come later to Asia and the Pacific, it has progressed substantially in a relatively short period of time. Given Asia's large populations, effective action in the region has great potential to reduce harm, prevent poverty among EAP countries, and influence the course of the epidemic globally. The World Bank, as a large funder, a knowledge broker, and influential policy advocate can make a greater contribution in the future. In formulating the Bank's future strategy in support of the fight against HIV/AIDS, a number of issues require consideration when determining the most appropriate course of action. These include factors related to the socioeconomic environment, the policy pathways adopted by client countries, and the role of the Bank in relation to other development partners.

Socioeconomic determinants

Socioeconomic factors contribute to increased prevalence of HIV as well as the distribution of vulnerabilities for HIV. The pace of economic development and the related issues of mobility and poverty are particularly significant. Increasing employment opportunities commonly result in migration to urban areas, often dislocating families and putting family members at greater risk of HIV/AIDS (Chantavanich 2000). Increased trucking of goods from rural to urban areas, and increased job opportunities with expansion of infrastructure, present another potential risk. Economic development can also contribute to increasing the gap between rich and poor, which in turn may drive migration from impoverished areas. Although macro-level data on links between AIDS and poverty is lacking, micro-studies suggest that mobility and poverty are intertwined risk factors (Bloom et al 2002). Given the interrelationship between population movement, development and HIV/AIDS (Hsu and du Guerny 2000), governments need to be attuned to these possible consequences of development, and intervene to ensure that HIV/AIDS does not become a pandemic in the EAP Region. The level of economic development will to a great extent also determine the resources available to address HIV/AIDS.

Level of political commitment by governments and across sectors

Government responses to the problem need to be ascertained. Consideration needs to be given to the level of political commitment to HIV, and government awareness of HIV/AIDS as a problem that will affect development if it is allowed to progress unchecked. Evidence now supports multisectoral responses as essential to effective management of the HIV epidemic (UNAIDS 2001). Thus, ensuring the willingness and preparedness of governments to take a whole-of-government approach (rather than solely a health sector response) to the problem should be a priority, in order to intervene early and minimize the impact of the epidemic. Political support at the highest level will be a strong determinant of governments being prepared to act early rather than later. Such political support could be seen in commitment of resources along with development of appropriate policy and legislative framework. If this is absent, strategies to achieve this support are prerequisites to achieving implementation readiness.

Resources to support HIV efforts

The adequacy of infrastructure and resources to manage the epidemic need to be assessed, and appropriate responses made to address shortcomings. These include:

- surveillance capacity - there is serious concern about the quality of surveillance systems and hence the reliability of data concerning the level of the epidemic. Measuring project impact and the effectiveness of other interventions also depends on adequate surveillance. The strong surveillance networks of Thailand are excellent examples of how surveillance information can be used to advocate with government for political commitment and meaningful financial support.
- human resources - the quantity and quality of workforce available to deliver effective interventions in a range of settings and across a range of population groups must be understood, and remedial action applied if needed.
- health infrastructure - without adequate organisational resources and coverage, efficacious interventions cannot be delivered in a cost-effective manner.
- financial resources - a thorough assessment of the financial resources available to implement proven interventions must be made.

The effective scaling-up of interventions requires sufficient funds, along with appropriately trained personnel and adequate delivery infrastructure.

Health sector reform climate

An analysis needs to be undertaken as to whether health sector reforms, such as decentralisation and cost-recovery (and possibly other public sector reforms), may pose additional challenges, and put further strain on an already burdened system. Under these circumstances, policy dialogue is needed at both national and provincial levels, and adequate resources for HIV need to be available at provincial or district levels to target areas that might have only been handled at the national level under a centralized system. A decentralizing system will require support and capacity-building at both the national level (eg analysis of surveillance data, policy development, operations research, reference laboratories) and provincial/district levels (eg surveillance and diagnosis, community outreach, behavior change communications, NGO development and support, care and treatment). Proposed interventions need to take account of all of these factors, and present strategies that address them.

Presence and role of other development partners and the Global Fund

The Bank needs to consider the presence and role of other development partners as it examines its own potential role in a country. Earlier sections of the report have identified the variety of activities being undertaken by other donors in countries in the region. It should be noted that the ADB has an increased presence in the health sector across the region. It is also a major funder adopting a regional approach. It is important for the Bank to look at where there are gaps in activities, based on what is now known to be best practice in terms of interventions required to combat the epidemic (highlighted earlier in the report). The Bank can identify where it can contribute directly (through project lending and/or sector work), or by supporting others with the expertise through co-financing or other funding mechanisms. Other

organisations can potentially take on a policy advocacy role as well as a capacity building role, building on the analytical work undertaken by the Bank.

The Global Fund provides an opportunity for countries to access significantly more grant funds to support HIV initiatives. There are risks attached to this if coordination is not ensured, with resultant duplication of effort. As the Bank was a prime mover in the formation of the Fund and is a Trustee of the Fund, the Bank can play a role in helping countries to access and use the funds for sustainable interventions. Under the umbrella/framework of the national plans and strategies that are required to access the funds, the Bank may provide further funding as a back-up resource ("funder of last resort").

Absorptive capacity of client countries

Closely associated with the above is the issue of absorptive capacity of countries where there is a heavy donor presence. Some examples are Vietnam (with many donors), PNG (with one large donor), and Pacific Islands (where the population is small). The Bank (along with all donor organisations) needs to consider how activities in these countries will be value-adding, and not add to administrative burden or implementation bottleneck.

World Bank role

The Bank is well placed to exercise influence across multiple sectors and at the highest levels of governments. Through effective policy dialogue (aka advocacy) by country directors and economists, supported by evidence from the sector and central HIV teams, it can raise the level of awareness of HIV/AIDS as a development problem, and highlight the social and economic consequences of allowing the disease to reach epidemic proportions. It is well placed to undertake information collection and present to governments the levels and trends on HIV, and prevalence of risk behaviours that will indicate predisposition to an HIV epidemic. Projecting the cost of inaction, as well as documenting the social and economic impacts to date, are also important ways of raising awareness and securing commitment. As well, the Bank is able to offer substantial levels of resources, often not available from other development partners.

How the Bank goes about exercising the influence, and how successful it is in having an impact on the HIV epidemic in the EAP Region, will depend on how the regional strategy incorporates a consideration of the relative strengths and weakness of the Bank and other development partners. Such an analysis, seen in Table 11 below, can point to pathways for harnessing the combined resources of all interested groups.

TABLE 11: SWOT ANALYSIS FOR THE WORLD BANK IN EAP

	Strengths	Weaknesses
World Bank	<ul style="list-style-type: none"> • Can achieve high-level political liaison and policy dialogue • Links with finance ministers • Undertakes economic analyses and has research orientation 	<ul style="list-style-type: none"> • Loan structure - with consequent country interest in borrowing only for hardware • Usually takes a country (rather than regional) focus

	<ul style="list-style-type: none"> • Substantial presence geographical across country and sectors through greater injection of funds • Project borrowing can impose discipline • Project implementation rests with country • Adopts systematic approach, through sector-wide approach to reform • Has role in donor coordination through PRSPs and CAS 	<ul style="list-style-type: none"> • Insufficient implementation and supervision resources • Perceived tendency to adopt one-size-fits-all approach across countries and to impose universal solutions • Dominance of economic analyses (relative to social and other analyses) • Absence of budget item for sector work at regional level • Devolution of responsibility to TTLs such that their relationships may drive policy agenda
Other donors	<ul style="list-style-type: none"> • Greater links with NGOs • Apply focused and intensive efforts • Give aid through grants 	<ul style="list-style-type: none"> • Geographical limitations of programs • Narrower program focus • Smaller funding capacity • Funding channelled to nationals
	Opportunities	Threats
World Bank	<ul style="list-style-type: none"> • Regional approach, given HIV/AIDS on ASEAN agenda and sector work in the Pacific • WBI can provide high-level policy training • Potential partnerships with other donors • Potential links with other sectors (mining, education, transport) • Global Fund 	<ul style="list-style-type: none"> • Loans may offer best in-built opportunity for policy dialogue • Underlying suspicion towards the Bank and its structural reform agenda
EAP	<ul style="list-style-type: none"> • Regional NGO and academic network ("Seven Sisters" and AIDS Society of Asia and Pacific) • Regional dialogue emerging from 2001 ICAAP Ministerial meeting • Increased pace of economic development, with attention to health and health sector development 	<ul style="list-style-type: none"> • Inadequate government commitments to health issues and to marginalized population groups • Poor policy and societal support for harm minimization approaches (for IDUs and CSWs), including cultural and religious sensitivities • Inadequate or immature civil society structure • Decentralization of health and public sector administration • Mobility and poverty associated with unequal economic development

The Bank has many strengths. Compared to other donors, the Bank may also have greater capacity to incorporate HIV into projects of other sectors (such as infrastructure development and education) and to support industry projects. The International AIDS conference in Barcelona highlighted as exemplary the political will of Brazil and Thailand, and India in terms of its focus on the production of generic drugs. The Bank has a history of financing industry development efforts (e.g. salt iodization for IDD, vaccine plants for Hep B) that require large capital inputs.

There is a potential to engage in a range of production efforts related to HIV prevention, such as condoms.

While some of the Bank's strengths are also common to other donors (e.g. sector-wide approach), other donors have strengths that can complement the Bank, highlighting the opportunity for the Bank to work more closely with these groups to achieve greater impact.

Some weaknesses in the Bank need to be recognized. Given that HIV/AIDS knows no boundaries, and migration and drug trafficking know no borders, the Bank should consider adopting regional approaches in EAP, as it has done in Africa and Caribbean, or consider working in partnership with organizations that have regional coverage. While some of the weaknesses in the Bank relate to its size and internal operational imperatives, the perceived weaknesses of other donors may be attributed to the smaller scale of their operations.

There are a number of opportunities for the Bank, given developments in the EAP. Given increased concern about the epidemic in the region, the Bank can play an active role in coordination and leadership at country level (for the Global Fund, with the Theme Groups) and at the regional level (with ASEAN, SPC). The World Bank is in a position to form partnership with other donors and technical agencies, link with other sectors (mining, education, transport), and facilitate a regional approach,

There are also threats that need to be ameliorated or managed. Given the analysis above, and the issues presented earlier in this Section, the following roles are proposed in order to achieve a more strategic and focussed role on HIV in the Region.

TABLE 12: PROPOSED ROLES FOR THE BANK IN HIV

Role	Outcome
Policy dialogue/advocacy	<ul style="list-style-type: none"> • Increase awareness of HIV/AIDS as a development problem • Highlight social and economic consequences of allowing the disease to reach epidemic proportions • Secure government commitment (of resources, policies, and legislative frameworks)
Leadership training	<ul style="list-style-type: none"> • Increase understanding and capacity at senior levels of national and provincial governments • Greater government commitment
Analytical studies: social and economic impact studies, estimating cost of interventions and projecting cost of inaction, social and behavioral studies, health services operations research	<ul style="list-style-type: none"> • Raising awareness and securing government commitment • Earlier intervention and greater impact • Better informed and more appropriate interventions
Support for multisectoral development: multisectoral projects, NGO capacity-building	<ul style="list-style-type: none"> • Incorporating HIV/AIDS into relevant projects in other sectors • Enhanced civil society capacity to participate in HIV prevention and control effort
Health sector strengthening: surveillance systems, appropriate	<ul style="list-style-type: none"> • Better functioning surveillance systems and improved documentation and analysis of epidemic

support in context of health sector reform (financing, management of decentralised services, technical skills, accountability)	<ul style="list-style-type: none"> • More reliable information collection to inform policy and intervention planning and evaluation • Adequate financing and more appropriate financing incentives • Adequate management capacity and accountability arrangements at lower levels • Adequate human resources capacity to deliver cost-effective interventions
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Some of these roles can be achieved through direct activity; others would be by way of support to groups with expertise, such as via technical agencies. All would contribute to securing greater and earlier government commitment. Dayton (1998) has highlighted the significance of a strong government commitment to the success of project interventions, and to a greater impact if interventions occur in the early stages of an epidemic as opposed to later. She also stressed the significance of sector and economic analysis contributing to greater success of projects and engagement by governments. The Bank has a particularly important role to play in this respect.

Donors, including the Bank, have also been influential in gaining government support for HIV/AIDS through support of high profile initiatives such as the Sixth Congress on AIDS in Asia and the Pacific, convened in Australia in 2001. Some outcomes from this have been helping China to acknowledge more openly its problem, India recently convening a major HIV conference with high level political representation, and greater engagement by ministers with NGOs directly working on HIV/AIDS. There are doubtless more similar examples. The importance of these types of activities which focussed strongly on leadership engagement cannot be underestimated.

The specific role of the Bank in any country at present and in the future can be defined in the context of (i) the level of the epidemic, (ii) the relationship between the Bank and the particular host country, and (iii) the relative positioning of the Bank and other donors. Table 13 reviews the possible issues and responses in relation to each contextual variable.

TABLE 13: CONTEXT FOR FUTURE PROGRAMMING AND BANK ROLE

Context	Issues/Response
Level of epidemic	<ul style="list-style-type: none"> • Early stage of an epidemic: secure government commitment to convince leaders of the importance of early action, provide leadership training, influence finance ministries, undertake formative analytical work to engage attention • Target other priority interventions, such as STI treatment services, as an effective HIV prevention strategy • Find "safe" entry points into the epidemic; incorporate HIV issues into broader health sector work as a way of seeding consciousness and capacity
Relationship between Bank and client country	<ul style="list-style-type: none"> • If seen as source of authoritative advice and a reliable partner in development, then adopt assertive approach to policy advocacy at the highest levels of government • If relationship marred by historical difficulties in business dealings or conditionalities associated with past lending, then work on reversing relationship as necessary precursor to significant Bank

	<p>involvement in HIV</p> <ul style="list-style-type: none"> • Consider introducing HIV activities into programs of sectors where relationships are positive and productive (eg if a client country is keen to work together on education, infrastructure development, etc.)
Relative positioning of the Bank and other development partners	<ul style="list-style-type: none"> • Where there is a myriad of donors and governments have accessed sizeable grant support, the Bank's role may be more as "funder of last resort" or in providing analytical work • Where client country prefers to borrow for "hardware", the Bank may partner with grant donors for co-financing of "software" development • Where the Bank have considerable presence or influence as development partner, the Bank can work comprehensively, such as investing in analytical work, building multi-sectoral policy and program capacity , and "AIDS proofing" all projects

7. Conclusion and proposed strategies for the future

7.1 *Dimensions of a new strategy*

Section 3 above presents an overview of donor responses in EAP, and Section 4 describes in detail the achievements of Bank projects to date. Compared to other donors, Bank projects tend to be large-scale, to be located in multiple sites, they may support the entire sector, and they may have strong policy and operational research components. The Bank also undertakes some multi-sectoral projects (eg HIV within roads/infrastructure development projects, or poverty projects). Additionally, the Bank actively engages with policy dialogue at the highest level of government and offers strong analytical support for project and policy work. The challenge now is to examine the issues that have been raised in relation to those initiatives, the strategic issues that have been identified, and determine how best to move forward with the HIV agenda to achieve progress in the fight against the epidemic, in partnership with governments and other donors. A new World Bank strategy for addressing HIV in the EAP can have the following dimensions.

- ***Strategic positioning of Bank projects***

The Bank will take into greater account the relative needs of countries, and the contribution of other donors, particularly the Global Fund. Detailed country/local level mapping of needs and interventions will identify where the Bank can contribute. This needs to be done in consultation with other donors who are also considering the same requirement for their own strategic planning. In so doing, the Bank will consider its comparative advantage and where it can add value. This can be by way of scaling up successful projects; assisting with blood supply management and other more costly interventions; examining health sector reform projects and assuring the place of HIV in these; ensuring a multi-sectoral approach (especially infrastructure and education) within projects in all sectors where HIV is a potential threat; and using projects for policy dialogue and building human resource capacity.

- ***Lending priorities linked to emerging needs***

The Bank will consider supporting HIV/AIDS initiatives through a variety of modalities:

- (i) discrete health projects, of which HIV/AIDS is just one component,
- (ii) specific projects that just focus on HIV/AIDS and are multidimensional in approach, and
- (iii) other sectoral or multisectoral projects in which HIV/AIDS sits appropriately – “AIDS proofing” projects e.g. roads projects that recognise the importance of inclusion of HIV/AIDS as an issue to be addressed.

The decision to select one of these approaches over another will be determined by a variety of factors, including:

- readiness of the government to address HIV issues,
- country capacity to resource projects that focus solely on HIV/AIDS, and
- the stage of the epidemic in a given country.

Many countries in EAP are not at the stage of supporting stand-alone HIV/AIDS projects, and for many it may be inadvisable to undertake projects that encourage vertical programming, rather than integrating HIV into overall service delivery, or including HIV/AIDS as one part of a health sector program, such as a family planning program. This latter approach may well provide an easy entry point where the issue is still sensitive with governments. Irrespective of which strategy is selected, it is essential that a multi-sectoral and multi-dimensional approach to HIV/AIDS is adopted.

- ***Flexibility between country and regional approach***

The Bank may choose to work in individual countries, or take a regional approach. The latter may be the appropriate choice where cross border issues are of greater significance, and in the Pacific, where absorptive capacity may be more limited, infrastructure is under-developed, and economies of scale can be achieved by taking a regional approach. Drawing lessons from Africa and the Caribbean about efficient and effective ways of managing regional funds will be important.

- ***Partnerships with other donors***

These have two clear benefits:

- (i) A preference by some countries to borrow for “hardware” has limited their commitment to tackling the HIV epidemic at an early stage; partnerships with other donors (bilaterals, UN agencies) through co-financing mechanisms, thereby softening the terms of loans, could improve implementation in offering greater and earlier support for “software” development.
- (ii) Other donors are also more expert in providing certain types of technical support, and can complement the areas where the Bank has greater expertise.

- ***Strong analytical and advisory work***

There is a need for continuing sector work, including economic and social analyses, that will underpin project designs, and see the Bank increasing its role in policy dialogue. This will take the form of operational studies focusing on a number of needs such as:

- (i) studies that examine the cultural and behavioural issues associated with HIV/AIDS,
- (ii) empirical analysis of socioeconomic determinants, especially poverty and migration issues,
- (iii) studies of the socioeconomic impact of HIV/AIDS, and
- (iv) other studies that might be required for planning projects such as investigations into the functionality (implementation and sustainability) of surveillance systems and adequacy of public health infrastructure and financing.

Studies will ensure there is appropriate targeting of IEC messages given the stage of epidemic, the level of education of communities, and socioeconomic status of communities. These studies can form the basis for advocacy that places HIV/AIDS at the center of the development agenda and helps other sectors to see how they can make a contribution to the HIV effort.

- ***Mainstreaming***

Where appropriate, HIV/AIDS activities will be mainstreamed into overall health service delivery programs. This can be via a sector-wide approach to health service delivery, or within primary health care projects. This is particularly valuable where human resources are limited, and personnel providing routine health services are also encouraged to integrate HIV/AIDS into their work, and where sustainability is questionable if projects are delivered as vertical programs. It will be important to ensure that key interventions are secured in decentralized systems.

- ***Evaluation with dissemination***

There has been limited attention to project communication. A greater effort is required to collate the lessons learned in HIV from Bank and other donor projects, and disseminate these to country directors and economists, sector managers, and task team leaders in all relevant sectors for application to new lending and non-leading initiatives. Given the importance of multi-sectoral cooperation for an effective AIDS response, it is important to bring task team leaders from various sectors together for discussion about mainstreaming of HIV prevention in all sectors.

- ***Expanded policy dialogue***

The Bank has good access to senior policy makers, and in particular to ministries of finance. This should be maximized. A greater focus will be given to undertaking rigorous analytical studies, operational studies, leading to the distilling of key issues to identify key priorities. Policy messages for governments will differ according to the stage of the epidemic. Policy dialogue should be contextualized in relation to other policy reform agenda. For instance, decentralisation is increasingly the norm in the EAP. Risks to national public health programs that may be brought by health sector reform need to be identified and managed, including HIV. At the Regional level, consideration should be given for a specific budget allocation for sectoral analyses, and support of high-level, multi-sectoral, regional and national policy conferences. The Bank should also foster links with key NGOs and involve them in both national and regional level dialogues.

- ***High-level policy training***

The World Bank Institute provides expertise to deliver high-level policy training to governments. If HIV/AIDS is to be recognised by governments as a serious threat to the health and economy of countries, senior policy makers need to be targeted. A coordinated effort between the WBI and those involved in lending and sector work will be important.

- ***Comprehensive and balanced project design***

Technical dimensions of projects will ensure that all key components required for greater effectiveness are included in designs, drawing from both public health best practice in comparable conditions as well as from more broadly-based cost-effective analyses. The appropriateness of designs will be considered in relation to the stage of the epidemic, and projects should be sufficiently flexible to accommodate new knowledge about the epidemic and respond to increasing urgency in the problem. There will be the need to balance interventions for the general population and the high risk populations. Tailored efforts are likely to be required not only on the basis of gender but also for disadvantaged population, given their knowledge rate tends to be poorer (Gwatkin and Deveshwar-Bahl 2001).

- ***Thorough project implementation planning***

A consistent problem in implementation has been insufficient attention to analysis of institutional capacity within country as well as insufficient resourcing of project monitoring and supervision by the Bank. Both of these dimensions should be given greater attention. A serious focus on resourcing issues is also needed, and the likely impact if projects are under-resourced (from both financial and technical support viewpoints). The best designs will have little impact if there are insufficient resources to implement applying best practice. There are many examples, such as surveillance systems, IEC initiatives, which can have zero impact when poorly implemented. Co-financing with grant donors can assist with increasing the level of support during implementation.

- ***Flexible project financing***

The Bank will consider softening terms of loans through engagement/use of other funding mechanisms. Non-lending instruments should also be made more widely known and available to governments. Innovative combinations in financial support can be particularly useful to ensure community grants can reach the grassroots level.

7.2 Next steps

Countries such as China and Indonesia demand major and ongoing attention and support. There are other parts of the Region that also have emergent needs. For immediate prioritising and focussing of Bank efforts in the EAP, the following program is recommended:

China and Indonesia:

- Designate as priority countries for both lending and sector work, as well as assistance across the spectrum of support mechanism, such as leadership training and assisting with obtaining other grants
- Establish a program of analytical studies, including social and economic impact studies, social and behavioral studies, and health sector operations research (particularly in evaluating effective models for reaching marginalised groups)
- Intensify engagement with ministers of finance and political leaders
- Extend partnerships with other donors to enhance potential impact of development assistance
- Convene multi-sectoral dialogue, including with task team leaders from other sectors, and ensure appropriate incorporation of HIV issues into all relevant projects
- Increase support for implementation, supervision and monitoring

Vietnam, Cambodia, and Thailand

- Continue with current support at project level, maintain policy dialogue, and expand analytical work

Pipeline projects:

- Integrate HIV into pipeline projects, such as in the Philippines, Vietnam, and Pacific islands

PNG:

- Complement AusAID efforts with social and economic research that address the nexus between HIV and development

Capacity-building for leadership and analytical work:

- Implement high-level and multi-sectoral leadership training, at national and provincial levels in priority countries and on sub-regional basis
- Develop plan of technical assistance to increase local capacity to undertake analytical work in priority countries on social and economic impact of the epidemic and on policy options
- Increase technical assistance/support to countries and to task team leaders for incorporating HIV into CAS and PRSPs and translating best practice guidelines into locally appropriate interventions
- Develop best practice guidance, in association with relevant organisations, on how to address priority problems in the Region (such as harm minimization approaches for IDUs, working with religious institutions, trafficking of women and children)

Regional programming:

- Address HIV needs through the planned Pacific human development sector study, including such issues as adequacy of monitoring and surveillance systems and with particular attention to Solomons, Vanuatu, and Samoa
- Commence dialogue with ASEAN Secretariat about potential partnership in support of the 2001 ASEAN Summit Declaration
- Develop links with Regional NGO Networks for involvement in policy dialogues and analytical work
- Adopt watching brief in relation to Mongolia and consider potential need for regional approach between Central Asia, northwest China, and Mongolia

- Examine the extent to which the ethnic minorities and hill tribes in northern parts of Vietnam, Laos and Thailand (and extending into Myanmar) would benefit from regional programming
- Continue engagement with Regional forums, such as ADB annual meetings and ICAAP

In summary, given the increasing level of epidemic, the World Bank cannot afford to continue to operate on a "business as usual" basis. At the same time, given the diversity of the Region - in terms of the epidemic, the historical relations between the Bank and various client countries, and in the positioning of the Bank vis-a-vis other donors - the Bank's role and approach would necessarily vary across countries. Nonetheless, the Bank can: be more proactive with analytical work and policy dialogue, increase support for multi-sectoral approaches, and give greater attention to regional programming.

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APPENDIX 1: HIV-RELATED PROJECTS IN EAP COUNTRIES SUPPORTED BY OTHER DONORS

COUNTRY	OTHER DONORS (\$US mil)
Nascent	
Mongolia	AusAID: STI/HIV education (UNDP), cofinancing (2000-02) - 249.05 UNDP: HIV/AIDS/STDs in Mongolia (1997-2000) - 0.30
Laos	AusAID: Mekong subregional HIV/AIDS care & support project (2000-02) - 0.52 USAID: HIV/AIDS (2002-06) - \$1.00 (2002) - \$1.00 (2003) UNDP: Lao PDR HIV/AIDS (1998-2000) - 0.27 NORA: Laos HIV/AIDS (2000-02) - 0.007 Global Fund: Prevention and Control of HIV/AIDS/STI, TB and Malaria in the Lao PDR - 0.72 (Year 1) - 3.41 (Total)
Philippines	USAID: The threat of HIV/AIDS & Selected Infectious Diseases is Reduced (1994-2004) - 4.40 (2000) USAID: The Threat of HIV/AIDS & Selected Infectious Diseases Reduced (1992-2004) - 3.50 (2001) JICA: Project for Prevention and Control of AIDS (1996-2001) - 0.51 UNDP: Promoting Multisectoral & Community-Based Approaches to HIV Prevention and Care in the Philippines (2000) - 0.26 UNDP: Increasing Awareness and Understanding of the development Implications of HIV/AIDS (2000) - 0.15
Concentrated	
Malaysia	
Indonesia	AusAID: HIV/AIDS Prevention & Care Project – Phase 1 (1998-2002) - 21.00 AusAID: HIV/AIDS Prevention & Care Project – Phase 2 (2002-07) - 30.00 KFW: HIV/AIDS prevention & family planning (2000-03) - 9.42 UNDP: Strengthening GOI/NGO Capacity and Partnership for HIV/AIDS Program Implementation (1997-2000) - 0.88 Global Fund: Strengthening DOTS expansion in Indonesia - 2.58 (Year 1) - 15.96 (Total)
Papua New Guinea	AusAID: National HIV/AIDS Support Project (2000-05) - 60.00
China	AusAID: HIV/AIDS Prevention & Care Project (2002-07) - 7.54 DFID: HIV/AIDS economic impact Study (2001-02) - 0.18 DFID: HIV/AIDS education project (2001-06) - 0.22 DFID: Support for HIV/AIDS education for young people (2001-06) - 21.87 UNDP: Multi-sector Approaches for HIV/AIDS Control and Prevention in China (1997-2000) - 1.90

Vietnam	<p>AusAID: HIV/AIDS Capacity Building Project (2002-04) - 0.82</p> <p>AusAID: UNDP HIV/AIDS Youth Awareness Project (2002-05) - 0.71</p> <p>AusAID: Care: NOVA2000: Confronting HIV/AIDS, project-NGO window (2000-03) - 0.35</p> <p>AusAID: Participatory HIV/AIDS Prevention (1998-2001) - 0.57</p> <p>AusAID: UNDP/HIV/AIDS: Awareness raising for youth, cofinancing (2000-03) - 1.14</p> <p>JICA (1999-2000) - 0.06</p> <p>UNDP: HIV/AIDS Capacity Building (1999-2001) - 0.75</p> <p>UNDP: HIV/AIDS, Environment and Youth (1999-2001) - 0.63</p> <p>UNDP: Strengthening the Capacity for Coordination, management and Planning of HIV/AIDS in Vietnam (1994-2000) - 1.04</p> <p>DFID: HIV/AIDS Control (2001-02) - 24.59</p> <p>Global Fund: Strengthening Care, Counselling, Support to People Living with HIV/AIDS (PLWHAs) and Related Community-Based Activities - 4.00 (Year 1) - 12.00 (Total)</p>
Generalized	
Myanmar	<p>AusAID: UNICEF: Mekong subregional HIV/AIDS Program (1999-2002) - 0.77</p> <p>AusAID: WVA: Eastern Shan state HIV/AIDS project (1998-2002) - 0.19</p> <p>AusAID: WVA: Southern Myanmar HIV/AIDS Project (1998-2002) - 0.19</p> <p>DFID: Community action for HIV/AIDS care & support in the Mekong Subregion (2001-04) - 0.34</p>
Thailand	<p>AusAID: Ambulatory Care Project (2000-01) - 0.51</p> <p>JICA: Project for model development of comprehensive HIV/AIDS prevention & care (1998-2003) - 0.03</p> <p>UNDP: HIV/AIDS Prevention and Care (1994-2000) - 0.80</p> <p>UNDP: Prevention and Control of AIDS in Thailand (1989-2000) - 0.89</p> <p>Global Fund: Strengthening National Prevention and Care Programs on HIV/AIDS, Tuberculosis and Malaria in Thailand - 13.99 (Year 1) - 109.50 (Total)</p>
Cambodia	<p>USAID: Reduced transmission of STT's and HIV/AIDS in high risk populations (1998-02) - 2.05 (2000) - 2.50 (2001)</p> <p>DFID: UNAIDS (2001-02) - 0.10</p> <p>DFID: Enhancing the response to HIV/AIDS (2001-06) - 14.05</p> <p>UNDP: Multi-Sectoral Assistance to the HIV/AIDS Program in Cambodia (1996-2000) - 0.95</p> <p>ADB: Technical assistance to Cambodia for capacity building for HIV/AIDS prevention & control (2001-02) - 0.07</p> <p>Global Fund: Partnerships for going to scale with proven interventions for HIV/AIDS, TB and malaria - 5.87 (Year 1) - 15.95 (Total)</p> <p>Global Fund: The Sangaha Thor Initiative (SANTI project) - 1.28 (Year 1) - 9.61 (Total)</p>
Regional	<p>AusAID: South East Asia Regional Program – Burma, Vietnam & 2 provinces of China (2002-06) - 4.51</p> <p>AusAID: Pacific Regional HIV/AIDS Project (2002-07) - 6.41</p> <p>USAID: Regional HIV/AIDS and Infectious Diseases (2001-2006) - 7.78 (2002)</p> <p>USAID: Asia and Near East Regional HIV/AIDS (1995-2004) - 7.00 (2001)</p> <p>ADB: Community action for preventing HIV/AIDS in the Greater Mekong Subregion – Cambodia, Vietnam & Laos (2000-03) - 10.00 US</p> <p>UNDP: Assistance for Development of a Effective Response to the HIV/AIDS Epidemic – All countries of Asia and the Pacific (1999-2001) - 5.55</p> <p>UNDP: Sub-regional Assistance for the Development of an Effective Response to the HIV Epidemic in Southeast Asia and China – Cambodia, China, Indonesia, Malaysia, Philippines, Thailand, Vietnam (1997-2001) - \$2.10</p> <p>UNDP: Response to the spread of HIV/AIDS in Pacific Island Countries – Samoa, PNG, SPC (1998-2000) - 0.26</p>

	<p>UNDP: Support to Development of an Effective Response to the HIV Epidemic in the Countries of North East Asia – All countries of North East Asia, ie. China, DPRK, Republic of Korea, Mongolia (1998-2000) - 0.51</p> <p>Global Fund: HIV/AIDS Initiative for Mobile and Border Populations (AIMBP) – Myanmar & Thailand - 0.55 (Year 1) - 1.07 (Total)</p>
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Appendix 2: WORLD BANK HEALTH LENDING IN EAP COUNTRIES

COUNTRY	Total Health Lending	HIV-Relevant Projects	HIV/AIDS-specific Components
Nascent			
Mongolia			
Laos	- \$19 mil: Health system reform & development (1995)		
Philippines	<p>Total: \$242 mil</p> <ul style="list-style-type: none"> - \$70 mil: Health sector reform: Reproductive health, urban health & nutrition (closed) - \$18 mil: Women's health & safe motherhood (1995) - \$19 mil: Early childhood development (1998) - \$70 mil: Health development (closed) - \$40 mil: Population (closed) - \$25 mil: Population (closed) 		
Concentrated			
Malaysia	<p>Total: \$72 mil</p> <ul style="list-style-type: none"> - \$50 mil: Health development (closed) - \$17 mil: Population & Health (closed) - \$5 mil: Population (closed) 	Health (1994)	- \$16 of 50 mil: <ul style="list-style-type: none"> • Blood transfusion service
Papua New Guinea	- \$6.9 mil: Population & family planning (1993)	Population & family planning (1993)	- Small portion/6.9 mil: <ul style="list-style-type: none"> • STD drugs
Indonesia	<p>Total: \$995.9 mil</p> <ul style="list-style-type: none"> - \$103 mil: Provincial health (2001) - \$77 mil: Water supply & sanitation (2000) - \$38 mil: Provincial health (2000) - \$44.7 mil: Health 5 (1998) - \$42.5 mil: Safe motherhood (1997) - \$28.5 mil: IDD (1996) - \$20 mil: HR capacity building (closed) - \$24.8 mil: HIV/STD (1996-99) - \$88 mil: Health 4 (closed) - \$93.5 mil: Community health & nutrition (closed) - \$104 mil: Population 5 (closed) - \$43.5 mil: Health 3 (closed) - \$33.4 mil: Nutrition & community health (closed) - \$39 mil: Health 2 (closed) - \$46 mil: Population 4 (closed) - \$27 mil: Provincial health (closed) - \$35 mil: Population 3 (closed) - \$24.5 mil: Population 2 (closed) - \$13 mil: Nutrition (closed) - \$5 mil: Population (closed) - \$65.5 mil: Health workforce & services (closed) 	<p>HIV/AIDS & STD prevention & management project (1996 - 1999)</p> <p>Safe Motherhood Project (1998)</p>	<ul style="list-style-type: none"> - \$24.8 mil: <ul style="list-style-type: none"> • Project cancelled – only lab system successful - \$.2 of 42.5 mil: <ul style="list-style-type: none"> • MCH project (STD survey & operations research)
China	<p>Total: \$1,072 bil</p> <ul style="list-style-type: none"> - \$104 mil: TB (2002) - \$60 mil: Health 9 (1999) - \$85 mil: Basic health services (1997) - \$100 mil: Disease Prevention (1995) - \$90 mil: MCH (1994) - \$27 mil: IDD (closed) - \$110 mil: rural health workers (closed) - \$150 mil: Tianjin indust dvlpt (closed) - \$129 mil: Infectious & endemic disease control (closed) - \$52 mil: Integrated regional health development (closed) - \$80 mil: Health 2 (closed) - \$85 mil: Rural health & medical education (closed) 	<p>Infectious Disease Control (1991)</p> <p>Maternal & Child Health (1994)</p> <p>Disease Prevention Project (1995)</p> <p>Health Nine Project (1999)</p>	<ul style="list-style-type: none"> - \$.48 of 129.6 mil: <ul style="list-style-type: none"> • STD training & operations research & HIV surveillance - small component for related training - \$5 of 100 mil: <ul style="list-style-type: none"> • Health 7 – Policy reform, surveillance, HRD, community-based interventions - \$25 of 60 mil: <ul style="list-style-type: none"> • Health 9 – Policy development, STD management, condoms, IEC, patient care, surveillance, blood transfusion
Vietnam	<p>Total: \$249 mil</p> <ul style="list-style-type: none"> - \$38 mil: Regional blood transfusion centres (2002) - \$50 mil: Population & family health (1996) - \$101 mil: National health support (1996) 	Blood transfusion project (2002)	- \$38 mil: <ul style="list-style-type: none"> • Blood safety project – centres in Hanoi, Hue, HCMC, Can Tho &

	- \$60 mil: Curative care for poor (pipeline)		National Institute of Haematology
Generalised			
Thailand	- \$33 mil: Population (closed)	Social Investment Project (1998)	- \$2.6 of 300 mil <ul style="list-style-type: none"> • Social investment project
Cambodia	Total: \$55 mil - \$30 mil: Disease Control & Health (1997) - \$25 mil: Health Sector Support	Disease control & health development project (1997) New projects (2002)	- \$6/30 mil: <ul style="list-style-type: none"> • National & provincial institutions, IEC, blood transfusion, outreach, condoms, STD treatment, surveillance and research, NGO small grants. - HIV prevention as part of 2002 rural roads/ infrastructure project - HIV to be part of new health sector project: <ul style="list-style-type: none"> • HIV testing, condom promotion, opportunistic infections in HIV+, ethical principles, supervision