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PROJECT APPRAISAL DOCUMENT

FOR

PROPOSED CREDITS

IN THE AMOUNT OF SDR 45.2 MILLION (US$59.7 MILLION EQUIVALENT)
AND SDR 37.9 MILLION (US$50.0 MILLION EQUIVALENT), RESPECTIVELY,
TO THE FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA AND THE REPUBLIC OF KENYA

IN SUPPORT OF THE FIRST PHASE OF

THE US$500 MILLION MULTI-COUNTRY HIV/AIDS PROGRAM FOR THE AFRICA REGION

AUGUST 14, 2000

AFRHV
AIDS Campaign Team for Africa (ACT*africa*)
Africa Regional Office

CURRENCY EQUIVALENTS
(Exchange Rate Effective July 31, 2000)

Currency Unit	=	US$
SDR 1	=	US$ 1.32
US$ 1	=	SDR 0.76

FISCAL YEAR

July 1 – June 30

WEIGHTS AND MEASURES

Metric System

ABBREVIATIONS AND ACRONYMS

ACT*africa*	AIDS Campaign Team for Africa
AIDS	Acquired Immune Deficiency Syndrome
APL	Adaptable Program Loan
ARV	Antiretroviral (Drugs)
BCC	Behavior Change Communication
CSW	Commercial Sex Worker
CBO	Community-Based Organization
DHS	Demographic and Health Survey
GPN	General Procurement Notice
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IAPSO	The Inter-Agency Procurement Services Office
IBRD	International Bank for Reconstruction and Development

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IDA	International Development Association
IEC	Information, Education & Communication
IPAA	International Partnership Against AIDS in Africa
KAP	Knowledge Attitudes & Practices
MAP	Multi-Country HIV/AIDS Program
M&E	Monitoring & Evaluation
NAC	National AIDS Council
NACP	National AIDS Control Program
NGO	Non-Governmental Organization
OI	Opportunistic Infections
O&M	Operation & Maintenance
PCU	Program Coordinating Unit
PLWHA	People Living with HIV & AIDS
PMR	Project Management Report
PO	Private Organization
PTCT	Parent-to-Child Transmission
STI	Sexually Transmitted Infection
TB	Tuberculosis
TTL	Task Team Leader
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Kenya HIV/AIDS Disaster Response Project
Technical Annex

AIE	Authorities to Incur Expenditure
CACC	Constituency AIDS Control Committee
CBK	Central Bank of Kenya
DACC	District AIDS Control Committee
DARE	Decentralized AIDS & Reproductive Health Project
FMA	Financial Management Agent
GOK	Government of Kenya
ICR	Implementation Completion Report
MTEF	Mid-Term Expenditure Framework
NACC	National AIDS Control Council
OP-NACC	Office of the President-National AIDS Control Council
PA	Procurement Adviser
PACC	Provincial AIDS Control Committee
PS	Procurement Specialist
SOE	Statement of Expenses
TOR	Terms of Reference
TOT	Training of Trainers

Ethiopia Multi-Sectoral HIV/AIDS Project
Technical Annex

AWP	Annual Work Program
BC	Beneficiary Communities
BG	Block Grants
BPA	Birr Project Accounts
CAS	Country Assistance Strategy
CPAR	Country Procurement Assessment Review
DPPC	Disaster Prevention & Preparedness Commission
EAF	Emergency HIV/AIDS Fund
EMSAP	Ethiopia Multisectoral HIV/AIDS Program
EOI	Expressions of Interest
ETL	Ethiopia Team Leader
FMF	Financial Management & Accounting Firm
FMM	Financial Management Manual
FSM	Federal Sectoral Ministries
GOE	Government of Ethiopia
HFO	HIV/AIDS Facilitation Officer
HNACS	Head, NAC Secretariat
HRD	Human Resources Development
IC	Individual Consultants
ICB	International Competitive Bidding
IDF	Institutional Development Fund
IPIP	Interim Program Implementation Procedure
KAC	Kebele Administration Committee
LC	Letters of Credit
MFI	Micro-Finance Institution
MOF	Ministry of Finance
NCB	National Competitive Bidding
NS	National Secretariat
PAS	Project Accredited Staff
PC	Program Coordinator
PCFM	PC Finance Manager
PCME	PCU M&E Consultant
PCPC	PCU Procurement Consultant
PCPF	PCU Program Facilitation Staff
PIM	Program Implementation Manual
QCBS	Quality- & Cost-Based Selection
RAC	Regional AIDS Council
RB	Regional Bureau
RFP	Request for Proposal
RPA	Regional Procurement Advisor
RPR	Rapid Plasma Reagin
RS	Regional Secretariats
SA	Special Account
SC	Special Commitment
SPN	Specific Procurement Notice
USAID	United States Agency for International Development
WA	Woreda Administration
WAC	Woreda HIV/AIDS Advisory Committee

AFRICA – MULTI-COUNTRY HIV/AIDS PROGRAM (MAP)

CONTENTS

AFRICA

Multi-Country HIV/AIDS Program (MAP)

Project Appraisal Document

Africa Regional Office
AFRHV

Date: August 14, 2000	**Team Leader:** Anwar Bach-Baouab
Manager: Debrework Zewdie	**Sector(s):** Multi-Sector
Project ID: P071233	**Theme(s):** HIV/AIDS
Lending Instrument: APL	**Poverty Targeted Intervention:** N

Program Financing Data
For Loans/Credits/Others:
Amount: SDR 378.4 million; $500 million equivalent

APL 1a

	IDA US$ million	Government US$ million	Civil society US$ million	Total US$ million
Kenya	50.0	2.4	..	52.4
Ethiopia	59.7	2.0	1.7	63.4

APL 1b

Countries Meeting Eligibility criteria	390.3	20.6*	4.1*	415.0

* Estimates based on first two country operations.

Projects financial data :
Amount: SDR 83.1 million (US$109.7 million equivalent)
Proposed terms: Standard IDA
Grace period (years): 10 — Years to maturity: 40
Commitment fee: Up to 0.5% — Service charge: 0.75%

Financing Plan

Multi-Country HIV/AIDS Program for Africa: Phase 1
IDA Financing

BALANCE:	(US$ million)
Total	500.0
Kenya	50.0
Ethiopia	59.7
Total Phase 1a	109.7
Balance	390.3

Kenya: AIDS Disaster Response Project
IDA's Estimated Disbursements
US$ million

FY	2001/2002	2002/2003	2003/2004	2004/2005
Annual	4.8	15.2	15.0	15.0
Cumulative	4.8	20.0	35.0	50.0

Ethiopia: Multi-Sectoral HIV/AIDS Project
IDA's Estimated Disbursements
US$ million

FY	2001/2002	2002/2003	2003/2004
Annual	14.1	20.4	25.2
Cumulative	14.1	34.5	59.7

Kenya: AIDS Disaster Response Project
Financing Plan

Source	Local US$ million	Foreign US$ million	Total US$ million
IDA	47.0	3.0	50.0
Government	2.4	0.0	2.4
Total	49.4	3.0	52.4

Ethiopia: Multi-Sectoral HIV/AIDS Project
Financing Plan

Source	Local US$ million	Foreign US$ million	Total US$ million
IDA	44.0	15.7	59.7
Government	2.0	0.0	2.0
Community	1.1	0.0	1.1
NGOs, etc.	0.6	0.0	0.6
Total	47.7	15.7	63.4

Borrowers: Governments of Ethiopia and Kenya
Other African country governments
Guarantors: Not applicable
Responsible agencies:
Ethiopia: Office of the Prime Minister
Address: P.O. Box 1031
Contact Person: Dr. Dagnachew Haile Mariam
Tel: 251-1-55-77-99 Fax: 251-1-55-20-20 Email:

Kenya: Office of the President
Address: National AIDS Control Council, Kenyatta National Hospital, P.O. Box 19361, Nairobi, Kenya
Contact Person: Dr. Tom Mboya
Tel: (254) (2) 714972/ 729549 Fax: (254) (2) 729504/726036 Email: Office of the President

Kenya Project implementation period: 4 years
Expected effectiveness date: 1st quarter FY2001 **Expected closing date:** FY2005

Ethiopia Project implementation period: 3 years
Expected effectiveness date: 1st quarter FY2001 **Expected closing date:** FY2004

A. Program Purpose and Development Objective

1. Program purpose and phasing:

1. The HIV/AIDS epidemic now poses the paramount threat to development in Sub-Saharan Africa. Nearly 25 million Africans are living with HIV/AIDS, the vast majority of them adults in the prime of their working and parenting lives. Another 14 million have already died from AIDS, with devastating social and economic consequences. The epidemic has erased many of the development gains of the past generation and now threatens to undermine the next. Twelve million African children have been orphaned. Life expectancy has fallen by decades in many countries, and in the most heavily affected may soon drop as low as 30 years. AIDS is costing the region close to one percent of economic growth each year, while imposing an unsustainable and mounting burden on households, firms, and the public sector. Yet despite heightened awareness in recent years, the epidemic continues to gain speed. Last year four million Africans were newly infected, the highest number to date. Three in four Africans now live in countries where HIV prevalence exceeds five percent—the threshold at which economic growth falters, demand for health care grows faster than government can supply it, and the epidemic typically hits a "takeoff" point. Unless far more aggressive action is taken across the continent, HIV/AIDS will continue its rapid advance and progressively choke off all other development efforts.

2. The tragedy of the epidemic is compounded by the fact that it is preventable. Despite the lack of a cure or a vaccine, preventive measures such as awareness programs to bring about behavior change, social marketing of condoms, treatment of sexually transmitted infections (STIs) and opportunistic infections such as tuberculosis, voluntary counseling and testing (VCT), a safe blood supply, and preventing parent-to-child transmission (PTCT) have all proven highly effective in reducing HIV transmission. Community-based programs have been especially effective in enhancing prevention, care, support, and treatment for those infected and affected by AIDS. All African governments have initiated responses of this sort to some degree. Few, however, have multisectoral programs of national coverage, and none has committed domestic and external resources commensurate with the epidemic.

3. While some countries in Sub-Saharan Africa have made progress in reversing the spread of the epidemic—notably Senegal and Uganda—most have not, despite having national HIV/AIDS programs. Their efforts have fallen short for five principal reasons: they have been *inadequately financed*; there has been inadequate government *commitment and leadership*; support from governments and the international community has been *too slow*, especially for scaling up programs that have proven effective; not enough resources have reached *communities*; and programs have been too *narrowly focused* on the health sector.

4. Although the Bank has supported HIV/AIDS efforts since 1986, few African countries have drawn more than token resources from IDA for this purpose. To step up its response, last year the Region adopted a new strategy, *Intensifying Action against HIV/AIDS in Africa: Responding to a Development Crisis*. The strategy rests on four pillars: (1) advocacy to position HIV/AIDS at the top of the development agenda and to stimulate an intensified response; (2) increased resources and technical support to mainstream HIV/AIDS into all sectors; (3) prevention efforts for both targeted and general audiences, and activities to enhance care, support and treatment; (4) expanding the knowledge base to help countries design and manage comprehensive programs based on local circumstance and best practices. Together, these measures constitute the Region's commitment to the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the International Partnership Against HIV/AIDS in Africa (IPAA), which comprises African governments, the UNAIDS cosponsors, bilateral donors, and the private sector. Early indications show that many other donors would be prepared to cofinance HIV/AIDS projects on a country-by-country basis. In launching the strategy, the Region undertook to work in full collaboration with these partners. Since then, the Region has taken several steps to integrate HIV/AIDS

into both lending and non-lending services. It is retrofitting its current portfolio to include prevention and mitigation components in as many sectors and projects as possible, continuing to develop free-standing HIV/AIDS projects, and carrying out analytical work. However, these ad hoc steps alone are not enough to outpace the epidemic or to avert its potential consequences. More systematic action is urgently needed.

5. Accordingly, as set out in the strategy, the Region has designed the proposed Multi-Country HIV/AIDS Program for Africa (MAP). The MAP is structured as a "horizontal" adaptable program lending (APL) instrument, which will consist of individual operations in African countries that meet the eligibility criteria set out in section C, below. The first two country cases are presented here; it is proposed that subsequent cases would come into the program with Management approval, following circulation of a country document for a 10-working-day period during which Executive Directors could request a Board discussion of the proposed operation.

6. Because mitigating the epidemic is a medium- to long-term challenge, the MAP will be phased over an estimated period of 12 to 15 years. Phase 1, which is presented here, will commit its resources over the next three years. Subsequent phases will be processed in a manner similar to that of repeater projects, each subject to Board approval. The goal of Phase 1 is to intensify action against the epidemic in as many countries as possible. Its twin objectives will be: (a) to scale up prevention, care, support and treatment programs; and (b) to prepare countries to cope with the unprecedented burdens they will face as the millions living with HIV today develop AIDS over the next decade. Following a rigorous stocktaking, Phase 2 will then be designed to mainstream those innovations that have proved effective, attain nationwide coverage wherever it was not achieved during Phase 1, expand care, support and treatment interventions, and attempt to include all interested countries that did not take part in the first phase. By Phase 3, it is expected that new infections will have declined, which will permit a sharper focus of prevention on areas or groups where the spread continues. The number of AIDS cases will probably peak during Phase 3, requiring a maximum effort in care, support and treatment.

7. The ultimate impact of the MAP will be to avert millions of HIV infections, alleviate suffering for tens of millions, and help preserve the development prospects of entire nations. Given the nature of the epidemic, once it has spread in the general population (adult prevalence in Africa as a whole is now 8.57%) *overall* HIV prevalence will not likely decline for several years. But the pace of *new* infections and a host of key factors that fuel the spread of HIV can be influenced in the short term. Each phase of the MAP will therefore play an important role in contributing to a cumulative impact on the epidemic.

Rationale for the Multi-Country AIDS Program (MAP)

8. Most Sub-Saharan African countries have strategic plans and ongoing AIDS prevention programs. Several countries have recently progressed to comprehensive national action plans and have managed to overcome denial through advocacy. Most also have excellent isolated examples of AIDS prevention and care projects managed by government departments, community-based organizations, PLWHA, NGOs, and the private sector. However, all these programs still operate on too limited a scale, often reaching only a small fraction of the population, and too many still remain limited to the health sector. National programs have, by and large, failed to scale up their own proven and culturally adapted interventions to achieve nationwide coverage.

9. The proposed MAP would redress all of these shortcomings. By visibly committing substantial IDA resources—an initial amount of US$500 million in flexible and rapid funding over three years—and leveraging co-financing on a country-by-country basis through the IPAA, it would help ensure adequate resources to fund all sound national HIV/AIDS plans in full. Prospects for cofinancing with other donors will be sought at each country level. By using streamlined procedures and generic prototypes, it would

quicken the pace of project preparation while reducing the transaction costs to countries and to IDA. By allowing for much broader disbursement, it would ensure that resources reach all actors involved in HIV/AIDS efforts, especially communities. The overall program is based on the new paradigm for addressing HIV/AIDS: strong national leadership coupled with strong support for local responses. While a great deal of work has gone into its design, the most concentrated effort will be devoted to implementation, both by the countries and by IDA and its partners.

10. The MAP would also remove some of the burden from the health sector, which has been expected to do far too much in spearheading national programs. Although some ministries of health have done a commendable job of coping with the impact of HIV/AIDS on the health system, none has succeeded in coordinating a multisectoral response. Those few countries that have made significant progress in slowing the epidemic (such as Uganda) have placed the coordinating body of national HIV/AIDS efforts under the president's office, where it has the visibility, reach and authority to coordinate and mobilize all stakeholders. Applying this lesson, the MAP would provide support multisectorally, directly to sector ministries and all other entities involved in the effort, rather than through the piecemeal approach of sector-specific operations.

2. Program development objective:

11. The overall development objective of the MAP is to dramatically increase access to HIV/AIDS prevention, *care, and treatment programs, with emphasis on vulnerable groups* (such as youth, women of childbearing age, and other groups at high risk). The specific development objectives *of each individual country project*, as stated in the national strategic plans, will provide the basis for this program and be agreed upon at the time of appraisal of the national projects.

3. Key performance indicators:

12. Given the rapidly evolving nature of the HIV/AIDS epidemic, strong and flexible monitoring will be critical to the development of effective programs. The ongoing availability of information regarding levels of HIV infection in various populations, in addition to behavioral data, provides crucial guidance in improving the impact of prevention, care, support and treatment interventions. Within the initial three years of the MAP, it will not be possible to measure longer term impacts such as reductions in HIV prevalence and AIDS-related deaths. It will, however, be possible to collect information on intermediate outcomes such as increased age at first sex among young people, that lead to the desired program impacts. Performance monitoring for the MAP will focus on three core groups of indicators, to be adapted to country circumstance in each case. The groups, with a few illustrative indicators for each, are as follows:

A. Output Indicators
Availability and quality of treatment for STIs and AIDS-opportunistic infections
Knowledge of means for preventing HIV/AIDS
Use of condoms during last risky sexual encounter

B. Process Indicators
Coverage of HIV/AIDS programs
Share of community-level action plans progressing toward achievement of their objectives
Availability of voluntary counseling and testing

C. Impact Indicators
Rate of new sexually transmitted infections among young people
Increase in median age of first sex
School enrolment rates among orphans

13. Performance indicators for countries will be tailored to the specifics of national programs. Specific performance indicators for the Ethiopia and Kenya projects are discussed in Annexes 6 and 7.

B. Main Issues and Strategic Context

14. Virtually every country in Sub-Saharan Africa has a national HIV/AIDS program encompassing prevention, care, and treatment. But in most countries the epidemic continues spreading despite these efforts. The most crippling problems have been the inability to act multisectorally or to deliver resources to the many local actors in such programs, and thereby generate a broad-based response at the community level. In nearly every country, the four most pressing needs are:

- ***Strong political and government commitment***

15. Strong government commitment has proved essential in every country that has made headway against the epidemic. This calls for bold political action and leadership, not merely tacit approval of public HIV/AIDS efforts. Leaders need to speak openly and frequently about HIV/AIDS, overcome taboos, and place the epidemic at the center of their development agendas. Governments need to re-examine spending priorities in light of the rapidly growing costs of AIDS, and reallocate accordingly. Governments can also leverage existing programs such as education and agricultural extension by integrating HIV/AIDS into them at modest cost. Management of national programs belongs in the highest office of government. The MAP can assist in all these measures, but government commitment and leadership is a prerequisite for success.

- ***Scaling up what works***

16. Almost every country has successful interventions underway at a small scale and in dispersed sites. But national HIV/AIDS programs often have insufficient funds and inadequate funding mechanisms to bring such activities up to scale, especially outside the public sector and at community levels. The central theme of the MAP is to build capacity and help expand these effective interventions wherever feasible (or replicate them where expansion is impractical), with a view toward reaching national coverage in the shortest time possible. Special emphasis will be put on monitoring and evaluation and a process of permanent social impact monitoring to ensure that what works well on a small scale works just as well when expanded.

- ***Increasing community participation and ownership***

17. Successful HIV/AIDS programs in Sub-Saharan Africa have involved local communities in the identification, design, preparation, and implementation of activities and governance mechanisms. In prevention, communities can set norms, influence behavior, and tailor interventions in ways appropriate to the local culture. In care and support, communities bear the lion's share of the responsibility, especially for such things as home-based care for those living with HIV/AIDS and support for orphans. But most communities lack the resources to mount programs of adequate scope, and central governments typically lack the means to deliver resources quickly and sustainably to the community level. The MAP will therefore support community involvement through capacity building and through the establishment of HIV/AIDS emergency grant facilities that will channel resources directly to communities. The activities to be supported will be identified at the local level and subject to transparent local accountability.

- ***Moving to a multi-sectoral approach with improved coordination and decentralization***

18. HIV/AIDS is a major development crisis affecting all sectors. It requires a national response involving all sectors, and should be both well-coordinated and decentralized to move quickly toward comprehensive national coverage. Past HIV/AIDS programs have typically been coordinated and supported by ministries of health, which seldom had the authority or experience to coordinate the many stakeholders in different sectors needed for effective prevention, care, and treatment. At the same time, programs were concentrated at the central level with little effort or involvement from regions and communities. More successful approaches in recent years have relied on programs, coordination mechanisms, and implementation channels that are multisectoral in nature, operate at national, regional, and local levels, and have broad stakeholder involvement. The role of multisectoral national HIV/AIDS councils in providing strategic guidance, leading institutional and policy reforms, ensuring coordination and adequate implementation, and monitoring and evaluation has been pivotal. At the same time, implementation has been decentralized to regional and local levels where programs can be effectively managed and expanded when successful. The MAP will place strong emphasis on supporting efforts across all sectors and at all levels.

C. PROGRAM DESCRIPTION SUMMARY

19. The Multi-Country HIV/AIDS Program is a "horizontal" APL under which country-specific IDA credits will be developed to support national HIV/AIDS programs. This first phase of the program will consist of individual lending operations up to an aggregate amount of US$500 million. Phase 1a comprises the first two projects, for Ethiopia and Kenya, which are submitted for Board approval at this time. Subsequent country operations under Phase 1b will be prepared in countries meeting the eligibility criteria set out below, and will follow the prototypes developed in Ethiopia and Kenya. In accordance with procedures for APLs, each such operation would be circulated to the Executive Directors for information after approval in principle by Management. Management approval would become effective 10 working days thereafter. Any operation could be scheduled for discussion if at least three Executive Directors so requested during the 10-day period.[1]

20. Countries will qualify for support from the MAP on the basis of eligibility criteria. Lessons from the past 20 years have shown certain elements to be essential to a successful response to HIV/AIDS. Foremost among these are government commitment and leadership. Key policy and structural building blocks must also be in place. In view of the urgency of making financing available to the greatest number of countries, the eligibility conditions focus on the readiness of national HIV/AIDS programs, and the commitment of the government to a stepped-up national response and to decentralized, community-based implementation mechanisms. To be eligible, each country will need to demonstrate:

- ***Satisfactory evidence of a strategic approach to HIV/AIDS.*** This would typically be demonstrated by a coherent national, multisectoral strategy and action plan for HIV/AIDS prevention, care, and treatment that has been developed through a participatory approach using social assessment techniques. It could also be demonstrated by having a participatory strategic planning process underway, with a clear roadmap and timetable.

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[1] The Board approved procedures for APLs, including "follow-on" operations in September 1997 (Please refer to documents R97-203 and M97-56).

- ***A high-level HIV/AIDS coordinating body*** such as a national HIV/AIDS council or equivalent has been established to oversee the implementation of the strategy and action plan. This body should encompass broad representation of key stakeholders from all sectors, including PLWHA..

- ***Government has agreed to use appropriate implementation arrangements*** to accelerate project implementation, such as channeling grant funds for HIV/AIDS activities directly to communities, civil society and the private sector, as well as having in place effective financial management (including controls and audits) and procurement, using outside expertise when necessary.

- ***Government has agreed to use and fund multiple implementation agencies***, especially community-based and non-governmental organizations.

21. The individual country operations will provide rapid, flexible support to implement national HIV/AIDS programs, and will finance expenditures to strengthen HIV/AIDS prevention, care, treatment, and impact mitigation. They will support a comprehensive range of activities:

- ***Investments and technical support*** to enhance a broad range of HIV/AIDS prevention, care, and mitigation activities implemented by the public, private, and non-governmental sectors and to provide capacity building;

- ***Community initiatives*** to develop and broaden the capacity of communities to plan and manage activities for HIV/AIDS infected, affected, and vulnerable groups;

- ***Institutional strengthening of national, regional, and local HIV/AIDS committees*** to establish more effective coordination, management, and mobilization of resources for multi-sector interventions; and

- ***Monitoring and evaluation systems*** and a process of permanent social impact assessment and stakeholder consultation to ensure that HIV/AIDS programs reach beneficiaries directly, quickly, and with maximum impact on the ground.

22. In each country, the national strategy and action plan will provide the guiding framework for support from the MAP, as well as from governments, the donor community, and stakeholders such as NGOs, professional and special interest associations, and civil society. Well-developed plans will include the following elements:

- A shared analysis and shared perspective of priorities and gaps;
- Negotiated annual work plans and budgets;
- Agreed milestones and indicators of achievement;
- Agreed working arrangements and responsibilities such as national coordination mechanisms, common design and appraisal, implementation, financial control mechanisms, monitoring and evaluation, and use of technical resources;
- Agreed resource mobilization plans drawing on all potential partners (government, donors, private sector);
- Mechanisms to ensure timely resource transfer and technical support to district/community-level actions; and
- Mechanisms to ensure active involvement of PLWHA.

23. The MAP will help finance a share of the investment spending and recurrent expenditures based on each country's assessment of its critical needs, resource gaps, and opportunities for scaling up actions.

The choice and emphasis of interventions to be financed within each country will vary according to a number of factors, including:

- Current and projected future stages of the epidemic in the country;
- Critical gaps and priorities in ongoing national responses to HIV/AIDS;
- Program development and implementation capacity;
- Participatory planning methods involving stakeholders in problem analysis and activity design;
- Multisectoral analysis of existing programs, coordination, and resource flows; and
- Implementation arrangements including fiduciary, monitoring, and evaluation mechanisms.

24. To define priority interventions, Annex 3 presents guidelines for operationalizing an intensified response at the country level and a typology that classifies the current African epidemic into two sets based on HIV prevalence rates (low and stable *vs.* growing or high). The MAP would finance essential expenditures to strengthen HIV/AIDS prevention, care, treatment, and impact mitigation. This would include the treatment of STIs and opportunistic infections—notably tuberculosis—and prevention of PTCT. It will typically support the following components:

- ***Prevention***, including information, education, and communication (IEC) for specific target groups, condom promotion, voluntary counseling and testing for vulnerable groups of the population; participatory approaches to behavior change;

- ***Care and treatment***, including the treatment of STIs and opportunistic infections such as TB; strengthening the availability of and access to essential drugs, training of health workers, clinical management of HIV/AIDS-related conditions, and support to home and community-based care and support activities; ensuring a safe blood supply through improved screening and blood transfusion;

- ***Research and surveillance***, including baseline surveys of epidemiology, knowledge and behavior, improved HIV sentinel surveillance to monitor the epidemic, and analysis for the design and implementation of cost-effective interventions;

- ***Capacity building*** for program coordination, resource management, and implementation at all levels; and

- The establishment of sound ***monitoring and evaluation systems*** to enable program implementing agencies to monitor performance indicators for each component of their programs.

25. Although the MAP will support the full spectrum of HIV/AIDS activities, four emerging interventions bear special comment. First, Sub-Saharan Africa remains the only global region where *more women than men are HIV-positive*. For biological, cultural and economic reasons, adolescent women are particularly vulnerable to HIV infection. In several countries, for every 15-to-19-year-old boy who is infected, there are five to six girls infected in the same age group. A host of factors account for the greater prevalence among women in Africa, including their limited autonomy and bargaining power, economic and legal marginalization, certain cultural practices (e.g. female genital mutilation, wife inheritance), low educational attainment, and the lack of female-controlled preventive methods. Given the heavy toll of HIV/AIDS on women in Africa, the MAP will incorporate interventions to help women protect themselves and to address the underlying causes of their women's vulnerability. Program interventions will include: providing women with improved economic, social, and educational opportunities; changing attitudes about men's and women's traditional gender roles; strengthening community-based women's organizations; safeguarding women's interests through legal reforms; and supporting technologies that enable women to protect themselves (e.g., female condom, microbicides).

26. Second, as the number of adults living with HIV/AIDS grows, the number of children infected with HIV is also increasing. Transmission can occur during pregnancy, childbirth, and breastfeeding. *Reducing PTCT* can therefore be a potent tool in a comprehensive HIV/AIDS program, if accompanied by appropriate health and social services for the woman and child. In the past two years, evidence has shown that short, cost-effective antiviral treatment can reduce the transmission of HIV from parent to child. Based on this evidence, WHO and UNAIDS have produced a broad spectrum of recommendations to help countries in reducing PTCT. Under the MAP, in resources will be available to support the expansion of PTCT programs appropriate to the country context.

27. Third, the rapid rise in adult deaths is also generating an unprecedented number of *orphans*. Before AIDS, only about two percent of children in developing countries were orphans. Today, AIDS alone has already orphaned ten percent of children in some African countries, and the share is growing fast. These children are at far higher risk for malnutrition, illness, abuse, and sexual exploitation, and are far less likely to attend school. Safeguarding the future of this generation poses one of the greatest social protection challenges that many of the affected countries have ever encountered. Many efforts to support and protect orphans are already showing promise. These usually involve enhanced public assistance for core social services (especially health and education) and for community-based care and support. The MAP will support an expansion of such efforts and other innovative interventions to reduce the vulnerability of these children.

28. The fourth intervention is the use of *anti-retroviral (ARV) drugs*. These drugs have proven effective in delaying the onset of AIDS and substantially prolonging life expectancy among HIV-positive persons in developed countries. Because of their high price and sensitivity, however, these therapies have been out of reach for most developing countries. Recent initiatives by pharmaceutical firms are likely to bring prices down considerably, but serious issues of sensitivity, resistance, and equity remain to be overcome before ARV drugs could be used in many of the countries MAP will support. The Bank has been working closely with its UNAIDS partners, drug companies, and developing-country governments on access to ARV therapy. As the situation evolves, individual ministries of health may explore ways of introducing ARV therapy. The MAP will support the development of guidelines and the strengthening of health infrastructure to make use of these drugs safe, effective and sustainable. IDA will also actively follow up the trend in affordability and efficacy and remain open, on a case-by-case basis, to supporting ARV drugs and the necessary infrastructure where resources may be required.

29. The MAP will also support systematic mechanisms for drawing lessons from the operations it finances. These will include cross-country workshops of staff from IDA and from participating countries, which will bring together project preparation/management teams from the first six or seven countries involved in the program to learn from one another. This will be followed up by further such meetings as additional countries join the program. The AIDS Campaign Team for Africa (ACT*africa*) will also conduct regular pre- and post-mission briefings and debriefings of the teams that work on preparation and supervision and collect feedback from the monitoring and evaluation systems of the operations. The midterm review of the MAP will also provide an opportunity to consolidate cross-country learning. The lessons of experience will be disseminated regularly by ACT*africa* to the task teams, as well as to a wider audience through the IPAA, and the UNAIDS knowledge management and best practice system.

Specific country programs

30. The first two countries seeking support under Phase 1 of the MAP are Ethiopia and Kenya. Several other Sub-Saharan African countries have begun developing programs under Phase 1, and will come forward in the next several months. Annex 2 provides an overview of the countries in relation to the eligibility criteria.

31. Ethiopia and Kenya have met the eligibility criteria for accessing funds under the MAP. Both countries have adopted far-reaching policies for national mobilization to fight the worsening situation of the epidemic. Both have recently developed comprehensive multisectoral strategic plans for the medium term, fully endorsed the principle of public/private partnerships to implement the national strategies, and established national HIV/AIDS councils and secretariats at the highest level of government to assume overall program coordination. Both have created an emergency HIV/AIDS fund to provide grants to local communities, non-governmental organizations (NGOs), community-based organizations (CBOs) and the private sector, and have agreed to autonomous management of the fund.

32. The proposed program for Ethiopia under the MAP would finance a US$63.4 million three-year slice of the Government's 2000-2004 HIV/AIDS strategic plan. The program includes support for capacity building for government agencies and civil society and the financing of prevention, care, and treatment activities to expand the public multisectoral response as well as the participation of civil society and communities in the fight against HIV/AIDS. A detailed program description and implementation arrangement is provided in Annex 6.

33. The Kenya program is designed to facilitate the launch of an expanded and intensified response to the HIV/AIDS epidemic. Five priority areas have been identified for support under the MAP for a total financing of US$52.4 million. They include prevention and advocacy, treatment and support of the continuum of care for those infected and affected by HIV/AIDS, management and coordination, mitigation of social impact and research, and monitoring and evaluation. These priorities have been grouped into three project components covering support to line ministries, coordination of program and project activities, and support to implementation of initiatives from civil society, private sector, and research institutions. A full description of the project is provided in Annex 7.

MAP activities in special situations: sub-regional programs, countries in arrears or conflict

34. Vital as they are, working through country operations alone will leave two gaps in Africa's response to HIV/AIDS: *sub-regional* activities; and countries in *conflict, or in arrears* to IDA. HIV travels beyond national borders through trade, tourism, migration, armed forces, and refugees. The strongest cross-border externalities arise among countries that are intensively linked via trade, migrant labor movements, and warfare. It is therefore important to build effective sub-regional programs that can address externalities across borders and in entire sub-regions. In addition, regional and sub-regional programs can achieve economies of scale for highly specialized activities associated with various national HIV/AIDS programs. Examples include encouraging behavior change among truckers and temporary migrants, including the distribution of condoms; strengthening of sub-regional technical institutions and resources for supporting country HIV/AIDS programs, training, policy analysis, research, monitoring and evaluation, and information exchange.

35. With respect to activities in many conflict countries, there is no or only rudimentary government capacity to plan, coordinate and execute a national HIV/AIDS program. However, it is precisely in such countries that movements of armed forces, refugees, and demobilized soldiers create a particularly high threat of rapid spread of HIV. Ways must be found to contain the spread of HIV and provide minimal care and support activities to the affected populations. This is not only necessary for the benefit of the affected populations, *but also to contain adverse spill-over effects into neighboring countries* which arise from the mobility of refugee populations, combatants, and ex-combatants. Two difficulties must be overcome for IDA to be able to support the fight against HIV/AIDS in these countries: First, IDA must find a way to work with organizations other than the government which have an operational capability in these countries, and which could add HIV/AIDS components to their ongoing programs; second, many of

the conflict and post-conflict countries are in non-accrual status. It will therefore be impossible to use the normal approach of making loan/credit to the country (or countries) involved.

36. Because of the externalities involved in such activities, individual countries are unlikely to be willing to use IDA or IBRD loans. In both subregional activities and countries in conflict or arrears, some grant funding may be necessary.

1. Project components (see Annexes 6 and 7 for detailed country project descriptions and cost breakdowns):

37. The components of the individual projects will depend on country circumstances. The following table provides, as illustrative cases, the component and cost breakdown for the Ethiopia and Kenya projects. These may be taken as indicative of the types of components many country programs will comprise, although some may vary according to the state of the epidemic, the nature of the national HIV/AIDS strategy, and local capacity.

Kenya: AIDS Disaster Response Project
Project Costs and IDA Financing

Components	Indicative Costs US$ million	% of Total	IDA Financing US$ million	% of Total IDA Financing
A. Improving and expanding government multi-sectoral interventions	10.3	20	9.5	19
B. Establishing AIDS program management institutions and enhancing implementation capacity of all participating agencies	12.1	23	10.5	21
C. Expanding and funding the capacity in the delivery of prevention, care, and support services by NGOs, etc.	30.0	57	30.0	60
Total project costs	52.4	100.0	50.0	100

Ethiopia: Multi-sectoral HIV/AIDS Project
Project Costs and IDA Financing

Components	Indicative Costs US$ million	% of Total	IDA Financing US$ million	% of IDA Financing
A. Capacity building for government agencies and civil society	8.8	14	7.6	13
B. Expand government multi-sectoral response	19.7	31	19.0	32
C. Emergency HIV/AIDS grant fund	28.1	44	26.4	44
D. Project coordination	6.8	11	6.7	11
Total project costs	63.4	100	59.7	100

2. Key policy and institutional reforms supported by the program:

38. The MAP is a multisectoral operation that does not intend to address long-term sectoral and institutional reforms within any one sector, or to include conditionalities linked to macroeconomic or sectoral policies. Institutional reform will be sought in the area of HIV/AIDS coordination at the national level, namely through activities such as:

- The staffing of the national HIV/AIDS council, its secretariat, and, where appropriate, PCU;
- The adoption of national strategic plans;
- The establishment of financial mechanisms for channeling resources to the community level; and
- The establishment of sound monitoring and evaluation mechanisms.

39. The MAP will also finance studies and other initiatives to enhance countries' preparedness to manage the evolution of the HIV/AIDS epidemic and its impact in the long term. Analytical work would be conducted to evaluate existing frameworks at regular intervals to ensure their compatibility with the evolving status of the epidemic.

3. Benefits and target population:

40. Phase 1 of the MAP would provide prevention, care, support and treatment to an estimated eight countries comprising about 280 million people. On those bases, the program would produce the following benefits:

- First, the population at large will benefit directly from avoidance of HIV infection and AIDS, and from better access to treatment, care, support and mitigation activities supported by the program. In particular,
    - Lower income groups will benefit from community-based assistance to households taking care of AIDS patients and orphans
    - Communities will be better able to plan and manage their own response to the epidemic
    - People living with HIV/AIDS will benefit from reduced stigma and improvements in their human rights, from improved care at home, in their communities, and in health centers and hospitals, and therefore from prolonged and healthier lives
    - Women and youth will benefit disproportionately from targeted interventions to improve their awareness of the disease and empower them to protect themselves
    - Commercial sex workers, men having sex with men, intravenous drug users, and people in correctional institutions will similarly be able to better protect themselves, and benefit from reduced stigma and improved human rights

- Second, the MAP would sharply reduce new infections, especially among young people, and therefore have a vast impact on future suffering and premature deaths. In total, the implementation of the first phase of the MAP would prevent an estimated 6.7 million AIDS-related deaths over a twenty year period.

- Third, the reduction in mortality will greatly reduce the future costs of care, treatment, mitigation and orphan care, thereby allowing governments to allocate the resulting budgetary savings to investment. Both the increased investment and larger labor force made possible by the fall in AIDS-related deaths will substantially increase total output.

Because of these substantial economic benefits, the prevention, treatment, and care of HIV/AIDS constitute a highly productive investment with an estimated internal rate of return of about 30 percent (see Annex 5).

4. Institutional and implementation arrangements:

Institutional and implementation arrangements

41. In order to respond rapidly to the HIV/AIDS epidemic, countries need to adopt implementation approaches on the basis of contracts and results on the ground. Sub-project financing is one of the approaches that has been used successfully in social funds and community-driven development programs. Though implementation arrangements may vary from country to country, their design would follow similar principles. A typical successful national HIV/AIDS program would include all or most of the following implementation arrangements:

- A coordinating body at the highest level of government with participation from sector ministries, PLWHA, youth and women, and from other civil society groups and the private sector. Such a body would usually define the national HIV/AIDS strategy, policies, and broad implementation arrangements, and oversee national program elaboration and implementation.

- An administrative/technical group reporting to the coordination body for management and coordination of program design, implementation, and monitoring and evaluation.

- Sub-programs and sub-projects designed and executed by a range of organizations at community, local, district, or municipal levels.

- HIV/AIDS coordination committees at regional and local levels, which would have a composition similar to that of the national coordination body. These committees would promote, facilitate, approve, and supervise the sub-programs and sub-projects of the executing organizations at their local level.

- Sub-programs and sub-projects executed by civil society and private sector organizations (national and regional contractors), with capacity to operate at the national or broad regional levels, as facilitators and trainers, in providing special services such as auditing, ensuring a safe blood supply, condom distribution, or in serving special populations such as street children, men having sex with men, and intravenous drug users.

- Sub-programs and sub-projects executed by entities of the national government (sectors and institutions), such as the national health service, education, or the military; and of institutions managed by the sectors.

42. The national HIV/AIDS programs would have to be able to finance any of the sub-programs or sub-projects of these different classes of executing agencies. Financing can be achieved in a number of ways:

(a) Via budget allocations for HIV/AIDS to each of the different actors involved, i.e., the local governments for their HIV/AIDS committees, government ministries and institutions, and the national HIV/AIDS council. The Government would then have to engage contractors from private sector enterprises and NGOs for the sub-programs executed by them.

(b) Via disbursement from an HIV/AIDS fund (such as a Social Fund) with separate windows to provide flexible financial resources for the different classes of actors and programs.

(c) A combination of (a) and (b).

43. Under option (a), IDA would verify that the appropriate budget allocations for all entities have been made and disbursed at the end of each year. In addition, IDA would have to be satisfied that the governmental and intergovernmental resource transfer procedures have the capacity to ensure transparency and accountability for the use of the funds, and to provide for a capacity-building program to make further improvements to these national-level procedures.

44. Option (b) is widely used in IDA operations and requires no special comment. However, there are only a few countries in Africa with the decentralized government structures and the necessary intergovernmental fiscal transfer system that would allow for efficient management of the fund within the existing government system. Outsourcing of financial management of the fund to a private firm should therefore be considered at the appraisal stage of country projects.

45. Option (c). In many cases it may be necessary or desirable to combine both the above disbursement arrangements. For example, a national HIV/AIDS program may rely on a fund (option b) for the financing of the local committees and functions contracted to the private sector and NGOs, while sectoral agencies may receive funding allocated for their HIV/AIDS programs as part of the regular budget process (option a).

Project coordination and management

46. In each country, overall project coordination will be set up in the secretariat of the national HIV/AIDS council or such other high-level entity as mandated by government. A decentralized project coordination system will be established by each participating ministry and private sector organization to coordinate and monitor implementation progress at all levels, according to agreed-upon performance indicators. Project coordination units (where they exist) will report to the national secretariat. Where necessary, the project will finance the contracting of a financial management firm for the duration of the project, for administration and management of funds. In each country, sub-project review committees will be set up to recommend the selection of proposed community-, district-, provincial-, and national-level initiatives for financing under the credit. The committees will consist of representatives of relevant sector ministries involved in the project as well as representatives from the private sector and civil society, including PLWHA and specific target groups such as youth and women.

Project implementation

47. In each country, each public sector project component will be implemented by the respective line ministry responsible for that component. For private sector and community-based initiatives, implementation will be done by NGOs, CBOs, local governments, and any other participating civil society entity. For some institutional strengthening, research, and monitoring and evaluation components, implementation arrangements may be devolved to the national HIV/AIDS council or secretariat. In each country, the project implementing units will prepare a project implementation manual delineating the project activities and implementation arrangements, monitoring and evaluation mechanisms, financial management systems, and control procedures, including financial and progress reporting requirements. Guidelines for such manuals have been developed and are available in the project files.

Financial management

48. Implementation approaches need to ensure the timely and reliable flow of funds to the implementing organizations at all levels. Slow disbursement and inadequate resources for communities have been two of the biggest roadblocks to the response to HIV/AIDS in Africa. Under the MAP, if a country's existing systems do not facilitate timely flow of funds directly to implementing entities, the implementation approach may include the outsourcing of financial management and disbursement of funds to the implementing entities. This approach will facilitate immediate disbursement of funds to sub-programs and sub-projects rather than delaying disbursements until the development and implementation of a government system that can achieve this same objective. During the period of outsourcing, countries will be encouraged to develop (a) their own methods for timely and effective flow of funds to implementing entities; and (b) the capacity to implement such systems. The MAP will support these initiatives.

49. Sub-project financing has been used successfully in social funds and community-driven development programs. Though implementation arrangements may vary from country to country, the key principles the MAP will observe are as follows:

- appraisal and approval of projects on a decentralized basis (e.g., a tiered approach with small projects approved at the local level, larger projects approved at the provincial or district level, and the largest projects approved at the national level);
- inclusion of in-kind contributions from participating local and community organizations;
- direct flow of funds from the project coordination unit to the implementing entities based on an agreed-upon tranche schedule;
- facilitation, monitoring, coordination, and capacity building at the local and community level by intermediary organizations (both NGOs and private sector firms);
- regular, integrated reporting on physical progress and financial results;
- review and approval of integrated reports prior to disbursement of the next tranche and/or approval of additional sub-projects;
- annual independent external audits of community and local implementing entities on a random sample basis; in addition, all implementing entities receiving larger grants (e.g., greater than 54
- annual independent external technical and process audits of community and local implementing entities on a random sample basis; and
- transparency and accountability to final beneficiaries at the local level, including publication in local language of the project-funded activities: the name of the implementing entity, amount of the grant, description of the activities, reports on the progress of activities, and audit reports.

50. An integrated approach to monitoring the financial and physical progress of the project will be an essential element in ensuring that the project funds are being used for the intended purposes and are being directed towards the activities and implementing entities that are actually producing results. To this end, reporting formats will be simple and focused on both physical progress and financial results; interim reports will be required to be reviewed before additional funds are disbursed to the implementing entities.

Procurement

51. IDA will finance goods, civil works, consultancies, training, and other local activities necessary to implement the program. Procurement for all IDA-financed activities will be carried out in accordance with the Bank's *Guidelines for Procurement under IBRD Loans and IDA Credits* (January 1995 and revised in January and August 1996, September 1997, and January 1999), in particular, Section 3.15, Community Participation in Procurement. Consulting services by firms or individuals financed by IDA

will be awarded in accordance with the Bank's *Guidelines: Selection and Employment of Consultants by World Bank Borrowers* (January 1997, revised in September 1997 and January 1999).

52. In terms of procurement, the program participants can be classified into two main groups: (a) the service delivery arms of government at the federal, regional, zonal, and local government levels; and (b) grassroots community organizations, NGOs, and private sector organizations. Under group (a), the structure will be based on a centralized procurement operation within the national AIDS council using the Bank's Standard Procurement Guidelines and Procedures. Group (b) will have a decentralized procurement process using the Bank's simplified Procurement & Disbursement for Community-Based Investments.

53. Given the urgency of the program, and to facilitate speedy procurement of items required urgently during the first 12 months, some of the critical requirements could be obtained on a fast track basis. For example: (i) drugs, condoms, and the like could be obtained directly from United Nations agencies (UNFPA, WHO); (ii) immediate requirement of vehicles specifically for the program could be acquired from IAPSO or by local shopping (preferably ex-bonded warehouses on a competitive basis); and (iii) furniture for coordinating offices could be procured through local shopping. In addition, where feasible, procurement agents could be used, including UNFPA for procurement and distribution of condoms, and possibly other United Nations agencies for procurement and distribution of drugs.

54. All procurement actions will follow standard IDA procurement Guidelines and annual General Procurement Notices (GPN) will be prepared for the project and published in *United Nations Development Business*.

55. Procurement will be bulked where feasible into packages valued at US$100,000 equivalent or more. In cases of consolidated procurement of goods by the central coordinating agency (both national and international), where the end users are spread in different geographical locations and there is adequate procurement/contracting capacity at the central coordinating agency, the Borrower may consider a central contracting system acceptable to IDA whereby through structured Bidding Documents and central contract monitoring procedures the end users will be responsible for ordering and receiving the goods directly from the suppliers. There are high risks involved with respect to actual monitoring and implementation of such a process and careful consideration will be given to all details (including capacity of the end users to raise orders based on the central contracting information) before any such system is adopted.

56. The institutional procurement arrangements for each country will be based on the individual procurement capacity assessment carried out for each country; country-specific action plans will be developed, including prior and post review thresholds. Procurement Plans will be developed for the first year of program operations based on the specific country work programs.

Disbursement

57. Specific disbursement procedures will be developed for each country based on the particular situation and design of the country project, taking into consideration IDA's disbursement policies and procedures. The key considerations for the disbursement procedures will be: (a) a link between physical progress and project expenditures; (b) the need for a sufficient balance in the Special Account for decentralized and emergency activities; and (c) an efficient and effective flow of funds to meet the needs of the project during a relatively short implementation period. Where appropriate capacity exists, the use of Project Management Report (PMR)-based disbursement will be encouraged to facilitate the disbursement process, provide adequate funds in the Special Account, and ensure close monitoring of the

link between physical progress and expenditures. In other cases, traditional disbursement procedures will be used until there is sufficient capacity to convert to PMR-based disbursement.

Supervision and auditing requirement

58. Because of their scope, speed, and use of innovative instruments, operations under the MAP will require intensive supervision. Accordingly, supervision budgets for MAP programs will be considerably larger than the norm. Local staff will be involved in every MAP-supported operation and will provide continual support and supervision at the country level. Staff from the key fiduciary areas will be permanent members of supervision teams and provide close support, especially in the critical first year of implementation. Supervision will be conducted jointly with other supporting partners and local UNAIDS representatives. Each operation will include frequent workshops and stocktaking exercises to ensure ongoing learning-by-doing. As the number of countries under the MAP grows, cross-country sessions will also be held to exchange lessons.

59. Projects will be subject to the standard IDA audit requirements, including submission of audit reports within six months of the end of the fiscal year. The selected independent auditor, acceptable to IDA, will need to have expertise in auditing a complex entity operating in a decentralized environment.

Monitoring and evaluation (see Annex 4)

60. Responding effectively to HIV/AIDS requires sustained and extensive monitoring and evaluation (M&E) of a broad range of measures. In most countries, M&E systems are weak and do not make adequate use of the data already available from a variety of local sources. The MAP will invest substantially in establishing or strengthening M&E capacity and a process of stakeholder and beneficiary assessments. This will permit activity and service reformulation based on lessons learned. A more complete discussion appears in Annex 4.

61. In particular, the MAP will support countries in adopting the principles of "second generation" HIV surveillance recently developed by WHO and UNAIDS. This approach tailors the use of data to the specifics of each country. It combines biomedical and behavioral surveillance and draws on data from a wide variety of local sources. Monitoring and evaluation of the HIV/AIDS programs funded under the MAP will be unique in a number of respects:

- The three year programs will provide more information on inputs, process, and outputs than on outcomes and impacts, which are longer term;
- Early indicators on program effectiveness and beneficiary receptivity will be needed in real time to improve service delivery;
- The MAP emphasis on multisectoral approaches and multiple implementation channels will require more monitoring and evaluation at the micro level;
- The commitment to beneficiary and stakeholder involvement and changing behavior of different groups will be enhanced if the M&E systems are complemented by a permanent process of social impact monitoring;
- The M&E system will be organized as a management tool for all concerned stakeholders and established on a network basis for better permit sharing of lessons learned.

Midterm review

62. Given the innovative nature of the MAP, its emphasis on learning-by-doing, and its long-term horizon, a joint midterm review will be carried out 21 months into the program. To ensure independence and broad ownership of the results, the review will be conducted jointly by IDA, UNAIDS, at least one partner NGO, client representatives, and staff from OED. The review will produce feedback for three purposes:

- To guide fine-tuning of program design and lessons for future country participants;
- To lay the groundwork for the second phase of the MAP; and
- As a guide toward using a multi-country approach for similar situations with regional dimensions and sharing the experience with other partners.

63. The outcome of the review will be presented to the Executive Directors for discussion, and disseminated widely to countries, partners, and all other interested stakeholders. Regional workshops will also be held to discuss the findings and their implications with all participating countries.

D. PROGRAM RATIONALE

Rationale for IDA involvement:

64. Helping African countries reverse the trend of the epidemic and intensify actions to mitigate its impact is a cornerstone of the Bank's Africa Region strategic plan against HIV/AIDS (*Intensifying Action against HIV/AIDS in Africa,* 1999) and will be pivotal both to Africa's human development goals and its overall development prospects. The Bank has placed HIV/AIDS at the center of its development agenda in Africa and has mainstreamed it in all aspects of its work in the Region. The Region's AIDS strategy offers a comprehensive framework for a wide range of possibilities to consolidate and expand successful HIV/AIDS interventions.

65. Expanding its HIV/AIDS response is also an institutional and partnership commitment by the Bank. As a founding member of the IPAA, the Bank has joined a coalition with the other UNAIDS cosponsors, governments, multilateral organizations, bilateral agencies, and private corporations and committed to invest greater resources in response to the growing dimensions of the epidemic in Africa. The overarching goal of the IPAA is to curtail the spread of HIV and to reduce its impact on human suffering and development. In both international and regional settings, IPAA has brought to the fore the need for an expanded response and for more resources to HIV/AIDS programs in Africa. The support the MAP will provide to national and sub-regional HIV/AIDS programs will be an important component of the Bank's contribution to the IPAA.

66. The increased focus on HIV/AIDS is also part of the Bank's emerging approach to combating communicable diseases. The Bank is playing a rapidly growing role in bringing into country policies the importance of HIV/AIDS in addressing opportunistic diseases such as STIs and TB. The Bank has also pioneered financing of communicable disease prevention in many African countries and has developed valuable global experience in supporting emergency projects involving coordinated responses and partnerships with governments, donors, NGOs, and communities.

1. Program alternatives considered and reasons for rejection:

67. Sector investment operations for individual countries and a "vertical" APL for Africa, in combination with the "horizontal" APL proposed, were two alternatives considered and rejected.

68. While SILs have been effective instruments generally, in this specific case, processing a series of country SILs over several years would not take advantage of economies of scale within the Bank that could be realized through the development of templates for components and common processing procedures. Moreover, the emphasis in the MAP on expanding existing programs and building additional implementation capacity once a government has an overall HIV/AIDS strategy in place is more appropriate for programmatic rather than investment lending, in view of the emergency nature of the situation.

69. "Vertical" APLs were also considered. However, adding a vertical dimension to a horizontal APL would make it difficult to implement and monitor. Success against HIV/AIDS requires speed, simplicity and diversity. The complex, long-term, institution-building approach and detailed design of sequenced phases and triggers associated with a "vertical" APL would not facilitate intensifying existing HIV/AIDS programs rapidly, and the use of emergency Bank procedures where possible. Rapid processing requires flexibility in design and streamlining in preparation within the bounds allowed by BP10.00 drawing, where appropriate, from the procedural provisions of BP8.50 on emergency lending.

2. Lessons learned and reflected in the program design:

70. Lessons drawn from two decades of global experience with the epidemic, including prior IDA-supported HIV/AIDS projects, have shown that the behavior change needed to prevent HIV transmission and deal with the consequences of the epidemic cannot be achieved without involving local communities in a deeply participatory diagnosis of the risks they face, including the root causes of vulnerability such as gender discrimination and poverty. Moreover, behavior change and reduction in denial and stigma cannot be achieved through prevention activities alone, but also require support and care for those infected with HIV/AIDS, their families, and the surviving families and orphans. Significant social and economic policy adjustments, including the strengthening of social safety nets for the most vulnerable, must complement these efforts.

71. A highly decentralized, participatory, and community-based approach to implementation of the multi-sectoral program is therefore needed. At subnational levels, local government, communities, NGOs, and the private sector all need to be involved. Expanded responses in the education, military, health, agriculture, and communication sectors must facilitate, support, and complement these local responses.

72. Prior experience indicates that best practice in political and social action—in a multi-dimensional approach—hinges on both government commitment and community responsiveness. Experience in countries such as Uganda, Senegal, and Thailand clearly shows that the rate of new infections can be reduced when governments adopt appropriate policies, commit their political prestige and financial resources, involve civil society fully, and place emphasis on activities in a range of sectors.

73. The program is also consistent with experience gained under Bank operations in natural disaster management and emergency recovery in post-conflict situations. These have demonstrated that in order to succeed, implementation processes and arrangements must be simple and flexible to permit the rapid execution at the required scale. These types of programs should not be burdened with conditions and should rely extensively on implementing agents for execution. Operations must also allow for change and

adaptation as activities are implemented and yield more information. Key lessons also indicate the need for early involvement, by the Bank and concerned parties, in assessing priorities and defining effective response strategies. Specific implications of these lessons, all of which have been incorporated in the MAP, are as follows:

- The operating procedures and incentive systems must be designed to link the activities of the individual actors to the national objectives and desired results and outcomes;
- The tools to be used to achieve the desired outcomes must include facilitation and training for the various actors, clear operating manuals under which they will operate, incentives and penalties (especially performance-based renewal and increases of contracts and financial allocations), effective fiduciary controls, and careful monitoring and evaluation of the program, its components, and the results;
- The large number of local (or sectoral/institutional) HIV/AIDS committees must be able to access training on HIV/AIDS, in best practices of prevention, care, and orphan support, how to rapidly diagnose their local/sectoral conditions, and how to design simple programs that reflect their special conditions and support national program goals. They should then be given the resources to implement their first programs in a learning-by-doing mode.
- The committees and other actors must also be informed of the criteria that will be used to review their proposals and evaluate their performance, and that will guide performance-based allocation of resources to them;
- The large-scale training program will require mobilization of HIV/AIDS specialists from public and private sector entities as well as NGOs and PLWHA;

3. Indications of borrower commitment and ownership:

74. African countries have urged IDA in various fora to support their immediate needs for stepping up the response to HIV/AIDS. African governments have recently increased their commitment to rapid implementation of prevention, care, and treatment and marked significant progress in establishing national multisectoral HIV/AIDS programs and adopting comprehensive nationwide strategic plans. Following a commitment by IDA to create the MAP, several governments have indicated their strong interest in participating in the program. The very rapid preparation of projects in Ethiopia and Kenya was possible because of the strong policy framework and strategic plans already developed through a broad participatory process. Both governments also committed to allocate half or more of the respective credits as direct grants to communities, which is one of the most important factors in ownership of HIV/AIDS programs. Borrower commitment will continue to be assessed case-by-case as part of the eligibility criteria to access the MAP, but at a regional level both commitment and ownership are manifest and provide a reasonable basis to proceed.

4. Value added of IDA support in this program:

75. No single government or agency can overcome HIV/AIDS alone. A vast, concerted effort is required both at national and international levels. That is the insight that guided the creation of UNAIDS, the establishment of the IPAA, and the move toward a pluralistic, multisectoral approach. Although agencies such as UNICEF and WHO will continue to set the overall technical parameters for HIV/AIDS, IDA has a number of comparative advantages that are critical to the success of these partnerships. First, no other external actor has the global knowledge and policy influence of IDA on the overall development agenda. This influence has proven central in helping to elevate HIV/AIDS beyond the health sector to a fundamental development issue, and to ensure the necessary visibility in discussion of national planning, poverty- reduction strategies, and debt-reduction programs. Second, IDA has experience in virtually all

sectors and can therefore work effectively in supporting a multisectoral response. Assisting sectors to plan for the impact of AIDS will be one of the most important tasks of the next few years. Third, IDA's long experience with implementation will be instrumental in helping to balance speed with accountability. Fourth, IDA involvement is essential to bridging the resource gap. Current annual investment on HIV/AIDS in Africa is only a fraction of the estimated US$3 billion needed to fund comprehensive programs. Both through its own resources and its convening and leveraging power, IDA can make a significant contribution to filling this gap, primarily on a country-by-country basis.

E. Summary Program Analysis

1. Economic (see Annex 5):

76. For illustrative purposes, it was assumed that some eight representative African countries (including Ethiopia and Kenya) would have access to the financing provided by the MAP. These countries include some 280 million people, just under half of Sub-Saharan Africa's population. The cost of implementing comprehensive, national HIV/AIDS programs in full in these countries was estimated at US$575 million per year.

77. If such nationwide scale could be achieved quickly, the MAP would help reduce the HIV prevalence rate in these countries from 7.9 percent in 1999 to 5.6 percent over ten years and below 4 percent over 15 years. The driving force would be the reduction by half in the number of new HIV infections among 15-24 year-olds over the next decade. This is an ambitious but achievable goal that has been met in some parts of Uganda and Zambia in the 1990s. For the rest of the adult population, new HIV infections would decrease in a similar fashion, but because of the stock of existing HIV infections, the adult HIV prevalence rate would fall by only 25 percent over ten years period. (Taking the counterfactual case in which effective national programs are *not* mounted, the HIV epidemic would continue to spread. As a conservative assumption, the HIV prevalence rate was projected to increase from 7.9 percent in 1999 to 10 percent by 2003 and remain at that level indefinitely thereafter.)

78. The economic benefits would be manifold. The fall in new HIV infections would reduce the number of new AIDS cases. Over the next 20 years, some 6.7 million adult deaths would be averted. In economic terms, this would result in lower costs of treatment and care of HIV/AIDS patients, which would offset part of the MAP costs. The macroeconomic benefits, while intuitively compelling, are difficult to quantify. Data constraints and the wide variety of ways through which the epidemic affects development limit the types of analysis that can be done. Cross-country analysis has produced estimates broadly consistent with those of other methods, but the limitations of this approach should be borne in mind. That said, on the basis of existing evidence as discussed in Annex 5, the fall in the HIV prevalence rate would likely increase the growth rate of GDP per capita. In addition, the reduction in AIDS-related deaths would increase labor force growth, further raising GDP growth. In total, the rate of growth of GDP would increase gradually by about 0.2 percentage points per year in 2007-2015 and 0.5 percentage points afterwards. Calculating the net economic benefits that would result from the combination of output increase and the different assumptions concerning costs is necessarily speculative. The estimated internal rate of return is, however, quite similar under the two cost assumptions, at around 30 percent.

2. Financial:

NPV=US$ million; FRR = %
Not applicable

Fiscal Impact

79. For each of the physical works components, the operation and maintenance costs will be calculated and a commitment required from government to finance and carry out effective O&M on an annual basis. An annual review of O&M for physical works will be carried out three months prior to the beginning of each fiscal year.

3. Technical:

80. The MAP follows internationally accepted best practice for HIV/AIDS responses, as validated by UNAIDS. Each country program will tailor the general principles to the country context and will follow current accepted best practices in technical standards for health infrastructure, especially the handling of medical equipment and supplies and the disposal of medical waste in order to minimize environmental impact. Line ministries will be involved in the preparation of components to ensure their consistency with national technical standards. Training will be provided as required to address the handling and disposal of medical equipment, supplies, and waste technology.

4. Institutional:

81. ***Implementing agencies***: Because individual country projects are multisectoral, each sector ministry and other implementing agency will be in charge of implementing its own components of the projects in consultation with the national HIV/AIDS programs. Technical ministries, NGOs, and other private sector organizations have been actively involved in the preparation of projects, ensuring their consistency with the national HIV/AIDS strategic plans. Technical assistance will be provided to line ministries and other participating organizations on an as-needed basis (mainly for strategic planning, financial management, procurement, and the recruitment of consultants in specialized areas). Because the capacity of some of the implementing agencies must be strengthened, projects will require government commitment of resources and staff for some of the implementing entities, while the IDA credit will finance some equipment and technical assistance.

82. ***Project Management***: Project coordination and management will be set up in the secretariat of the national HIV/AIDS program or at any other higher-level entity mandated by government to coordinate and monitor the national HIV/AIDS strategy. Sub-project coordinators will be assigned by each participating ministry or private sector organization to coordinate and monitor implementation progress according to agreed-upon performance indicators and to report to the national council secretariat. Where necessary, the project will finance the contracting of a financial management firm for the duration of the project for administration and management of the funds. In each country, sub-project review committees will be set up to recommend the selection of proposed community-, district-, provincial-, or national-level initiatives for financing under the IDA Credit. The committees will consist of representatives of relevant ministries involved in the project as well as representatives from the private sector and civil society including representatives of PLWHA and specific target groups such as youth and women.

5. Social:

83. The MAP is expected to have a very positive social impact by assisting and empowering people and institutions to deal more effectively with the HIV/AIDS epidemic. MAP activities will deal with a broad and sensitive range of social issues concerning HIV/AIDS. Opposition may arise to providing assistance and empowerment to vulnerable groups such as youth and women, and especially socially marginalized groups such as intravenous drug users, men having sex with men, and inmates of

correctional institutions. Moreover, PLWHA and their families face continued violations of their economic and human rights. Individual country projects will therefore put in place a process of permanent social impact monitoring to take account of and correct for social issues that may arise during implementation.

6. Environmental:

84. **Environmental Category: C (Not Required).** It is expected that the program activities would not generate any adverse environmental effects. For each participating country, guidelines will be prepared as part of the procedural manual to ensure that environmental considerations are taken into account in the selection and design of project activities. The key environmental risk relates to inappropriate handling, poor disposal methods and inadequate management of the disposal sites for medical waste in urban and peri-urban areas where domestic and medical waste are mixed, and where scavenging is a livelihood. Capacity to deal with this risk needs to be built at the central, district and municipal council level, and NGOs, CBOs and neighborhood groups have to be provided with training through the HIV/AIDS programs. The operating manuals of the country projects under the MAP will include guidelines for a corresponding training program and mitigation measures. In addition, the Africa Safeguard Policies Enhancement Team will ensure that environmental assessment of urban environment and infrastructure projects routinely cover this aspect so that coverage is broader than what is provided in the projects supported under the MAP.

7. Participatory approach:

85. The MAP approach was developed following a long process of consultation with key community, national, and international stakeholders led by UNAIDS and its cosponsors. Those consultations resulted in a consensus that the existing HIV/AIDS programs in Sub-Saharan Africa were having insufficient impact overall and needed to be scaled up and intensified through multisectoral approaches using a variety of implementation channels and the full spectrum of stakeholders. The proposed country projects have been established with different degrees of participation among national, regional, and local stakeholders, but one of the key goals under the MAP will be to mainstream participation and provide substantial resources to community-based organizations founded on participatory principles (ownership, transparency, accountability).

F. Sustainability and Risks

1. Sustainability:

86. The sustainability of the program would largely depend on the degree of ownership of this initiative by the various concerned entities at national, regional, and local levels, their implementation capacity, their ability to organize for specific sub-project activities, and the reliability of their access to funds. The process at the community level would be demand-driven; sustainability at that level will be promoted by targeting priorities identified by the beneficiary population group. In addition, the focus of some of the project activities on training and capacity building will further enhance the sustainability of local sub-projects.

2. Critical Risks (reflecting assumptions in the fourth column of Annex 1A):

On the country side

87. The MAP is a high-risk undertaking. For 20 years, AIDS has thrived on denial, stigma, insufficient capacity, and ineffective implementation. Although some progress is being made in these areas, these conditions still prevail to various degrees in the majority of African countries and could easily impede execution of the program. The most serious risks are that implementation will be slow and coverage inadequate. There is also considerable fiduciary risk arising from the use of new financial mechanisms and myriad implementing agencies. Because the pace of the epidemic does not allow the luxury of overcoming these problems before taking action, they will need to be addressed in most cases as part of implementation.

88. To bring the risks within tolerable limits, the MAP has built in multiple, redundant safeguards at each stage. It must be recognized that overcorrecting for either implementation or fiduciary risk could jeopardize program effectiveness. On the one hand, moving too quickly could create unmanageable fiduciary and implementation problems. On the other hand, insisting on airtight fiduciary procedures would hamper implementation to a disabling degree. Consequently, the MAP has struck a balance between flexibility and accountability. The program has explicitly traded off time-consuming *ex ante* programming and centralized controls for empowerment of local agents, end-user accountability, and flexibility. While specific safeguards will be adapted to each country circumstance as appropriate, they will all follow these general lines:

89. ***Design.*** MAP programs will be designed with broad participation, especially of PLWHA, to help overcome denial and social exclusion and to bring replicable local successes to light. Both in process and substance, program design will be informed by best practice and by lessons from other MAP-supported countries, and will be supported by UNAIDS strategic planning specialists. Designs will pay exhaustive attention to implementation and fiduciary issues—particularly to ensuring accountability in the flow of funds—and will typically include a detailed first-year action plan to ensure a fast, strong start. Designs will also be flexible and allow for frequent corrections as experience warrants.

90. ***Implementation.*** To manage risk, MAP implementation will be structured around subsidiarity, end-user accountability, subcontracting, flexibility, and transparency. The MAP will empower and directly fund a wide range of actors, who will be accountable to stakeholders at the relevant level(s) for implementation of agreed plans. Direct support to communities will increase coverage immediately and help ensure culturally appropriate ways of overcoming social barriers. Allocations to local implementers will be made commensurate with absorptive capacity. In most countries, financial flows to communities will be briefly tested in a smaller number of districts and then expanded as soon as any blockages in disbursements have been removed. Procedures will be simplified and streamlined both by countries and on the part of IDA. Each program will include a significant capacity-building component to strengthen implementing agencies (whether public or private) wherever necessary. Key responsibilities such as accounting, disbursement, auditing, procurement, and training will be outsourced as necessary. Accountability of all actors will be enforced through performance-based replenishments.

91. ***Supervision.*** In its design, ambition, and scope, the MAP is virtually without precedent. Country programs will build quickly toward nationwide coverage and involve actors at all levels from individual villages to central ministries. Because of the elevated risk and the capacious span of these programs, IDA supervision will need to be more intensive than for regular projects. Supervision budgets will be considerably larger than the norm. Country office staff will be involved in every MAP operation and provide continual support at the country level. Supervision will be conducted jointly with other

supporting partners. Each program will include frequent workshops and stocktaking exercises and, as the number of countries under the MAP grows, cross-country sessions to exchange experiences. All large-scale executing agencies will be audited regularly. Local agencies will be audited on a random basis both for technical and financial performance, and the results published.

92. ***Monitoring and Evaluation.*** The MAP will devote special attention to strengthening M&E systems and to generating early and regular information on program outputs, impact, and the progress of the epidemic. Monitoring will follow the principles of "second generation" HIV surveillance recently developed by WHO and UNAIDS. This approach tailors the use of data to the specifics of each country. It combines biomedical and behavioral surveillance and draws on data from a wide variety of local sources. It closely tracks risk behavior, STI rates among youth, and at-risk sub-populations, which are all important leading indicators that can provide early warnings and improve program effectiveness. The MAP will dedicate an uncommonly large share of resources to M&E—on the order of five to ten percent of total program costs in each country. The joint midterm review will also provide an independent assessment of the effects of the MAP and an opportunity to make indicated corrections.

93. The MAP is designed to foster learning by doing. It must be expected that mistakes will be made. The cost of such mistakes will be contained, tightly scrutinized, and progressively reduced as lessons from experience guide midcourse corrections. But even with rigorous eligibility criteria and the above provisions in place, a significant degree of residual risk will remain.

94. The risk in being less ambitious or moving more cautiously, however, would be even greater. Anything short of the innovative, comprehensive, and pluralistic approach in the MAP would be powerless to overcome the deficiencies of scale and speed that have rendered Africa's efforts to date catastrophically ineffective. The result would be a deeper entrenchment of HIV/AIDS where it has struck hardest and a potential explosion in those countries that have so far escaped the worst. The MAP may pose high risks, but compared to the alternatives it is the safest course of action available.

Risk	Risk Rating	Risk Minimization Measure
From Outputs to Objective		
Central and Regional Government, sector ministries and community leaders may not honor their commitment to participatory development and to the creation of an enabling environment for local responses to HIV/AIDS.	S	ACT Africa, in partnership with UNAIDS and country teams will continue to create demand and commitment at all levels, including the participatory development of comprehensive national HIV/AIDS strategies and action plans. The country eligibility criteria will eliminate countries with inadequate commitment. The decentralized and participatory implementation will help sustain the political commitment.
The denial due to cultural, religious and other reasons may prohibit countries from intensifying actions	M	This will be addressed by developing and implementing programs sub-programs and sub-projects in a fully transparent and participatory manner. All these processes will include civil society and in particular people living with HIV/AIDS.
From Components to Outputs		
Some countries, regions and districts may lack the capacity and resources needed to design, coordinate, and evaluate their respective components of the comprehensive programs.	H	The processes and documentation required for sub-programs and subprojects will be simplified, and standardized. Program design will emphasizes capacity building through massive training of executing entities and technical support at all levels.
Decentralized implementation entities and communities may lack the capacity to propose and mange their sub-programs and sub-projects	S	Rapid allocation of small resource envelopes will permit generalized learning by doing Performance based replenishment weeds out implementing entities whose capacities are not improving Use of simple procurement and disbursement procedures for community-based investments will be used for a large part of the program.
Slow disbursement of country operations: • due to limited financial management capacity • due to inadequate procurement procedures and capacities • due to delays in appraisal and approval of sub-programs and sub-projects	H	Where necessary, outsourcing of fund management and financial reporting procedures and control will be agreed upon during project preparation. And the necessary contracts initiated prior to IDA credit effectiveness. A large part of the national programs will be implemented using the simple the simplified procedures for procurement and disbursement for community-based investments Standard small equipment and supplies needed in multiple locations will be procured via a central unit using a structured contract whereby the deliveries to the end user will be based on actual demand. Appraisal and approval of intermediate and small sub-programs and sub-projects will be decentralized to regional and local coordinating committees, using the subsidiarity principle These committees will be provided with training and opportunities for learning by doing.
Poor intersectoral collaboration at national , regional and local levels	H	Establishment of HIV/AIDS coordinating bodies and committees at national, regional and local levels will allow for coordination to take place at the lowest possible level. Sectoral components will be managed by sectoral HIV/AIDS committees
The highly decentralized implementation mechanisms will result in unmanageable fiduciary problems, including misuse of funds	H	Five sets of provisions have been built into the program design: (a) Accountability to end users via participation in program and project design and implementation, and via transparency rules and use of local languages (b) Contracting out of financial management, where necessary (c) A random financial technical and process audit of all small executing entities, and mandatory publication of all audit results, complemented by audits triggered by beneficiary complaints. (d) Financial audits of all large scale executing entities (e) Integrated reports from executing entities which link performance to financial report
Overall Risk Rating	H	

Risk Rating - H (High Risk), S (Substantial Risk), M (Modest Risk), N(Negligible or Low Risk)

On IDA's side

95. Given the multisectoral nature of the country project design, the limited capacity of the often newly created national HIV/AIDS councils, the number of concerned public and private parties involved in project implementation, and the use of funding mechanisms through new structures that have not been tried and tested, IDA preparation, supervision and monitoring of program implementation will require a larger-than-standard effort. IDA will have to ensure: (i) strong preparation teams, including specialists in key fiduciary areas such as financial management and procurement; (ii) funding substantially above current supervision coefficients is provided; (iii) supervision task teams are composed of IDA staff from a number of sectors and from both headquarters and country offices; (iv) specialists in key fiduciary areas are part of supervision teams; (v) HIV/AIDS projects receive regular attention from country and sector management, especially during the first year of implementation; and (vi) ACT*africa*, UNAIDS, and major stakeholders outside IDA remain involved in assessing implementation and identifying requirements of Sub-Saharan Africa during and beyond the MAP period. In addition, the existing partnership between IDA country teams and ACT*africa* should be continued to help other Sub-Saharan Africa countries to access resources under the MAP. The magnitude of the epidemic and the emergency nature of its spread requires a different way of doing business. Countries needing assistance to meet the criteria for eligibility should have access to the Project Preparation Facility. Country teams will have access to additional preparation and supervision resources.

3. Possible controversial aspects:

96. No aspects of the MAP are likely to spark external controversy. If anything, the criticisms of the international community are likely to be that the program is not ambitious enough; the US$500 million proposed will cover only about 10 percent of the lower estimate of Africa's annual needs. In this vein it will be important to emphasize that this is merely the first phase of a long-term commitment, and that the MAP could be replenished. Such a replenishment could take the form of repeater operations, for each of which Board approval would be sought.

97. At the country level, two aspects may provoke controversy:

98. ***Governance.*** Outsourcing key functions such as financial management and auditing either in-country or externally may be politically controversial. Mindful of the disappointing record of long-term technical assistance, Governments may see such outsourcing as coming at the expense of capacity building for their own systems. Outsourcing will not be required on principle in every country, but will be approached case-by-case from a practical standpoint. If it is the only way of ensuring adequate speed and accountability, it will be required. Where viable alternatives exist, they will be used.

99. ***Social.*** Governments may be uncomfortable working with socially excluded groups such as commercial sex workers, intravenous drug users, prisoners, or men who have sex with men. Issues such as distributing condoms to youth may raise cultural and religious sensitivities. The involvement of stakeholders experienced in dealing with such issues—especially NGOs and PLWHA—will help overcome such cultural barriers in locally appropriate ways and ensure that no groups are excluded in program implementation.

G. Main Credit Conditions

Effectiveness Conditions for Ethiopia:

- The borrower has adopted the Project Implementation Plan
- The borrower has appointed a financial manager and financial controller both acceptable to the Association
- The borrower has established an accounting and financial management system satisfactory to the Association
- The borrower has appointed a project coordinator, an assistant project coordinator, and a senior procurement specialist

Main Effectiveness Conditions for Kenya:

- A subsidiary financing agreement has been executed on behalf of the borrower
- Government has furnished the Project Implementation Plan, including a first year procurement plan, in form and substance satisfactory to IDA
- NACC has appointed specified key staff with qualifications and under terms and conditions acceptable to IDA

H. Compliance with Bank Policies

100. This program complies with all applicable Bank policies.

Anwar Bach-Baouab	Debrework Zewdie
Team Leader	**Manager**

Annex 1: Logframe Template for HIV/AIDS Program

Hierarchy of Objectives	Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
Sector-related CAS Goal: To promote long-term poverty reduction and strengthen the capacity and effectiveness of poverty-focused interventions, with a view to promote human development.	**Sector Indicators:**	**Sector/Country Reports:**	**From Goal to Bank Mission:** The supported programs will enable the mobilization of sufficient financial and human resources to develop multi-sectoral and sustainable national and/or sub-regional responses to the HIV/AIDS epidemic. Commitment to address existing barriers to the development of comprehensive national and sub-regional programs will be present among key actors in both the public and private sectors.

Hierarchy of Objectives	Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
Long-Term Program Objectives:	**Long-Term Program Indicators:**	**Program Reports:**	**From Purpose to Goal:**
To curtail the spread of HIV infection and to reduce sharply the impact of AIDS on the development of human, social, and economic capital in Africa	Reduced overall HIV incidence and prevalence rate Baseline: _____ Target: _____	**HIV/AIDS surveillance reports**	sustained Government commitment to enable a multi-sectoral response to the HIV/AIDS epidemic.
	Reduced infant mortality rate Baseline: _____ Target: _____	**DHS**	
	Reduced child mortality rate Baseline: _____ Target: _____	**DHS**	
	Reduced adult mortality rate Baseline: _____ Target: _____	**DHS**	

Hierarchy of Objectives	Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
Project Development Objective: To dramatically increase access to HIV/AIDS prevention, care, and treatment programs, and impact mitigation programs, with particular emphasis on vulnerable populations (e.g., youth, women of childbearing age, and other groups at increased risk of infection)	**Outcome/Impact Indicators:** **By 2005, at least 90 percent of 15-24 year olds have access to information, education, and services** **By 2005, HIV/AIDS prevalence reduced by 25 percent in 15-24 year olds** **By 2005, parent-to-child transmission of HIV reduced by ___ percent**	**Project Reports:** **HIV/AIDS surveillance reports** **HIV/AIDS surveillance reports** **HIV/AIDS surveillance reports**	**From Objective to Goal:** Availability of local NGOs with capacity to implement the community-level initiatives Interest and commitment from beneficiaries and local governments Motivated non-health sectors and private sector implementing HIV/AIDS activities Decreased resistance to behavior change because of strong cultural beliefs

Output from Each Component:	**Output Indicators:**	**Project Reports:**	**From Outputs to Objective:**
1) Expansion of HIV/AIDS prevention programs	Increase in condom availability nationwide Increased percentage of retail outlets and service delivery points with condoms in stock Increased percentage of condoms in central stock and retail outlets that meet WHO quality control measures Increase in percentage of population with correct knowledge of HIV/AIDS transmission and prevention methods Increase in percentage of women testing positive at selected antenatal clinics who are provided with a complete course of ARV therapy to prevent PTCT in accordance with national/international guidelines Increase in the number of communities with improved prevention services Reduction in number in target group's reported non-regular sexual partners	Project data Survey data	Effective monitoring of targeted coverage Sustained intersectoral collaboration at national and local levels Improved implementation capacity of local government, communities, and NGOs Improved Ministry of Health implementation capacity Improved effectiveness of IEC programs

	Percent increase in reported barrier method use during last sexual contact with regular partners Increased percentage of commercial sex workers who report using a condom with their most recent client Increased percentage in male/females who have discussed HIV/AIDS or STIs with their regular partners Increase in median age at first sex among young men and women Reduction in percentage of young single people who have had premarital sex in the past year Increase in percentage of adults with access to quality STI case management Increase percent of blood units transfused that have been screened for HIV according to national/WHO standards Increase in percent of districts in which the largest hospital has a functioning blood bank and does not pay blood donors Increase in percent of health care facilities having guidelines to prevent nosocomial transmission of HIV, having adequate sterilization procedures, and having surgical gloves in stock		

2) Improved care and support services for those both infected and affected by HIV/AIDS	Percent of graduates of medical and nursing school in the past year trained in natural history of HIV and in diagnosis and care of common opportunistic infections	Project data	
	Percentage of health facilities that are currently stocked with drugs for common opportunistic infections and to provide palliative care, and report no stock-outs in the past year	Survey data	
	Percent of districts with at least one center staffed by trained counselors providing HIV testing and counseling at either free or affordable rates	Service delivery data	
	Increase in the percentage of clients served by VCT services that meet minimum requirements for provision of quality counseling and testing services		
	Percent increase in number of communities with improved prevention services, care, and support		
	Increase in percent of orphaned children under 15 who are currently attending school		
	Increase in percent of population receiving quality HIV/AIDS/STI/TB case management		

	Increase in percent of households with a chronically ill adult (15-49 years) who have received external help in caring for a patient or replacing lost income in the past year Increase in percentage of households caring for an orphan that has received assistance from outside the family Increase in percent of adults with access to quality STI/TB/OI case management Percent decrease in reported STI/TB/OI prevalence Percentage of people expressing nondiscriminatory attitudes towards people with HIV/AIDS		
3) Strengthened capacity of institutions and communities to respond to the epidemic in a multisectoral and sustained manner	Increase in the number of institutions providing effective coordination at nat'l, provincial, and district levels for the planning and implementation of HIV/AIDS interventions Proper mechanisms in place to transfer funds for prevention, care, and support at district and community levels Percent increase in number of organizations capable of designing, implementing, and evaluating HIV/AIDS/STI activities	Project data Survey data Survey data	

	Percent increase in number of facilities implementing and evaluating STI/TB diagnosis and treatment activities		
4) Partnerships established with key implementers in all sectors and at all levels and increased financial and human resources available to support HIV/AIDS activities	Increase in number of public sector institutions implementing a strategy to address the impact of HIV/AIDS on their sector Number of private firms implementing a strategy to cope with the HIV/AIDS impact on their firm Number of public and private sector organizations that implement HIV/AIDS strategies in the public interest (i.e., beyond the scope of their immediate institutional and corporate interests) Number of community-based organizations implementing programs for orphans and vulnerable children Increased activity of the UN Theme Groups on HIV/AIDS Percent increase in total expenditures per individual infected with HIV/AIDS	Survey data	

Hierarchy of Objectives	Key Performance Indicators	Monitoring and Evaluation	Critical Assumptions
Project Components:	**Inputs (budget for each component):**	**Project Reports:**	**From Components to Outputs:**
1) Prevention	US $...TBD	National and/or sub-regional HIV/AIDS progress reports	
2) Care and support	US $...TBD	Financial data from MOF and line ministries	
3) Capacity building	US $...TBD	Project financial data	
4) Partnerships	US $...TBD	Survey data	

Annex 2: Eligibility Criteria

Eligibility for Country Participation	In-Country Activities
• Satisfactory evidence of a strategic approach to HIV/AIDS. This would typically be demonstrated by a coherent national, multisectoral strategy and action plan for HIV/AIDS prevention, care and treatment which has been developed through a participatory approach using social assessment techniques. It could also be demonstrated by having a participatory strategic planning process underway with a road map and timetable. • A high level coordinating body such as a national HIV/AIDS council or equivalent has been established to oversee the implementation of the strategy and action plan. This body should encompass broad representation of key stakeholders, including persons living with HIV/AIDS. • Government has agreed to use appropriate implementation arrangements to accelerate project implementation, such as channeling grant funds for HIV/AIDS activities directly to communities, and outsourcing financial management and procurement where necessary. • Government has agreed to use and fund multiple implementation agencies, especially community-based and non-governmental organizations.	The in-country technical criteria will encompass all activities aiming to prevent and mitigate HIV/AIDS, and improve care and treatment; ▪ Expand HIV/AIDS prevention program; ▪ Improve care and support services for those both infected and affected by HIV/AIDS; ▪ Strengthen the capacity of concerned institutions and communities to respond to the epidemic in a multisectoral manner; ▪ Establish partnership with key implementers in all sectors and at all levels and increase the financial and human resources available to support HIV/AIDS activities; ▪ The following categories of expenditure will be eligible from the proceeds of the program -- **goods** (e.g., condoms, biomedical equipment, office and transportation equipment, income-generating equipment, testing kits for STI/TB/HIV, drugs for related infections) -- **services including *training* and *technical assistance*** (e.g., training for institutions and communities, including overseeing training/ workshops/seminars, technical assistance from national and international partners such as consulting firms/NGOs/executing agencies, design/production/distribution of didactic and multimedia IEC materials) -- **grants for community interventions** -- **incremental operating costs**

Africa MAP: Candidate Countries

Attached is a typology of potential countries for the Africa MAP. Each country is assigned a score (0-4) indicating readiness to participate in the program. The columns correspond to the eligibility criteria detailed in Annex 2 of the Project Appraisal Document. Countries are listed according to their adult HIV prevalence rate (December 1999 estimate).

For reference:

 = Score of 4  = Operations in process

 = Score of 3

 = Score of 2

 = Score of 1

 = Score of 0

MAP Candidates

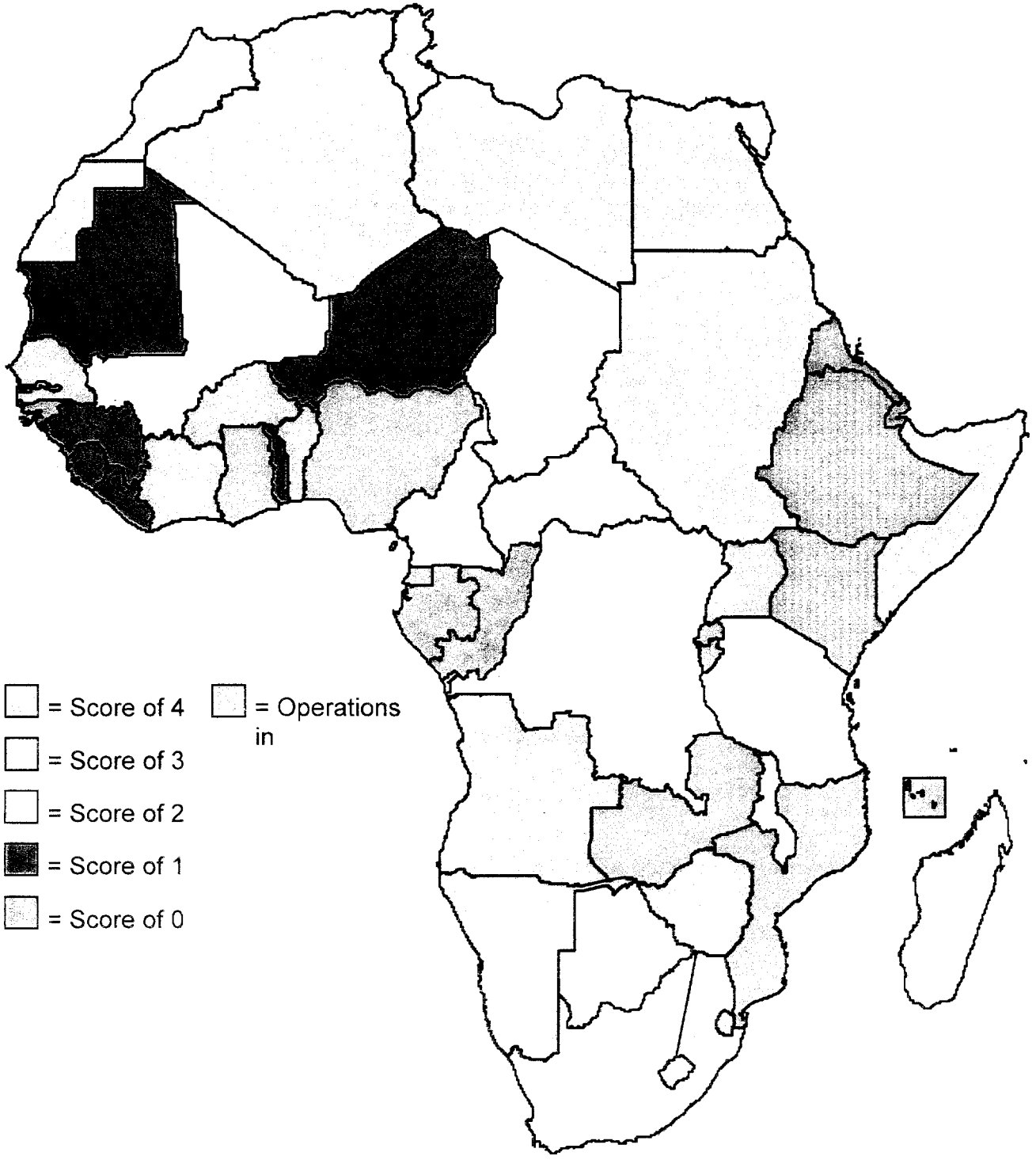
Countries ranked by adult HIV prevalence rates	Adult HIV Prevalence Rate* (end 1999)	Satisfactory Evidence of Strategic Approach to HIV/AIDS	National HIV/AIDS Coordinating Bodies in Place	Arrangements with Implementing Agencies (NGOs, private sector, etc.) in Place	Request and Readiness by Country Team for MAP Involvement	Score (0-4 checks)
1. Botswana*	35.80	√	√			2
2. Swaziland*	25.25	√	√	√		3
3. Zimbabwe	25.06	√	√	√		3
4. Lesotho	23.57	√	√			2
5. Zambia*	19.95	√	√	√	√	4
6. South Africa	19.94	√	√			2
7. Namibia	19.54	√	√	√		3
8. Malawi*	15.96	√	√			2
9. Kenya*	13.95	√	√	√	√	4
10. CAR	13.84		√		√	2
11. Mozambique*	13.22	√	√	√	√	4
12. Djibouti	11.75					0
13. Burundi	11.32	√	√	√	√	4
14. Rwanda	11.21	√	√	√	√	4
15. Cote d'Ivoire*	10.76	√	√	√		3
16. Ethiopia*	10.63	√	√	√	√	4
17. Uganda*	8.30	√	√	√		3
18. Tanzania*	8.09	√		√		2
19. Cameroon	7.73		√		√	2
20. Burkina F.*	6.44	√	√	√		3
21. Congo	6.43					0
22. Togo	5.98		√			1
23. DRC	5.07	√	√			2
24. Nigeria*	5.06	√	√	√	√	4
25. Gabon	4.16					0
26. Ghana*	3.60	√	√	√	√	4
27. Sierra Leone	2.99		√			1
28. Eritrea	2.87	√	√	√	√	4
29. Liberia	2.80				√	1
30. Angola	2.78	√	√	√		3

31. Chad	2.69	√	√			2
32. Guinea-Bis.	2.50					0
33. Benin	2.45	√	√		√	3
34. Mali	2.03	√	√			2
35. Gambia	1.95		√		√	2
36. Senegal	1.77	√	√	√		3
37. Guinea	1.54		√			
38. Niger	1.35		√			
39. Mauritania	0.52		√			
40. Eq. Guinea	0.51					0
41. Madagascar	0.15		√		√	2
42. Comoros	0.12					0
43. Mauritius	0.08		√		√	2
Cape Verde	N/a					
Sao Tome/Prin.	N/a					
Seychelles	N/a					
Somalia	N/a					
Sudan	N/a					

* IPAA Priority Country

Note: HIV prevalence rates were provided by UNAIDS (Report on the Global HIV/AIDS Epidemic, June 2000). In its June 2000 report, UNAIDS did not provide updated prevalence rates for Cape Verde, Sao Tome/Principe, Seychelles, Somalia, or Sudan.

Typology: Africa Multi-Country AIDS Project



Annex 3: Guidelines for Operationalizing an Intensified Response at the Country Level

INTRODUCTION

Every nation threatened by HIV/AIDS must lead its own response. There is no substitute for strong national commitment and ownership. Building an effective response requires an enabling environment and the necessary resources to bring proven interventions quickly up to nationwide scale. In many countries, it is government that creates such an environment so that all sectors of society can contribute. Many governments have initiated a limited response to HIV/AIDS. Few, however, have brought it to the nationwide scale necessary. Governments of all vulnerable countries (with their partners) need to expand and intensify their responses rapidly, and to address HIV/AIDS as a multisectoral development issue.

Developing country governments, however, cannot overcome the HIV/AIDS challenge alone. Given the scope of the epidemic, its costs, widespread denial and sensitivities, sustained effort from all development partners will be required. The primary goal is to replicate what has been proven to work—that is, *to help every country at risk to establish an appropriate multisectoral, national HIV/AIDS program comprising basic prevention, basic treatment, basic care, and mitigation tools.*

While there are many components that comprise an ideal HIV/AIDS program, the issues African governments will face will differ depending on the state of the epidemic in their countries. Countries with lower levels of HIV prevalence, for example, can intervene early to stop the rapid spread of HIV through active prevention efforts. Those with higher prevalence must confront the dual challenge of preventing HIV/AIDS while simultaneously coping with its impact on the health system and society.

This overview presents general guidelines for Task Team Leaders (TTLs) working in the Africa Region to operationalize an intensified HIV/AIDS response at the country level. For the purposes of these guidelines, a typology is suggested that classifies the current African epidemic into two states, based on HIV prevalence rates: lower/more stable, and higher/less stable epidemics. Although these categories are somewhat arbitrary and not necessarily adequate to reflect country-specific situations, they do provide a framework to enable TTLs to define priority HIV/AIDS interventions and action steps in the countries in which they work.

The two epidemic states and the main challenges task team leaders will face in working on HIV/AIDS issues in countries with these epidemics are described below.

Lower or more stable epidemic

Characteristics

- HIV infection may have existed for many years. While not highly established in the general population, HIV may have spread in defined sub-populations.
- HIV prevalence less than 5% in the general population, and
- Rates have been relatively stable for the past few years.

Main challenges

Countries will be called upon to minimize the impact of HIV/AIDS as early as possible. Given that the threat of the epidemic may not be that visible, TTLs working in these countries may face the challenge of sustaining, or increasing, a response in the face of limited resources and a possible atmosphere of complacency.

The focus of HIV/AIDS interventions therefore should be to:

- Create or strengthen an enabling environment by increasing government commitment, attention and funding.
- Scale up prevention activities.
- Monitor epidemic trends and ensure an adequate surveillance system.
- Initiate care and support.

Higher or less stable epidemic

Characteristics

- HIV is firmly established among sub-populations and groups whose behavior puts them at high risk, as well as in the general population because of sexual networking patterns;
- HIV prevalence is at least 5% in the general population, or;
- Rates have grown rapidly in the past few years.

Main challenges

Countries will be called upon to maintain and augment their prevention responses, while also strengthening care and support initiatives. TTLs working in these countries may face the challenge of limited resources in light of the growing cost of AIDS, maintaining the momentum of HIV/AIDS prevention initiatives, caring for those infected with AIDS, caring for AIDS orphans, and preparing for the impact HIV/AIDS will have on different sectors.

The focus of HIV/AIDS interventions therefore should be to:

- Create or strengthen an enabling environment by increasing government commitment, attention and funding.
- Request more assistance.
- Expand all prevention efforts.
- Scale-up care activities.
- Mitigate the impact HIV/AIDS will have on different sectors.
- Shore up health system in particular.

General guidelines for creating a Multi-Country HIV/AIDS Program

Seven actions are fundamental for governments to scale-up national responses to HIV/AIDS, to create an enabling environment , and to address HIV/AIDS as a multisectoral development issue. Table 1 provides a summary of program recommendations for each action for low and high-level HIV/AIDS epidemics in Africa.

1. Increase government commitment, attention, and funding

Strong government commitment has proved essential in every country that has made headway against the epidemic. This calls for bold political action and leadership, not merely tacit approval of public HIV/AIDS interventions. Leaders need to speak openly about HIV/AIDS, overcome taboos, and place the epidemic at the center of their development agendas.

2. Prevention activities of national coverage

Governments and their partners need to expand proven interventions to a scale large enough to reach all vulnerable individuals. Because of scarce resources, this calls for setting priorities and focusing on a core set of activities that have proven effective and feasible. To ensure effectiveness, governments need to work in partnership with persons living with HIV/AIDS, community groups, religious organizations, NGOs, health professionals, and the private sector.

3. Scale up care activities

Governments will need to develop strategies to care for and support the vast numbers of people who are infected and/or affected by HIV/AIDS. Given that the costs of life-prolonging triple-drug therapy remain out of reach for virtually all developing countries, governments will need to focus on effective treatment for the opportunistic infections that afflict persons living with AIDS and prevention of parent-to-child transmission. In addition, governments and their partners need to mount programs to care for the millions of orphans and other vulnerable children where extended families can no longer bear the full load.

4. Support community-level activities

In all countries, communities will need to play a decisive role in fighting against HIV/AIDS because of their capacity for social mobilization, their awareness of the local cultural and social context, and their daily influence on the lives of their members.

5. Link HIV/AIDS with poverty-reduction strategies

Poverty is an important contributor to the HIV/AIDS epidemic. It can drive people to leave their families to find work or into commercial sex for economic survival, placing them at high risk for HIV infection. It is therefore important to address the socioeconomic factors that make people vulnerable to HIV.

6. Support more research

Continued research is needed into the cost of HIV/AIDS treatment and care alternatives, the sectoral impact and costs of the epidemic, and monitoring and evaluating the effectiveness of existing interventions in different cultural and infrastructure settings. Leaders in each sector will continue to view HIV/AIDS as a health issue unless they see the potential impact on their sector and the relatively low cost of interventions.

7. Make policy and program changes to mitigate public and private impact

AIDS is shrinking capacity in the public sector and imposing new social welfare burdens as families collapse. Countries need to explore innovative ways of rebuilding capacity in government, as well as changes in labor and social legislation and new means of delivering social services to aid the growing number of households headed by orphans.

Table 1: Components of a Multi-Country HIV/AIDS Program for Low- and High-level Epidemics

	Low/stable prevalence	High prevalence/growing
Increase government commitment, attention, funding	√√√	√√√
Leadership/ Program Management Reorganize the National AIDS Committee (NAC) and National AIDS Control Program (NACP) to create a high-level, multi-sectoral HIV/AIDS task force. Ideally, the task force should function above the sectoral ministries, report to the highest level of government, and specify the human and financial resources needed for an intensified national response to HIV/AIDS. It should include sectoral ministries, religious and cultural leaders, civil society, people living with HIV/AIDS, women's groups, youth groups, NGOs, the private sector, and other key stakeholders. In specific, the role of the task force is to: identify and mobilize critical partners; appoint skilled and dedicated leaders to guide and manage the response; mobilize the needed resources from the government budget, donor agencies, and the private sector; and work with partnership with UNAIDS theme groups.	√√√	√√√
Advocacy Mobilize additional support by having the task force and UNAIDS Theme Groups address government, community, private sector, and religious leaders throughout the country and inviting them to join both the advocacy and response initiatives.	√√√	√√√
Policy Development Work with the task force and theme groups to review and revise existing policies and develop new policies where needed. Policies should include: protecting the blood supply; facilitating condom distribution by subsidizing costs; ensuring adequate supply and accessibility of drugs for Sexually Transmitted Infections (STIs) and opportunistic infections; requiring reproductive health education in schools; ensuring non-discrimination and human rights; and addressing the issue of care for orphans.	√√√	√√√

Sector Planning Help each sector assess the current and projected impact of the HIV/AIDS epidemic within the sector to determine how it can best: 1) respond to slow the epidemic among its workers; 2) avoid contributing to epidemic spread; and 3) plan for future resource shortages that will be created by the epidemic. Commission studies to examine how this epidemic will affect human resources, productivity, profits, and the manner of doing business. Use the data to plan for future needs as well as to mobilize leaders at all levels.	√√√	√√√
Donor Council Work with government and the UNAIDS Theme Group to establish a Donor Council to work closely with the reorganized NAC and NACP to ensure donor coordination and increase support.	√√√	√√√
Institutional Strengthening Help establish institutional strengthening programs that provide training and management systems and address the developing human resource needs for a multi-sectoral approach.	√√√	√√√
Surveillance of HIV/AIDS/STI Cases and Behaviors Ensure that the government strengthens its current HIV/AIDS/STI surveillance program and initiates programs to monitor behavior trends through behavioral surveillance.[2]	√√√	√√√
Scale up prevention activities	√√√	√√√
Blood safety Implement a comprehensive blood-safety program that increases the number of voluntary blood donors as opposed to paid donors, screens all blood for HIV and other infectious agents, and ensures an adequate blood supply by decreasing the number of unnecessary transfusions.	√√√	√√√
Behavior change communication (BCC) interventions Use multiple media channels and other means to reach those at highest risk of infection (CSWs, traders, migrant labor, military, truckers), women and youth, and the general public. Focus on changing behaviors, not just raising awareness and knowledge. Scale-up existing interventions to a national scale. Integrate BCC interventions into existing programs, such as training, schools, and the workplace.	√√√	√√√
Workplace interventions Integrate HIV/AIDS interventions into the workplace. Interventions include the behavior-change communication tools described above as well as condom distribution, treatment of STIs, and care for infected workers and their families. These interventions also benefit the surrounding communities.	√√√	√√√
Voluntary counseling and testing Strengthen counseling and testing centers, create demand for these services, and provide them on a sustainable basis, making them available to all who want them. Implement policies that protect the rights of people regarding privacy and test results.	√√√	√√√

[2] For specific recommendations for designing surveillance systems according to epidemic states, please review WHO/UNAIDS (2000). *Guidelines for Second Generation HIV Surveillance.* Geneva.

Management of STIs Implement a comprehensive STI management program that teaches people how to recognize STI symptoms, where to seek treatment, and how to reduce the risk of contracting HIV. The program provides timely and accurate diagnosis of STIs, appropriate treatment for the patient and his/her sexual contacts, and condoms. Develop and disseminate guidelines for syndromic management of STIs. Strengthen the essential drug program.	√√√	√√√
Condom supply and logistics Provide affordable and accessible male and female condoms. Distribute condoms at subsidized prices through social marketing, commercially through the private and public sectors.	√√√	√√√
Prevention of parent-to-child transmission (PTCT) of HIV Establish the infrastructure and plans for implementation of drug regimen that reduces parent-to-child transmission of HIV. Implement this program gradually, beginning with a pilot project in selected urban sites. Organize meetings to develop guidelines on other options for reducing PTCT, such as breast-feeding alternatives and vitamin A treatment.	√√	√√√
Scale up care activities	√	√√√
Drugs to control opportunistic infections Provide availability of low-cost drugs to control the common opportunistic infections associated with AIDS and to alleviate suffering. Ensure procurement of these drugs and integration of them into logistics systems to ensure availability to all who need them. Review the essential drug list to ensure that appropriate drugs are available, and logistics systems are strengthened to increase accessibility.	√	√√√
Treatment with anti-retroviral therapy Work with UNAIDS and other partners to evaluate treatment options and costs.	√	√√√
Home-based care Examine alternatives to traditional medical care. Provide families with the essential skills, tools, and financial resources to provide home-based care for sick family members.	√√	√√√
Hospice and hospital care Train health care workers in the treatment and care of AIDS patients and provide the needed supplies and drugs. Identify and strengthen other care alternatives.	√√	√√√
Care for orphans and vulnerable children Determine how to bear the burden of care for orphaned children. This goes beyond the basic needs of food and shelter to ensure orphans' basic education and health care.	√√	√√√
Psychosocial counseling Provide counseling for the infected individual, family and community. Provide training for counselors.	√√	√√√

Support community-level prevention, care, and support	√√	√√√
Financial support to NGOs and CBOs Help empower local governments, the private sector, communities and NGOs to participate actively in designing and implementing parts of the national AIDS program. Examples of instruments/actions include: Legal and policy changes that permit easy creation and operation of NGOs and community-based organizations (registration, licensing, tax status, etc.); training of local government and NGO staff; mapping and engagement of local groups; alliance-building, networks of NGOs and local governments; financing local groups via social fund mechanisms that encourage competitive, demand-driven design of local initiatives and cost-sharing; and working with local and international business associates.	√√	√√√
Link-HIV/AIDS with Poverty Reduction Strategies	√√	√√√
Mitigate the impact of HIV/AIDS upon households Provide policy options and community initiatives to strengthen the coping capacity of households to the impact of HIV/AIDS and which prevent people from adopting risky survival strategies.	√√	√√√
Support more research	√√√	√√√
Monitoring and evaluation Establish indicators to monitor and evaluate the national program. Make use of existing data, such as HIV/AIDS/STI sentinel surveillance and reporting data and Demographic and Health Surveys.	√√√	√√√
Cost studies Conduct research on the cost of HIV/AIDS prevention, treatment and care alternatives.	√	√√√
Make policy and program changes to mitigate public and private impact Support policies and programs that reduce the negative socioeconomic impact of HIV/AIDS on production systems, public services, and households.	√√	√√√

√ → √√√ = lower to higher priority interventionS

HIV/AIDS PREVALENCE RATES FOR SUB-SAHARAN AFRICA

(Among adults aged 15-49, as of end-1999)

Rank by Prev.	Country	Adult HIV/AIDS rate (percent)	Rank by Prev.	Country	Adult HIV/AIDS rate (percent)
1	Botswana	35.80	**23**	Dem. Rep. of Congo	5.07
2	Swaziland	25.25	**24**	Nigeria	5.06
3	Zimbabwe	25.06	**25**	Gabon	4.16
4	Lesotho	23.57	**26**	Ghana	3.60
5	Zambia	19.95	**27**	Sierra Leone	2.99
6	South Africa	19.94	**28**	Eritrea	2.87
7	Namibia	19.54	**29**	Liberia	2.80
8	Malawi	15.96	**30**	Angola	2.78
9	Kenya	13.95	**31**	Chad	2.69
10	Central African Rep.	13.84	**32**	Guinea-Bissau	2.50
11	Mozambique	13.22	**33**	Benin	2.45
12	Djibouti	11.75	**34**	Mali	2.03
13	Burundi	11.32	**35**	Gambia	1.95
14	Rwanda	11.21	**36**	Senegal	1.77
15	Cote d'Ivoire	10.76	**37**	Guinea	1.54
16	Ethiopia	10.63	**38**	Niger	1.35
17	Uganda	8.30	**39**	Mauritania	0.52
18	Tanzania	8.09	**40**	Equatorial Guinea	0.51
19	Cameroon	7.73	**41**	Madagascar	0.15
20	Burkina Faso	6.44	**42**	Comoros	0.12
21	Congo	6.43	**43**	Mauritius	0.08
22	Togo	5.98			

Source: UNAIDS, *Report on the Global HIV/AIDS Epidemic* (June 2000).

Note: UNAIDS did not list new HIV prevalence estimates for Cape Verde, Sao Tome and Principe, Seychelles, Somalia, or Sudan.

Annex 4: Program Monitoring and Evaluation

Responding effectively to HIV/AIDS requires sustained monitoring and evaluation of a broad range of measures. Each HIV epidemic behaves differently and often unpredictably, especially once it reaches the mature phase. A proper M&E system must therefore include much more than just general serosurveillance. It is especially important to identify and track the key leading behavioral and epidemiological indicators of where the epidemic is headed, such as sexual behavior and STI prevalence among persons aged 15-24 and among those whose behavior puts them at risk. A complete M&E program for HIV/AIDS should compile data of four types: (1) knowledge, attitudes and sexual behavior; (2) program context, inputs and outputs; (3) coverage and quality of key services; and (4) health status. Each country needs to choose its own particular measures according to the state of the epidemic and the main behavioral factors driving its spread. A country program should identify and measure at least one indicator within each of the following categories:

- Program coverage, including the share of communities covered
- Condom accessibility and quality
- Stigma and discrimination
- Knowledge of HIV transmission and prevention
- Rates of counseling, testing and referral
- Parent-to-child transmission (where such services are offered)
- Sexual behavior in the general population and among young people
- Blood safety
- STD care and treatment (e.g. appropriate diagnoses, STD drug supply)
- Care and support for those infected and affected by HIV/AIDS
- Health and social impact (including rates of STIs, especially among young people, and prevalence of orphans)

Given the importance of such information, each country program should invest substantially in establishing a robust M&E system for which coordination may be done by the secretariat of a country's national HIV/AIDS council. This need not be done from scratch. Most countries have some system in place, and some of the data needed are available from existing information systems. But most systems need strengthening, especially in the areas of systematic data synthesis and use. M&E units will be able to call on technical expertise from IPAA partners in reinforcing their systems. WHO and UNAIDS have just issued *Guidelines for Second Generation HIV Surveillance* (May 2000), which provides an excellent overview of how to tailor M&E for maximum benefit in individual country cases. UNAIDS can also provide substantial technical assistance to secretariats on demand in this area.

A country program will usually support the establishment of a Monitoring and Evaluation (M&E) unit in the HIV/AIDS council or secretariat. The unit will define the scope of work on program activities to be included in the M&E arrangements. As a principle, the M&E Unit will rely on formal links with external expertise for generation of information and analysis, including such bodies as the Central Statistical Authority, Regional Statistical Offices, universities and private institutions. It will be especially important to support the establishment of a network of local social scientists to undertake much of the M&E field work and analysis.

With respect to implementation, the M&E Unit will normally be in charge of developing and exploiting a data collection system appropriate to establish the performance indicators of each program component, clearly distinguishing among: (a) program outputs; (b) progress

towards outcomes; and (c) early indications of trends towards longer term impact. The unit will need to establish what monitoring and which kinds of evaluation will be done at various levels of activity. It will probably compile and consolidate, on a quarterly basis, monitoring information including data related to expenditures and disbursements. It will also prepare consolidated quarterly implementation reports for the overall program. Implementation progress reports will be submitted to the national HIV/AIDS council and to IDA every six months. It would also be useful to have an independent performance evaluation of the program conducted every two years to focus on: (i) the assessment of the short term impact of program activities on the epidemic, with particular focus on vulnerable groups; and (ii) an operational audit of the program, including activity completion, impact of activities and progress towards sustaining activities. The evaluation will highlight lessons learned which will be used to improve the efficiency of program implementation, to make adjustments to the program implementation manual, and to identify improvements for content and implementation procedures for future programs.

Since the objective of many of the project activities will be changing *behavior* of a large number of disparate groups in the short, medium and long terms, a process of beneficiary and stakeholder feedback and of social impact monitoring is essential to the success of the project. In this regard, a series of key social impact monitoring and mitigation steps along the following lines is essential:

(a) Identification of key social and cultural development and participation issues

- Linking the key social and cultural development issues regarding HIV/AIDS, particularly with regard to participation of the poor, youth, women, PLWHA and other vulnerable groups

- Identifying stakeholders whose participation in the project is of strategic importance, including those who hold power over vulnerable groups

- Defining a project-specific information strategy—particularly important since the program is multisectoral in nature and national in scope, and uses a wide variety of implementation mechanisms; and

- Establishing mitigation plans if the project is found to have adverse impacts on social groups.

(b) Evaluation of institutional and social organizational issues

- Identifying impediments to equitable access to project activities for intended beneficiary groups, especially those that are currently disempowered or face other obstacles

- Recommending strategies for strengthening institutional capacity. This is especially relevant for areas in a country where CBOs, which are vital implementation mechanisms for the project, are not well developed or are unaccustomed to designing and implementing activities such as those envisaged under the program.

(c) Definition of a participation framework

- Defining implementation arrangements based on stakeholder consultation that ensures ownership of and inclusion in project activities.

Annex 5: Economic Analysis of HIV/AIDS

Introduction

HIV/AIDS is a major development crisis. Not since the Black Death devastated medieval Europe has humankind observed infectious disease deaths on such a scale. Life expectancies, which rose steadily before the onset of the HIV epidemic, are decreasing in nearly all the 25 countries where the adult prevalence rate exceeds 5 percent. In the countries most heavily affected by HIV/AIDS, life expectancy is projected to fall to about 30 years by 2010– a level not seen since the beginning of the 20th century.

Various factors related to poverty, inequality, gender inequality, sexually transmitted infections, social norms, political and social changes, including labor migration, conflicts and ethnic factions have facilitated the rapid spread of HIV. But what has enabled HIV/AIDS to undermine economic and social development is its unprecedented erosion of some of the main determinants of economic growth such as social capital, domestic savings and human capital. For these reasons, the HIV epidemic has been transformed from a health issue into a much wider issue impairing economic and social development. Because it prevents an increasing share of the population from participating in economic growth, the HIV/AIDS epidemic increases poverty. The result is a vicious circle whereby HIV/AIDS reduces economic growth and increases poverty, which in turn accelerates the spread of HIV. Preventing further spread of HIV/AIDS, in addition to providing care and support programs to those both affected and infected by this epidemic, requires early intervention and the mobilization of external resources. The purpose of this annex is to discuss and quantify the economic rationale that underlies such an effort.

I. HIV/AIDS and Economic and Social Stagnation

HIV/AIDS is a major health issue, but it is only recently that it has become recognized as a major development issue. There are two reasons for this: (i) HIV/AIDS can spread like wildfire unless controlled through early prevention activities; and (ii) HIV/AIDS reverses economic and social development gains.

HIV/AIDS: A Wildfire

HIV/AIDS has now become one of the worst adult killers among infectious diseases. Worldwide, some 18.8 million people have died since the beginning of the HIV/AIDS epidemic. In Africa, AIDS-related diseases are the main cause of mortality. Both the speed and scale of the HIV epidemic have been much worse than expected. As long as the HIV prevalence rate remains below 5 percent, the HIV epidemic tends to spread slowly. But once it reaches a level around 5 percent, the HIV infection spreads exponentially with the prevalence rate sometimes increasing by 50 percent every year. The result is that there are now 16 countries in Africa in which more than 10 percent of the adult population is infected with HIV.

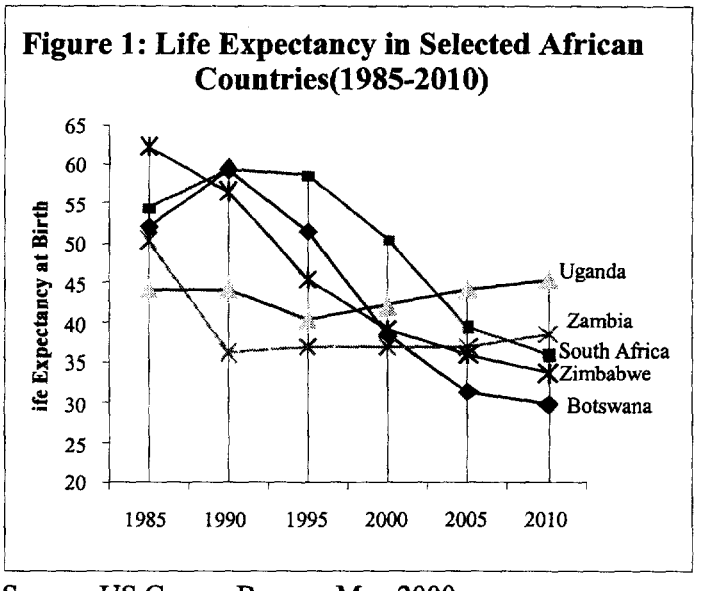
Few governments have responded forcefully. To a large extent this is because the HIV epidemic has remained an "invisible" disease for many years. Because of the long incubation period of the virus, individuals manifest few signs of illness for nearly a decade. It is only when the immune system has been sufficiently weakened by the HIV virus that opportunistic infections such as tuberculosis result in death. It is therefore only in the few years that the devastating demographic, economic and social impacts of the HIV epidemic have become apparent.

An Unprecedented Demographic Catastrophe

In the most heavily-affected countries, the demographic impact is staggering. Projections from the US Census Bureau indicate that by 2003 Botswana, South Africa and Zimbabwe will be experiencing negative population growth –an outcome that was judged highly unlikely just a few years ago.[3] Several other countries, including Malawi, Swaziland, Namibia and Zambia, will see their population remain constant. In the absence of AIDS, their population would have grown by 1.0-2.3 percent per year.

Hard-won gains in life expectancies are being wiped out in countries affected by the HIV epidemic. In the countries with the highest HIV prevalence rate such as Botswana and Zimbabwe life expectancy has fallen from 70 to about 39 years (Figure 1). In four other countries (Malawi, Mozambique, Rwanda and Zambia) life expectancies have been cut by a decade or more by the HIV/AIDS epidemic. If these trends continue unabated, the future looks even bleaker. By 2010, life expectancy in Botswana, Zimbabwe and South Africa would fall to about 30 years, nearly half its level of twenty years ago.

Figure 1: Life Expectancy in Selected African Countries(1985-2010)



Source: US Census Bureau, May 2000

Such outcomes are not ineluctable. Uganda's life expectancy declined in 1990-95, but since then it has been showing signs of increase. Similarly, Zambia's life expectancy is expected to increase in the 2000-2010 period as a consequence of the decline in the HIV prevalence rate among the young. In Senegal, early and sustained interventions have contained the HIV infection rate to below 2 percent, and life expectancy has been increasing. Nevertheless, such developments remain more the exception than the norm. For most developing countries, the recent spread of the HIV epidemic augurs poorly for long-term economic growth and poverty reduction.

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3 U.S. Bureau of Census, World Population Profile 2000, Washington, U.S. Bureau of Census

Erosion of the Process of Economic Development

HIV/AIDS' extraordinary impact on development is due to its ability to undermine three main determinants of economic growth, namely physical, human and social capital. But due to the long incubation period of the HIV virus (7-10 years), the impact of the HIV/AIDS epidemic is likely to be drawn over time with the rate of growth of physical and human capital and the efficiency of social capital declining slowly in parallel with the maturing of the HIV epidemic. Over time, the behavior of GDP would reflect a similar gradual downward reduction of the rate of growth of GDP rather than a sudden fall in GDP per capita.

Initially, the HIV/AIDS epidemic has a negligible impact on physical investment. As time passes, the HIV/AIDS epidemic leads to an increase in opportunistic infections and a worsening of the health status of the population, which can result in lower domestic savings by governments and households. The government budget is adversely affected because expenditures increase due to the treatment and care of AIDS-related diseases, pension payments for AIDS-related deaths, and training of newly hired civil servants to replace those that died. In most cases, the fiscal deficit would worsen as few countries can offset the fiscal cost of the HIV/AIDS epidemic by cutting other expenditures or raising taxes. One reason is that the HIV epidemic is often the most advanced in those economies that are already in a weak economic condition and least able to adjust expenditures and revenues.

The second consequence of the HIV epidemic is to affect the savings of households. Faced with the illness of adult family members, HIV-infected households experience a fall in income, which forces them to deplete their savings and/or assets. Other households may, however, increase their precautionary savings if the risk of contracting AIDS-related diseases is viewed as significant. Savings would also increase if households' earnings rise. This could occur for the better-off households. In view of the scarcity of skilled labor in most developing countries, the reduced availability of skilled labor (such as caused by AIDS-related deaths) would increase wages for skilled labor. But this is unlikely to be the case for unskilled labor given the usually large pool of unemployed workers and potential migrant workers from rural areas.

On balance, the domestic saving rate of developing countries was negatively related to the level of the HIV prevalence rate (Table 1). Because domestic saving is the main source of financing for most developing countries, the reduction in savings would lead to less domestic investment, which in turn would reduce long-term economic growth. To the extent, however, that developing countries have access to external financing, the shortfall in domestic savings can be offset by the mobilization of external resources. In such a case, the reduction in economic growth may not occur.

The second effect of the HIV epidemic is to destroy human capital and reduce the incentives to invest in training and schooling. Unlike most other infectious diseases, HIV/AIDS has ignored income or social barriers. In the absence of adequate information on HIV/AIDS, both high and low-income groups have been affected. In the high HIV prevalence countries a generation of educated civil servants, teachers, health workers and professionals is being lost at a time when these skills are still in short supply. If this leads to increased wages for skilled labor, the return to schooling and training would increase. However, the shorter life expectancy resulting from HIV/AIDS means that the benefits of training and education can only be recovered over a shorter time horizon, which reduces the rate of return on investment in human capital. On balance, this latter effect is likely to be predominant for the high HIV prevalence countries. In these countries the reduction in life expectancy to about 30 years is such that long-term investment in human capital ceases to be financially profitable. As shown by Table 1, the

econometric evidence suggests that the secondary school enrollment rate fell in 1990-95 on account of the HIV epidemic.

Table 1: Education, Domestic Saving and HIV Prevalence Rate 1/

	Dependent Variables	
	Change in secondary enrollment rate (1990-95)	***Change in domestic saving rate (1990-96)***
Constant	-6.73 (-1.2)	0.46 (0.1)
Gross domestic saving rate (1990)	--	-0.28** (-2.8)
Secondary enrollment rate (1990)	-0.11* (-1.6)	-0.10** (-2.02)
Growth rate of GDP per capita (1980-90)	124.3** (3.54)	86.6** (2.4)
Number of phones per capita (in log) 2/	5.06** (2.1)	2.49* (1.8)
Log of HIV prevalence rate (1997)	-0.39 (-0.62)	-1.18 (-1.5)
Log of HIV, squared	-0.49** (-2.6)	-0.61** (-2.6)
Dummy variable for Southern Africa	11.2** (2.8)	10.2** (2.2)
R^2	0.40	0.38
No of observations	64	77

Notes:

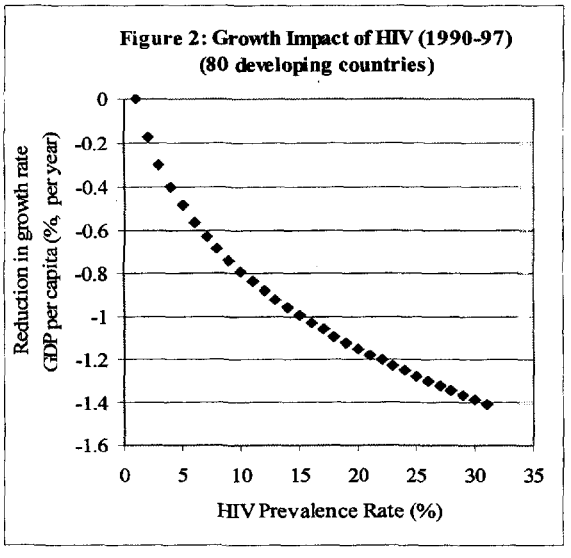
1/ Cross-country regression. Heteroscedasticity-consistent t statistics in parentheses (White correction). ** indicates that the coefficient is statistically significant at the 5% level; * indicates statistical significance at a 10% level.

2/ Number of phones per person is used as an index of development. Regression with the log of GDP per capita would generate the same result.

Equally important is the erosion of social capital. As shown by several recent studies, the quality of regulations and of the legal system as well as the extent of trust and civic cooperation within countries have been found to matter for economic growth. Because HIV affects the social structure of local communities, it erodes existing social network and traditional support mechanisms. One result is a generation of AIDS-related orphans who might have to grow up without the traditional support and guidance of adults in addition to changes in community structures.

HIV/AIDS and Economic Stagnation

The empirical relation between HIV/AIDS and economic growth during the 1990s was investigated through a cross-country regression covering some 70-80 developing countries for which data is available. The approach that was followed consisted of estimating a system of three equations to take into account the relationships among economic growth, policy and institutional variables, and the determinants of the HIV epidemic (see Attachment for a description of the model).[4]



The main implication is that infectious disease matter substantially for economic development. Figure 2 shows the reduction in the growth rate of GDP per capita resulting from HIV/AIDS while holding constant the other factors that affect growth. Had the HIV prevalence rate not reached 8.6 percent in 1999, Africa's income per capita would have grown at 1.1 percent per year – or nearly three times the growth rate (0.4 percent per year) achieved in 1990-97.

For the countries with high prevalence rates, the economic cost of HIV/AIDS is even more staggering. In the case of a typical sub-Saharan country with a prevalence rate of 20 percent, the rate of growth of GDP would be some 2.6 percentage points less each year.[5] At the end of a twenty year period GDP would be 67 percent less than otherwise. One reason for the large impact of HIV/AIDS is that it includes the effect of AIDS-related opportunistic infections and other communicable diseases.

HIV/AIDS and Poverty

The economic impact of HIV/AIDS will not be uniform across countries or even within countries. Countries that are well developed with a strong health infrastructure can usually mobilize the resources needed to provide care and treatment. Furthermore, because of their well-

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[4] Developed countries were excluded partly due to the lack of data concerning some of the policy variables that were used in the econometric estimation, and partly because the spread of HIV in these countries reflects different causes (non-heterosexual) than Africa.

[5] This is the sum of the reduction in growth per capita (1.2 percent) and the shortfall in population growth (1.4 percent)

developed educational systems and stock of human capital, the AIDS-related loss of human capital does not entail the same consequences it has in countries where skilled labor is in short supply. By contrast, poor countries and poor households which do not have access to such resources are especially vulnerable to a rapid spread of HIV. The HIV epidemic creates a vicious cycle whereby HIV/AIDS reduces economic growth, slower growth increases poverty, and poverty facilitates the rapid spread of HIV/AIDS. This affects poor households through the following chain of events. When adults in a family become infected, they fall ill and stop earning. Children, especially girls, are then often taken out of school to look after the ill members of the families, which sharply constrains children's opportunities for higher income later in life. In such circumstances, the poor are forced to reduce their expenditure on food, which reduces further their resistance to the opportunistic infections made possible by HIV/AIDS. The consequence is an increase in the mortality rate and the reversal of most development gains of the last decade.

II. The Unaffordable Cost of Policy Inaction

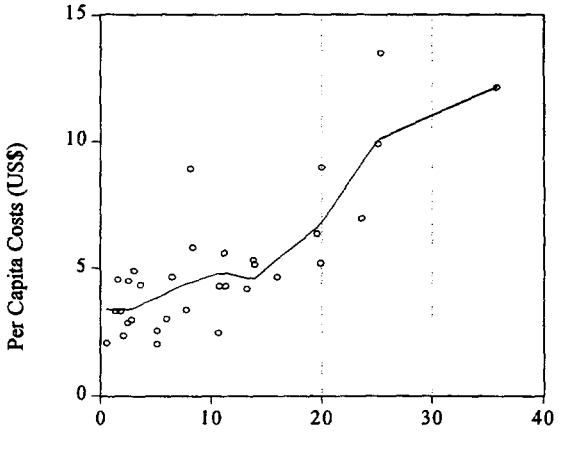
Faced with a potentially rapid spread of HIV/AIDS, countries have the following two options:

i) delay HIV/AIDS interventions while the prevalence rate remains low and implement HIV/AIDS programs once the epidemic becomes highly visible;

ii) implement comprehensive prevention and treatment programs early on while the HIV prevalence rate is low.

So far, most developing countries have unfortunately followed the first option. They have implemented HIV/AIDS programs, but with various lack of success in controlling the HIV epidemic due to the limited scale of these programs. This option is now no longer sustainable over the longer term due to the increasing fiscal and economic cost of delaying the implementation of a comprehensive program of interventions.

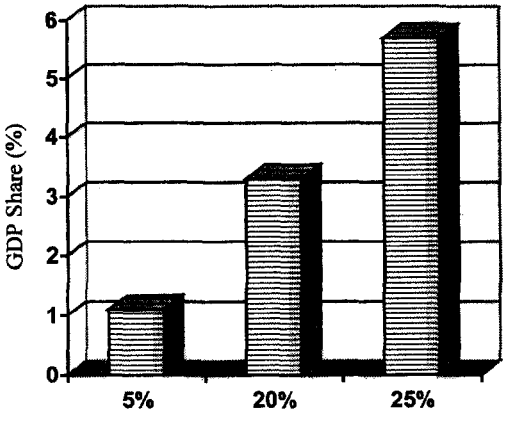
Figure 3: HIV/AIDS: Prevention, Treatment and Basic Care (sub-Saharan Africa)



The cost of delaying action is illustrated by Figure 3. This graph shows the estimated per capita cost of implementing the package of interventions in prevention and care that would be supported under the MAP.[6] When the HIV prevalence rate in the general population is below 5 percent, HIV/AIDS program costs about US$3 per capita. But once the HIV prevalence rate exceeds 15%, the cost of HIV/AIDS program rises rapidly to about US$10-12 per capita.

Few countries can afford the financial cost of inaction. In the case of a developing country with a per capita income of US$300, the budgetary cost of implementing a national scale HIV/AIDS program amounts to 1.0 percent of GDP when the HIV prevalence rate is less than 5 percent. If the implementation is delayed so that the HIV prevalence rate reaches 20 percent of the population, the budgetary cost amounts to 3.3 percent of GDP. This cost excludes the provision of antiretroviral drugs. For illustrative purposes, Figure 4 also shows the typical cost of a HIV/AIDS program that would include the provision of antiretroviral therapy to 10 percent of the target group in a country with a prevalence rate of 25 percent. Even under the assumption that antiretroviral drugs would be provided at a reduced price, the cost would amount to 5.7 percent of GDP.[7] However, countries that implement early on a comprehensive package of HIV prevention measures would be in a position to afford antiretroviral drugs. Due to the reduction in the number of HIV infections, the number of AIDS patients would be less, which would result in an affordable budgetary health cost.

Figure 4: HIV Epidemic and Annual Budgetary Cost



[6] This is based on a study of the costs of scaling up HIV/AIDS programs to a national level in some 30 sub-Saharan African countries for which data was available. The cost estimates do not include the cost of triple antiretroviral therapy with the exception of antiretroviral treatment to prevent parent-to-child transmission of HIV.

[7] For simulation purpose the cost of the antiretroviral drugs is assumed to be US$1,400 per patient per year, which is much lower than current commercial costs.

III. Cost-Benefit Analysis of the Multisectoral HIV/AIDS Program (MAP)

Given the relationship demonstrated above, one of the key development goals of countries should be to control and reverse the spread of the HIV epidemic. This can be achieved through the implementation of the comprehensive package of measures that are part of the MAP. Both the previous discussion and the econometric evidence suggest that the implementation of the package of measures included in the MAP will have a substantial impact on the HIV prevalence rate, which would improve the welfare of households.

Benefits of the MAP. The program would have the following four main benefits.

- First, because of the national coverage of the program, the population at large will benefit directly from avoidance of HIV infection and from better access to treatment, care and mitigation activities supported by the program.

- Second, the MAP would sharply reduce new infections, especially among young people, and therefore prevent future suffering and premature deaths. These benefits will be especially important for women and youth that will benefit from targeted interventions to improve their awareness of the disease and empower them to protect themselves.

- Third, the MAP program would help improve standards of living among disadvantaged groups and reduce income inequality. People living with HIV/AIDS will benefit from reduced stigma and improvements in their human rights, from improved care at home, in their communities, and in health centers and hospitals, and therefore from a prolonged and more healthy life. Lower income groups will also benefit from community-based assistance to households taking care of AIDS patients and orphans.

- Fourth, the implementation of the MAP will reduce the future number of HIV/AIDS patients and orphans. As a result, the costs of treatment and care of HIV/AIDS patients would be less than otherwise. This will allow countries to allocate the savings to productive investments and significantly improve long term per capita income growth.

Cost-Benefit Analysis

For illustrative purposes, it was assumed that some eight representative African countries (including Kenya and Ethiopia) would have access to the financing provided by the MAP. These countries include some 280 million people -about half of sub-Saharan African population.

Costs of MAP. The cost of implementing nation-wide HIV/AIDS programs in eight representative African countries was estimated to amount to some US$575 million per year. This financing would cover the cost of providing a basic package of HIV/AIDS interventions and treatment on a nation-wide basis. Provided implementation constraints are alleviated faster, a larger percentage of the population could have access to a basic care package, including treatment of opportunistic infections such as tuberculosis. Under that assumption, the annual cost of the MAP would increase to US$740 million (column B of Table 3).

Reduction in new infections. In the absence of the MAP, the HIV epidemic would continue to spread. This assumption is based on the increase in the average prevalence rate, which rose from 0.6 percent in 1984 to 3.3 percent in 1990, 6.5 percent in 1995 and 7.9 percent in

1999.[8] As a conservative assumption, the HIV prevalence rate was projected to increase from 7.9 percent of the adult population (15-49 years of age) to 10 percent by 2003 and remain at that level.

With the MAP, the HIV prevalence rate would fall from 7.9 percent in 1999 to 5.6 percent by 2010 and below 4 percent after 2015. The driving force would be the reduction in half of the number of new HIV infections among the 15-24 year-olds by 2010. This is an achievable goal as it has been met by several countries in the 1990s. For the rest of the adult population, new HIV infections would decrease in a similar fashion, but because of existing HIV infections among adults, the adult HIV prevalence rate would be cut by only 25 percent over a ten-year period.

Budgetary savings. The fall in new HIV infections would reduce the number of new AIDS cases. Given an average incubation period of the HIV virus of about eight years, some 6.7 million adult deaths would be averted over the period 2000-2020. In economic terms, the reduction in HIV infections would result in lower costs of treatment and care of HIV/AIDS patients, which would offset part of the MAP costs (column C of Table 3).

Increased output growth. Based on the econometric results discussed above, the fall in the HIV prevalence rate would increase the growth rate of GDP per capita. In addition, the reduction in AIDS-related deaths would increase labor force growth, which would further raise GDP growth. In total, the rate of growth of GDP would increase gradually by about 0.2 percentage points per year in 2007-2015 and 0.5 percentage points afterwards. The absolute increase in the value of GDP for the eight countries is shown in Table 3 (column E).

Internal rates of return. The last two columns of Table 3 show the net economic benefits that would result from the combination of output increase and the different assumptions concerning costs. Overall, the internal rate of return is quite similar under the two cost assumptions as it ranges from 29 to 31 percent.

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[8] The HIV prevalence rate was estimated by weighting the adult population (15-49 years of age) of each country by the HIV prevalence rate of each country.

Table 3: Costs and Benefits of MAP
(US$ million, constant 2000 prices)

Year	*Cost of Multi-Sectoral HIV/AIDS Program 1/*		*Savings due to reductions in infections*	*GDP Base Case (4% p.a.)*	*Increase in GDP due to lower HIV Rate*	*Net Economic Benefits*	
	(A)	*(B) 2/*	*(C)*	*(D)*	*(E) 3/*	(E) - (A-C) *(F)*	(E) - (B-C) *(G)*
2001	-115	-115	0.0	79173	0	-115	-115
2002	-288	-288	15.9	82340	0	-272	-272
2003	-460	-460	32.5	85634	0	-428	-428
2004	-575	-575	66.5	89059	0	-508	-508
2005	-575	-740	71.4	92621	93	-411	-576
2006	-575	-740	83.4	96326	193	-299	-464
2007	-575	-740	99.4	100179	411	-64	-229
2008	-575	-740	115.9	104186	647	188	23
2009	-575	-740	133.1	108354	902	460	295
2010	-575	-740	150.8	112688	1211	787	622
2011	-575	-740	169.3	117196	1543	1138	973
2012	-575	-740	184.4	121883	1901	1511	1346
2013	-575	-740	200.1	126759	2286	1911	1746
2014	-575	-740	220.9	131829	2700	2345	2180
2015	-575	-740	240.6	137102	3479	3144	2979
2016	-575	-740	256.9	142586	4319	4001	3836
2017	-575	-740	272.0	148290	5224	4921	4756
2018	-575	-740	288.0	154221	6198	5911	5746
2019	-575	-740	300.2	160390	7246	6971	6806
2020	-575	-740	308.3	166806	8371	8105	7940
2021	-575	-740	316.8	173478	9579	9321	9156
2022	-575	-740	316.8	180417	10874	10616	10451
2023	-575	-740	316.8	187634	12262	12004	11839
2024	-575	-740	316.8	195139	13748	13490	13325
2025	-575	-740	316.8	202945	15338	15080	14915
Internal Rate of Return						**31%**	**29%**

Notes:

1/ Program covers eight sub-Saharan African countries with a total population of 280 million. Cumulative disbursement is assumed to be: first year: 20%; second year: 50%; third year: 80%; fourth year: 100%.

2/ Cost of program is assumed to reach US$740 million in 2005 with further expansion of coverage of HIV/AIDS interventions.

3/ Rate of growth of GDP increases from 4% to 4.1% in 2005-07, 4.21% in 2007-2010, 4.24% in 2010-15, and 4.48% in 2015-2025.

Attachment

A. Key Determinants of HIV/AIDS

Several economic, sociological and cultural variables account for the spread of the HIV epidemic. The main economic variables that have been identified include: life expectancy, human capital, income inequality, gender inequality, and the extent of labor migration.[9] As expected, there is a strong relationship between good health (reflected in life expectancy) and HIV/AIDS. Because access to health services is generally dependent on the level of income, there is a positive association between income inequality and HIV/AIDS (Figure 1).

Unequal regional development among countries as well as within countries can induce labor migration to urban areas or other countries. The resulting concentration of single men in urban areas or project sites is generally accompanied by a parallel increase in commercial and casual sex with a concomitant rise in the risk of HIV infection.

Gender and income inequality make societies more vulnerable to HIV because a woman who is poor relative to men, will find herself exposed to a much greater risk of getting infected with the HIV virus. As shown by Figure 2, empowerment of women through greater economic independence is associated with a lower HIV prevalence rate (Figure 2).[10] Increasing women's economic independence does two things. First, it provides women with the financial and legal independence they need to take into account their own welfare at crucial times. Without such independence, women are often not in a position to follow safe prevention techniques which have been found to reduce the risk of HIV infection. Limits on independence include land inheritance laws and legal obstacles to opening banking accounts and starting their own businesses. Second, the availability of market employment opportunities increases the opportunity cost of commercial sex work. On one hand this implies that fewer women will become commercial sex workers to survive, and on the other hand it also leads to more condom use by commercial sex workers.

A key determinant of economic independence is education. It is therefore not surprising that education is associated with a lower HIV prevalence rate (Figure 3). Education also operates to raise the costs of becoming infected,[11] and, particularly if it includes sexual education, it will improve the knowledge of the risks entailed by unprotected sexual relations. Both factors increase the incentives to invest in HIV prevention activities and account for the broad negative relationship between education and HIV.

Sociological and cultural variables include the type of sexual relations, religious belief, and the structure of societies. The type of sexual relations is important because it affects the relative spread of HIV among men and women. In Africa, HIV is mainly spread through heterosexual relations. As a result, HIV/AIDS affects men and women much more uniformly than in other countries.

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9 "Confronting AIDS". World Bank Research Report (1997).

10 The share of female labor in the industrial sector was taken as an indicator of the lack of market opportunities for women.

11 The cost is proportional to the lost earnings resulting from AIDS-related mortality. This means that educated workers have higher incentives to invest in HIV prevention measures than unskilled workers.

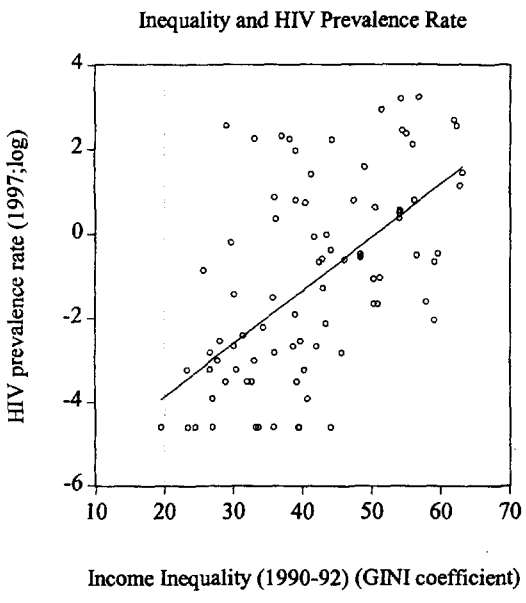

Figure 1

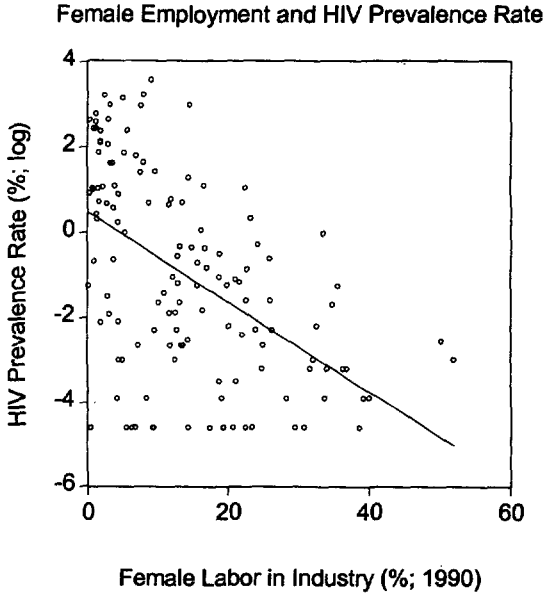

Figure 2

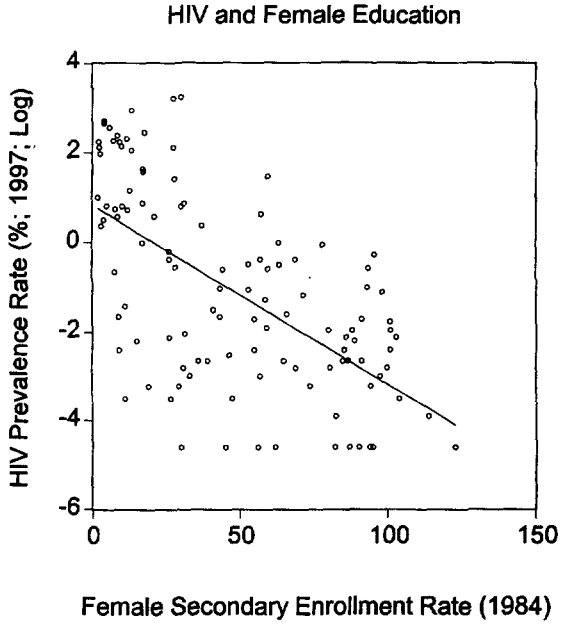

Figure 3

Ethnic fractionalization could be an important determinant of the HIV prevalence rate to the extent that it entails discrimination against some ethnic groups in the allocation of public expenditures. Ethnically-diverse societies, with some groups being more affected by HIV than others, may experience difficulty in agreeing on spending priorities. The result may be less public spending on public goods as documented by Alesina, Baqir and Easterly (1999). However, this effect may be offset by strengthening community-based response to the HIV epidemics as this may facilitate the formation of a broad-based response in the face of an HIV epidemic.

Epidemiological variables include cofactors that increase the risk that sexual contacts will result in HIV infection. The most important cofactor is probably ulcerative sexually transmitted diseases. As is usual in epidemiological models, the age of the epidemic, i.e. how long it has been since the first infectious case was reported in a country, affects the evolution of the HIV prevalence rate over time. Because HIV/AIDS weakens the immune response, it gradually becomes the main cause of opportunistic infections such as tuberculosis. There are also some indications that HIV is a cofactor of malaria. All these factors combine to make HIV/AIDS one of the most potent diseases of developing countries.

Econometric results. The evidence shown in the previous graphs suggest that the spread of the HIV epidemic is related to various economic, sociological and cultural characteristics. This was further explored through a cross-country regression of the HIV prevalence rate for some 60 developing countries for which data was available. Table 1 provides statistical evidence that education, increased job opportunities for women, and cultural belief reduce the prevalence of HIV. Their coefficients are highly statistically significant even when controlling for the level of income per capita and infrastructure by countries. Similarly, income inequality, ethnic fractionalization, and the age of the epidemic increase the spread of HIV/AIDS. In total, these factors explain about 70 percent of the variation of the HIV prevalence rate among developing countries.

Table 1: Key Determinants of HIV Prevalence Rate (1997)

Dependent Variable: Log of the HIV prevalence rate	*Coefficient*	*t-Statistic 1/*
Log of the number of phones per person (1994)	-0.84	-2.2**
Growth rate of GDP per capita (1980-90)	4.58	0.5
Share of female labor in industry (1990)	-0.0035	-1.7*
Muslim (% of population)	-0.024	-5.2**
Ethnic fractionalization 2/	0.027	3.5**
Time since first HIV case was reported	0.379	2.9**
Labor migration (1990) 3/	0.003	3.2**
Secondary school enrollment rate (1990) 4/	-0.016	-1.2
Constant	-1.7	-0.85
R-squared	0.69	
Number of observations	59	

Notes:

1/ White Heteroskedasticity-Consistent Standard Errors & Covariance.
** indicates that the coefficient is statistically significant at the 5% level;
* indicates statistical significance at a 10% level.

2/ Ethnic fractionalization index from Levine, Easterly (1997)

3/ As a proxy for labor migration, the share of factor receipts in exports was used.

4/ Due to multicollinearity between income inequality and gender inequality, the income inequality variable was excluded from the regression. However, when gender inequality is excluded, the income inequality measure is highly significant. For the same reason, female education was replaced by total education to reduce multicollinearity with gender inequality.

B. HIV/AIDS and Economic Growth

One of the main difficulties involved in assessing the impact of HIV/AIDS on growth is a fundamental identification problem. Does HIV affects policy variables and institutional variables, or do institutional variables --for example, political instability-- cause HIV? To address that question, a system of three equations is used to model explicitly the interactions among HIV/AIDS, policy and institutional variables and growth.

The first equation follows the standard approach of the recent growth literature by regressing the average rate of growth of GDP per capita on macroeconomic policy, institutional variables and other variables that have been identified as important determinants of economic growth (Table 3). The second equation links macroeconomic policy ratings and institutional variables to the HIV prevalence rate and other exogenous variables that can account for differences among countries (Table 2). The third equation expresses the HIV prevalence rate as a function of the main determinants discussed in the previous section (Table 1). The impact of the HIV/AIDS epidemic on growth is then obtained by solving the system of three equations.[12]

Before turning to the empirical results, it should be stressed that the estimates presented below should be treated with caution for the following reasons. First, GDP per capita is a biased estimate of the impact of HIV/AIDS. Such measure neglects the welfare of the generation that died because of HIV/AIDS as it takes into account only the income per capita of the surviving generation. The principal reason for focusing on GDP per capita is simply that it is a widely used indicator.

Second, the cross-section econometric methodology that was adopted has inherent limitations. In particular, the HIV variable could be picking up the effects on growth of other factors rather than the impact of the epidemic. To address this issue, various variables that could play such a role were added to the econometric regressions. These included the malaria morbidity rate and geographical factors such as tropical location or being landlocked. With the exception of malaria, the statistical significance of these variables was too low to affect the magnitude of the estimated impact of the HIV epidemic. A remaining issue, however, is the estimation procedure that relates GDP growth to the level of HIV/AIDS rather than the change of HIV/AIDS over time. A more complete analysis involving panel data will be conducted following the release of data for the 1999 HIV prevalence rate.[13]

The estimated **growth equation** is consistent with the findings of the growth literature. Nearly all the coefficients are statistically significant with the expected sign (Table 3). The coefficient of per capita income is negative, which is consistent with the hypothesis of conditional convergence of GDP per capita between poor and rich countries. The level of infrastructure and the primary school enrollment rate are significant with the expected positive effect on GDP growth.

Malaria and growth. What could bias the estimated impact of HIV on growth is the omission of relevant variables from the growth regression. If these variables are positively correlated with HIV, the coefficient of HIV would be biased upwards as it would include their impact. Among the possible diseases that are important for Africa, malaria stands out. Following the approach of McCarthy, Wolf and Wu (2000), data on the morbidity caused by malaria was used to construct an index of morbidity rate per

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[12] Ordinary least squares and instrumental variables were used to estimate these three equations. Instrumental variables were measured at the beginning of the period to reduce the extent to which some of the variables would endogeneous. The results obtained by using two stage least squares to address issues of endogeneity and possible simultaneous determination of some variables are quite similar. For these reasons, they are not included in the attached tables.

[13] "Report on the Global HIV/AIDS Epidemic". June 2000, UNAIDS.

100,000 persons.[14] Overall, the results suggest that the per capita growth of the countries affected by malaria was reduced by 0.3 percentage points per year in 1990-97.

HIV/AIDS and policy variables. The econometric results of Table 2 are consistent with the hypothesis that HIV/AIDS affects a broad range of institutions and policies. Since it covers most developing countries, the country ratings of macroeconomic policy done by the World Bank was used as an indicator of macroeconomic outcome. As shown by the second column of Table 2, the coefficient of the HIV prevalence rate variable is highly significant and negative. The same result is obtained as concerns indicators of regulation and government effectiveness, which are available for some 60 developing countries (third and fourth columns of Table 2). By contrast, there is little evidence that the quality of the legal system or the extent of democracy were affected by the HIV epidemic.

HIV/AIDS and GDP growth. For Africa with an average HIV prevalence rate of 8.7 percent, the rate of growth of GDP per capita was reduced by about 0.7 percentage points per year in the 1990s. The implication is that Africa's per capita income would have grown at a rate of 1.1 percent per year in the absence of HIV/AIDS, i.e. nearly three times as fast as was achieved in the 1990s.

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[14] Published by the World Health Organization (WHO) in its Weekly Epidemiological Record, 8/13/99, www.who.int/wer.

Table 2: Macroeconomic Outcome, Institutional Variables, and HIV/AIDS 1/
(Ordinary Least Squares Estimates)

	Dependent Variables		
	Macroeconomic Policy Rating (1998) 2/	**Regulation 3/**	***Government Effectiveness 3/***
Constant	1.57 (1.0)	-1.31** (-2.4)	-1.77 (-1.5)
Log of GDP per capita (1990) 4/	0.16 (0.5)	n.s.	-0.09 (-0.4)
Secondary school enrollment rate (1990)	-0.003 (-0.3)	0.001 (0.2)	0.002 (0.4)
Growth rate of GDP per capita (1980-90)	0.2 (0.04)	-1.73 (-0.5)	0.44 (0.14)
Log of phone per capita (1994)	0.13 (0.7)	0.26** (2.4)	0.25 (1.7)
Institutional Country Rating (1990) 5/	0.019* (2.4)	0.009 (1.19)	0.025** (3.14)
Log of HIV prevalence rate (1997)	-0.21** (-2.4)	-0.17* (-2.0)	-0.12 (-1.6)
Log of HIV, squared	-0.058** (-2.1)	-0.051** (-2.8)	-0.048 (-3.2)
Dummy variable for Southern Africa	1.1** (2.7)	0.96** (2.3)	0.58* (1.9)
R^2	0.25	0.38	0.45
No of observations	58	61	60

Notes:

1/ Heteroscedasticity-consistent t statistics in parentheses (White correction). ** indicates that the coefficient is statistically significant at the 5% level; * indicates statistical significance at a 10% level.

2/ World Bank unpublished ratings.

3/ Kaufman D.,Kray A., and Zoido-Lobaton, P. "Governance Matters" World Bank Working Paper No. 2196 (October 1999).

4/ In purchasing power parity terms.(World Development Indicators).

5/ Institutional Investor Guide; average economic rating by country (1990).

Table 3: Economic Growth and HIV/AIDS (1990-97) 1/

	Rate of Growth of GDP Per Capita (1990-97)
Constant	0.12** (2.3)
Log of GDP per capita (1990) 2/	-0.03** (4.1)
Log of number of phones per person (1994)	0.019** (-2.9)
Macroeconomic policy rating (1998) 3/	0.01** (2.0)
Rule of law rating (1995-96) 4/	0.016** (2.6)
Primary school enrollment rate (1990)	0.0004** (2.3)
Malaria morbidity rate (1990) 4/	-7.6E-07 (-1.9)*
R^2	0.33
No of observations	83

Notes:

1/ Heteroscedasticity-consistent t statistics in parentheses (White correction). ** indicates that the coefficient is statistically significant at the 5% level; * indicates statistical significance at a 10% level.

2/ In purchasing power parity terms.

2/ World Bank unpublished ratings.

3/ From: Kaufman D.,Kray A., and Zoido-Lobaton, P. "Governance Matters" World Bank Working Paper No. 2196 (October 1999).Kaufman (1999).

4/ Morbidity data is from WHO. It was expressed as a rate per 100,000

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[15] Developed countries were excluded partly due to the lack of data concerning some of the policy variables that were used in the econometric estimation, and partly because the spread of HIV in Europe reflects different causes (non-heterosexual) than Africa.

[16] This is the sum of the reduction in growth per capita (1.2 percent) and the fall in population growth (1.6 percent)

[17] This is based on some 30 sub-Saharan African countries for which data was available. The cost of triple antiretroviral therapy was not included in these estimates. However, they include the cost of antiretroviral treatment to prevent parent-to-child transmission of HIV.

[18] For simulation purpose the cost of the antiretroviral drugs is assumed to be US$1,400 per patient per year, which is much lower than current commercial costs.

[19] "Confronting AIDS". World Bank Research Report (1997).

[20] The share of female labor in the industrial sector was taken as an indicator of the lack of market opportunities for women.

[21] The cost is proportional to the lost earnings resulting from AIDS-related mortality. This means that educated workers have higher incentives to invest in HIV prevention measures than unskilled workers.

[22] "Report on the Global HIV/AIDS Epidemic". June 2000, UNAIDS.

[23] Published by the World Health Organization (WHO) in its Weekly Epidemiological Record, 8/13/99, www.who.int/wer.

ETHIOPIA

ETHIOPIA MULTI-SECTORAL HIV/AIDS PROJECT (EMSAP)

TECHNICAL ANNEX

Africa Regional Office

AFTH4

Date: August 14, 2000	**Team Leader:** Gebreselassie Okubagzhi
Country Director: Oey Meesook	**Sector Manager:** Arvil Van Adams
Project ID: P069886	**Sector(s):** MY - Multi-sectoral
Lending Instrument: Specific Investment Loan (SIL)	**Theme(s):** HIV/AIDS
	Poverty Targeted Intervention: *N*
Project Financing Data:	**Credit** √ Grant
For Loans/Credits/Others: **Amount (US$m): 59.7 million SDR 45.2**	
Proposed Terms: Standard IDA	
Grace period (years): 10	**Years to maturity:** 40
Commitment fee: Up to 0.5%	**Service charge:** 0.75%

Financing Plan (US$m)

Source	Local	Foreign	Total
IDA	44.0	15.7	59.7
Government	2.0	0.0	2.0
Community	1.1	0.0	1.1
NGOs, etc	0.6	0.0	0.6
Total	**47.7**	**15.7**	**63.4**

Borrower: Government of the Federal Democratic Republic of Ethiopia
Responsible Agency: Office of the Prime Minister
Address: P.O. Box 1031 Contact Person: Dr. Dagnachew Haile Mariam Tel: 251-1-55-77-99 Fax: 251-1-55-20-20 Email:

Estimated Disbursements (Bank FY/US$m):

FY	2001/2002	2002/2003	2003/2004
Annual	14.1	20.4	25.2
Cumulative	14.1	34.5	59.7

Project Implementation Period: 3 years
Expected Effectiveness Date: December 1, 2000
Expected Closing Date: June 30, 2004

Ethiopia: Multi-Sectoral HIV/AIDS Project
Financial Summary

Total Financing Required	Year 1	Year 2	Year 3
Project Costs			
Investment Costs	13.7	20.4	25.2
Recurrent Costs	1.0	1.2	1.9
Total Project Costs	**14.7**	**21.6**	**27.1**
Project Financing			
IDA	14.1	20.4	25.2
Communities	0.3	0.3	0.5
NGO, etc.	0.2	0.3	0.1
Government	0.4	0.6	1.0
Total Project Financing	**15.0**	**21.6**	**26.8**

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A. Project Purpose, Development Objective, and Strategic Context

Project purpose:

1. The overarching purpose of the project is to reduce the spread of the HIV/AIDS epidemic, alleviate its impact, and increase access to treatment, care, and support for those infected and affected by HIV/AIDS. The overall project is premised on the development and expansion of local responses to the epidemic.

Project development objective:

2. In collaboration with other members of the International Partnership Against AIDS in Africa (IPAA), the project will help accelerate implementation of the Federal and Regional Multi-Sectoral HIV/AIDS Strategic Plans, particularly through the provision of HIV/AIDS prevention, care, and treatment services at all levels and in a number of sectors. The project will prioritize support for community-driven initiatives.

Key performance indicators:

3. The following constitute the summary indicators for outputs, process, and impact of the project:

A. Output Indicators
Access to treatment for opportunistic infections increased from 30 to 50 percent.
The number of national surveillance sites will have increased by 2 in the first year and by 10 by the end of the project.
The number of blood banks will have increased by 25 percent by the end of the project.
At least 70 percent of the participating *woredas* have implemented their agreed action plans.
EAF disbursements are at least 70 percent of plan level.

B. Process Indicators
Functional HIV/AIDS councils will have increased as follows: regional from 1 to 11 by the end of the year 1; zonal from 0 to 20 and *woredas* from 0 to 165 by the end of year 3 of the project.
Councils at all levels (in participating *woredas*) have defined work programs in year 2 of the project.
The number of affordable VCT services incorporated into ANC, TB, and STI clinics will have increased by 10 percent by the end of the project.
Increase in the number of anti-AIDS clubs in high schools: year 1, 25 percent increase and 20 percent increase each in subsequent two years of the project.
Funds distribution and financial management mechanisms will have been installed within three months of project effectiveness at the national level.

C. Impact Indicators
Eighty percent of the population will be aware of HIV/AIDS and its prevention in participating *woredas* by the end of the project.
Use of condoms at last sexual contact among young people (14-19 years) will increase by 20 percent by the end of the project.
Prevalence of HIV and STIs will be reduced.

4. While a more extensive list of indicators appears in the logical framework (Attachment 1), the project will contribute to its goal of reducing the impact of HIV in Ethiopia.

Relation to Country Assistance Strategy:

5. The last Country Assistance Strategy (CAS) for Ethiopia was discussed by the Board of Directors in August 1997. The CAS did not mention HIV/AIDS. The Bank's recent lending in education and health has dealt with HIV/AIDS inadequately in view of the current epidemic and its projected impact on society and economic development. The proposed CAS under preparation will give HIV/AIDS a very prominent place in the Bank's program of assistance to the country.

B. Main Issues and Strategic Context

6. HIV/AIDS now poses the foremost threat to Ethiopia's development. Globally, Ethiopia has the 16th highest HIV/AIDS prevalence rate of any country and the third largest population of people living with HIV/AIDS (PLWHA). One of every 11 people living with HIV/AIDS today is an Ethiopian. Life expectancy is already falling, and the epidemic is systematically undermining the country's efforts to reduce poverty—especially its investments in health, education, and rural development. Beyond its vast toll in suffering and death, AIDS may also be costing Ethiopia as much as one percent of economic growth each year, further reducing the scope for poverty reduction. If it continues unchecked, HIV/AIDS will alter the trajectory of the country's development by retarding growth, weakening human capital, discouraging investment, exacerbating poverty and inequality, and leaving the next generation increasingly vulnerable to the impact of the epidemic. For this reason, HIV/AIDS cannot be viewed as merely one among many competing priorities in the nation's development. Investing adequately in HIV/AIDS is now a precondition for virtually all other development investments to succeed. Ethiopia's future depends on addressing the epidemic forcefully and fast.

7. HIV started to spread in Ethiopia in the early 1980s. While data on the Ethiopian epidemic are imperfect, the following picture can be sketched with a sufficient degree of confidence. The first evidence of HIV infection was found in 1984 and the first AIDS case was reported in 1986; HIV/AIDS prevalence was low in the 1980s, but increased quickly through the 1990s, and rose from an estimated 3.2 percent of the adult population in 1993 to some 10.6 percent by the end of 1999. This makes Ethiopia the most populous country to cross the 10 percent prevalence threshold. Rates among women attending antenatal clinics at sentinel surveillance sites in Addis Ababa have exceeded 10 percent for many years and were most recently estimated at 15.1 percent. Even higher rates have been reported from Gambella (19.0 percent) and Bahir Dar (20.8 percent). There is no routine surveillance in rural areas, however, where 85 percent of the country's population live, making both the level and the trend of HIV/AIDS prevalence in these areas difficult to estimate. Although some data suggest that HIV/AIDS prevalence may be leveling off in urban areas, the evidence is by no means conclusive and there is no reason to believe that rates will remain low in rural areas. An estimated 5,000 people are newly infected each week. If incidence does not drop quickly, one-third of Ethiopians now aged 15 could ultimately die of AIDS.

8. The impact of HIV/AIDS on health in Ethiopia has been devastating. Already, an estimated 2.9 million Ethiopian adults and 150,000 children are living with HIV/AIDS, more than in any other country except South Africa and India. More than 900,000 Ethiopian children are thought to have been orphaned by AIDS. In many urban areas, half of the hospital beds are now occupied by AIDS patients. About 90 percent of reported AIDS cases are among adults between the ages of 20 and 49, the most important years from both an economic and a parenting standpoint. Among this group, AIDS is now the leading cause of death. By 2014, the number of AIDS deaths each year will be about 525,000—more than twice the 230,000 that will be expected without AIDS.

9. The two most important risk factors involved in the spread of HIV infection are unprotected sex, and having a sexually transmitted infection (STI). The peak ages for AIDS cases are 20-29 for females and 30-39 for males—which indicates that the peak ages for HIV infection are 15-24 for females and 25-34 for males. With most infections acquired through heterosexual contact, a roughly equal number of men and women are infected. However, women are infected earlier, often before the age of 20, because of earlier sexual activity and the fact that they often have older partners. HIV differs from most other STIs in that 15-24 age bracket, infection rates can be as much as 5-6 times higher among women than among men.

10. Stigma, fear, and denial are still common among the population and HIV/AIDS is also still perceived as a health issue. However, civil society has started mobilizing against the epidemic, creating a mosaic of small-scale actions promoted by local and foreign non-governmental organizations (NGOs). These actions are largely concentrated in and around the main cities, and have so far had little impact on the rural population. In addition, they operate on a limited scale, reaching only a small fraction of the population. They are not properly funded, and activities often suffer from a "stop and go" syndrome due to irregular and insufficient funding. As illustrated by the abundance of didactic material available in Ethiopia, most NGOs concentrate on public awareness; few focus on voluntary counseling and testing (VCT), community-based care, or social support. There is, however, considerable scope for strengthening the activities of national-, regional-, and local-level civil society agencies to support community-driven initiatives.

11. The interface between local government (*woreda*, *kebele*) and local community governance structures is strong in Ethiopia. These structures, often used for governmental mobilization campaigns, can be used as a basis on which the local response to HIV/AIDS can be built. Ethiopian society also features prominent traditional social groups such as the *edir* or *mahaber*, and religious committees, all of which can be mobilized in the fight against HIV/AIDS.

12. For all the difficulties in combating the epidemic in Ethiopia, there are grounds for optimism. Because very few Ethiopian children aged 5-14 are infected with HIV, they represent a "window of hope" for the country. If they can be taught and empowered to protect themselves from HIV infection before they become sexually active, they could avoid HIV infection. In countries with aggressive youth prevention programs, rates among successive cohorts of young people have dropped significantly (mainly due to delayed sexual debut). Ethiopia also has a growing number of promising HIV/AIDS

initiatives in place, both governmental and non-governmental—and if the scope of such efforts can be expanded quickly enough, the course of the epidemic could be altered.

Government strategy:

13. Ethiopia established a National Task Force on HIV in 1985. Two medium-term prevention and mitigation plans were designed and implemented between 1987 and 1996. These interventions were inadequate in scale, however, and largely ineffective in implementation, for lack of adequate stakeholder involvement in planning and implementation, especially at the community level; coordination and integration across sectors and among service providers; priority within government, society in general, and in the international community; and financial and human resources. Programs that were effective and service providers with proven credentials were simply too few and too small in scale to have an impact on the spread of the disease. With the HIV/AIDS situation worsening, the Government—assisted by UNAIDS and donors, and adopting a process of national consultation with key stakeholders—established a far-reaching policy for national mobilization. The Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia was approved in August 1998. The policy has the overall objective of providing an enabling environment for the prevention and mitigation of HIV/AIDS. Its specific objectives are to:

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

14. As the policy framework was being developed, the Ministry of Health coordinated a process of strategic planning and program development in Ethiopia's nine regions and two city administrations. This process involved national and regional governmental institutions, the major regional sector NGOs and religious organizations, and other key stakeholders. The result was a five-year Federal Level Multi-Sectoral HIV/AIDS Strategic Plan 2000-2004 (costed at US$11 million) and accompanying Regional Multi-Sectoral HIV/AIDS Strategic Plans 2000-2004 (costed at US$45 million). Together, these plans were synthesized into the Strategic Framework for the National Response to HIV/AIDS in Ethiopia for 2000-2004. The framework focuses on reducing the transmission of HIV and associated morbidity and mortality, and its impact on individuals, families, and society at large. The strategy is built on four main pillars:

multi-sectoralism, *participation*, *leadership*, and efficient *management* (including adequate monitoring and evaluation). Multi-sectoral and multi-dimensional in nature, the strategy calls for mobilizing the population at every level, from the individual and the community to regional and national organizations, and for the use of multiple implementation channels (the public and private sectors, and national and international NGOs).

15. The strategy highlights the following priority areas for action:

Prevention:

- Improve access to and quality of STI, tuberculosis (TB), and HIV/AIDS prevention, care, and support services to meet the needs of groups at increased risk of HIV infection;
- Increase the provision of comprehensive STI/TB management in health care facilities;
- Increase access to education in general and to HIV/AIDS education and communication in particular;
- Increase accessibility and availability of condoms;
- Promote information, education, and communication (IEC) messages that are continuous, appropriate, acceptable, and effective in inducing behavior change;
- Contribute to national and local initiatives to alleviate poverty and increase employment opportunities, particularly for youth and women;
- Empower women and girls to reduce their risk of HIV infection; and
- Prevent HIV transmission in hospital settings.

Care and support:

- Provide clinical and home/community-based care for PLWHA;
- Increase social support to PLWHA and their families;
- Establish an ethical, legal, and human rights framework for PLWHA;
- Expand and accelerate sector-specific interventions to mitigate impact; and
- Increase HIV/AIDS research and surveillance.

16. The expected benefits from this approach are substantial. With regard to the prevention of HIV, interventions include promoting reductions in the number of sexual partners, encouraging delays in the onset of sexual activity among adolescents, promoting the use and availability of condoms, and strengthening programs for STI prevention and treatment of opportunistic infections, including TB, and preventing parent-to-child transmission (PTCT).

17. The National AIDS Prevention Council was established in April 2000. In opening the first meeting of the Council, the President of Ethiopia, His Excellency Dr. Negaso Gidada, said, "It is high time for all of us to realize that if the [HIV/AIDS] situation is allowed to continue unabated, we will reach the point where the loss of a generation will be a real possibility." The Council, which will meet three times a year, is headed by the

President of Ethiopia and consists of members from government, NGOs, religious bodies, and broad representation from civil society. The Council will oversee the implementation of the federal and regional HIV/AIDS plans, examine and approve annual plans and budgets, and monitor plan performance and impact. The Council has appointed a National HIV/AIDS Board of Advisors to meet on a monthly basis to oversee the plan. More recently, a National AIDS Council (NAC) Secretariat was established under the Prime Minister's office to coordinate and facilitate implementation activities.

18. The Government expects that if its HIV/AIDS plans receive the support of the international community, the people and institutions of Ethiopia will have the capacity to begin to reduce the spread of the epidemic and its enormous burden on society and the economy. The first phase of the project will last three years, and will expand and accelerate existing programs, as well as improve the institutional and policy framework and build more effective monitoring and evaluation (including a process of continual impact assessments). Based on progress made and lessons learned, Ethiopia will reassess the impact of this first phase in mid-2002 and will readjust its plans as necessary.

C. SUMMARY PROJECT DESCRIPTION

19. The project will finance a US$63.4 million, three-year component of the Government's 2000-2004 HIV/AIDS Strategic Plans, and will include more than US$28 million for community-driven HIV/AIDS initiatives. The first year of the project will aim at expanding and accelerating existing prevention and mitigation programs, and building additional planning, implementation, and monitoring and evaluation capacity. The second and third years of the project will, on the basis of lessons learned, focus on mainstreaming the programs and implementation channels evaluated as most effective.

20. To achieve the above, the project will include support for:

- Capacity building, by enhancing the planning, implementation, and monitoring capacity of public, private, non-governmental, and community-based organizations.

- Prevention, care, and treatment, by expanding governmental activities that cover the full spectrum of basic prevention, care, and treatment through a multi-sectoral approach, largely at the regional level and below. The prevention measures will include, among others, IEC activities, social marketing of condoms, provision of VCT, access to STI/TB treatment, empowering vulnerable groups such as women and youth, and the prevention of PTCT. The project will also help strengthen the health infrastructure so that antiretroviral (ARV) drugs could be considered once they become affordable and accessible. Care and mitigation measures will include improved treatment, social support, and the creation and enforcement of a supportive legal framework for PLWHA and their families. The project will strengthen care activities at all levels from home-based care to tertiary care, as well as orphan care. It will also strengthen communities' capacity to deal with care issues at a local level. Special attention will be paid to the monitoring and evaluation of the epidemic to ensure that project components are regularly adjusted as needed.

- New funding channels, by creating an Emergency HIV/AIDS Fund to provide grants to community organizations, NGOs, and the private sector for HIV/AIDS prevention and mitigation measures.

- Project coordination and implementation arrangements, by establishing an effective Project Coordination Unit (PCU) in the NAC Secretariat, which is located in the Office of the Prime Minister. The PCU will be responsible for the day-to-day coordination and facilitation of the project.

21. The project will be implemented by a wide variety of public, private, and non-governmental organizations, both domestic and international, and by community-based organizations (CBOs).

22. The project will be built around three overarching principles: flexibility, speed, and coverage.

- Flexibility. The project will operate in a learning-by-doing mode, continually refining implementation arrangements and reallocating resources as lessons from experience emerge and other sources of funding become available.

- Speed. The project has been designed to ensure implementation can proceed as quickly as possible, within the limits imposed by capacity constraints. As a national emergency project, it will be largely exempt from restrictive Government administrative and budgetary regulations, and will use streamlined procedures such as community-based procurement and fast-disbursing financial arrangements.

- Coverage. The project will aim to scale up as quickly as possible. Limited implementation capacity, however, means the project will have to be built systematically. At the community level, it is expected that at least 10 percent of the country's 550 *woredas* will be added to the project each year. The speed at which new *woredas* could be added to the project will largely depend on their demand for assistance and capacity. If it proves possible for more *woredas* to take part in the project, the pace of expansion will be quickened.

23. The project has been developed in full partnership with members of the IPAA, including the other UNAIDS cosponsors active in Ethiopia. Many IPAA members are already supporting Ethiopia's HIV/AIDS effort financially or technically. Others may offer support in the coming months. The project will expand to accommodate all such support, both by relying on technical expertise of partners wherever appropriate, and by adding new funding and thereby broadening its scope. (See detailed Project Description in Attachment 2.)

24. Total project costs are estimated at US$63.4 million, including US$15.7 million in foreign costs and US$47.7 million in local cost equivalent. The project will be funded by US$2 million from the Government in cash (in addition, the Government will cover taxes and duties associated with imports related to the project, which have been valued at a

further US$3 million). Other service providers such as NGOs, the private sector, and CBOs will contribute US$1.7 million in cash and kind, while IDA will provide US$59.7 million. (See Attachment 3, Estimated Project Cost Summary.)

D. RATIONALE FOR IDA INVOLVEMENT

25. Ethiopia is one of the countries most seriously affected by the HIV/AIDS epidemic in Africa. A significant effort is required at this juncture of the situation in Ethiopia. Conscious of this, the Government of Ethiopia has enacted an HIV/AIDS policy that calls for a multi-sectoral response and the participation of multiple stakeholders. Toward this end, it has also developed a comprehensive five-year plan of action for mitigating the social and economic impacts of the epidemic. Without an injection of substantial resources, it will be difficult for the government to implement a program of this magnitude.

26. This IDA-financed Credit for Ethiopia is in direct accordance with the Bank's regional HIV/AIDS strategy, *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis.* IDA is in a unique strategic position to support the Government's Strategic Plan including the mobilization of external resources.

27. The increased focus on HIV/AIDS is also part of IDA's emerging approach to combating communicable diseases. IDA is playing a rapidly growing role in bringing into country policies the importance of HIV/AIDS in addressing such diseases as STIs and TB. IDA has also pioneered financing of communicable disease prevention in many other African countries and has developed valuable global experience in supporting emergency projects involving coordinated responses and partnerships with governments, donors, NGOs, and communities.

Major related projects financed by the Bank and/or other development agencies:

28. The Bank has not had a free-standing HIV/AIDS project in Ethiopia. However, the IDA- financed HSDP and ESDP projects have by design included HIV/AIDS activities in their programs. In addition, existing projects in the country's portfolio such as ESRDF, Roads, Energy, and Agricultural research projects are currently being considered for retro-fitting to incorporate HIV/AIDS activities. The pace of implementation of both the health and education projects has been slow and their financial management structures need further strengthening largely due to a high turnover of technical and administrative staff.

		Implementation Progress (IP)	Development Objective (DO)
Bank-financed			
The Health Sector Development Program has eight components; the health service delivery and quality of care component is designed to address HIV/AIDS from the health service perspective.	HSDP	U	S
The Education Sector Development Program includes HIV/AIDS-related activities in many of its components	ESDP	U	S
Other Development Agencies			
UNICEF UNDP WHO UNFPA GERMANY USAID Netherlands NORWAY	Ongoing programs and projects implemented by NGOs		

IP/DO Ratings: HS (Highly Satisfactory), S (Satisfactory), U (Unsatisfactory), HU (Highly Unsatisfactory)

Lessons learned and reflected in the project design:

29. The HSDP and ESDP projects are probably the first programs that by design included HIV/AIDS activities. These are new sector programs that have not been fully implemented to provide lessons learned at this stage. The experiences generated by HIV/AIDS programs undertaken by the Ministry of Health for the last 15 years indicate the following lessons:

- Attempts to include other non-government sectors will not only help increase coverage of HIV/AIDS-related activities but also widen the scope of services to be provided;
- A sector ministry (MOH) driving a complex program like that of HIV/AIDS, which demands the involvement of various stakeholders, will not be successful in generating sufficient interest and command of all stakeholders, thus pointing to the need for the creation of a National AIDS Council to coordinate the country's HIV/AIDS response at higher levels of government.
- Implementation of HIV/AIDS in a decentralized environment requires substantial attention during the transition period. Although decentralization processes require

time and capacity building, empowering regions and communities for effective local response in the fight against the epidemic is essential.

- While a number of NGOs are involved in HIV/AIDS prevention, care, and support, there is need for more efficient coordination mechanisms.
- Initially HIV/AIDS was addressed mainly as a health issue and hence all activities were directed and implemented by the health sector. Global and local experiences reveal that treatment of HIV/AIDS as a health issue alone will not address the complex issues involved in HIV/AIDS prevention. Approaching HIV/AIDS as a development crisis widens the scope and nature of interventions and ensures better management of the social-economic impacts of the epidemic .
- Adequate HIV/AIDS surveillance systems must be strengthened for effective monitoring and evaluation of the impact of HIV/AIDS interventions.

Indications of borrower commitment and ownership:

- National comprehensive HIV/AIDS policies and strategies have been adopted and are in the process of being implemented;
- A National AIDS Council (NAC) at the President's Office and its Secretariat at the Prime Minister's Office has been established to provide overall leadership for HIV/AIDS activities in the country.
- Participatory consultations with civil society, the regions, donors, and community representatives were held to seek guidance, build up ownership, and encourage local initiatives.

Financial:

NPV=US$ million; FRR=%
Not applicable

	Total (US$63.4 million)
Government	2.0
Community	1.1
NGOs, other	0.6
IDA	59.7
Total Project Cost	**63.4**

Fiscal impact:

30. For each of the physical works components, the operation and maintenance costs will be calculated and a commitment required from government to finance and carry out effective O&M on an annual basis. An annual review of Operation and Maintenance (O&M) will be carried out three months prior to the beginning of each fiscal year.

E. Project Management and Implementation Arrangements

Project implementation:

31. Each project activity will be implemented by the respective line ministry/regional bureau and NGO, or by local administrations in the case of direct assistance by the Emergency HIV/AIDS Fund (EAF). The implementing agencies will provide progress reports to the PCU on a quarterly basis. Procurement contracting and payments to contractors will be undertaken by the respective implementing agencies using World Bank guidelines, with the assistance of PCU-contracted specialists. Project implementation arrangements have been streamlined to conform to the emergency nature of the assistance. Apart from direct support for institutional strengthening of the government's focal points for project facilitation, the main thrust of the assistance will be to finance sub-projects that directly address identified needs at the community or local level.

32. Consequently, emphasis is placed on the timely flow of funds to implementing communities and organizations through contractual arrangements. Simplified procurement, disbursement, accounting, and auditing procedures will be used for sub-projects implemented by communities, NGOs, private sector firms, and local government administrative units/committees mandated to execute these sub-projects. These procedures will be set out in the Operational Manual for the HIV/AIDS Fund. The Bank's standard procedures for procurement, disbursement, accounting, and auditing will apply to the funds disbursed to other public or private institutions, as set out in *Guidelines: Procurement under IBRD Loans and IDA Credits; Guidelines: Selection and Employment of Consultants by World Bank Borrowers;* and *Financial Reporting and Auditing of Projects Financed by the World Bank.* Pre-financing of expenditures will be facilitated through the use of two Special Accounts, one of which will be dedicated to the EAF.

33. The role of the PCU, as its name implies, will primarily be one of coordination rather than implementation. The project implementing agencies will be the Federal Ministries at the national level, and the Regional Bureaux (RB) at the city government/ administration level, while at the local government level a special focus will be given to supporting community-level activities, *woreda* administrations (WAs), or zonal administrations depending upon the governmental structures in a region. Federal Sectoral Ministries (FSM) will implement national programs/activities in addition to providing technical support to RBs. FSM will also facilitate the contracting and importation of goods for the RBs with the assistance of the procurement consultants in the PCU. The Regional Secretariats, which will act as the executives of the Regional AIDS Councils (RACs), will review and consolidate annual HIV/AIDS work programs (AWPs) at the regional level, channel to the RBs funds from the NAC Secretariat for local expenditures, and provide training advisory support to WAs or equivalents. In addition, they will assess all applications from NGOs and private organizations for project assistance for regional-level programs/activities. The WAs will channel funds to support activities at the community level that may be implemented by NGOs/POs (private organizations) and community organizations, including religious establishments.

34. The PCU organization chart is provided as Attachment 4. The PCU will be organized into four main divisions. The *procurement division* will be supervised by the Assistant Project Coordinator (APC), supported by a team of procurement consultants. The *project facilitation and training division* will be headed by the Project Coordinator (PC) and assisted by a human resource development consultant to coordinate the facilitation and training activities required under the project. The *monitoring and evaluation division* will consist of one consultant reporting to the PC, but essentially working with the Monitoring and Evaluation (M&E) Unit of the NAC Secretariat. The *finance division* will be headed by a Finance Manager, who will be responsible for the management of the EAF and the accounting and finance functions of the project. He/she will be assisted in carrying out these responsibilities by a Financial Controller.

35. A review of the institutional arrangements pertaining to the project will be undertaken and completed within three months of Credit effectiveness. The review will inter alia recommend requisite structural and staffing needs for the NAC Secretariat.

Project supervision, reporting, and audit requirements:

36. The Program Implementation Manual (PIM) will delineate processes and responsibilities for general management, procurement activities, and financial management and control, including Terms of Reference for internal and external audits acceptable to the Bank. The PIM, which will be submitted to the Bank for its approval, will be finalized no later than three months after the Credit has been approved by the Bank's Board. As the proposed implementation arrangements are partially based on experience in other countries, the adaptation of these will need to be seen as a continuous process responding to local circumstances. Consequently, the PIM will be reviewed and amended by mutual agreement with the Bank as and when needed, with the first revised PIM being issued at the first anniversary of the signing of the Credit Agreement. In order for implementation to proceed without having to wait for the preparation of the PIM, *Interim Program Implementation Procedures (IPIP)* will be developed and agreed to by the Bank, and presented and discussed at a project launch workshop to be held within one month of Credit signing. All parties managing the implementation of the different components of the project will participate in the workshop. A second workshop to impart the contents of the PIM will be held immediately upon its finalization, after consultation with the Bank.

37. The PCU will submit to the Bank an AWP and on this basis will submit quarterly progress reports on achievements and problems. Similarly, it will obtain AWPs and quarterly progress reports from all implementing agencies. The PIM will further elaborate on reporting requirements.

38. Implementing agencies will provide an annual disbursement forecast to the NAC Secretariat and the EAF on amounts to be withdrawn from the Special Account on a quarterly basis. The consolidated forecast for the NAC Secretariat and the EAF will be submitted by the PCU to the Bank at least 15 days ahead of the forthcoming quarter and will be accompanied by a quarterly statement on sources and uses of funds. Financial audits for all accounts and components will be carried out annually in accordance with

Bank Guidelines. Financial audits will be submitted to the Bank and to the Audit and Control Committee of the NAC no later than six months after the end of each fiscal year. Performance and impact audits as set out in the PIM will also be carried out to assess the project's contribution to Ethiopia's HIV/AIDS program.

39. IDA's supervision of the project will need to be full-time and staff-intensive, given the "learning-by-doing" concept used for the project design. It will have to be conducted for the most part from the Ethiopia Country Office to ensure regular contact and consultation between IDA and the NAC Secretariat. This will be especially important prior to Credit effectiveness as a host of activities must be undertaken to maximize implementation in the three years of the project. In the first project year, IDA staff will have to take active part in the project launch and PIM review workshops, the workshop to review implementation progress toward the end of the year, and workshops on project implementation experience (preferably to take place at two or three decentralized locations). The supervision needs for the following two years are unlikely to diminish, as the community-level program will see rapid expansion each year. The project implementation experience workshops will become an annual feature of the project, so that lessons learned could be applied. Proper supervision will require at least two additional full-time staff in the Country Office—an implementation specialist and a specialist in community mobilization. Supervision support from the Country Office will also have to include close monitoring by a financial management specialist of the preparation for a Project Management Report-based disbursements system, as well as significant engagement/leadership from the Country Representative. (A detailed outline of the Project Monitoring and Evaluation Plan is provided in Attachment 5.)

Procurement procedures:

40. The above implementation arrangements will be supported by procurement procedures that take into account the urgency of the project as well as the nature of the participating institutions. Procurement for all IDA-financed activities will be carried out in accordance with the Bank's *Guidelines: Procurement under IBRD Loans and IDA Credits* (January 1995 and revised in January and August 1996, September 1997, and January 1999), in particular Section 3.15, Community Participation in Procurement. Consulting services by firms, organizations, or individuals financed by IDA will be contracted in accordance with the Bank's *Guidelines: Selection and Employment of Consultants by World Bank Borrowers* (January 1997, revised in September 1997 and January 1999). With respect to the EAF, the Bank's simplified Procurement and Disbursement Procedures for Community-Based Investments will be used. To facilitate speedy import of items valued at less than US$100,000 equivalent required urgently for diagnosis/treatment and institutional strengthening, contracts may be made based on international shopping and national shopping procedures, respectively, per IDA Procurement Guidelines (Clauses 3.5 and 3.6) or through procurement from the United Nations (i.e., IAPSO, UNFPA, UNICEF, WHO), provided contract awards are made within 12 months of the Credit effectiveness date.

41. Given the urgency of the project, a wide-ranging General Procurement Notice (GPN) for the first year of operations will be placed on the *United Nations Development*

Business web site without a need for hard-copy publication. The Borrower will prepare a procurement plan for the first year of project operations to be included in the PIM. The plan will include relevant information on goods, works, and consulting services under the project as well as the timing of each milestone in the procurement process. The procurement schedule will be updated every quarter and reviewed by IDA.

42. Procurement performance (including sub-project procurement activities) will be assessed on an annual basis (in the form of procurement/physical audits by an external agency). In addition to the formal annual audits, ad-hoc procurement reviews will be conducted periodically. Details of procurement arrangements are provided in Attachment 6.

Financial management:

43. The project will have an adequate financial management system in place by Credit effectiveness. Appropriate safeguards will be included in the design of the financial management system; these safeguards include the competitive recruitment of a Finance Manager and a Financial Controller, each with internationally recognized qualifications, for the management of the EAF and the project's accounting and financial functions; the centralization of accounting responsibilities in the PCU; direct payment from the PCU to *woredas* and other executing entities; and close links between and analysis of financial and physical progress reports.

44. Not all executing entities (e.g., line ministries, Regional Secretariats, *woredas*) have established financial management systems adequate for the project's demands. Before disbursing funds to these entities, the PCU will need to confirm that appropriate financial management systems are in place, including the opening of project bank accounts and employment of qualified accounts staff.

45. A Financial Management Action Plan was agreed with the Borrower at negotiations; upon completion of this plan and a subsequent assessment of the financial management system, the project should convert to Program Management Report (PMR) -based disbursements. The conversion to PMR-based disbursements is expected to happen at least 12 months after Credit effectiveness.

46. A detailed assessment of the financial management and internal control systems is presented in Attachment 6.

Disbursement procedures:

47. Timely procurement is only efficient if it is accompanied by timely disbursements. In the case of community-managed sub-projects, pre-financing of expenditures is essential as communities are unlikely to start contracting without the assurance of funds. Also at the national or central level, traditional methods of disbursement and the use of the Special Account pre-financing mechanism has to reckon with the need to open letters of credit (LC) for virtually all imports, which then leads to Special Account funds being deposited with the issuing bank as a substitute for IDA special commitments (which are

not issued for sums below the procurement prior review threshold). These funds cannot be replenished until the LCs are cashed, which can take more than six months. In addition, when a significant amount of the Credit is used to pre-finance project activities through advances to the local currency project accounts of implementing agencies, the standard 90-day turnaround time for documentation of expenditures against advances can rarely be met. Therefore, the authorized allocation for the Special Account based on a standard four-month cash flow is in most cases not sufficient. Thus, under this Credit the estimated IDA financing for the first four months of project implementation will be disbursed into two Special Accounts in the National Bank of Ethiopia or a bank acceptable to IDA. Both Special Accounts will be operated by the PCU.

48. All disbursements against expenditures originating from local currency project accounts will be made against statements of expenditure (SOEs). All procurement contracts not subject to IDA prior review will be disbursed against SOEs and documentation will be retained by the NS/PM/RS/zonal/*woreda* administrations and made available for review by IDA financial management and procurement specialists and project financial and procurement auditors. Expenditures by beneficiaries arising out of Financing Agreements signed by the EAF or NS/RS/zonal/*woreda* levels will be subject to simplified accounting procedures, review of interim reports, and random ex-post financial, physical, and technical audit to be carried out by financial and technical consultants employed by the NAC Secretariat and Regional Secretariats.

Key implementation steps in Project Year 1:

49. Given the emergency nature of the project and the need to innovate with institutional arrangements and flow-of-funds procedures, it is important that project activities be programmed for early implementation so that the process of "learning-by-doing" can begin at once. Key implementation steps and deliverables in Project Year 1 to facilitate this are listed in Attachment 4.

F. BENEFITS AND RISKS

Benefits:

50. The project will provide the following benefits to Ethiopia:

- Improved ability of households and individuals to prevent or cope with HIV/AIDS;
- Improved community response and local empowerment in mitigating the impact of the epidemic;
- Reduced poverty through improved income and food security particularly in vulnerable groups;
- Reduced HIV/STI incidence, and better diagnosis and treatment of opportunistic infections;
- Increased productivity and significant savings in public and private health care and expenditures;
- Increased local capacity to better respond to the HIV/AIDS crisis.

51. The project as designed will benefit not only groups at increased risk of HIV infection such as young people, pregnant women, commercial sex workers (CSWs), long-distance drivers, members of the defense forces, and traders, but also will address key sectors such as agriculture, industries, road construction, power and energy, and others. In addition to helping local communities reduce the adverse effects of HIV/AIDS, the project will improve the capacity of communities for involvement in other community-based development programs.

Critical risks:

Risk	Risk Rating	Risk Minimization Measure
From Outputs to Objective		
Central and regional governments, sector ministries, and community leaders may not honor their commitment to participatory development and to the creation of an enabling environment.	M	The Ethiopia Country Team, in partnership with the UNAIDS Theme Group, the Secretariat of the NAC, and the PCU, will continue to help stimulate demand and commitment at all levels. The decentralized and participatory implementation will empower many actors to help sustain political commitment.
The denial due to cultural, religious, and other reasons may make it difficult for many actors to participate effectively in the project.	M	This will be addressed by developing and implementing programs, sub-programs, and sub-projects in a fully transparent and participatory manner. All these processes will include civil society and in particular PLWHA.
From Components to Outputs		
Some ministries, regions, *woredas*, *kebeles*, NGOs, and POs may lack the capacity and resources needed to design, coordinate, and evaluate their respective components of the comprehensive project.	S	The processes and documentation required for sub-programs and sub-projects will be simplified, and standardized project design will emphasize capacity building through massive training of executing entities and technical support at all levels. Facilitation services provided by NGOs will be deployed from the regional or national level if local effective demand is found to be inadequate.
Decentralized implementation entities and communities may lack the capacity to propose and manage their sub-programs and sub-projects.	M	Rapid allocation of small resource envelopes will permit generalized learning-by-doing. *Woredas* have been given a 5 percent commission on funds they allocate to implementing entities to cover their costs. Performance-based replenishment weeds out implementing entities whose capacities are not improving. Use of simple procurement and disbursement procedures for community-based investments will be used for a large part of the project.
Government caution in empowering NGOs and CBOs.	S	Involve experienced NGOs from other countries and from the different regions in special sessions of Project Launch Workshop to share experiences and publicize early successes of NGOs and CBOs across the regions.
Slow disbursement of the loan: - due to limited financial management capacity;	H	The managers of the finance unit will need to possess internationally recognized qualifications and to be engaged on highly remunerative terms. They will lead a team,

		including an MIS Officer, in the development and implementation of the project's financial management system, which will need to be in place prior to Credit effectiveness.
- due to inadequate procurement procedures and capacities;		A large part of the project will be implemented using simplified procedures for procurement and disbursement for community-based investments. Standard small equipment and supplies needed in multiple locations will be procured via a central unit using a structured contract whereby the deliveries to the end user will be based on actual demand.
- due to delays in appraisal and approval of sub-programs and sub-projects.		Appraisal and approval of intermediate and small sub-programs and sub-projects will be decentralized to regional and *woreda* coordinating committees, using the subsidiarity principle. These committees will be provided with training and opportunities for learning by doing.
Poor intersectoral collaboration at national , regional, zonal, *woreda,* and *kebele* levels.	M	Establishment of HIV/AIDS coordinating bodies and committees at these levels will allow for coordination to take place at the lowest possible level. Sectoral components will be managed by sectoral HIV/AIDS committees.
The highly decentralized implementation mechanisms will result in unmanageable fiduciary problems, including misuse of funds.	H	Four sets of provisions have been built into the project design: Accountability to end users via participation in program and project design and implementation, and via transparency rules and use of local languages; Engagement of highly qualified finance managers in the PCU and the development of a financial management system to track and monitor project expenditures; A random financial technical and process audit of all small executing entities, and mandatory publication of all audit results, complemented by audits triggered by beneficiary complaints. Financial audits of all large scale executing entities; Integrated reports from executing entities that link performance to financial reporting.
Overall Risk Rating	**S**	

Risk Rating: H (High Risk), S (Substantial Risk), M (Modest Risk), N (Negligible or Low Risk).

On the Bank side:

52. Given the multi-sectoral nature of the country project design, the limited capacity of the newly created NAC, the number of concerned public and private parties involved in project implementation, and the use of funding mechanisms through new structures that have not been tried and tested, Bank supervision and monitoring of project implementation will require more than standard supervision. The Bank will have to ensure that: i) funding substantially above current supervision coefficients is provided; ii) the supervision task team is composed of Bank staff from various sectors and from both headquarters and country offices; iii) specialists in key fiduciary areas such as financial management, procurement, monitoring and evaluation, and social assessment are part of the supervision team; iv) the HIV/AIDS project receives regular attention from country and sector management, especially during the first year of implementation; v) at least one local and one international staff are recruited to support implementation of the project; and vi) ACT*africa*, UNAIDS, and major stakeholders outside the Bank remain involved in assessing progress. In addition, the existing partnership between the Bank's country team and ACT*africa* should be continued.

G. Main Credit Conditions

Effectiveness conditions:

- The Borrower has adopted the PIM;
- The Borrower has appointed a Financial Manager and Financial Controller both acceptable to the Association;
- The Borrower has established an accounting and financial management system satisfactory to the Association;
- The Borrower has appointed a PC, an APC, and a senior procurement consultant satisfactory to the Association.

Readiness for implementation:

- Preparation of the project implementation plan including the first-year AWP has been prepared and is being finalized; and
- The procurement plan for first-year activities is completed prior to Credit effectiveness.

H. Compliance with Bank Policies

53. The project complies with all applicable Bank policies.

Gebreselassie Okubagzhi	**Arvil Van Adams**	**Oey Astra Meesook**
Task Team Leader	**Sector Manager**	**Country Director**

Attachment 1. Ethiopia Multi-Sectoral HIV/AIDS Project Logical Framework

Hierarchy of Objectives	Key Performance Indicators	Monitoring & Evaluation	Critical Assumptions
Sector-related CAS Goal: To mitigate the negative social and economic impact of HIV/AIDS in Ethiopia	Long-term Project Indicators: The number of people below the absolute poverty line will either stabilize or reduce by the end of 5 years from the start of the Project. Life expectancy should stabilize or begin to increase 5 years after the start of this Project.	Project Reports:	
Project Development Objective: To give urgent support to scale up and accelerate the rapid implementation of the National Strategic Plan in the provision of HIV/AIDS prevention, care and support services at all levels and in all sectors.	Outcome/Impact Indicators: Access to treatment for opportunistic infections increased from 30% to 50%. The number of national surveillance sites will have increased by 2 within 1st year and by 10 by the end of year 3. Reduce HIV/STI prevalence	 Base line and follow-up surveys Base line and follow-up surveys Base line and follow-up surveys	(From Purpose to Goal) There will be no major drought during the life of the Project Educational opportunities will remain at least as favorable as they are currently for Ethiopians.
Hierarchy of Objectives	**Key Performance Indicators**	**Monitoring & Evaluation**	**Critical Assumptions**
Output from each component: 1. Capacity of HIV/AIDS Councils, Government Agencies, Non Governmental Organizations (NGOs), Community Based Organizations (CBOs), Private sector, and Civil society at all levels built.	Output Indicators: 1.1. Functioning AIDS Council will have increased as follows: * Regional, from 1 to 11, by the end of year 1of the project. * Zonal, from 0 to 20 and Woreda, from 0 to 165, by the end of year 3 of the Project. 1.2. Councils at all levels (in participating Woredas) have defined Work Programs by the second year of the project;	Examination of records of the Secretariat of the NAC. Examination of the Consolidated Progress Report from all Council levels.	(From Outputs to Objective) Continued Government support to use of NGOs, CBOs, POs, and Civil society. Continued Government support to funding mechanisms.

2. Governmental Multi-sectoral response to HIV/AIDS epidemic expanded.	2.1. Drugs for the treatment of STD and tuberculosis and opportunistic diseases will be available in 90% of health institutions in participating Woredas by end of the project; 2.2 The number of affordable Voluntary Counseling and Testing services incorporated into ANC, TB and STD clinics will have increased by 10 % by end of Project; 2.3. Increased use of condoms at last sexual contact among young (14-19) by 20 % by end of year 3; 2.4. The number of blood banks will have increased by 25% by end of Project; 2.5. 80% of the population will be aware of HIV/AIDS and its prevention in participating Woredas by the end of the project; 2.6. Increase in the number of active Anti-AIDS Clubs in High Schools – Year 1 = 25% increase over base year 2000 with an additional 20% increase each of the two following years;	Reports from MOH, Rib's and health institutions Reports from MOH, Rib's and health institutions Annual Surveys Reports from MOH, Rib's and health institutions Report from PLWHA Report from Ministry of Education	The condoms distributed will be used by the recipients.
3. Emergency HIV/AIDS community initiatives and NGOs, CBOs, Private sector, Civil society, and PLWHA service delivery funded.	3.1. At least 70% of the participating *woredas* have implemented their agreed action plans; 3.2 EAF disbursements are at least 70% of the planned level;	Found in the Financial and Annual Audit Report of the NAC Secretariat. Reports and visits to regional health bureaus, NGOs, Religious Institutions, and Regional HIV/AIDS Councils.	

Hierarchy of Objectives	Key Performance Indicators	Monitoring & Evaluation	Critical Assumptions
4. Project activities and resources well coordinated and managed.	4.1. Procurement unit will have been made functional according to standard practices at national level Procurement units will have made procurements with Project funds in accordance with auditable practices as follows: --National level – within 3 months of Project effectiveness. --Regional level – within 12 months; 4.2. Funds distribution and financial management mechanisms will have been installed within 6 months after Project effectiveness at the national level.	Progress Report	
Project Components & Activities: 1. Capacity building for Government and Civil society a) Equipping, training & providing resources to the National Regional, Zonal and Woreda HIV/AIDS Councils to play their role as coordinators and facilitators b) Enhancing capacity of NGOs. Private sector, CBOs to better respond to HIV/AIDS epidemic. 2. Expansion of Multi-sectoral intervention to control HIV/AIDS a) Strengthen STD/TB services: access to STD/TB clinics for diagnosis, treatment, training on syndromic approach and counseling for STD/TB patients; b) Expanding voluntary counseling and testing services c) Promoting the use of condom by expansion of social marketing and other channels; d) Ensuring safe blood supply with the help of Blood Banks and reducing occupational exposure;	US$8.8 Million US$19.7	Project Reports: Progress Reports Audit Reports Supervision Reports Progress Reports Audit Reports Supervision Reports	(From Components to Outputs) The disbursement of funds from the Government of Ethiopia and The World Bank will proceed according to plan. NGOs, CBOs, POs and Civil society participate in the training programs. Information provided to NGOs, CBOs, POs and Civil society to upcoming training programs to improved capacity. The policy framework is adequate for moving forward with the activities of this Project. Drugs related to STD/TB treatment and HIV testing will be available in a timely manner. There will be leaders at the kebele level who will be willing to receive training and form HIV/AIDS Committees.

Hierarchy of Objectives	Key Performance Indicators	Monitoring & Evaluation	Critical Assumptions
e) Gender specific interventions to help girls and women access to care, education and economic opportunity; f) Care and support and provide legal framework for human rights to HIV/AIDS affected families. g) Mobilize multi-sectoral line ministries to disseminate IEC materials and interventions in their workplace; h). Conduct periodic cross-sectoral surveys and organize sentinel surveillance; i). Disseminating HIV/AIDS information by IEC mass campaign;			Teachers, social workers and rural extension workers will accept and use latest information and materials on HIV/AIDS prevention. Resistance to HIV/AIDS information by parents will be minimal in most regions.
3. Emergency HIV/AIDS Fund a) Funding community initiatives for the care, prevention and control of HIV/AIDS; b) Providing matching grants for uninterrupted and sustain service delivery by NGOs, CBOs, PO and Civil society; c) Expanding the capacity and visibility of PLWHA to control HIV/AIDS and to be the custodians of human rights against stigma, denial and discrimination.	US$28.1 Million	Progress Reports Audit Reports Supervision Reports	
4. Project Coordination and Management Program Planning; PCU Operations; Fund Management; Accounting FMS; Economic & Social Assessment; Monitoring and Evaluation.	US$6.0 Million	Progress Reports Audit Reports Supervision Reports	

Attachment 2. Project Description

Component 1: Capacity Building for Government Agencies and Civil Society (US$8.8 million)

The purpose of this component is to enhance the institutional capacity of governmental agencies, civil society, and the private sector at the national, regional, zonal, *woreda*, and *kebele* levels, to plan and execute multi-sectoral activities to combat the HIV/AIDS epidemic. The component will strengthen a) the National AIDS Council (NAC) and its decentralized bodies; b) government agencies; and c) NGOs, the private sector, and CBOs.

Capacity-building support will consist of the deployment of skilled and experienced manpower to staff essential structures; the provision of equipment and materials; and training and technical support, especially in areas essential to implementation (which will include program development, expansion and outreach, financial management, procurement, and monitoring and evaluation).

a) Strengthening the National AIDS Council and Its Decentralized Bodies

Ethiopia recently created AIDS Councils and Secretariats at the national level and in five of the country's regions, including two of the major urban areas. These structures need strengthening, and similar structures have to be created in six other regions in order to achieve national coverage.

The NAC Secretariat, which is responsible for coordinating Ethiopia's response to the HIV/AIDS epidemic by providing guidance and facilitation to decentralized bodies and other institutions (e.g., NGOs, the private sector, CBOs), will be provided financial and material support, and endowed with the capacity to monitor and evaluate the project.

The regional[1] HIV/AIDS Councils and their Secretariats are key institutions in the fight against HIV/AIDS, and will play a leading role in helping the Government to implement the project in a decentralized way and to provide support to *woredas* and *kebeles* to deliver community-level programs. The majority of regional HIV/AIDS council members will be from civil society, based on agreed composition lists. The heads of the regional secretariats will be selected by the regional HIV/AIDS councils using a competitive process that will ensure the identification of a competent coordinator with good technical, organizational, and managerial skills. A Regional Secretariat will have at least three technical staff—a Head of Secretariat who will also act as a Project Coordinator, a Financial Manager, and a Program and Training Officer. The Financial Manager (with appropriate internationally recognized qualifications) and the Program and Training Officer will also be selected on a competitive basis. The project will

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[1] A small part of the assistance planned for regions will be used for zones, which are administrative units within regions but do not generally operate within a participatory framework in the way that *woredas* and *kebeles* do. In Southern Nations and Nationalities and People's Region, however, zones play a role akin to that of a small region.

finance initial equipment and materials as well as operating costs for the regional secretariats.

Woreda HIV/AIDS councils will be responsible for coordinating HIV/AIDS-related activities carried out in *woredas*, in particular information dissemination, facilitating the formation of *kebele* HIV/AIDS committees, organizing training on project preparation, and encouraging communities to prepare projects for funding. The *kebele* HIV/AIDS committees will focus on raising community awareness of HIV/AIDS, deciding on what HIV/AIDS activities should be submitted to a *woreda* for financing, implementing HIV/AIDS prevention, mitigation, and care activities, and providing feedback on their impact. The majority of members of both *woreda* councils and *kebele* committees should be from civil society, and should include representatives of religious organizations, youth, women, and PLWHA. The project will build capacity at these levels by funding running costs, basic equipment and materials, workshops, training, and outreach activities.

b) Improving Government Agencies' Multi-Sectoral Implementation Response Capacity

Government efforts to improve multi-sectoral institutional capacity to expand and implement HIV/AIDS activities will focus on 10 ministries and commissions on the front line in combating the epidemic: the Ministries of Health, Defense, Education, Agriculture, Labor and Social Affairs, Information and Culture, Trade and Industry, the Women's Affairs Office, and the Commissions of Science and Technology and of Disaster Prevention and Preparedness. The objective will be to mainstream HIV/AIDS concerns and activities in these agencies.

The project will finance, for each agency, based on detailed institutional improvement plans, equipment and material, staff training, and technical assistance. The latter will be provided in the areas of program innovation, expansion, and implementation; policy and planning review; outreach activities; and the monitoring and evaluation of the impact of HIV/AIDS prevention, mitigation, and care activities.

c) Enhancing the Capacity of Civil Society to Respond to the HIV/AIDS Epidemic

While the private sector and international NGOs working in Ethiopia have the capacity and resources to develop and implement HIV/AIDS programs, local NGOs and CBOs will benefit from support to improve and expand their institutional capacities. The project will provide funding in the form of training, workshops on important thematic areas and planning/implementation, and the provision of a limited amount of equipment, material, and other costs to scale up their activities. In addition, NGOs and religious organizations will be contracted to mobilize and support CBOs in the areas of community organization, training, and technical services, especially in parts of the country where CBOs are weak.

Funding for capacity building for FY2000/2001 should be allocated on the basis of an inventory of relevant ongoing government, donor, and NGO-financed capacity-building activities, leading to the definition of priorities and criteria. The inventory/

prioritization exercise will be managed by the PCU and the results considered and approved by the NAC. The FY2001/2 and FY2002/3 tranches will be approved by the National Advisory Board formed by the NAC.

Component 2: Expanding Governmental Multi-Sectoral Response (US$19.7 million)

The purpose of this component will be to support a major expansion of HIV/AIDS activities being implemented by Government entities. Sixteen ministries, agencies, and NGOs with formal links to the Government have prepared sound, costed HIV/AIDS . plans as part of Government's strategic planning process.[2] The plans include activities targeted both at the *staff* and the *clients* of the implementing agencies. All these entities will be eligible for support under the project, as will additional ministries and agencies once they develop their own plans. The plans encompass the full spectrum of activities in prevention, treatment, care, and support. The framework below is derived from these plans and presents an illustrative (but not exhaustive) list of activities to be supported under Components 2 and 3.

Expansion of STI/TB services adapted to the needs of specific groups at increased risk:

- Creation of user-friendly STI clinics focusing on commercial sex workers (CSWs) and their clients in red-light districts;
- Training of CSWs in red-light districts in order for them to provide peer counseling to other CSWs;
- Provision of user-friendly STI/TB services for adolescents; and
- Provision of HIV/AIDS-related information, and referral to VCT centers as appropriate.

Management of STIs:

- Training of trainers at the regional level on the syndromic approach to STI management;
- Training of health personnel on the syndromic approach at the zonal, health center, and health station levels;
- Provision of STI treatment in all health facilities using the syndromic approach;
- Systematic screening of pregnant women during antenatal care with the standard kits, down to the health center level (and including partner referral); and

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[2] The Ministries of Health, Labor and Social Affairs, Education, Defense, Information and Culture, Agriculture, Trade and Industry, Transport and Communications; the Women's Affairs Office of the Prime Minister's Office; the Disaster Prevention and Preparedness Commission; the Coffee and Tea Authority; the Christian Relief and Development Association; the Ethiopian Red Cross Society; the Society for the Advancement of Human Rights Education; the Organization for Social Services for AIDS; DKT-Ethiopia (social marketing firm); and the Science and Technology Commission. The plans are synthesized in the *Summary of Federal Level Multi-sectoral HIV/AIDS Strategic Plan 2000-2004.*

- Provision of HIV/AIDS-related information, and referral to VCT centers as appropriate.

Condom promotion and accessibility:

- Expansion of condom social marketing countrywide, including in remote rural areas;
- Ensuring the availability of condoms in all hotel rooms countrywide;
- Installing and regularly supplying condom boxes in bars, hotels, restaurants, barber shops, taxis, etc;
- Regularly supplying condoms in AIDS clubs in junior high and high schools;
- Increased condom promotion among civil society groups, particularly among the military and police; and
- Examination of means to adapt expiration dates printed on condoms to the Ethiopian calendar.

IEC campaigns:

- Producing audio messages in the main languages for broadcast on national and regional radios;
- Preparation and distribution of IEC materials specific to various audiences;
- Use of folk entertainment in HIV/AIDS campaigns, particularly in rural areas;
- Use of sports (e.g., AIDS football clubs) and sports heroes as advocates;
- Supporting and encouraging PLWHA to participate as advocates in HIV/AIDS campaigns;
- Strengthening AIDS clubs in schools by:
  - establishing formal linkages with the school in order to ensure proper and regular functioning;
  - training selected students to provide peer counseling;
  - providing audiovisual (television, video) and audio equipment;
- Producing short, engaging video spots to broadcast on national television and disseminating them through video to theaters (between movies);
- Financing HIV/AIDS-related dramas by theater groups, puppet shows, drummer and dancers groups, etc.;
- Mass production of audio cassettes containing popular songs, interspersed with engaging IEC messages for wide dissemination;
- Production of highly engaging posters in major languages countrywide;
- Producing, printing, and disseminating comic strips on HIV/AIDS-related subjects specifically designed for populations with low literacy levels; and
- Maximizing involvement of religious leaders and organizations in IEC efforts.

Gender-specific interventions:

- Development of age-appropriate IEC messages for women of reproductive age (15-49);

- Involving representatives of the Committee against Harmful Traditional Practices in HIV/AIDS councils and committees at local levels;
- Provision of life-skills training for young girls; and
- Micro-financing programs for those infected and affected.

Ensuring a safe blood supply and preventing occupational exposure:

- Standardizing and disseminating universal precaution guidelines to health care workers in the formal and non-formal sectors;
- Provision of requisite supplies and services to ensure observation of universal precautions by health workers in the formal and non-formal sectors, including traditional birth attendants (TBAs);
- Training health personnel to minimize the risk of occupational exposure to HIV;
- Training health personnel and hospital clinicians on the appropriate use of blood or blood alternative (e.g., plasma expanders);
- Equipping all hospitals (where surgery is being performed) with blood bags and HIV rapid tests (and possibly also hepatitis B and syphilis testing) to facilitate immediate transfusion with blood collected from relatives; and
- Training of laboratory technicians on HIV testing and guidelines for blood transfusions.

Care and support:

Care of people living with HIV/AIDS:

- Training of health workers in diagnosis and clinical management (i.e., recognition of AIDS-related conditions, the use of available standardized treatments, and carrying out the requisite follow-up in terms of the medical and psychosocial services needed for the patient and household);
- Provision of essential drugs for the treatment of opportunistic infections; and
- Support and training for home- and community-based care for AIDS patients and their household members.

Social support for people living with HIV/AIDS:

- Provision of social support (household assistance including the care of orphans and vulnerable children, school fees, food supplements) to those infected with HIV/AIDS;
- Provision of home-based social support by social workers (hired at the health center level) performing outreach activities to those infected with HIV/AIDS; and
- Training of home-based care providers, such as training to involve PLWHA.

Alleviation of the social impact of HIV/AIDS:

- Enforcing the legal framework related to the protection of PLWHA; and
- Providing IEC on the reduction of stigma and discrimination faced by PLWHA and their households.

It is anticipated that all ministries will serve as channels for IEC messages. The list below is relevant to ministries that will serve as primary providers of the indicated services.

Education:

- Beginning HIV/AIDS education during the final year of primary education;
- Including HIV/AIDS/STI information in school curricula (social science, biology, health hygiene, civic education, etc.) from the junior high school level on up;
- Linking HIV/AIDS club activities with classroom-based activities and exploring means of increasing the appeal/effectiveness of these clubs (provision of membership items, such as T-shirts, etc.);
- Developing guidelines, training, and materials for teachers;
- Supplying selected school HIV/AIDS clubs (based on regular activities or contests) with televisions, VCRs, or audio material;
- Designing, printing, and distributing age-appropriate, high-quality, self-explanatory brochures directed at high-school students, aiming to disseminate the information within the student's household.

Trade and Industry and Transport and Communications:

- Providing targeted IEC, distribution, and advocacy of condoms to long-distance truck drivers and service workers, including CSWs.

Defense:

- Providing targeted IEC, distribution of condoms, and STI treatment to military personnel.

Agriculture:

- Providing IEC through agricultural extension workers and Service Cooperatives, and to agricultural workers in state farms.

Women's Affairs:

- Involving representative(s) of the Committee against Harmful Traditional Practices in AIDS councils at the central and regional levels.

Labor and Social Affairs:

- Involving this sector to ensure care and support activities in addition to workplace interventions.

Information:

- Providing the necessary support for transmitting key messages through the major media.

Science and Technology Commission:

- Providing support to research institutions to conduct HIV/AIDS-related studies.

Disaster Prevention and Preparedness Commission:

- Promoting and supporting HIV/AIDS activities in refugee camps and internally displaced populations.

HIV/AIDS research:

- Conducting periodic cross-sectional surveys of sexual behavior, representative of the whole country (urban/rural mix and population diversity) using standardized methodology and questions, and providing training, supervision, and quality-control checks;
- Identifying critical determinants of behavior change among young people, especially young girls;
- Monitoring the socioeconomic impact of the HIV/AIDS epidemic;
- Identifying behavioral and attitudinal factors to limiting condom use among men and women (both adolescents and adults);
- Organizing a pilot study on female condom use by CSWs; and
- Examining alternatives to HIV testing of blood (e.g., use of saliva-based tests, urine).

HIV/AIDS surveillance:

- Organizing antenatal clinic-based sentinel surveillance for the whole country (number of sites and size of sample proportional to the urban/rural mix and population size), using a simple reliable rapid test, and providing training, supervision, and quality-control checks; and
- Exploring the possibility of linking biological and behavioral surveillance for HIV, especially among young people.

Other interventions:

Expansion of VCT services, including the establishment of linkages with appropriate follow-up services (e.g., contraception promotion among women of reproductive age) down to the health center level.

During the life of the project, the Government will review the case for piloting programs to prevent PTCT, and strengthening the health infrastructure for ARV drug therapy if and when it becomes accessible and affordable. Pursuant to Government guidelines and national ethical clearance, such programs will be considered for support under the project.

Funds for this component will be disbursed directly to participating government agencies from Special Account B. For FY2000/20001, the initial allocation will be made on the basis of the most pressing immediate needs. During the first weeks of implementation, the PCU will carry out diagnostic work, possibly by contracting it out, to identify additional needs. This work will comprise an inventory of ongoing HIV/AIDS activities being carried out by the various government entities, a basic assessment of their overall effectiveness, and a prioritization between various potential programs on the basis of capacity in place. This work will be approved by the National Advisory Board by 30 November, 2000.

For subsequent years, each national-level structure will be responsible for submitting an Annual Action Plan to the PCU. Funds will be disbursed against agency annual HIV/AIDS work programs (AWPs) approved by the National Advisory Board. Annual plans will be expected to place special emphasis on reaching vulnerable groups such as youth, street children, CSWs, and mobile populations including the military and refugees (as relevant within the mandate of the implementing agency). Before funds could flow to a regional bureau of a participating agency, a Regional AIDS Council (RAC) and Secretariat will need to be established.

Component 3: The Emergency HIV/AIDS Fund (US$28.1 million)

The Emergency HIV/AIDS Fund (EAF) aims to expand the response of communities, NGOs, and the private sector to better manage the epidemic crisis. This demand-driven fund will channel funds directly to NGOs, religious organizations, the private sector, and local communities on a cost-sharing basis to finance multi-sectoral HIV/AIDS programs. The EAF will have the following fundamental characteristics:

- Participatory identification and selection of local HIV/AIDS initiatives;
- Mandatory counterpart contributions of selected NGOs and private sector recipients;
- Transparent management of resources;
- Local implementation of HIV/AIDS initiatives;
- Random ex-post technical, financial, and impact audits;
- A fast-disbursing financial system; and
- Periodic and regular financial and impact reporting.

The EAF will have two windows: one for NGOs and the private sector, the other for local community initiatives in *woredas* and *kebeles*. Funding will be subject to contractual arrangements, with obligations to report, plus results-oriented and monitorable indicators and clearly defined financial accountability and transparency. EAF payments will be disbursed directly to *woredas*.

For NGOs and the private sector, EAF matching funds will be provided only for a positive list of eligible HIV/AIDS activities and will cover prevention, care, support, treatment, and behavior change-related activities. Cost contributions will be in cash and will be reviewed on a case-by-case basis, but minimum contributions envisaged are 10 percent from local NGOs, rather more from international NGOs, and 20 percent from the private sector. Activities covered will include IEC, awareness, and prevention campaigns, the preparation and diffusion of didactic material in local languages (radio, video, pamphlets, newsletters), VCT activities, condom distribution, promotion of HIV/AIDS-related drama and folk shows, support to orphans, and AIDS community-based care initiatives. These will also include income-generating activities, support to HIV/AIDS clubs, financial assistance to AIDS patients and orphans, provision of drugs for opportunistic infections, sensitization campaigns against stigma and discrimination, promotion of behavior changes, psychosocial support, targeted life-skills training to vulnerable groups, school fees, and food allowances. The cost sharing will be in cash and reviewed on a case-by-case basis, but minimum contributions envisaged are 10 percent from the NGOs and 20 percent from the private sector. The selected programs could be at the national, regional, and/or local levels.

The funding for local initiatives through *woreda* administrations (WA) and to *kebeles* will cover the same range of activities in prevention, care, support, treatment, and behavior change. The cost-sharing will be in kind, labor, or cash, with a minimum contribution of five percent from the community.

The project will expand support to PLWHA. It will increase their capacity, visibility, and activities to better mitigate the epidemic, in addition to addressing human rights and fighting against stigma, denial, and discrimination. In addition to the above-mentioned activities, the EAF will provide funding to PLWHA associations in the areas of care and support for affected families, training for succession planning and positive living, social and household support, the promotion of advocacy, the creation of PLWHA organizations and networks, and updates on medical research. The list of eligible activities under the EAF will be the same as the illustrative list provided above for Components 2 and 3 of the project.

Since the EAF is meant to promote demand-driven initiatives from NGOs, the private sector, and communities, an intensive promotional campaign will be undertaken by the NAC and RACs in collaboration with local governments and NGOs.

The proposed implementation arrangements for the component will be based on the following principles: i) participatory identification of needs by the concerned recipients; ii) flexibility and simplicity, with phased empowerment of local communities and gradual enlargement of the range of local initiatives; iii) implementation of HIV/AIDS initiatives by NGOs, private contractors, or communities themselves; iv) ownership, transparency, and accountability at all levels based on clear contractual agreements; and v) responsibility for technical supervision, monitoring, and evaluation of the HIV/AIDS initiatives in the hands of the NAC and RACs.

A National Review Board of the NAC will be established to select NGOs and private sector proposals at the national and inter-regional levels. Likewise, a Regional Review Board of the RAC will select NGO/private sector proposals of regional and local scope. These reviews will be guided by criteria and procedures to be included in the Program Implementation Manual (PIM). Upon approval, instructions will be sent to the EAF to effect direct payments to the recipient's bank account.

The amount of funds provided for each NGO/private sector proposal will depend on the targeted population, the prevalence rate, and criteria relating to activity eligibility. For national-level activities a limit of US$500,000 per proposal, with appropriate tranching, will initially be observed. For regional-level activities the limit will be US$200,000 per proposal, with tranching. These limits will be reviewed with experience. They will not apply to proposals specifically intended to procure and distribute inputs such as condoms or drugs for opportunistic infections; financing for these will be determined on the basis of coverage. A contractual agreement will be signed with the recipient describing proposal content, mutual obligations, payment modalities, and penalties in case of financial mismanagement.

EAF funding for local government and community initiatives is expected to reach at least 30 percent of Ethiopia's *woredas* during the three years of project implementation.[3] The access of communities to this fund will be based on clear and specific eligibility criteria to be detailed in the PIM. For first-time eligibility, criteria will include establishment of an HIV/AIDS community forum at the *woreda* level, appointment of project facilitation staff, and provision of training to representatives of beneficiary communities. Each participating *woreda* will receive an initial allocation based on a sum of US$1,000 per *kebele*. Funds will be disbursed directly to the WA's bank account, and will be replenished upon satisfactory use of each tranche in accordance with the procedures set out in the PIM.

Component 4: Project Coordination and Management (US$6.8 million)

The project organization chart is provided as Attachment 4. The overall management and coordination of the project will be entrusted to a PCU in the NAC Secretariat. The PCU will be a lean structure, with management of most day-to-day

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[3] In order to have a real impact on the epidemic, EMSAP should reach national coverage in the shortest possible time. If during project implementation it becomes evident that implementation of EAF can proceed more quickly than foreseen, particularly with regard to coverage of *woredas/kebeles*, then the EAF will accelerate its operations.

activities being the responsibility of executing line ministries, regional secretariats and bureaux, and zonal/*woreda* administrations. The main responsibilities of the PCU will be coordination, liaison, supervision, monitoring, and longer-term planning and policy support. In addition, it will oversee the financial management and procurement functions of the project.

The PCU will be headed by a Project Coordinator (PC), who will be supported by an Assistant PC. They will oversee a core of expert contract staff selected to handle the financial and procurement aspects of the project. To facilitate the programming, coordination, and monitoring of project operations, the PCU will, through the Secretariat, report to the NAC Board of Advisors. The Board will convene once a month to review the progress of the project, to ensure complementarity and efficient coordination of the activities of the different project components, and to consolidate activity plans, budgets, and progress reports.

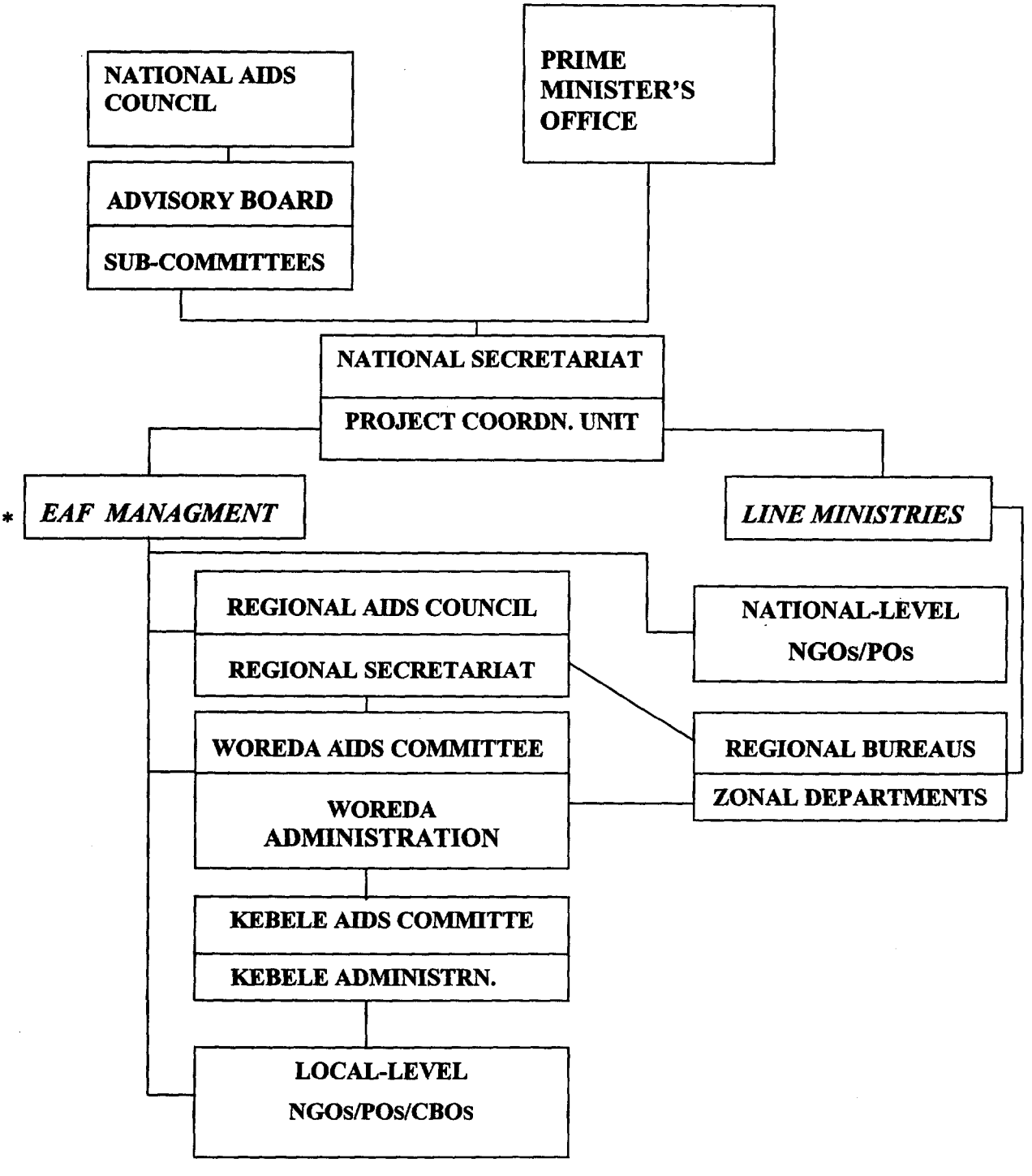
The PCU will prepare documents for the NAC Secretariat to submit to the Board, including consolidated AWPs, related annual budget proposals, and regular progress/performance reports. These will be based on the AWPs and budgets prepared by the executing agencies of the different project components and activities.

Attachment 3. Estimated Project Cost Summary ($US million)

Component	Indicative Costs (US$M)	% of Total	Bank Financing (US$M)	% of Total Bank Financing
1. Capacity Building for Government Agencies and the Civil Society	8.8	14	7.6	13
2. Expand Government Multi-sector Response	19.7	31	19.0	32
3. Emergency HIV/AIDS Grant Fund	28.1	44	26.4	44
4. Project Coordination	6.8	11	6.7	11
Total Project Costs	63.4	100	59.7	100

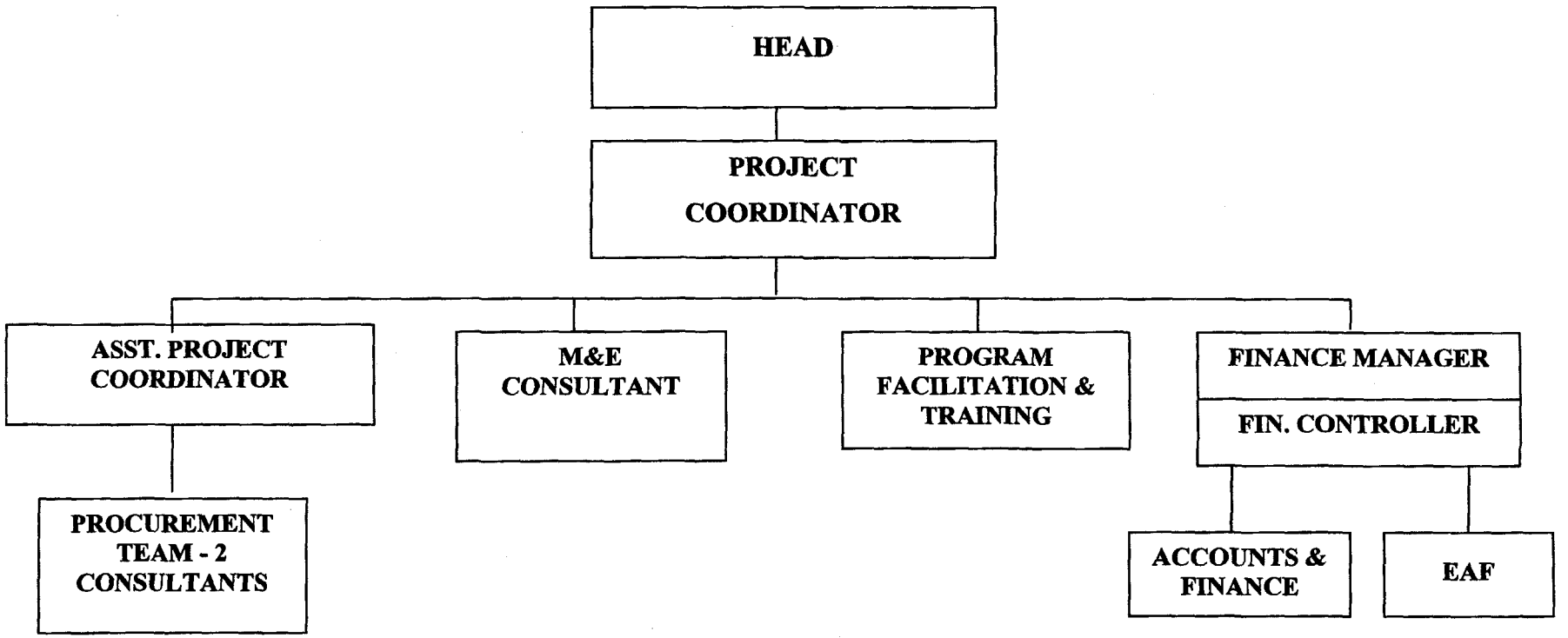
Project Cost by Category	Local US$ Million	Foreign US$ Million	Total US$ Million
Investment Costs			
Equipment	0.3	10.5	10.8
Furniture	0.4	0.0	0.4
IEC Materials	3.1	0.0	3.1
Vehicles	0.0	0.6	0.6
Training	5.9	0.0	5.9
International Technical Assistance	0.0	2.6	2.6
Local technical Assistance	4.6	0.0	4.6
Grants to Communities, NGOs & PLWHA	24.4	0.0	24.4
Total Investment Costs	38.8	13.7	52.5
Recurrent Costs			
Staff Salaries	0.7	0.0	0.7
Operations & Maintenance	1.9	0.0	1.9
Stationery & Office Expenses	0.7	0.0	0.7
Total Recurrent Costs	3.4	0.0	3.4
Total Baseline Costs	42.1	13.7	55.8
Physical Contingencies	1.6	1.4	3.0
Price Contingencies	3.9	0.7	4.6
Total Project Costs	47.7	15.8	63.4

Attachment 4. ETHIOPIA MULTI-SECTORAL HIV/AIDS PROJECT ORGANIZATION CHART



* EAF= EMERGENCY HIV/AIDS FUND

Project Coordination Unit



Implementation Arrangements for Community-Level, NGO, and Private Sector Interventions

Under the project, a large number of initiatives will take place at the community level. The presumption is that effective local actions can only happen if the beneficiary communities (BCs) take direct responsibility for activities that aim to benefit them. Consequently, the role of government is to provide facilitating support. The approach requires that the BCs should feel involved in all phases of the programs addressing their needs. Thus, participation by a community has to be an overriding consideration in designing project procedures, including procurement, financial management, and funds disbursement. Bank international experience in such community-level investment operations has shown that *participation can be a good substitute for control.* For all these functions, but particularly for procurement and disbursement, project staff, and beneficiaries will have to be much more extensively trained than for normal Bank-assisted projects, because numerous tasks will be performed by decentralized units and people who have little experience with them. Also, there will have to be support for a strong IEC campaign that will, firstly, create awareness among potential beneficiaries of the assistance available under the Credit, and secondly, make available to communities, associations, NGOs, and private and public bodies standardized agreement/contract forms to enable communities to apply for assistance and to manage sub-projects.

Assistance to communities:

The EAF will provide assistance to communities in the following ways :

- By providing annual grants to WAs, which, after approving applications, will send these funds to communities for carrying out HIV/AIDS- related activities according to criteria established by EAF; and

- By government contracting with a private agency or NGO to provide specific HIV/AIDS-related services to communities.

A community will be defined for project purposes as one of the following:

- A population living within the confines of a geographical area delimited by an administrative boundary at the level of local government (*woreda* or equivalent) or below (e.g., *kebele*);

- A group of 10 or more people coming together to prevent and treat HIV/AIDS and care for those infected and affected, and being accepted by a *woreda* or *kebele* administration (or equivalent) as a bona fide group; traditional groups such as the *eider* (voluntary funeral support group) and *mahaber* (diverse social activities) as well as religious organizations will meet this criterion;

- Any legally registered club, association, or cooperative that is assessed by the *kebele* or *woreda* administration (or equivalent) as capable of carrying out HIV/AIDS activities. This will especially include PLWHA associations.

A *woreda* is the equivalent of a district and on average has a population of around 100,000 persons (but could be substantially larger where it includes a major town within its boundaries). A *kebele* is the equivalent of a borough and has a population of around 1,000 families (or about 5,000 persons). A *kebele* has an administrative unit composed normally of five elected representatives, with a chairman and members responsible for the following functions: treasury, secretarial, judicial, consultation with elders, and security. A *woreda* has a council usually comprised of three elected representatives from each *kebele* who in turn elect from among themselves a chairman and members to head various portfolios in the WA. Each *woreda* has its own finance unit with an accountant and treasurer selected by the Regional Finance Bureau. Regional variations exist in the structure of the administrative units and these will be accommodated in selecting *woredas* and their equivalents.

For project purposes, an NGO will be defined as a non-profit organization that is not owned by government or managed by its appointees, and is engaged in activities that benefit communities and help populations improve their economic and social well-being using resources that are either provided by the organization, managed by the organization, or both. The organization will be legally registered under the appropriate Ethiopian law.

For project purposes, a private sector organization will be defined as a company incorporated under Ethiopian law or any individual who is able to provide evidence of successfully organizing HIV/AIDS activities at the community level, mobilizing resources for this, and contributing his/her own resources both in terms of time and funds.

Block grants to *woredas:*

Block Grants (BG) will be provided to WAs:

- To finance small projects, referred to hereafter as *community sub-projects*, that have been subject to formal preparation resulting in the WA receiving from communities a brief document containing a technical, administrative, and financial plan and an application for funds (the format for this will be provided in the PIM); this document will also detail proposals for community contributions to financing the sub-project.

- By granting each *kebele* an initial sum of US$500 to carry out any activity that is among the eligible activities in a positive list to be provided by the PCU. This small grant will be funded out of the BG to be received by a *woreda* and sent to its *kebeles* by the WA upon approval by the *Woreda* HIV/AIDS Advisory Committee (WAC).

Identification, selection, and approval of community sub-projects and small grants:

Community sub-projects will be approved on the basis of preparation documents submitted to the WAC. The WA will employ an HIV/AIDS Facilitation Officer (HFO) who will review the documents and submit a recommendation to a meeting of the WAC. The WAC will select the proposals that meet EAF criteria and can be financed within the funds made available to the *woreda*. The WAC will invite RAC Secretariat staff and zonal technical specialists to participate in the meeting to provide support. After the sub-projects are approved, the WA and the benefiting community will make an agreement, specifying the commitment of the government to grant funds, and of the community to use the funds for the agreed purposes. The agreement will specify how sub-project implementation will be monitored and what sanctions will be imposed if the funds were misused. An example of a simple sub-project financing agreement and of the required reporting formats will be provided in the PIM. The cost of the preparation of sub-projects will be partly pre-financed from the BG to the WA, with no more than 10 percent of the BG used for this purpose. Any sub-project that will require EAF financing in excess of US$2,500 equivalent will, after it had been accepted by the WAC as worthy of support, be referred to the w*oreda* council for final approval.

Small grants will be the *kebele* equivalent of the annual BG to the *woreda*. The *Kebele* Administration Committee (KAC) will form an HIV/AIDS Committee on which there shall be at least one youth (18-25 years), one woman, and one person who is infected with HIV/AIDS or has someone in the family that is infected by the virus. The sum of US$500 equivalent will be transferred to the *kebele* administration once the WAC has received an application indicating how the funds are to be used in a manner consistent with a list of activities eligible for EAF financing. The HFO will assist in creating awareness about the availability of small grants and their use. The chairman of the KA and a member of the KAC will acknowledge receipt of the funds by signing a letter that indicates their approval of the funds and the purposes for which they will be used. An example of such a letter will be provided in the PIM. *Kebeles* that could show effective use of the funds provided will be eligible for subsequent small grants of US$500 equivalent using the same process of application—except that the appropriate use of the *previous* US$500 will need to be verified by the chairman of the Municipal Administration (in the case of urban *woredas*), by a development agent, or by a school principal (in the case of a *kebele*). This will serve as a report on the use of the funds.

In both these financing arrangements, support to PLWHA will be given added emphasis, especially at the time of creating awareness and training of beneficiary representatives. The aim will be to increase their capacity, visibility, and activities to better mitigate the epidemic, be custodians of human rights, and fight stigma, denial, and discrimination. In addition to the above-mentioned activities, the *woreda* BGs will provide funding to PLWHA associations for activities that combat the epidemic.

In the interests of transparency, the WAC will disseminate monthly the list of applications received, the amounts applied for, and the applications approved/ applications not approved. A copy of this list will be sent to all KAC and also displayed on *woreda* office notice boards.

Disbursement of grants for community sub-projects and small grants:

Prior to the BGs being transferred to the selected *woredas*, the following steps will be followed:

- A first workshop will have been held to introduce the concept of the project and the actions needed before funds are approved, with participation as listed in the bullets below;

- Each *woreda* will need to have formed a WAC with mandatory representation from non-governmental community organizations, women's organizations, youth organizations, and PWLHA; this non-governmental representation should be more than 50 percent of the members of the WAC;

- Each *woreda* will have conducted a workshop for all *kebele* administrations in the *woreda*; the curriculum for the workshop should include information on disease, its prevention, its treatment, and types of activities that can support PLWHA. The assistance of the zonal/*woreda* health officers and NGOs will be enlisted for this purpose; a draft curriculum will be provided to all *woreda* representatives attending their first workshop;

- Each *woreda* will have appointed an HFO to work with communities and *kebele* administrations to promote the activities of the Ethiopia Multi-Sectoral HIV/AIDS Project and assist these organizations in preparing proposals. The HFO will have attended a workshop organized either by the EAF or the RAC Secretariat in which project concepts and procedures will be explained; and

- *Woreda* representatives will have attended a second workshop in which the PIM had been explained to them and the mode of funds transfer to each *woreda* agreed at that workshop.

The BGs to the *woredas* will then be transferred to the selected WAs through an account in the nearest bank branch or, if impractical, through an account with a registered micro-finance institution (MFI), a post-office, or, if impractical, to a separate account in the name of the *woreda* concerned in the nearest branch of the Regional Finance Bureau. The funds for each sub-project will be paid by the WA into a community account in a bank or MFI upon approval of a sub-project and signing of a financing agreement. The small grants will be transferred to *kebele* administrations from the WA after representatives of the *kebele* administrations and KAC had attended a workshop organized by the WAC to explain the objectives of the project and the procedures to be followed. *Woredas* that had received BGs for sub-projects and small grants will submit to the EAF a quarterly progress report on the sub-projects showing both financial and physical progress. All *woredas* receiving BGs will be required to submit to the EAF simple accounting statements on sources and uses of funds on a quarterly basis. All transfers out of the account for a *woreda* BG will be co-signed by one member of the WAC and one other person in the WA who could be the chairman/secretary of the *Woreda* council or the *Woreda* accountant. Random financial and technical audits of

woreda, *kebele*, and BC accounts and activities will be undertaken by RAC Secretariat staff/consultants. Quarterly reports will be submitted to EAF by the RAC Secretariat, listing out the accounts and activities audited and findings of the audits. Each participating *woreda* will be audited at least once a year.

Procurement for sub-projects and small grants:

The BCs could start procurement activities once they had received information from the WAC or *kebele* administration that their application for financing had been approved. In practice, some preliminary actions, such as preparing invitations to bid, identifying contractors or suppliers, and providing the community's own contribution, could begin even earlier. The method of procurement will largely depend on the budget value of the contract that is contemplated. *The Bank's Africa Region's Guidelines for Simplified Procurement and Disbursement*, dated March 1998, will be used as a reference, but cognizance of local practices and the capacity of the community to manage the process will be an important consideration. As sub-project funding is within the accepted upper limit for *local shopping*, at least three qualified local bidders should be invited to make offers for each contract. The details of the process and a model contract will be provided in the PIM. This should not be taken as the only method to be used. *Direct contracting* should also be acceptable when competition is not available or not practical, and this will apply especially to the small grants of US$500. If consultants need to be employed, *single-source selection* will be permitted, but *other procedures such as those based on qualifications* could also be used. These procedures will be further elaborated in the PIM. The RAC Secretariat will, on behalf of EAF, engage audit firms who will conduct random checks to ascertain whether the prices paid and the quality of work performed are within acceptable limits.

Financing of administrative costs and overheads of the WAs:

Upon receiving the BG, the WA will set aside a sum equivalent to 5 percent to meet the cost of the operations of the WAC, the *kebele* workshops, and other administrative expenses related to the project. These will be separately accounted for by the *woreda* finance unit. Another 5 percent of the BG will be put in a separate account to help pre-finance sub-project preparation by NGOs and local private consultants. The WA could advance up to 50 percent of the estimated sub-project preparation costs to the NGO/private consultants, with the balance being paid upon approval of the application by WAC. The cost of sub-project preparation will be included in the application for the sub-project grant but will not exceed 10 percent of the total sub-project cost.

Phasing/sequencing of the grants program:

Each participating *woreda* will receive a yearly amount of US$500 equivalent per *kebele,* or equivalent administrative unit, which will be disbursed as a small grant directly by EAF to the WA account. Thus, for a typical *woreda* the equivalent of US$10,000 per year will be sent for small grants. The subsequent year's allocation of small grants could be sent to the *woreda* upon proof of disbursement of the previous year's small grants and their proper use. In addition to small grant funds, the *woreda* will receive another

US$500 equivalent per *kebele* for financing *community sub-projects*. The total sum provided for community sub-projects could be allocated to activities that go beyond *kebele* boundaries and support *woreda*-wide activities. An additional US$500 equivalent per *kebele* will be sent to the participating *woredas* for financing community sub-projects once a *woreda* had produced evidence of satisfactory disbursement to communities of the first tranche of US$500 per *kebele*. This process will continue over the three years with each subsequent tranche dependent on satisfactory disbursement of the previous tranche. Initially, satisfactory disbursement will mean that funds approved by the WAC were equivalent to 85 percent of the tranche, and funds disbursed were 70 percent of the tranche.

In the first year, 55 *woredas* will be selected to enter the project. The entry of these first *woredas* will be in two phases. In the first phase, 25 pilot *woredas* will receive BGs immediately upon satisfying the conditions discussed earlier. Upon satisfactory resolution of start-up and facilitation hitches in these 25 *woredas* (expected not to exceed six months from the time the BGs are provided), the remaining 30 *woredas* will be given BGs, upon satisfying the conditions set out above. After the first year of implementation, all *woredas* in the country will be eligible for BGs subject to satisfying the same disbursement conditions. It is expected that the project will reach at least 165 (30 percent) of *woredas* in the country during the three years of operation.

EAF financing of NGOs/private organizations (POs):

Matching funds will be provided only for a positive list of eligible HIV/AIDS activities and will cover prevention, care, support, treatment, and behavior change-related activities. The main activities will include IEC, awareness and prevention campaigns, preparation and diffusion of didactic material in local languages (radio, video, pamphlets, newsletters), VCT, support to orphans, AIDS community-based care initiatives, income-generating activities, support to HIV/AIDS clubs, financial assistance to AIDS patients and orphans, provision of drugs for opportunistic infections, sensitization campaigns against stigma and discrimination, promotion of behavior changes, psychosocial support, targeted life-skills training to vulnerable groups, school fees, and food allowances. The selected programs could be at national, regional, or local levels. Cost-sharing will be in cash, and the basis for assessing the appropriate level of contribution by an NGO/PO could be set out in the PIM. A minimum of a 10 percent contribution from local NGOs and 20 percent from the private sector will be used as an initial guide, though each application will be considered on its own merits. International NGOs will generally be expected to contribute more than local NGOs.

Many NGOs are involved in HIV/AIDS-related activities but most of them work in the area of prevention. A few of them work in the area of care and assisting PLWHA. An assessment of this latter group of NGOs shows that their main weaknesses are lack of funds and logistical and technical support. In terms of prevention, there is one NGO (Public Service International) that is already doing social marketing of condoms on a national basis and could be tapped to enlarge the scale of such activities. Another NGO, the Family Guidance Association, is active nationally in the area of reproductive health but has extended its activities to HIV/AIDS prevention and youth counseling. There are

NGOs that operate at a regional level, an example of which is ACORD, which focuses its activities on the training of trainers and commercial sex workers.

A National Review Board for EAF will select NGOs/POs for national and inter-regional activities. Regional Review Boards of the RAC will perform a similar function at the regional or sub-regional levels. A financing agreement will be signed with an NGO/PO by the EAF, or the RAC Secretariat as the case might be. All procurement could be in accordance with the procedures of the contracted organization or as required by the PCU to enhance transparency. These procedures will be clearly spelled out in the financing agreement and will require the NGO/PO to retain relevant documents pertaining to the procurement process to enable review by Bank staff, and by project procurement and financial auditors. Funds approved for each proposal will be on a case-by-case basis taking into account capacities of participating institutions to provide their own financial resources. For national-level activities a limit of US$500,000 per proposal will initially be observed. For regional-level activities the limit will initially be US$200,000 per proposal. These limits will be reviewed with experience. They will not apply to proposals that were specifically intended to procure and distribute inputs such as condoms and drugs for opportunistic infections. Financing for these will be determined on the basis of coverage. Payments of approved funds will be made direct to beneficiary NGOs/POs upon approval by the appropriate review board.

To facilitate the entry of NGOs into the project apex, NGOs in Ethiopia will be invited to encourage their members to participate in a first workshop that will introduce them to the project and the type of activities that it will fund, as well as procedures for preparing and submitting applications. They will then be invited to a second workshop where detailed procedures will be explained so they could then submit applications for support. Members of the National and Regional Review Boards will also participate in the workshop to obtain a better understanding of how NGOs operate and the demand for project support.

NGOs providing support to PLWHA will be especially targeted for project assistance.

PCU staff will seek out POs that will like to participate in the project. Among the possible areas of cooperation/support will be piggy-backing on advertisements for products, sponsorship of sports programs, and joint-assistance to youth clubs. PCU staff will seek innovative ways of tapping private sector resources for joint programs.

Participating NGOs/POs will be required to provide quarterly progress reports giving financial and physical progress to the EAF and with copies to the RAC Secretariat where appropriate. All proposals with approved amounts in excess of US$10,000 will require a separate annual audit report from the external auditors of the organization.

ETHIOPIA MULTI-SECTORAL HIV/AIDS PROJECT
Key Implementation Steps in Project Year 1

	Deliverable/Action	Person Responsible	Date	Remarks
1	Govt. of Ethiopia (GOE) approves negotiated documents	Min. Finance	Aug 11/00	
2	GOE to deposit initial $ 300,000 equivalent in a Project Account in the NS to be managed by the PCU to pre-finance expenditures until IDA Credit funds become available.	Min. of Finance and MEDAC	Aug 15/00	*Retroactive financing up to six months prior to loan signing equivalent to $ 1.0 million provided for in Credit agreement. Bank procurement procedures to be complied with.*
2	GOE advertises positions of Procurement Specialist, Sr. Procurement Specialist in local newspapers and other media	Head NAC Secretariat (HNACS)	Aug 20/00	*To use draft TORs agreed at negotiations*
3	GOE submits to Bank 2 names each and CV of proposed candidates for Project Coordinator (PC) and Assistant PC.	HNACS	Aug 21/00	*The normal process of advertisement and selection is too long for the short implementation period.*
4	Bank provides to GOE its comments on candidates proposed for PC and Assistant PC	Bank Ethiopia Team Leader (ETL)	Aug 24/00	
5	GOE submits draft of Interim Program Implementation procedures (IPIP) to Bank *(Bank has worked with the GOE Task Force during Appraisal to produce a working draft for development by the GOE)*	HNACS	Aug 31/00	*Bank reviews draft and provides comments by Sept 21/00*
6	GOE and Bank agree on selection criteria for the first 55woredas to receive grants	HNACS	Aug 31/00	
7	GOE initiates work on drafting positive list of activities to be sponsored by NGOs & Woreda Administrations for Project financing by appointing a consultant or one of its staff. This will be an important input for project	HNACS	Aug 31/00	*TORs and name of consultant to be submitted to Bank for no objection by Aug 31/00 and Bank to provide*

	facilitation activities and should be of sufficient detail to identify items that are eligible for financing.			*comments and no objection within one week*
8	GOE proposes sole source appointment (including TORs) of Consultants to prepare Project Implementation Manual (PIM).	HNACS/PC	August 31/00	*Bank no objection by Sept 8/00*
9	GOE appoints PC and Assistant PC	HNACS	Sept 1/00	
10	GOE submits recommendation on selection of Procurement Consultant, Sr. Procurement Consultant, and Finance Manager	HNACS	Sept 7/00	*Bank provides no objection or comments by Sept 13*
11	PC and Assistant PC report for duty	PC	Sept 11/00	
12	Bank board approves Credit	Bank APL Team Leader	Sept 14/00	
13	GOE submits list of first 55 woredas to be provided block grants	Head NS/PC	Sept 14/00	
14	GOE submits draft RFP for M&E Consultant.(*Working draft of TORs prepared by Bank by Sept 7/00)*	PC	Sept 14/00	*Bank gives no objection by Sep 29/00*
15	GOE submits to Bank positive list of activities to be sponsored by NGOs and Woreda administrations.	Head NACS/PC	Sept 15/00	*Bank provides comments by Sept 22/00*
16	General Procurement Notice submitted for publication in UN Development Business	Bank ETL	Sept 24/00	*Bank ETL reviews draft with PC prior to submission to DB*
17	Credit Agreement signed	Bank ETL	Oct 12/00	
18	PCU sends out RFP for M&E consultants	PC	Oct 14/00	
19	Project Launch Workshop (1): Project Scope; Interim Implementation Procedures, Procurement Schedules and Work Plan preparation guidance.	Head NACS , PC, Bank ETL	Oct 14/00	Participants: Major Stakeholders: Line Ministries, Regional Aids Secretariat & Bureaus
20	NGOs/Woreda Administration Workshop (1): Project Scope and Interim Implementation Procedures. Positive list of activities eligible for financing agreed to and provisional check list for "appraisal" criteria for proposals discussed and agreed upon.	Head NACS , PC, Bank ETL	Oct 16/00 to 20/00 at Two locations?	NGOs advised to prepare proposals for consideration by PCU. Woredas to start facilitation at Kebele and community level
21	GOE submits draft RFP for study to make an inventory of existing HIV/AIDS activities and review institutional arrangements for the Multi-Sectoral Program	Head NACS , PC	Oct 25/00	*Bank provides no objection by Nov 3/00*
22	PCU submits draft bidding documents	PCU Proc.	Oct 18/00	*Bank provides no*

	for goods for Bank no objection	Consultant (PCPC)		*objection by Nov 1/00*
23	Woreda Administrations conduct workshop for Kebele Representatives.	Woreda Administration	Oct 27-31/00	Each Kebele to be represented by head of Kebele Admin., 1 youth and 1 woman
24	PCU completes procurement schedules for all main implementing agencies	PCPC	Oct 30/00	
25	PCU initiates assessment of activities and funding in the first Program year for Components 1 & 2.	PC/APC	Oct 30/00	
26	GOE confirms procedures for funding payment of duties and taxes for Program imports	Min. of Finance	Nov 1/00	
27	PCU advertises Bid for Goods for First Year of Project	PCPC	Nov 6/00	
28	Special Accounts A and B to be opened in NBE or acceptable commercial bank	PC/APC	Nov 15/00	
29	Draft PIM submitted to Bank	PC	Nov 15/00	*Bank comments by Nov 30/00*
30	Capacity building funds under Component 1 for FY 2000/1 allocated by NAC	Head NACS	Nov 30/00	
31	Government program intensification funds under Component 2 for FY 2000/1 allocated by NAC	Head NACS	Nov 30/00	
32	Final version of PIM submitted to Bank	PC	Dec 7/00	
33	GOE provides legal opinion and meets effectiveness conditions	MOF	Dec 1/00	
34	PCU receives M&E consultancy proposals on Nov 15/00 and submits award recommendation to Bank	PC	Dec 4/00	
35	Bank gives no objection to M&E consultancy appointment		Dec 12/00	
36	PCU sends M&E consultancy appointment letter to *commence work on Jan 15/01*	PC	Dec 15/00	
37	Bank declares Credit effective	Bank ETL	Dec 15/00	
38	PCU submits first withdrawal application (WA) to Bank for Special Accounts (SA) initial deposit together with letter from MOF on authorized signatories for withdrawals from the Credit.	PC/Bank ETL	Dec 15/00	*Bank HQ receives WA on Dec 22/00 and approves on Dec 29/00*
39	(a) PCU submits TORs and proposal on appointees for National Review Board (NRB) for NGO/Private Sector	PC	Dec 15/00	*Bank provides comments within one week*

	applications for Grants. (b) PCU sends TORs for Regional Review Boards to Regional Secretariats and requests appointments to be completed by Jan 15/00	PC		
40	Training of Woreda Grants facilitators	PC/RS/Bank ETL	Dec 22-25/00	
41	GOE submit to the Bank draft report on inventory of HIV/AIDS activities and recommendations on institutional arrangements for the Program	Head NACS/PC	Jan 10/00	*Bank provides comments by Jan 25/01*
42	Draft Manual on flow of funds and reporting mechanism submitted to Bank	PC Finance Manager (PCFM)	Jan 30/01	*Bank comments provided by Feb 12/00*
43	Draft Manual on structure, management and reporting mechanisms on Emergency HIV/AIDS Fund (EAF) submitted to Bank	PCFM	Jan 30/01	*Bank comments provided by Feb 12/00*
44	Draft Outline of Manual on Monitoring and Evaluation submitted to Bank	PCU M&E Consultant (PCME)	Jan 30/01	*Bank comments provided by Feb 8/00*
45	GOE submit to the NAC final report on inventory of HIV/AIDS activities and recommendations on institutional arrangements for the Program complete with an action plan to implement recommendations.	Head NACS	Feb 7/00	
46	Project Launch Workshop (2) to explain PIM to major stakeholders.	PC/Bank ETL PCU Project Facilitation Staff (PCPF)	Feb 12/01-13/01	Regional H/A Councils to be formed by then to permit flow of funds to Regional Bureaus and NGOs
47	NGOs/Woreda Administration Workshop (2): to explain PIM and agree on mode of funds transfer to first 20 Woredas which satisfy criteria set during the first workshop.	PC/Bank ETL /PCPF	Feb 14 -17 /01	*NRB members to attend*
48	Workshop on M&E Work Program and Responsibilities and Draft Outline of Manual	PCME	Feb 15/01	Participants: Line Mins.; Regional Secretariats, Central and Regional Statistical Bodies
49	Funds transferred to 25 first phase Woredas	Directly by PCU	Feb 21/01	
50	Funds transferred to Mins. and Regional Secretariat Project Accounts	PCU Financial Manager	Feb 21/01	

		(PCFM)		
51	Request for Proposals for Project Auditors	PCFM	Feb 26/01	*Evaluation to be submitted to Bank two weeks after closing date for submissions and appointment made within one week of Bank no objection*
52	Submission of Draft Manual on M&E to Bank and all participating agencies for comment	PCME	Feb 28/01	*Final version of M&E Manual to be issued by March 30/01*
53	FY 02 (July-June) Annual Work Plans requested from Line Mins. and Regional Secretariats (inc. Regional Bureaus)	PCPF	Apr 15/01	*To be submitted by May 15/00*
54	Consolidated Annual Work Plans presented to Advisory Board for endorsement with a copy to World Bank	PCME/PCPF	June 15/01	*Line Mins., etc informed of work plan approvals*
55	Remaining 35 woredas sent block grants on satisfying criteria established earlier	PCFM	By Sept 1/01	*Upon satisfactory de-snagging of initial implementation hitches.*
56	Woreda, NGO/Private Sector Grants Program for FY 02 presented to Advisory Board for endorsement with a copy to World Bank	EAFM	Sept 15/01	

Annex 5. Project Monitoring and Evaluation

The project will support the establishment of a Monitoring and Evaluation (M&E) Unit in the NAC Secretariat.

Responding effectively to HIV/AIDS requires sustained monitoring and evaluation of a broad range of measures. Each HIV epidemic behaves differently and often unpredictably, especially once it reaches a mature phase as it has in Ethiopia. A proper M&E system must therefore include much more than just general serosurveillance.

It is especially important to identify and track leading behavioral and epidemiological indicators, such as sexual behavior and STI prevalence among persons aged 15-24 and among those whose behavior puts them at risk. A complete M&E program for HIV/AIDS should compile data of four types: i) on knowledge, attitudes, and sexual behavior; ii) on project inputs and outputs; iii) on coverage and quality of key services; and iv) on health status. Each country needs to choose its own particular measures according to the state of the epidemic and the main behavioral factors driving its spread. The Ethiopia project will identify and measure at least one indicator within each of the following categories: level of project effort; condom accessibility and quality; stigma and discrimination; knowledge of HIV transmission and prevention; counseling, testing, and referral; PTCT (where such services are offered); sexual behavior in the general population; sexual behavior of young people; blood safety; STI/TB prevention and care (e.g., appropriate diagnoses, STI/TB drug supplies); care and support for those infected and affected by HIV/AIDS; and health and social impact (including rates of STIs, especially among young people, and numbers of orphans).

Monitoring and evaluation of the HIV/AIDS project will differ from other M&E systems in that:

- Within the initial three-year project period, information on longer-term impact and outcomes will be less telling than information on inputs, process, and outputs.
- However, early indicators of project effectiveness and beneficiary receptivity/ response will be essential for all project activities so they can be quickly adjusted.
- With the emphasis on scaling up programs that are multi-sectoral in nature and that use a variety of implementation channels, monitoring and evaluation will have to be extensive and will require more resources than a single-sector project.
- The commitment to beneficiary and stakeholder involvement in decision-making and in implementation will be enhanced if the M&E system can provide real-time, relevant information both to the PCU and to relevant decentralized decision-makers.

Ethiopia currently conducts no systematic monitoring of HIV/AIDS or the impact of efforts to address it. Given the importance of such information, the project will invest substantially in establishing a robust M&E system. The NAC Secretariat will be able to call on technical expertise from IPAA partners in developing the system. WHO and UNAIDS have just issued *Guidelines for Second Generation HIV Surveillance* (May

2000), which provide an excellent overview of how to tailor monitoring and evaluation for maximum benefit in individual country cases. UNAIDS can also provide substantial technical assistance to the NAC Secretariat in this area. As a principle, the M&E Unit will rely on formal links with external expertise for generation of information and analysis, including such bodies as the Central Statistical Authority, regional statistical offices, universities, and private institutions.

With respect to implementation, the M&E Unit will be charged with establishing performance indicators for each project component, clearly distinguishing among: a) project outputs; b) progress toward outcomes; and c) early indications of trends toward longer-term impact. The Unit will compile and consolidate, on a quarterly basis, monitoring information including data related to expenditures and disbursements. Implementation progress reports will be submitted to the NAC and to IDA every six months. In addition, an independent project performance evaluation will be conducted at the end of each year, and will focus on: a) an assessment of the short-term impact of project activities on the epidemic, with particular focus on vulnerable groups; and b) an operational audit of the project, including activity completion, the impact of project activities, and progress toward sustaining them. The evaluation will highlight lessons learned, and these will be used inter alia to make adjustments to the PIM.

Since the objective of many project activities will be to change the behavior of a large number of disparate groups, a process of beneficiary and stakeholder feedback and social impact monitoring will be essential. Social impact monitoring will be used to identify key social and cultural development/participation issues, including impediments to equitable access to project activities by intended beneficiary groups, especially those currently disempowered in some way, and to recommend strategies for strengthening community institutional capacity. It will be used to design a systematic participation framework to ensure that the needs of the poor and vulnerable are catered to, and that their level of participation in the project is appropriately captured in the project's operational procedures.

Annex 6. Procurement, Disbursement, and Financial Management Arrangements

Procurement:

1. **General**: It is not possible at this stage to determine the exact mix of goods and services to be procured under the overall project. This is due to the following reasons: a) adaptable feature of an APL; b) the mission has received only summary aggregate data for the different regional and sub-regional Units; and c) 40 percent of the project funds is allocated to local initiatives under community-based sub-projects. The procurement plan for the first year will be prepared based on the initial needs of the NAC and NAC Secretariat and the work programs submitted by the concerned ministries. Costs for the subsequent years are only indicative at the time of project preparation. The exact mix of procurement will be determined on an annual basis during annual joint reviews between the NAC Secretariat, IDA, and other donors, where a draft procurement plan for the following financial year will be presented and agreed upon.

2. IDA will finance goods, civil works, consultancy, training, and other local activities necessary to implement the project under EAF. Procurement for all IDA-financed activities will be carried out in accordance with the Bank's *Guidelines for Procurement under IBRD Loans and IDA Credits* (January 1995 and revised in January and August 1996, September 1997, and January 1999), in particular, Section 3.15, Community Participation in Procurement. Consulting services by firms, organizations, or individuals financed by IDA will be awarded in accordance with the Bank's *Guidelines: Selection and Employment of Consultants by World Bank Borrowers* (January 1997, revised in September 1997 and January 1999).

3. **Procurement Capacity**: A Country Procurement Assessment Review (CPAR) was undertaken in 1998. National procedures for procurement of works, goods, and services were found to be wanting in several areas; the Government responded by making some changes in its financial directives in this regard but further revisions are needed to make the procedures acceptable. The Bank provided an IDF grant to help in the production of a procurement manual and carry out of training of trainers in 1999. Follow-up Bank assistance is being considered to help in the preparation of a procurement code.

4. An assessment of procurement capacity of the NAC Secretariat indicates relatively high risks. In consideration of the fact that the PCU is yet to be established, there is no capacity and experience in procurement-related activities. Unless outside support (i.e., hiring of a senior procurement specialist and procurement specialist) is provided to PCU, it is likely that PCU capacity will be inadequate to handle the procurement workload under the project. Discussions with the Government and the Bank's FY 1999 Country Portfolio Performance Review have confirmed that the procurement management capacity is severely constrained. Accordingly, it has been agreed that long-term procurement consultants should be engaged by the PCU as early as possible. These consultants will work with all regional and sub-regional Units to prepare annual procurement plans, bidding documents, and bid evaluation reports.

5. **Institutional Arrangements**: The overall coordination of project implementation will be done by the PCU of the NAC Secretariat, with each line ministry and NGO/CBO responsible for implementation of their relevant work programs. All major procurement activities for Components 1, 2, and 4 will be handled and coordinated centrally by PCU with participation of the relevant line ministries with respect to preparation of technical specifications and Terms of Reference. Ownership of the signed contracts will be with respective line ministries including contract management. It is not expected that PCU will be involved in all work program-related procurement activities of the line ministries. Items such as IEC materials, workshops, training, and supplies will be handled by the line ministries using the specified procurement methods identified for the project. With respect to Component 3, the procurement activities will be based on Simplified Procurement and Disbursement Procedures for Community-Based Investments.

6. The central procurement activities under the project will be handled by hiring a team of two individuals as senior procurement specialist and procurement specialist. One of them should preferably be fully acquainted with procurement of drugs and pharmaceuticals. Terms of Reference are prepared for both positions and are attached to this document. Regional and national advertisements for these positions will be carried out as early as possible and prior to the Bank's Board date. These individuals will be hired before Credit effectiveness, will prepare the detailed first year procurement plan, and will start the procurement process for the more pressing procurement activities, including acquisition of urgent drugs for treatment/diagnosis of the disease, recruitment of a Finance Manager and a Financial Controller, preparation of the simplified procurement procedures manual for the community-based programs, hiring of a firm for the initial information campaign program, and other required items for institutional capacity strengthening. In order to build capacity at the local level, the procurement team will also provide procurement training workshops at national and regional levels. The Bank's Country Office will monitor the performance of the procurement team and will also provide the necessary support where required. During the first 12 months of project operations, the detailed procurement plans for the following years will be developed and submitted to IDA for review and approval.

7. Considering the emergency needs, and in order to expedite the procurement and subsequent disbursement process, it is recommended that partial delegation of the procurement fiduciary responsibilities be assigned to the Country Office. This action should be taken by the Country Director for RPA/OPRC approval.

8. Procurement performance (including sub-project procurement activities) will be assessed on an annual basis in the form of procurement/physical audits by an external agency. In addition to the formal annual audits, ad-hoc procurement reviews will be conducted periodically. For the first year of operations it is recommended that the procurement arrangements be reviewed after six months of operations to fine-tune the activities and ensure that the proposed arrangement is sufficiently covering the needs of the project. This review should be undertaken by a procurement specialist from the Bank.

Procurement methods:

9. Procurement of goods and works for all IDA-financed components will be carried out in accordance with the Bank's *Guidelines for Procurement under IBRD Loans and IDA Credits* (January 1995 and revised in January and August 1996, September 1997, and January 1999). Consulting services by firms, organizations, or individuals financed by IDA will be awarded in accordance with the Bank's *Guidelines: Selection and Employment of Consultants by World Bank Borrowers* (January 1997, revised in September 1997 and January 1999).

10. Given the urgency of the project, a General Procurement Notice (GPN) for the first year of operations will be placed in the local newspapers as well as in the *United Nations Development Business* (UNDB) web site without the need for hard-copy publication. The requirement for printed publication of GPN has been waived by the RPA office. The detailed GPN for the subsequent years will be prepared for the project and published in UNDB. GPNs will describe all outstanding ICB for goods contracts as well as consulting assignments. Specific Procurement Notices (SPN) and Expressions of Interest (EOI) will be prepared for the individual procurement actions where necessary. The Borrower will prepare a procurement plan for the first year of project operations. The plan will include relevant information on goods, works, and consulting services under the project as well as the timing of each milestone in the procurement process. The procurement schedule will be updated every quarter and reviewed by IDA during each supervision mission.

Civil works:

11. No large civil works are scheduled for the project. The design does provide for flexibility for NGOs/CBOs (Component 3) to undertake small works within the context of their work programs, though the budgets for the grants must be approved prior to disbursements and the number of such works will be quite limited, as described below.

12. Contracts for small works estimated to cost less than US$20,000 equivalent per contract, up to an aggregate amount of US$200,000 equivalent, may be procured under lump-sum, fixed-price contracts awarded on the basis of quotations obtained from three qualified domestic contractors invited in writing to bid. The invitation shall include a detailed description of the works, including basic specifications, the required completion date, a basic form of agreement acceptable to IDA, and relevant

drawings where applicable. The awards will be made to the contractors who offer the lowest price quotation for the required work, provided they demonstrate the experience and resources to complete the contract successfully.

13. Contracts for small works estimated to cost more than US$20,000 equivalent per contract are ineligible for financing under the project.

Goods:

14. The total cost of goods is estimated at US$17.4 million for the project as detailed below. These exclude any goods that might be procured in small quantities through work programs under Component 3 of the project.

(a) Emergency requirements:

15. Given the urgency of the project, and to facilitate speedy procurement of items required urgently for institutional strengthening, specific contracts will be handled in the following manner:

To be procured centrally by PCU:

- Drugs, chemicals, kits, and condoms: US$1.7 million, to be sourced from United Nations Agencies;
- Lab Equipment: US$300,000, to be sourced through international shopping procedures;
- Computers and accessories, office and power equipment: US$150,000, to be sourced from the United Nations Agency (IAPSO);
- Vehicles: US$200,000, to be sourced from IAPSO and/or national shopping procedures (preferably from "bonded warehouses" on a competitive basis);
- Furniture for PCU and Regional Coordinating Offices: US$200,000, to be sourced from local manufacturers/suppliers by national shopping procedures.

16. All shopping procedures will follow the IDA Procurement Guidelines (Para. 3.5 and 3.6) and June 9, 2000 Memorandum "Guidance on Shopping" issued by the Bank, and procurement from the United Nations Agencies (i.e., UNFPA, UNICEF, WHO, IAPSO) will follow para. 3.9 of the Procurement Guidelines. All contracts under the above-stated "Emergency Requirements" must be concluded within 12 months of the Credit effectiveness date. The list of these items and their estimated value should be agreed upon with IDA as per the approved Procurement Plan. The procurement and timely distribution of the goods will be the responsibility of PCU.

(b) Other goods:

17. Goods that are estimated to cost more than US$100,000 equivalent per contract will be subject to Prior Review and will be procured through ICB procedures. Procurement will be bulked where feasible into packages valued at US$100,000

equivalent or more. In cases of consolidated procurement of goods by PCU (both national and international), where the end users are spread in different geographical locations, PCU may consider the feasibility and possibility of devising a system acceptable to IDA whereby through structured bidding documents and contract monitoring procedures the delivery of goods will be based on decentralized ordering from the end users and based on their specific needs. There are high risks involved with respect to actual monitoring and implementation of such a process and careful consideration should be given to all details before such system is placed.

18. Goods estimated to cost less than US$100,000 equivalent per contract, up to an aggregate amount of US$4.3 million equivalent, will be procured through NCB. Office furniture and production of IEC materials for which capacity exists in the country and in the case of the latter requires proximity to the client for editing and proofreading may be procured through NCB. Another factor that has to be taken into account is multiple languages in which the materials have to be produced. In any case, there will be no restriction on the participation of foreign suppliers in NCB. The draft standard bidding document for NCB will be submitted by PCU to IDA for prior review. The approved bidding document will form the basis of all NCB procurements under this project.

19. Goods that are estimated to cost less than US$30,000 equivalent per contract, up to an aggregate of US$500,000 equivalent, may be procured through International and local Shopping procedures, in accordance with the Bank Guidelines, and/or through the United Nations Agencies (IAPSO, UNICEF, UNFPA, WHO). Any direct contracting for goods valued at below US$5,000 subject to an aggregate value of less than US$ 20,000 per annum, per regional and sub-regional Implementing Unit, should be agreed upon as part of the annual reviews of their respective work programs (these being largely for the purpose of operations, maintenance, office, and stationery expenses). The procedures followed, and total aggregate amount for all shopping method under the project, will be reviewed after six months of project operations; depending on performance, and the results of the review, the total aggregate amount may be adjusted downward where necessary. Standard request forms and establishment of guidelines for conduct of the shopping method (as per the June 9, 2000 Memorandum "Guidance on Shopping") should be prepared and included in the PIM). These aggregate limits do not include contracts under Component 3.

20. Specialist equipment spare parts (i.e., medical equipment related to HIV/AIDS, power generators for cold-storage facilities) in packages costing less than US$10,000 up to an aggregate amount of US$100,000 may be procured directly from the original manufacturers or suppliers.

21. Contracting the procurement and distribution of drugs and other inputs to United Nations agencies with prior approval of IDA may also be undertaken in instances where these organizations are already procuring these inputs for supply and distribution in Ethiopia or in other countries.

Storage and distribution:

22. Current storage facilities at the federal, regional, and hospital/clinic levels appear to be adequate and distribution is not a major problem except for cold-chain items where more use of private sector facilities could prove beneficial. The usual process is for the drugs or equipment to be acquired by the Ministry of Health (MOH) and received at its central stores in Addis Ababa. The goods are then sent to regional stores and then on to zonal stores where distribution to hospitals and health centers takes place.

23. One issue requiring attention is the existing arrangements for storage of drugs in the MOH. The current manual inventory controls do not provide for easy identification of the expiry dates of the drugs. Additionally, under a manual system, stock levels, forecasting of demands, issues, and receipts can not be easily identified. This is a high-risk situation where expired drugs could be distributed. Other donor funding should be sought for automation of MOH inventory management. USAID has been supporting such drug logistics management systems in other African countries. As such, USAID should be approached for funding of this purchase. Additional funding from other international donors should be sought for fast implementation of this system.

24. The other issue relates to the MOH cold-storage facilities. Currently, there is only one working cold-storage facility with two rooms in Addis Ababa. This store is used for all vaccines and other supplies; however, the frequent power interruptions and lack of a back-up generator for the storage facility has occasionally resulted in damage of medical supplies. The other cold store that was available at the Addis Ababa Airport has been out of order for more than two years. There is another cold store in Dessie district; however, there is no exact information on its condition, and it is about 400 kilometers away from the airport. The MOH has indicated that it has a plan to place deep freezers at the airport to alleviate the problem. Immediate measures should be taken to either purchase a new generator or fix the existing one. Project funds could be used for the related procurement. Furthermore, the capacity of the cold storage facility should be assessed with respect to the additional drug purchases under the donor-funded projects, and if necessary funds should be secured for expansion of the facility.

25. To enhance the capacity for storage and distribution of project drugs and condoms, PCU with support from the MOH should consider the possibility of using private companies to support drug storage facilities (including cold storage) and the distribution network throughout the country. Funding for such activities should be sought from the international donor community.

Grants to community-based sub-projects:

26. The project will support a community-based pre-payment scheme for EAF-related activities. The total cost for this activity (Component 3) is US$28.1 million equivalent. The HIV/AIDS fund will finance small-scale, community-based HIV/AIDS-related activities, including minor repairs or works, purchase of drugs and

supplies in small quantities (in emergency cases), care and maintenance for AIDS patients and orphans, AIDS-prevention promotion, and other interventions at the community level.

27. Work programs under Component 3 will depend on applications received from communities, NGOs, and private organizations against a positive list of activities. It is not possible to determine the exact mix of goods, small works, and services to be procured under these activities due to their demand-driven nature. Funding for these activities will be in the form of grants. Therefore, the types of activities to be financed under these activities and their procurement details will depend on the needs identified by communities.

28. In accordance with the established guidelines (as part of the PIM), large works contracts and vehicles are ineligible for financing under the BGs to *woredas* under Component 3. The Africa Guidelines for Simplified Procurement and Disbursement for Community-Based Investments will be used in the design of procurement under this aspect of the project. The NAC Secretariat through PCU will be responsible for ensuring compliance with these guidelines, and ex-post reviews of random sub-projects will be conducted periodically by the Bank and independent consultants appointed by PCU.

    Simplified procurement and disbursement procedures for community-based programs, including the positive list of items qualifying under this component, will be developed and included in the PIM for approval by IDA. The PIM will also include procedures for IDA prior review thresholds for NGOs, private sector, and other community initiatives.

Consultancy services:

29. The total cost of consultant services is estimated at US$8.2 million equivalent for the entire project, excluding any services to be procured under Component 3, as detailed in the above. Except as detailed below, consulting services will be selected through competition among qualified short-listed consultants (selected through advertisement of EOIs) based on *Quality and Cost-Based Selection (QCBS)* whereby the quality of the technical proposals is given highest score and evaluation of the technical proposals is carried out before opening the financial proposals (Section II, para. 2.1-2.28 of the Consultant Guidelines).

30. The consultancy services required will be mostly in the areas of AIDS research, AIDS education, trainers, community development, financial management, monitoring and evaluation, information dissemination, auditing, and accounting. The exact mix (types of consultancy, budgets, procurement methods) will be discussed and agreed annually during joint reviews.

31. Consultants for financial audits and other repetitive services estimated to cost less than US$50,000 equivalent per contract, up to an aggregate of US$250,000

equivalent, will be selected through *Least Cost Selection* method (para. 3.1 and 3.6 of the Consultant Guidelines).

32. Consultants for services meeting the requirements of Section V of the Consultant Guidelines will be selected under the provisions for the *Selection of Individual Consultants* method (Section V, para. 5.1-5.3 of the Consultant Guidelines). Individual Consultants (IC) will be selected through comparison of job description requirements against the qualifications of those expressing interest in the assignment or those approached directly. For both firm and individual contracts, *single-source selection* may be used only on an exceptional basis, with prior agreement by IDA, in accordance with the provision of para. 3.8-3.11 of the Consultant Guidelines. All consultancy services valued at below US$5,000 up to an aggregate value of US$75,000 equivalent may be sole-sourced subject to these being included in the annual approved work programs. All Terms of Reference for consultancy services are subject to prior agreements with IDA. To the extent possible, standard Terms of Reference will be prepared for the small consultancy contracts, and they will be submitted to IDA for no objection.

33. Service contracts for the research studies will be subject to IDA prior review and will be awarded based on a two-stage approval process. Initial review of the research proposals will be carried out by the NAC Secretariat, PCU. The award recommendations from PCU should receive the approval of the Ethiopia Science and Technology Commission (ESTC) before IDA no objection can be issued. Universities, chartered and private academic and research institutions, and individuals affiliated with such institutions may qualify to receive funds under this component.

34. To ensure that priority is given to the identification of suitable and qualified national consultants, short-lists for contracts estimated under US$100,000 or equivalent may be comprised entirely of national consultants (in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines), provided that a sufficient number of qualified individuals or firms (at least three) are available at competitive costs. However, if foreign firms have expressed interest, they will not be excluded from consideration. The Standard Request for Proposal (RFP) as developed by the Bank will be used for requesting proposals, and for selection and appointment of consultants. Simplified contracts will be used for short-term assignments—simple missions of standard nature (i.e., those not exceeding six months) carried out by individual consultants or firms. The Government was briefed during negotiations about the special features of the new guidelines and the RFP, in particular with regard to advertisement, public bid opening, and evaluation criteria.

Training, workshops, and study tours:

35. The total cost for this component (Capacity Building for Government Agencies and Civil Society, Component 1) is estimated at US$7 million for the project. Training, workshops, and study tours will be carried out on the basis of approved annual programs that will identify the general framework of training activities for the year, including the nature of training/study tours/workshops, the number of trainees, and

cost estimates. The training institutions for all workshops/training with costs exceeding US$5,000 should be identified within the annual program; where the training cost exceeds US$20,000, the selection of the training institution should be based on a competitive process preferably using the quality-based method of selection. Any and all "out of country" training is subject to prior review by IDA, and such training is ineligible under Component 3. Post-reviews will be conducted from time to time to review the selection of institutions/course contents/trainees and justifications thereof, and costs incurred.

Prior review:

36. All ICB and emergency procurement for goods will require prior review by IDA. The first three NCB contracts will require prior review by IDA. Contracts with consulting firms costing the equivalent of US$50,000 or more and contracts with individual consultants costing the equivalent of US$30,000 or more will require prior review by IDA. All single-sourced selection of consultants valued at US$5,000 equivalent and above will require prior review by IDA. These prior review requirements will not apply to community-based operations under Component 3, except as provided above.

37. A review of the prior review thresholds will be made 12 months after the effective date of the project; based on performance these thresholds may be revised.

Table A: Project Costs by Procurement Arrangements (US$63.4 million equivalent)

	Procurement Method[1]				
Expenditure Category	ICB	NCB	**Other[2]**	**N.B.F.**	**Total Cost**
1. Goods	12.05	4.30	3.15	1.50	21.00*
	(12.05)	(4.30)	(3.15)	(0.00)	(19.50)*
2. Services	0.00	0.00	8.20	0.50	8.70
	(0.00)	(0.00)	(8.20)	(0.00)	(8.20)
3. Community Based Grants	0.00	0.00	25.00	1.70	26.70
	(0.00)	(0.00)	(25.00)	(0.00)	(25.00)
4. Training	0.00	0.00	7.00	0.00	7.00
	(0.00)	(0.00)	(7.00)	(0.00)	(7.00)
Total	12.05	4.30	43.35	3.70	63.40
	(12.05)	(4.30)	43.35)	(0.00)	(59.70)

1/ Figures in parenthesis are the amounts to be financed by the IDA Credit. All costs include contingencies.

2/ Includes civil works and goods to be procured through national/local shopping, consulting services, community-based activities, services of contracted staff of the project management office, training, technical assistance services, and incremental operating costs related to (i) managing the project; and (ii) re-lending project funds to local government units.

* This amount includes operational expenses including supplies.

Table B: Thresholds for Procurement Methods and Prior Review

Category	Procurement Method	Prior Review	Value (US$ million)	Remarks
1. Works Small works under grant financing Community initiatives	At least three quotations from qualified contractors	Ex-post	<20	*Civil works up to US$20,000 per contract and US$200,000 in aggregate*
	Simplified as set down in the PIM	Ex-post		*Prior review thresholds for NGOs, private Sector and community initiatives to be established in PIM*
2. Goods	ICB > US$100,000 NCB<US$100,000 Shopping . <US30,000 Direct contracting: <US$5,000 Spares <US$10,000	 All IDA to review first 3 contracts for each implementing agency Ex-post Ex-post		*Shopping will be permitted for up to US$2.55 million for contracts valued at $<100,000 and signed within 12 months of Credit effectiveness* *US$4.3 million in aggregate* *US$0.5 million in aggregate including direct contracting* *US$100,000 in aggregate*
3. Consultancies (contracts with individual consultants >US$30,000 subject to prior review)	QCBS>US$50,000 Individual	>US$50,000 (for firms) >US$30,000 (for individuals)		*For <US$ 100,000 contract value only national consultants may be short-listed*
	LCS	>US$50,000 and TORs of All		*US$250,000 in aggregate*
	CQ	>US$30,000 and TORs for all		
	Other	>US$5,000 and TORs of All		*For <US$5,000 Contracts with Individual Consultants on short-term assignments not to exceed US$75,000 in aggregate Post-review, but annual plans to be reviewed by IDA*
4. Training, Workshops, Study Tours	QBS/Other	>=20		*Post-review, but annual plans to be reviewed by IDA*

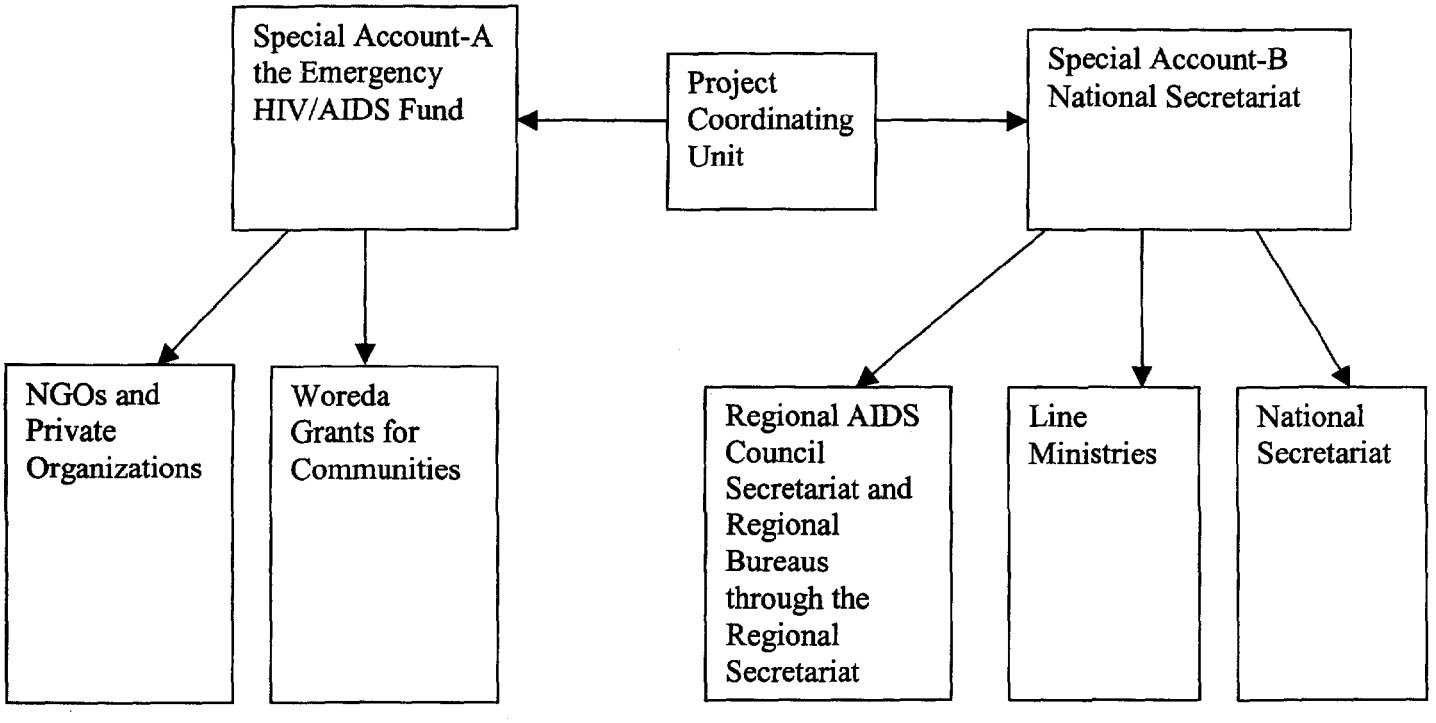
Frequency of procurement supervision mission proposed: Once every six months; in addition, ad-hoc reviews/audits will be done by the Country Office Procurement Specialist or other appointed consultants.

Financial Management and Disbursements

Financial management:

The project will be coordinated by the PCU, NAC Secretariat, and implemented by various implementing entities. The NAC Secretariat is responsible for overall implementation of the project and is accountable for the proceeds of the entire Credit. The flow of funds is as follows:

Funds flow:



The PCU has not yet been established; however, it has been agreed with the Borrower that a financial management team acceptable to IDA will be mobilized before Credit effectiveness. The team will perform the accounting and other financial management functions of the PCU, including preparation of the Financial Management Manual (FMM). The PIM (which includes the basic accounting procedures), acceptable to IDA, will be completed by effectiveness.

Other project implementing entities:

Line ministries:

Line ministries are among the implementing entities of the project. After opening a Birr Project bank account, they will receive money directly from the NAC Secretariat based on a work plan prepared by each line ministry and approved by the NAC Secretariat. In some of the ministries, HIV/AIDS units/committees have been established and in others, there are no units/committees to deal with HIV/AIDS activities. Thus, if a line ministry is to participate in this project, the first step is to establish a unit/committee to deal with HIV/AIDS activities in the ministry.

In each line ministry, there is a Finance Department that handles all the transactions of the ministry. Each department is staffed with a sufficient number of accountants who are qualified enough to handle the ministry's financial transactions. The department reports monthly to the Ministry of Finance (MOF) on the uses of funds obtained from the MOF. There is also an internal audit department at each of the line ministries whose main activity is to check compliance with the internal control systems of the ministry. In addition to this, MOF inspectors regularly inspect the work of the department.

The Finance Department will handle the financial transactions of the project. The PCU will provide training to the department staff who will handle the recording and reporting of project transactions in line with government and IDA procedures.

Regional Secretariats:

The Regional AIDS Committee (RAC) Secretariats will coordinate all HIV/AIDS activities in the regions. Each RAC Secretariat will open a Birr Project bank account to be used solely for the advances received from the PCU for this project.

The RAC Secretariats will: a) pay for their local operating expenses; and b) make payments on behalf of the Regional Bureaus, based on an approved work program prepared by each of the Bureaus. In order to discharge their responsibilities, the RAC Secretariats will be staffed with skilled and adequate staff including an accountant. Currently, none of the RAC Secretariats are fully staffed. The establishment of the project bank account and adequate accounts staffing of the RAC Secretariats will be a prerequisite for the disbursement of their funds.

Woredas:

Selected *woredas* will receive grant money directly from the EAF for HIV/AIDS activities. The money from the EAF will be transferred to a Birr Project bank account opened and used specifically for this purpose. The *woredas* in turn will transfer money to the communities in accordance with the PIM

Each *woreda* has a Finance Office that handles all financial transactions related to government funds. The main activities of the office are collecting taxes and effecting payments to sector line ministries and other *woreda* offices. The office is staffed with skilled and adequate accounts staff. The Finance Office submits monthly financial reports to the Zonal Finance Department; inspectors from the Zonal and Regional Finance Office regularly supervise the work of the *woreda* office.

The Finance Office will handle the financial transactions of the project. The PCU and RAC Secretary will provide training to the Finance Office staff who will handle the recording and reporting of project transactions in line with government and IDA procedures.

Communities:

Communities will receive money from the *woredas* and report on its use in accordance with the implementation arrangements in Attachments 2 and 4. The community organization will manage the activities and be responsible for proper accounting of the funds. The *woreda* will monitor the progress and financial transactions. In addition, there will be publicity regarding the grants made to the community (e.g., name of organization, activities, and amount of the grant) to enhance transparency and accountability.

NGOs/POs:

NGOs/ POs will receive money from the EAF. The money will be transferred to the NGO/PO bank accounts opened for this purpose and payments from these bank accounts will be made for eligible project expenditures.

Under the country's law, each of the NGOs is required to register with the Ministry of Justice and the Disaster Prevention and Preparedness Commission (DPPC). Each year, they are required to file annual audit reports with the DPPC. In addition to this, each of the NGOs is required to report to their other donors regularly. POs will be required to comply with Ethiopian law and corresponding auditing requirements.

Based on a review of the systems of several NGOs (international, national, and regional), it appears that these NGOs have effective financial management systems, including accounting, reporting, and internal control. However, before making a grant to an NGO/PO, the EAF will ensure that the organization has a reliable system of accounting and reporting and will review the latest audited financial statements of the NGO/PO.

Program Management Report (PMR)-based disbursements:

Initially the PCU will not have the capacity to produce PMRs for disbursement purposes. The capability of the financial management system will be assessed during the first year of the project to determine if the project can convert to PMR-based disbursements within 12 months of effectiveness.

The following financial management action plan has been agreed with the Borrower at negotiations:

Action	Completion Date	Responsibility
1. Appointment of a financial management team at the PCU	Before effectiveness	PCU
2. Appointment of the EAF Fund Manager	Before effectiveness	PCU
3. Appointment of Accountants at the RSs and Woredas	Before disbursement to the respective RS and Woreda	RS and Woreda in coordination with the PCU
4. Completion of Financial Management Manual (FMM)	2 months after effectiveness	PCU (using the financial management team)
5. Implementation of the accounting system prescribed by the FMM	3 months after effectiveness	PCU (using the financial management team)
6. Preparation of complete PMRs	9 months after effectiveness	PCU (using the financial management team)

Financial management arrangements:

Methods of payment:

Payment from the credit proceeds could be made in three ways:

- Direct payments by the Bank to suppliers/contractors upon request of the PCU. This applies to large contracts, which require more than 20 percent of the Special Accounts (SA) authorized limit. A withdrawal application is prepared and submitted to the Bank, and then payment will be effected directly to a supplier/contractor.

- Payments made through the Special Commitment (SC) upon request of the PCU. This applies for payments to be made through letters of credit if the amount of the contract is in excess of the minimum withdrawal application size. In this case, the Bank gives guarantee to the negotiating bank to settle the amounts on presentation of certain documents from the bank as agreed in the letters of credit.

- Payments from the SAs by the PCU. One SA is for Component 3 (the EAF) and the other SA is for Components 1, 2, and 4.

Detailed accounting procedures for managing the two SAs are shown below. The other two payment methods are straightforward and need no more explanation.

Accounting procedures for SA-A:

In line with Component 3 of the project, the EAF will be established to disburse funds to communities, NGOs, and POs to ensure the timely and effective flow of funds to these entities. SA-A will be opened for this purpose and the management of this fund will be carried out by the financial management team acceptable to IDA.

Fund and reporting flows—NGOs and POs:

In accordance with the financing agreement signed between the NGO/PO and EAF, funds will be transferred to the NGOs/POs from SA-A on a tranche basis. The first transfer to each of the NGOs and POs will be as outlined in the financing agreement. Subsequent transfers will be made after the EAF has received interim reports (including financial and physical reports). The interim reports will be reviewed prior to disbursing the next tranche. Formats of the financial reports will be in the PIM. All the source documents will be kept at the offices of the NGOs and POs and should be available for external auditors and Bank staff during supervision mission.

The EAF team will be responsible for following up with the NGOs/POs to ensure that reports are received on a timely basis. Each NGO/PO that receives a grant in excess of the equivalent of US$10,000 will be required to submit an annual audit report to the EAF.

Based on the financial reports received from the NGOs and POs, the PCU will request IDA replenishment of the SA. Based on the replenishment application, IDA will replenish the SA.

Fund and reporting flows—woredas and communities:

Following the detailed implementation arrangements of the EAF, money will be transferred to *woredas'* project bank account from SA-A. This bank account will be used solely for the purposes of the EAF activities of the *woreda*; disbursements from this bank account will require two signatures: one from the WAC and one from the *woreda* administration. The *woredas* are required to submit quarterly financial and progress reports in line with the PIM. The reports will be reviewed on a regular basis; in addition, *woredas* will be subject to random financial and technical audits.

Replenishment of the SA will be made on the basis of SOEs submitted by the *woredas* to the PCU. It is assumed that the amount to be given for each of the *woredas* will be less than the SOE limit. All the original source documents should be kept at each of the *woreda* offices and should be available for external auditors and Bank staff during supervision mission.

Accounting procedures for SA-B:

SA-B will be used to finance Components 1, 2, and 4. Based on approved work programs, money will be transferred to each of the Birr Project bank accounts in the line

ministries and RAC Secretariats. Each of the line ministries and RAC Secretariats will maintain proper books of accounts to record all the transactions related to the project. Each quarter, every line ministry and RAC Secretariat will submit financial and progress reports to the PCU (formats to be shown in the PIM). Based on the quarterly financial reports, the PCU will replenish the Birr Project bank accounts at each of the line ministries and RAC Secretariats. All the original source documents should be kept at the offices of each of the line ministries and RAC Secretariats and available to external auditors and Bank staff during supervision mission. The PCU's financial management team will follow up with the line ministries and RAC Secretariats to receive the interim financial reports.

The PCU will request replenishment of the SA based on the financial reports received from the line ministries and RAC Secretariats.

A Birr Project account could be opened by the PCU for the purpose of Component 4 and a 90-day advance could be made from the SA to the local currency account. Advances to the Birr Project account will be used for eligible expenditures and accounted for properly by the project financial management team.

Financial reporting and auditing:

Each of the line ministries, RAC Secretariats, NGOs/POs, and *woredas* will submit quarterly financial and progress reports in line with the PIM. The PCU will consolidate all the financial reports from each of the implementing entities and produce monthly, quarterly, and annual consolidated financial reports. These consolidated accounts will include the transactions from the EAF, prepared by the EAF fund manager.

The project consolidated annual financial statements will be audited by independent external auditors appointed by the Federal Auditor General, acceptable to IDA. Detailed Terms of Reference will be prepared for the auditors by the PCU and cleared by IDA. The auditors' report should be submitted to IDA no later than six months after the end of a fiscal year. The auditors' report should include a management letter to be issued at the end of their audit.

Disbursements:

Allocation of credit proceeds (Table C):

The project will be implemented over a three-year period, estimated to start on December 1, 2000. The closing date of the Credit is set for December 1, 2003.

At this stage, the PCU is not ready for PMR-based disbursements. Therefore, traditional disbursement procedures will be followed for at least the first 12 months. Table C below sets out the categories of expenditures to be financed by the Credit and the allocation of the amount of the Credit to each of the categories and the percentage of expenditures to be financed by the Bank for each category.

Table C: Allocation of Credit Proceeds

Expenditure Category	Amounts in SDR Equivalent	Financing Percentage
Goods	11,350,000	100% of foreign expenditures 85% of local expenditures
Grants	18,950,000	100%
Consultancies and Training	10,200,000	100%
Incremental Operating Costs	1,150,000	90%
Unallocated	3,550,0000	
Total	45,200,000	

Use of Statements of Expenditures (SOEs):

SOEs will be submitted for withdrawals from the Credit Account to be made on the basis of statements of expenditure for (i) goods under contracts costing less than US$100,000 equivalent each; (ii) services under contracts costing less than (A) US$100,000 equivalent each for consulting firms, and (B) US$50,000 equivalent each for individual consultants; (iii) all Incremental Operating Costs and training; and (iv) all Grants to (A) *woreda*, and (B) other Beneficiaries, costing less than US$50,000 equivalent each.

Replenishment of funds from IDA to the SAs will be made on evidence of satisfactory utilization of the previous advance, reflected in the consolidated SOEs prepared by the PCU. Withdrawal applications for direct payment and special commitments will be for a minimum of US$100,000 or 20 percent of the SA authorized allocations, whichever is lower.

Special Accounts:

To expedite disbursements, the Government will open two SAs with the National Bank of Ethiopia or any other bank acceptable to IDA, operated by the PCU.

One SA will be used exclusively for expenditures incurred by the EAF (i.e., Component 3 of the project). These expenditures will include the BGs (in Birr) to the *woredas* and the financing of NGOs/POs for community-level activities.

The other SA will be used for expenditures incurred by the NAC Secretariat under Components 1, 2, and 4 of the project. These expenditures will include operating expenditures of the NAC Secretariat and amounts advanced to Birr Project accounts, which will be established for all major participating ministries and the RAC Secretariats. Expenditures of the Regional Bureaus (RB) will be made from the RAC Secretariat Birr Project account. Based on initial annual work plans approved by the PCU, the Birr Project accounts will initially receive funds required to meet the needs of the first quarter. Subsequent transfers to the Birr Project accounts will be based on the quarterly cash needs and the receipt and review of quarterly reports (physical progress and financial). Birr Project accounts will be used solely to pre-finance their direct expenditures related to approved HIV/AIDS activities under the project.

The authorized allocation for SA-A (for Component 3) will be US$4.0 million; the authorized allocation for SA-B (for Components 1, 2, and 4) will be US$3.5 million. Upon Credit effectiveness the PCU will submit withdrawal applications for initial deposit into the SAs. The two SAs will be used to pre-finance expenditures incurred by the project directly and also to advance funds to Birr Project accounts, which will be established for all major executing entities. Auditors carrying out the financial audit will be required to provide a separate opinion on the procedures and use of the SAs.

Retroactive financing:

Up to about US$1,000,000 will be available for retroactive financing for eligible project expenditures that have been incurred in accordance with IDA Procurement Guidelines. This will particularly apply to the establishment of facilities for setting up the Project Administration, preparation of the PIM, and associated workshops and seminars. This portion of the Credit will be used to reimburse the Government for eligible expenditures made no earlier than six months from the date of loan signing.

Program Management Report (PMR)-based disbursements:

Recognizing the importance of linking physical progress, the status of procurement, and financial data on this project, the project will seek to convert to PMR-based disbursements at least 12 months after effectiveness. While using traditional disbursements, the project will submit at least PMR reports 1A and 3 within 45 days of the end of each quarter.

Attachment 7

Project Processing Schedule

Composition of Task Team:

Task Manager:	Gebreselassie Okubagzhi (AFMET)
Quality Advisors:	Debrework Zewdie (ACT*africa*)
	Hans Binswanger (AFTRE)
	Jonathan Brown (AFTQK)
Health Economist:	Keith Hansen (ACT*africa*)
	Rene Bonnel (ACT*africa*)
Health Specialist:	Sheila Dutta (ACT*africa*)
	Jean-Pierre Manshande (AFTH4)
Principal Operations Specialist:	Surjit Singh (AFMET)
Lead Community Development Specialist:	Bachir Souhlal (ACT*afrcia*)
Financial Management Specialist:	Robert J. Saum (LOAAS)
	Eshetu Yimer (AFMET)
Procurement Analyst:	Samuel HaileSelassie (AFMET)
NGO and Civil Society Specialist:	Hagos Araya (AFMET)
Task Team Assistant:	Elsa Araya (AFMET)

Quality Assurance Arrangements:

The task team included key people from ACT*africa*, HDNHE, and AFTQK who have brought in their long design experience with HIV/AIDS and community-based programs, as well as an experienced financial management specialist from outside the Region (LOAAS).

Management Decisions:

Issue	Action/Decision	Responsibility
Identification	June 26 to July 15, 2000	Task Team
Draft Technical Annex	July 10, 2000	Task Team
Decision Meeting	July 12, 2000	ROC
Appraisal	July 17-27, 2000	Task Team
Technical Discussion	July 31, 2000	Task Team
Negotiations	August 1-4, 2000 (in Washington)	Res. Rep.
Board Package	August 14, 2000	Task Team
Board Presentation	September 14, 2000	ACT*africa*

Total Preparation Budget:	(US$200,000)
Bank Budget:	US$200,000
Trust Fund:	
Cost to Date:	(US$)

Gebreselassie Okubagzhi	Arvil Van Adams	Oey Astra Meesook
Team Leader	**Sector Manager**	**Country Director**

Attachment 8. Documents in the Program File

A. Program Implementation Manual

B. Bank Staff Assessments

C. National HIV/AIDS Strategic Plans

D. Regional Plans

E. Guidelines for the Preparation of the Program Implementation Manual and Operational Manual for HIV/AIDS Funds

F. *The Impact of World Bank Support to the HNP Sector in Zimbabwe* (OED 1998)

G. Tuberculosis Control Activities in the Context of Care for People Living with HIV/AIDS (template for activity needs assessment/project proposals)

H. *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis* (World Bank 1999)

I. *Safeguarding Development in the Age of AIDS* (World Bank 2000)

J. Report on the Global HIV/AIDS Epidemic, June 2000 (UNAIDS 2000)

K. Terms of Reference for Procurement Specialists

Attachment 9. Statement of Loans and Credits

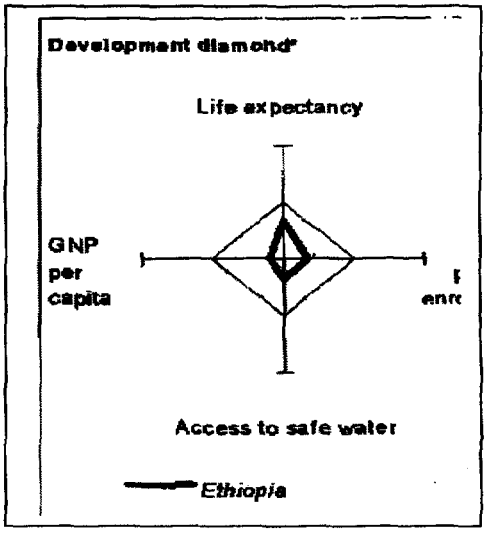
In USD Millions

				Original amounts				Expected and Actual Disbursements	
Project ID	Year of approval	Borrower	Purpose	IBRD	IDA	Cancelled	Undisbursed	Original	Revised
ET-PE-732	1998	Government of Ethiopia	Education Sect. Inves.	0.00	100.00	0.0	76.59	16.24	1.76
ET-PE-733	1998	Government of Ethiopia	AG. Research &Training	0.00	60.00	0.0	52.99	7.35	7.35
ET-PE-734	1993	Government of Ethiopia	Road Rehabilitation	0.00	96.00	0.0	33.13	38.00	37.38
ET-PE-736	1998	Government of Ethiopia	Energy II	0.00	200.00	0.0	161.48	30.85	30.85
ET-PE-752	1995	Government of Ethiopia	National Seeds	0.00	22.00	0.0	11.67	12.32	18.64
ET-PE-753	1995	Government of Ethiopia	National Fertilizer	0.00	120.00	0.0	20.68	5.65	6.87
ET-PE-755	1998	Government of Ethiopia	Road Sec. Dev.	0.00	309.20	0.0	250.77	85.00	6.64
ET-PE-756	1999	Government of Ethiopia	Health Sect. Invest.	0.00	100.00	0.0	89.80	29.88	6.87
ET-PE-758	1994	Government of Ethiopia	Calub Energy	0.00	74.31	0.0	59.05	60.36	60.36
ET-PE-764	1996	Government of Ethiopia	Water Supply & Rehab.	0.00	35.73	0.0	19.17	22.80	5.21
ET-PE-771	1996	Government of Ethiopia	ESRDF	0.00	120.00	12.8	54.63	22.06	63.59
Total				0.00	1237.24	12.8	829.96	330.51	245.52

	IBRD	IDA
Original Principal	108,600,000	2,908,756,976
Cancellation	3,023	206,145,300
Disbursed	108,596,977	1,913,881,537
Undisbursed	0	829,796,822
Repaid	102,561,482	145,204,095

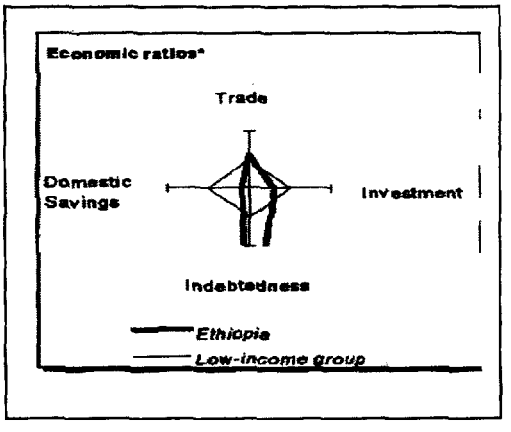
Attachment 10. Ethiopia at a Glance

POVERTY AND SOCIAL	Ethiopia	Sub-Saharan Africa	Low-Income
1998			
Population . Mid-year (Millions)	61.3	628	3.515
GNP per capita (Atlas method. US$)	100	480	520
GNP (Atlas Method. US$ billions)	6.1	304	1.844
Average annual growth. 1992-98			
Population (%)	2.8/a	2.6	1.7
Labor force (%)	..	2.6	1.9
Most recent estimate (latest year available. 1992-98			
Poverty (%of population below national poverty line)	45	..	..
Urban Population (%of total population)	17	33	31
Life expectancy at birth (years0	43	51	63
Infant Mortality (per 1,000 live births)	107	91	69
Child Malnutrition (% of children under 5)	48	..	..
Access to safe water (% of population)	26	47	74
Illiteracy (% of population)	65	42	32
Gross primary enrollment (%of school-age population	38	77	108
Male	48	84	113
Female	27	69	103



KEY ECONOMIC RATIOS AND LONG-TERM TRENDS	1977	1987	1997	1998
GDP (US$ billions)	..	7.4	6.4	6.6
Gross Domestic investment/GDP	..	14.6	19.1	18.2
Exports of goods and services/GDP	..	8.4	15.8	15.8
Gross domestic savings/GDP	..	6.4	8.6	6.3
Gross national savings	..	8.5	12.0	10.3
Current account balance/GDP	..	-5.9	-7.1	-7.9
Interest Payments/GDP	..	0.8	1.1	1.6
Total debt/GDP	..	98.9	149.3	149.5
Total debt service/exports	5.9	38.9	30.5	10.8
Present value of debt/GDP	..	..	129.7	120.5
Present value of debt/exports	..	..	795.0	762.5

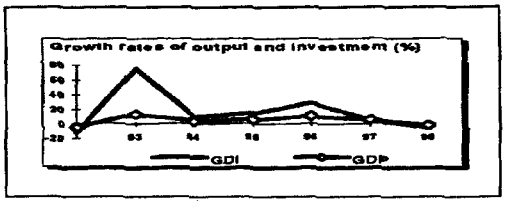
	1977-87	1988-98	1997	1998	1999-03
(average annual growth0					
GDP	-0.3	3.6	5.9	-1.0	6.4
GNP per capita	-3.0	0.6	2.9	-4.6	3.4
Export of Goods and services	3.7	4.2	51.0	-9.4	7.1

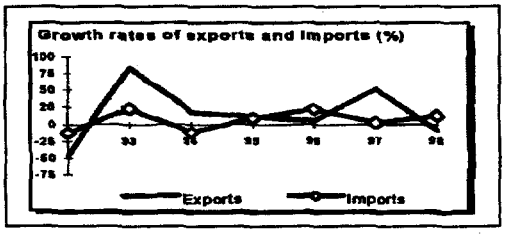


STRUCTURE OF THE ECONOMY

	1977	1987	1997	1998
(% of GDP)				
Agriculture	..	49.8	55.5	49.8
Industry	..	15.3	6.7	6.7
Manufacturing	..	9.1	..	..
Services	..	34.9	37.8	43.5
Private consumption	..	78.7	80.0	79.4
General government consumption	..	14.8	11.4	14.3
Imports of goods and services	..	16.5	26.4	27.7

	1977-87	1988-98	1997	1998
(average annual growth)				
Agriculture	-2.1	2.7	3.4	-10.3
Industry	2.2	2.7	6.8	6.3
Manufacturing	-1.6	2.9	5.9	5.8
Service	1.6	4.8	7.1	10.4
Private consumption	-1.6	3.5	-1.0	-0.7
General government conniption	2.5	-1.0	13.4	31.3
Gross domestic investment	1.2	7.4	5.9	-5.7
Imports of goods and services	0.9	2.3	1.8	11.7
Gross national product	-0.4	3.6	5.9	-1.8

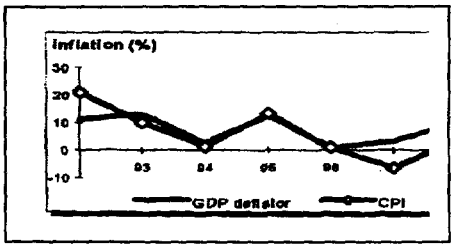




Note: Data in fiscal years ending June 30 of year shown unless otherwise indicated.
* The diamond show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete

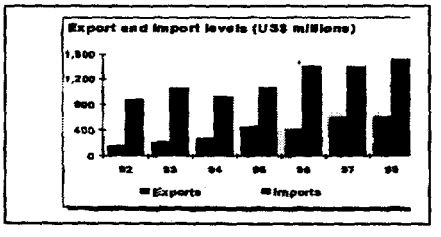
PRICES AND GOVERNMENT FINANCE

	1977	1987	1997	1998
Domestic prices				
(% change)				
Consumer prices	16.7	-2.4	-6.4	3.6
Implicit GDP deflator		-6.4	3.2	9.7
Government finance				
(% of GDP includes current grants)				
Current revenue		19.0	18.2	18.0
Current budget balance		1.9	4.4	2.2
Overall surplus/deficit		-7.1	-5.2	-6.8



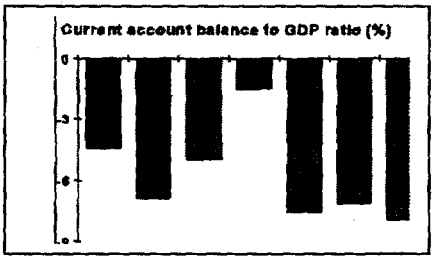
Trade

	1977	1987	1997	1998
(US$ millions)				
Total exports (fob)	312	391	599	602
Coffee		253	355	420
Hides		52	57	51
Manufactures	..	..	..	..
Total Imports (cif)	386	1081	1403	1519
Food		194	110	172
Fuel and energy		109	232	246
Capital goods		463	515	569
Export price index (1995=100)		77	86	99
Import price index (1995=100)		118	107	104
Terms of Trade		65	81	95



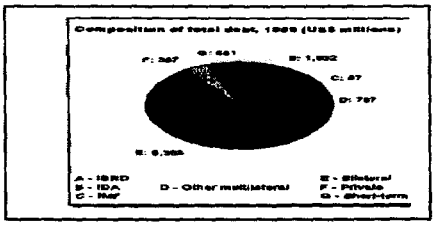
BALANCE OF PAYMENT

	1977	1987	1997	1998
(US$ millions)				
Export of goods and services	406	623	1012	1037
Imports of goods and services	510	1217	1683	1815
Resource balance	-105	-594	-671	-778
Net income	-2	-48	-43	-91
Net current transfers	59	204	259	349
Current account balance	-47	-473	-455	-520
Financing items (net)	26	416	265	650
Changes in net reserves	74	21	191	-129
Memo:				
Reserves including gold (US$ millions)	260	224	584	412
Conversion rate (DEC local/US$)	2.1	2.1	6.5	6.9



EXTERNAL DEBT AND RESOURCE FLOWS/B

	1977	1987	1997	1998
(US$ millions)				
Total debt outstanding and disbursed	501	7364	9529	9812
IBRD	66	57	0	0
IDA	142	601	1604	1632
Total debt service	25	249	317	114
IBRD	10	13	0	0
IDA	1	9	26	29
Composition of net resource flows				
Official grants	44	346	..	..
Official creditors	41	422	14	-209
Private creditors	-2	72	-163	-6
Foreign direct investment	6	-3	..	..
Portfolio equity	0	0	..	..
World Bank Program				
Commitments	57	50	0	769
Disbursement	35	86	64	69
Principal repayments	5	13	15	18
Net flows	30	73	49	51
Interest payments	6	10	11	11
Net transfers	24	64	38	40



Attachment II. Ethiopia HIV/AIDS Brief

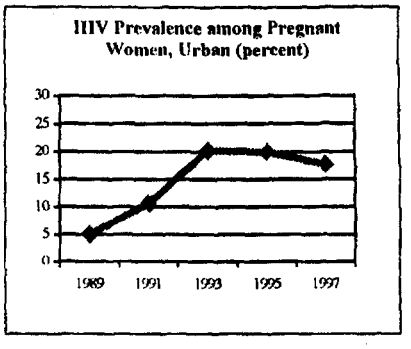
HIV/AIDS Prevalence Ranking in Sub-Saharan Africa: 16

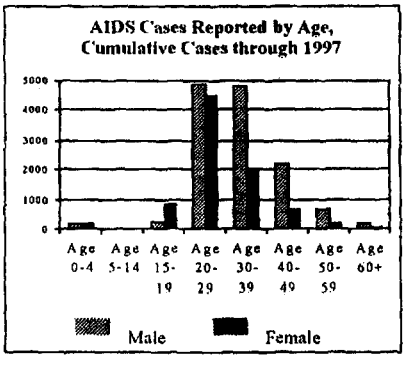
Background

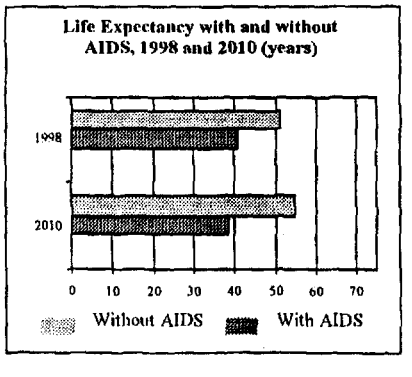
- In the early years of the HIV/AIDS epidemic, people engaging in high-risk behavior were most affected. HIV prevalence among sex workers tested in Addis Ababa increased from less than 1 percent in 1985 to 54 percent in 1990 Prevalence among male STI patients tested in Addis Ababa rose from 8 percent in 1987 to 38 percent in 1992
- In recent years, the epidemic has become increasingly generalized. In Addis Ababa, HIV prevalence among antenatal clinic attendees rose from 5 percent in 1989 to 20 percent in 1993; in 1997, 18 percent of antenatal clinic attendees tested in Addis Ababa were HIV-positive Outside Addis Ababa, prevalence among antenatal clinic attendees increased from 5 percent in 1991 to 9 percent in 1998
- The epidemic is orphaning Ethiopian children in huge numbers By the end of 1999, 1.2 million children had lost their mother or both parents to AIDS
- Information on knowledge and behavior related to HIV/AIDS is essential in identifying populations at risk of infection and is critical in assessing changes over time as a result of prevention efforts In 1994, less than half of people ages 15-49 (urban males and females) reported using a condom during the most recent intercourse of risk.

Key Data (end 1999)

Prevalence among ages 15-49: 10.63%
Total population: 61.923 million
People living with HIV/AIDS: 3 million
Adults (15-49): 2.9 million
Women (15-49): 1.6 million
Children (0-14): 150,000
AIDS deaths in 1999: 280,000
Number of HIV/AIDS orphans since the start of the epidemic: 1.2 million
HIV prevalence among pregnant women (median):
Urban: 17.6% (1997)
Rural: 9.2% (1998)







Country Response/Obstacles

- In 1998, the Council of Ministers ratified the national HIV/AIDS policy, advocating a multisectoral response to the epidemic However, the health sector remains the only player in many regions of the country.
- All 11 regions of the country have formulated strategic plans for 1998-2002 and a national strategic framework for the HIV/AIDS response has been drafted
- An international conference focusing on the epidemic in Ethiopia took place in November 1999. Participants discussed new initiatives to prevent further spread of HIV to rural populations and school-aged children
- The instability of Ethiopian society caused by war and famine and the breakdown of community cohesiveness continue to contribute to epidemic spread and hinder efforts to stop it

Bank Activities to Date

	Yes	No
Is HIV/AIDS a regular part of our high-level dialogue with govt and civil society?	√	
Does HIV/AIDS receive substantive treatment in the CAS or its update?		√
Has the portfolio been reviewed for HIV/AIDS retrofitting?	√	
Do all projects include the necessary HIV/AIDS-mitigation components?	Underway	
Does the Bank regularly attend UNAIDS meetings?	√	

Project Name	Approval Date	$M	AIDS $M
Health Sector Dev Program	10/27/98	100 0	2 0
Multi-sectoral HIV/AIDS Project	9/14/00	59 7	59 7

Opportunities

[To be identified by the Country Team.]

KENYA

Kenya HIV/AIDS Disaster Response Project

TECHNICAL ANNEX

Africa Regional Office
AFTH1

Date: August 14, 2000	**Team Leader:** Albertus Voetberg
Country Manager/Director: Harold E. Wackman	**Sector Manager/Director:** Dzingai B. Mutumbuka
Project ID: P070920	**Sector(s):** MY-Multi-sector
Lending Instrument: Specific Investment Loan (SIL)	**Theme(s):** HIV/AIDS
	Poverty Targeted Intervention: *N*

Project Financing Data:

Loan **Credit** √ Grant Other (specify)

For Loans/Credits/Others:
Amount: SDR 37.9 million (US$50 million equivalent)

Proposed Terms: Standard IDA

Grace Period (years): 10	**Years to Maturity:** 40
Commitment Fee: Up to 0.5%	**Service Charge:** 0.75%

Financing Plan: Source (US$M)	**Local**	**Foreign**	**Total**
GOVERNMENT	2.4	0.0	2.4
IDA	47.0	3.0	50.0
Total:	49.4	3.0	52.4

Borrower: Government of Kenya

Responsible Agency: Office of the President

Address: Office of the President, National AIDS Control Council, Kenyatta National Hospital Grounds, P.O. Box 19361, Nairobi, Kenya
Contact Person: Dr. T. Mboya
Tel: (254) (2) 714972/ 729549 Fax: (254) (2) 729504/726036 Email:

Estimated Disbursements (Bank FY/US$M):

FY	2001/2002	2002/2003	2003/2004	2004/2005
Annual	4.8	15.2	15	15
Cumulative	4.8	20	35	50

Project Implementation Period: 4 years
Expected Effectiveness Date: December 1, 2000
Expected Closing Date: June 30, 2005

Implementation Period				
Total Financing Required	Year 1	Year 2	Year 3	Year 4
Project Costs				
Investment Costs	4.7	15.4	15.0	15.0
Recurrent Costs	0.5	0.6	0.6	0.6
Total Project Costs	5.2	16.0	15.6	15.6
Total Financing	5.2	16.0	15.6	15.6
Financing				
IDA	4.8	15.2	15.0	15.0
Government	0.4	0.8	0.6	0.6
Total Project Financing	5.2	16.0	15.6	15.6

Table of Contents

Attachments

A. PROJECT PURPOSE AND DEVELOPMENT OBJECTIVE

Project purpose:

1. The project contributes to the partnership against HIV/AIDS in Kenya by supporting the Government's program as articulated in the National HIV/AIDS Strategic Plan. The purpose of this program is to reduce the spread of HIV/AIDS, to mitigate the socio-economic impact of the disease, and to increase access to care and support for people infected or affected by the HIV/AIDS epidemic in Kenya. The overall project is based on a new approach for addressing HIV/AIDS, supporting and strengthening community-based responses to the epidemic. The National HIV/AIDS Strategic Plan, the Executive Summary of which is annexed in the Project Implementation Plan, is the reference for both the program and the project.

Project development objective:

2. The objective of the project is to intensify the multi-sectoral response to HIV/AIDS and accelerate the process of achieving the targets as elaborated in the National Strategic Plan with broad participation of communities.

Key performance indicators:

3. While a more extensive list of indicators appears in the logical framework, the project will contribute to the achievement of two key targets indicating progress against the goal of reducing the transmission of HIV in Kenya as described in the National HIV/AIDS Strategic Plan:

i) the decrease from 14 percent to 13 percent of HIV prevalence among people aged 15-24 years by 2003;
ii) by 2004, HIV/AIDS prevalence among adults (15-49 years) will remain below 14 percent.

4. The following constitute the summary indicators for outputs, process and impact of the program:

A. Output Indicators
The percentage of Credit Proceeds under Part C disbursed per constituency, district, and province;
The number of line ministries that have sensitized their staff on the facts about HIV/AIDS;
The number of public sector training institutions that have integrated HIV/AIDS issues in their curriculum;
The percentage of CACCs/DACCs/PACs having submitted approved proposals under Part C;
The proportion of proposals under Part C that focus on prevention, and care and support, respectively.

B. Process Indicators
The percentage of districts and constituencies that have functional voluntary counseling and testing (VCT) centers;
Knowledge of parent-to-child transmission and ways to prevent it;
The percentage of districts and constituencies that have functional patient support centers;
The extent to which HIV/AIDS issues are examinable subjects in a) primary schools; b) secondary schools; and c) other training institutions;
The percentage of districts and constituencies with active programs to support orphans;
As above for widows;
VCT utilization rates;
The percentage of ministries with budget line items for HIV/AIDS-related programs.

C. Impact Indicators
Prevalence rates of HIV infection, by age group and gender;
Median age at first sex;
Reported condom use at last sex with non-regular partner;
STI incidence/prevalence;
Primary school enrollment and completion rates among orphans;
The number of non-regular sexual partners during a defined period, by marital status, age group, and gender.

B. Strategic Context

Sector-related Country Assistance Strategy (CAS) goal supported by the project:

5. To promote long-term poverty reduction, and target and improve the effectiveness of poverty-focused interventions by concentrating project assistance on key social sectors.

Document number: 18391 KE Date of latest CAS discussion: 09/24/1998

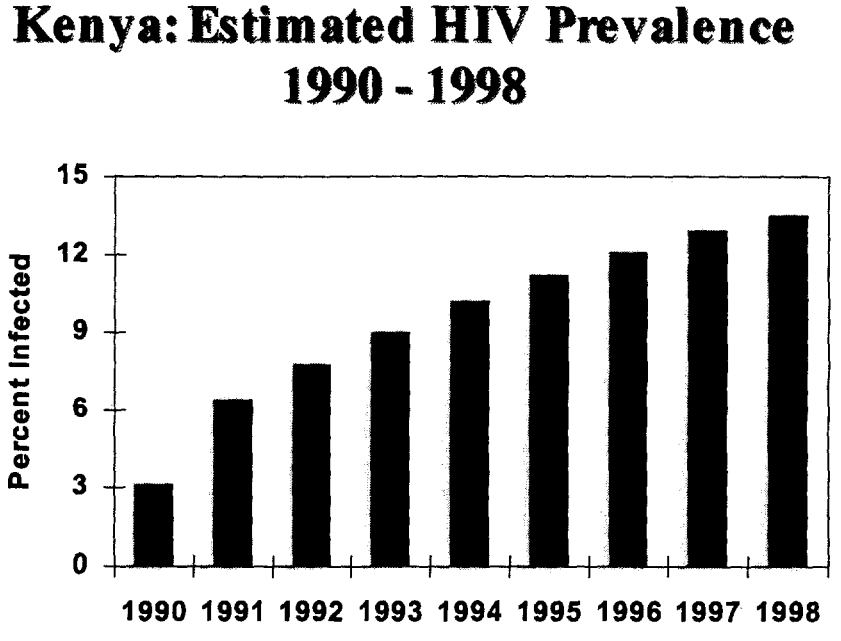
Main sector issues and Government strategy:

6. Approximately 14 percent of all adults (15-49 years) in Kenya are infected with HIV, with the prevalence rate exceeding 20 percent in some districts. Of the approximately 2.2 million Kenyans who are now infected, 106,000 are children under the age of five years. Of particular concern is HIV prevalence among young women, with 24 percent of women aged 15-24 being infected versus 4 percent of men in the same age group (1998 Demographic and Health Survey). On average, close to 500 people in Kenya are estimated to die daily because of AIDS, with 80 percent of these being aged 15-49 years—the most economically productive. The economic loss incurred by the country is estimated at US$3 million daily.

7. Kenya has achieved significant success in making HIV/AIDS-related information and services available to its people. Basic awareness of the disease and ways to prevent transmission are high. Condom use has increased dramatically from 0.3 million being

used each month in 1990 to 10 million per month today. Blood screening has resulted in more than 98 percent of the country's blood supply being safe from HIV. However, prevalence has continued to increase despite these gains (see Figure 1), and life expectancy has decreased from a projected figure of 65.4 years without AIDS for the period 1995-2000 to an actual figure of 54.7 years with AIDS. By 2005, life expectancy is projected to further decline to 53.1 years. To date, HIV/AIDS has been addressed primarily as a health issue; however, in actuality it has become a national development crisis that reaches far beyond the health sector.

Figure 1



8. The impact of HIV on poverty is significant. With the negative impact of HIV/AIDS on all aspects of development, it compromises all other measures intended to reduce poverty. In addition to escalating health care expenditures for both the government and families, the disease has created growing numbers of AIDS orphans. It reduces the size and experience of the labor force, with negative economic impact for households and the economy at large. This impact is exacerbated by the fact that it strikes mainly people in their most productive years. Therefore, prevention and mitigation of HIV/AIDS is central to an effective poverty-reduction strategy, as the economic effects of AIDS ripple outwards from individuals to their families, to firms and businesses, and to the macro economy.

9. HIV/AIDS exacerbates poverty because of its negative impact on all aspects of development. Several studies (by the Food and Agriculture Organization [FAO], among others) have shown how effectively HIV/AIDS can drive households into poverty when their assets (e.g., livestock) are sold to cover the costs of medical care, or when the available labor force becomes insufficient to tend to the necessary agricultural activities.

10. Therefore it seems likely that in Kenya measures to reduce poverty cannot succeed in the current environment where HIV prevalence is high and increasing. Therefore,

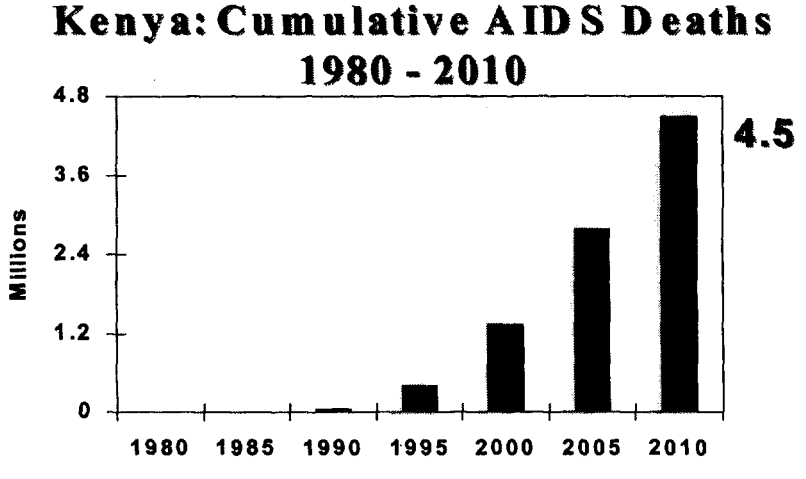
prevention and mitigation of HIV/AIDS is central to an effective poverty-reduction strategy, while poverty reduction in itself is needed to mitigate the socio-economic impact that the epidemic imposes on society.

11. Poverty provides the conditions for the spread of HIV/AIDS. The impact of poverty on women drives them to adopt coping mechanisms that may include increased risk exposure (e.g., commercial sex). Poverty also limits the scope for long-term development prospects, thereby reducing the barriers for taking otherwise unacceptable risks. A study in Kenya has shown that school enrollment rates for children from HIV affected households, including orphans, are significantly lower than the national average. The limited access to formal education of this increasingly substantial cohort of children, particularly girls, may well provide the fertile ground for poverty and increased risk of exposure to HIV.

12. The fact that HIV prevalence has been rising steadily throughout the 1990s is of considerable importance. It indicates that the most serious impacts of the Kenyan epidemic, in terms of overall morbidity, mortality, and socio-economic consequences, are yet to come.

13. Between 2000 and 2010, another 3.2 million Kenyans may die, for a cumulative total of 4.5 million deaths since the beginning of the epidemic. This is enormous mortality for a mid-sized country and illustrates that the full brunt of HIV/AIDS will be felt in the future. Figure 2 illustrates this point well.

Figure 2



14. Realizing the enormity of the problem, the Government of Kenya has declared AIDS a national disaster and established the National AIDS Control Council (NACC) to coordinate a multi-sectoral response to the crisis. NACC was established in December 1999, in accordance with the National AIDS Policy, which was passed by Parliament in 1997. A small Secretariat for NACC is currently being recruited and is expected to be operational by the end of August 2000.

15. AIDS Control Units (ACUs) are currently being established in seven ministries, and ACUs will subsequently be established in the remaining eight ministries and seven "major departments" over the next year, for a total of 22 ACUs to be coordinated by NACC. The NACC will be responsible for the implementation of the National HIV/AIDS Strategic Plan, which is now being finalized. At the district and provincial levels, Provincial AIDS Control Committees (PACCs)/Provincial AIDS Control Coordinators and District AIDS Control Committees(DACCs)/District AIDS Control Coordinators will coordinate the decentralized aspects of the strategy's implementation. The Constituency AIDS Control Committees (CACCs) will be responsible for the coordination of efforts at the community level.

16. Within the context of the National HIV/AIDS Strategic Plan the following priorities have been recognized and the project will, complementary to the efforts by all partners and other Bank-financed projects, focus on the same.

- Prevention and Advocacy
  - Behavior modeling and promotion of behavior change
  - Prevention of blood-borne infection
  - Treatment and control of sexually transmitted infections (STIs)
  - Prevention of parent-to-child transmission of HIV
- Treatment and Support of Continuum of Care of the Infected and Affected
- Monitoring, Evaluation, and Research
- Mitigation of the Socio-economic Impact of HIV/AIDS
- Management and Coordination

Sector issues to be addressed by the project and strategic choices:

17. *Institutional and Organizational Development*: The Sessional Paper on AIDS, which comprises the National AIDS Policy, provides for the participation of all sectors of society in the implementation of the National HIV/AIDS Strategic Plan. This decision by the Government to expand the responsibility for the response to the epidemic beyond the health sector and the public sector brings important and major challenges for the establishment of a new institutional and organizational framework. An important aspect of the project will be to support the institutional and organizational development of the multi-sectoral response. Analytical work (e.g., impact assessments), technical assistance to design appropriate organizational mechanisms, and capacity building to formulate and design adequate interventions will be supported by the project. This support will be inclusive of the coordinating agencies at various levels (NACC/PACCs/DACCs/CACCs) as well as the implementing agencies such as the ACUs, the private sector, Non-Governmental Organizations (NGOs)/Community-Based Organizations (CBOs), the Network of People Living with HIV/AIDS, and research institutions.

18. *The Prevention of New HIV Infections*: Reducing the incidence of HIV is the single most important objective to address the epidemic. Strategies and activities to achieve this vary according to the target population and encompass health education, sex education, anticipatory guidance for children and parents, peer support programs, behavior-change interventions, the promotion of condom use, voluntary counseling and

testing, the promotion of abstinence, the prevention of parent-to-child transmission, the reduction of susceptibility through STI treatment, the screening of blood before transfusion, post-exposure treatment for rape-victims, etc. The implementing agencies will be required to put special emphasis on three target groups for prevention activities to be funded under the project: a) the poor and vulnerable (e.g., women and children); b) those in whom significant investments will be made or have been made (e.g., new recruits, school and university entrants, employees); and c) potential core transmitters of HIV (e.g., commercial sex workers, migrant workers, truck drivers, construction workers). The extent to which the various implementing agencies will be involved with any given target group will depend on their respective mandates and access to these groups.

19. Major roles are anticipated for the education sector (children, school and university entrants, employees), the private sector (employees, new recruits, migrant workers), public sector institutions (employees, new recruits), especially those with important extension services like agriculture, police, defense, health, and livestock (rural poor and vulnerable), and NGOs/CBOs (commercial sex workers, women, the poor, street children). NACC and its equivalents at the provincial, district, and constituency levels will be supported to coordinate these activities, promote consistency in the various approaches, and disseminate experiences and best practices. NACC's work-program will include the development of clear guidelines on breastfeeding, vaccination, and treatment of HIV positive expectant women, as well as support for HIV orphans and other vulnerable populations. These guidelines will be based on the latest national and international research policy.

20. *Mitigating the Socio-Economic Impact of the HIV/AIDS Epidemic*: The HIV/AIDS epidemic in Kenya has significant impact on individuals, households, businesses, public institutions, and whole sectors. The growing number of orphans poses an enormous challenge for the social sectors. Reaching them in order to provide just the very basic health and education services already constitutes a significant problem. Coping mechanisms for households are stretched to the limit and businesses find themselves confronted with increased costs for social benefits, a high turnover of staff, and a less-productive workforce. Whole sectors such as health, agriculture, and education now realize that their usual service delivery mechanisms and the content of those services will have to be revisited (an example of the issues in rural extension services is given in Box 1). Implementation of the National HIV/AIDS Strategic Plan will include measures to be supported by the project to mitigate these effects of the epidemic, including the design and promotion of social safety nets for those affected by HIV/AIDS.

Box 1: Excerpt from FAO study in Rakai, Uganda

"Extension workers are often absent from work to attend funerals and care for sick relatives. At the same time, several staff members from all levels have contracted the disease and some have died. The problem was compounded by the fact that it is difficult to find trained people to replace former staff, both because the area is remote and also because it has the reputation of being a highly HIV/AIDS-affected area.

The epidemic has also made it more difficult for extension staff to meet the farmers; if a meeting should coincide with a funeral, the meeting has to be rescheduled. As there were as many as 10 to 15 deaths a month in the community, such meetings were difficult to organize.

Extension messages will have to be revised to take into account the impact of the disease on agricultural systems. Extension packages appropriate for families with plenty of labor might not be suitable for households where several adults have died. Special target groups such as widows and orphans will have to be paid special attention."

21. *Increasing Access to Care and Support for Those Infected or Affected by HIV/AIDS*: An estimated 2.2 million HIV infected people are currently living in Kenya. In addition, an estimated 700,000 children have been orphaned through the death of their mother or both parents. To provide at least a basic, sustainable, but meaningful package of care and support to both groups poses enormous economic, social, ethical, and organizational challenges to Kenyan society. While there are great efforts undertaken by families, communities, the Government, and its development partners to address the issues involved, there remains a huge and growing demand. The project will support activities that increase access to social support services, such as patient support groups coordinated by the Network of People Living with HIV/AIDS, and initiatives to provide care and support for orphans. Activities will be formulated that promote the human rights of those infected or affected, including the articulation of policies that guard against discrimination in employment practices and access to benefits. The support for medical care, in the form of treatment for opportunistic infections, including tuberculosis, will be addressed through the parallel health project (Decentralized AIDS and Reproductive Health–DARE).

22. *Promoting an Enabling Socio-Cultural Environment for a Multi-sectoral Response*: One of the key reasons a broader approach to the HIV/AIDS issue is necessary is the influence of socio-cultural norms and values on the spread of the disease. Attitudes toward gender, religious teachings on sexuality, and social and cultural practices often facilitate the spread of HIV. Efforts will be made to promote socio-cultural norms, values, and beliefs that are consistent with the reduction of HIV transmission, and that protect the human rights of those infected or affected by HIV. NACC-coordinated activities are expected to pursue this objective through education, advocacy, counseling, consultation, and intensified enforcement of both customary and written laws, particularly with respect to gender-specific issues. The reduction of stigma will receive special attention as it constitutes an important obstacle for affected individuals and households to access support and care services. The project will support such efforts through both the financing of work-programs of the implementing partners of NACC and of activities directly coordinated by NACC on this issue.

23. Women are especially vulnerable to HIV infection due to a variety of social and biological factors. The Government will work with community agencies to provide support for activities that reduce the risk of HIV infection among women, such as basic education on sexual and reproductive health, HIV, and STIs; activities for youth designed to delay sexual debut; harmonizing the age of consent, marriage, and maturity to 18 years; encouraging voluntary testing; and empowering women on matters pertaining to access to information, employment, and economic/social recognition.

24. A large percentage of new HIV infections occur among youth, particularly young women (15-19 years). NACC, in close cooperation with the education sector, will provide direction in the development of culturally, morally, and scientifically acceptable AIDS education programs for youth in and out of school and advocate for the protection of youth against behaviors that place them at increased risk of HIV infection. These activities will be supported both through the financing of work-programs and activities coordinated by NACC.

25. *Research*: Developments in the area of HIV/AIDS are occurring rapidly, as related to new approaches in the field of prevention as well as in relation to treatment and care. Studies are needed to establish the effectiveness, feasibility, affordability, and appropriateness of these in the Kenyan context. In addition, in order to develop an appropriate response, impact assessments that quantify specific changes due to HIV/AIDS are needed in various sectors. NACC has the mandate to set the priority research agenda and the project will consider supporting studies that may lead to a more effective and efficient response to the epidemic. It is anticipated that studies related to parent-to-child transmission, women-controlled methods for HIV and STI prevention such as microbicides, and impact studies will be supported.

C. PROJECT DESCRIPTION SUMMARY

Overall project design:

26. During the early phase of implementation, the project is designed to facilitate the launch of the expanded and intensified response to the HIV/AIDS epidemic in Kenya. Since the arrangements and mechanisms for this expanded response are in their early stages of development, considerable flexibility has been provided to adjust work-programs after the first year of project implementation. The first year of project implementation has been fully defined, describing the activities that could, and should, be implemented sooner rather than later. During project preparation significant lack of detail was allowed in the work-programs for subsequent years although clear frameworks and criteria for project activities have been agreed.

27. The following five priority areas of the National HIV/AIDS Strategic Plan will be supported. These five themes run through the three components of the project described in attachment 4:

i) *Prevention and Advocacy*: Includes behavior modeling and promotion of behavior change through community mobilization for social change to reduce the spread of HIV, promotion of counseling and voluntary HIV testing, and protecting children and youth from HIV. Priority strategies are to prevent sexual transmission and parent-to-child transmission.

ii) *Treatment and Support of the Continuum of Care of the Infected and Affected*: Includes training, drugs, supplies, and equipment support to institutions to provide HIV/AIDS management, counseling, and home-based care. The priority strategy is to reduce the impact of HIV/AIDS on society.

iii) *Management and Coordination*: Includes training, management, and coordination support to the NACC Secretariat, 22 ACUs in line ministries and departments, eight PACCs, 68 DACCs, and 210 CACCs. Review of national policies and finalization of legislation to support AIDS prevention and mitigation are also included. The priority strategy is to increase efficiency and effectiveness in the implementation of the National HIV/AIDS Strategic Plan.

iv) *Mitigation of the Socio-economic Impact*: Includes support to the most vulnerable orphans and widows in the community. These community-based activities will be coordinated through the CACCs. Mobilization of community-based associations, the private sector, civil society, and Government departments to support people most devastated by AIDS will be enhanced. The priority strategy is to reduce the impact of HIV/AIDS on society.

v) *Research, Monitoring, and Evaluation*: Includes basic operations research to strengthen prevention and care, surveillance, monitoring, and implementation of the National HIV/AIDS Strategic Plan. The priority strategy is to increase efficiency and effectiveness in implementation of this strategic plan.

The three project components are:

- Support to line ministries (US$10.3 million): The purpose of this component is to initiate, facilitate, and support the mainstreaming of HIV/AIDS-related activities into all line ministries.

- Coordination of program and project activities by NACC and its decentralized entities (US$12.1 million): This component will focus on the institutional strengthening of NACC and related entities (PACCs, DACCs, and CACCs) and the activities by these institutions to co-ordinate the national program as well as the project activities.

- Support to implementation of initiatives from civil society, private sector, and research institutions (US$30.0 million): This component will make financial resources available to civil society, private sector, and research institutions, with a strong priority given to community-driven initiatives.

- **PROJECT RATIONALE**

Major related projects financed by the Bank and/or other Development Agencies (completed, ongoing, and planned):

Sector Issue	Project	Latest Supervision (PSR) Ratings (Bank-financed projects only)	
Bank-financed		Implementation Progress (IP)	Development Objective (DO)
HNP: HIV/AIDS	Cr. 2686: Sexually Transmitted Infections Project (Closes June 30, 2001)	S	S
HNP: Decentralization, HIV/AIDS and Reproductive Health	Kenya Decentralized HIV/AIDS and Reproductive Health Project (Board Date: October, 2000)		
Other development agencies			
CIDA	STI Management Program Support		
DFID	NGO/Program/Budget Support		
EU	NGO/Program Support		
GTZ	NGO/Program Support		
JICA	Research		
UNAIDS	Program Support		
UNDP	Program Support		
UNICEF	Prevention of PTCT/Program Support		
UNFPA	Program Support		
USAID	NGO/Program Support		
WHO	Program Support		

IP/DO Ratings: HS (Highly Satisfactory), S (Satisfactory), U (Unsatisfactory), HU (Highly Unsatisfactory)

Lessons learned and reflected in proposed project design:

28. *Stakeholder Consultation*: Key stakeholders, particularly those with an important role in implementation, should be involved from project identification, through preparation and appraisal, and throughout implementation. The project has been prepared in as consultative a manner as possible in the short time available. The community and CBO/NGO focus of the project design will assure consultation during implementation.

29. *Procurement*: The employment of an independent procurement agency should be considered whenever appropriate. Provision has been made for procurement support, but a procurement agency would not be appropriate for this project in view of the limited procurement under International Competitive Bidding (ICB) procedures.

30. *Financial Management*: Particularly given the new structures, it is important to have both sound financial management and clear accountability in place for both Government of Kenya and external financing. Particular stress has been put on this during preparation and it is reflected in the detailed documentation available on financial management.

31. *Implementing across Ministries*: Past experience with IDA projects has demonstrated the undesirability of implementing projects across multiple ministries, and Implementation Completion Reports (ICRs) have recommended avoiding this approach in the future. Obviously, a multi-sectoral AIDS project has no choice. However, the risks inherent in this arrangement will be mitigated by the fact that the project will be coordinated by NACC, which is located in the Office of the President. Coordination from OP gives the project sufficient authority over the other ministries involved to facilitate timely resolution of the types of problems that have plagued past projects.

32. *Policy Body vs. Implementing Agency*: The experience of IDA's Kenya population projects in supporting the National Council on Population and Development has shown the danger of a policy body overstepping its appropriate role and attempting to undertake implementation. This results in numerous implementation problems and compromises the mission of the policy body. Both the Government of Kenya and IDA have kept this issue at the forefront of the discussions on the establishment of NACC and any project support. During preparation of the project, assurances were obtained that the NACC system has only policy and coordination functions.

Indications of borrower commitment and ownership:

33. Earlier signs of commitment date back to the period 1993-1997 when the Government of Kenya released HIV surveillance data and hosted the first National Conference on HIV/AIDS. The Minister of Health declared that HIV/AIDS was a national crisis, and government and international development partners initiated socio-economic impact assessments. In 1994, the Government of Kenya borrowed US$40 million from IDA for prevention and mitigation programs. This step made Kenya's investment of resources in HIV/AIDS prevention and care among the highest in the developing world.

34. The national Parliamentary Sessional Paper on HIV/AIDS has set out Government of Kenya policy on the epidemic and promotes a multi-sectoral response. The document was intended to define national policy for the next 15 years. In June 1997, the document was tabled in Parliament and later that year (September) approved as Sessional Paper No. 4 of 1997 on HIV/AIDS. The approval of the document was seen as ground-breaking in the area of advocacy and policy development and provided for the establishment of a National HIV/AIDS Control Council (NACC).

35. From 1997 onwards, the momentum generated by the debates on national policy with regard to the HIV/AIDS epidemic led to greater national awareness of the problems. During this period a number of Regional Forums were held and addressed by President Moi and other political leaders. These led to renewed and vigorous political commitment to reducing the spread of HIV/AIDS and in particular the declaration in November 1999

by the Government that HIV/AIDS is a national disaster. The formulation and establishment of NACC immediately followed this declaration.

36. Budgetary provisions for the Fiscal Year starting July 1, 2000 indicate significant support for the functioning of NACC, and the Government has initiated important steps to mobilize additional resources from both national, bilateral, and multilateral partners.

Value added of Bank support in this project:

37. The Bank has taken the lead in the re-orientation of the response to the HIV/AIDS epidemic from a medical issue to a development one. The August 1999 launch in Nairobi of the Bank's regional AIDS strategy, "Intensifying Action Against HIV/AIDS in Africa," was well received by both the Government and the private sector, as well as by bilateral and multilateral donors. Through the Bank's regional AIDS Campaign Team for Africa (ACT*africa*) and UNAIDS, the Bank is well positioned to make regional issues and experiences available to the project. In addition, the ongoing STI Project has been re-worked since its Mid-Term Review to concentrate on the creation of an enabling environment for the expansion of the response to the HIV/AIDS epidemic. The proposed project would build on the Bank's recognized achievements in this area.

Implementation support and supervision arrangements:

38. In view of the risks described in the next section, and the number of implementing and coordinating partners, from the central to constituency level, implementation support and supervision activities are envisaged to be intensive. On a regular basis, support and supervision activities will be the responsibility of a Nairobi-based team comprising a senior health specialist/task team leader, a financial management specialist, a social development specialist, a procurement specialist, an operations analyst, an operations officer, and a disbursement officer.

39. Back-up support in Washington would involve an operations analyst, an HIV/AIDS specialist, two quality assurance specialists, a senior procurement specialist, and a senior disbursement specialist. Given the intense nature of the implementation support and supervision, no formal Mid-Term Review is envisaged for the project. The Task Team will pay special attention to, and act upon, any need to formally restructure or "re-work" the project.

40. In addition to the regular implementation support and supervision of the project, NACC will organize formal semi-annual program reviews involving all those involved in the partnership against HIV/AIDS in Kenya. These reviews will focus on the achievements made and constraints faced in the implementation of the National HIV/AIDS Strategic Plan, and on the work-program and budget for the subsequent year.

E. Risks

41. The project has a high risk of failure. But the potential returns—politically, economically, and socially—from stemming or partly reversing the HIV/AIDS epidemic in Kenya are so large that it is considered that this level of risk is very well justified. The overall project is designed such that the allocations of funds to the main components have been made with regard to the risks and likely returns associated with each component.

42. After a period of several years in which Kenya has been judged to have been both politically and macro-economically fragile with governance issues looming large, the country has now entered a more stable period. Overall Bank lending is projected to expand rapidly. In this circumstance, the political and economic risks for the project are judged to be moderate, especially given the genuinely very high priority that the government is giving to addressing the HIV/AIDS epidemic.

43. Analysis of the implementation experience with the Bank's health portfolio in Africa shows that the three most common areas of difficulty are monitoring and evaluation, project management, and procurement. Much of these stem from problems of low capacity, particularly in reaching communities.

44. This project design, through its emphasis on community involvement, active project progress monitoring, and focused technical assistance in such areas as financial management and procurement, seeks to address these issues. Nonetheless, the large number of different organizations involved in the project—both community and government agencies—remains a potential source of weakness as well as strength. Further, despite the project inputs, risks associated with coordination and sub-project quality and implementation capacity remain. Despite the attention given to financial management and probity in the project design and the generally improved governance situation in Kenya, substantial governance risks remain especially from political interference.

45. The decentralized implementation mechanisms contribute to the high risks associated with this project, including the potential for misuse of funds and related fiduciary risks. By involving the communities and other groups in the decision-making and monitoring processes, these same decentralized mechanisms are also factors that will contribute to the successful implementation of the project. The risks are being addressed in the project design through a) accountability to end users via participation in program and project design and implementation, and via transparency rules and use of local languages; b) use of an FMA for disbursement of the Community Initiative Account; c) a random financial technical and process audit of all small executing entities; d) financial audits of all large-scale executing entities; and e) integrated reports from executing entities that link performance and financial reports.

46. There is a risk of delayed disbursements due to the need for implementing entities to meet certain criteria before the flow of funds will start. These steps are required to monitor the quality of project activities and to ensure that proper fiduciary safeguards are in place, while not unnecessarily delaying project implementation. The government's possible reluctance to support NGOs and CBOs could also be a contributing factor in

slow disbursements in the Community Initiative Account; NACC has expressed its commitment to the use of NGOs and CBOs.

47. The Government and the country generally have now accepted that the epidemic needs to be addressed urgently, and therefore the risk of backsliding or denial is judged to be low. Finally, the high speed with which the project has been prepared itself generates increased risks. While the project design and preparation have sought to mitigate many of these risks, the realization of any combination of these risks would result in slow disbursements and disappointing performance.

Critical risks:

(reflecting assumptions in the fourth column of Attachment 1):

Risk	Risk Rating	Risk Minimization Measure
From Outputs to Objective		
The environment for an efficient partnership between public, private and civil society sectors deteriorates.	M	The NACC, bringing all partners together, will be pivotal in the decision making processes within the context of the project.
Standard operating procedures on financial management and procurement will be poorly understood, accepted and applied by the coordinating agencies.	H	Technical assistance will be used effectively in the form of a Financial Management Agency (Part C), a procurement specialist and intensive supervision.
Government, civil society, and religious leaders may be reluctant to support program efforts.	N	Representation by all parties will be solicited in the Project Steering Committee. Consensus-building will be promoted among GoK and its partners will be supported as a continuous process.
The HIV/AIDS Community Account established under the project may not become operational in the present political environment.	M	The effectiveness of the contract between NACC and the Financial Management Agency will be a condition for disbursement under Part C of the project.
From Components to Outputs		
Political commitment to address HIV/AIDS may decrease.	N	This issue will also be addressed in broader discussions on Poverty Reduction Strategies and include other stakeholders.
Legal mechanisms to protect vulnerable populations may not be put in place.	H	Special attention will be given to the inclusion of human right issues and the protection of the poor and vulnerable during the review of annual work-programs and the joint annual program reviews.
Basic logistical and physical facilities may not be available at all levels of coordination.	M	Emergency procurement of basic logistical requirements will be supported under the project.
Accountability and transparency of the HIV/AIDS program management may be insufficient.	H	Joint reviews by NACC and all its partners will provide for full accountability and transparency.
Basic health and social services may not be available	M	The DARE project will be operational in parallel to the KADRE project.
Overall Risk Rating	H	

Risk Rating - H (High Risk), S (Substantial Risk), M (Modest Risk), N(Negligible or Low Risk)

F. Main Loan Conditions

Effectiveness conditions:

48. Conditions of Effectiveness are intended to be minimal in order to ensure a swift progression from board presentation to effectiveness. Most outstanding issues were addressed as conditions of appraisal or negotiations. The **Conditions of Effectiveness** include:

(a) a Subsidiary Financing Agreement has been executed on behalf of the Borrower and NACC. GoK will make available to NACC, as a grant, the proceeds of the Credit under this agreement to be entered into between the Borrower and NACC under terms and conditions acceptable to IDA;

(b) the Government has furnished a Project Implementation Plan, including a finalized first year procurement plan in form and substance satisfactory to IDA;

(c) NACC has appointed the following key staff with qualifications and under terms and conditions acceptable to IDA: (i) Director, (ii) Procurement Manager, (iii) Deputy Director, Finance and Administration, (iv) Finance Manager, (v) IEC Manager, (vi) Private Sector/Civil Society Manager, (vii) Deputy Director, Technical Services and (viii) Manager, Monitoring and Evaluation; and

(d) the Government has advised the Bank of authorized check signatories for the accounts, including provision of specimen signatures.

Other:

49. A **Condition of Disbursement** of Credit proceeds under the Community Initiative Account of the project includes NACC having employed, not later than January 31, 2001 employ a Financial Management Agency with qualifications and under terms and conditions satisfactory to IDA which shall be responsible for assisting NACC in the implementation of the project as referred to in Attachment 2.

Financial covenants:

50. NACC shall prepare and submit to IDA, not later than 45 days after the end of each calendar quarter a Project Management Report, each of which:

(i) describes the sources and applications of funds for the project both cumulatively and for the period covered, and projected sources and applications of funds for the project for the subsequent six-month period;

(ii) describes physical progress in project implementation, both cumulatively and for the period covered by said report, and explains variances between the actual and previously forecast implementation targets; and

(iii) sets forth the status of procurement under the project and expenditures under contracts financed out of the proceeds of the credit.

G. Readiness for Implementation

☐1. a) The engineering design documents for the first year's activities are complete and ready for the start of project implementation.
☒1. b) Not applicable.

☐2. The procurement documents for the first year's activities are complete and ready for the start of project implementation.
☐3. The Project Implementation Plan has been appraised and found to be realistic and of satisfactory quality.
☒4. The following items are lacking and are discussed under loan conditions (Section F):

The final Project Implementation Plan: Condition of Effectiveness
The final first year Procurement Plan: Condition of Effectiveness

H. Compliance with Bank Policies

☒1. This project complies with all applicable Bank policies.

☐2. The following exceptions to Bank policies are recommended for approval. The project complies with all other applicable Bank policies.

Albertus Voetberg	**Dzingai Mutumbuka**	**Harold E. Wackman**
Team Leader	**Sector Manager**	**Country Director**

Attachment 1. Project Design Summary

Sector-related Country Assistance Strategy (CAS) Goal: To mitigate the social and economic impact of the HIV/AIDS epidemic in Kenya.	**Long-Term Program Indicators:** • By 2003, HIV prevalence will be reduced from 14 percent to 13 percent among young people (15-24 years). • By 2004, HIV/AIDS prevalence among adults (15-49 years) will remain below 14 percent.	**Program Reports:** • National HIV/AIDS surveillance reports, midterm review, and end of project evaluation. • National HIV/AIDS surveillance reports, midterm review, and end of project evaluation.	**(From Goal to Mission)** • Social and cultural behavior change improves throughout the life of the project
Project Development Objective: To intensify the achievement of the multi-sectoral HIV/AIDS primary targets in the National HIV/ AIDS Strategic Plan with the full participation of communities.	**Outcome/Impact Indicators:** • By 2003, the proportion of adults (15-49 years) possessing accurate knowledge of means of preventing HIV infection will increase. Baseline (KDHS, 1999): 90 percent Target (KDHS, 2003): 100 percent • By 2003, the median age of first sex among young women (15-24 years) will increase. Baseline (KDHS, 1999): 12 years Target (KDHS, 2003): 14 years • By 2004, HIV/AIDS curricula will be integrated and examinable in an increasing number of primary and secondary schools, and various post-graduate institutions. Baseline: less than 1 percent Target: 75 percent	**Project Reports:** • Kenya Demographic and Health Survey (KDHS) data • Kenya Demographic and Health Survey (KDHS) data • Reports from the Ministry of Education and other Ministries	**(From Purpose to Goal)** • Poverty reduction efforts continue throughout the life of the project. • Economic situation will improve during project life. • Intensified program of HIV/AIDS prevention, care and support will be socially and culturally acceptable at community level.

Output from each component:	**Key Performance Indicators:**	**Project Reports:**	**(From Outputs to Objective):**
1. The quality and accessibility of multi-sectoral HIV/AIDS educational curricula and IEC material improved.	• By 2004, the number of ministries/departments with a budget line item for HIV/AIDS-related programs will increase. Baseline: One Target 22	• Ministry financial and budget reports	• Enabling environment for effective partnership between public, private and civil society sectors continues.
2. AIDS program management institutions (NACC, PACC, DACC, CACC, and ACUs) established with enhanced coordinating capacity and accountability.	• Disbursements will rise to 25 percent by the end of Year 1, 40 percent by the end of Year 2,70 percent by the end of Year 3, and 100 percent by end of Year 4 of project implementation. • Number of program management institutions submitting acceptable accounting and expenditure reports will increase between Year 2 and Year 4 of project implementation.	• Disbursement expenditure returns by implementing agencies • Project audit report.	• Standard operating procedures on finances and procurement will be understood, accepted and applied by coordinating agencies.

3a. Capacity and funding in the delivery of prevention, care and support services by PLWHA, NGOs, CBOs, private sector, civil society, and research institutions expanded at the community level.	• Credit Disbursement Rate to finance local initiatives will increase to 10 percent, 30 percent, 65 percent and 100 percent by 1st, 2nd, 3rd and 4th year of project implementation, respectively.	• NACC Annual Progress Report.	• Communities and institutions in each area are willing to actively participate and support the overall HIV/AIDS prevention, care and support program
	• Proportion of constituencies submitting at least three proposals to the Community Initiative Account will increase between Year 2 and 4 of project implementation.	• Annual reports submitted by NACC, PACCs, DACCs, and CACCs.	
	• Number of implementing organizations applying acceptable accounting and reporting systems will increase between Year 2 and Year 4 of project implementation.	• Project audit report	• HIV/AIDS Community Initiative Account established under the project will be operational under the present political environment.
	• Proportion of households receiving assistance in caring for chronically ill adults and/or orphans will increase by Year 4 of program implementation. Baseline: Less than 10 percent Target: 50 percent	• Independent assessment reports on the level of HIV/AIDS care and support services available in a representative sample of communities.	
	• The number of peer educators/counselors in the 210 constituencies will increase by 30 percent by the end of Year 1, 50 percent by the end of Year 2, 70 percent by the end of Year 3, and 90 percent by the end of Year 4 of project implementation.	• NACC/Ministry of Health reports	• Governmental, civil society, and religious leaders will support program efforts
	• The number of people participating in voluntary counseling and testing services for HIV/AIDS will increase by 30 percent by the end of Year 1; 50 percent by the end of Year 2; 60 percent by the end of Year 3; and 70 percent by the end of Year 4.	• NACC/Ministry of Health reports	
3b. Flexibility to pilot new HIV/AIDS technologies and services increased.	• By 2004, the number of feasibility studies conducted on the utilization of new HIV/AIDS technologies and services will increase.	• Independent assessment reports on the studies conducted. • Reports on PTCT pilot studies	

Projects Components & Activities:	**Inputs (budget for each component):**	**Monitoring:**	**(From Components to Outputs):**
1. The quality and accessibility of multi-sectoral HIV/AIDS educational curricula and IEC material improved. *Activities to include:* 1.1 Design, produce, disseminate and implement gender and culturally sensitive educational curricula and IEC materials. 1.2 Train and sensitize target groups on the use of HIV/AIDS educational curricula and IEC materials. 1.3 Provide education, care, and support to AIDS orphans and other children in difficult circumstances. 1.4 Implement HIV/AIDS prevention services, including IEC campaigns focusing on behavior modeling and condom promotion. 1.5 Expand condom distribution system. 1.6 Formulate/strengthen policies and interventions addressing anti-discriminatory and gender-specific issues, in addition to developing interventions for populations at increased risk of HIV infection.	US$ 10.3 million	• Proportion of Ministry staff receiving AIDS training • Project progress reports • Annual Surveys & Audits	• Political commitment to address HIV/AIDS remains strong. • Legal mechanisms will be in place to protect vulnerable populations. • Basic logistical and physical facilities exist at all needed levels of coordination.

2. AIDS program management institutions (NACC, PACC, DACC, CACC, and ACUs) established with enhanced coordinating capacity and accountability. *Activities to include:* 2.1 Develop and disseminate guidelines for program management within NACC, PACCs, DACCs, CACCs, ACUs, and also for coordinating and linking with relevant organizations at all levels. 2.2 Create a mechanism within NACC for reviewing/approving work plans submitted by implementing organizations 2.3 Provide orientation and training for core staff of NACC and its related structures within three months of employment. 2.4 Develop, disseminate, and implement performance benchmarks and service standards for NACC and all implementing agencies of the national HIV/AIDS program. 2.5 Create a critical mass of HIV/AIDS master trainers (TOTs) in order to develop cascade training teams at all levels. 2.6 Strengthen program management, financial systems, accountability, planning, budgeting, and MIS at NACC and its related structures by the end of Year 1 of program implementation. 2.7 Provide prevention, care, and support services to staff, including the timely payment of benefits to those infected and affected by HIV/AIDS.	US$ 12.1 million	• Project progress reports • NACC Annual Progress Reports • Annual Surveys & Audits	• Accountability and transparency will be enforced.

2.8 Assist community mobilization efforts with respect to program planning and accessing resources, with particular focus on supporting gender-specific programs and programs for other groups at increased risk of HIV infection. 2.9 Formulate policy and programs which promote human rights and strengthen linkages between HIV/AIDS prevention, care and support services. 2.10 Coordinate mass media and other media campaigns focusing on enhanced HIV/AIDS-related knowledge, skills, attitudes, and behavior. 2.11 Prepare and submit quarterly budgets and quarterly progress monitoring reports for all HIV/AIDS interventions from community-level to the national-level.			

3a. Capacity and funding in the delivery of prevention, care and support services by PLWHA, NGOs, CBOs, private sector, civil society, and research institutions expanded at the community level. *Activities to include:* 3a.1 CACCs to coordinate NGOs, CBOs, private sector organizations, and civil society organizations at community level. 3a.2 NGOs to increase capacity of the CBOs, private sector organizations and civil society organizations at all levels for planning, prioritizing, drawing work plans and budgets for HIV/AIDS prevention, care and support services 3a3 CBOs, private sector, and civil society organizations to provide and deliver care and support services to those infected and affected by HIV/AIDS. 3a4 Establish voluntary counseling and testing (VCT) centers 3a5 Establish support groups for people living with HIV/AIDS (PLWHA). 3a.6 Support vulnerable populations, including orphans and widows; 3a.7 Support training activities for NGOs and CBOs. 3a.8 Support the development and implementation of small and micro enterprises for social support groups for those both infected and affected by HIV/AIDS.	US$ 30.0 million	• Project progress reports • Annual Surveys & Audits	• Community based groups will initiate and/or expand programs for supporting vulnerable populations. • Basic health and social services will be available.

3b. Flexibility to pilot new HIV/AIDS technologies and services will increase. *Activities to include:* 3b.1 Research, review, develop and implement HIV/AIDS new technologies and services in selected sites within communities. 3b.2 Phased introduction of Parent to Child Transmission (PTCT) prevention services in communities.			

Attachment 2. Project Description

Project components:

Part A: Support to line ministries (US$10.3 million):

The purpose of this component is to initiate, facilitate, and support the mainstreaming of HIV/AIDS-related activities into all line ministries. Ministries will start activities in a phased manner through the project period. The project will support the building of capacity within the ministries and the implementation of their work-programs. The capacity-building aspects are likely to be particularly relevant for those sectors not previously considered to have a direct role in combating HIV/AIDS.

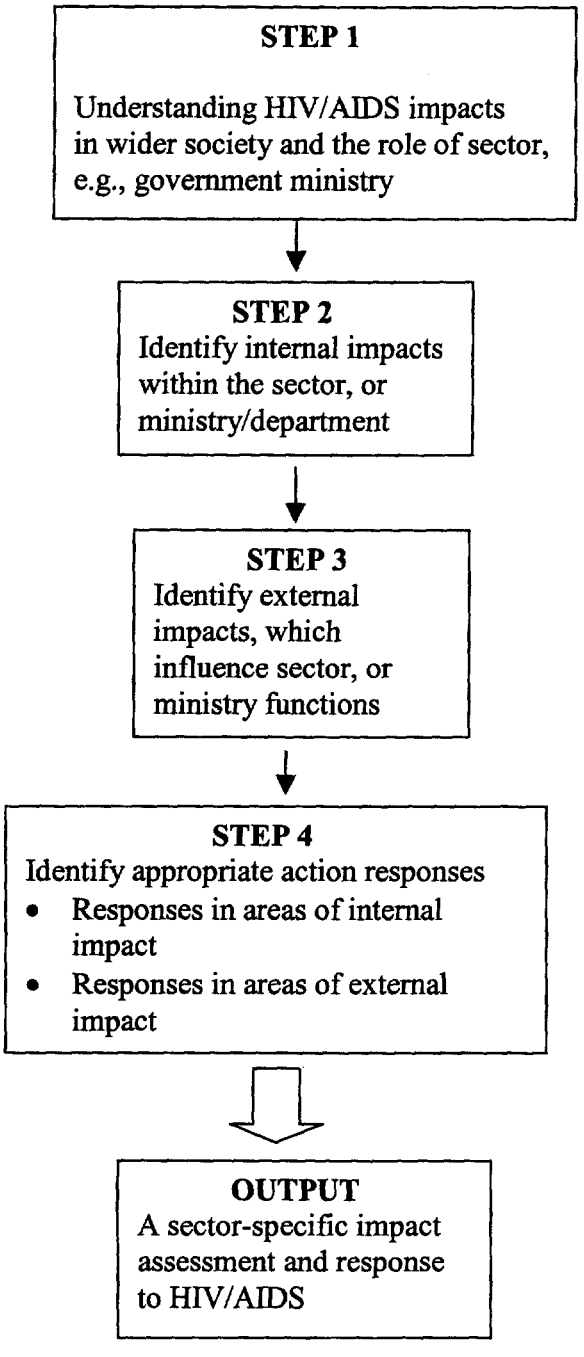
Work-programs of implementing ACUs within line ministries will be reviewed and approved by their ministry's senior management and NACC, and thereafter they will be eligible for credit financing. While the different units will have freedom to develop work-programs that meet the needs of their respective ministries and sectors, guidelines and training will be provided to ensure that there is broad participation in the formulation of the work-programs and that the applicable range of issues is taken into account. While the project seeks to be flexible, there will be restrictions placed on what will be eligible for credit financing. For example, expenditures that are expected to be ineligible for credit financing under the work-programs include: a) vehicles; b) civil works of any size; and c) overseas training. Any training expenditures and purchases of equipment or commodities will be closely scrutinized by NACC to ensure consistency with the project's development objectives.

The Government has elaborated an approach (see Figure 3) for sector-specific responses to the HIV/AIDS epidemic and the work-programs of the ACUs will follow this approach. The capacity-building aspects to be supported under this component are reflected in Steps 1 to 4, and Step 5 will be reflected in the work-program once the sector-specific response has been defined. Guidelines have been developed to assist ministries in formulating a sector-specific response and will be made available.

ACUs will be expected to address, among other issues, the manner in which HIV/AIDS has affected the quality and quantity of available services, the ability to supply the required services, the organization of the sector, the role of service providers, human resources policy and management practices, the planning and management of sector resources, the availability of public and private resources for the sector, and also financial support to the sector provided by both the Government of Kenya and the donor community.

Figure 3

Flow chart of steps to develop a sector-specific response to HIV/AIDS:



While internal impacts will differ among sectors, many issues will be common across sectors. For the first year of project implementation, nine ministries are participating in the project and have formulated their activities within the following three broad categories and general areas of activity:

- Capacity Building
  - ACU administrative costs (standard package)
  - Training of trainers (TOT)
  - Training of target populations
- Prevention, Care, and Support Services
  - IEC campaigns focusing on behavior modeling
  - Commissioning and distribution of IEC materials
  - Distribution of condoms within ministry offices at national, provincial, and district levels
  - Distribution to all staff of information regarding available benefits
  - Referral to health and social services
- Planning and Policy
  - Conduct of impact assessments within the ministry itself, in addition to target populations
  - Policy and procedures
    - Review of staff and dependent benefits with respect to long-term needs posed by HIV/AIDS
    - Establishment and implementation of guidelines for timely disbursement of benefits to staff and dependents
    - Strengthening the implementation of policies regarding discrimination and the protection of human rights for people living with HIV/AIDS (PLWHA)
    - Review and strengthening of gender-specific policies and programs affecting both ministry staff and populations served

These issues will involve extensive collaboration with NACC, the umbrella agency for the ACUs. Equally important is the need for the ACUs to build meaningful operating relationships with counterparts at the national, provincial, and district levels. Government, through ACUs, will play a leadership role in policy direction, institutional development, resource mobilization, and advocacy. In order to achieve maximum impact, the entire public sector will be mobilized through a process of mainstreaming HIV/AIDS-related activities into the core functions of every sector.

The core functions include the budget and Medium-Term Expenditure Framework (MTEF) process. It is essential that the budgets for the core services include appropriate allocations to achieve the National HIV/AIDS Strategic Plan objectives. This will need the support of all concerned at all levels. With the support provided through the project, HIV/AIDS-related topics will be integrated into the training and induction programs of public servants in all sectors and at the workplace in order to support the achievement of the desired changes in both individual and institutional behavior and decision-making processes.

Part B: Coordination of program and project activities by NACC and its decentralized entities (US$12.1 million):

This component will focus on the institutional strengthening of NACC and related entities (PACCs, DACCs, and CACCs) and the activities by these institutions to co-ordinate the national program as well as the project activities. Given that NACC and related structures are newly established, the credit, which supports a

significant part of this program, will support the Government of Kenya in equipping these entities so that they can fulfill their mission. The component will also support activities that are to be coordinated centrally by NACC, such as training workshops for PACCs, DACCs, CACCs, various levels of Government personnel, and other stakeholders, and national information campaigns. This will also include technical assistance to support NACC in developing guidelines, strengthening capacity, and other activities necessary to address the sector issues detailed above.

A challenging task will be strengthening NACC's coordinating ability to monitor and ascertain that the activities taking place in the field are consistent with the National HIV/AIDS Strategic Plan, working closely with the line ministries and other stakeholders. The project will support this effort both at the national level through NACC and at the local level through the PACCs, DACCs, and CACCs.

NACC management will be responsible for the overall monitoring of progress against the Strategic Plan. This will require the stakeholders and implementing partners to take responsibility for data gathering at the micro level. The mechanism for conducting joint monitoring activities will include regular review meetings and reports. The budget required for these monitoring and review responsibilities will be supported under the project, both directly as well as through the provision of consultant services.

Also important is the need to publicize widely to the population of Kenya and stakeholders the role and responsibilities of NACC and the relationship with and responsibilities of the ACUs and other organs that have been established under NACC. The project will support public information activities for this purpose.

A modest part of the credit under this component will be applied toward technical assistance for the financial management, monitoring and evaluation, and external auditing of an HIV/AIDS Community Initiative Account (see Part C).

Part C: Support to implementation of initiatives from civil society, private sector, and research institutions (US$30.0 million):

For the specific purpose of involving civil society organizations, the private sector, and research institutions in the national response to the HIV/AIDS epidemic, and making financial resources under the project available to these organizations, NACC will establish an HIV/AIDS Community Initiative Account. Allocations of resources among the various organizations underline the strong priority that will be given to community- driven local initiatives. Initiatives with national or regional coverage, private sector activities, and research initiatives will only receive modest support.

The HIV/AIDS Community Initiative Account will contribute to the improvement of the welfare of communities by increasing their access to financial and human resources to prevent further spread of HIV and to address the impact of the epidemic on individuals and households. The sub-projects will be identified, prepared, implemented, managed, and maintained by beneficiary communities.

The responsibility for operation and maintenance of the sub-projects will depend on the nature of the sub-project, but is likely to be that of the community and supporting NGOs/CBOs and religious organizations.

The HIV/AIDS Community Initiative Account will respond to demands for sub-projects that aim to address the prevention of HIV infection or the problems related to the impact of HIV/AIDS on those infected or affected. These may include:

- activities aimed at behavior modeling or behavior change. Examples include peer programs, formal and informal education programs for out-of-school children, and condom promotion;
- social support to those affected by HIV/AIDS, including orphans. Examples of assistance to orphans include psychosocial support, school fees, school uniforms, health care, food, and shelter;
- training programs for community volunteers and support to training for counselors and home based care-givers, procurement of supplies for home-based care such as gloves and essential drugs;
- support to organizations of people who are HIV positive or affected by the epidemic, seed funding to start income-generating activities and establish patient support centers.

Some groups of PLWHA have formed themselves into HIV/AIDS support organizations. Most of these groups are urban-based. Attempts will be made to create a conducive environment at district and community levels to enable formation of more such groups to support PLWHA at these levels. Formation of these groups is important because they enhance the profile and visibility of PLWHA and help to reduce the stigma directed at the infected and affected. The Kenya Legal and Ethical Network on HIV/AIDS (KELIN) and the Attorney General's office will collaborate to ensure protection of PLWHA against discrimination.

There are over 450 NGOs/CBOs dealing with HIV/AIDS in Kenya. These NGOs have specific strengths in resource mobilization both nationally and internationally. It is intended that NACC will continue to capitalize on existing infrastructure and strengths to increase the coverage and quality of service provision. There is, however, a need to enhance the capacities of these NGOs/CBOs to enable them to perform better and to scale up some of the best practices in care and support especially at district and community levels.

Support will also be given to training of community members in appropriate service delivery, such as home-based care and counseling. These capacity-building programs will be on a demand-led basis and technically qualified persons hired to deliver the program. The grant program will also support community-based capacity-building and training programs. These will be aimed at enhancing the capacity of communities to plan and manage their own HIV/AIDS-related programs.

All 68 districts in Kenya will be eligible for support through the HIV/AIDS Community Initiative Account. NACC will, however, allocate funds on an annual basis and according to an agreed formula to all districts. Initially, these indicative planning figures are likely to be based on population only. Every six months an evaluation will be made of the distribution of the submitted proposals, in terms of their geography and content, and the actual expenditures. Annual allocations to districts, or constituencies, that do not submit or process sub-project proposals or that incur significant delays in their expenditures will be reviewed and re-directed to better performing geographic areas. In such circumstances the CACC, DACC, and PACC involved will be informed of such re-allocation and NACC may invite Members of Parliament, DACCs, CACCs, or NGOs to intervene and make a special effort to correct the situation.

Projects will be identified following an examination of HIV/AIDS-related problems by communities themselves. The "community" includes all those who are interested and involved in the project, who are prepared to participate, and who will benefit from the services provided by the project. Proposed projects should present solutions to identified priority problems and show evidence of widespread support within the community. The community will be encouraged to contribute to the total costs of the sub-project in cash or in kind.

The role of the community is to initiate the project, implement and manage the project, and complete and maintain the project. The role of the District AIDS Control Coordinator will be to provide information, advise communities on all aspects of the project cycle, and assist in the facilitation of a participatory decision-making process.

Applications made on standard application forms will be submitted to the CACCs. Applications are appraised according to the following agreed criteria:

- Whether the activities in the project proposal comply with the priorities formulated in the National HIV/AIDS Strategic Plan;
- Whether there is evidence that the project represents a community priority need, that the community is committed to the projects, and that they will contribute to the project;
- Whether the benefits accrue to the poor, vulnerable, and those infected or affected by HIV/AIDS;
- Whether the project costs are reasonable, and whether its size and complexity are within the capacity of the community.

The review and approval process will follow a standard format and is described in the Manual of Procedures for the HIV/AIDS Community Initiative Account. This manual will be reviewed and further developed by the Government, NACC, and its partners during the period prior to effectiveness of the credit.

Concerning support to research initiatives, it is anticipated that studies related to parent-to-child transmission, women-controlled methods for HIV and STI prevention such as microbicides, and impact studies will be supported. NACC will have the responsibility to review such proposals and determine whether they comply with research priorities as reflected in the National HIV/AIDS Strategic Plan.

Attachment 3. Project Costs

Component	Indicative Costs (US$M)	% of Total	Bank-Financing (US$M)	% of Total Bank Financing
Part A (support to line ministries)	10.3	20	9.5	19
Part B (support to NACC)	12.1	23	10.5	21
Part C (Community Initiative Account)	30.0	57	30.0	60
Total Project Costs	52.4	100	50.0	100
Total Financing Required	52.4	100	50.0	

Project Cost by Category	Local US$ million	Foreign US$ million	Total US$ million
Equipment	0.5	0.9	1.4
IEC Materials	6.8	-	6.8
Vehicles	0.1	0.3	0.4
Training	1.8	-	1.8
International Technical Assistance	0.3	1.5	1.8
Local Technical Assistance	3.6	-	3.6
Community Initiative Account	30.0	-	30.0
Unallocated	0.8	-	0.8
Total Investment Costs	43.9	2.6	46.5
Recurrent Costs			
Staff Salaries	0.3	-	0.3
Overhead, Operations, and Maintenance Costs	1.6	-	1.6
Total Recurrent Costs	1.9	-	1.9
Total Baseline Costs	45.8	2.6	48.5
Physical Contingencies	1.6	0.3	1.9
Price Contingencies	2.0	0.1	2.1
Total Project Costs	49.4	3.0	52.4

An annual review of Operation and Maintenance (O&M) will be carried out three months prior to the beginning of each fiscal year.

Attachment 4. Project Management and Implementation Arrangements

The overall project:

The Permanent Secretary to the Office of the President, in charge of Provincial Administration, will be the overall accounting officer for resources made available to the Office of the President/NACC for the implementation of the National HIV/AIDS Strategic Plan and for all project resources. Coordination of activities and accounting responsibilities for all three parts of the project will be delegated to NACC.

A Project Oversight Committee will be established, comprised of the Permanent Secretary, Secretary to the Cabinet and Head of Public Service (chair); the Accounting Officer, Office of the President; a representative of the Ministry of Finance and Planning; the Chairman of NACC; a representative of the private sector; and a representative of the NGOs/religious organizations. This committee will review annual progress reports, annual work-programs, and, when necessary, address major constraints in project implementation. Progress reports and work-programs will subsequently be presented to NACC for approval. The Chairman of NACC will organize the Project Oversight Committee meetings, to be convened at least twice a year and to be chaired by the Permanent Secretary, Secretary to the Cabinet and Head of Public Service.

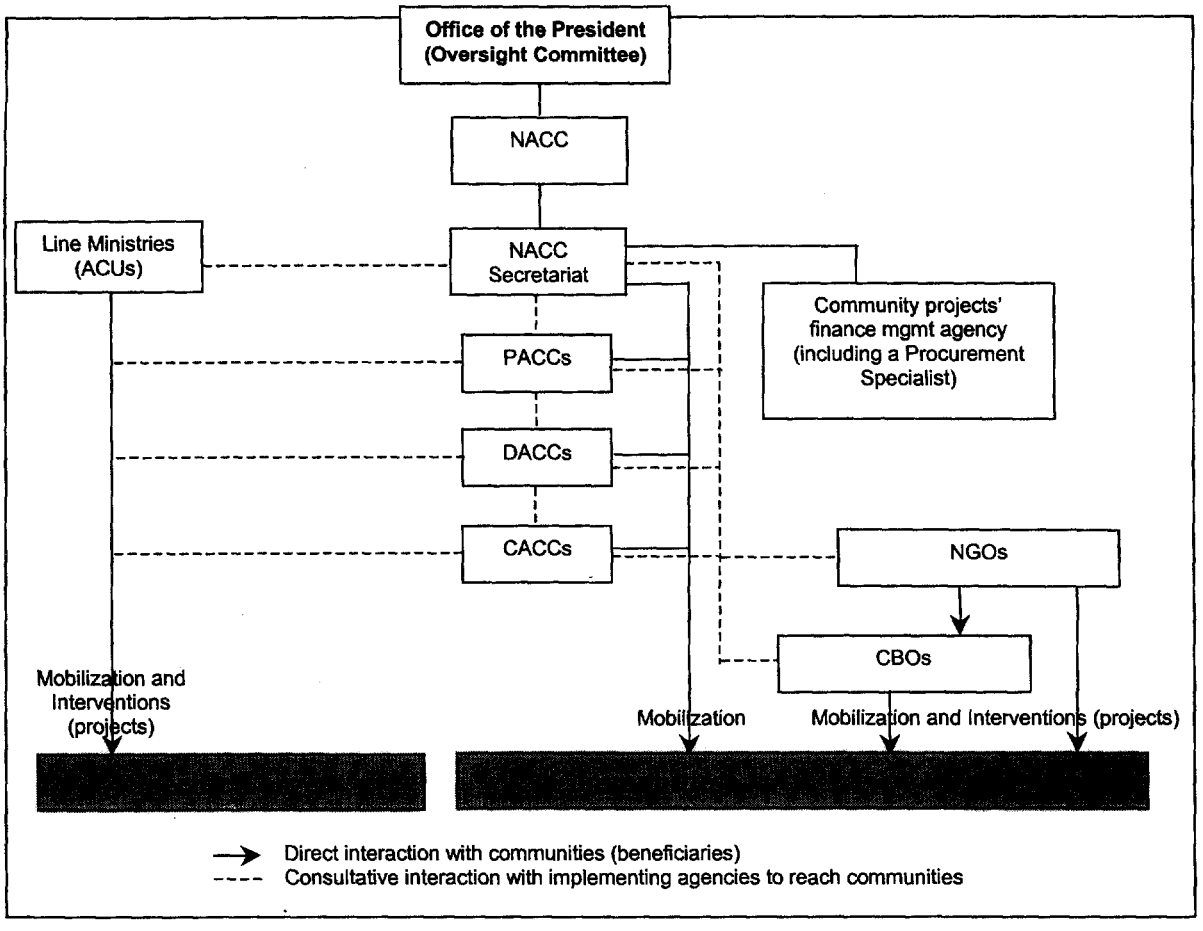
Overall project coordination will be the responsibility of the Secretariat of NACC under the direction of its Chief Executive Officer, the Director of NACC. The Secretariat will assume the implementation, financial management, and monitoring and evaluation responsibilities for the project. It will organize semi-annual Joint Reviews to report on work-program achievements and on all financial matters concerning the project, as part of the overall HIV/AIDS strategy implementation. In addition, it will present the work-program for the next fiscal year to all partners after it has been endorsed by the Project Oversight Committee and approved by NACC. The administrative hierarchy of the project and program is represented in Figure 4.

Part A: The line ministries:

The Accounting Officer of each implementing ministry will ensure that program and project activities are aimed at mitigating the impact of the HIV/AIDS epidemic on her/his sector and that prevention activities are integrated into its programs. She/he will review annual work-programs and budgets, as elaborated by the ACU in her/his ministry, and ensure that the use of project resources is applied to the intended purposes. In addition, as a member of the Board of NACC, she/he will review and where appropriate approve the overall project work-program of NACC and the project.

The ACU, under the leadership of the Senior Assistant Director, will coordinate the implementation of project activities at the level of the individual ministry. The ACU will be responsible for the elaboration of annual work-programs and budgets, for the financial management of project resources, and for the monitoring and evaluation of project activities. Annual work-programs and budgets will be submitted to the Permanent Secretary for approval, and consequently to the Secretariat of NACC in order to obtain financial support from project resources.

Figure 4



The ACU will report on project progress primarily to the Accounting Officer of the parent line ministry with copies to the Permanent Secretary in charge of Provincial Administration, Office of the President, and the Director of the NACC Secretariat. The ACU will account and submit financial reports primarily to the Accounting Officer, Office of the President, copied to the Accounting Officer of the line ministry and the Director of NACC.

Part B: Program coordination by the NACC and its decentralized entities:

The Office of the President, under the leadership of the Permanent Secretary, will be responsible for the overall program and project performance and ensure consistency between project activities and national policy. It will ensure the timely transfer of project resources to NACC and to the line ministries, and be responsible for the timely accounting for these resources.

NACC will review and approve annual work-programs for the implementation of the National HIV/AIDS Strategic Plan and, as part thereof, the project. NACC will ensure consistency in the approaches adopted by all implementing agencies concerning HIV prevention and mitigation of the impact of the epidemic.

The Chairman of NACC will convene Council meetings at least twice a year in order to review annual progress reports and to submit consolidated annual work-programs and budgets for approval.

The Secretariat of NACC, under the leadership of the Director, will be responsible for the coordination of program and project activities. The Secretariat will elaborate its own annual work-programs and budgets, consolidate the work-programs of the various implementing line ministries, and coordinate common activities such as training, IEC, procurement, and printing of IEC material. It will organize semi-annual Joint Reviews for all major stakeholders to report on program and project achievements. In addition, the Secretariat will establish a Technical Committee to review the proposals submitted with request for funding as described under Part C. Finally, the Secretariat will assist line ministries with the conduct of impact assessments and with the elaboration of sectoral work-programs and budgets. The Secretariat will account to the Permanent Secretary in charge of Provincial Administration, Office of the President.

The PACCs will be responsible for the coordination of project activities at the provincial level, for the support to DACCs, for the monitoring of all HIV/AIDS activities at the provincial level, and for the review and approval of proposals, within the prescribed guidelines (see below). The PACC will report to the Secretariat of NACC.

The DACCs will coordinate HIV/AIDS activities at the district level. The DACCs will review and approve proposals within the prescribed guidelines (see below). The DACCs will report to the PACC.

The CACCs will coordinate HIV/AIDS activities at the constituency level. The CACCs will be responsible for the social mobilization in favor of an intensified response to the epidemic. They will review proposals submitted with requests for funding and advise the DACC accordingly

Part C: The HIV/AIDS Community Initiative Account:

NACC, through its Secretariat, will be responsible for the management of an HIV/AIDS Community Initiative Account, the financial management, monitoring, and evaluation functions of which will be contracted to an independent agency. The Secretariat will monitor the execution of the contract, and the performance of the agency will be reviewed during the regular external audit of NACC. The agency will also provide a procurement specialist for the first year of the project to work closely with the procurement officer of NACC.

The Deputy Director (Technical Services) of NACC, together with the Private Sector/Civil Society Manager, the Research and Development Manager, the Finance Manager of NACC, and five expert independent members will constitute a Technical Committee that will have the responsibility to review the larger proposals (see below) submitted with requests for funding and advise the Director of NACC accordingly.

Attachment 5. Monitoring and Evaluation

Monitoring and evaluation results will be used as important benchmarks to indicate whether or not the project targets have been achieved. The results of such monitoring and evaluation will guide adjustments and modifications during the project implementation period. The Project Design Summary and Logical Framework will form the basis of designing and administering the monitoring and evaluation tools. The guiding document containing targets to be achieved is the Government's HIV/AIDS Strategic Plan for the period 2000-2003.

Project implementation monitoring:

The implementation of project activities will be monitored by the NACC Secretariat through quarterly project management reports, providing insight into physical progress against work-programs, disbursement figures, and projections for the next quarter. In addition, the agreed format for the technical reports allows for the regular evaluation of geographic coverage of project activities and disbursements (Part C) and the analysis of project activities by objective (see Attachment 1) and expenditure categories.

For monitoring purposes, the NACC Secretariat will be responsible for the consolidation of quarterly financial reports, by component, submitted by the line ministries for Part A, by the FMA for Part C, and elaborated by the Secretariat itself for Part B. Quarterly technical reports will be submitted to the NACC Secretariat by the line ministries (for Part A) and the NACC structures at the various levels (Part B and Part C).

This component of the monitoring process is specific for the project and relates to activities financed and disbursements effected through the project. Indicators include:

1. The percentage of Credit Proceeds under Part C disbursed per constituency, district, and province;
2. The number of line ministries that have sensitized their staff on the facts about HIV/AIDS;
3. The number of public sector training institutions that have integrated HIV/AIDS issues in their curriculum;
4. The percentage of CACCs/DACCs/PACCs having submitted approved proposals under Part C;
5. The proportion of proposals under Part C that focus on prevention, and care and support, respectively.

Process monitoring:

Indications of behavior change, and access to care and support, would reflect the progress against specified outcomes of the National HIV/AIDS Strategic Plan to which the project contributes. Indicators for this purpose include:

1. the percentage of districts and constituencies that have functional voluntary counseling and testing (VCT) centers;
2. knowledge of parent-to-child transmission and ways to prevent it;
3. the percentage of districts and constituencies that have functional patient support centers;
4. the extent to which HIV/AIDS issues are examinable subjects in a) primary schools; b) secondary schools; and c) other training institutions;
5. the percentage of districts and constituencies with active programs to support orphans;
6. as in 5. above for widows;
7. VCT utilization rates;
8. the percentage of ministries with budget line items for HIV/AIDS-related programs.

The NACC Secretariat will establish a computerized database for the purpose of documenting and monitoring these indicators. The project will assist in the installation and functioning of this database.

Impact monitoring:

The impact of the national response to the epidemic will be reflected in a broad range of indicators, including:

1. prevalence rates of HIV infection, by age group and gender;
2. median age at first sex;
3. reported condom use at last sex with non-regular partner;
4. STI incidence/prevalence;
5. primary school enrollment and completion rates among orphans;
6. the number of non-regular sexual partners during a defined period, by marital status, age group, and gender.

The collection of these indicators will be the responsibility of the various implementing agencies and will be measured through a variety of instruments, including the Demographic and Health Survey of 2003. The Ministry of Health collects monthly HIV/AIDS prevalence data from 22 sentinel surveillance sites (13 urban and nine rural). This existing surveillance system of HIV prevalence will be improved to include behavioral indicators ("second-generation surveillance") with the assistance of cooperating partners.

Trends in the above-mentioned indicators will be attributed to the collective efforts of the partnership against HIV/AIDS in Kenya, and to the project as part thereof.

Attachment 6. Financial Management, Procurement and Disbursement Arrangements

Financial management:

The project will have an adequate financial management system. Appropriate safeguards are included in the design of the financial management system; these safeguards include the engagement of a financial management firm to manage the HIV/AIDS Community Initiative Account, centralized accounting responsibility in NACC, and a close link between and analysis of financial and physical progress reports.

The financial management mechanisms of the project are based on the understanding that:

- All the project funds will initially be budgeted for under the Office of the President-National AIDS Control Council (OP-NACC). The OP-NACC will transfer funds to implementing line ministries through issuance of Authorities to Incur Expenditure (AIEs).
- Funds for the HIV/AIDS Community Initiative Account will be managed and disbursed by a private Financial Management Agent (FMA) under contract with NACC.
- NACC, PACCs, DACCs, and CACCs will be responsible for coordinating activities including review and approval of work-programs, but will not be involved in the implementation.

Operation of a project special bank account:

Disbursement of project funds will flow from the IDA Credit account to a Special Account in a commercial bank on the basis of Project Management Reports (PMRs). The Government of Kenya, through the Central Bank of Kenya (CBK), will open and operate the Special Account under instructions from the Treasury, which is responsible for ensuring that all loans to the Government of Kenya are properly accounted for.

The initial deposit amount will be based on the estimated project budget and cash forecast for the first six months. Subsequent replenishments of the Special Account will be based on project budget and cash forecast for the following quarter and the submission of PMRs for the preceding quarter. PMRs will broadly comprise:

i. Physical progress report;

ii. Procurement progress report;

iii. Financial report.

The PMRs will be subjected to review by the World Bank Task Team members for their relevant areas of specialization. If the PMRs are acceptable, and the project budget and cash forecast for the following quarter are satisfactory, credit proceeds will be used to replenish the Special Account for the value of the expenditure projections and cash needs. The flow of funds, request for funds, progress reports, and work-programs and budgets are further elaborated in the Project Implementation Plan.

Flow of funds:

Funds from the NACC-designated project bank account will flow directly to:

- Project accounts for the ACUs of central ministries and to a common account at the district level for their units in each district;
- NACC operating project bank account for coordinating activities implemented by NACC, PACCs, DACCs, and CACCs;
- HIV/AIDS Community Initiative Account project bank account.

An initial advance equivalent to the approved budget for the first two quarters will be released to the respective project bank accounts. Subsequent quarterly replenishments of the accounts will be made after the respective bodies have submitted to the OP-NACC certified physical progress reports and Statements of Expenditure (for the previous quarter), analyzed by project components/activities and DCA Categories of Expenditure. The funds will be released on the basis of the following quarter's approved budget and cash flow projection.

Accounting for funds released to NACC for coordinating activities:

The NACC operating project bank account will be credited with funds for coordinating activities undertaken by NACC, PACCs, DACCs, and CACCs. DACCs will operate project bank accounts in commercial banks and make payments to or on behalf of the PACC and CACCs in the district. The initial flow to the DACC project bank account will be an advance equivalent to the approved budget for the first quarter for the PACC, DACC and CACCs in the district.

NACC will document appropriate accounting and reporting procedures to be observed at the provincial, district, and constituency levels and provide training to the relevant staff. The Finance Officer at the DACC will be responsible for maintaining separate accounting for the PACC, DACC, and each CACC in the district. He will ensure that the accounting records at the DACC Secretariat clearly analyze data by each level, and payment vouchers together with supporting documents for each level are filed separately. NACC's internal audit unit will conduct regular but random visits to verify operations and accounts records at the DACC level.

Accounting for funds released to implementing ministries:

The implementing line ministries will operate project accounts in accordance with Treasury Circular No. 3 of 2000. One HIV/AIDS district project account will be opened and operated in each district, which will serve the decentralized entities of the ACUs supported under the project. This will save both on administrative costs and bank charges. The cheque signatories for the account will include two representatives of the ministries' ACUs, who should also be members of the DACC, and the district accountant.

The decentralized entity of each ACU will maintain a memorandum cash-book to monitor payments made to it or on its behalf from the Joint Account. The main project cash-book will be maintained by the district accountant and will be analyzed by the ministry, both on the receipts and payments side, to facilitate separate accounting for each ministry for reporting purposes.

Ministries will issue requisitions for funds to the OP-NACC clearly showing requirements for the ministry's ACU and include requirements for each of the provinces and districts. The OP-NACC will issue AIEs and transfer funds directly to the ministries' project accounts and the HIV/AIDS district joint project accounts. They will prepare expenditure reports at the district level (expenditure statements and cash movement and balances) and ensure they are reviewed and certified by the district accountant and AIE holder. These, together with progress reports certified by the AIE holder, will be forwarded to the respective ministry headquarters. The bank reconciliation and statement for the HIV/AIDS district project bank account will be forwarded to the OP-NACC on a quarterly basis.

The ministries will consolidate the expenditure statements, analyze them by implementing Units, and forward them to the OP. The respective Accounting Officers of the line ministries will assign an accountant in the ministry the responsibility for consolidation and accounting for the entire ministry's expenditures under the project.

AIEs will be issued and project bank accounts replenished only after the implementing ACUs have accounted for the previous period's disbursements. The replenishments will be based on the following quarter's approved budget and projected cash needs.

Accounting for funds released to the HIV/AIDS community initiative account:

Funds for implementing activities other than those conducted by line ministries will be released through the NACC HIV/AIDS Community Initiative Account. NACC will outsource the financial management of the account to a reputable FMA, which will be responsible for releasing funds to the implementing CBOs and NGOs, and ensuring that the funds disbursed to communities for approved activities are properly and fully accounted for. NACC will have the ultimate responsibility for approval of all work-programs and budgets for activities to be funded through the HIV/AIDS Community Initiative Account. However, detailed review and approval will be delegated to lower levels as shown on the table below:

Approval of work-programs and budgets for national, regional, local, and private initiatives:

Initiative	Cate-Gory	Proposal Value In US $	Detailed Review and Approval By	To Be Approved Within
1. Local Initiatives	1.1	Up-to 5,000	CACC	2 weeks
	1.2	From 5,001 to 15,000	DACC	2 weeks
	1.3	From 15,001 to 25,000	PACC	3 weeks
	1.4	From 25,001 to 100,000	NACC	4 weeks
	1.5	Above 100,000	NACC in consultation with the World Bank	4 weeks
2. National, Regional, Research and Private Sector Initiatives	2.1	Up-to 100,000	NACC	4 weeks
	2.2	Above 100,000	NACC in consultation with the World Bank	4 weeks

The threshold of proposals for both local and national initiatives to be funded through the NACC/IDA-HIV/AIDS Community Initiative Account is US$200,000.

All levels of the NACC system will have technical committees to review proposals from implementers based on the budget threshold levels. Approvals/comments must be given within the number of weeks provided above. In case of failure in complying with the framework, the NGO/CBO/private sector entity can send a reminder or complaint either to the next higher level or to NACC directly. The NACC Secretariat (Technical Committee), as the body responsible for authority to release funds, will work closely with the FMA to ensure that after satisfactory accounting for previous grants and approval, funds are released within seven days.

An initial advance based on the approved work plans and budgets for the first two quarters will be released by the FMA directly to the bank accounts of the implementing entities at the community level. Subsequent releases will be made quarterly on the basis of the approved work plans, and budget and cash need projections, and after the entity has satisfactorily accounted for the previous quarter's release.

Financial and physical progress reports, in agreed formats that will be included in the funding agreements, will be forwarded both to the FMA and NACC. The implementing NGOs/CBO/private sector institutions will be classified into two categories for accounting purposes:

Category 1 will report directly to the FMA and will consist of those:

- presenting financial proposals in excess of US$15,000 that are reviewed and approved by PACCs or NACC;
- presenting financial proposals of up to US$15,000 that are reviewed and approved by DACCs or CACCs, but whose financial management capability is confirmed adequate and satisfactory by the FMA.

Category 2 will report through a facilitating NGO and will consist of those presenting financial proposals of up to US$15,000 and whose financial management capacity is considered inadequate.

The FMA will transfer funds directly to the implementing entities and notify the facilitating NGOs. The facilitating NGO will be responsible for reviewing, certifying, and forwarding to the FMA the financial reports of the CBOs under their supervision. They will also be responsible for enhancing the financial management capacities of these CBOs.

Project-level budgetary control and monitoring:

To facilitate monitoring of expenditure against budget at the project level, budgets and expenditure reports for coordinating and implementing units will be captured in NACC's accounting and reporting system. It is envisaged that NACC's accounting system will be based on a package recently implemented for the STI Project, which has a strong data analysis and reporting capability. Currently the STI Project is running on a single-user version that will be upgraded to a multi-user version as the volume of transactions increases. This system will be fully assessed prior to project effectiveness for the purpose of the Kenya HIV/AIDS Disaster Response Project and recommendations will be made on areas that require special attention and changes to meet the project's unique needs.

NACC will prepare comprehensive financial management procedures including guidelines for implementing Units to ensure data is properly captured and analyzed. It is expected that project financial transactions from the FMA and ministries will be electronically transferred to NACC's accounting system to avoid duplicate processing of data. Once transactions are entered into the system, NACC should be able to generate required PMRs and other internal financial management reports showing actual versus budget and variance, analyzed by project components, activities, expenditure categories, and implementing/coordinating units over required time periods.

Auditing arrangements:

NACC will prepare consolidated annual project accounts using the expenditure statements submitted by the various implementers. The detailed audit review and voucher verification will take place at various points:

- For funds released through the HIV/AIDS Community Initiative Account:
  - an external audit report will be required from those NGO/CBO/private sector institutions receiving more than US$20,000;
  - the FMA will audit, either directly or by sub-contracting an audit firm, a sample of those NGO/CBO/private sector institutions receiving up to US$20,000;
  - the audit of NACC will be extended to cover disbursements made by the FMA.

It will be clearly stated in the funding agreement that the FMA and NACC technical review committee will have access to the financial management records of the beneficiaries for periodic reviews/audits. Annual project audits will be performed by private independent auditors and subject to approval by the Controller and Auditor General (Corporations) and IDA. The audit reports should be submitted to IDA within six months of the end of the financial year.

Procurement:

General:

It is not possible at this stage to determine the exact mix of goods and services to be procured under the overall project. This is due to the reasons that only summary aggregate data for the different participating line ministries are available, and that 60 percent of the project funds are allocated to local initiatives under community-based sub-projects. The procurement plan for the first year will be prepared based on the initial needs of the NACC and the work-programs submitted by the concerned ministries. Costs for the subsequent years were only indicative at the time of project appraisal. The exact mix of procurement will be determined on an annual basis during annual joint reviews between NACC, IDA, and the other partners, where a draft procurement plan for the following financial year will be presented and agreed upon.

IDA will finance goods, civil works, consultancy, training, and other local activities necessary to implement the project. Procurement for all IDA-financed activities will be carried out in accordance with the Bank's *Guidelines for Procurement under IBRD Loans and IDA Credits* (January 1995 and revised in January and August 1996, September 1997, and January 1999), in particular, Section 3.15, Community Participation in Procurement. Consulting services by firms or individuals financed by IDA will be awarded in accordance with the Bank's *Guidelines: Selection and Employment of Consultants by World Bank Borrowers* (January 1997, revised in September 1997 and January 1999).

Procurement performance (including sub-project procurement activities) will be assessed on an annual basis (in the form of procurement/physical audits by an external agency. In addition to the formal annual audits, ad-hoc procurement reviews will be conducted periodically.

Institutional arrangement:

The overall coordination of the program implementation will be done by NACC through its Secretariat, with each line ministry and CBO/NGO responsible for implementation of their relevant work programs. All major procurement activities for Part A and Part B will be handled centrally by NACC, except minor procurements for contracts valued at less than US$5,000 equivalent per contract subject to an aggregate of US$50,000 equivalent per line ministry per year, which will be handled by the respective line ministries in accordance with the agreed work-programs. In order to kick-start the procurement activities under the program, NACC will be hiring a procurement adviser to provide support in the initial procurement activities of the project including hiring of the FMA, and preparation of the simplified procurement procedures manual for the community-based programs.

As part of the FMA's contract, a procurement specialist will be hired for the first year of project operations for coordination and support of the project-related procurement activities including contract management. The procurement specialist will provide on-going procurement and contract management training to designated NACC staff, who will take over the procurement activities at the end of the first year of operations. Furthermore, in order to build capacity at the local level, where necessary, the procurement specialist will provide procurement training workshops at the local level. It should be noted that since 60 percent of the project funds (US$30 million) will be channeled to communities for local initiatives, it is not expected that the NACC Secretariat would be involved in extensive procurement activities with large-value contracts, and the bulk of the major procurements should be completed during the first year of the project activities.

As a part of the capacity-building process, NACC requested that IDA provide procurement workshops for in-house staff as well as the concerned parties at the district level. This can be achieved through the semi-annual procurement supervision missions, where the procurement specialist can conduct these workshops without extra burden on the supervision budget. The costs of the workshops arrangements will be covered from the project. In addition, the procurement specialist in the Country Office will, on a regular basis, provide training and hands-on assistance to the staff involved in procurement.

The above procurement arrangements should be reviewed within six months of the project operations, and where necessary modifications/changes should be made. At the end of the first year, an assessment should be made by a Bank procurement specialist with respect to the in-house procurement capacity, and a decision on whether the outstanding workload can be handled by these individuals should be reached.

Procurement capacity assessment:

An assessment of NACC procurement capacity has been carried out, and a report has been prepared. The report indicates relatively high risks at the NACC. In consideration of the fact that NACC is a newly established parastatal, there is limited capacity and experience in procurement-related activities. The current capacity of NACC without outside support (i.e., hiring of the procurement advisor and procurement specialist) is likely to be inadequate to handle the procurement activities workload under the project. During the appraisal, a recommendation was made to appoint a procurement adviser to handle the initial key procurement activities (including the FMA), and thereafter as a part of the FMA's contract, a procurement specialist will be hired for the first year of project operations to handle and coordinate the on-going procurement and contract management support within NACC. This individual will train the in-house NACC staff to take over the procurement activities of the project from the end of the first year onward. The rationale for this recommendation, as communicated to NACC, is as follows:

- Considering the relatively low number of procurement actions that will be carried out centrally, hiring of a procurement agent will not be a cost-effective method, and since the selection would have to be through a competitive process, it would take too long to have the agents on board.

- There is an urgent need to start the procurement process for hiring of the FMA since this will be a pre-condition for disbursement under Part C. Hiring of a procurement adviser can be done in a relatively short time. This individual can provide all the necessary support in the procurement process including finalization of the Terms of Reference, preparation of the Request for Proposals, evaluation of proposals, negotiations, and award.

- Hiring of the procurement specialist through the FMA contract will simplify the contract administration process for NACC, and since there is a direct relationship between the procurement process, contract management, and disbursement, the coordination and communication between the relevant parties will be simplified. Additionally, in case of problems the Agency will have the facility to provide back-up support where necessary.

- Since the volume of the project procurement activities may not require a full-time position, the procurement specialist will provide support in capacity building for both NACC in-house staff and local levels, through provision and conduct of procurement workshops in different regions.

Time did not suffice to conduct an assessment of procurement capacity at local levels, but a review of the Country Procurement Assessment report (CPAR) prepared in 1997 shows that the risks for **procurement at the local level** are considered to be high, and the procurement capacity at the local level is generally weak. However, the value of procurement actions that will be carried out at the local levels under the project are relatively small, and the types of works, goods, and services will be very limited. They will mostly deal with minor civil works, small service contracts, or small procurement of goods (including furniture items required for setting up the offices in the various constituencies) and supplies of mainly the recurrent nature through shopping. Furthermore, through the conduct of the NACC procurement workshops, local capacity will be enhanced over the project implementation period.

As a part of the capacity-building process, NACC has also requested that IDA provide annual procurement workshops for in-house staff as well as the concerned parties at the district level. This can be achieved through the semi-annual procurement supervision missions, where the procurement specialist can conduct these workshops without extra burden on the supervision budget. The costs of the workshops arrangements will be covered from the project.

Procurement of goods, works, and consulting assignments:

Procurement of goods and works for all IDA-financed components will be carried out in accordance with the Bank's *Guidelines for Procurement under IBRD Loans and IDA Credits* (January 1995 and revised in January and August 1996, September 1997, and January 1999). Consulting services by firms or individuals financed by IDA will be awarded in accordance with the Bank's *Guidelines: Selection and Employment of Consultants by World Bank Borrowers* (January 1997, revised in September 1997 and January 1999).

Given the urgency of the program, a General Procurement Notice (GPN) for the first year of operations will be placed in the local newspapers as well as in United Nations Development Business (UNBD on-line publication). Detailed annual GPNs for the subsequent years will be prepared for the project and published in United Nations Development Business. The subsequent GPNs will describe all outstanding ICB for goods contracts, as well as consulting assignments. Specific Procurement Notices (SPN) and Expressions of Interest (EOI) will be prepared for the individual procurement actions where necessary. The Borrower will prepare a procurement plan for the first year of project operations to be included in Project Implementation Plan (PIP). The plan will include relevant information on goods, works, and consulting services under the project as well as the timing of each milestone in the procurement process. The procurement schedule will be updated every quarter and reviewed by IDA during each supervision mission.

Civil works:

No large civil works are scheduled for the project. The design does provide for flexibility under Part C of the project, for CBO/NGOs to undertake small works within the context of their work-programs, though the budgets for the grants must be approved prior to disbursements and the number of such works would be quite limited, as described below.

Contracts for small works estimated to cost less than US$20,000 equivalent per contract, up to an aggregate amount of US$500,000 equivalent, may be procured under lump-sum, fixed-price contracts awarded on the basis of quotations obtained from three qualified domestic contractors invited in writing to bid. The invitation shall include a detailed description of the works, including basic specifications, the required completion date, a basic form of agreement acceptable to IDA, and relevant drawings where applicable. The awards will be made to the contractors who offer the lowest price quotation for the required work, provided they demonstrate they have the experience and resources to complete the contract successfully.

Contracts for small works estimated to cost more than US$20,000 equivalent per contract are ineligible for financing under the project.

Goods:

The total cost of goods is estimated at US$10.7 million for the project as detailed below. These exclude any goods that might be procured in small quantities through work-programs under Part C of the project.

Emergency requirements:

Given the urgency of the project, and to facilitate speedy procurement of items required urgently for institutional strengthening, specific contracts will be handled in the following manner:

To be procured centrally by NACC:

- Computers and accessories, office and power equipment: US$1.5 million—to be sourced from the United Nations Agency (IAPSO);
- Vehicles: US$300,000—to be sourced from IAPSO and/or National Shopping procedures (preferably from "bonded warehouses" on a competitive basis);
- Furniture for NACC and Regional Coordinating Offices: US$100,000—to be sourced from local manufacturers/suppliers by National Shopping procedures.

To be procured by various constituencies:

- Furniture by National Shopping for contracts not exceeding US$3,000 equivalent per contract subject to an aggregate of $200,000 for all the 210 constituencies. Contracts under this category exceeding US$3,000 equivalent per contract are not permissible.

All Shopping procedures will follow the IDA Procurement Guidelines (Para. 3.5 and 3.6) and the June 9, 2000 Memorandum "Guidance on Shopping" issued by the Bank; procurement from the United Nations Agencies (i.e., IAPSO) will follow para. 3.9 of the Procurement Guidelines. All contracts under the above-stated "Emergency Requirements" must be concluded within 12 months of the Credit Effectiveness date. The list of these items and their estimated value should be agreed upon with IDA as per the approved Procurement Plan. The procurement and timely distribution of the goods will be the responsibility of NACC.

Other goods:

Procurement of drugs, pharmaceutical items/medical equipment, and condoms will be ineligible under this project due to the fact that the Kenya D.A.R.E project will be financing these types of procurement activities.

Goods that are estimated to cost more than US$100,000 equivalent per contract will be subject to prior review and will be procured through ICB procedures. Procurement will be bulked where feasible into packages valued at US$100,000 equivalent or more.

Goods estimated to cost less than US$100,000 equivalent per contract, up to an aggregate amount of US$3 million equivalent, will be procured through National Competitive Bidding (NCB) procedures. The draft standard bidding document for NCB will be submitted by NACC to IDA for prior review. The approved bidding document will form the basis of all NCB procurements under this project.

Goods that are estimated to cost less than US$30,000 equivalent per contract, up to an aggregate of US$500,000 equivalent, may be procured through National Shopping procedures (for goods available locally) and/or through International Shopping procedures (for those goods not available on the national market), in accordance with Bank Guidelines, and/or through the United Nations Agencies (i.e., IAPSO). The procedures followed and total aggregate amount for shopping method will be reviewed after six months of project operations, and depending on performance and the results of the review, the total aggregate amount may be adjusted downward where necessary.

Standard request forms and establishment of guidelines for conduct of the shopping method (as per the June 9, 2000 Memorandum "Guidance on Shopping") should be prepared and included in the Project Implementation Plan (PIP).

Grants to community-based sub-projects:

The Project will support a community-based prepayment scheme for HIV/AIDS Community Initiative Account-related activities. The total cost for this activity (Part C) is US$30 million equivalent. The HIV/AIDS Community Initiative Account will finance small-scale, community-based HIV/AIDS-related activities, including minor repairs or works, purchase of drugs and supplies in small quantities (in emergency cases), care and maintenance for AIDS patients and orphans, AIDS-prevention promotion, and other interventions at the community level.

Work-programs under Part C will depend on applications received from communities, NGOs, and private organizations against a positive list of activities. It is not possible to determine the exact mix of goods, small works, and services to be procured under these activities due to their demand-driven nature. Funding for these activities will be in the form of grants. Therefore, the types of activities to be financed under these activities and their procurement details will depend on the needs identified by communities.

In accordance with the established guidelines (as part of the Project Implementation Plan), large works contracts and vehicles are ineligible for financing under Part C. The Africa Guidelines for Simplified Procurement and Disbursement for Community-Based Investments will be used in the design of procurement under this aspect of the project. The Office of the President through NACC will be responsible for ensuring compliance with these guidelines, and ex-post reviews of random sub-projects will be conducted periodically by the Bank, and independent firms/consultants appointed by NACC.

Simplified procurement and disbursement procedures for community-based programs including the positive list of activities qualifying under Part C will be developed by NACC, for approval by IDA.

Services:

The total cost of consultant services is estimated at US$6 million equivalent for the entire project, excluding any services to be procured under Part C of the project, as detailed in the above paragraph. Except as detailed below, consulting services will be selected through competition among qualified short-listed firms (selected through advertisement of Expression of Interests) based on *Quality and Cost Based Selection (QCBS)* whereby the quality of the technical proposals are given highest scores and the evaluation of the technical proposals are carried out before opening the financial proposals (Section II, para. 2.1-2.28 of the Consultant Guidelines).

The consultancy services required would be mostly in the areas of AIDS research, AIDS education, trainers, community development specialists, public relations firms (information campaign), financial management, monitoring and evaluation, audit, and accounting. The exact mix (types of consultancy, budgets, procurement methods) will be discussed and agreed annually during joint reviews.

Consultants for financial audits estimated to cost less than US$50,000 equivalent per contract, up to an aggregate of US$250,000 equivalent, will be selected through the *Least Cost Selection* method (para. 3.1 and 3.6 of the Consultant Guidelines).

Consultants for services meeting the requirements of Section V of the Consultant Guidelines will be selected under the provisions for the *Selection of Individual Consultants* method (Section V. para. 5.1-5.3 of the Consultant Guidelines). Individual Consultants (IC) will be selected through comparison of job description requirements against the qualifications of those expressing interest in the assignment or those approached directly. For both firms and individual contracts, *single-source selection* may be used only on an exceptional basis, with prior agreement by IDA, in accordance with the provision of para. 3.8 through 3.11 of the consultants. All terms of reference for consultancy services are subject to prior agreements with IDA.

For services procured at the district level (Community-Based Activities—Part C) under approved work-programs, contracts for services under US$5,000 equivalent per contract, and an aggregate amount per NGO/Consultant not to exceed US$50,000 equivalent, will not be subject to prior review by IDA of Terms of Reference for services, and may be awarded on a single-source basis based on the qualifications of the consultant.

To the extent possible, standard Terms of Reference will be prepared for the small consultancy contracts, and they will be submitted to IDA for no objection.

The service contracts for the research studies will be subject to IDA prior review and will be awarded based on a two-stage approval process. The initial review of the research proposals will be carried out by the AIDS Research Technical Committee (to be established). The award recommendations from the Technical Committee should receive the approval of the National Medical Research Review Board before IDA no objection can be issued.

To ensure that priority is given to the identification of suitable and qualified national consultants, short-lists for contracts estimated under US$100,000 or equivalent may be comprised entirely of national consultants (in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines), provided that a sufficient number of qualified individual or firms (at least three) are available at competitive costs. However, if foreign firms have expressed interest, they will not be excluded from consideration. The Standard Request for Proposal (RFP) as developed by the Bank will be used for requesting proposals, and for selection and appointment of consultants. Simplified contracts will be used for short-term assignments—simple missions of standard nature (i.e., those not exceeding six months) carried out by individual consultants or firms. The Government was briefed during negotiations about the special features of the new guidelines and the RFP, in particular with regard to advertisement, public bid opening, and evaluation criteria.

Training, workshops, and study tours

The total cost for this component is estimated at US$2.1 million for the project. Training, workshops, and study tours will be carried out on the basis of approved annual programs that would identify the general framework of training activities for the year, including the nature of training/study tours/workshops, the number of trainees, and cost estimates. The training institutions for all workshops/training with costs exceeding US$5,000 should be identified within the annual program, and where the training cost exceeds US$20,000, the selection of the training institution should be based on a competitive process preferably using the quality-based method of selection. Overseas training is ineligible for financing under the project. Post-reviews will be conducted from time to time to review the selection of institutions/course contents/trainees and justifications thereof, and costs incurred.

Prior review

All ICB for goods will require prior review by IDA. The first three NCB contracts will require prior review by IDA. The first two contracts for goods procured against the "Emergency Requirements" will require prior review by IDA. Contracts with consulting firms costing the equivalent of US$50,000 or more and contracts with individual consultants costing the equivalent of US$30,000 or more will require prior review by IDA. All single-sourced selection of consultants valued at US$5,000 equivalent and above will require prior review by IDA. These prior review requirements will not apply to Community-Based Operations under Part C, except as provided above.

Table A: Project Costs by Procurement Arrangements
(US$ 52.4 million equivalent)

	Procurement Method[1]				
Expenditure Category	**ICB**	**NCB**	**Other[2]**	**N.B.F.**	**Total Cost**
1. Works	0.00	0.00	0.00	0.00	0.00
	(0.00)	(0.00)	(0.00)	(0.00)	(0.00)
2. Goods (includes IEC)	3.90	3.00	2.30	1.50	10.70
	(3.90)	(3.00)	(2.30)	(0.00)	(9.2)
3. Services	0.00	0.00	7.70	0.90	8.60
	(0.00)	(0.00)	(7.70)	(0.00)	(7.70)
4. Community Based Grants	0.00	0.00	30.00	0.00	30.00
	(0.00)	(0.00)	(30.00)	(0.00)	(30.00)
4. Training	0.00	0.00	2.10	0.00	2.10
	(0.00)	(0.00)	(2.10)	(0.00)	(2.10)
5. Unallocated	0.00	0.00	1.00	0.00	1.00
	(0.00)	(0.00)	(1.00)	(0.00)	(1.00)
Total	3.90	3.00	43.10	2.40	52.40
	(3.90)	(3.00)	(43.10)	(0.00)	(50.00)

1/ Figures in parenthesis are the amounts to be financed by the IDA Credit. All costs include contingencies.

2/ Includes civil works and goods to be procured through national/local shopping, consulting services, community-based activities, services of contracted staff of the project management office, training, technical assistance services, and incremental operating costs related to (i) managing the project; and (ii) re-lending project funds to local government units.

Table B: Thresholds for Procurement Methods and Prior Review [1]

Expenditure Category	Contract Value Threshold (US$ thousands)	Procurement Method	Contracts Subject to Prior Review (US$ millions)
1. Works **Small works through Work-programs**	<20	At least three Quotations from qualified contractors	All post-review
2. Goods	>=100 <100 <30	ICB NCB LS/IS/IAPSO	All contracts First three contracts, all other post-review All post-review
3. Services **Firms** **Individuals**	>=100 and <100 <100	QCBS/QCS/other (will be determined from annual plans) Individual	>$50,000 (for firms) >$30,000 (for individuals)
4. Training, Workshops, Study Tours	>=20	QBS/Other	Post-review, but annual plans to be reviewed by IDA

Total value of contracts subject to prior review: **US$7.5 M**

Overall Risk Assessment: High

Frequency of procurement supervision mission proposed: Once every six months. In addition, ad-hoc reviews/audits will be done by Country Office procurement specialist or other appointed consultants.

Disbursement

The project will use Project Management Report (PMR)-based disbursements. This will result in the project having a sufficient balance in the Special Account to fund the emergency activities of the project and linking the physical progress and status of procurement to the financial reports. PMRs will be produced on a quarterly basis.

It is proposed that the Government initially establish a Special Account. Funds from the Credit Account would be transferred to the Special Account quarterly. IDA funds would only be used to finance eligible expenditures under the project. Agreement has been reached regarding the arrangements for establishing and operating the Special Account.

The authorized allocation for the Special Account will be 20 percent of the Credit. The initial deposit into the Special Account will be for the estimated cash requirements for the first six months of the project. Future replenishments into the Special Account will be based on the submission of the quarterly PMRs, including a projection of estimated cash needs for the following six months.

Funds from the Special Account will be advanced on a quarterly basis to the various project accounts in the implementing entities. These advances will be accounted for on a quarterly basis and continuing advances will be dependent upon the receipt and positive review of the quarterly financial and physical progress reports.

Table C: Allocation of Credit Proceeds

Expenditure Category	Amount in US$ million	Financing Percentage
Equipment, supplies, vehicles, IEC materials, and other goods		100% of foreign expenditures and 90% of local expenditures
Part A	3.4	
Part B	4.35	
Consultant's services and training		100%
Part A	5.3	
Part B	3.2	
Grants under Part C	30.0	100%
Incremental Operating Costs	1.25	90%
Unallocated	2.5	
Total Project Costs	52.4	
Total	50.0	

Attachment 7

Project Processing Schedule

Composition of Task Team:

Task Team Leader:	Albertus Voetberg (AFTH1)
Quality Advisors:	Debrework Zewdie (AFRHV, ACT*africa*), Christopher D. Walker (HDNHE) Ok Pannenborg (AFTH4)
Health Economists:	Oscar Picazo (AFTH1), Rene Bonnel (AFRHV, ACT*africa*)
Financial Management Specialist:	John Nyaga (AFMKE)
Health Specialist:	Sheila Dutta (AFRHV, ACT*africa*)
Operations Analysts:	Andrew Follmer (AFTH1), Catherine Wanjiku Gachukia (AFMKE)
Social Development Specialist:	Nyambura Githagui (AFMKE)
Procurement Specialist:	Dahir Warsame (AFMKE)
Disbursement Officer:	Margaret Olale (AFMKE)
Operations Officer:	Wacuka Ikua (AFMKE)
TT Assistants:	Meena Ramchandani (AFMKE), Therese Cruz (AFTH1)

Management Decisions:

Issue	Action/Decision	Responsibility
Concept Note	June 1, 2000	
Identification	June 26-30, 2000	
Draft Technical Annex	July 10, 2000	
Decision Meeting	July 12, 2000	
Appraisal	July 17-22, 2000	
Negotiations	August 2-4 (in the field)	
Board Package	August 14, 2000	
Board Presentation	September 14, 2000	

Total Preparation Budget: (US$90,000)
Bank Budget: US$90,000
Trust Fund:
Cost to Date: (US$000)

Albertus Voetberg	**Dzingai Mutumbuka**	**Harold E. Wackman**
Team Leader	**Sector Manager**	**Country Director**

Attachment 8. Documents in the Project File

A. Project Implementation Plan

Draft (July, 2000) -- final document a condition of Effectiveness

B. Bank Staff Assessments

Economic Assessment, Umbrella PAD – April, 2000
Economic Assessment DARE Project-- April, 2000
Institutional Assessment (ETC Consultants) -- March, 2000
Social Assessment DARE Project -- April, 2000
Environmental Data Sheet (cleared by AFTE1 and AFTI1), July 2000

C. Other

Sessional Paper No. 4 of 1997 on HIV/AIDS
Kenya's Health Policy Framework – November, 1994
Project Concept Note – June, 2000
The macro economic impact of HIV/AIDS in Kenya, March 2000
(draft Technical Paper by Robalino, Voetberg and Picazo)
World Bank Identification Mission Aide-Memoire – July, 2000
National HIV/AIDS Strategic Plan 1999-2004 draft – July, 2000
World Bank Appraisal Mission Aide-Memoire – July, 2000
Legal Notice No. 170 establishing NACC – November, 1999
Agreed Minutes of Negotiations, August, 2000
Kenya DARE Project, draft PAD, August, 2000

*Including electronic files

Attachment 9. Status of Bank Group Operations

Status of Bank Group Operations
(As of end FY00)

Status of Bank Group Operations (Operations Portfolio)

Board Date Fiscal Year	Active Projects		Last PSR Supervision Rating b/		Original Amount in US$ Millions				Difference Between Expected and Actual Disbursements a/	
			Development Objectives	Implementation Progress	IBRD	IDA	Cancel.	Undisb.	Orig.	Frm Rev'd
1993	P001348	PARASTATAL REFORM TA	U	U	0	0	0	0	0	0
1994	P001353	MICRO & SMALL ENTERP	S	S	0	21.83	0	15.82	13.58	9.99
1995	P001367	INST. DEVELOPMENT	U	U	0	0	0	0	0	0
1995	P001333	SEXUALLY TRANSMITTED	S	S	0	40	0	4.94	4.52	0
1996	P001331	ARID LANDS	S	S	0	22	0	11.82	10.85	0
1996	P035691	NAIROBI MOMBASA ROAD	S	S	0	50	0	19.87	16.08	0
1996	P001319	URBAN TRANSPORT	S	S	0	115	0	53.16	22.01	0
1997	P034180	EARLY CHILDHOOD DEV	S	S	0	27.8	0	20.06	9.34	0
1997	P001344	ENERGY SECTOR REFORM	S	S	0	125	0	106.06	92.45	0
1997	P046838	LAKE VICTORIA ENV.	U	U	0	12.8	0	8.53	4.58	0
1997	P001354	NARP II	S	U	0	39.7	0	19.9	-4.76	0
1999	P056595	EMERGENCY INFRAS.REHAB	S	S	0	40	0	32.38	33.25	0

Statements of IFC and MIGA Program

Kenya - IFC and MIGA Program, FY 1998-2001

	1998	1999	2000	2001
IFC approvals (US$m)	20.00	51.80	39.08	
Sector (%)				
FINANCIAL SERVICES	50	88		
FOOD & AGRO-BUSINESS		5	17	
INFRASTRUCTURE	50	4	54	
MINING & METALS			29	
TIMBER, PULP & PAPER		3		
Total	100	100	100	0
Investment instrument(%)				
Loans	85	97	80	
Equity		3	3	
Quasi-Equity	15		17	
Other			0	
Total	100	100	100	0
MIGA guarantees (US$m)	0.000	4.700	4.700	

KENYA
STATEMENT OF IFC's
Held and Disbursed Portfolio
31-Jul-1999
In Millions US Dollars

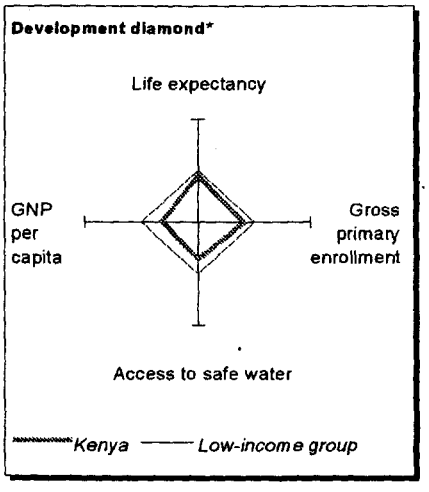
		Committed IFC				Disbursed IFC			
FY Approval	Company	Loan	Equity	Quasi	Partic	Loan	Equity	Quasi	Partic
1970/74/77/79/81/88/	Panafrican	25.21	0.00	4.51	0.00	25.21	0.00	4.51	0.00
89/94/96	TPS (Kenya)	0.00	0.00	0.04	0.00	0.00	0.00	0.04	0.00
1972	DBK	10.00	0.00	1.31	0.00	3.00	0.00	1.31	0.00
1980/83/98	Diamond Trust	0.00	0.00	0.80	0.00	0.00	0.00	0.80	0.00
1982	IPS(K)	0.00	0.00	0.55	0.00	0.00	0.00	0.55	0.00
1982	LIK	0.00	0.00	0.63	0.00	0.00	0.00	0.63	0.00
1983/91	EBP	3.89	0.00	0.00	0.00	3.89	0.00	0.00	0.00
1985	IPS(K)-Allpack	0.00	0.00	0.36	0.00	0.00	0.00	0.36	0.00
1986	IPS(K)-AL	0.00	0.00	0.62	0.00	0.00	0.00	0.00	0.00
1986	IPS(K)-Prem Food	0.00	0.00	0.11	0.00	0.00	0.00	0.11	0.00
1986	IPS(K)-Frigoken	0.00	0.00	0.06	0.00	0.00	0.00	0.06	0.00
1986	AEF Future Hotel	0.29	0.00	0.00	0.00	0.29	0.00	0.00	0.00
1992	AEF Capital Fish	0.26	0.00	0.00	0.00	0.26	0.00	0.00	0.00
1994	AEF Mosi	0.03	0.00	0.00	0.00	0.03	0.00	0.00	0.00
1994	Intl Hotels-Ken	4.29	0.00	0.00	0.00	4.29	0.00	0.00	0.00
1994	EARC	0.00	0.00	1.15	0.00	0.00	0.00	0.85	0.00
1994/99	AEF Bawan Roses	0.35	0.00	0.00	0.00	0.35	0.00	0.00	0.00
1995	AEF Kihingo Rose	0.39	0.00	0.00	0.00	0.39	0.00	0.00	0.00
1995	AEF Vegpro	0.12	0.00	0.00	0.00	0.12	0.00	0.00	0.00
1995	Magadi Soda Co.	6.60	0.00	0.00	0.00	6.60	0.00	0.00	0.00
1995	AEF Equitea	0.26	0.00	0.12	0.00	0.26	0.00	0.12	0.00
1996	AEF K-Rep Bank	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00
1996	AEF Landmark	0.38	0.00	0.00	0.00	0.38	0.00	0.00	0.00
1996	AEF Ceres	0.93	0.00	0.00	0.00	0.93	0.00	0.00	0.00
1997	AEF Makini	0.54	0.00	0.00	0.00	0.54	0.00	0.00	0.00
1997	AEF Redhill Flrs	0.31	0.00	0.00	0.00	0.24	0.00	0.00	0.00
1997	CFC	10.00	0.00	0.00	0.00	10.00	0.00	0.00	0.00
1997	AEF AAR Clinic	0.00	0.00	0.50	0.00	0.00	0.00	0.50	0.00
1998	AEF Deras Ltd.	1.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00
1998	AEF Locland	0.58	0.00	0.00	0.00	0.58	0.00	0.00	0.00
1998	GBHL	7.00	3.00	0.00	0.00	3.50	3.00	0.00	0.00
1998	AEF Multi Hauler	1.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00
1999	AEF Transenergy	1.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00
	Total Portfolio:	74.43	3.00	11.76	0.00	63.86	3.00	9.84	0.00

Approvals Pending Commitment

FY Approval	Company	Loan	Equity	Quasi	Partic
	Total Pending Commitment:	0.00	0.00	0.00	0.00

Attachment 10. Kenya at a Glance

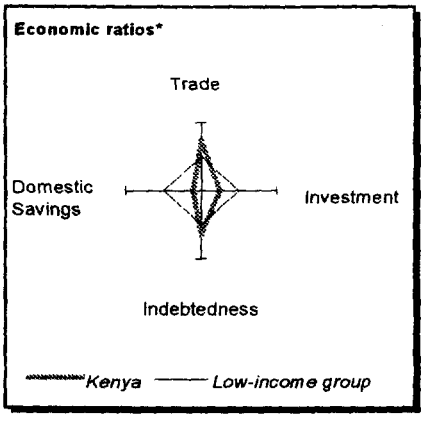
POVERTY and SOCIAL	Kenya	Sub-Saharan Africa	Low-income
1998			
Population, mid-year *(millions)*	28.7	628	3,515
GNP per capita *(Atlas method, US$)*	330	480	520
GNP *(Atlas method, US$ billions)*	9.5	304	1,844
Average annual growth, 1992-98			
Population *(%)*	2.5	2.6	1.7
Labor force *(%)*	2.7	2.6	1.9
Most recent estimate (latest year available, 1992-98)			
Poverty *(% of population below national poverty line)*	42	..	..
Urban population *(% of total population)*	31	33	31
Life expectancy at birth *(years)*	57	51	63
Infant mortality *(per 1,000 live births)*	61	91	69
Child malnutrition *(% of children under 5)*	23	..	..
Access to safe water *(% of population)*	53	47	74
Illiteracy *(% of population age 15+)*	..	42	32
Gross primary enrollment *(% of school-age population)*	89	77	108
Male	89	84	113
Female	89	69	103



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

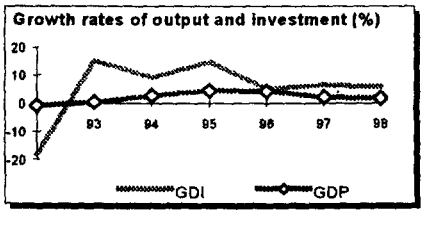
	1977	1987	1997	1998
GDP *(US$ billions)*	4.5	8.0	10.6	11.6
Gross domestic investment/GDP	23.7	20.8	15.4	14.4
Exports of goods and services/GDP	35.0	21.3	28.2	24.6
Gross domestic savings/GDP	27.0	15.7	8.1	6.7
Gross national savings/GDP	22.9	12.7	15.0	13.5
Current account balance/GDP	-0.2	-7.7	-4.2	-4.4
Interest payments/GDP	1.3	2.8	1.7	1.1
Total debt/GDP	36.9	72.2	61.3	60.8
Total debt service/exports	20.4	41.4	21.5	19.1
Present value of debt/GDP	..	..	46.1	..
Present value of debt/exports	..	..	161.8	..

	1977-87	1988-98	1997	1998	1999-03
(average annual growth)					
GDP	3.9	2.3	2.1	1.8	4.8
GNP per capita	0.3	-0.2	0.1	0.2	2.5
Exports of goods and services	1.4	3.5	-13.5	-5.8	6.1

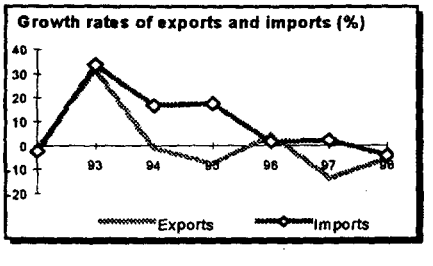


STRUCTURE of the ECONOMY

	1977	1987	1997	1998
(% of GDP)				
Agriculture	42.0	31.5	27.5	26.1
Industry	18.0	18.5	15.0	16.2
Manufacturing	11.0	11.6	9.7	10.8
Services	40.1	50.0	57.5	57.7
Private consumption	55.8	65.8	75.7	77.2
General government consumption	17.2	18.6	16.2	16.1
Imports of goods and services	31.6	26.4	35.5	32.3



	1977-87	1988-98	1997	1998
(average annual growth)				
Agriculture	3.1	1.2	1.2	1.6
Industry	3.6	2.3	2.0	1.3
Manufacturing	4.9	2.9	1.9	1.3
Services	5.4	3.7	3.1	2.1
Private consumption	2.6	2.2	0.0	-3.8
General government consumption	2.4	10.8	22.8	11.0
Gross domestic investment	-2.9	2.5	6.4	5.8
Imports of goods and services	-4.5	8.6	2.5	-4.2
Gross national product	4.1	2.5	2.6	2.7

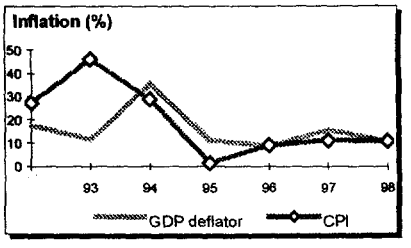


Note: 1998 data are preliminary estimates.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

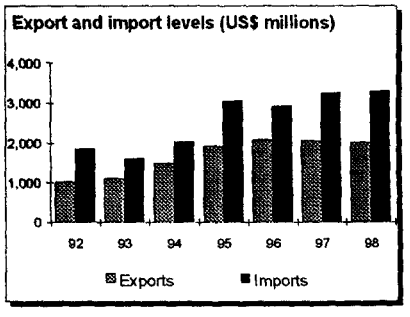
PRICES and GOVERNMENT FINANCE

	1977	1987	1997	1998
Domestic prices				
(% change)				
Consumer prices	..	8.7	11.2	10.7
Implicit GDP deflator	16.9	5.4	15.5	10.6
Government finance				
(% of GDP, includes current grants)				
Current revenue	..	24.7	27.4	27.6
Current budget balance	..	1.4	2.9	2.7
Overall surplus/deficit	..	-4.8	0.1	0.1



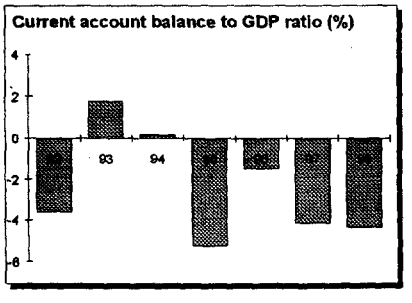
TRADE

	1977	1987	1997	1998
(US$ millions)				
Total exports (fob)	..	907	2,060	2,012
Fuel	..	77	170	149
Coffee	..	236	296	212
Manufactures	..	123	283	220
Total imports (cif)	..	1,898	3,255	3,307
Food	..	130	996	1,044
Fuel and energy	..	348	519	532
Capital goods	..	433	844	920
Export price index *(1995=100)*	..	77	110	99
Import price index *(1995=100)*	..	112	97	86
Terms of trade *(1995=100)*	..	69	114	115



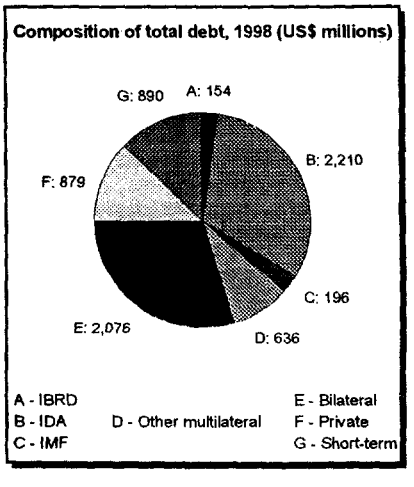
BALANCE of PAYMENTS

	1977	1987	1997	1998
(US$ millions)				
Exports of goods and services	1,553	1,698	2,972	2,849
Imports of goods and services	1,434	2,104	3,738	3,737
Resource balance	119	-406	-766	-887
Net income	-158	-280	-172	-133
Net current transfers	31	72	497	515
Current account balance	-8	-614	-441	-506
Financing items (net)	284	1,049	541	547
Changes in net reserves	-277	-435	-100	-42
Memo:				
Reserves including gold *(US$ millions)*	526	294	811	783
Conversion rate *(DEC, local/US$)*	8.3	16.5	58.7	60.4



EXTERNAL DEBT and RESOURCE FLOWS

	1977	1987	1997	1998
(US$ millions)				
Total debt outstanding and disbursed	1,658	5,755	6,486	7,041
IBRD	202	1,128	213	154
IDA	112	553	2,032	2,210
Total debt service	326	709	648	551
IBRD	18	145	97	83
IDA	1	7	27	30
Composition of net resource flows				
Official grants	47	246	207	190
Official creditors	124	228	-47	9
Private creditors	-29	144	-119	-72
Foreign direct investment	57	43	20	20
Portfolio equity	0	0	12	4
World Bank program				
Commitments	120	128	178	165
Disbursements	53	113	156	123
Principal repayments	3	63	85	81
Net flows	50	50	71	42
Interest payments	16	89	39	32
Net transfers	33	-39	32	10



Attachment 11. Kenya HIV/AIDS Brief

HIV/AIDS Prevalence Ranking in Sub-Saharan Africa: 9

Background

- In Nairobi, HIV prevalence among sex workers increased from 62 percent in 1985 to 86 percent in 1992. In 1993-95, 55 percent of sex workers tested in Mombassa were HIV positive. Prevalence among male STI patients tested in Nairobi rose from 16 percent in 1985 to 28 percent in 1991-92. In 1996, 14 percent of male STI patients tested in Nairobi were HIV positive.
- In recent years, the epidemic has become increasingly generalized. In the major urban areas, HIV prevalence among antenatal clinic attendees rose from 2 percent in 1985 to 19 percent in 1995. In Nairobi, prevalence among antenatal clinic attendees reached 25 percent in 1995; in 1997, 16 percent of antenatal clinic attendees tested in Nairobi were HIV positive. Outside the major urban areas, HIV prevalence among antenatal clinic attendees increased from less than 1 percent in 1988 to 13 percent in 1997.
- The epidemic is orphaning Kenyan children in large numbers. By the end of 1999, 730,000 children had lost their mother or both parents to AIDS.
- In 1993, only 9.9 percent of women ages 25-29 reported ever using a condom.

Country Response/Obstacles

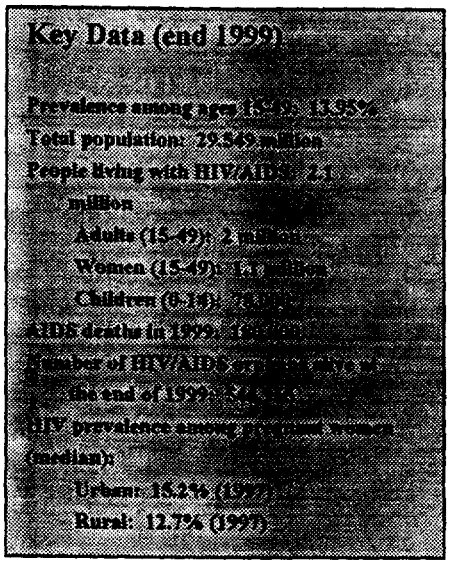
- The political response has been slow and without strong commitment from the highest lev-els of government. However, this seems to be changing as some politicians and administrators regularly speak out on the subject.
- There remains a strong undercurrent of skepticism and opposition to assertive HIV/AIDS prevention and care.
- Highly placed policymakers and many religious organizations oppose efforts to standardize family life education (including HIV/AIDS) in schools even though Kenyan youth are extremely vulnerable.
- Some influential opinion leaders oppose condom distribution.
- The responsibility for HIV/AIDS rests with the National AIDS and STI Control Programme within the Ministry of Health, though the National AIDS Council will serve as a platform to respond across sectors.
- Despite the level of infection, care and support do not feature prominently in national or district plans; a growing number of communities are willing to respond to the epidemic but need support and guidance to get started.

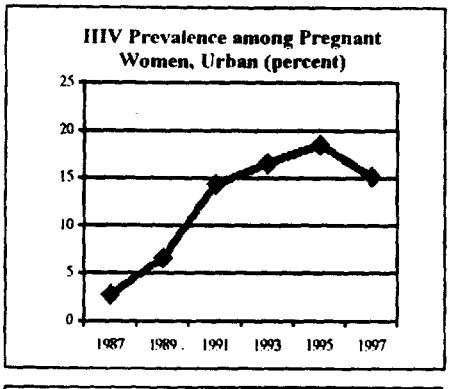
Bank Activities to Date

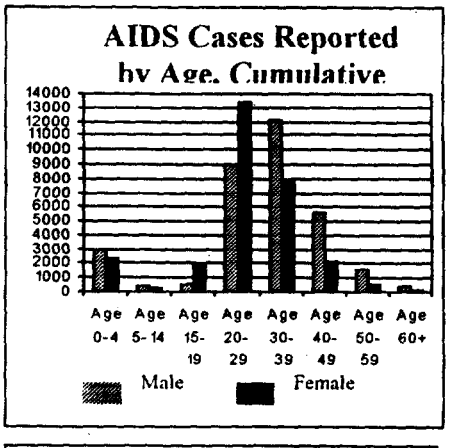
	Yes	No
Is HIV/AIDS a regular part of our high-level dialogue with govt. and civil society?	√	
Does HIV/AIDS receive substantive treatment in the CAS or its update?		√
Has the portfolio been reviewed for HIV/AIDS retrofitting?	√	
Do all projects include the necessary HIV/AIDS-mitigation components?		√
Does the Bank regularly attend UNAIDS meetings?	√	

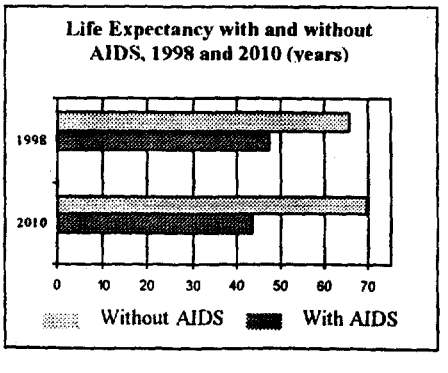
Project Name	Approval Date	$M	AIDS $M
Population III Project	05/10/88	12.2	1.0
STI Project	03/14/95	40.0	40.0
DARE Project	FY01	50.0	25.0
AIDS Disaster Response	09/14/00	50.0	50.0

Opportunities [To be identified by the Country Team.]









Annex 8

Program Processing Schedule

Composition of Task Team:

Manager:	Debrework Zewdie
Task Team Leader:	Anwar Bach-Baouab,
ACT*africa* Team Members:	Hans Binswanger, Jonathan Brown, Rene Bonnel, Therese Cruz, Sheila Dutta, Keith Hansen, Yasmin Jiwa, Srish Kumar, Nadeem Mohammad, Robert Ritzenthaler, Bachir Souhlal, Robert Saum, Irene Xenakis, Mahtab Zolghadri
Ad Hoc Committee:	Joanne Salop (OPS), Ulrich Zachau (OPS), Katherine Sierra (OCSVP), Rene Ruivivar (OCSOK), Nicolette deWitt (LEGOP), Geoffrey Lamb (FRM), David Webber (LOAAF), Nadjib Sefta (AFTQK), Robert Calderisi (AFC07), Ok Pannenborg (AFTH), Birger Fredriksen (AFTHD), Laura Frigenti (AFTH4), Steen Jorgensen (HDNSP), Maryvonne Plessis-Freissard (AFTT2), John Roome (AFTQK), Alan Gelb (AFTMI), Roger Sullivan (AFTI1), Meskerem Grunizky-Bekele (UNAIDS)

Management Decisions:

May 31, 2000	Concept Review Meeting
June 2, 2000	Operations Committee Meeting
July 12, 2000	Technical Review Meeting; authorized appraisal
July 17-22, 2000	Kenya appraisal
July 17-27, 2000	Ethiopia appraisal
July 27, 2000	ROC Review Meeting; authorized negotiations
August 2-4, 2000	Kenya negotiations
August 1-4, 2000	Ethiopia negotiations
August 11, 2000	Board package to RVP; RVP approval
August 21, 2000	Distribution of Board Package
September 14, 2000	Board Presentation

Total Preparation Budget:	(US$ 317,000)
Bank Budget:	US$ 250,000
Trust Fund:	US$ 67,000
Cost to Date:	US$ 317,000

Annex 9. Documents in the Program File

AFRICA - MULTI-COUNTRY HIV/AIDS PROGRAM

A. Project Implementation Plans

B. Bank Staff Assessments

C. National HIV/AIDS Strategic Plans

D. Guidelines for the Preparation of Project Implementation Plans and Operational Manuals for HIV/AIDS Funds

E. *The Impact of World Bank Support to the HNP Sector in Zimbabwe* (OED 1998).

F. Tuberculosis Control Activities in the Context of Care for People Living with HIV/AIDS (template for activity needs assessment/project proposals)

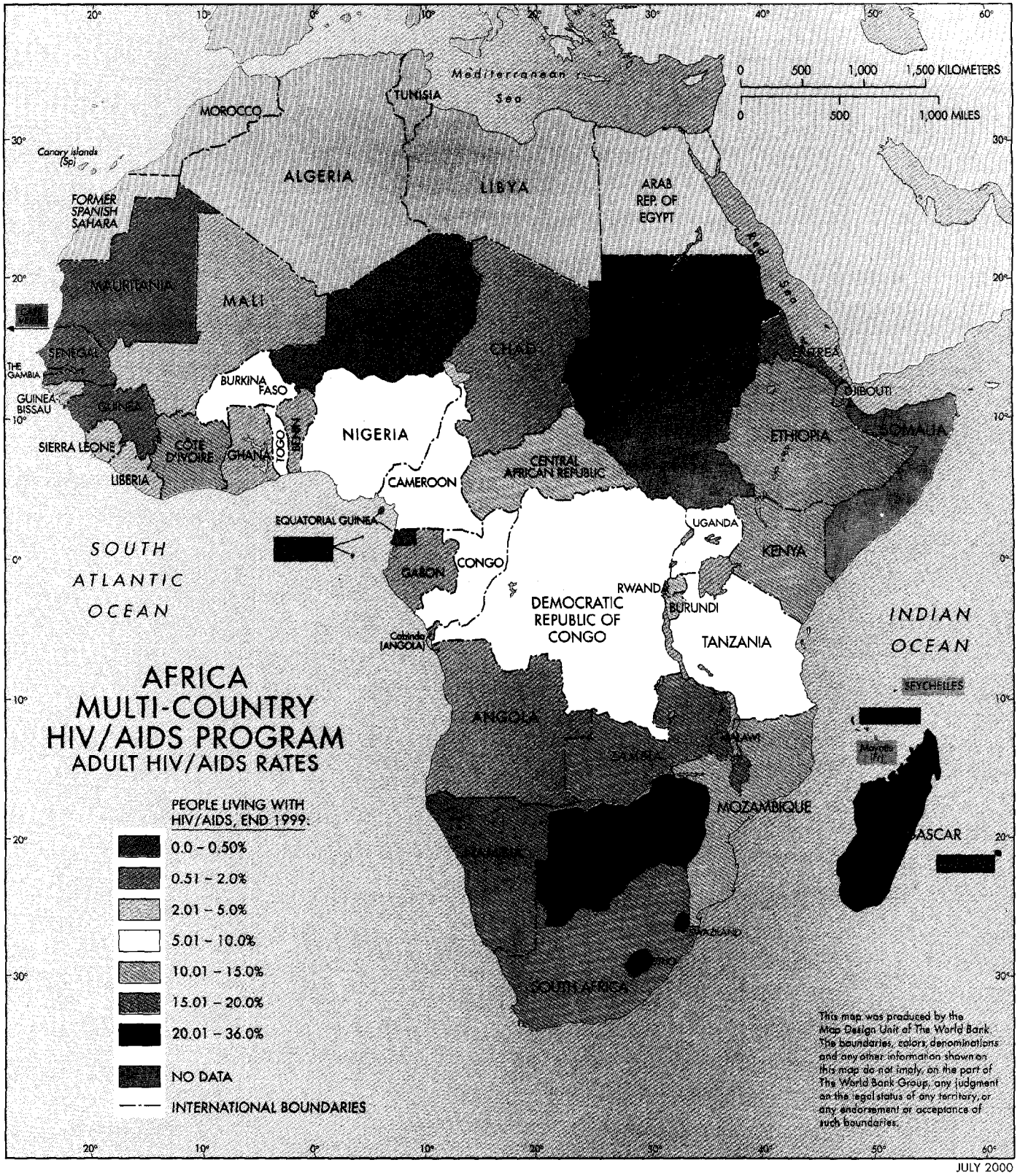
G. *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis* (World Bank 1999)

H. *Safeguarding Development in the Age of AIDS* (World Bank 2000)

I. *Report on the global HIV/AIDS epidemic - June 2000* (UNAIDS 2000)

MAP SECTION

IBRD 31006



JULY 2000