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IMPLEMENTATION COMPLETION REPORT
(SCL-41680 TF-29515)

ON A

LOAN

IN THE AMOUNT OF US$ 15.0 MILLION

TO THE

ARGENTINE REPUBLIC

FOR AN

AIDS AND SEXUALLY TRANSMITTED DISEASES CONTROL PROJECT

June 21, 2004

Argentina, Chile, Paraguay and Uruguay Country Management Unit
Human Development Department
Latin America and Caribbean Regional Office

CURRENCY EQUIVALENTS

(Exchange Rate Effective April 26, 2004)

Currency Unit	=	Argentina Peso
ARS$ 2.85	=	US$ 1.00
US$ 0.35	=	ARS$1.00

FISCAL YEAR

January 1 - December 31

ABBREVIATIONS AND ACRONYMS

ADC:	Anonymous Diagnostic Centers
AIDS/SIDA:	Acquired Immune Deficiency Syndrome
CAR:	Country Assistance Review
CAS:	Country Assistance Strategy
CONASIDA:	National AIDS Council
CSO:	Civil Society Organization(s) (church-, community-, company-, trade union-, etc. based organizations)
DCC(s):	Day Care Center(s)
GDP:	Gross Domestic Product
GNP:	Gross National Product
GoA:	Government of Argentina
HIV/VIH:	Human Immuno-Deficiency Virus
IBRD:	International Bank for Reconstruction and Development
IDB:	Inter-American Development Bank
IDU:	Injected Drug Users
IERR:	Internal Economic Rate of Return
KAP:	Knowledge, Attitude, Practice (Survey)
LUSIDA:	AIDS and Sexually Transmitted Disease Control Project
MCH:	Maternal and Child Health
MoE:	Ministry of Education
MoH:	Ministry of Health
NCB:	National Competitive Bidding
NPV:	Net Present Value
OM:	Operational Manual
PAHO/WHO:	Pan-American Health Organization/World Health Organization
PCU:	Project Coordinating Unit
PISP(s):	Participatory Institutional School Projects
PROMIN:	Argentina Maternal and Child Health and Nutrition Project (I and II)
SIDALAC:	Latin American/Caribbean Initiative for AIDS/STD Control
SOE:	Statement of Expenditures
STD:	Sexually Transmitted Disease(s)
TA:	Technical Assistance
UNAIDS:	United Nations AIDS Program
UNDP:	United Nations Development Programme
ARV:	Anti-retroviral Drugs
NGOs:	Non-governmental Organizations
CSW:	Comercial Sex Workers
MSM:	Men Who Have Sex with Men

Vice President:	David de Ferranti
Country Director	Axel van Trotsenburg
Sector Manager	Evangeline Javier
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ARGENTINA
AIDS and Sexually Transmitted Diseases Control Control

CONTENTS

Project ID: P043418	*Project Name:* AR-AIDS and STD Control
Team Leader: Cristian C. Baeza	*TL Unit:* LCSHH
ICR Type: Core ICR	*Report Date: June 21, 2004*

1. Project Data

Name: AR-AIDS and STD Control
L/C/TF Number: SCL-41680; TF-29515
Country/Department: ARGENTINA
Region: Latin America and the Caribbean Region

Sector/subsector: Health (79%); Central government administration (7%); Primary education (7%); Secondary education (7%)
Theme: HIV/AIDS (P); Health system performance (P); Population and reproductive health (S); Participation and civic engagement (S); Gender (S)

KEY DATES		*Original*	*Revised/Actual*
PCD:	02/15/1996	*Effective:*	08/22/1997	11/14/1997
Appraisal:	02/03/1997	*MTR:*	03/20/2000	03/27/2000
Approval:	05/22/1997	*Closing:*	12/31/2001	12/31/2003

Borrower/Implementing Agency: REPUBLIC OF ARGENTINA/MINISTRY OF HEALTH
Other Partners:

STAFF	Current	At Appraisal
Vice President:	David de Ferranti	Shahid Javed Burki
Country Director:	Axel van Trotsenburg	Gobind T. Nankani
Sector Manager:	Evangeline Javier	Alain Colliou
Team Leader at ICR:	Cristian C. Baeza	Alexander Abrantes
ICR Primary Author:	Cristian C. Baeza; Jorge C. Barrientos; Isabel Noguer	

2. Principal Performance Ratings

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HL=Highly Likely, L=Likely, UN=Unlikely, HUN=Highly Unlikely, HU=Highly Unsatisfactory, H=High, SU=Substantial, M=Modest, N=Negligible)

Outcome:	S
Sustainability:	L
Institutional Development Impact:	SU
Bank Performance:	S
Borrower Performance:	S

	QAG (if available)	ICR
Quality at Entry:	S	S
Project at Risk at Any Time:	No	

3. Assessment of Development Objective and Design, and of Quality at Entry

3.1 Original Objective:

The HIV epidemic in Argentina had increased significantly during the first half of the 1990s when, for the first time in the Argentine health system reached more than 2000 by the end of 1994. Although the pattern of the epidemic was similar to other countries in the region and Argentina at that time had the fifth highest AIDS prevalence in the region, Argentina was the only one without an effective public HIV/AIDS prevention program.

The development objectives of the Argentina Aids and Sexually Transmitted Diseases Control Project (LUSIDA) were: a) to reduce the rate of growth of the incidence of HIV infection by 15 percent; and b) to improve the quality and efficiency of care provided to AIDS patients. The project planned to achieve these objectives through improving information and decreasing misconceptions about HIV transmission and prevention among the population-at-risk; promoting more effective adoption of preventive measures against HIV; improving specialized facilities for diagnosis, treatment and care practices of HIV/Sexually Transmitted Diseases (STD) patients; and improving the monitoring and evaluation of HIV and STD infection, diagnosis, treatment and care in the country.

The project was designed to finance HIV/AIDS and STD-related health promotion and disease prevention activities with a focus on the federal capital and the provinces of Buenos Aires, Córdoba and Santa Fé, where 85 percent of the HIV/AIDS cases were concentrated at the time of preparation. The project would also strengthen existing diagnostic, treatment, counseling and care services in the targeted areas.

3.2 Revised Objective:

The original objective was not formally revised.

3.3 Original Components:

The Aids and Sexually Transmitted Diseases Control Project (LUSIDA) consisted of the following components:

A. Health Promotion**.** (US$12.5 million; 42% of total costs). This component supported the implementation of subprojects in the participating provinces and the city of Buenos Aires to increase the knowledge of the population about the transmission and prevention of HIV/AIDS and STDs, and to reduce the social discrimination against HIV/AIDS patients. These subprojects included: (i) the design, production, distribution, and dissemination of mass- and targeted communication campaigns; and (ii) education on HIV/AIDS in primary and secondary schools, including the development of educational materials for teachers, parents and students, the training of teachers, and the preparation and execution of school-based participatory activities.

B. Prevention of HIV and STD Transmission**.** (US$7.3 million; 24% of total project costs). This component supported the implementation of subprojects, selected on a competitive basis in project areas, to reduce the spread of HIV and STDs through increasing the proportion of the population at high risk that adopts preventive measures, to reduce the transmission of HIV through transfusion of blood and other biological products, and to reduce the mother-child transmission of HIV and syphilis. Activities included: (i) prevention subprojects for specific high-risk groups organized by NGOs and other civil society organizations; (ii) subprojects to improve blood quality control through equipping and training of staff in blood banks where the quality of blood was not yet fully ensured; (iii) review and, when necessary, change of routine prenatal care standards to include the diagnosis and treatment of HIV in pregnant women; (iv) introduction of the diagnosis and treatment of HIV in pregnant women as part of the standard prenatal care

package in order to reduce vertical transmission; and (v) revision and change of legislation to include diagnosis and treatment of HIV in pregnant women in the package of essential services to be covered by government health services, by the social insurance system and by private health insurers in order to reduce vertical transmission.

C. Diagnosis, Treatment and Care of HIV Infection and STDs. (US$6.5 million; 21.7% of total project costs). This component supported the implementation of subprojects, selected on a competitive basis in the project areas, aimed at improving the diagnosis, treatment, counseling and care provided for HIV and STD patients. It included: (i) the establishment of anonymous diagnostic centers; (ii) the establishment or improvement of hospitals or ambulatory health centers, laboratories, day care services, and STD diagnosis and treatment services, and (iii) training of physicians and other health care personnel in the diagnosis, treatment, counseling and care of HIV/AIDS and STD patients.

D. Monitoring, Evaluation and Research. (US$1.7 million; 5.6% of total project costs). This component supported the implementation of studies and provision of technical assistance and training to improve information on AIDS and STDs, to monitor project performance, and to advance knowledge on AIDS and STDs. These included: (i) the establishment of an HIV and STD surveillance system, including the creation of at least 20 sentinel sites for high risk groups; (ii) updating of equipment and software and training of provincial and national ministries of health staff in the operation of the HIV/AIDS management information system; (iii) training of physicians and other health personnel in the preparation of death certificates and hospital discharge summaries and statistics, using AIDS and STDs as tracer conditions; (iv) surveying of HIV/STD related knowledge, attitudes and practices (KAP) surveys; (v) conducting ex-post evaluation and financial and management reviews of a sample of subprojects, and (vi) carrying out research and development studies on AIDS/STDs.

E. Project Administration. (US$2.0 million; 6.7% of total project costs). This component supported the Project Coordination Unit for project management, including the provision of specialized technical assistance and staff and the acquisition and use of appropriate office space, equipment and communications services.

Assessment. Overall, the components were appropriate, reflected current knowledge and experience at the time, and were directly related to the achievement of project objectives. The project focus on preventive efforts was complementary to the Ministry of Health's (MOH) efforts to address treatment and care through other programs. At the time of project design, there were no Bank-financed projects of similar nature that had been evaluated. Most experience was drawn from the design of HIV/AIDS projects in Brazil, Africa and programs in the USA, as well as other health projects with relevant features.

3.4 Revised Components:

The project components were not revised. As mentioned above, only the indicators for monitoring were adjusted (rate of incidence measured by variation in percent of prevalence in at least two sentinel populations and the level of knowledge about HIV in different populations surveyed).

In late 2002 the Borrower and the Bank agreed on a reallocation of the remaining loan proceeds (US $1.2 million) from Civil Works to Consultant Services in order to implement the massive media communication campaign for HIV/AIDS prevention. Also, about US $0.4 million was reallocated to the Goods category to purchase HIV diagnosis kits to be used for prevention of vertical transmission.

3.5 Quality at Entry:

The project objectives were coherent and adequate for the epidemic level at the time when they were

formulated. There was no Quality Assurance Group review. The project pursued strategic priorities for controlling the HIV/AIDS epidemic, which were badly needed in Argentina by the time it was prepared. The project supported existing CAS objectives of enhancing social development in Argentina and improving social services for the most vulnerable groups in Society. Project design was consisted with the CAS objectives of institutional building and enhancing the participation of community based organizations in project implementation. The project complemented other projects including the CAS, such as the Provincial Health Development Project and the Health Insurance Reform Project. Together they responded to the CAS objectives of reducing the catastrophic impact of AIDS of lower income families where the disease was more prevalent.

The Ministry of Health capacity to manage and implement the project was assessed and found satisfactory, reflecting the extensive experience of the National Ministry of Health in implementing Bank financed projects. The MOH however required substantial technical assistance for the specifics of the HIV/AIDS prevention aspects of project design. The Bank played a significant role in bringing such expertise into project preparation.

The Bank played an important role in both, the design and implementation stages mainly by helping to maintain a focus on prevention, on high risk groups and by involving other key actors, particularly NGOs and Civil Society Organizations (CSO).

The project design was appropriate to the needs identified in the sector, but there were several design features that could have been improved, including: a) a better definition of the first development objective in order to facilitate measurement; and b) weak government commitment at appraisal on the prevention communication campaign (Component A). The impact of these issues during project implementation is detailed in Sections 4.1 and 4.2.

Although there was no QER before project effectiveness, in early March 2001, an external QER was conducted at the request of the LAC Region. The QER review was unusual in that the project was nearing completion. The Closing Date at that time was December 31, 2001. The Mid-Term Review was carried out in March/April 2000. The QER determined that the project's original development objectives were too ambitious and were unlikely to be realized by the Closing Date. The Loan had been structured in a way that resulted in the Bank financing 97 percent of total project expenditures with consequent unusually low counterpart funding at the time of the review. From the PAD and other documentation, the Panel members felt that the original project design was much too ambitious for the modest resources allocated, and that even a scaled-down set of objectives would be difficult to realize without additional funding, whether from government or from the Bank. The Panel advised the team to focus next missions on the prevention components as the most critical contribution the Bank could make at the time would have been to help ensure the prevention program achieves a sustainable level of effort, with or without more financial support from the Bank.

The extensive participation of NGOs and grassroots organizations fostered the development of public-private collaboration, which was critical for achieving the desired outcomes. The Bank team encouraged the national team efforts to engage with NGOs and CSOs and the role of these organizations, a key design feature of the project, was fundamental. First, they brought an essential knowledge of local realities and needs to both preparation and implementation, ensuring ownership of the project particularly by populations at risk. Second, some of the organizations also had state-of-the art technical expertise that significantly enriched project strategy design. Third, and most importantly, the active presence of NGOs and CSOs during preparation and particularly during the first two to three years of project implementation, maintained the pressure and the debate regarding the need for implementing the massive prevention

communication campaign. The Bank also played an important role in this regard. Records show that project appraisal was delayed for a few months until an agreement was reached with the Ministry of Health to include the prevention communication campaign.

The Bank had four project preparation missions (including identification and appraisal). Mission team included TTL and high level experts on HIV/AIDS programs in OECD countries.

4. Achievement of Objective and Outputs

4.1 Outcome/achievement of objective:

The LUSIDA Project had a significant development impact on the AIDS epidemic in Argentina, mostly due to support for the prevention of vertical transmission (from mother to child), the development of a significant HIV/AIDS surveillance system, and the implementation of the prevention communication campaign. The project had a slow start and some initial implementation problems, but these outcomes were mostly achieved through an acceleration of project implementation during the last three years of the project and to a significant increase in the government's commitment to prevention and promotion with its own funds, even during the socioeconomic crisis of 2001-2002. During the last two years of implementation, LUSIDA had a preeminent role in supporting the government's renewed agenda for HIV/AID prevention and it was fully integrated into the Ministry of Health as a line unit.

In 2001-2002, the Argentine economy entered into the deepest recession in generations, with its GDP falling by 20 percent in the last four years, including by 10.9 percent in 2002. Combined with the strong depreciation of the Argentine peso, the economic decline had left per capita income at US$2,695 (in 2002), down from over US$8,000 in the 1997/98 period. According to the Bank's Atlas methodology, per capita GNI in 2002 declined to US$4,060 from US$8,030 in 1998. The crisis had a very negative effect on all IBRD-financed projects in Argentina. The implementation of the LUSIDA Project was significantly delayed during this time. Troublesome signs and symptoms were observed in core public health programs, in access to and delivery of individual health care services (of all complexity levels), and in the coverage and effectiveness of the various health insurance systems. Critical national health programs including immunizations, tuberculosis (TB), maternal and child health (MCH) and HIV-AIDS, suffered major deterioration during 2001 and early 2002, precisely in a moment of soaring needs.

However, in late 2002, under a new government and project management, the project significantly contributed to establishing the strategy and managing the overall HIV/AIDS prevention and antiretroviral programs during the peak of the crisis and thereafter. It was also at that time that the project was able to support the new MOH authorities to finally launch the prevention communication campaign under Component A. It was this renewed commitment that persuaded management to request an extension of the Closing Date by two years until December 2003, which was approved by the Bank. Project implementation during the extension period significantly improved overall project development objective performance.

Reduction of rate of growth of HIV incidence / prevalence: **Satisfactory**

The original definition of this objective made it difficult to evaluate and monitor project performance for this objective. The project was prepared in 1996, when epidemiological surveillance systems available in the country did not allow for identifying and monitoring HIV incidence (number of new infection cases in the year). New infection cases are usually a-symptomatic. At that time, no Latin American country or National AIDS Programs had such systems or data available and it was unlikely they would be available in the short term. At that time Argentina also did not have a baseline for growth of incidence of HIV infection.

Argentina's epidemiological information system in 1995-96 was based on the AIDS cases (patients with symptomatic infection) registry and a few only sentinel sites existed but few systematized information was collected. This led to the use of different statistical methods, mostly based on population surveys rather than testing, to evaluate growth of HIV incidence. Moreover, it was not possible to define a base line for HIV incidence, and trends had to be estimated based on the evolution of AIDS prevalence (total number of symptomatic). When monitoring of prevalence was introduced in different segments of the populations it allowed the possibility to make indirect estimates of HIV incidence. During the mid-term review, and recognizing the methodological difficulties to monitor this objective resulting from the definition of reducing incidence growth by 15 percent, the Bank and the borrower agreed on a new monitoring indicator based on prevalence of HIV positive among blood donors, with the target set specifically at reducing prevalence among blood donors by 5%.

According to official data, it is estimated that about 120,000 persons are currently living with HIV in Argentina. The prevalence rate (as estimated from HIV positive blood donors) is relatively high at 1.7 per thousand inhabitants in 2003, down from 2.2 per thousand in 2002. Also, AIDS cases (adjusted by reporting delays) decreased by about 31 percent (from 2,900 cases to 2,000) between 1998-2002. Although establishing direct causality is very difficult in both cases, it was during this period of time when the project actively implemented most of the prevention components and, at that time, it was the only major prevention initiative in the country. As described above, given that there was no available data on incidence for most of the project lifetime, it is not possible to evaluate the impact of the project on reducing the incidence of HIV infection. However, considering the revised objective of reducing HIV prevalence, as measured from blood donors, the project contributed to the reduction of about 23 percent of prevalence of HIV infection, significantly higher that the revised target of 5 percent. In addition, as detailed in Section 4.2 and in Annex 1, project output far exceeded most of its targets and, perhaps more importantly, it significantly contributed to maintain the public debate about HIV/AIDS prevention, even during the early years of implementation when the lack of political commitment for public education was a significant problem.

Data on HIV prevalence from Sentinel Surveillance studies suggest that the evolution of HIV prevalence in different populations between 1998 and 2001 has been positive. The HIV prevalence in high-risk populations, such as commercial sex workers (CSW), people attending the testing centers or STD patients has decreased in an important way, as well as the prevalence of those of at low or variable risk. However, the shortcomings of using prevalence of HIV infection as a proxy for general population HIV infection support the implementation of the HIV incidence system. During project implementation, the Bank and the borrower discussed the possibility of implementing an information system collecting new HIV diagnosis, allowing the recollection of countrywide HIV diagnosis incidence rates and better estimates of HIV incidence. A new system was implemented in late 2001 but, it still needs more time to extend coverage and be as comprehensive as needed. The design and implementation process of this new HIV incidence system has been satisfactory, but results and data would only become available by the end of 2004. Indeed, extrapolations of the blood donor HIV prevalence to the general population suggest that the general population prevalence might be around 3.2 per one thousand, which is comparable with that estimated for countries more affected by the epidemic.

It should be noted that the latest advances in treatment and their impact on AIDS incidence and mortality rates have affected the evolution of the epidemic, increasing the prevalence of people living with HIV. The AIDS incidence has been reduced and in most cases, probably affecting under-diagnosed people. The evolution of care and its quality have also been satisfactory during the last five years. New diagnosis and counseling centers have been opened and hospitals have adapted structures and developed training programs to cope with the epidemic.

In summary, the evolution of the epidemic in Argentina has been positive. In accordance with the evolution of AIDS incidence, project interventions contributed significantly to reduce the incidence of new infections in wide sectors of the population at risk. The LUSIDA Project appropriately deserves a significant share of credit for the overall success of the HIV/AIDS program in Argentina.

Yet, a word of caution seems to be necessary. The current turnaround of the incidence of STD among populations with sexual risk, the fatigue in prevention measures in certain groups and the devastating effects of the recent economic crisis need a solid strategy with renewed efforts and resources. The key challenges faced by the MOH, at present are: (i) to slow down the wave of sexual transmission, secondary to the epidemic among Injected Drug Users (IDUs) mainly affecting women; (ii) to approach the epidemic of illegal drug use with programs of "Harm Reduction" (exchange of syringes and extensive provision of sterile injection material), promotion of testing and access to health care; (iii) to reduce the diagnosis delay for AIDS and HIV cases to be able to intervene preventively and to ensure that those infected by HIV can benefit from treatment and care; (iv) to avoid HIV infections and AIDS cases transmitted from mother to child by offering HIV testing to all pregnant women and Antiretroviral (ARV) prophylaxis to all those infected by HIV. Regarding the last issue, the MOH has recently launched a fortified milk distribution program for children of infected mothers.

Improve the quality and efficiency of care provided to AIDS patients: **Satisfactory**

The project contributed to many improvements in quality of care through multiple subprojects. Unfortunately, there is scarce data on monitoring patient care sub-projects, except for the quality of care of the Mother-Child during pregnancy, avoiding vertical transmission. The rating of this component is based mainly on the significant results (output and outcomes) showing prevention of vertical transmission. On time, sound treatment of pregnant women resulting in prevention of vertical transmission is one (significant) indicator of improvements in the quality of care of AIDS patients (mother and child in this case). It also is determined by, although causality is more difficult to demonstrate, important reductions in HIV/AIDS related mortality.

Testing of pregnant women for HIV increased from 0 to 72 (Cordoba)–67 percent (City of Buenos Aires) in the four areas of the project (greater than target of 50 percent) due to direct project policy, advocacy, technical support and, in many cases, supply of testing kits. Treatment for HIV positive pregnant women (direct impact on preventing vertical transmission) went from less than 50 to 92 percent countrywide (target was 75 percent). This led to one of the most positive effects of the project, the reduction in AIDS cases due to vertical transmission (from mother to child during pregnancy), which decreased from 7.8 percent of total AIDS cases in 1997 (very high) to 3.4 percent in 2003 (which is still high, but within reasonable limits). Similarly, mortality related to HIV/AIDS decreased by 28 percent between 1996 and 2001 (from 2,055 to 1,472 deaths). In both cases, the evolution has been favorable and within the limits that could be expected under an adequate coverage of Antiretroviral (ARV) therapies, purchased and financed by the MOH, but with significant policy advice from the project.

4.2 Outputs by components:

Component A. Health Promotion: Satisfactory

The Health Promotion Component was widely implemented in schools in 1999 and 2000. However, over the next two years, the effort was considerably reduced due to shortages of budgetary resources. Despite these shortcomings, more than 3,000 educators in the project areas were trained and qualified on AIDS and STD prevention education, resulting in more than 90 percent of all schools having at least one leading

teacher on this subject, significantly more than the original project target of 40 percent. In addition, the first sexual education materials for school activities were issued and distributed to schools. It should be highlighted that health promotion in schools, in any AIDS program, is usually not as effective as one would hope, independently of the level of resources. This is due to the social, cultural and political complexities of this type of intervention, as well as the need to reach commitments involving a high number of relevant actors. Currently, the signature of a new agreement with the Ministry of Education is in progress and the borrower is committed to continue such activities.

Another important achievement of the project was the implementation and successful operation of an answering and counseling service through a dedicated telephone line (800 number) available to the general population. This service is the only permanent prevention tool on a countrywide basis and has been included to the National AIDS Program in the MOH. The number of daily telephone calls received has increased continuously since its inception.

There was an apparent lack of political commitment by the MOH authorities at appraisal time regarding the AIDS prevention communication campaign (evidenced in project files and delay in appraisal), which became evident during early implementation. Even when most loan proceeds were spent or committed by early 2001, the project had not implemented yet the prevention communication campaign and the prevention strategy, which was a key activity of the project. The lack of government commitment was solved only in late 2001 with changes in government and particularly, with the arrival of new authorities in the MOH in late 2002. It was this renewed commitment that persuaded management to request successive extensions to the Closing Date until December 2003.

The LUSIDA Project carried out three large campaigns targeting the general population, apart from the World AIDS day annual event. The last campaign, finally developed in late 2002 and early 2003, was based on the promotion of the use of condoms, following Bank recommendations in several missions, clamor from NGOs and CSOs and their own program. The rating of the last campaign, as measured by the MORI survey (a specialized survey firm), was 75 percent of target population.

Component B. Prevention of HIV and STD Transmission: Satisfactory

This component had one of the largest impacts over the course of the epidemic. It contributed to reducing new infections by creating an important network of support within the civil society. A citizen movement was stimulated and many NGOs and CSOs were created or strengthened by the LUSIDA Project through subproject financing. The activities supported by the NGOs and CSOs were instrumental in promoting development of self-esteem and partnership among the most vulnerable, marginal and socially excluded groups, such as commercial sex workers (CSW), men who have sex with men (MSM) and others. The LUSIDA Project was very successful in implementing four rounds of competitive proposals for subprojects prioritizing the most vulnerable and high risk segments of the population. More than 116 CSOs and NGOs implemented these projects (significantly more than the initial project target of 50 subprojects). These interventions were designed to achieve greater effectiveness and impact on the incidence of HIV infections in segments such as intravenous drug users (IDU) and their environment, MSM and CSW.

Several Bank supervision missions recommended that the project consider developing prevention programs in the penitentiary environment. This suggestion coincided with the strategy of “Healthy Jails” being promoted by Pan American Health Organization (PAHO) at the time. After some reluctance by the penitentiary authorities, the project started a small program that facilitated the development of several small interventions, basically promoting the use of condoms. However, in the future, it will be necessary to cover a larger number of prisons, create access to confidential HIV tests, and extensively promote the use of condoms. The prevention program recently launched in federal penitentiaries is a positive step in this

direction.

This component also included a program that aimed to reduce vertical transmission (from mother to newborn). Results show a considerable reduction in the cases of AIDS as well as an increased coverage of HIV test to pregnant women, as noted above, from 0 at the beginning of the project to 67- 92 percent in all four areas of the project, well beyond the 50 percent target at appraisal. The ARV prophylaxis coverage among seropositive pregnant women was more than 90 percent in 2003, achieving a transmission rate of 3.2 percent. It should be noted that it is still possible to improve these results and to achieve lower rates of vertical transmission, hopefully below 1 percent. Such a drastic reduction would require close multisectoral collaboration to ensure wider coverage of prenatal care and, at the same time, improve the quality of the current services provided.

Blood safety has also reached higher levels of quality. The LUSIDA Project has been instrumental in achieving these results, working in close collaboration with other agencies and international sponsors. Coverage of HIV screening for blood donors went from less than 70 percent to nearly 100 percent at the end of the project.

Component C. Diagnosis, Treatment and Care of HIV Infection and STDs: Satisfactory

Diagnosis of HIV and other STDs improved considerably during the LUSIDA Project. The project introduced centers for anonymous HIV diagnosis in Argentina. Eighteen centers were established, covering an important demand coming mainly from populations with high risk of infection (IDU, CSW, people with STD, MSM and others in risk situations). The original project target for establishing anonymous diagnosis centers was 10. Still, coverage needs to be expanded even further, especially in areas with high HIV prevalence that were not the target areas of the project.

The need to train health professionals in the management and treatment of the HIV/AIDS patient was covered with different programs, executed in the first two years of the project. Simultaneously, health facilities were adapted for the specific care of HIV infection and its associated pathologies. The project started a program for remodeling reference hospitals, creating hospital day units capable of covering relevant pathologies, microbiology laboratories and immunology for the diagnosis of infections, STD and CD4 and viral load monitoring. Only 52 percent of the remodeling projects foreseen at appraisal were executed. The main reasons for the lack of progress were: a) investments carried out by the provincial level that anticipated some of the originally planned projects; b) difficulties in resolving jurisdictional issues with provincial governments; and c) delays in execution and shortage of counterpart funds. The MOH requested a reallocation of the remaining loan proceeds in the civil works category to the massive prevention communication campaign. A loan amendment for this purpose was completed in June 27, 2002.

Component D. Monitoring, Evaluation and Research: Satisfactory

The LUSIDA Project made critical contributions to establishing epidemiological surveillance systems in Argentina. During the early stages of implementation it was understood that the MOH needed good quality information that would support the definition of adequate strategies for controlling the epidemic. Initially, emphasis was on the availability of adequate AIDS case identifiers that could be cross-checked with the mortality registry and other relevant sources. The surveillance system was implemented, although late in the project life. It is estimated that the AIDS reporting system currently has an under-reporting of about 30 percent. This is due to a variety of factors, such as difficulties in applying AIDS case definition countrywide, lack of professional confirmation of diagnosis (physicians and epidemiologist) , gaps in inter-provincial/national consensus about procedures or quality of data, high reporting delay, and need for

guidelines for HIV/AIDS epidemiological surveillance, etc.

The HIV surveillance system also has a high level of under-reporting, mainly due to its recent implementation and rather limited geographical coverage, which has not yet allowed for monitoring HIV incidence. It is expected that the first reliable information on HIV incidence will be available at the end of 2004. However, one key output of the project is the implementation of a reporting system for new HIV diagnosed cases. This system started in 2001 and at present, has national coverage allowing the MOH to be informed when and where new HIV cases are being diagnosed. This information is critical for HIV and STD prevention planning. The city of Mendoza is a good example of the impact of a complete and comprehensive HIV reporting system supported by the project. During 2001, it reported an incidence rate of new HIV diagnoses of 57 per million.

Finally, the project's HIV surveillance system created 218 new sentinel surveillance centers, well above the target of 20 centers.. HIV sentinel surveillance centers cover a wide range of high, low and variable risk population groups (IDU, prison inmates, STD patients, pregnant women, MSM, and CSW) throughout the country. All centers provide valuable periodical information about specific populations. There is still some room for improving the quality of the surveillance system and its coverage. To achieve this goal, it would be necessary to staff these centers with a well-trained epidemiologist and provide the necessary resources to operate and improve them. Lastly, HIV sentinel surveillance should have quality control related to the characteristics of populations reached and their possible variations over time.

The implementation of behavioral surveillance was only partially successful. Only one KAP survey was undertaken through monitoring of HIV knowledge covered by phone interviews. Although having only one KAP did not allow for monitoring the trend, it showed, at least in one measurement, an increase from 60 to 75 percent, in line with appraisal target.

Component E. Project Administration: Satisfactory

In general, although project management was satisfactory, it fluctuated depending on the commitment of the MOH authorities at each moment of project implementation. During the early years of project implementation, project management was focused on epidemiological research and surveillance issues with a significant emphasis on the virological aspects of the epidemic. There was a clear lack of attention to public education campaigns, in line with the MOH high authorities' commitment at that time. However, project management continued supporting the participation of NGOs and CSOs, which, as mentioned above, were able to maintain the demand for public education. From late 2002 until December 2003, project management played a very important technical and advocacy leadership role in the full implementation of the key preventive aspects of the project, particularly the prevention campaign.

A critical decision that had to be made at project entry was whether to entrust project implementation to the line structure of MOH or to create a Project Coordination Unit (PCU) within the ministry. From the outset, the borrower had decided that treatment and care would not be included as a project component since these were already being addressed directly by an ad-hoc department within the MOH, under a program created in 1992. Consequently, the focus of the project centered on activities to address the control of the epidemic. The borrower and the Bank decided to establish a PCU that would, during project implementation, merge with the AIDS treatment unit in the MOH to create the HIV/AIDS unit. There was an uneven development of both areas during project implementation. The LUSIDA Project, with an adequate management structure, well trained staff and sufficient resources was well positioned for carrying out effective interventions for slowing down the progress of the epidemic. The treatment unit of the MOH limited its activities to the logistics for providing Anti Retroviral Drugs (ARV) and supplies to the public

sector hospitals and agencies. Moreover, coordination between these two branches within the MOH was less than optimal and only improved during the last two years of project implementation. At present, the MOH has integrated both areas under one national program, created with the support of the project team.

4.3 Net Present Value/Economic rate of return:

For comparability purposes, the ICR replicated the methodology used at appraisal (Human Capital Approach). An ex-post evaluation estimated the NPV at US$ 1,089 million for a 10 year horizon, noting the high benefits deriving from a prevention strategy for HIV/AIDS. It is estimated that this intervention prevented about 42,000 cases of HIV infection, which is equivalent to about 1.5 million years of live saved (YLS) at a cost of US$ 16 per YLS (see Annex 3). Data available at project end were insufficient to carry out a further detailed economic analysis of the project.

4.4 Financial rate of return:

N/A.

4.5 Institutional development impact:

The institutional development impact of the project was ***substantial***. Mostly as a result of the project support, Argentina developed from an HIV/AIDS program exclusively focused on Antiretroviral therapy for a few AIDS patients in 1998 to a program that fully integrates prevention and treatment both, at the national and the provincial level. The project emphasis on partnerships with NGOs and CSOs is unique among all public health programs and has provided the MOH with the opportunity to explore similar partnerships for other programs. Likewise, the school education and training component, also unique among public health programs in Argentina, provided an analogous opportunity. Without the project, it is likely that the implementation of the national program would have been much slower with a more prolonged exclusive focus on treatment.

Other clear signs of the significant institutional impact include: i) the creation and implementation of the national HIV surveillance system; ii) the modifications and update of technical norms for prevention and treatment; and iii) the pivotal role the LUSIDA Project unit and the national program have had in harnessing Global Fund financing for Argentina.

One of the most important institutional strengthening results of the project was its full integration in the line ministry. Project management was fully integrated as a new unit in the Ministry and, since late 2002 all HIV/AIDS activities in the MOH have been integrated, creating a new integrated unit resulting from the line MoH HIV/AIDS treatment unit and the LUSIDA Project unit. All HIV/AIDS activities since then are managed from this new integrated unit, mostly financed by national funds. Today, prevention activities are well integrated into the national program under an institutional scheme that was practically nonexistent when the project was launched.

5. Major Factors Affecting Implementation and Outcome

5.1 Factors outside the control of government or implementing agency:

The significant level of decentralization determined by the constitutional federal nature of Argentina makes implementation of any national program very challenging and complex. This project was no exception. The operational and health policy autonomy of provinces as determined by the federal structure of the country, led to uneven development of actions across the country. This is an outstanding issue well beyond the scope of this project. As provinces began to assume administrative responsibilities for implementing aspects of the project, difficulties arose from political interference in handling sensitive matters, such as prevention campaigns. It seems that formal agreements between National and the Provincial governments

were not always effective and that it was necessary to ensure a consensus process between national government and provincial authorities.

5.2 Factors generally subject to government control:

As mentioned previously, the severe macroeconomic crisis that affected Argentina in 2001-2002, from which the country is still recovering, had an impact on project implementation. The crisis negatively affected the entire Bank portfolio. Changes in authorities and project management in 2002 brought new leadership and a commitment to the MOH, which significantly improved project development impact.

Another important factor was the availability of counterpart funds. Although project implementation was not significantly delayed by the lack of funds (other factors played a more important role), it did cause the difficulties in finishing the facilities improvements (only 52 percent of the projects were implemented).

5.3 Factors generally subject to implementing agency control:

The most important factor during the first three years of project implementation was the lack of commitment of the MOH authorities to the communication campaign (Component A). The prevailing ideology at the highest level of the MOH considerably delayed campaigns for the use of condoms and activities to reach certain high-risk groups. In addition, also at that time, there was political resistance to working with NGOs and grassroots organizations, thus delaying the subproject selection process and activity implementation. These two issues were resolved in late 2001/late 2002.

The organizational structure in the PCU to manage monitoring and evaluation (M&E) became an issue during implementation. Initially, it was agreed that there would be a special section within the PCU to manage these activities. It was structured accordingly and started to set up business processes and tools to monitor project performance indicators, including those designed to control the epidemic. This scheme worked well for about two years until the person in charge of M&E left the project and was not replaced. Successive Bank missions insisted on filling this position, but the process dragged on and, eventually, no one was hired. As an interim measure, monitoring activities were distributed among the rest of the project organization and operated in this manner until project completion.

5.4 Costs and financing:

At appraisal, project costs were estimated at US$30.0 million, of which the IBRD loan would finance US$15.0 million and the government would contribute US$15.0 million. At project closing, the total cost was US$21.98 million with Bank financing of US$14.98 million (68 percent of total cost) and the Borrower contribution amounted to US$7.0 million (32% of total cost) (see Table 1).

Table 1: Project Financing Appraisal Estimate and Actual Cost

Financing	Appraisal Estimate (US$ million)	Actual (US$million)	% of Appraisal
IBRD	15.0	14.98	99.8
Government	15.0	7.0	46.6
TOTAL	30.0	21.98	73.2

Although project implementation, particularly regarding the prevention and education campaigns, was slow during the first three years of the project, the loan disbursement pace was accelerated during that time, with loan proceeds for consultants completely utilized in 2000. This rapid disbursement in the context of low implementation of some key elements of the project is essentiately explained by loan disbursement in the presence of low counterpart funds availability. In early 2001, loan proceeds accounted for 92 percent of all project cumulative expenses. This decreased to 68 percent at the end of the project due to a significant increase in counterpart funds during 2002 and 2003. Bank response to the 2001-2002 crisis, also contributed to improve both project implementation in general and availability of counterpart funds. Loan amendments were approved at the request of the government to implement the communication campaign in 2002-2003 (US$1.2 million was shifted from civil works and goods to consulting services); a small amount (US$0.4 million) was shifted from civil works to goods to purchase HIV testing kits and a small amount of ARV during the peak of the crisis in 2002. Peso devaluation in 2001 significantly improved purchasing capacity of these funds, providing sufficient funding for a full communication campaign.

The lack of counterpart funds from 1998-2001 forced the project management to focus on activities and modalities that were particularly suitable for Bank financing. As a consequence, LUSIDA was completed with substantial savings and the total project cost was about two-thirds of the original estimated project cost.

6. Sustainability

6.1 Rationale for sustainability rating:

The sustainability of the project is considered ***likely*** due to several factors. In early 2002, the newly-appointed authorities in the MOH decided to merge activities under the project with the National Program to Fight AIDS, which was dealing mainly with supporting treatment of the disease in the public sector. Consequently, the HIV/AIDS surveillance, the prevention and the health promotion activities became unified with the treatment of the disease under a single program and a single manager within the MOH, who previously led the project. These actions, together with the definition of a national policy to continue preventing the spread of the disease (DATE of national policy), are considered the cornerstones for providing sustainability in future activities. Another critical factor is that Argentina now has a sizable number of health and public health professionals available and adequately trained for preventing and treating HIV/AIDS. For the future, the availability of adequate human and financial resources, and the continued political commitment are the main challenges for the sustainability of the program.

6.2 Transition arrangement to regular operations:

The Argentine HIV/AIDS program is currently well consolidated. Furthermore, the MOH has been implementing a series of transition arrangements to ensure the continuity of surveillance, prevention, promotion and care activities. These arrangements are related to: (i) improving coordination within the

MOH, particularly with maternal and child programs, to improve prevention and early diagnosis of STDs and distribution of fortified milk to children of infected mothers; (ii) stronger links with provincial ministries of health to strengthen their capabilities to manage prevention and care programs; (iii) improved coordination with other federal ministries and agencies, including youth programs under the Ministry of Social Development, implementing a prevention program within the federal system of prisons, preventive actions with the federal agency responsible for handling drug abuse and trafficking issues; and (iv) sponsoring programs in medical academia related to antiretroviral therapy and HIV prevention issues in perinatal care.

In addition, the MOH has continued to carry out project-related activities under the following lines of action:

- Carrying out massive and targeted prevention campaigns, focused on the use of condoms, addressing vertical transmission, reducing risks among HIV drug users, strengthening the prevention role of civil society organizations in terms of providing condoms, materials and financing, and maintaining and promoting the use of the line 800 for providing advice.

- Improving the quality of life of persons living with the disease through programs to provide assistance in covering the cost of treatment and making available support for actions addressing social acceptability issues.

- Strengthening epidemiological surveillance by integrating the HIV/AIDS morbidity and mortality surveillance, which uses the sentinel posts created under the project, with the national Epidemiological Surveillance System.

- Strengthening provincial programs to enhance their capabilities to manage preventive and care services provided in a decentralized manner.

7. Bank and Borrower Performance

Bank

7.1 Lending:

The Bank performance in preparing the project was ***satisfactory***. In the opinion of the borrower, the assistance provided by the Bank team during preparation and appraisal was very helpful to define the project scope and components. In several interviews, the borrower expressed appreciation for the expertise and technical assistance provided by the Bank. The borrower acknowledged that the Bank's role was instrumental in overcoming reservations in the MOH leadership about the use of condoms as an effective preventive mechanism and the active participation of NGOs and CSOs representing high-risk groups. Project processing was delayed for about four months until this issue was resolved.

7.2 Supervision:

The Bank's supervision performance was ***satisfactory***. The Bank carried out regular supervision missions supplemented by visits from specialists and provided oversight of project implementation and fiduciary aspects. There were four Task Team Leader changes during project implementation. The first change occurred when the original Task Leader was reassigned to another region in 2000; a third Task Team Leader was appointed in 2002; and the last one was appointed in July 2003. These transitions were generally smooth, but it should be noted that they also implied changes in specialized consultants involved in supervising the project. The borrower emphasized the Bank's rapid and adequate responsiveness during the peak of the socioeconomic crisis. In early 2002, the project was virtually completed and the Bank acted promptly to reallocate available financing to the supply the HIV diagnosis kits for the project's activities

for prevention of vertical transmission.

Aside from the generally good opinion about the Bank's technical expertise provided during project implementation, the borrower pointed out one specific issue in which the Bank could have improved its performance, specifically related to the frequent changes in Bank staff and consultants participating in supervision missions. In the opinion of the borrower, these changes implied several redefinitions of emphasis and priority areas for the project, particularly related to the activities targeting the various vulnerable groups involved in the program. In addition, the borrower was left with the impression that missions too often based their judgments and advice on their own experience in different countries without taking into account the socioeconomic and legal framework prevailing in Argentina.

7.3 Overall Bank performance:

The overall Bank performance is rated ***satisfactory***. The Bank's team, according to the borrower, added value during project preparation and assisted in the design process of key project components. The Bank also contributed to helping the government implement a badly-needed program to prevent the evolution of the epidemics in Argentina.

Borrower

7.4 Preparation:

The borrower's performance in preparation was ***satisfactory***. The borrower was able to create a technical team that quickly focused on designing key components. The local team had to overcome deficiencies in available information on the epidemics and assumptions had to be made based on the assistance provided by the Bank's team drawing from its experience in other countries. Overall, the team was high quality and worked very effectively.

7.5 Government implementation performance:

The government's performance during implementation was ***satisfactory***. Although there were significant shortcomings in the provision of counterpart funds during the first two years, the last two administrations made a significant effort to reverse the situation.

7.6 Implementing Agency:

Overall the MOH's performance during implementation was ***satisfactory***. The problem of the MOH commitment to the AIDS prevention communication campaign was solved in late 2002, with changes in governments and particularly, with the arrival of the current authorities in the MOH in late 2002. It was this renewed commitment that persuaded management to extend project closing dates until December 2003. Project implementation during these extension significantly improved overall project development objective performance as discussed in previous sections.

Towards its completion, LUSIDA managed to achieve an overall positive balance even at times when Argentina was undergoing the most severe social, political and economic crisis in its recent history. The project established a number of new activities that are crucial for the control of the epidemics. In particular, the project was very successful in reducing vertical transmission and establishing a number of sentinel surveillance centers.

Financial management of the project was satisfactory in general, including submission of auditing reports, with disruptions during the crisis in late 2001 and early 2002. The staffing of the Project Management Unit was adequate with the exception of the monitoring specialist. Although significant staffing changes occurred in 2002, such changes resulted in a revitalized unit and better project implementation.

7.7 Overall Borrower performance:

Overall, borrower performance is rated as ***satisfactory***. There were some shortcomings during early implementation, which had to be refocused at mid-term. However, by completion, the development objectives had been achieved and the borrower prepared a sound sustainability plan with strong support at the political level.

8. Lessons Learned

There are at least five key lessons to be derived from the design and implementation of the LUSIDA project:

(a) Ensuring up-front political support and commitment for important, and often politically difficult, HIV/AIDS policy changes is crucial to effectively address the HIV/AIDS epidemic;
(b) Involving NGOs during project preparation is necessary to ensure buy-in from civil society as main actors in project implementation and to ensure accountability of policy makers in HIV/AIDS prevention policy;
(c) Reaching clear agreements and setting effective monitoring of counterpart funds during project preparation is essential to ensure they will be available during project implementation;
(d) Early and effective integration of project activities to the mainstream implementing agency responsibilities and organization is essential to ensure project sustainability;
(e) Ensuring ownership and commitment by decentralized agencies and local governments, who have the ultimate responsibility for implementing policy and project activities, is essential for achieving both, Development and Implementation objectives.

(a). **Ensuring up-front political support and commitment for important, and often politically difficult, HIV/AIDS policy changes is crucial to effectively address the HIV/AIDS epidemic.** Project preparation files suggest that there was lack of **political commitment** by the Ministry of Health authorities at appraisal time regarding the AIDS prevention communication campaign (Component 1). This was demonstrated by the length of time it took the MoH to send the policy letter with clear commitments regarding the communication campaign. The subsequent delays in the implementation of the communication campaign underlines the need for ensuring political commitment up-front. The Bank team did all it could to ensure Government commitment including taking sufficient time for the necessary policy dialog with the MoH, as shown by the delay of appraisal, and requesting a well though policy letter with explicit commitments in it. Unfortunately this did not prevent the delay for that component. However, in retrospect, the inclusion of the communication campaign and the NGOs/CSOs provided sufficient "resilience" from key actors for a later successful implementation of the component. The lack of government commitment with that component was solved only since late 2001 with changes of governments and particularly with the arrival to the National Ministry of Health of the current authorities who took office in late 2002. It was this renewed commitment that persuaded management to extend project closing dates until December 2003. Project implementation during these extensions significantly improved overall project development objective performance.

(b). **Involving NGOs during project preparation is necessary to ensure buy-in from civil society as main actors in project implementation and to ensure accountability of policy makers in HIV/AIDS prevention policy. The role of NGOs and CSOs**, a key design feature of the project, was fundamental. First, they brought into project preparation and implementation essential knowledge of local realities and needs ensuring ownership of the project particularly by populations at risk. Second, some of them also had state of the art technical expertise that significantly enriched project strategy design. Third, and most importantly, the active presence of NGOs and CSOs during preparation and particularly during the first 2-3 years of project implementation, maintained the pressure and the debate regarding the need for

implementing the massive prevention communication campaign.

(c). **Reaching clear agreements and setting effective monitoring of counterpart funds during project preparation is essential to ensure they will be available during project implementation.** Lack of counterpart fund during the first 2-3 years of project implementation was a clear problem. Although project preparation included an in depth cost analysis, it was not able to **ensure actual contribution of counterpart funds**. This was later on improved after mid-term review.

(d). **Early and effective integration of project activities to the mainstream implementing agency responsibilities and organization is essential to ensure project sustainability.** The current HIV/AIDS program at the National Ministry of Health in Argentina is a fully integrated and dynamic program which has been able to significantly change AIDS prevention and treatment policy in the country. A significant part of its accomplishments is due to the key decision of fully integrating the program as a line unit in 2002 together with all other related programs. This emphasizes the importance of **appropriate full integration** of the program to line ministerial units. However, the timing of the integration in the LUSIDA case was essential. Full integration during the first years of the program might well have meant loosing a force for change in the effort to introduce the communication campaign. The separation of the program at that time allowed for the vital collaboration with NGOs and CSOs and the pressure for a prevention debate in the country.

(e). **Ensuring ownership and commitment by decentralized agencies and local governments, who have the ultimate responsibility for implementing policy and project activities, is essential for achieving both, Development and Implementation objectives.** This is particularly essential for federal countries such as Argentina, Mexico and Brazil in LAC, which have affectively decentralized most of the health care delivery responsibility to the provincial and state level. In the case of Argentina the project achieved a very good level of coordination and ownership on the policy and strategy side with the provinces. However, it faced significant challenges for the investment components.

9. Partner Comments

(a) Borrower/implementing agency:
The Borrower, through the Implementing Agency (the National Ministry of Health), provided substantial comments, data and feedback during the preparation of this ICR, most of which were included in the report. Formal final comments from the Implementing Agency on behalf of the Borrower were received on June 3, 2004. Copy of the comments are included as annex 8. The Borrower agrees with the findings of the ICR, mainly that the project had a difficult start but that it had a significant impact on the National and Provincial strategy for prevention and treatment of the HIV/AIDS epidemic, as well as a key role in facilitating the development of Government-NGO partnership and collaboration. The Borrower also acknowledges the need to further strengthen key components of the strategy: a) further reaching populations at risk (e.g. jail populations); and b) extend the project activities beyond the target project areas.

(b) Cofinanciers:
N/A.

(c) Other partners (NGOs/private sector):
N/A.

10. Additional Information

ICR Team:
Cristian C. Baeza, ICR Task Team Leader

Luis O. Pérez, Sr. Public Health Specialist
Jorge C. Barrientos, Consultant
Isabel Noguer, Consultant
Natalia Moncada, Program Assistant

Comments received from:
Jesko Hentschel, Sector Leader
Susana N. de Campos Abbott, Lead Operations Officer
Evangeline Javier, Sector Manager, LCSHH

Annex 1. Key Performance Indicators/Log Frame Matrix

Outcome / Impact Indicators:

Indicator/Matrix	Projected in last PSR[1]	Actual/Latest Estimate
Modified in Mid-Term Review: Reduction in growth rate of HIV/AIDS prevalence in one or two population subgroups.	Reduce prevalence one or two population subgroups (army recruits or blood donors) by 5%.	Prevalence among Blood donors reduced by 23% (from 0.22% to 0.17%).
Original PAD: Reduced growth rate in the incidence of HIV infection.	Reduce incidence among blood donors from 0.19%.	N/A.

Output Indicators:

Indicator/Matrix	Projected in last PSR[1]	Actual/Latest Estimate
Increase the proportion of correct answers in KAP surveys: Knowledge on HIV prevention.	Increased from 60 to 75% by 2001	75% (2001)
Ratings of mass communication campaigns: (i) Open TV, (ii) Radio	No target	75% (based on Mori's survey)
Proportion of Schools w/trained teachers and educational materials:	From 0% to 40%	Buenos Aires: 93% Cordoba: 98% Santa Fe: 91%
Number of CSOs carrying out prevention subprojects	From 0 to 50	116
Proportion of Blood Units tested for HIV	From 68% to 100%	99%
Proportion of pregnant women tested for HIV	From 0 to 50%	City of Buenos Aires: 92% Province of Buenos Aires: 67% Santa Fe: 91% Cordoba: 72%
Proportion of HIV+ pregnant women that received Antiretroviral therapy	From 50 to 75%	92%
Number of new HIV/ AIDS anonymous diagnostic centers:	From 0 to more than 10	18
Number of new active sentinel HIV	From 0 to more than 10	218
Pregnant women		164
Prisoners		15
IDU		2
STD		30
CSOs		4
MSM		2
Armed forces		1
Total		218

[1] End of project

Annex 2. Project Costs and Financing

Annex 2(a): Project Cost by Component (in US$ million equivalent)

	Appraisal Estimate	**Actual/Latest Estimate**	**Percentage of Appraisal**
Component	US$ million	US$ million	
A. Health Promotion	12.50	8.86	71
B. Prevention of HIV and STD Transmission	7.30	6.42	87
C. Diagnosis, Treatment and Care of HIV infection and STDs	6.50	2.36	36
D. Monitoring, Evaluation and Research	1.70	0.47	28
E. Project Administration	2.00	2.04	102
Reallocations for Communications Campaign and Diagnosis Kits		1.83	
Total Baseline Cost	30.00	21.95	
Total Project Costs	30.00	21.95	
Total Financing Required	30.00	21.98	

Annex 2(b): Project Costs by Procurement Arrangements (Appraisal Estimate) (US$ million equivalent)

Expenditure Category	**ICB**	**Procurement NCB**	**Method Other 1/**	**N.B.F. 2/**	**Total Cost 3/**
1. Civil Works		2.50 (1.50)	0.50		3.0 (1.50)
2. Goods Equipment and Supplies	2.00 (1.00)	1.50 (0.50)	0.50 (0.25)		4.0 (1.75)
Pharmaceuticals & Medical Supplies			1.00/a (0.75)/a		1.00 (0.75)
3. Services Consulting			20.0 (10.0)		20.0 (10.0)
Administrative			2.00 (1.00)		2.00 (1.00)
Total		2.0 (1.00)	4.0 (2.00)	24.0 (12.00)	30.0 (15.00)

1- Figures in parentheses are the amounts to be financed by the Bank loan

Annex 2(c): Project Costs by Procurement Arrangements (Actual/Latest Estimate) US $ million equivalent)

Expenditure Category	**ICB**	**Procurement NCB**	**Method Other 1/**	**N.B.F. 2/**	**Total Cost 3/**
1. Civil Works		0.96 (0.51)	0.25 (0.0)		1.2 (0.51)
2. Goods Equipment and Supplies	0.00 (0.00)	0.00 (0.00)	0.08 (0.04)		0.08 (0.04)
Pharmaceuticals & Medicals Supplies			1.83 (1.83)		1.83 (1.83)
3. 3. Services Consulting			16.79 (11.64)		16.79 (11.64)
4. Administrative			2.04 (0.966)		2.04 (0.966)
Total		0.96 (0.51)	20.99 (14.476)	0.0 (0.00)	21.95 (14.986)

Annex 2(d). Project Financing by Component (in US$ million equivalent)

Component	Appraisal Estimate			Actual/Latest Estimate			Percentage of Appraisal		
	Bank	**Govt.**	**Total**	**Bank**	**Govt.**	**Total**	**Bank**	**Govt.**	**Total**
A. Health Promotion			12.5	6.04	2.82	8.86			71%
B. Prevention of STD Transmission			7.3	4.55	1.87	6.42			87.9%
C. Diagnosis, Treatment and Care			6.5	1.15	1.18	2.33			36%
D. Monitoring Evaluation and Research			1.7	0.45	0.02	0.47			28%
E. Project Admin. Emergency Supplies			2.0	0.96 1.83	1.08	2.04 1.83*			102%
TOTAL Project Costs	15.0	15.0	30.0	14.98	6.98	21.95			73%

* Not included at Appraisal

Note that there is no data available for Appraisal Estimate for Bank and Govt.

Annex 3. Economic Costs and Benefits

3.1 Economic Analysis

An ex-ante economic benefits analysis was carried out during project appraisal that estimated that the net present value (NPV) of the benefits exceeded US$ 360 million. Also an Internal Economic Rate of Return (IRR) was estimated at 67 percent.

Using a similar methodology (Human Capital Approach), an ex post evaluation estimated the NPV at US$ 1,089 million, highlighting the high benefits from a prevention strategy for HIV/AIDS. It is estimated that this intervention prevented about 42,000 cases of HIV infection, which is equivalent to about 1.5 million years of life (YLS) saved at a cost de US$ 16 per YLS. The estimated costs and benefits are shown in the following table.

Table 1: Costs and Estimated Benefits
(US$ million, 2003)

Year	Benefits (PV)	Costs	NPV
1997	0	1,6	-1.6
1998	69,7	4,0	65.7
1999	112,8	8,9	104.0
2000	134,7	3,2	131.5
2001	138,9	3,2	135.7
2002	129,4	0,5	129.0
2003	135,8	0,6	135.1
2004	134,9	0,7	134.2
2005	131,4	0,7	130.8
2006	126,1	0,6	125.5
Total	**1.113,8**	**24,0**	**1.089.8**
Basic assumptions			
HIV infection prevented			42.186
Year of live saved			1.476.523
Cost per HIV infection prevented (US$)			569
Cost per YLS (US$)			**16**

The economic analysis is based on a stream of benefits and costs estimated over a ten-year period. The main assumptions include: (i) 42,000 cases of HIV infection prevented with the project; (ii) an average of 35 healthy years saved per case – representing 30 additional years of active productive life; (iii) a discount rate of ten percent; and (iv) an average annual income of US$ 5,700 for the period 1997-2003 and of US$ 2,300 starting in 2004.

3.2. Fiscal Impact Analysis

The following table shows the project's annual costs and the budget for the National HIV/AIDS and STD Program over the period 1997-2003. The table also compares these expenditures with the MOH budget and total expenditures in health services provided by the federal government. It can be seen that LUSIDA

represented only about 0.5 percent of the MOH budget and, on average, about 5 percent of the National HIV/AIDS Program. Only in 1999, it reached 1 percent.

Table 2: Fiscal Impact
(US$ million, 2003)

Fiscal Impact							
	1997	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**
Project Cost (LUSIDA)	1.6	4.0	8.9	3.2	3.2	0.5	0.6
National AIDS/STD Program	53.1	60.7	77.1	56.6	53.2	24.0	45.3
Ministry of Health Expenditure	s/d	634,0	612,3	516,9	450,0	239,3	335,7
Federal Public Health Expenditure	720.0	823.0	875.0	805.0	750.0	284.1	366.8
% Project Cost / Federal Public Health	0.23%	0.49%	1.01%	0.40%	0.43%	0.16%	0.18%
% Project Cost/National AIDS/STD Program	3.1%	6.6%	11.5%	5.7%	6.0%	1.9%	1.4%

Source: Integrated Financial Information System, Ministry of Finance

Annex 4. Bank Inputs

(a) Missions:

Stage of Project Cycle	No. of Persons and Specialty (e.g. 2 Economists, 1 FMS, etc.)		Performance Rating	
Month/Year	Count	Specialty	Implementation Progress	Development Objective
Identification/Preparation				
03/17/1996	*3*	TM (1); CONSULTANTS (2)		
10/25/1996	*4*	TM (1); CONSULTANTS (4)		
Appraisal/Negotiation				
02/10/1997	*4*	TM (1); CONSULTANTS (3); PROCUREMENT SPECIALIST (1)		
Supervision				
03/21/1998	*5*	SECTOR LEADER/TM (1); PH SPECIALIST/HLTH SER (1); PH SPECIALIST/PREVENTI (1); PH SPECIALIST/PROMOTIO (1); SENIOR ECONOMIST (1)	S	S
07/10/1998	*2*	TASK MANAGER (1); PUB. HEALTH SPECIALIST (1)	S	S
10/23/1998	*5*	SECTOR LEADER/TTL (1); PUB. HEALTH SPECIALIST (2); OPERATIONS SPECIALIST (1); FINANCIAL MANAGEMENT (1)	HS	HS
05/04/1999	*4*	TASK TEAM LEADER (1); PUB. HEALTH SPEC. (3)	S	S
12/07/1999	*4*	TASK TEAM LEADER (1); SIDALAC CONSULTANT (1); AIDS CONSULTANT (1); PROCUREMENT ANALYST (1)	S	S
09/25/2000	*3*	TASK TEAM LEADER (1); OPERATIONS OFFICER (1); PUBLIC HLTH SPEC. (1)	S	U
05/04/2001	*2*	TASK TEAM LEADER (1); OPERATIONS OFFICER (1); PUBLIC HLTH SPEC. (1)	S	S
04/02/2002	*2*	TASK TEAM LEADER (1); HIV/AIDS SPECIALIST (1)	S	S
12/06/2002	*2*	OPERATIONS OFFICER (1); CONSULTANT (1)	S	S
02/01/2003	*3*	TASK TEAM LEADER (1); HIV/AIDS SPECIALIST (1); CONSULTANT	S	S
ICR				
02/14/2004	*2*	TASK TEAM LEADER	S	S

(b) Staff:

Stage of Project Cycle	Actual/Latest Estimate	
	No. Staff weeks	US$ ('000)
Identification/Preparation	2.0	8.2
Appraisal/Negotiation	10.2	38.7
Supervision	46.57	194.9
ICR	4.9	16.0
Total	63.67	257.8

Annex 5. Ratings for Achievement of Objectives/Outputs of Components

(H=High, SU=Substantial, M=Modest, N=Negligible, NA=Not Applicable)

	Rating
☐ *Macro policies*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Sector Policies*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☐ *Physical*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Financial*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Institutional Development*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☐ *Environmental*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
Social	
☐ *Poverty Reduction*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Gender*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Private sector development*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Public sector management*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*

Annex 6. Ratings of Bank and Borrower Performance

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HU=Highly Unsatisfactory)

6.1 Bank performance	*Rating*			
☐ *Lending*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Supervision*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Overall*	○ *HS*	● *S*	○ *U*	○ *HU*

6.2 Borrower performance	*Rating*			
☐ *Preparation*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Government implementation performance*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Implementation agency performance*	○ *HS*	● *S*	○ *U*	○ *HU*
☐ *Overall*	○ *HS*	● *S*	○ *U*	○ *HU*

Annex 7. List of Supporting Documents

1. AIDS and STD Control Project (LUSIDA). Project Appraisal Document. May 1997.
2. AIDS and STD Control Project (LUSIDA). Mid-Term Review Mission Report. April 2000.
3. Informe de Cierre. Proyecto de Control de Sida y ETS (LUSIDA). Ministerio de Salud. Febrero 2004.
4. Boletín sobre el SIDA en la Argentina. Ministerio de Salud – Programa Nacional de Lucha contra los Retrovirus del Humano, SIDA y ETS. Año X. Número 22. Octubre 2003.
5. Documento Legal del Acuerdo de Crédito para el Proyecto LUSIDA.
6. Project Appraisal Document (PAD), for an AIDS and Sexually Transmitted Diseases Control Project, (LUSIDA).
7. Ayudas Memorias de 1998 a 2002.
8. Informe de Evaluación de Medio Término.
9. Situación de Salud en Argentina, 2003. Documento elaborado por el Ministerio de Salud, con apoyo de OPS/OMS.
10. Informe Final de la Evaluación e Impacto sobre beneficiarios de la IV Convocatoria a proyectos apoyados por el Fondo de Asistencia a OSC. Lic. Graciela Biagni y equipo. Enero de 2003.
11. Informe de la Evaluación e Impacto de una muestra de beneficiarios del Fondo de Asistencia a OSC., en una muestra de proyectos. Lic. Silvia Necchi y asociados. 16 de Enero de 2001.
12. Informe Final de Infraestructura, elaborado por el equipo de Infraestructura de UFI-S.
13. Informe final de Campaña Masiva de Prevención. Estudio de evaluación e impacto final de Campaña. Elab. Equipo técnico de LUSIDA.
14. Informe de Distribución de materiales de Comunicación desde Noviembre de 2002.
15. Informe oficial de prensa del Ministerio.
16. Anexo de Actividades desarrolladas por el Componente de Educación. Elab. por equipo LUSIDA.
17. Anexo de Actividades desarrolladas por el Componente de Prevención del VIH/SIDA y ETS – Fondo de asistencia para OSC's. Elab. por equipo LUSIDA. Junio 2002.
18. Anexo de Actividades desarrolladas por el Componente de Promoción de la salud, Educación. Elab. por equipo LUSIDA.
19. Informe de Campaña de Comunicación Focalizada II etapa – 2001 a 2003.Elab. por equipo LUSIDA.

20. Anexo de Actividades desarrolladas por el Componente Promoción de la salud. Elab. por equipo LUSIDA.

21. Boletín Sobre el SIDA en la República Argentina, Marzo 1994. Ministerio de Salud y Acción Social, LUSIDA.

22. Casos de SIDA en el sexo femenino. Abril 1994. Ministerio de Salud, LUSIDA.

23. Informe sobre la situación de los casos de SIDA. Abril 1994.

24. Boletín Sobre el SIDA en la República Argentina, Noviembre 1994. Ministerio de Salud y Acción Social, LUSIDA.

25. Boletín Sobre el SIDA en la República Argentina, Marzo 1995. Ministerio de Salud y Acción Social, LUSIDA.

26. Boletín Sobre el SIDA en la Republica Argentina, Julio 1995. Ministerio de Salud y Acción Social, LUSIDA.

27. Boletín Sobre el SIDA en la República Argentina, Noviembre 1995. Ministerio de Salud y Acción Social, LUSIDA.

28. Boletín Sobre el SIDA en la República Argentina, Marzo 1996. Ministerio de Salud y Acción Social, LUSIDA.

29. Boletín Sobre el SIDA en la República Argentina, Noviembre 1996. Ministerio de Salud y Acción Social, LUSIDA.

30. Boletín Sobre el SIDA en la República Argentina, Marzo 1997. Ministerio de Salud y Acción Social, LUSIDA.

31. Boletín Sobre el SIDA en la República Argentina, Diciembre 1997. Ministerio de Salud y Acción Social, LUSIDA.

32. Boletín Sobre el SIDA en la Republica Argentina, Marzo 1998. Ministerio de Salud y Acción Social, LUSIDA.

33. Boletín Sobre el SIDA en la República Argentina, año V, Julio 1998. Ministerio de Salud y Acción Social, LUSIDA.

34. Boletín Sobre el SIDA en la República Argentina, año V, Número 15, diciembre 1998. Ministerio de Salud y Acción Social, LUSIDA.

35. Boletín Sobre el SIDA en la República Argentina, Año VI, Número 16, Marzo 1999. Ministerio de Salud y Acción Social, LUSIDA.

36. Boletín Sobre el SIDA en la República Argentina, Año VI, Número 17, Julio de 1999. Ministerio de Salud y Acción Social, LUSIDA.

37. Boletín Sobre el SIDA en la República Argentina, año VII, Número 19, septiembre 2000. Ministerio de Salud y Acción Social, LUSIDA.

38. El SIDA en la Argentina, su evolución de 1982 al 2000, (informe), LUSIDA.

39. El SIDA en la Argentina, la situación entre 1982 y 2000. La transmisión madre-hijo, (informe), LUSIDA.

40. Boletín Sobre el SIDA en la República Argentina, Año VIII, Número 20, Junio 2001. Ministerio de Salud y Acción Social, LUSIDA.

41. El SIDA en la Argentina, situación al 30 de septiembre de 2001. VIH – SIDA en mayores de 50 años, (informe), LUSIDA.

42. Boletín Sobre el SIDA en la República Argentina, Año IX, Número 21, Agosto de 2002. Ministerio de Salud y Acción Social, LUSIDA.

43. Anexo Otras Actividades del Proyecto LUSIDA: Proyecto ”Cárceles Saludables”, Programa Nacional “Médicos de Cabecera”. LUSIDA.

44. Informe de Línea 0800 “pregunte SIDA”. Ministerio de Salud de la Nación, LUSIDA.

45. Anexo Sustentabilidad del Proyecto LUSIDA, Ministerio de Salud de la Nación.

46. Vigilancia Epidemiológica del VIH – SIDA en la República Argentina. Ministerio de Salud de la Nación, LUSIDA.

47. Presentación gráfica del Proyecto del Fondo Global de SIDA en la Argentina. Dra. Gabriela Hamilton.

48. Presentación gráfica de Actividades realizadas por LUSIDA en el área médica.

Additional Annex 8. Borrower's Contribution

2004 Año de la Antártida Argentina

Ministerio de Salud

retaría de Programas de Prevención y Promoción
grama Nacional de lucha contra los R.H. y SIDA

Sr. Dr. Cristian Baeza
Task manager World Bank

En referencia al Documento de Evaluación de la implementación del proyecto LUSIDA sus contenidos reflejan el desarrollo que ha tenido el mismo, con mayor dificultad al inicio pero logrando los objetivos establecidos en los dos últimos años de gestión del proyecto.

Cabe resaltar que en la pagina 10 donde dice " 2.2 per thousand in 2000" debe decir "2.2 per thousand in 2002".

Este proyecto estableció los cimientos de lo que es hoy una política pública en VIH/SIDA actuando como facilitador de la articulación del Estado con las Organizaciones de la Sociedad Civil.

Es importante resaltar las líneas que se plantean como de necesario fortalecimiento a saber:

El trabajo en poblaciones de riesgo en ETS, las estrategias de reducción de daño, la transmisión vertical del VIH/SIDA, el trabajo en cárceles, entre otros.

Aumentar la accesibilidad al diagnóstico y el fortalecimiento de instituciones publicas son aspectos que hay que profundizar y fundamentalmente poder replicar esta experiencia que se realizo en 4 jurisdicciones en todo el país.

Buenos Aires, 3 de Junio del 2004

Dra. Gabriela HAMILTON
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Programa Nacional de Lucha
Contra los Retrovirus Humanos