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1. Country and Sector Background

Current Health Status: Pakistan has long lagged its neighbors and many other low-income countries in terms of health and fertility outcomes although both contraceptive prevalence and infant mortality rates have improved during the 1990s. The infant mortality rate was 85/1000 live births in 2000/01 (Pakistan Reproductive Health and Family Planning Survey 2000-01) as compared to 101/1000 in 1991-1993 (PIHS 1995/96). The total fertility rate (TFR) is currently 4.8 (Pakistan Reproductive Health and Family Planning Survey 2000-01) as compared to 5.4 at the beginning of the 1990s (PDHS 1990/91). In spite of the gains, progress has been much slower than in neighboring countries and appears to be leveling off. An analysis of the burden of disease (BOD) conducted in 1996 (Pakistan: Towards Health Sector Strategy, World Bank) indicated that almost 40 percent of the total BOD was related to communicable diseases, and 12 percent to reproductive health problems. Nutritional deficiencies accounted for a further 6 percent of the total BOD. Thus, Pakistan appears to be in an early stage of the epidemiological transition, with basically preventable or readily treatable diseases primarily affecting young children and women accounting for a dominant share of morbidity and premature mortality.Determinants of Health: Further progress in health outcomes will partly depend on factors outside the health sector, such as advances in primary education, particularly of girls, and improvements in the social status and power of women. However, there is also much scope to improve health outcomes through improvements in health services. For example, routine immunization coverage nationwide remains low with only 56% of infants receiving DPT3. Government expenditure on health services is very low, and the public obtains poor value from what expenditure there is. Public sector health services suffer from weak management, frequent transfers, lack of accountability, and imbalances in the object composition of expenditure (too many staff relative to workload coexisting with insufficient budgets for key non-salary inputs). The quality of care is often low in the public sector and quality assurance mechanisms are barely operative. There are also quality problems and widespread consumer abuse in the largely unregulated private sector, which accounts for about four-fifths of outpatient contacts. Initiatives to protect and educate consumers of

health services have been very limited and most households lack access to risk pooling mechanisms for catastrophic diseases or accidents. The Social Action Program: Beginning in 1993, the Government tried to address a number of the above weaknesses through its Social Action Program (SAP), focusing on programmatic and management reforms with a clear thrust toward communicable disease control and maternal and child health. However, progress was limited, especially in improving immunization coverage and the nutrition of mothers and children. Management and organizational reforms either were not implemented or implemented halfheartedly with little effect on the quality of health care. In addition, issues related to governance including staff absenteeism, lack of adequate measures to monitor outputs and outcomes and lack of supervision significantly hindered progress. The Government's Current Health Policy: The GOP's devolution initiative, while broader than just health, is aimed at addressing some of the important issues facing the sector by enhancing the accountability of staff, improving the efficiency and quality of services, and improving coordination with the private sector. Besides the devolution initiative, a medium-term strategy for human development has been outlined in the I-PRSP and the GOP's 2001 Health Policy, which focuses on: (i) strengthening preventive health services including immunization, communicable diseases such as malaria, TB, and HIV/AIDS, maternal and child health, and family planning; (ii) improving the quality of health care at the tehsil and district headquarter hospitals; and (iii) strengthening management capacity at the district level. Lessons Learned in the Government Health Sector: While overall there has been only limited progress during the last decade in improving the delivery of publicly funded health services, there are some areas where good results have been achieved. For example, the number of community-based female health workers, including female physicians and paramedics has improved significantly in all provinces, resulting in improved availability of maternal and child health and family planning services. Similarly, through the lady health worker (LHW) program, access to primary health care and family planning services in the periphery has improved. The recent third party evaluation of the program indicates that those areas with LHWs have better access to services compared to areas without LHWs (see table 1). Given the increasing number of LHWs, they could become an important conduit for health education related to HIV and other diseases. The experience of these successes and a few others suggests that for the Government to achieve results on the ground requires: (i) a clear and coherent strategy; (ii) bold thinking and a willingness to innovate; (iii) rigorous evaluation of programs; (iv) consistent financing; and (v) strong and dedicated management.Table 1: Household Survey Results Related to Service Delivery in Rural Areas With and Without Lady Health Workers, PercentMeasureLHW AreasControl Areas% of mothers having at least 1 antenatal consultation5338% of mothers receiving at least 1 tetanus toxoid injection during last pregnancy5130% of currently married women using any method of contraception3223% of currently married women using modern method of contraception2215% of children under 3 years ever weighed by health worker339% of children with diarrhea given more liquids to drink3215% of children 12-35 months fully vaccinated4745Source: External Evaluation of the National Program for Family Planning and Primary Health Care, Oxford Policy Management, May 2001Safety of Blood Transfusion Services: About 1.2 million units of blood are transfused annually in Pakistan and a recent external review by WHO and the Swiss Red Cross found that at least 20% of blood used is inadequately tested for HIV and

Hepatitis B. The actual figure may be higher because in many instances good records are not being kept, despite the existence of national guidelines for blood transfusion services. Three of the four provinces of Pakistan have passed legislation establishing blood transfusion authorities (BTAs). Unfortunately, none of these BTAs has been formally constituted and so both the public and private sector blood banks are unregulated. While there is clearly much work to do, the successful experience in Punjab is encouraging. Punjab has been able to establish quality transfusion services in the public sector and had been able to finance the introduction of Hepatitis C screening using its own resources.The Government's AIDS Control Program: In recognition of the threat of HIV, the GOP established a National AIDS Control Program (NACP), in the late 1980's. The program made slow progress in the early 1990's due to: (i) a failure to recognize the seriousness of the HIV threat, resulting in low allocations and expenditures; (ii) a vague strategy that mainly concentrated on blood screening and did not address the vulnerable populations; (iii) weak surveillance and operational research which resulted in GOP officials not having credible data on which to base decisions; and (iv) slow mobilization of staff and other resources. Towards the mid-1990s there was a gradual improvement in the level of GOP commitment to the program which resulted in its inclusion in the Social Action Program Project financed by the World Bank and other donors. This enhanced commitment was reflected in slowly increasing expenditures, increases in staffing levels, and establishment of provincial AIDS control programs. However, the overall strategy remained unchanged with the exception of an increased focus on health promotion and HIV education aimed at the general public. In 2000, the GOP, through a broad consultative process, developed a National Strategic Framework for HIV/AIDS that set out the broad strategies and priorities for effective control of the epidemic. While the framework was very comprehensive, it did provide for increased focus on working with the vulnerable populations. The framework has been formally adopted by the GOP and its development partners and provides a useful general approach for HIV prevention. The program is currently spending about $2.5 million per year from all sources. Institutional Analysis: An external review of the federal and provincial AIDS control programs was carried out in 2001 and indicated some progress since the previous program review in 1993. However, it identified a number of key issues, including: (i) there were strong program units at the federal level and in Sindh province but the other provinces needed to have their management strengthened and their staffing increased significantly; (ii) there was a need to enhance the GOP's reliance on NGOs for working with vulnerable populations; (iii) the surveillance and research components of the program were found to be weak and needed to be brought into line with global best practices; and (iv) there was an urgent need to expedite release of funds and provide the provincial programs with greater autonomy in using available funds. NGO Interest in HIV/AIDS Activities: During preparation of the project, considerable attention was given to consulting with NGOs and assessing their capacity to implement HIV/AIDS prevention activities. In large meetings and also during visits to their offices, a wide variety of NGOs expressed great interest in being involved in expanded efforts to prevent HIV. NGOs who are currently involved in other aspects of health care delivery, including some very large ones, also voiced a desire to take on HIV prevention activities. All the NGOs already involved in HIV prevention felt constrained by the severe lack of resources and the fact that funding

was only available on a year-by-year basis, which, they felt, significantly interfered with program development and expansion. Much of the support currently being provided by donors does not allow for overhead costs, including the costs of management. The concern most frequently expressed by all the NGOs consulted was about the Government's ability and willingness to pay them on time for work they carried out. For example, one NGO involved in family planning recently had bills for Rs. 5 million outstanding with the Government for more than five months. Because they have limited capital, the NGOs realize that failure to receive timely payments could seriously interfere with their work. NGO Capacity: In terms of the financial and management systems required, it appears that there are a reasonably large number of NGOs in Pakistan who have at least the management capacity to carry out extensive HIV prevention activities. For example, a recent study of 27 NGOs from all over Pakistan currently involved, or interested, in HIV work found that 85% of the NGOs surveyed had annual audits carried out by certified accountants, 89% had computerized accounting systems, and 52% had substantial experience with procurement. In-depth visits were made to the offices and field sites of more than 15 NGOs during project preparation and corroborated the findings of the above study. The visits also found that the NGOs were impressive in terms of their commitment, dedication, and innovativeness. While the NGOs visited were not necessarily a representative sample, they can be classified into roughly four groups: (i) Small HIV NGOs of Limited Capacity: These NGOs, mostly comprising volunteers, have limited funds (often less than $1,000 per year) and carry out HIV prevention activities on a very small scale. These kinds of NGOs could not take on significant HIV prevention activities now although some of them may grow into effective NGOs with training and support. (ii) Small to Medium-Sized HIV NGOs of Uncertain Capacity: These NGOs are more sophisticated, have a deeper knowledge and understanding of HIV prevention, and have often been in existence for more than five years. They often have reasonable accounting, information, and management systems and their management is often charismatic and strong. Their capacity to expand their activities is uncertain because they have always faced limited budgets. This kind of NGO might be able to significantly expand its HIV activities if provided sufficient resources, technical guidance, and management support. (iii) Medium to Large HIV NGOs of Demonstrated Capacity: These NGOs are working with particular vulnerable populations on a reasonable scale and have a detailed understanding of HIV prevention activities acquired through experience on the ground. They are better funded than the smaller NGOs and have strong management systems. They are well managed and have dynamic leadership that is willing to innovate and take on new challenges. This kind of NGO could significantly expand its operations if provided sufficient resources. (iv) Medium to Large Health NGOs: These NGOs have long and successful track record of delivering health, nutrition, and family planning services in various parts of the country. The have fairly secure financing for their health service delivery and are interested in becoming involved in HIV prevention as a natural extension of their ongoing activities. They have well developed management systems and very experienced managers but their knowledge of HIV prevention, particularly working with vulnerable populations, is pretty limited. While expressing a keen interest in HIV prevention they would require additional resources to take it on. They frankly admit their need to learn more about working with vulnerable populations and the details of HIV prevention.

2. Objectives
With a systematic and immediate response, Pakistan has an opportunity to prevent a widespread HIV/AIDS epidemic. Hence, the objective of the proposed project is to prevent HIV from becoming established in vulnerable populations and preventing its spread to the general adult population, while avoiding further stigmatization of the vulnerable populations. The vulnerable populations include sex workers, injecting drug users (IDUs), men who have sex with men (MSM), prisoners, and migrant workers particularly long-distance truck drivers.

3. Rationale for Bank's Involvement
ñ The Bank has by now extensive experience across a variety of countries concerning HIV prevention programs. It can thus play an important role in ensuring that the lessons learnt elsewhere are incorporated in the design and implementation of the enhanced program. ñ The Bank can help provide a broad perspective that takes account of the context into which the investment will fit, thereby assisting in building capacity and sustainability. ñ The Bank can help ensure a proper mix of different interventions in the program. This is important because the internal political dynamics could otherwise result in some interventions being given an undue weight while other key interventions are downplayed (e.g., support for blood safety interventions is generally strong among senior government officials and the public, but there is much less awareness of the importance of interventions that focus on behavioral change among sex workers and their clients).ñ The Bank, through its knowledge and experience of helping governments to work with NGOs on delivery of social services, can also contribute to the development of a successful public-private partnership.

4. Description
The National Strategic Framework for the control of HIV/AIDS, adopted by the Government and its development partners in 2000, provides the basis for a detailed design. Building on the framework, the project would comprise 4 components:1. Expansion of Interventions Among Vulnerable PopulationsThe National Strategic Framework for the control of HIV/AIDS, adopted by the Government and its development partners in 2000, provides the basis for a detailed design. Building on the framework, the project would comprise 4 components: (i) expansion of interventions among vulnerable populations; (ii) improved HIV prevention by the general populations; (iii) prevention of HIV/STI transmission through blood transfusion; and (iv) capacity building and program management. 1. Expansion of Interventions Among Vulnerable Populations a. Service Delivery Contracts with NGOs: This component would support the rapid expansion of HIV prevention services to vulnerable populations at the greatest risk of HIV, including: (i) sex workers; (ii) IDUs; (iii) MSM; (iv) migrant workers, particularly truck drivers; and (v) prisoners. Preventing the spread of HIV among these populations, particularly those living in large cities, will be critical and will be the project's highest priority.The Government would contract with NGOs to measurably change behaviors through the provision of services in geographically defined areas to a particular vulnerable population. The service package would include: (i) behavior change communication aimed at improving the vulnerable population's knowledge, attitudes, and behaviors related to HIV; (ii) promotion of effective condom use; (iii) voluntary counseling and HIV testing; (iv) proper management of STIs; (v) needle exchange and

promotion of safe injection practices (among IDUs); and (vi) empowering activities that allow members of the vulnerable populations to assert greater control of their lives. The Government would contract with NGOs to measurably change behaviors through the provision of services in geographically defined areas to a particular vulnerable population. The service package would include: (i) behavior change communication aimed at improving the vulnerable population's knowledge, attitudes, and behaviors related to HIV; (ii) promotion of effective condom use; (iii) voluntary counseling and HIV testing; (iv) proper management of STIs; (v) needle exchange and promotion of safe injection practices (among IDUs); and (vi) empowering activities that allow members of the vulnerable populations to assert greater control of their lives. The Government would select NGOs through an open and competitive process. The contracts would have specific measurable goals that the NGOs would be responsible for achieving in their geographical area. NGOs would be short-listed mainly on the basis of their relevant experience and be eligible to bid if they met certain minimum criteria including: (i) being a legal entity with named officers, (ii) having audited financial statements for the last three years, and (iii) having experience delivering social services in Pakistan. Evaluation of the submitted proposals would be based both on price and technical merit including: (i) experience of the NGO in successfully delivering health and other social services; (ii) the competence of key personnel; and (iii) the adequacy of the methodology and work plan for delivering the services. Bid evaluation would be carried out by multi-disciplinary teams including representatives of the local and national governments, the NGO community, United Nations technical agencies, and academic institutions, while ensuring that there are no conflicts of interest. Monitoring of NGO performance would be carried out by the local and provincial governments on a regular basis and would be supplemented by visits to project areas carried out by a third party. Annual evaluations of performance on key indicators would also be carried out by the third party based on interviews with members of the vulnerable population. The key indicators would be spelled out in the contracts and would include reduction in syphilis prevalence, increase in reported condom use, and increased use of STI treatment services. Eight service delivery contracts will be signed by the concerned AIDS control program with the selected NGOs shortly after effectiveness of the credit as part of advanced procurement actions. Further service delivery contracts will be signed during the subsequent year and documents could be changed to reflect lessons learned from the first batch of contracts. The package for IDUs will be financed for three years by the Department for International Development (DFID).b. Small Grants: As part of the project a small grants system will be established to: (i) help develop the capacity of NGOs and other institutions to carry out work on HIV/AIDS; (ii) allow small NGOs, and NGOs who have not previously worked in HIV, to develop a track record so they can eventually take on a greater role in HIV prevention; and (iii) create opportunities for testing and rigorously evaluating innovative approaches and carrying out needed operational research. NGOs, universities, and other organizations will submit project proposals using a standard format which will be evaluated by peer reviewers and a grant committee. Draft guidelines for this program have already been developed by the NACP. 2. Improved HIV Prevention by the General Population This component would comprise four sets of activities:a. Behavior change communication (BCC) aimed at the general adult population: The NACP in coordination with provincial programs will undertake BCC with the following behavioral

objectives: (i) use of condoms with non-regular sexual partners; (ii) use of STI treatment services when they have symptoms of STI and knowledge of the link between STIs and HIV; (iii) use of sterile syringes for all injections; (iv) reduction in the number of injections received; (v) voluntary blood donation (particularly among the age group 18-30); (vi) use of blood for transfusion only if it has been screened for HIV; and (vii) displaying tolerant and caring behaviors towards people living with HIV/AIDS and members of vulnerable populations. These objectives would be achieved by a series of activities that would include mass-media campaigns and inter-personal communications (IPC) by lady health workers (LHWs). For the mass media campaigns, the NACP's new strategy calls for: (i) recruitment on a competitive basis of an advertising firm to carry out the entire campaign; (ii) explicit market segmentation so that advertisements and activities are specifically tailored to important sub-populations; (iii) formative research among the important sub-populations; (iv) testing the messages and advertisements on members of the target audience; (v) a more extensive use of mass media, including print and radio spots in local languages; and (vi) follow-up surveys to judge the effectiveness of the mass media campaign. The IPC to be carried out by the LHWs will use specially designed materials aimed at informing women in the community and reinforcing the BCC messages that are being broadcast. b. Advocacy: In order to raise awareness of decision makers and opinion leaders about HIV/AIDS, the project will support activities aimed at having these groups: (i) appreciate the threat of HIV to Pakistan; (ii) better understand the actions that can prevent a full-blown HIV epidemic; (iii) become effective sources of information for the rest of the community; (iv) take actions themselves to assist their communities to avoid HIV; (v) provide continuous support for the AIDS control program; and (vi) help avoid stigmatization or harassment of vulnerable populations. To accomplish these objectives, priority will be given to the large cities, formative research will be undertaken, specific messages will be developed and tested for this group, and the messages will be employed in a number of innovative ways, including personal visits by influential personalities. c. Targeted interventions for youth, the police, and formal sector workers: In addition to the mass-media BCC that will be targeted at youth, IPC techniques will be used to reach a particularly high risk group, i.e., in-school youth in grades 9 and 10 in the large cities. The IPC will be carried out by NGOs and the provincial departments of education. A comparison will be made between NGOs and the government in terms of cost-effectiveness. Contracts would be competitively bid for the delivery of BCC to other specific high risk groups, particularly the police and migrant laborers. d. Improved and expanded management of sexually transmitted infection (STI) cases: The project will support the improvement and expansion of STI case management based on a protocol developed by WHO and the Government that uses a "syndromic" approach. In the public sector diagnosis, treatment, and contact tracing will be expanded to all health facilities down to at least the district hospital level. 3. Prevention of HIV/STI Transmission Through Blood TransfusionIn order to prevent the transmission of HIV and other STIs through blood transfusions, the project will support the following three sets of activities: a. Establishing and building the capacity of provincial blood transfusion authorities: Building on the successful experience in the Punjab, the project would help establish effective provincial blood transfusions services and BTAs and build the latter's capacity to regulate private and public sector blood banks.

b. Implementation of a quality assurance system: The project would support the operationalization of a robust and practical quality assurance system that would likely include laboratory proficiency testing, monitoring and supervision, improved record keeping, end use audits for test kits, and re-testing of screened blood by reference laboratories.c. Screening of blood for HIV and other STIs: The project would help provide the necessary materials and reagents for testing all blood in the public sector for HIV and hepatitis B. The introduction of hepatitis C outside Punjab, would be dependent on the successful implementation of the quality assurance system as judged by third party evaluation and a functioning provincial BTA. d. Waste management: In order to begin implementing the EMP, the Ministry of Health would develop guidelines for proper handling of wastes in blood banks and needle exchange programs. Staff of health facilities with blood banks and NGOs involved in needle exchange would be provided with training in these guidelines and the materials for properly handling bio-hazardous wastes. 4. Capacity Building and Program Management In order to strengthen the capacity of the National and Provincial AIDS Control Programs and their NGO partners to undertake significantly expanded HIV prevention activities, the Project would support the following four sets of activities.a. Strengthening of federal and provincial AIDS Control Programs: The project would support the strengthening of the national and provincial AIDS control programs through: (i) recruitment of a firm to help build the capacity of the federal and provincial staff to manage contracts and carry out procurement; (ii) recruitment of more full time staff to work in the federal and provincial AIDS control programs; (iii) office support including furniture, equipment, vehicles, and access to the world wide web; (iv) an annual conference that would bring together staff from government, NGOs, and research institutions to discuss lessons learned and latest findings; (v) short term attachments of technical staff to other AIDS control programs in the region to learn first hand about the successes and difficulties encountered. b. NGO capacity development: Technical assistance and training would be provided to NGOs in bid preparation and proposal writing for the small grants. The project management and procurement firm would provide the winning bidders with assistance in general management procedures and project implementation techniques. Staff from the winning NGOs would also be given the opportunity to visit other NGOs in the region who have been successful in working with vulnerable populations, for example, the work of Sonorgachi in Kolkota with sex workers. Technical support for the NGOs would be provided by other partners, particularly UNAIDS and UNICEF. c. Second generation HIV surveillance and evaluation: Systematic behavioral surveillance and HIV sero-prevalence surveillance would be undertaken among the vulnerable populations on a regular basis using consistent methodologies. The surveillance activities will be undertaken by a cell in the NACP which would also have staff based in each province. Technical and financial support for surveillance activities will be provided by CIDA. The project will support the recruitment of an independent firm/organization to carry out evaluations of the project's components, including: (i) interviews with members of the vulnerable populations in the areas covered by service delivery contracts; (ii) quality of care provided in public STI clinics; (iii) implementation of the quality assurance systems in blood banks; and (iv) household surveys to examine the effectiveness of the mass media campaigns. d. Care for people living with AIDS: The project will support the care of people living with

HIV/AIDS (PLWHA) through the establishment or strengthening of five units for HIV/AIDS management which would provide the following services: (i) counseling for patients and their families; (ii) treatment of opportunistic infections; (iii) palliative care; (iv) supportive care for the patient and their families; (v) linkages with other programs and services such as the Tuberculosis Control Program; and (vi) prevention of mother to child transmission of HIV in cases of HIV positive mothers who are referred. Such units would comprise staff with various skills and backgrounds who will receive training under the project. The project will also provide the medicines needed for these units. WHO will provide technical assistance to plan for the medium to long-term needs of a program of care for PLWHA. This sub-component would not involve any construction or acquisition of land.

5. Financing
Total (US$m)
BORROWER $6.50
IBRD
IDA $36.00
Total Project Cost $42.50

6. Implementation
Timing of Implementation: The proposed project would use a focused, phased approach to implementation. During the first phase, which would correspond to the first year of the project, only the highest priority activities would be implemented and disbursements would be modest. The focus would be on HIV prevention activities among vulnerable populations, particularly sex workers, IDUs, and truck drivers concentrated in the largest cities, and the establishment of a second generation HIV surveillance system. Some other activities that have high political profile, such as mass media campaigns and initial advocacy work would also begin implementation during the first phase. The lessons learned from the initial experience would be applied to the second phase during which HIV prevention activities would expand to other vulnerable populations and other parts of the country. Blood safety activities, and improved management of STIs for the general adult population would also gear up during the second phase which corresponds to the second and third years of implementation. The third phase of the project would allow for the consolidation of these activities, for example, the accomplishment of 100% of blood in the public sector being properly screened for HIV and other STIs. The proposed project would last five years.Roles and Responsibilities: The NACP has had overall responsibility for the program and would oversee implementation of the proposed project. However, a strong multi-sectoral and decentralized approach lies at the heart of project design and implementation. Provincial AIDS control program managers would oversee the implementation of most activities, including signing contracts with, and monitoring the performance of, NGOs who are providing HIV prevention services to vulnerable populations and targeted interventions for youth and migrant labor. The provincial programs would also have responsibility for: (i) administering the small grants program; (ii) helping to carry out BCC and advocacy work in local languages; (iii) working with districts to improve STI management; (iv) helping to coordinate HIV surveillance and operational research; and (v) ensuring the development of units to care for people living with HIV/AIDS. District governments will be responsible for implementation of the STI management and blood screening activities

that occur in district health facilities. Activities to be carried out by the Ministries of Labor and Education with migrant labor and in-school youth will also be coordinated through the NACP and the provincial AIDS control programs. Both ministries will second people to work full time with NACP on implementation of their activities.The NACP will focus on: (i) formulating policy and guidelines; (ii) directing behavioral and sero-surveillance as well as monitoring and evaluation; (iii) implementing the BCC campaign on national mass media; (iv) carrying out advocacy work at national level for decision makers and opinion leaders; (v) procuring HIV, Hepatitis B, and Hepatitis C test kits; (vi) coordinating activities with international partners; and (vii) overseeing the work of an NGO contracted to work with long-distance truck-drivers nationwide. A detailed description of the roles and responsibilities of the various actors is included in the project implementation plans (PIPs) and the PC-I. Project Coordination and Oversight: A multi-sectoral Federal Committee on AIDS, comprising high level Government officials from the Ministries of Finance, Education, and Interior, and chaired by the Minister of Health, has been recently established and will meet twice a year to formulate the Government's policy on HIV. In order to support and coordinate AIDS control activities at the working level a Technical Committee on AIDS has been established which comprises representatives of government, civil society, academic institutions, UN agencies, and donors. The committee would be similar to the Interagency Coordinating Committee that has been established for immunization which has been quite successful. The NACP has begun organizing quarterly meetings of all the provincial AIDS control program managers to exchange information and coordinate activities. The project will support annual conferences which would bring together people and organizations involved in HIV prevention. Monitoring and Evaluation: The indicators for tracking the project's development objectives and implementation success are described in Annex 1 (including the details in Tables 2 and 3) and for judging the performance of NGOs in Annex 2. Many of the activities aimed at preventing the spread of HIV are difficult to effectively monitor simply through tracking of inputs, like the number of workshops held or the number of HIV test kits procured. Instead, there is a need to regularly evaluate progress by measuring changes in outcomes, outputs such as knowledge, attitudes, and behaviors, as well as process indicators like the quality of STI management and blood transfusion services. In order to collect information on outputs and outcomes, the project will support behavioral and sero-surveillance aimed at tracking behaviors and sero-prevalence of HIV and syphilis among vulnerable populations. A firm will also be hired to provide third party assessments of: (i) individual service delivery contracts with NGOs; (ii) BCC and advocacy activities; (iii) targeted interventions aimed at youth, migrant labor, and the police; (iv) LHW inter-personal communications; (v) STI services; and (vi) blood transfusion services. These types of evaluation should be carried out independently to avoid distraction of managers and staff from the work of actually preventing HIV and to ensure an unbiased evaluation. The terms of reference for the third party evaluation firm have already been developed and approved and the recruitment process has already begun as part of advanced procurement activities. Procurement: Goods under the Project will be procured in accordance with the Bank's Procurement Guidelines, and Consultants' services in accordance with the Consultants' Guidelines. Details on the applicable procurement procedures are provided in Annex-6. An assessment of the procurement capacity of the implementing agencies was carried out and it was determined that the NACP

has had limited experience with procurement, particularly under Bank financed projects, and the provincial AIDS control programs have had even less. Given the amount of service contracts and goods that will need to be procured under the proposed project, the capacity of NACP and the provincial AIDS control program will need to be strengthened through the engagement of consultants and training to effectively and efficiently carry out procurement, manage and monitor the contracts. NACP will engage a qualified individual procurement consultant for at least the first year of the project. The procurement consultant will serve as the focal point for all procurement matters under the project, and will provide comprehensive procurement assistance and guidance, including procurement planning and monitoring, preparation of bidding documents, evaluation of bids, and contracts, to the national as well as the provincial AIDS programs in complying with agreed procurement procedures. The procurement consultant will be engaged by June 30, 2002, through DFID financing. For the subsequent years of the Project, procurement support and assistance will be provided as part of the contract with a Management Consulting firm that is to be engaged through a competitive process under the project. It is expected that the contracts for such a firm would contain performance clauses related to timely procurement and implementation. IDA will conduct procurement training workshops for key procurement staff of the implementing agencies, before the start and during implementation of the project, in order to improve their knowledge of IDA's procurement procedures. The dates for these workshops will be mutually agreed.Advanced Action on Procurement: The shortlist of firms and draft Request for Proposal documents for the key consulting services contracts expected during the first year of the Project, particularly the eight service delivery contracts, the management and procurement contract, and the evaluation and monitoring contract will be completed and ready for issuance by Negotiations. Also, the draft bidding documents for the key contracts for goods expected during the first year of the Project, particularly blood screening kits (HIV, Hepatitis B) will be completed and ready for issuance by Negotiations. Financial Management: Effective financial management and expeditious funds flow are crucial to project success, particularly as key activities will be undertaken by NGOs or private firms under contract. The funds flow arrangements have not been agreed to by all stakeholders, but the options basically are either the use of special accounts managed by the program managers or use of the GOP's budgetary mechanism. Both approaches have significant associated problems that have been identified previously. Special accounts have experienced weak financial control, inconsistent financial management, and have not fed into the GOP's systems of national accounts. The GOP's budget mechanism suffers from: (i) slow release of funds; (ii) diffuse and unclear responsibility; (iii) poor track record of releasing money to NGOs in a timely and transparent way; (iv) ad hoc spending restrictions that interfere with project expenditures; and (v) a very difficult process for advanced payments to facilitate NGO mobilization and training activities. During appraisal of the project, the funds flow mechanism will be finalized and a financial management consultant will be recruited to develop a financial information system (FIS) and a corresponding financial procedures manual. This manual will be agreed to and used by the various Government departments involved in the management and oversight of the project's finances. Each of the AIDS control programs (at federal and provincial level) will recruit a finance officer and a finance manager will be recruited with funds from DFID to work with the NACP to help

implement the FIS and the financial procedures manual. As part of the conditions for negotiations of the credit, it has been agreed that the GOP will: (i) recruit finance officers as part of proper staffing of the AIDS control programs; (ii) finalize the FIS and financial procedures manual; and (iii) resolve outstanding audit objections on the HIV/AIDS program; and (iv) provide written confirmation from the finance departments that there are adequate funds (at least 50% of annual requirements) to meet project needs.

7. Sustainability
Technical sustainability of the project would be sought through focusing on relatively low-cost preventive activities that will reduce the number of future cases of HIV. Through extensive training, technical assistance and operational research the capacity of NGOs to delivery effective HIV prevention services would be strengthened. In addition, the small grant program would help build the technical capacity of smaller NGOs or NGOs without experience in HIV prevention. Political sustainability of the project would be achieved by increasing awareness among the general adult population and intensive advocacy efforts among decision makers and opinion leaders. There would be a focus on leaders who could be instrumental to the project including religious leaders, politicians and local officials, and journalists. Managerial sustainability of the project would be accomplished through enhancing the capacity of the national and provincial AIDS control program managers and their staffs. By working closely with management professionals from the management and procurement firm, they would develop new skills in project and contract management, procurement, financial management, and monitoring and evaluation. The managerial capacity of the NGOs would also be strengthened. The management and procurement firm would receive incentives for performance based on their ability to ensure timely disbursement of project funds.Financial sustainability would be almost completely a question of the GOP's willingness to finance the project's recurrent costs in the long run. Almost all the activities financed under the project are pure public goods with few opportunities for cost-recovery.

8. Lessons learned from past operations in the country/sector
The design of the proposed project reflects global state of the art information on HIV/AIDS control. The key lessons from field experience and scientific studies are: (i) a strategy of early and aggressive prevention is the most effective in low prevalence countries; (ii) interventions targeted at specific vulnerable populations is the most effective way of combating HIV during the early stages of the epidemic; (iii) these targeted interventions need to be coupled with broader awareness and advocacy efforts to ensure political support and prevent stigmatization of vulnerable groups; and (iv) close coordination and partnering among concerned sectors is an important aspect of success. There have not been many completed Bank-financed HIV projects in countries that are at a similar level of development as Pakistan, although OED has begun a study that is in its initial stages. The anecdotal experience from Asia and Africa seems to point out that most implementation difficulties have centered around weak management capacity and inadequate staffing of AIDS programs, lack of coordination among the various stakeholders, slow financial disbursements, and delayed procurement of goods and services. The first HIV project in India, while generally successful in developing the Government's AIDS control program, also suffered from implementation

difficulties that arose from: (i) unfamiliarity with guidelines and project processing requirements; (ii) delays in funds release and poor financial management; (iii) staffing vacancies and frequent transfers; and (iv) insufficient ownership at state level of what was perceived as a centrally driven scheme. The experience in India and elsewhere has also pointed out how difficult it is to effectively reach the vulnerable populations on a significant scale although experience in Thailand and Cambodia does indicate that it is possible to influence condom use among sex workers and their clients. The Cambodia experience suggests that this can significantly effect HIV prevalence. A Bank-financed HIV/AIDS prevention project in Bangladesh became effective in February, 2001 and has experienced delays in implementation. The initial implementation experience suggests that: (i) avoiding initial implementation delays requires advanced action on procurement, particularly when NGOs are to be recruited; (ii) additional staff positions in the AIDS control programs need to be filled prior to effectiveness; and (iii) early recruitment of technical assistance for capacity development should also be a subject of advanced action. These findings are consistent with the lessons learned from previous health sector projects in Pakistan which also experienced significant procurement delays due to lack of advance preparation. The experience of the Northern Health Project and SAPP II suggests that public-private partnerships will work best when: (i) the services provided by the NGO are clearly defined; (ii) the Government is directly involved and can maintain oversight; and (iii) the Government has confidence in the NGO and there is a strong working relationship.

9. Program of Targeted Intervention (PTI) N

10. Environment Aspects (including any public consultation)

Issues : The proposed project will NOT add to the amount of bio-medical wastes generated by the health care system in Pakistan, nor would it increase the hazard posed by such waste as is currently being produced. However, it makes sense for the project to help prevent HIV infection through contaminated waste and demonstrate how such materials can realistically be handled and disposed of safely. Hence, the project will help mitigate existing hazards such as: (i) the disposable equipment used in blood transfusions including blood bags and bottles, silastic tubing, and catheters and needles; (ii) the needles and syringes used in needle exchange programs (although a needle exchange program is a critically important component of bio-hazard containment because it deals with the highest risk of spread of HIV associated with medical devices) and in HIV testing; and (iii) the relatively small amount of materials associated with testing blood for HIV including used HIV test kits, small aliquots of blood used for quality assurance, and blood found to be HIV positive. The risk of HIV infection resulting from improper handling of medical waste must be seen in perspective. Medical waste poses much less of a risk to the community than improperly screened blood, high risk sexual activity, or sharing of syringes and needles among IDUs. The main features of the draft EMP are to safely handle, store, and dispose of syringes, needles and sharps, and blood bags. For syringes and needles two strategies should be envisaged for initial handling and storage: (i) the safe destruction of the syringe and needle shortly after patient use through the use of needle cutters in a specially designed, puncture proof box and treatment of the waste with disinfectant (the strategy mentioned in the current version of the EMP) ; and (ii) auto-disabled syringes that

prevent re-use through a locking mechanism in the barrel of the syringe and are then put into a specially designed safety box. The second approach has been introduced in Pakistan through the expanded program on immunization (EPI). Under no circumstances would needles ever be recapped or syringes re-used. Blood bags and related, non-sharp equipment would be segregated into specially marked, non-permeable, plastic bags.The storage and disposal of syringes, needles, and blood transfusion equipment would depend on the volume of waste generated at the health facility. In health centers or hospitals with small volumes of bio-hazardous waste, deep burial in appropriate locations which are not accessible to the public, would be the preferred option. In facilities with large amounts of bio-hazardous waste, incineration in high temperature furnaces/incinerators with burial of the resulting ash is the preferred option. These waste materials would not be stored for more than 24 hours. In order to begin implementing the EMP, the Ministry of Health would develop guidelines for proper handling of wastes in blood banks. Staff of health facilities with blood banks would be provided with training in these guidelines and the materials for properly handling bio-hazardous wastes. A systematic checklist that provides a score of compliance with the guidelines would be developed and used by third party auditors to monitor compliance.The above procedures would provide a sensible means for reducing the bio-hazard posed by medical waste and would provide a useful beginning to a longer-term effort to properly deal with all medical waste. The key stakeholders regarding environmental issues include: (i) laboratory staff and other health workers, (ii) Government regulators, (iii) NGOs involved in trying to make injection practices safer; (iv) blood transfusion patients, (v) NGOs who are involved in needle exchange programs, and (vi) the communities affected by improper bio-medical waste disposal practices. Extensive consultations were carried out with Government regulators, health workers and laboratory staff, and NGOs involved in needle exchange and harm reduction. These consultations involved meetings and interviews with key informants. Initial discussions were held with some of the other stakeholders during preparation and need to be followed up during appraisal.The draft EMP will be put on the NACP web-site and other web-sites that are deemed appropriate. Copies will be provided to NGOs who have expressed interest in this or related issues.

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Note: This is information on an evolving project. Certain components may not be necessarily included in the final project.

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