



Introduction

The global AIDS epidemic has profoundly affected both the quality of life and progress toward poverty alleviation in many of the poorest developing countries, especially in Sub-Saharan Africa. In countries that have been less severely affected, it threatens to do so in the absence of effective and timely prevention efforts.

Since the late 1980s, but particularly over the past decade, the World Bank has launched efforts to prevent HIV/AIDS and mitigate its impact through participation in global programs; financing analytic work; engaging in policy dialogue; and providing loans, credits, and grants for HIV/AIDS projects. As of June 2004, the World Bank had committed \$2.46 billion in credits, grants, and loans to 62 low- and middle-income countries for 106 projects to prevent, treat, and mitigate the impact of HIV/AIDS (see figure 1.1), of which about \$1 billion had been disbursed.¹

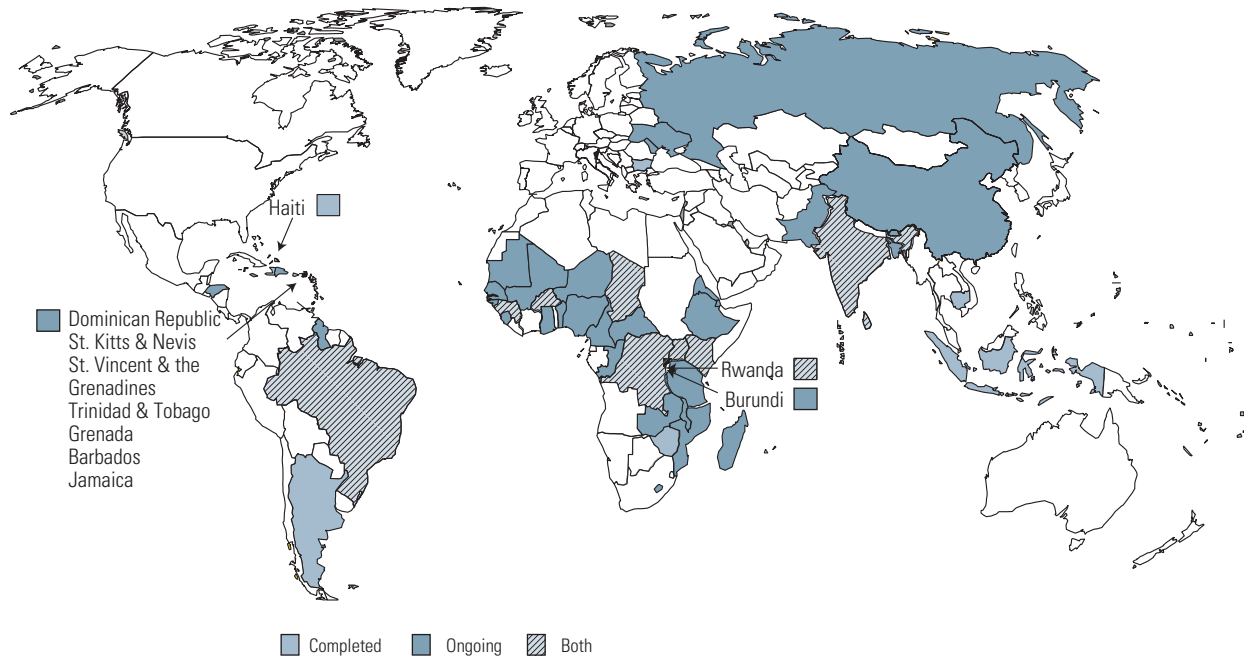
The Rationale for World Bank Involvement

The World Bank has assisted governments in improving health outcomes since the early 1980s.² Good health is an asset in its own right and an objective of public policy. It is also central to the World Bank's mandate of poverty reduction: better health contributes to higher productivity and incomes, while poor health both results from and exacerbates poverty (see, for example, CMH 2001; Jamison and others

1993; World Bank 1993). This would be sufficient rationale for the Bank to be concerned about AIDS, as one of many other health problems facing developing countries. Yet the Bank has put forward additional arguments for a role in preventing the spread of HIV and mitigating its impact—and for the urgency of doing so.

First, the economic and poverty impact of HIV/AIDS is exceptional (World Bank 1993, 2000a). In Sub-Saharan Africa, AIDS is the major killer of adults at the peak of their reproductive and economic lives (box 1.1). It has wiped out the hard-won gains in life expectancy over the past half-century in the hardest-hit countries.³ AIDS-related illness is dramatically raising the demand for expensive medical care and fueling a resurgence of tuberculosis (TB), its most common opportunistic infection. AIDS deaths are robbing the workforce of some of its most skilled members, leaving families without breadwinners and children without parents. While the impact of AIDS on economic growth is varied (see, for example, Arndt and Lewis 2000; Bell and others 2003, 2004; Cuddington

Figure 1.1: World Bank–Supported HIV/AIDS Projects, 1988–2004



1993; Kambou and others 1992; and discussion in World Bank 1997a), the distributional impact in terms of worsening poverty is unambiguous.

Second, in some developing regions, HIV/AIDS is only beginning to make inroads and has not spread widely. By encouraging governments in those areas to intervene early to prevent the spread of HIV, the Bank can help to avert the worst impacts on health and poverty.

Third, governments are reluctant to act. Because there is a lag of a decade or more between HIV infection and AIDS, the early and explosive spread of HIV is invisible to policy makers. During this period, only a few people are sick. Indeed, even when HIV prevention is launched, its impact is observable mainly in the

The AIDS epidemic's impact is exceptional, it is just emerging in some countries, and governments are reluctant to act.

long run. In the short run, other endemic diseases may be debilitating or killing many more people. Moreover, the social stigma and denial attached to some of the behaviors that spread HIV—sexual

intercourse and intravenous drug use—make policy makers extremely reluctant to intervene in a timely manner.⁴ Both early and late in an epidemic, the constituency for prevention is small and politically marginalized; demand for prevention among the general population is diffuse and weakened by denial. Yet in the absence of a cure, prevention is the only way to reduce the ultimate size of an AIDS epidemic. The World Bank is in a strong position to encourage governments to act, given its mandate for poverty reduction, its experience of over two decades of support for health systems, its convening power at high levels of government, and its multisectoral reach.

Objectives of the Evaluation

This evaluation assesses the development effectiveness of the Bank's country-level HIV/AIDS assistance and identifies lessons to improve the relevance, efficiency, and efficacy of ongoing and future activities. It focuses on evaluating *country-level* assistance because this is the most direct way that the Bank can influence outcomes and because of the enormous recent efforts by the

Box 1.1: The Global HIV/AIDS Epidemic

As of the end of 2004, 39 million people worldwide were living with asymptomatic human immunodeficiency virus (HIV) infection or acquired immune deficiency syndrome (AIDS), and more than 20 million had died of AIDS^a since the beginning of the epidemic. More than 95 percent of people living with HIV/AIDS (PLWHA) live in low- and middle-income countries; nearly two-thirds are in Sub-Saharan Africa and nearly one in five live in South or Southeast Asia (see table). In 2004, 4.9 million people were newly infected and 3.1 million died of AIDS.

Globally, HIV is spread most frequently through unprotected sex with an infected partner and by sharing infected injecting equipment. It is also spread from HIV-infected mothers to their children through childbirth and breastfeeding; through transfusion of contaminated blood and blood products; and in health facilities that do not take precautions to protect patients and staff. Thus, most of the infected are prime-aged adults; about 5 percent are children under 15. AIDS is now the leading cause of death in the world for people aged 15–59.^a

Estimates of HIV Infections and AIDS Mortality by Region as of December 2004

Region	Persons living with HIV/AIDS	Number of new infections in 2004	Number of AIDS deaths in 2004
Sub-Saharan Africa	25.4 million	3.1 million	2.3 million
South and Southeast Asia	7.1 million	890,000	490,000
Latin America and Caribbean	2.1 million	293,000	131,000
Eastern Europe and Central Asia	1.4 million	210,000	60,000
East Asia	1.1 million	290,000	51,000
Middle East and North Africa	0.5 million	92,000	28,000
North America, Western Europe, and Oceania	1.6 million	70,000	23,200
Total	39.4 million	4.9 million	3.1 million

Source: UNAIDS 2004a.

a. Kaiser Foundation Web site (www.kff.org/hiv/aids/timeline), accessed November 28, 2004.

Bank and the international community to scale up implementation on the ground. This evaluation complements OED's recent evaluation of World Bank involvement in global programs, including a case study of 14 global programs in health, one of which was UNAIDS.⁵

The World Bank can act to reduce HIV/AIDS at the country level directly, through helping governments to implement HIV/AIDS prevention, care, and mitigation, and indirectly, by supporting activities that reduce social vulnerability to infection. Examples of the latter are policies and programs to raise literacy, reduce poverty, and improve the status of women, all of which the World Bank also finances. For the purpose of this evaluation, *HIV/AIDS assistance* includes policy dialogue, analytic work, and lending with the explicit objective of reducing the scope or impact of the AIDS epidemic. This

is not to deny the importance of indirect channels; rather, it is recognition that OED has recently completed or has ongoing evaluations of many Bank activities that affect social vulnerability,⁶ while the Bank's direct HIV/AIDS assistance has never been evaluated by OED.⁷

This evaluation is forward-looking. The Bank's HIV/AIDS project portfolio is young: only 9 free-standing AIDS projects and 22 with AIDS components of at least \$1 million have closed (see table 1.1). Among the completed components, only half comprise at least 10 percent of the total World Bank commitment. In contrast, nearly two-thirds of projects and commitments have been launched since 2000. Further, as will be discussed in the next chapter, a change in Bank strategy in Africa precipitated fundamental changes in the preparation and design of AIDS projects beginning in 2000, compared with the "first

This report evaluates direct country-level assistance for HIV/AIDS control—policy dialogue, analytic work, and lending.

generation” of completed projects.

The Bank has never adopted an institution-wide strategy for HIV/AIDS, but its policy objectives can be inferred from Regional strategies and the objectives of country lending:

to assist governments in preventing the spread of HIV, strengthening health systems to treat and care for AIDS patients, mitigating other impacts, and developing national institutional capacity to manage and sustain the long-run response. This evaluation assesses the effectiveness of country-level HIV/AIDS assistance against these policy objectives and brings to bear the lessons from past assistance for improving the relevance, efficiency, and efficacy of the Bank’s ongoing and future HIV/AIDS activities. It also offers insights on the efficacy and lessons from four approaches that are central to the Bank’s current country-level AIDS assistance:

- Building government commitment to fight HIV/AIDS
- Adopting multisectoral approaches in the national AIDS response
- Engaging nongovernmental organizations (NGOs) and communities in Bank-supported HIV/AIDS assistance

- Strengthening information, monitoring, and evaluation in national AIDS programs to enhance “learning by doing” and improve decision making.

The evaluation assesses the development effectiveness and lessons from countries with past assistance and examines the quality of a subset of the ongoing portfolio—the Africa Multi-Country AIDS Program (MAP)—including the extent to which these lessons have been incorporated. The rationale for a closer look at the Africa MAP is that, first, these projects account for about two-thirds of active projects and about half of ongoing AIDS commitments and, second, the design of the Africa MAP is somewhat of a departure from the standard investment projects that make up the completed AIDS project portfolio and the active project portfolio in other Regions. Further, the Africa MAP addresses the most severely affected continent and signals the start of a long-term, 10-to-15-year commitment by the Bank. Both Africa and other Regional groupings within the Bank are in the process of assessing which aspects of this approach to keep, which to modify in the next round of lending, and which might be applicable to other Regions.

Analytic Framework and Methodology

The challenge of this evaluation is to assess the difference that the Bank’s country-level

Table 1.1: Distribution of World Bank HIV/AIDS Lending^a by Project Status

Project status	Type of project				Total	
	Free-standing AIDS		AIDS component		Projects (number)	Commitments ^c (\$ millions)
	Projects (number)	Commitments (\$ millions)	Projects (number)	Commitments (\$ millions)		
Closed	9	577.7	22	96.4	31	674.1
Active	44	1,535.8	31	254.7	75	1,790.5
Total	53	2,113.5	53 ^b	351.1	106	2,464.6

Source: Appendix C.

a. Projects with components of more than \$1 million allocated for HIV/AIDS.

b. In only 20 projects (9 closed and 11 active) does the AIDS component exceed 10 percent of the total Bank commitment.

c. The amount committed for closed projects in this table reflects what was actually disbursed.

Box 1.2: The Distribution of HIV across Risk Groups and the Stages of an Epidemic

HIV and other sexually transmitted diseases (STDs) tend to spread most rapidly among people who practice high-risk behaviors—those who have unprotected sex with many partners or who share unsterilized injecting equipment, for example. These individuals are not only more likely to become infected but, by virtue of their behavior, to unknowingly transmit HIV to others, including spouses and children who do not practice high-risk behavior. The extent of spread from populations with high-risk to those with lower-risk behavior depends on the level of interaction between them; it is not easily predicted and varies across cultures and geographic areas. High-risk groups (HRGs) are groups of people with identifiable characteristics—such as occupation, workplace, or location—that practice higher-risk behavior, on average, compared with the general population. Examples include sex workers, injecting drug users (IDUs), and occupational groups that separate people from their families (such as long-distance truckers, sailors, members of the military, migrant workers, or miners). HIV spreads at different rates within countries; regional differences are common.

Epidemiologists have classified countries according to the extent of infection of different population groups. In countries with a *nascent* epidemic, HIV has yet to spread, even among people who practice high-risk behavior. An epidemic is *concentrated* when infection levels have risen substantially among those who practice high-risk behavior but have yet to rise in the general and much larger low-risk population. A *generalized* epidemic is one in which HIV has moved out of populations with high-risk behavior and substantially infected the low-risk population.

In reality, there is a continuum in infection rates in different groups; these “stages” are intended to highlight where an epidemic is in relation to that continuum. For the purposes of this report, a nascent epidemic is defined as one in which HIV prevalence is less than 5 percent in high-risk populations. A concentrated epidemic is defined by HIV prevalence of more than 5 percent in high-risk populations but less than 5 percent in the general population, and a generalized epidemic is defined by HIV prevalence of 5 percent or more in the general population.^a

a. There are different conventions for a “cutoff” point in HIV prevalence for defining these stages. For a generalized epidemic, World Bank (2000a) used a 7 percent threshold in the general population; at the other extreme, UNAIDS has used a rate of only 1 percent. This report uses an intermediate value, 5 percent, the same used in World Bank (1997a), which classified all developing countries by “stage” of the epidemic in 1997 and in 1999, in an updated edition.

HIV/AIDS assistance has made relative to what might have happened in the absence of that assistance (the counterfactual). The evaluation’s conceptual framework is based on documenting the results chain that links the Bank’s assistance (inputs) to government actions (outputs) to individual and household behavioral outcomes and epidemiological impacts (Appendix A). By assessing the counterfactual at different points in this results chain—documenting the activities of the Bank, the government, internal actors, and other international donors, and establishing a timeline of events—the evaluation assesses the plausibility of attribution of outputs and outcomes to the Bank’s assistance. One of the important characteristics of countries that will be useful in understanding both the relevance and efficiency of the Bank’s assistance is the internal distribution of HIV within countries, or “stage” of the epidemic (box 1.2).

The evidence for this evaluation was distilled from background papers, country case studies,

OED project assessments, and in-depth interviews (box 1.3), in addition to published and unpublished research and evaluation literature referenced at the end of this report. It also draws on findings and lessons from other OED evaluations that are relevant to the Bank’s HIV/AIDS assistance—in particular, those on the Bank’s lending in health, population, and nutrition (Johnston and Stout 1999); social funds (Carvalho and others 2001); nongovernmental organizations (NGOs) in World Bank projects (Gibbs, Fumo, and Kuby 1999); community development (OED 2005a); and capacity building in Africa (OED 2005b).

The next chapter reviews the evolution of the Bank’s HIV/AIDS assistance in relation to its inferred policy objectives and to interna-

The analytic framework is based on the results chain linking Bank assistance to government actions, outcomes, and impacts.

tional developments. Chapter 3 assesses the development effectiveness and lessons from the “first generation” of completed HIV/AIDS projects. Chapter 4 reviews the assumptions and design of the ongoing Africa MAP in light

of these findings. Chapter 5 offers conclusions and points to the changing relevance of Bank HIV/AIDS assistance in the light of the dramatic increase in international resources. The final chapter presents recommendations.

Box 1.3: Evaluation Building Blocks

- Timelines of World Bank assistance and international HIV/AIDS events (Appendix B).
- An inventory of the Bank’s HIV/AIDS lending portfolio in the health, nutrition, and population; education; transport; and social protection sectors (Appendix C).
- Review of project appraisal, supervision, and completion documents; Country Assistance Strategies; Poverty Reduction Strategy Papers (Appendix D); and Regional HIV/AIDS strategic documents.
- An inventory of Bank-sponsored analytic work on HIV/AIDS (Appendix E) and surveys of the Bank’s human development staff and participants in the 2003 Nairobi AIDS Conference on the reach, quality, and usefulness of the Bank’s analytic work (Appendix F).
- Detailed evaluations (OED Project Performance Assessment Reports, PPARs) of completed HIV/AIDS projects in Brazil, Cambodia, Chad, India, Kenya, Uganda, and Zimbabwe.
- Field-based country case studies to evaluate the entirety of World Bank lending and nonlending HIV/AIDS assistance in Brazil, Ethiopia, Indonesia, and Russia (Appendix G).
- A review of national HIV/AIDS strategies in 26 countries receiving World Bank assistance (Mullen 2003a, b); and analysis of the statistical association between state-level HIV/AIDS spending and AIDS awareness in India (Subramanian 2003).
- Self-administered questionnaires completed by current and former Bank task team leaders on the design and implementation of 24 country-level Africa MAP projects effective for at least a year, as of August 2004 (Appendix H).
- Interviews with the task team leaders for 19 Africa MAP projects (Appendix I) and the country directors for 26 of the 28 approved country-level MAP projects as of June 30, 2004 (Appendix J).