



# The Evolution of the World Bank's Response to HIV/AIDS

By the end of June 2004, the Bank had committed nearly \$2.5 billion for 106 free-standing AIDS projects or projects in the health, education, transport, or social protection sectors with AIDS components of more than \$1 million (figure 2.1).<sup>1</sup> Over that same period, the Bank financed or managed at least 230 completed pieces of analytic work on HIV/AIDS, including research and operational economic and sector work (figure 2.2).<sup>2</sup>

## Two Phases of the World Bank Response

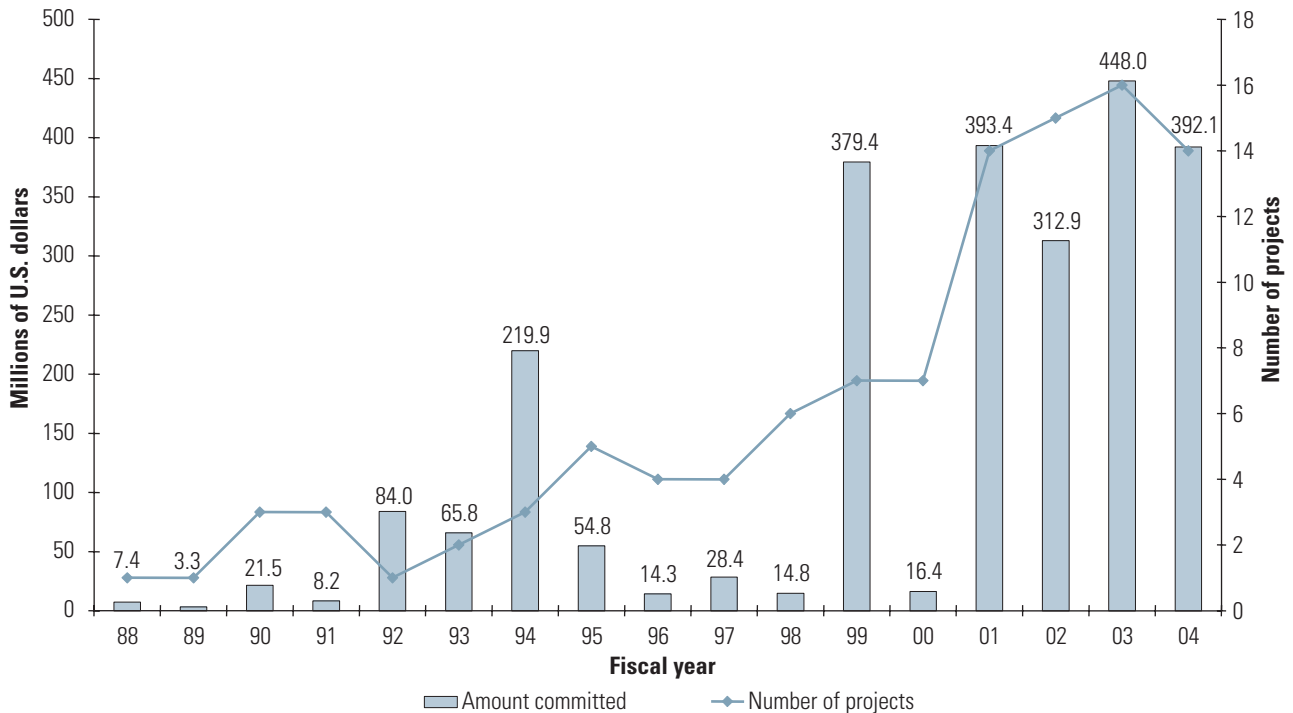
The evolution in World Bank strategies and assistance can be divided into two phases distinguished by the strategies adopted, the size and content of the HIV/AIDS lending portfolio, international partnerships, and the degree of institutional commitment. These phases are discussed below, based on timelines of the World Bank's HIV/AIDS lending, strategies, analytic work, and institutional response (in Appendices B-1 and B-2) and interviews conducted for this evaluation.

In assessing the Bank's response, it is important to keep in mind, first, that HIV/AIDS was a totally new disease. Little was initially known about it. The history of the past two decades has been one of an extended learning process about the characteristics of HIV, its modes of transmission, and its treatment. For example, even after the major modes of transmission were established, it was not clear how easily (or not) HIV spread sexually or how long the incubation period was.<sup>3</sup> Some research produced

seemingly conflicting policy conclusions.<sup>4</sup> Programmatic decisions, particularly in developing countries, were often based on intuition, notional "best practice," or hypothetical effectiveness, with incomplete information on the true extent of infection or risk behavior. This sometimes contributed to contentious views on how the epidemic should be addressed. The learning process about the disease, both scientifically and in terms of its impacts, is ongoing. Appendix B-3 provides a timeline of some key international events, scientific developments, policy prescriptions, and spread of HIV/AIDS since the first cases were reported in 1981.

A second factor framing the Bank's response is that HIV/AIDS was—and remains—incredibly sensitive to discuss, and those infected are often stigmatized. This is both because HIV is spread sexually and through injecting drug use and because it is nearly always fatal. The intense denial of the problem in virtually all countries has been facilitated by the lack of information on the prevalence of HIV and risk

**Figure 2.1: New AIDS Commitments and Projects, by Fiscal Year of Approval**



Source: Appendix C.1.

Note: AIDS projects are defined as AIDS projects and components greater than US\$1 million, including projects in health, education, and social protection sectors. The full amount of the commitment is attributed to the year of approval.

behaviors and the general atmosphere of uncertainty about the epidemic.

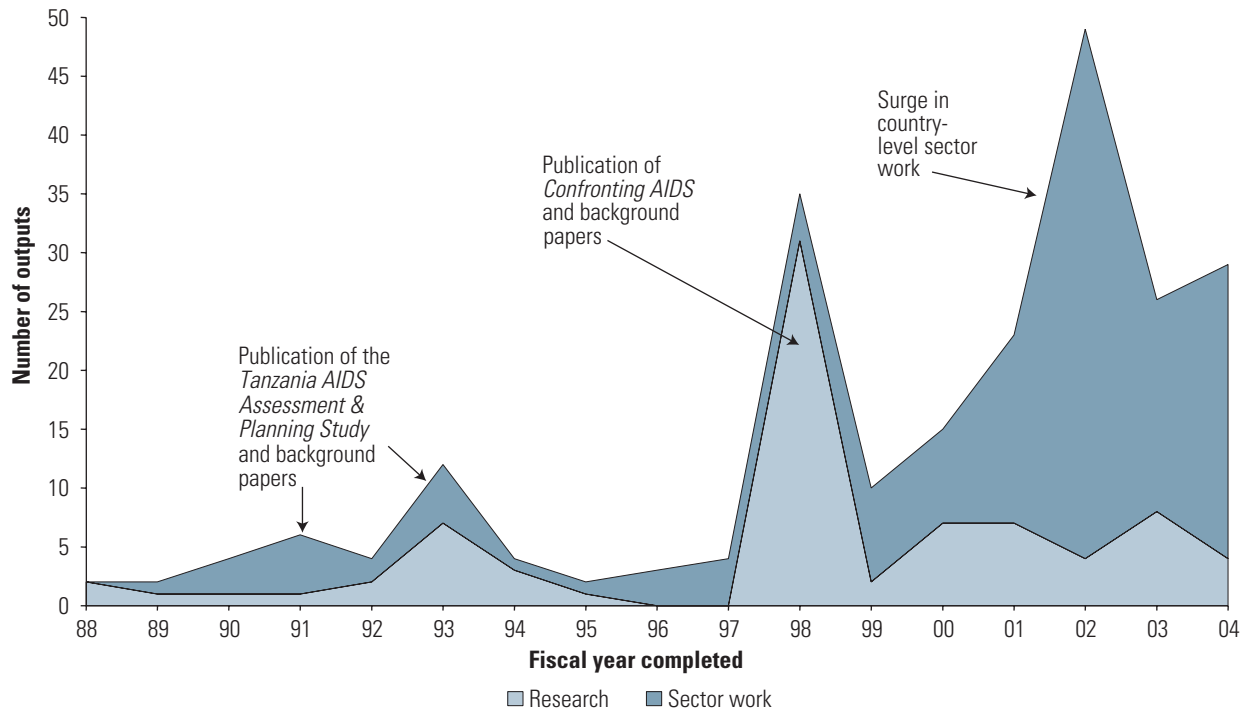
**1986–97: The Tension Between AIDS and Health Priorities**

**In its initial response, the Bank collaborated closely with the newly formed World Health Organization (WHO) Global Program on AIDS (WHO/GPA).** The first AIDS cases were reported in the United States in 1981. During the first several years, the international research community strived to understand the cause and modes of transmission.<sup>5</sup> As of 1985, when it became clear that a serious HIV/AIDS epidemic of unknown

mainly for expansion of primary health care infrastructure to rural areas.<sup>6</sup> It had very limited expertise on health or AIDS and followed the lead of the WHO. In 1986, Bank management decided to support AIDS prevention and control through the lending program<sup>7</sup> and to offer technical assistance in economic analysis to the GPA, formed in 1987.<sup>8</sup> A Bank staff economist was assigned to work with GPA to document the economic impact of the epidemic. Out of this collaboration came the Bank’s first analytic work on the direct and indirect costs of HIV/AIDS in Africa (Over and others 1988, 1989) and the jointly sponsored *Tanzania AIDS Assessment and Planning Study* (1992), which assessed the demographic impact of AIDS, the cost-effectiveness of interventions (information, STD treatment, blood screening, condoms), treatment and care options, and the need for survivor assistance for orphans and house-

*HIV/AIDS was a totally new disease . . . and it remains a very sensitive issue.*

Figure 2.2: Trends in Analytic Work by Fiscal Year of Completion



holds. GPA also played a key technical role in development of the first free-standing Bank-supported AIDS projects in Zaïre (1988), India (1992), and Brazil (1993).

**The initiative for AIDS strategies and lending came primarily from health staff in the Regional operational groupings of the Bank.** The Africa Region developed four AIDS strategies (box 2.1).<sup>9</sup> In 1991, an HIV/AIDS specialist was recruited to the Africa Technical Department to provide support for HIV/AIDS lending and to coordinate an informal working group of staff working on AIDS.<sup>10</sup> While other regions did not develop formal strategies, an “AIDS in Asia” technical support unit was set up in 1993 in the East Asia and Pacific (EAP) Region and in 1995 the Latin America and Caribbean (LAC) Region sponsored multi-year Regional technical and analytic support through the Regional AIDS Initiative for Latin America and the Caribbean (SIDALAC), based in the Mexican Health Foundation in Mexico City. The Regional vice president for Africa repeatedly raised the

issue of AIDS with African leaders, ministers of health and finance from the mid-1980s and chaired a symposium on the development impact of AIDS at the annual meeting of the African Development Bank in 1993. However, AIDS was rarely raised as an issue in Country Assistance Strategies (CASs):<sup>11</sup> in fiscal 1994-95, only 28 percent of the 96 CASs mentioned HIV/AIDS, and this was often only to set the context (Appendix D). OED could find no evidence that other top Bank management raised the issue with borrowers or pushed the issue to a higher level internally during this first phase.

**Bank HIV/AIDS lending supported national programs on four continents in countries at all stages of the epidemic, but broader action was constrained by lack of client interest.**<sup>12</sup>

Between 1988 and 1997, the Bank committed \$500.5 million in credits and loans to 8 free-

*As the AIDS epidemic broke, the Bank was just starting to lend for health.*

**Box 2.1: The Bank's AIDS Strategies in Africa during the First Decade of the Response**

*Acquired Immunodeficiency Syndrome (AIDS): The Bank's Agenda for Action in Africa (1988)* calls for country-level assistance: policy dialogue on AIDS prevention and control; reviews of the current and potential spread of AIDS and other STDs; financing priority activities through free-standing AIDS projects and AIDS components, or restructuring active health projects and structural adjustment loans; mobilizing donor resources; training Bank staff; launching Regional studies and programs; and assisting governments to establish sub-regional AIDS research and training centers.

*Combating AIDS and Other Sexually Transmitted Diseases in Africa: A Review of the World Bank's Agenda for Action (1992)*. This strategy updates the country-level action plan to include developing multisectoral policies for coping with the impact of the epidemic; allocating prevention resources to groups with low HIV but high STD infections and to "core transmitter" groups, such as sex workers and truck drivers, who are not only most likely to become infected, but also to transmit HIV to their partners in the general population; setting priorities for prevention; integrating HIV and STD responses; and strengthening the health infrastructure. It further calls for strengthening and broadening the Bank's analytical and operational agenda by assessing the impact of AIDS on development in countries where HIV has or is likely to spread and on non-health sectors; including STD/HIV overviews in non-health sector studies; conducting analytical work on the effectiveness of STD/HIV interventions; raising the priority of lending for parts of the health system critical to STD/HIV prevention and control; increasing involvement of nongovernmental organizations (NGOs) and community-based organizations (CBOs); improving information of Bank staff inside and outside of the health sector; and continued collaboration with WHO/GPA. However, AIDS should not dominate the Bank's health agenda in Africa.

*Regional AIDS Strategy for the Sahel (1995)*. HIV prevalence was low in the Sahel, which fed denial. Leaders were reluctant to address the epidemic early, and grants from other sources were viewed as adequate to finance the immediate response. The two-pronged strategy includes: (1) country-level support through lending and sector work that focuses on medium- to longer-term strategies to develop sustainable policies and programs, such as strengthening communications; accelerating condom social marketing programs; expanding clinical management of STDs; increasing assistance for NGO and private sector initiatives; broad-based policy analysis and program coordination; and (2) Regional advocacy and capacity-building programs with grant financing from the donor community to bring urgency to the issue by mobilizing political and opinion leaders; supporting pilot projects; conducting studies and research; and providing technical support and training.

*AIDS Prevention and Mitigation in Sub-Saharan Africa: An Updated World Bank Strategy (1996)* highlights prevention and mitigation of the household and sectoral impacts of the epidemic and the slow progress in developing multisectoral policies. Interventions need to be targeted early in the epidemic to the highest risk groups, at which time they are most cost-effective, and the care of AIDS patients needs to be integrated with primary health care services. Research and pilot efforts had succeeded in changing risky behavior and lowering HIV infections rates but needed to be expanded in depth and breadth to slow the epidemic. Five new areas for Bank attention are: generating political commitment; changing risk behaviors; mobilizing resources to intensify the breadth and depth of programs; increasing the analysis of AIDS and its impacts; and improving the design and implementation of cost-effective measures to mitigate the epidemic.

standing AIDS projects and 17 AIDS components of more than \$1 million (box 2.2). Most of the projects were in countries that had requested assistance (Brazil, India) or that already had some degree of government commitment to addressing AIDS (Cambodia, Uganda, Zimbabwe). In Burkina Faso, Chad, and Kenya,<sup>13</sup> AIDS projects were launched in parallel with health projects. Two projects launched in countries where government

commitment was weak—Indonesia and Zaïre—were eventually cancelled.<sup>14</sup> Countries where the epidemic was the most devastating—such as Haiti and Zaïre—not only had weak health systems but major unrest and governance problems. The availability of grant monies from GPA and other sources to address AIDS may have contributed to low demand for World Bank assistance, but denial of the problem (including within ministries of health) was also still

common and there were many competing priorities for funding, both within and outside the health sector, for which there was strong demand. In addition to free-standing projects and components, many ongoing health projects were “retrofitted” with AIDS activities to accelerate the response.<sup>15</sup>

**Internally, mobilizing resources to fight any single disease, including HIV/AIDS, was seen by the Bank’s health sector leadership as a lower priority than reforming weak health systems in poor countries, which would lead to improvements in all health outcomes over the longer run.** During the 1990s, the health sector’s strategy shifted from an emphasis on extending primary health care to an emphasis on reform of health systems, launched by the 1987 policy paper, *Financing Health Services in Developing Countries: An Agenda for Reform* (Johnston and Stout 1999). The importance of these reforms in Sub-Saharan Africa was widely recognized and there was concern that the urgent need to address the AIDS epidemic might somehow compete with this agenda, given scarce capacity. The 1992 AIDS strategy for Africa, for example, cautioned that an expanded role of the Bank in AIDS should not be allowed to overtake the critical agenda for strengthening health systems. The Africa Region’s major analytic paper for improving health outcomes—*Better Health in Africa* (1994)—acknowledged that AIDS is “the most dramatic new threat to Africa” (p. 19) and a major reason for the urgency of health system reform. But AIDS is grossly neglected in the document, which focuses on making health systems work better. The analysis relies on burden of disease data that show AIDS as the fifth-ranking disease among women and seventh-ranking among men;<sup>16</sup> AIDS does not figure in the main conclusions and recommendations of the report,<sup>17</sup> and HIV is absent from the country-level health indicators in the annexes.

Within this broader health reform agenda, AIDS did gain some ground in the early 1990s.

- The *World Development Report 1993: Investing in Health* (WDR) advocated that governments

provide a cost-effective package of basic health services that included low-cost HIV prevention. It justified early and effective prevention because HIV was widespread and spreading rapidly; the cost-effectiveness of preventive interventions is lower when infections move out of high-risk groups into the general population; the consequences of AIDS are severe and costly; and prevention is politically charged. The WDR made specific programmatic recommendations<sup>18</sup> and highlighted AIDS as a development issue that required national leadership, along with the involvement of many agencies both inside and outside government, including NGOs.

- *Disease Control Priorities in Developing Countries* (1993) highlighted the need for communicable disease control. The chapter on HIV/AIDS and STDs provided a comprehensive review of the disease burden, the epidemiology of HIV/AIDS and STDs, and evidence of the effectiveness and cost-effectiveness of key interventions for prevention and care, particularly approaches that target services to people most likely to transmit HIV and other STDs (Over and Piot 1993).

**But the systemic approach did not favor singling out individual diseases, and by the end of the period AIDS was even less strategically prominent in the Bank’s health sector strategy.** The 1997 *Health, Nutrition, and Population (HNP) Sector Strategy* was the first major product of the Bank’s newly configured HNP family. It defined the sector’s objectives as improving HNP outcomes of the poor, enhancing the performance of health care systems, and securing sustainable health care financing. The annex tables to the *Strategy* reveal that 2 percent or more of adults in 30 African countries and more than 5 percent in 15 countries were infected with HIV/AIDS

*The Bank supported many national AIDS programs, but broader action was limited by lack of borrower interest and denial.*

*Within the Bank’s health sector, action on any single disease was a lower priority than health system reform.*

**Box 2.2: The “First Generation” of World Bank HIV/AIDS Projects**

The first free-standing AIDS project was the Zaïre National AIDS Control Project (\$8.1 million credit, 1988).<sup>a</sup> It was the first World Bank health project in that country and appears to be the first free-standing Bank health project for a single disease.<sup>b</sup> It built on a 1987 health sector study and a strong research base established by *Projet SIDA*, the first international AIDS research project in Africa, based in Kinshasa.<sup>c</sup> Other AIDS projects in Africa followed two models: the AIDS/sexually transmitted infection projects (STIPs) in Zimbabwe (1993), Uganda (1994), and Kenya (1995),<sup>d</sup> all countries with generalized epidemics, and projects that linked substantial HIV/AIDS activities with population or reproductive health, in Burkina Faso (1994), Chad (1995), and Guinea (1998), countries with concentrated epidemics.<sup>e</sup>

Substantial projects also were launched in other Regions. The India National AIDS Control Project (\$84 million credit, 1992) emphasized awareness, prevention, blood safety, and setting up the institutions for directing the national AIDS response. At that time, HIV had taken off in several Indian states but not in others, and with fewer than 100 reported AIDS cases, the epidemic was largely in-

visible to policy makers. The Brazilian AIDS and STD Control Project (\$160 million loan, 1993) financed prevention for both the general population and high-risk groups; better services for HIV and STD patients; institutional development, including training of service providers and upgrading laboratory services; and surveillance, research, and evaluation. A free-standing AIDS and STD Control Project (\$30 million loan) was approved for Argentina in 1997. Both Brazil and Argentina had concentrated epidemics. The Indonesian HIV/AIDS and STD Management Project (\$24 million loan) was approved in 1996, in anticipation that Indonesia, with a nascent epidemic, might follow the route of the explosive AIDS epidemic in Thailand. The other significant East Asian project was the Cambodia Disease Control and Health Development Project (DCHDP, \$30.4 million credit, 1996), the first health project in that low-income, war-torn country. In addition to vital health infrastructure, the project had major components for AIDS, TB, and malaria. Formal AIDS components or activities were financed as part of new health projects in six additional countries<sup>f</sup> and in a social protection project in Uganda.<sup>g</sup>

a. The total project cost of \$21.9 million included an International Development Association (IDA) credit and parallel financing from other donors. Zaïre is now known as the Democratic Republic of Congo.

b. OED was unable to identify any previous free-standing projects for single diseases in the Bank's portfolio before 1988.

c. *Projet SIDA* was funded primarily by the U.S. Centers for Disease Control and Prevention (CDC), with the collaboration of the U.S. National Institutes of Health, the Institute of Tropical Medicine (Antwerp), and the Ministry of Health of Zaïre.

d. A \$19.2 million STD Prevention Project for Nigeria was fully prepared and appraised over the period 1993-95, to be financed by a \$13.7 million credit and with the strong support of the minister of health. However, negotiations were not pursued for reasons unrelated to the project that had to do with overall relations between the Bank and Nigeria.

e. The integration of HIV/AIDS, STD, and reproductive health services was a theme promoted by the 1994 International Conference on Population and Development (ICPD), in Cairo.

f. Brazil (1988), Haiti (1990), Madagascar (1991), Mali (1991), Morocco (1990), and Rwanda (1991).

g. The Program to Alleviate Poverty and the Social Costs of Adjustment (PAPSCA, 1990).

as of 1994. Yet there is no discussion of HIV/AIDS, the impact of the epidemic on health systems, or on priorities anywhere in the main body of the report.<sup>19</sup>

**Yet there were other pressures in 1996–97 from outside and inside the Bank stressing the exceptionality of HIV/AIDS as a health and development problem to the Bank's management.** In 1996 the Bank became one of six cosponsors of the newly formed Joint United Nations Program on HIV/AIDS (UNAIDS), with the mission to “lead, strengthen, and support an expanded response” to the global AIDS epidemic and to

improve coordination of the HIV/AIDS activities of U.N. agencies.<sup>20</sup> That partnership required an institution-level dialogue with the cosponsors. UNAIDS became a force for global advocacy, capable of getting the attention of top Bank management through the media and other channels (Poate and others 2002). The year 1996 also marked the advent of highly active antiretroviral therapy (HAART), which dramatically reduced AIDS mortality rates in high-income countries and in Brazil, but at the time was unaffordable (more than \$10,000 per patient yearly) and difficult to administer in the most severely affected low-income countries.

Pressure also came from the Bank's research department, which released *Confronting AIDS: Public Priorities in a Global Epidemic*<sup>21</sup> in November 1997. The Policy Research Report assembled evidence on the economic impact of the AIDS epidemic, its economic and societal determinants, and the effectiveness of AIDS interventions in developing countries. It made the economic case for government involvement in fighting AIDS and proposed principles for setting government priorities in resource-constrained settings. Two key priorities for countries at all stages of the epidemic, based on principles of epidemiology and public economics, were to provide public goods and to ensure that the people most likely to contract HIV and transmit it to others engage in safer behavior. The report also advocated improving access of AIDS patients to cost-effective health care and integrating AIDS mitigation programs and policies with poverty reduction programs. It called for early action to prevent HIV in countries where the epidemic was not yet widespread.<sup>22</sup>

### ***1998 to Present: Institutional Mobilization and Advocacy***

**The winter of 1997 and spring of 1998 were a turning point with respect to high-level commitment within the Bank and advocacy**

**to raise demand among borrowers.** *In 1998, high-level Bank management became proactive in raising demand for HIV/AIDS assistance among borrowers.*

This new climate was signaled by speeches of high-level Bank management to policy makers: President Wolfensohn emphasized AIDS at his February 1998 speech to the Economic Commission for Africa,<sup>23</sup> and the Regional vice president for Africa delivered a speech at the 12th International AIDS Conference in Geneva in June.<sup>24</sup> In 1999, the Regional vice presidents for Africa and South Asia both addressed Regional AIDS conferences. Following the Asian AIDS Conference in December 1999, President Wolfensohn wrote to South and East Asian heads of state, emphasizing the economic impact of the epidemic and the need to act as soon as possible. In 2000, he called for a "War on AIDS" in an address to the U.N. Security Council in January and AIDS was the first item before the Development Committee at the Spring Meetings of the World Bank and the IMF.

**The most recent period has seen completion of Bank HIV/AIDS strategies in nearly all Regions and in many sectors.** The Africa Region launched a new strategy in 1999 to accelerate action (box 2.3) and an AIDS

#### **Box 2.3: Intensifying Action against HIV/AIDS in Africa**

In 1999 the Africa Region of the Bank unveiled a new AIDS strategy. It finds the HIV/AIDS epidemic to be a major threat to development in Sub-Saharan Africa and identifies the lack of political commitment, competing priorities, insufficient resources, inadequate capacity, and cultural norms as the major impediments to action. Noting that many interventions have been shown to be cost-effective in changing behavior and reducing HIV transmission, the strategy focuses on advocacy and mobilizing resources to increase coverage of national programs. Its four "pillars" are: advocacy to strengthen political commitment; mobilizing additional resources; support for HIV/AIDS prevention, care, and treatment; and expanding the knowledge base. The strategy advocates a "decentralized participatory approach."

a. World Bank 2000a, p. 19.

It also proposes programmatic priorities in relation to the stage of the epidemic:<sup>a</sup>

- In countries with relatively lower HIV prevalence, "priority should be given to changing the behavior of those at highest risk of contracting and spreading HIV," and "quickly followed by broader approaches to reach other vulnerable groups, such as women and youth."
- In countries with high HIV prevalence, strategies should be adopted to "strengthen interventions targeted to groups at highest risk" and extend rapidly the coverage of programs to "all vulnerable groups in all urban areas and rural districts. These countries must also move rapidly to provide care and mitigate the impact of the epidemic."

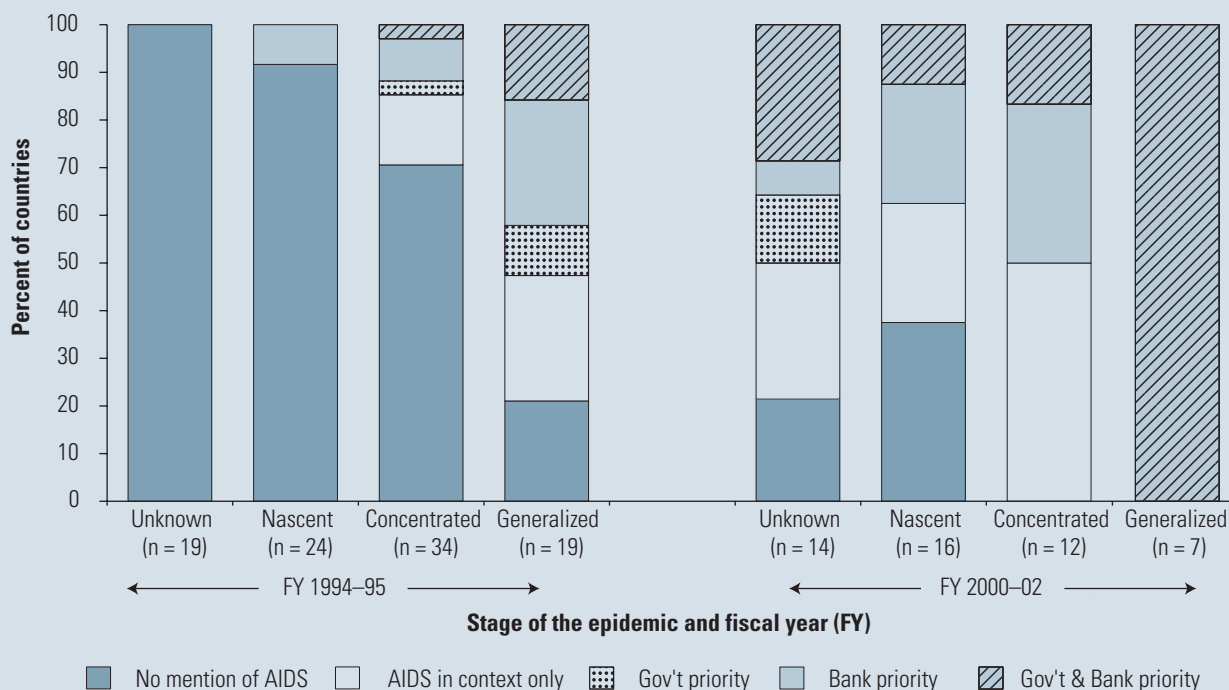
Campaign Team for Africa (ACTAfrica) unit was created to provide resources and technical support to country teams to mainstream HIV/AIDS activities in all sectors. AIDS strategies or business plans have been developed for Central America (2003), Eastern Europe and Central Asia (2003), South Asia (2004), and East Asia and the Pacific (2004). The Middle East and North Africa Region commissioned analytic work showing the consequences of inaction (Robalino and others 2003) and will release a formal strategy in 2005. Major strategic papers

and analytic work have informed Bank efforts in Latin America (2003) and the Caribbean (2000). Both the education and transport sectors of the Bank have developed AIDS strategies and are fostering AIDS components and activities in sectoral projects. Country and Regional economic and sector studies, including toolkits, have overtaken research in the Bank portfolio of analytic work (figure 2.2). The priority given AIDS in CASs between fiscal years 1994–95 and 2000–02 increased dramatically (box 2.4).

**Box 2.4: AIDS Increased as a Priority in Country Assistance Strategies**

Although the recognition of AIDS as a priority rose quickly among Regional health staff, especially in Africa, it was much slower to develop as a priority in the Bank's overall development agenda, represented by the Country Assistance Strategies (CASs). In fiscal years 1994–95, AIDS was mentioned as a priority by the Bank or both the Bank and government in fewer than half of the CASs for countries with generalized AIDS epidemics, and rarely in countries with concentrated or nascent epidemics (see figure, left

panel). The CASs for Côte d'Ivoire, Ethiopia, Mozambique, Republic of Congo, Uganda, and Zimbabwe—all with generalized epidemics—either did not mention AIDS or did so only to set the context. This picture had changed radically by fiscal years 2000–02 (see figure, right panel). In both periods, the Bank was more likely to raise AIDS as a critical issue than was the government. However, over time the priority of AIDS rose among both the Bank and government, and more so, the more severe the epidemic.



Source: Appendix D.

**Two new instruments have helped to accelerate AIDS project approval and increase client demand.**

The MAP is organized around country eligibility criteria, a project template, a funding envelope sufficient for multiple projects, and appended appraisal documents for the first projects in the series. Following approval of this package by the Bank's Board, appraisal documents for each subsequent project are circulated to the executive directors for information. Any operation can be scheduled for Board discussion at the request of at least 3 executive directors within 10 days of its circulation, after which approval by the Regional vice president becomes effective.<sup>25</sup> The rationale for this approach is that the eligibility criteria and project design template can be quickly adapted to individual countries, greatly reducing preparation time and thereby accelerating implementation. The MAP also permits funding of Regional (non-country-specific) projects. The second innovation was approval of International Development Association (IDA) grants for AIDS projects, in September 2002. All AIDS projects or components approved in low-income countries since then have been eligible for IDA grants, as have 25 percent of AIDS projects or components in blend countries (those eligible for both IDA credits and International Bank for Reconstruction and Development [IBRD] loans).<sup>26</sup>

**Project approvals have accelerated since 1998, particularly among low-income African countries.** The Bank's Board to date has approved envelopes of \$500 million each for two Africa MAPs, in 2000 and in 2001. As of the end of June 2004, a total of 29 country-level projects and 2 Regional projects had been approved through the first and second African MAPs. A \$155 million Caribbean MAP was approved in 2001, with 8 free-standing country projects and one regional project approved by June 2004. Free-standing AIDS projects have been launched in most of the rest of South Asia—Bangladesh, Bhutan, India (a second project), Pakistan, and Sri Lanka—and major projects that link HIV/AIDS and TB control have been approved in Moldova, Russia, and

Ukraine. A third AIDS project was approved for Brazil. Altogether, 45 free-standing AIDS projects and 32 substantial components totaling nearly \$2 billion in AIDS commitments have been approved since 1998—roughly 4 times the commitments of the previous decade—with slightly more than half of the total destined for Sub-Saharan Africa. The vast majority of these projects are active (table 2.1). The share of AIDS projects in Sub-Saharan Africa has risen slightly, compared with the closed project portfolio, but Africa's share of commitments has doubled. The share of commitments in Latin America and the Caribbean has fallen to a quarter of what it was in the closed portfolio. However, AIDS commitments have increased in absolute terms in all Regions.

**In parallel with these internal Bank developments, there has been a sharp increase in the international commitment to fight HIV/AIDS since 2000.** The Millennium Development Goals (MDGs) were adopted in 2000, including the goal of reversing the spread of HIV; the U.N. General Assembly Special Session on HIV/AIDS (UNGASS) was held in 2001, leading to the formation of the Global Fund to Fight AIDS, TB, and Malaria (GFATM), and the "3 by 5" initiative was launched in 2003 to get 3 million people in developing countries on antiretroviral care by 2005. The global resources for fighting AIDS have dramatically increased. As of March 2005, the GFATM had committed \$1.6 billion for AIDS in 128 countries. In 2003 the U.S. government announced the President's Emergency Plan for AIDS Relief (PEPFAR), a \$15 billion fund to combat AIDS in Africa, the Caribbean, and Vietnam over five years.

### The Portfolio of World Bank Project Assistance

Among the 106 closed and active AIDS projects in table 2.2, 70 projects in 56 countries account for \$2.36 billion in AIDS commitments, or 96 percent of the total. These include all 50 free-standing country-level AIDS projects and 20 AIDS components that amount to at least 10 percent of World Bank commitments. Eighteen of the 70

**Table 2.1: Distribution of AIDS Projects<sup>a</sup> and Commitments by Region, as of June 30, 2004 (US\$ million)**

Region	Closed projects		Active projects		Total commitments	
	Number (%)	Amount committed <sup>b</sup> (%)	Number (%)	Amount committed (%)	Number of projects (%)	Amount committed (%)
Sub-Saharan Africa	16 (51.6)	199.1 (29.5)	45 (60.0)	1,132.5 (63.3)	61 (57.5)	1,331.6 (54.0)
Latin America and Caribbean	6 (19.4)	356.1 (52.8)	14 (18.7)	239.0 (13.3)	20 (18.9)	595.1 (24.1)
South Asia	3 (18.8)	92.3 (13.7)	8 (10.7)	296.5 (16.6)	11 (10.4)	388.8 (15.8)
East Asia and Pacific	4 (12.9)	15.9 (2.4)	3 (4.0)	25.9 (1.4)	7 (6.6)	41.8 (1.7)
Eastern Europe and Central Asia	1 (3.2)	2.7 (0.4)	4 (5.3)	87.6 (4.9)	5 (4.7)	90.3 (3.7)
Middle East and North Africa	1 (3.2)	8 (1.2)	1 (1.3)	9 (0.5)	2 (1.9)	17.0 (0.7)
Total	31 (100)	674.1 (100)	75 (100)	1,790.5 (100)	106 (100)	2,464.6 (100)

a. Includes operations in health, education, social protection, and transport with AIDS components exceeding US\$1 million.

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

projects have closed and 52 are active. All but one of the AIDS components is embedded in a health or population project.<sup>27</sup>

Half of these projects have been in countries with concentrated epidemics, about a quarter in countries with generalized epidemics, and one-eighth each in countries with nascent epidemics or an epidemic of unknown distribution (table 2.2).<sup>28</sup> About half of the projects in the Africa MAP are in countries with concentrated epidemics and a third are in countries with generalized epidemics. A higher share of projects in the closed than in the active portfolio addressed countries with generalized epidemics.

*Half of Bank-supported AIDS projects are in countries with concentrated epidemics.*

The main objective of these projects, as articulated in design documents, has been to prevent the spread of HIV (see table 2.3). More recently approved projects (those that are

still active) are more likely to have explicit objectives related to treatment and care of AIDS patients and mitigating the impact of HIV/AIDS than are completed projects. Active projects are less likely to articulate objectives related to institutional strengthening and providing public goods. Table 2.3 understates the types of activities that were supported, however, because of the general way that objectives often are articulated: for example, three-quarters of projects actually undertook or planned treatment and care activities—56 percent of closed and 83 percent of active projects—although fewer than half had an explicit treatment and care objective.<sup>29</sup>

**The outcomes of completed AIDS projects, as rated by OED against their objectives, are similar to those of other health projects.** OED rates the outcome of every completed project against its stated objectives, in terms of its relevance, efficacy, and efficiency.<sup>30</sup> Figure 2.3 presents OED outcome ratings of the 9

**Table 2.2: Distribution of Closed and Active Projects by Stage of the Epidemic (percent)**

Stage of the epidemic	Closed	Active			Total Active	All projects	
		Non-MAP	Africa MAP	Caribbean MAP		Percent	N
Nascent	16.7	20.0	6.9	—	9.6	11.4	8
Concentrated	44.4	46.7	48.3	62.5	51.9	48.5	34
Generalized	38.9	13.3	34.5	—	23.1	27.1	19
Unknown	—	20.0	10.3	37.5	15.4	12.8	9
Total	100.0	100.0	100.0	100.0	100.0	100.0	
N	18	15	29	8	52		70

Note: "N" is the number of projects. The 70 projects are in 56 countries. Three countries (Brazil, Kenya, Uganda) had three projects each and 8 (Burkina Faso, Chad, Congo DR, Guinea, Guinea-Bissau, India, Rwanda, and Sri Lanka) had two projects each. See Appendix C.1.

**Table 2.3: Stated Objectives of the World Bank's HIV/AIDS Projects (percent)**

Objective	All projects	Closed	Active
Prevention-related <sup>a</sup>	93	79	96
Treatment and care <sup>b</sup>	43	28	48
Institutional <sup>c</sup>	37	50	33
Mitigate impact	36	22	40
Public goods <sup>d</sup>	16	39	8
Other <sup>e</sup>	29	22	31
Number of projects	70	18	52

Note: These objectives are as articulated in the appraisal documents. Column totals exceed 100% because most projects had more than one objective. The fact that a project didn't have an explicit prevention-related objective does not mean that preventive interventions were not undertaken.

a. Includes: prevent the spread of HIV or lower the incidence; increase access to prevention interventions; change behavior; raise awareness; reduce morbidity and mortality from a preventable condition.

b. Includes: increase access to/strengthen capacity for care and support; reduce morbidity and mortality, improve the quality of life of people with AIDS, increase life expectancy; increase access to treatment/strengthen capacity to treat; reduce incidence of and treat opportunistic infections and TB.

c. Includes: build implementation capacity; build or strengthen institutions; strengthen activities in non-health sectors.

d. The two types of public goods cited were blood safety and research/surveillance/data collection.

e. Includes encouraging NGOs and the community response; promoting a multisectoral response; supporting the national AIDS program; reducing stigma and discrimination; "scaling up" the response.

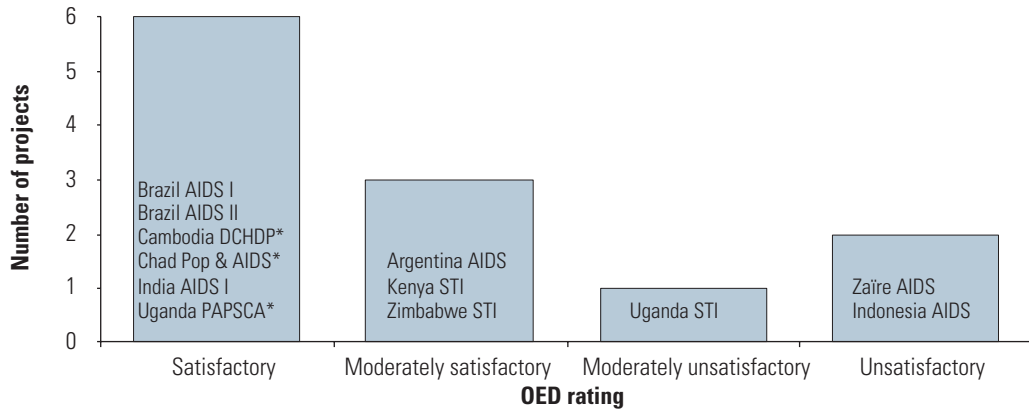
completed free-standing HIV/AIDS projects and ratings of 3 project components that were the subject of an OED field assessment.<sup>31</sup> Half of the projects were rated (fully) satisfactory, meaning that the project "achieved, or is expected to achieve, most of its major relevant objectives efficiently with only minor shortcomings." A quarter of the projects were rated moderately satisfactory, which applies when the project "achieved or is expected to achieve its major

relevant objectives efficiently but with either significant shortcomings or modest overall relevance." Finally, a quarter of the projects were rated moderately unsatisfactory or unsatisfactory. An unsatisfactory rating is assigned when the project "has failed to achieve and is not expected to achieve most of its major relevant

*The outcome ratings of AIDS projects are comparable to those of the health portfolio.*

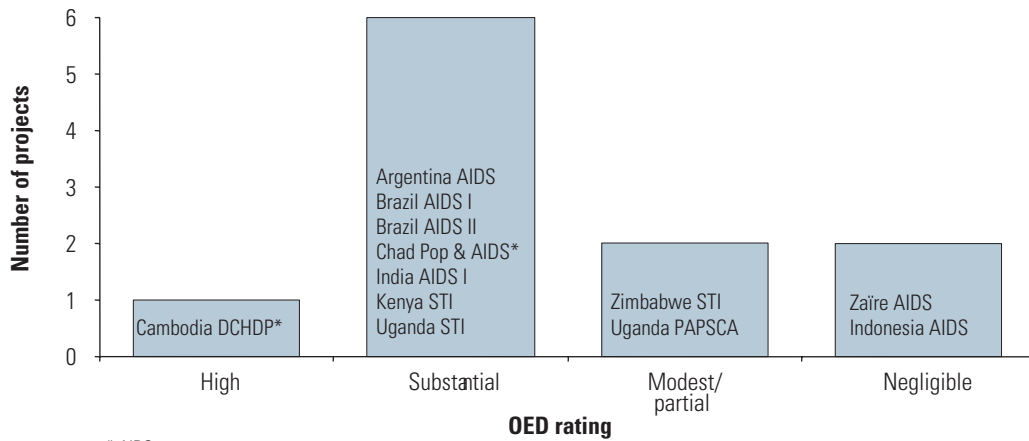
**Figure 2.3: OED Ratings for Completed Projects**

**A. Outcome in Relation to Objectives**



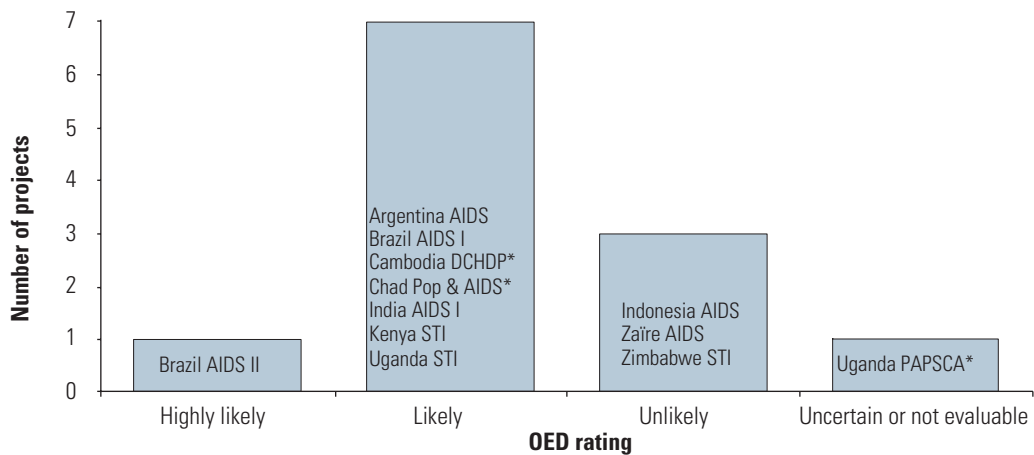
Note: None of the projects or components were rated highly satisfactory or highly unsatisfactory.  
 \* Rating for the AIDS component, based on OED Project Performance Assessment Report.

**B. Institutional Development Impact**



\* AIDS component.

**C. Sustainability**



\* AIDS component.

objectives, with only minor development benefits” or, in the case of moderately unsatisfactory, “when it achieves only some of its major relevant objectives but with positive efficiency.” The number of projects is small, but the AIDS project outcome ratings—75 percent moderately satisfactory or better—are similar to the outcome ratings for the 159 HNP projects completed from fiscal year 1994 to fiscal year 2003 (67 percent moderately satisfactory or better) (OED 2004c, Appendix table A-1).

Both of the projects with unsatisfactory outcomes were cancelled after partial implementation. The Indonesia AIDS and STD project was the Bank’s first attempt to preemptively launch an AIDS response through a free-standing operation in a country with a nascent epidemic. At that time, Indonesia was a middle-income country with long, active, and largely successful experience with the Bank in both health and population assistance. HIV was rare, even among those at high risk of infection, but officials were mindful of the explosive takeoff of the epidemic in Thailand, and projections suggested that the same could happen in Indonesia. The project was prepared in an “emergency” mode, as a three-year operation that was to develop an institutional response and would finance NGOs to pilot interventions to high-risk groups, prior to their widespread replication in later operations. But the project got off to a slow start, government was not as committed to enlisting NGOs or working with high-risk groups as had been thought during project

preparation, and the new AIDS office in the Ministry of Health competed with other units with overlapping responsibilities.

Political commitment was weakened when the predicted explosion of HIV did not occur. Following the East Asian economic crisis, only about 18 months after the project’s launch (but already at its midpoint), the project was cancelled with only \$4.8 million of the \$24.8 million loan disbursed. The Zaïre project was well prepared, but failed because of low commitment, low capacity, and political and economic chaos. The credit was cancelled with only \$3.3 million of the \$8.1 million credit spent. The performance of both the Bank and the borrower in these two projects was rated unsatisfactory by OED (see Appendix C-2).

**OED ratings of the institutional development impact (IDI) for these AIDS projects are substantially higher than for the HNP sector as a whole.** Two-thirds of the 12 AIDS projects received IDI ratings of substantial or high,<sup>32</sup> compared with only 36.5 percent for the HNP sector as a whole (OED 2004c, Appendix table A-1). However, their sustainability ratings (67 percent “likely” or higher) are similar to the rest of the HNP portfolio (62 percent). Lack of sustainability in 4 of the 12 projects was linked to low political commitment, economic turmoil, or doubts about the long-run ability to finance drugs and support NGOs.

*AIDS projects rate better than health projects on institutional development.*