



Findings from the First Generation of Bank HIV/AIDS Assistance

The Bank's overall policy objectives, inferred from Regional strategies and the objectives of country lending, have been to assist governments to prevent the spread of HIV, strengthen health systems to provide cost-effective treatment and care for AIDS patients, mitigate other impacts, and develop national institutional capacity to manage and sustain the long-run response. The severe lack of good information on which to base decisions is a theme that runs through most—if not all—strategy and project documents.

The technical recommendations of the Bank in Regional strategies and country-level assistance have followed evolving international knowledge, but with an emphasis on the need to prioritize in light of scarce capacity, limited resources for health, and other demands for assistance from within and outside the health sector. The revealed priorities in lending, strategic documents, and Bank analytic work put foremost on the agenda the production of public goods,¹ prevention (for efficiency, because AIDS is fatal and incurable, and because of the positive externalities), and affordable and cost-effective care and mitigation services for AIDS patients and their families. These prioritization principles, coupled with an understanding of the way that HIV and other STDs spread, resulted in a typology of programmatic priorities at different stages of the HIV/AIDS epidemic that has guided both the Bank and the international community since the mid-1990s (see box 3.1).

This chapter presents the findings and lessons—in terms of policies, institutions, services, and outcomes—of the Bank's country-level HIV/AIDS assistance to date, based on a review of the portfolio; assessments of completed AIDS projects; and case studies in Brazil, Indonesia, and Russia. It also presents an assessment of the reach, technical quality, and utility of the Bank's analytic work on AIDS, based on surveys of Bank human development staff and delegates at an African AIDS conference.

Findings and Lessons from the Bank's Country-Level HIV/AIDS Assistance

Political Commitment and AIDS Policy

The Bank's assistance has helped to generate, deepen, and broaden political commitment.

OED's assessment found that the first India AIDS Control Project, including the policy dialogue around it, likely advanced the government response to HIV/AIDS by several years relative to

Box 3.1: Government Priorities and Stage of the Epidemic

When financial or human resources are scarce, policy makers need to decide what to finance first with public funds to have the greatest impact with available resources—ensuring efficiency—while also promoting equity.

Providing public goods that are essential to stop the HIV/AIDS epidemic—such as improving access to information, monitoring HIV and risk behavior, and evaluating pilot projects—is a priority for governments to finance at all stages of an AIDS epidemic. This is because everyone can enjoy or benefit from these activities, even if some beneficiaries do not pay. The private sector is unlikely to provide them in sufficient quantity. A public good may not be provided at all unless financed by the government.

A second government priority is preventing HIV and its transmission among those most likely to pass it to others. Prevention among individuals who practice high-risk behavior directly protects their partners and indirectly prevents many more secondary infections in the low-risk, general population (the partners' spouses, children, and other sexual or injecting partners).^a In other words, when people with the highest risk of HIV transmission adopt safer behavior, it reduces everyone's chance of getting HIV. The cost-effectiveness of preventing HIV among those most likely to contract and spread it, relative to alternative interventions, is highest

in nascent and concentrated epidemics, because the potential benefits in terms of stopping transmission to the entire population are greatest.

In generalized epidemics, this strategy will still prevent a greater number of secondary infections than would one of untargeted prevention. Unless the interventions are very expensive to deliver, they are still likely to be cost-effective relative to alternatives, and necessary to bring the epidemic to a halt. However, they will not be sufficient.^b The cost-effectiveness of preventive interventions for relatively lower-risk populations improves in a generalized epidemic, but their benefits accrue mainly to the person who uses them, and the cost of providing these services to the entire population can be expensive. The demand for treatment and social assistance also is dramatically higher in generalized epidemics, when HIV is widespread. To ensure both efficiency and equity in a generalized epidemic, the priority for public resources should be on ensuring that the highest-risk behavior is addressed and providing these other services as efficiently as possible, while ensuring equity in access to them by the poor.^c While these are general principles, the specific types of activities and cost-effectiveness of alternatives in a given setting will vary, depending on a host of epidemiological, social, political, and economic factors.

a. Hethcote and Yorke 1984; Over and Piot 1993.

b. Nagelkerke and others (2002), for example, found that in India (a concentrated epidemic) a sex worker intervention would eventually extinguish the epidemic; in Botswana (a generalized epidemic), no single intervention would have this effect, but a sex worker intervention would reduce HIV prevalence by half.

c. The importance of ensuring HIV prevention among those with the highest-risk behavior in a generalized epidemic is well established in epidemiological research (see Over and Piot 1993; World Bank 1997a) and advocated by UNAIDS (2004b, p. 17) and the Bank's own Regional strategies (for example, World Bank 2000a, p. 19).

the counterfactual of no project. Further, the government contributed nearly twice the counterpart funds agreed to in the credit agreement, a sign of increased commitment.² In Brazil, federal programmatic AIDS expenditures rose from an average of \$9.3 million annually in 1990–92 to \$53 million annually in 1993–2002, during the first and second AIDS projects. During the financial crisis of 1998, AIDS spending *increased*, an indication of strong commitment.³ The Sexually Transmitted Infection Project (STIP) in Kenya supported the Ministry of Health (MOH) and AIDS control program in the development of a Parliamentary Sessional Paper on HIV/AIDS that defined the policy and legal framework, but there was no politi-

cal backing for its recommendations. In 1998–99, the project and other donors sponsored meetings with leaders and a parliamentary session at which the president declared AIDS a national disaster, raising commitment and improving implementation. The Argentine AIDS and STD Control Project funded virtually the entire AIDS prevention program, which previously did not exist. The Bank's policy dialogue that highlighted the consequences of inaction was in large part responsible for that country's agreement to borrow and the opening of a national dialogue on AIDS. A number of strategies have been used to raise government commitment in Bank projects (see box 3.2).

Box 3.2: What Has Worked in Building Political Commitment?

- **Epidemiological and Behavioral Surveillance**, especially in nascent and concentrated epidemics when denial is high and the epidemic is “invisible.” When the first round of national HIV surveillance in India found that 2 percent of pregnant women in Andhra Pradesh were HIV-positive, the chief minister spoke out publicly and allocated the state’s own funds to supplement funding from the national program. The 1989 announcement that 44 percent of brothel-based sex workers in the northern town of Chiang Mai were infected spurred government action in Thailand.^a
- **Analytic Work**, when done in a way to engender ownership and address the concerns of a relevant audience. The analysis of the economic impact of AIDS in Russia by Ruehl and Pokrovsky (2002) was widely disseminated and raised the commitment of senior officials. In Chad, research, data collection and analysis, and strengthening of the sentinel surveillance system have provided concrete, region-specific information to sensitize officials.
- **Pilot Projects**, which can demonstrate the political and technical feasibility of controversial interventions. The pilot testing of the Cambodian 100 percent condom program among sex workers in Sihanoukville helped to mediate strong discomfort among policy makers about interventions in commercial sex. Channeling resources to areas with effective programs and higher commitment can have a similar effect of demonstrating the political and technical feasibility of new programs, as in the first India AIDS Control Project.
- **High-Level Policy Dialogue with Public Officials and Key Leaders**, supplemented by study tours to hard-hit countries, public forums, and south-south interactions. Policy dialogue has been important in most cases, including in Ethiopia and other African countries in the MAP (see Chapter 4). Visits by Cambodian officials of the AIDS program, the Ministry of Health, the Ministry of Economy and Finance, and provincial health authorities to India, Kenya, South Africa, and Thailand were reported to have solidified commitment to attacking AIDS, to decentralizing the national program, and to strengthening the health system to care for the rising number of AIDS patients.
- **Leveraging** through project conditionality or design. Conditions in the first India AIDS project created the National AIDS Control Organization (NACO); the Cambodia DCHDP elevated the National AIDS Office within the Ministry of Health to the National Center for HIV/AIDS, Dermatology, and STDs. In Brazil, the project design kept the focus of the program on prevention among the most marginalized groups.
- **Engaging** NGOs to broaden the political constituency for HIV/AIDS control in the long run, as was the case in Argentina, Cambodia, Chad, India, and Uganda. In Brazil, NGOs were already strong advocates following the democratization movement of the 1980s, but the Bank project helped them become implementers as well.

a. World Bank 2000e.

Experience in building political commitment in the first generation of AIDS assistance has highlighted two lessons.

First, commitment to fighting AIDS from top leadership is necessary but not sufficient for results; efforts are needed to raise, broaden, and sustain commitment to fight HIV/AIDS at all levels of government and society. For example, in Brazil, the needle-exchange programs launched by the municipality of Santos and the state of São Paulo in 1989–90 were halted by the Federal Narcotics Council and the political leadership in the State Secretariat of Health, respectively. In the Indian state of Andhra Pradesh, NGOs were hampered

in their attempts to work with sex workers because local law enforcement was not fully behind the objectives of the AIDS program. At the time of OED’s mission to Cambodia, brothels in Battambang province had been closed for several months, even while government was trying to expand the 100 percent condom use program in commercial sex. When commitment rests with an individual or political regime, it is fragile. The strong commitment of the minister of health to the 1988 National AIDS

An important lesson is that commitment to fighting AIDS must be raised, broadened, and sustained at all levels of government.

Control Project in Zaïre was not enough to overcome the lack of interest in the rest of government. During the Kenya STIP, the National AIDS and STD Control Program was demoted from a department to a division in the Ministry of Health, undercutting its ability to lead the national response. Over the period 1990–92, Brazil’s national AIDS control program was disarticulated by a change in government, and Brazil was isolated from the international AIDS community. Thus, commitment to fighting AIDS needs to be more widely entrenched across the political and institutional spectrum than in a head of state or minister of health. It also needs to be sustained: in Uganda and Thailand, a sense of complacency has taken hold with respect to safe sexual behavior because of the perception that prevention has succeeded and that antiretroviral treatment is available. In places such as San Francisco, Sydney, and Amsterdam, as complacency has taken hold, risk behaviors have returned and HIV incidence has risen.

Second, generating political commitment early in an epidemic requires a deliberate strategy. The Indonesia case study found that declaring HIV (an invisible problem at the time) a national “emergency” is not persuasive in the absence of credible data to show it, based on local conditions. Political leaders may be willing to take reasonable measures in a quiet way that does not grab attention, if they are convinced that the potential for spread exists. In a nascent epidemic, public goods are the priority and may not be controversial. Experience shows that analytic work can contribute to generating political commitment when it is based on local data, relevant to key decision makers, and there is ownership of the results—although it is no guarantee of success (see box 3.3).

With respect to AIDS policy, Bank assistance has enhanced the efficiency of national AIDS programs by helping governments to focus on prevention, cost-effectiveness, and prioritization of activities in the face of scarce resources. In the early 1990s, the Government of India approached the Bank with a proposal for an AIDS project that would finance blood safety, even though most

infections could be attributed to heterosexual transmission. Following an intensive dialogue with the Bank and the WHO, the government prepared a National Strategic Plan for 1992–97 that broadened the scope of the project to embrace involvement of states and to focus on awareness-raising among the general population and on behavior change among high-risk groups. The OED case study on Brazil concluded that the national response has been more focused on HIV prevention among groups with high-risk behavior, including marginalized groups such as injecting drug users (IDUs) and sex workers, than might have been the case in the absence of the Bank’s involvement.⁴

The Bank also supported key laboratory and treatment monitoring infrastructure—a public good—to improve the efficiency of the government’s treatment program. The OED case study on Russia concluded that in the absence of World Bank engagement on HIV/AIDS, the government’s approach would have been less targeted to the main drivers of the epidemic and less in tune with international best practice in key areas. The Bank’s persistence in policy dialogue promoted and achieved acceptance of harm reduction, the involvement of IDUs and sex workers, emphasis on HIV prevention, and replacement of mass HIV testing of the population with sentinel behavioral and serological surveillance. In Cambodia, the Disease Control and Health Development Project (DCHDP) financed the AIDS response of the Ministry of Health, which embraced prioritization and sequencing of activities to reflect capacity constraints and improve cost-effectiveness. Scarce capacity was focused on the areas where policy and programs can make the biggest difference.

Institutions for the Long-Run AIDS Response

The Bank has helped to create or strengthen robust national and subnational HIV/AIDS institutions. The first India National AIDS Control Project created the National AIDS Control Organization (NACO), a semi-autonomous entity under the Ministry of Health and Family Welfare, and State AIDS Control

Box 3.3: Analytic Work Can Build Commitment, But It Is Not a Panacea

During extended project negotiations over the Russia TB and HIV/AIDS project, the economic impact of AIDS was identified as a potentially effective lever for increasing government commitment. With Department for International Development (DFID) funding, Bank staff teamed with researchers from the Russian Federal AIDS Center to develop a computer model of the economic consequences of the AIDS epidemic.^a In the most pessimistic scenario, the model forecast a 4 percent decline in GDP by 2010. The results were disseminated in the Russian broadcast and print media, through op-ed articles, letters to the editor, press conferences, and presentations to government. Respondents to the OED case study believe it had a major impact on government commitment at the highest levels. Within a year, President Putin mentioned AIDS for the first time in a speech to a domestic audience.

Epidemiological modeling can be precarious in a nascent epidemic when very little reliable information is available on risk behaviors in the population. In the mid-1990s, HIV prevalence in Indonesia was low, even in high-risk groups, but stakeholders feared that HIV would take off among sex workers there in much the same way that it had in Thailand. Using 1993 as the start date

for the epidemic, a researcher from the U.S. Centers for Disease Control and Prevention (CDC) projected an explosive increase in HIV that got the attention of policy makers. The AIDS and STD Prevention and Management Project was launched in early 1996 in an “emergency” mode to pilot—in two provinces over three years—interventions among sex workers that could be replicated nationally. However, by early 1997 the predicted explosion in HIV had not occurred. The project was not performing well and its rationale and urgency, based on the projections, were undermined. Recently the dialogue has resumed, sparked by rising HIV among IDUs and its spread to sex workers.

In Ethiopia, a 1996 social sector analysis carried out jointly with Ethiopian experts estimated that HIV/AIDS accounted for 7.7 percent of all life years lost nationwide and 17.7 percent in Addis Ababa. It also projected HIV prevalence, AIDS cases, and mortality through 2020 and assessed the impact of the epidemic on health expenditure. However, the analysis left the Ministry of Health unconvinced of the urgency to address the HIV/AIDS epidemic. The validity of the AIDS data was also questioned. Addressing issues in the health system and health conditions that were affecting rural areas following a period of famine and war was felt to be more urgent.

a. Ruehl and others 2002.

Societies (SACS) in all 25 states and 7 union territories.⁵ The Argentine LUSIDA project institutionalized HIV prevention within the Ministry of Health, where previously the response had focused almost entirely on treatment and blood safety. While LUSIDA was launched as a separate unit, by the end of the project the functions had been embedded in the Ministry of Health. The Cambodia DCHDP elevated the AIDS control program within the Ministry of Health and roughly doubled the public budget for the National Center for HIV/AIDS, Dermatology, and STDs (NCHADS) over the project’s life, financing the program’s basic functions (activities, training, supervision) and extending operations to all provinces.⁶ The Brazil AIDS projects created HIV/AIDS and STD Control Coordination Units within all 27 states and in 150 municipalities to design and implement AIDS action plans. The Kenya and Uganda STIPs changed the “rules” for project

implementation and budgetary transfers to districts, strengthening the institutional response at the district level and raising political commitment.

Bank assistance often financed collaborative responses in a small number of other key sectors, usually through its support to the Ministry of Health, to improve the effectiveness of the response on the ground. In Brazil, for example, support to prevention programs among high-risk groups involved inputs from the police and security forces, to move them from punitive policies to become partners in prevention. Condom programs in the prison system required inputs and cooperation from the Ministry of Health, Ministry of Justice, and Ministry of Interior. In India, during the first AIDS project, activities were launched to

The Bank has helped build or strengthen national and subnational institutions for the fight against AIDS.

varying degrees in the ministries of education, information and broadcasting, tourism, mines, labor, social justice and employment, and women's affairs. The Kenya STIP provided information and condoms for security forces, but met resistance from religious groups on sex education in the schools. At the time, Kenyan government commitment was still relatively weak. The Uganda STIP funded condoms and sexually transmitted infection (STI) treatment in the military, among police, and in prisons.⁷ The ministries that became engaged tended to be those most severely affected by AIDS and with a comparative advantage in addressing it.⁸

An important lesson arising from this experience is the need to strengthen the institutions and capacity of Ministries of Health, the lead technical and implementation agencies in the national AIDS response. The first phase of the Bank's HIV/AIDS assistance strengthened institutions highly placed within the Ministry of Health (as in Brazil and Cambodia) or high-level autonomous units linked to the

Strengthening the capacity of Ministries of Health has been central to success.

Ministry of Health (as in India). Assistance to low-level units of the Ministry (as in Kenya and Zaire) was relatively less successful, primarily because low organizational prominence often signals low political commitment within or outside the Ministry of Health.⁹ Elevating the institutional home of the national response within the Ministry has been a condition for several of the projects (Cambodia, India). In contrast, placing the responsibility for coordination of AIDS projects in the Ministry of Planning in Chad was associated with low ownership by the Ministry of Health, which was charged with implementation.

Enlisting the Nongovernmental Sector¹⁰

World Bank assistance has encouraged governments to create the mechanisms to enlist NGOs in implementing a national response and has financed capacity building in the nongovernmental sector. Among the 18 completed HIV/AIDS projects, 17 had planned

NGO or community-based organization (CBO) involvement, and at least 15 succeeded (see table 3.1).¹¹ The stated objective of their involvement was generally to deliver preventive services, in many cases to marginalized, high-risk populations not easily reached by government, and mitigation and care services to hard-hit communities. Mechanisms for government financing of NGOs were set up in Argentina, Brazil, Burkina Faso, Cambodia, Chad, India, Uganda, and even Indonesia, where the legal framework was finalized just before the project was cancelled, but remains for the potential benefit of future activities. The recruitment models of the projects ranged from contracting NGOs for delivery of well-specified interventions in specific locales (as in India and Uganda PAPSCA) to providing funds that could be tapped by NGOs with a proposal that satisfied eligibility criteria in terms of the type of intervention (as in Argentina, Brazil, Chad, and the Uganda STIP), or a combination of these. The Cambodia DCHDP contracted with the Khmer HIV/AIDS Alliance (Khana), with support and guidance from the International HIV/AIDS Alliance, to build the capacity of 40 national NGOs to prepare and implement AIDS interventions. Prior to the project, international NGOs were working throughout the country, but there were few indigenous NGOs. The Chad Population and AIDS Project created a social fund and a social marketing agency that have engaged local NGOs, decentralized the response, and reformed the way population and HIV/AIDS activities are carried out.

NGOs have played an important role in expanding access to prevention and care among groups at greatest risk of contracting and spreading HIV (high-risk groups) and in empowering them to become key stakeholders. Projects in Brazil particularly, but also in Argentina, Burkina Faso, Cambodia, Chad, and India engaged NGOs to become involved in service delivery to high-risk groups (see figure 3.1). Implementation was most successful and coverage easiest to track when NGOs were enlisted strategically and systematically and when there were parallel efforts to create an enabling environment through legal reform

Table 3.1: Number of NGOs and CBOs Supported by Completed AIDS Projects

Projects ^a	Fiscal year of operation	NGOs	CBOs
Uganda <i>PAPSCA</i> (AIDS component only)	1990–1995	4	
Haiti <i>First Health and AIDS</i>	1990–2001	7–9	
Rwanda <i>Health and Population</i>	1991–2002	13	
India <i>AIDS I</i> (6 states ^b only)	1992–1999	149	
Brazil <i>AIDS I</i>	1993–1998	181	
Uganda <i>STIP</i>	1994–2002		935 ^c
Burkina Faso <i>Population and AIDS Control</i>	1994–2001		650 ^c
Chad <i>Population and AIDS Control</i>	1995–2001	18	50–60 ^d
Cambodia <i>DCHDP</i>	1996–2002	40	
Brazil <i>AIDS II</i>	1998–2003	795	

Source: PPARs, ICRs.

a. Projects in Zimbabwe, Bulgaria, and Sri Lanka did not finance any NGOs. The project in Kenya was supposed to, but the NGO contracts were not executed. Figures were unavailable for the projects in Zaire, Indonesia, and Guinea.

b. Andhra Pradesh, Delhi, Maharashtra, Tamil Nadu, Uttar Pradesh, West Bengal. Of the total, 109 were in Tamil Nadu. These states were visited by OED; NGOs were supported in other states but the number is not known.

c. Includes NGOs and CBOs. A 9-month extension of the Burkina Faso project financed 600 subprojects (included in this figure) through a community-driven development (CDD) pilot in one region (Poni).

d. Includes local associations and local NGOs.

and sensitization of law enforcement. However, NGOs may not always be better placed than government to work with them. In Indonesia, the departments responsible for health, social affairs, and tourism, for example, all have regular contact with female and transvestite sex workers.

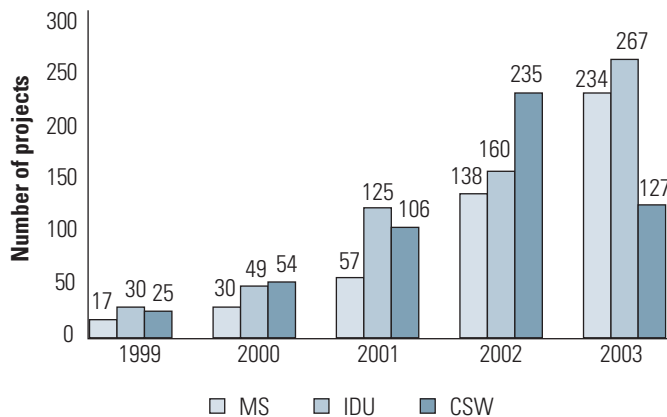
The lack of political will, the low capacity of NGOs and CBOs, and the Bank's cumbersome procedures were often major impediments to enlisting civil society. Despite the project's plans, the Kenya STIP provided only limited direct financial support for local NGOs and none for national NGOs, because the Ministry of Health never awarded three "umbrella" contracts to provide support and capacity. Notwithstanding planned capacity-building activities, *the existing capacity of NGOs to design, implement, and evaluate AIDS interventions was overestimated in virtually all countries receiving Bank HIV/AIDS assistance.*¹² Implementation was also delayed because of lack of familiarity with Bank procedures and overly cumbersome procedures in withdrawing funds. The efforts of NGOs in India

and elsewhere were hindered by funding gaps between cycles and sporadic availability of funds brought about by the government's budgetary processes. These issues were found to be common in Bank projects involving NGOs, according to an earlier OED evaluation (Gibbs and others 1999).

While these activities expanded access to information and services, very little is known about the quality, efficacy, or coverage of the NGO/CBO AIDS activities financed through Bank projects or the degree to which they complement or compete with decentralized government programs. NGOs and CBOs can make a major contribution to the national response through their reach, their local expertise, their flexibility, and the potential cost-effectiveness of their activities. However, the efficacy of their efforts is rarely measured; to the extent that Bank project-sponsored NGO AIDS activities have been monitored, results are generally measured in terms of outputs.¹³ As a

Bank assistance has encouraged governments to enlist NGOs in their response to AIDS.

Figure 3.1: Growth in Targeted Interventions for High-Risk Groups in Brazil, 1999–2003



Source: Beyrer and others 2004.

Note: MSM = men who have sex with men; IDU = injecting drug user; CSW = commercial sex worker.

Bank and other donors should not take for granted the existence of implementation capacity when it comes to AIDS programs. Second, Bank projects need to develop more flexible project implementation procedures.¹⁴ Third, much remains to be learned about the conditions under which government-NGO partnerships in AIDS programs are effective, efficient, sustainable, and complementary to local government activities.

Service Delivery

The first generation of HIV/AIDS projects primarily supported awareness and prevention in the general population, in high-risk groups, and, in hard-hit countries, medical training and drugs for treatment and care.

Two-thirds or more of closed free-standing AIDS projects provided information, education and communication (IEC), STD treatment, condoms, counseling and testing to the general population, IEC and condoms targeted to high-risk groups, and training to medical staff in treatment and care (see figure 3.2).¹⁵ The extent of investment in other treatment, care, and mitigation services depends on the stage of the epidemic and was less consistent. However, public goods, including HIV and behavioral surveillance, operational research, evaluation, and prevention for high-risk groups should be a high priority for government at all stages of the epidemic; the expectation is that these activities should have been universally supported.

The shortfall in prevention targeted to high-risk groups is often the result of a failure to implement planned activities.

Almost all of the projects planned some interventions targeted to those most likely to spread HIV through risky behavior,¹⁶ but priority was often given to lower-risk populations in implementation. An objective of the Indonesia project was to pilot interventions to sex workers in two provinces; to the extent that the project was executed before it was cancelled, the emphasis on high-risk groups was diluted. Both the Kenya and Uganda STIPs were to include activities targeted to high-risk populations, but the implementers pitched the program to the wider population.¹⁷ In Argentina, where the main modes of transmission are

But, the capacity of NGOs was consistently over-estimated and the efficacy of NGO and CBO activities supported by Bank assistance has rarely been calculated.

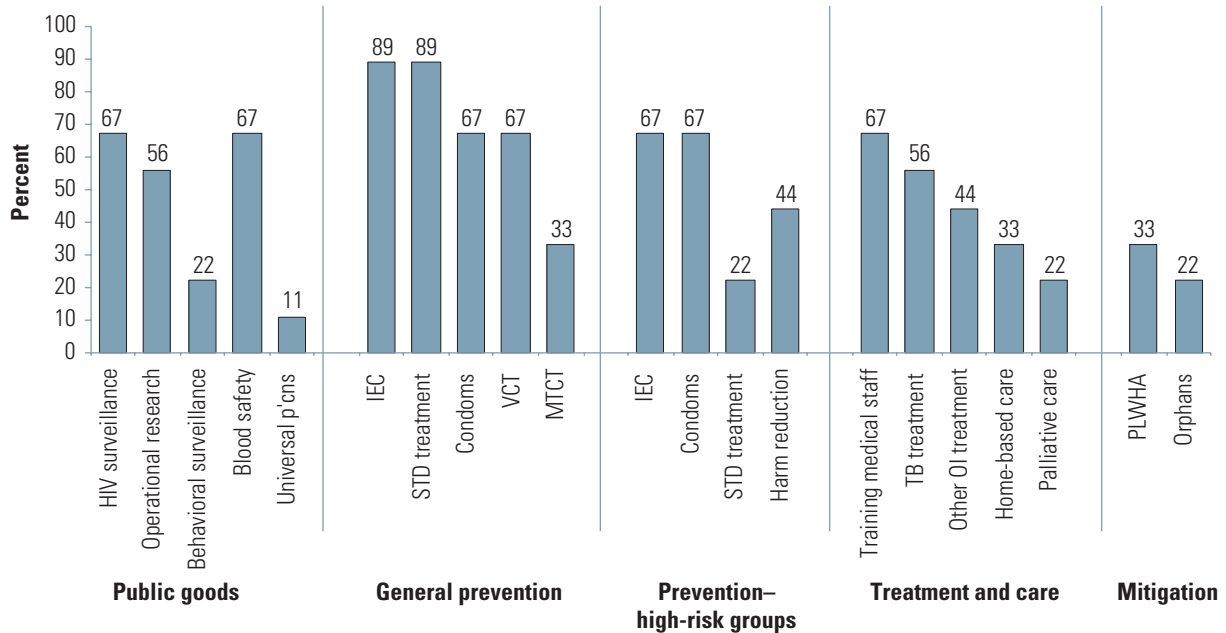
result of the lack of evaluation, there is little evidence about the conditions under which NGO service delivery is more cost-effective than government services in any of the countries. The extent to which NGOs are economizing on

scarce public sector capacity or increasing the administrative burden is not known. There is little systematic information on the coverage of NGO- or CBO-delivered AIDS services, their effectiveness in targeting the highest-risk populations, or the extent to which they are complementing decentralized government activities. OED's 1999 evaluation of NGOs in World Bank-supported projects more generally was unable to link NGO or CBO involvement to higher outcomes, institutional development, or sustainability (Gibbs and others 1999).

Prevention targeted to those most likely to spread HIV was planned, but often not implemented.

Three important lessons arise from this experience. *First, even in countries with a strong civil society, the*

Figure 3.2: Activities and Interventions Supported by Closed Free-Standing AIDS Projects (n = 9)



Source: PPARs and ICRs.

Note: IEC = information, education, and communication; VCT = voluntary counseling and testing; MTCT = prevention of mother-to-child transmission; OI = opportunistic infections; TB = tuberculosis; PLWHA = people living with HIV/AIDS. *Harm reduction programs* (such as needle exchange, bleach for sterilization of injecting equipment, drug rehabilitation) reduce the likelihood of transmission among injecting drug users (IDUs). *Universal precautions* (such as sterilization of medical equipment, use of rubber gloves and other protective gear) prevent transmission in medical settings.

among men who have sex with men (MSM) and IDUs, LUSIDA initially financed NGO interventions for women and children. Only late in the project, with strong encouragement from the Bank and after a new government took office in 2002, were these efforts focused on IDUs and MSM. The failure to implement interventions to those at higher risk is often a product of political and social stigma and lack of the expertise on the part of government and NGOs needed to work with them.

There is often resistance to implementing interventions for high-risk groups, both in government and civil society. *An important lesson is that including these interventions in implementation plans or on a list of interventions to be supported does not ensure that they will be implemented to the extent necessary to reduce HIV transmission.* Strong incentives and supervision by the

Bank are critical to ensure that they are implemented.

Evaluation, Monitoring, and Research

Evaluation, monitoring, and research, which are public goods and should be among the highest priorities of government HIV/AIDS programs at all stages of the epidemic, have been under-implemented (see figure 3.2).

They can improve the relevance, efficacy, and efficiency of program design and management, are important for accountability and transparency, and can raise political commitment. They take on particular significance in HIV/AIDS programs

because of the dearth of information at the country and local levels on the epidemic and on program efficacy.

Evaluation, monitoring, and research have been under-implemented.

Evaluation and research have been grossly neglected in the Bank's HIV/AIDS projects.¹⁸

The interventions supported often have been shown effective in controlled research settings in other countries¹⁹ or promoted on the basis of international notions of what constitutes a good program, without the benefit of locally evaluated pilot interventions. The STIPs in Kenya, Uganda, and Zimbabwe, for example, did not conduct or evaluate any local pilot activity of syndromic STD management or training before going to a national scale. When pilot interventions have been undertaken, they have often expanded without evaluation of their efficacy or cost-effectiveness. The feasibility and efficacy of Cambodia's 100 percent condom use program was demonstrated in Sihanoukville, for example, but it was never fully evaluated and the cost-effectiveness relative to alternatives was not assessed before it was expanded nationwide.²⁰ The cost-effectiveness of pilot interventions was not evaluated in the first Brazil AIDS project, despite an explicit project component for monitoring and evaluation (M&E). The second Brazil AIDS project, which also featured evaluation as a prominent objective, was equally unsuccessful in getting evaluation done—in a country with lots of capacity to do it. The efficacy and cost-effectiveness of the main programmatic activities of national AIDS control programs supported by the Bank—such as IEC, capacity building, syndromic STD management, and condom programs—by and large have rarely been independently evaluated.

Project budgets for research and analytic work generally have not been used to inform programs, often allocating resources based on demand by researchers rather than for evaluation of high-priority programmatic areas. OED's assessment of the first and second AIDS projects in Brazil found, for example, that the research program was “ad hoc and uncoordinated in its conception,” generating a large amount of information that was of limited use for improving program performance and impact.

Project research budgets have not been used to inform the programs. **Bank assistance has helped governments expand coverage of epidemiological and**

behavioral surveillance, but implementation often has been delayed, and the systems have not been brought to focus on the highest-risk behavior.

The Indian HIV surveillance system did not achieve national coverage until 1998, the last year of the first AIDS project; almost all surveillance was of pregnant women, among the last populations in which HIV rises.²¹ There was no national behavioral survey until 2002, well into the second AIDS project. National HIV surveillance in Brazil was not achieved until the second AIDS project, in 2000.²² Only pregnant women are systematically followed, in an epidemic that remains concentrated in IDUs, MSM, sex workers, and other high-risk groups. Brazil's first national behavioral survey did not take place until 1998.²³ National programs in Ethiopia and Uganda, which once systematically monitored HIV in sex workers and truck drivers, no longer do so, despite the Bank's support. In contrast, the Cambodia DCHDP financed government implementation of HIV and behavioral surveillance of high-risk groups, with technical inputs from other donors. Yet at the time of OED's assessment, there was still no nationally representative survey of risk behavior of men and women in Cambodia.

The overwhelming M&E emphasis of Bank-supported AIDS projects has been on monitoring, but it has often been poorly designed, under-implemented, and under-supervised. Key issues that have arisen include:

- There are often too many indicators, but with *no plan* to ensure that the information is collected, *no incentives* to collect it, and *little use of the data* in decision making (Wilson 2004).
- Projects are often launched without *baseline data* that should be critical to their design. The lack of behavioral baseline data in Indonesia led the project to believe that the epidemic was about to take off among sex workers, while it eventually spread through injecting drug use. In almost every country where population-based HIV prevalence surveys have been conducted, levels were lower than those predicted by surveys of pregnant women—with enormous implications for the design of treatment and mitigation programs.²⁴

- The indicators are not always *appropriate to the objective* being assessed. For example, lack of understanding of the basic epidemiology of HIV has led many projects to select HIV prevalence as an indicator of program impact (see box 3.4). There have been few attempts to monitor HIV incidence,²⁵ proxies for incidence, or AIDS mortality. Treatment indicators tend to be in terms of the number of people receiving treatment, not the extent to which they are actually healthier or live longer.
- Repeated national surveys conducted by government and donors *have failed to ensure the comparability of questions across surveys*, making it impossible to track changes in behavior over time—in Cambodia,²⁶ Chad,²⁷ India, and Uganda,²⁸ for example—even when both surveys are sponsored by the same agency. This is evidence of a lack of collaboration among the Bank, sponsoring agencies, and government.²⁹
- Project *output data* is too often not monitored; without it, the attribution of changes in outcome to public programs is impossible.³⁰

This experience points to multiple needs: (1) to identify fewer monitoring indicators and ensure that

they are relevant to objectives; (2) to ensure a viable implementation plan for collecting monitoring data; (3) to commission independent evaluation of key program components; (4) to provide incentives to borrowers and Bank staff to ensure that monitoring and evaluation take place and are used for decisions—such as by linking the availability of M&E results to key programmatic decisions and to continued funding; (5) to improve the coordination among government, donors, and technical assistance to ensure the comparability of large population-based surveys over time; and (6) to structure research and analytic work in such a way that it will inform key programmatic decisions.

Outcomes and Impacts

This section reviews evidence of trends in knowledge and behavior in a few of the countries that have received World Bank assistance. In many of the countries, the Bank was not the only donor supporting HIV/AIDS control and was part of a broader collaboration.³¹ It is not possible in

Monitoring has suffered from too many or inappropriate indicators, lack of baseline data, and failure to ensure comparability over time.

Box 3.4: The Limited Usefulness of HIV Prevalence as an Indicator of Program Impact

The goal of HIV/AIDS prevention programs is to reduce the number of new HIV infections, or *incidence*. However, measuring incidence is complicated and expensive; it involves monitoring a cohort of HIV-negative people over time to count how many become HIV positive. Trends in knowledge and risk behaviors are predictors of HIV incidence and easier to monitor—for example, changes in the onset of sexual activity among youth, the frequency of sex with casual or commercial sex partners, condom use in casual and commercial sex, and injecting drug use behaviors.

Most national AIDS programs monitor the percentage of the population infected with HIV, or HIV *prevalence*. The number of HIV-positive people can rise or fall, depending on whether more people become infected than die over a given period. When HIV prevalence “stabilizes,” it means that new infections and deaths are in balance: both could be high or both could be low.^a HIV prevalence declines

when deaths exceed new infections. Thus, neither “maintaining stable HIV prevalence” nor “reducing HIV prevalence” (both of which are often the objectives of HIV/AIDS projects and national plans) indicate success in prevention programs, since they reveal nothing about the number of new infections.

Changes in HIV prevalence are a useful proxy for HIV incidence only when AIDS mortality is expected to be low—for example, early in an epidemic or among young adults who have only recently initiated sexual activity or drug-injecting behavior. A third instance would be if all HIV-positive people could be kept alive. Then HIV prevalence would *rise* at a rate exactly equal to the number of new infections. While not generally useful in measuring the success of prevention programs, in mature epidemics HIV prevalence is useful in predicting the demand for treatment and related services. Among pregnant women, it measures the need for services to prevent HIV transmission to children.

a. Wawer and others 1997.

most cases to attribute these trends to public policy in general—as supported by the Bank or implemented by government or donors—because monitoring of the outputs has been poor, making it difficult to link outputs to outcomes, and establishing a counterfactual is also difficult. Knowledge and behavior can change based on the personal experience of individuals

It is difficult to isolate the impact of the Bank on outcomes, partly because of poor monitoring and evaluation.

whose friends or family members contract HIV or die of AIDS. Nevertheless, it is useful to know whether trends in these countries that the Bank has supported have moved in the correct direction, even without clean attribution to government. Even then, poor monitoring and lack of coordination among donors and government in data collection have resulted in limited availability of trend data.

Knowledge and awareness of HIV/AIDS. Knowledge of modes of preventing HIV has increased in Burkina Faso, Kenya, and Uganda, countries that received early support from the Bank and many other donors (figure 3.3a). The percentage of respondents who spontaneously report condom use as a way to avoid AIDS has increased modestly in Burkina Faso and Kenya, but has more than doubled in Uganda. The percentage of women in Chad responding correctly to a prompted question on condom use to avoid AIDS³² has tripled in three years. The share of 15–19-year-olds who have never had sex has been creeping upward (figure 3.3b), among both men and women, reducing their exposure to the risk of HIV/AIDS (as well as to pregnancy and other STDs).³³ Unfortunately, the results on other measures of knowledge, sexual behavior, and condom use in risky sex—the variables of key interest to AIDS programs—are difficult to compare between the 1998 and 2003 surveys. Even in these countries where changes have occurred, the counterfactual is elusive. Would these parameters have changed even in the absence of the Bank's support?

In Tamil Nadu state of India the percentage of ever-married women of reproductive age

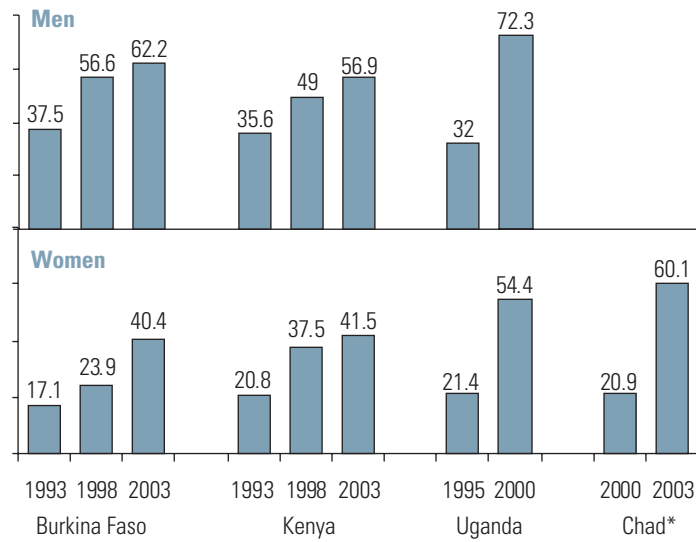
who had heard of AIDS rose from 23 to 87 percent between 1992/93 and 1998/99; the percentage who spontaneously reported that condoms prevent HIV transmission rose from 3 to 10 percent.³⁴ In the state of Maharashtra (with the second-highest project expenditures), AIDS awareness rose from 19 to 61 percent and spontaneous reports of condoms for prevention rose from 6 to 12 percent over that period. Per capita state spending on HIV/AIDS in India over the 1990s is associated with higher levels of knowledge of HIV/AIDS transmission in as well as higher receipt of interpersonal information on HIV and condoms in 2001 (see box 3.5), although there was no relationship between spending and risk behavior.³⁵

Risk behavior. In Kenya, the share of men who ever used a condom rose from 34 to 49 percent between 1993 and 2000;³⁶ the share with more than one sexual partner declined from 27 to 19 percent between 1998 and 2000, while the percent who used a condom in their last episode of sex with a non-regular partner rose from 43 to 63 percent. In Uganda, condom use with non-regular sexual partners rose modestly from 1995–2000 in association with STIP support for condom social marketing—from 20 to 38 percent among women and from 36 to 59 percent among men.

The Indian state of Tamil Nadu received the largest share of funds during the first National AIDS Control Project (1992–99). Between 1996 and 1999, the percentage of truck drivers in urban Tamil Nadu reporting commercial sex dropped by half, from 40 to 20 percent, and condom use among truck drivers who bought sex rose from 55 to 80 percent by 1999, and 94 percent by 2001.³⁷

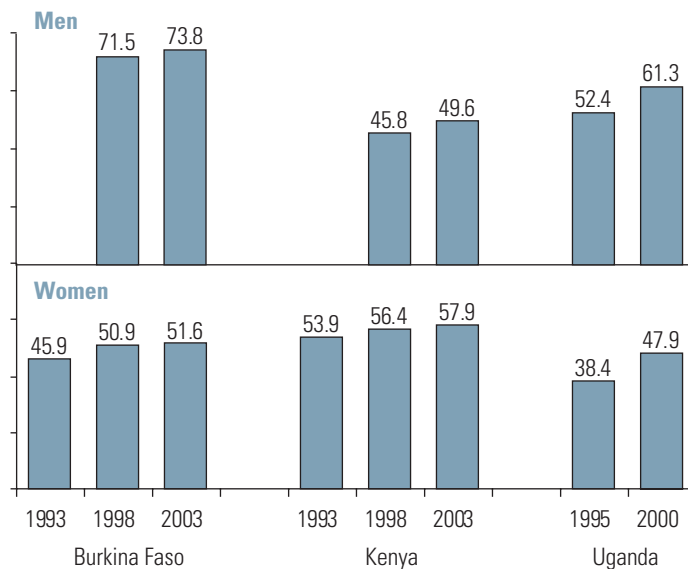
Consistent condom use among sex workers in urban areas of Cambodia more than doubled, from less than 40 percent to more than 90 percent between 1997 and 2001 (see figure 3.4). Over the same period, the percent of high-risk men who used brothel-based sex workers in the past 12 months declined by 55–65 percent (NCHADS behavioral surveillance data, cited in OED 2004a). The \$4.9

Figure 3.3a: Among Respondents Who Had Heard of AIDS, Percentage Spontaneously Reporting Condom Use as a Way to Avoid AIDS



*For Chad, answers are from a prompted question on condom use (not spontaneous).

Figure 3.3b: Percentage of 15–19-Year-Olds Who Have Never Had Sex



Source: Demographic and Health Survey data (Burkina Faso, Kenya, Uganda) and OED 2005c (Chad).

Box 3.5: The Relationship Between Public Spending, AIDS Knowledge, and Receipt of Information in India

During the first National AIDS Control Project (1992–99), state and union territory governments spent a mean of Rs.13.1 (US\$0.29) per capita on all HIV/AIDS programs and Rs.3.2 (US\$0.07) per capita on HIV/AIDS public awareness. Has there been any impact on awareness and knowledge?

A study of the relationship between awareness and knowledge from the 2001 India National Behavioral Surveillance Survey (BSS) and levels of state per capita spending on AIDS and AIDS awareness from 1992–2001 found that higher state spending on HIV/AIDS programs in the 1990s is associated with higher HIV prevention knowledge and access in 2001:

- ➔ A 3-rupee (US\$0.07) increase in public HIV/AIDS spending per capita (1992–99) is associated with a 1 percentage point increase in HIV/AIDS prevention knowledge and in reported receipt of general information and condom-specific information.
- ➔ A 3-rupee increase in public spending on AIDS awareness is associated with a 3 percentage point increase in re-

ported receipt of general and condom-specific HIV/AIDS information.

The study controlled for other factors that also might have affected AIDS awareness over that period: state-level marital status and literacy levels from the 1991 and 2001 Indian census; state income (gross national product, GNP) per capita; the extent of the AIDS epidemic (proxied by the percentage of respondents who knew someone with AIDS); and the gender and area of residence of the respondents. These results are suggestive of an impact of public information, but would need to be confirmed by more formal evaluation linking the project's IEC inputs to changes in knowledge.

Questions on *misinformation* about AIDS were also asked in the BSS, but the results were not reported in the final report. Release of the data to researchers would allow further analysis of the possible impact of public information spending on reducing misinformation.

Source: Subramanian 2003.

million AIDS component of the Cambodia DCHDP credit funded roughly half of the costs of the government's national AIDS program over the life of the project (1996–2002), which emphasized raising condom use among high-risk groups. Roughly two-thirds of all HIV/AIDS spending in Cambodia over the same period was from U.N. agencies, bilateral and multilateral donors, and international NGOs, most of it implemented outside of the Ministry of Health.

Epidemiological outcomes. In several countries supported by the Bank, HIV prevalence in specific population groups has declined. However, in the absence of information about HIV incidence or AIDS mortality, it is impossible

Trends in HIV prevalence are not indicative of prevention success.

to interpret these results in terms of reducing the spread of HIV. Indeed, in countries like Brazil where ever larger numbers of AIDS patients are receiving antiretroviral therapy, HIV prevalence would be expected to remain at

current levels or even climb if treatment efforts succeed in reducing mortality.

STIs in Kenya and Zimbabwe appear to have declined during the course of the STIPs. In Nairobi, syphilis prevalence among women attending antenatal clinics declined from 7 percent in 1995 to 5 percent in 2000. From 1996 to 2000, the share of reported cases of vaginal and urethral discharge declined compared with other STI syndromes, a decline that corresponds to strengthened training and syndromic management of STIs sponsored by the project. Moreover, the share of these infections increased in 2001 when drug availability fell following the end of the project (OED 2002, Annex B, p. 27, citing, for share of discharge, NASCOP 2002). In Zimbabwe, STI drug availability (supported by the project) and training of health practitioners (supported by other donors) rose dramatically while reported cases of bacterial STIs declined during the life of the project. It cannot be discerned whether these changes in STI incidence had any effect on HIV incidence in the two countries.³⁸

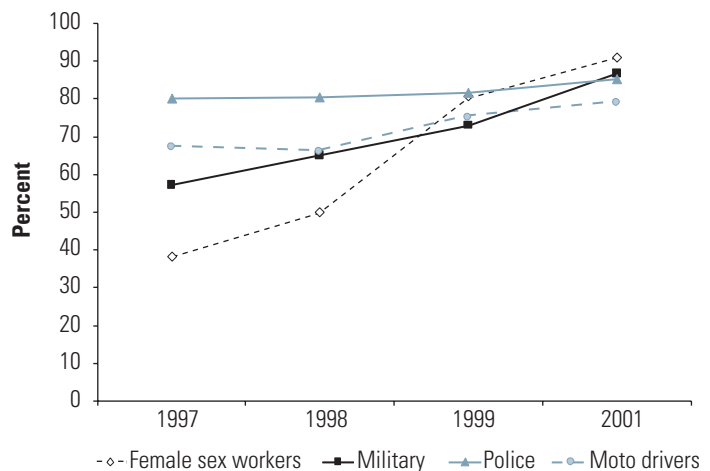
AIDS morbidity, mortality, and other welfare outcomes. Although a high percentage of projects have invested in strengthening treatment and care of AIDS patients and, in hard-hit countries, assistance to people living with HIV/AIDS (PLWHA) and orphans, there has been very little evidence collected on the outcomes of these activities. One of the few exceptions is the Brazil AIDS program's monitoring of AIDS patients. The Bank provided major support for setting up and improving the quality of laboratories and testing facilities, including services to evaluate and monitor the viral and immune status of HIV/AIDS patients, in order to improve the efficiency and efficacy of the national treatment program. The death rate of AIDS patients has declined dramatically, particularly since the broad introduction of triple antiretroviral therapy (see figure 3.5).

The Reach, Perceived Quality, and Relevance of the Bank's Analytic Work on HIV/AIDS

In 1996, President Wolfensohn called for the World Bank to become a "Knowledge Bank." As was seen in Chapter 2, there has been an extreme lack of information on most aspects of the AIDS epidemic and available information has changed rapidly. Further, in the area of AIDS, the Bank faced a problem of low client demand for assistance; some types of information can have a major impact on generating commitment. Knowledge was one of the four pillars of the Africa Region's most recent AIDS strategy, which included several actions to improve access to information.³⁹

To measure the scope of the Bank's analytic work on AIDS, OED conducted an inventory. An important finding is that the Bank's analytic work on HIV/AIDS is not very accessible, even for those within the institution. It is not systematically recorded in the internal record-keeping system, nor does any existing Web site pull together all of the material in a comprehensive way.⁴⁰ The inventory of analytic work summarized in Appendix E is based on responses to a questionnaire sent to task managers of AIDS projects and to AIDS researchers, and from a search of publica-

Figure 3.4: Increase in Consistent Condom Use among High-Risk Groups in Urban Cambodia, 1997–2001



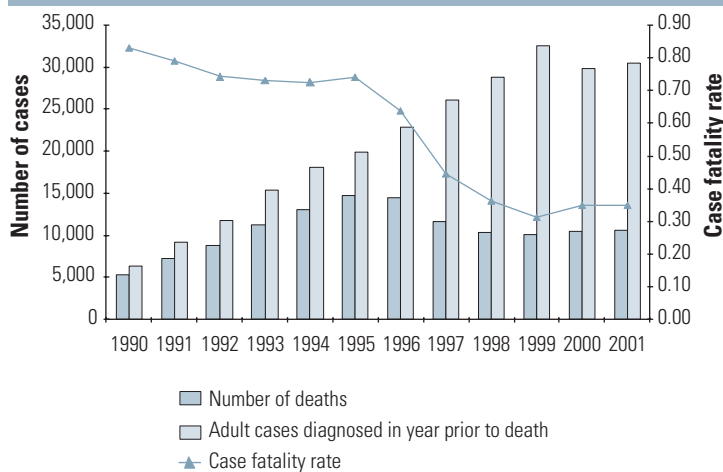
Source: NCHADS behavioral surveillance data, as cited in OED 2004a.

tions and document databases maintained by the Bank (intranet, Business Warehouse, ImageBank), bibliographies of AIDS project appraisal documents, and official recording systems (SAP). Because of the irregular reporting conventions and recall biases that can be expected, this inventory is an indicative rather than a definitive list.

Using key products in this inventory, OED assessed the extent to which the Bank's analytic work on HIV/AIDS is reaching key internal and external audiences, the perceived technical quality of the work, and its usefulness through surveys conducted for two key audiences: (1) 212 Bank staff working in the human development sectors who were attending the Human Development Forum in November 2003;⁴¹ and (2) 466 delegates at the 13th International Conference on AIDS and STDs in Africa (ICASA), held in Nairobi, Kenya, in September 2003.⁴² Recognition of and access to the Bank's analytic work as well as its perceived quality are key dimensions of efficacy. The audiences reached and the perceived usefulness of specific reports to them is a measure of their relevance. In both

Little evidence has been collected on the effect of AIDS treatment and mitigation measures on welfare outcomes.

Figure 3.5: Decline in AIDS Mortality in Brazil with Expanded Treatment



Source: FIOCRUZ and others 2004.

surveys, respondents were first asked if they had heard of a specific report and, if so, whether they had read it. All respondents who had read the report were asked to rate the technical quality and its usefulness to their work.⁴³ A list of the analytic work that was included and detailed results are in Appendix F. The main findings are as follows.

The Bank’s analytic work on HIV/AIDS is not very accessible.

The Bank’s analytic work on AIDS is not reaching key audiences in the African AIDS community. Government policy makers had low recognition and readership of most of the studies, including those for which they are the main intended audience. Their levels of recognition and readership were akin to the levels of national and local NGOs. The respondents with the highest recognition and readership were other donors; academia recognized many of the studies at the same rate but had read fewer. Surprisingly, the international NGOs had relatively low recognition and very

Lack of French translations and Internet access are barriers to African users of Bank research.

low readership—only slightly higher than policy makers and national NGOs.

The non-availability of these reports in French and low access

to the Internet are major barriers to greater access in Sub-Saharan Africa. Among the delegates who completed a French questionnaire, only 29 percent could read technical AIDS articles in English without difficulty; 59 percent could read them with difficulty, and 12 percent not at all. Among the studies that had been published in French, the Francophone respondents had equal or higher recognition compared with English-speaking respondents, but the readership for reports only available in English was substantially lower for French-speaking delegates. With respect to the Internet, while 90 percent of delegates had some access, only half of African respondents had regular Internet access (at home or at their offices), compared with 94 percent of non-Africans.

Bank staff who should be most familiar with cross-sectoral analytic work and toolkits—particularly the task team leaders for AIDS projects—often are not familiar enough. Although about 80 percent of the 29 task team leaders had read the Bank’s Policy Research Report, *Confronting AIDS*, only 30 percent had read the World Bank/UNAIDS manual on M&E of AIDS programs, and only 55 percent had read the MAP support toolkit.⁴⁴ Task team leaders for AIDS projects are being asked to work across sectors, yet only 30 percent had read *AIDS and Education: A Window of Hope*, and 35 percent had read the paper on social protection of orphans and other vulnerable children in Africa.

Regional human development staff are most likely to read AIDS reports about their Regions (rather than reports on the global problem), and sector staff are most likely to read reports about AIDS in their sectors. Nevertheless, readership of some non-Regional reports was relatively high. Among the four Regions for which there were adequate staff responses (Africa, East Asia, South Asia, Eastern Europe and Central Asia), a higher percentage of South Asian human development staff had read the main (non-Regional) AIDS reports and were equally likely to have read about AIDS in Thailand as respondents from the East Asia Region.

Among respondents who had read the reports, both the international community

and Bank human development staff gave them high marks on technical quality and usefulness. Half or more Bank respondents rated the quality of 8 out of 10 reports as high or very high, and 4 reports received high or very high ratings by 70 percent or more of respondents. Among the ICASA respondents, technical quality ratings were even higher, from 60 to 79 percent high or very high. Bank staff rated the 10 studies as either useful or one of the most

useful from 31 to 65 percent of the time, but only 3 surpassed 50 percent.⁴⁵ The ICASA respondents found the papers much more useful than Bank staff, rating them very to most useful from 57 to 75 percent of the time. Five of the 12 papers received 70 percent or higher very or most useful, and five others, 60 percent or higher.

Bank reports get high marks for technical quality and usefulness.