
ENDNOTES

Chapter 1

1. Includes disbursements to date of all free-standing AIDS projects, active and closed, and the disbursement of closed AIDS components or activities exceeding US\$1 million. Of these projects, figure 1.1 shows those for which AIDS was at least 10 percent of the Bank's total commitment.

2. The World Bank began lending for population programs in the early 1970s. It was not until the 1980 *Health Sector Policy Paper* that the Bank committed to direct lending to the health sector (Johnston and Stout 1999).

3. Between 1950 and 1990, life expectancy in developing countries rose from 40 to 63 years, in large part because of economic progress and investments in social services (World Bank 1997a). As of 1996, Zimbabwe's life expectancy was 22 years lower than it would have been in the absence of AIDS, and South Africa's life expectancy was 7 years lower. For more evidence on the impact of AIDS on mortality in Africa, see articles by Boerma and others 1998, Timaeus 1998, and Stover and Way 1998.

4. Indeed, virtually every society has initially reacted to indications of the spread of HIV by claiming that an infection spread in these ways could never take off indigenously (Mann and others 1992, Mann and Tarantola 1996, World Bank 1997a). Once convinced that there is a threat, the first official reaction more often than not has been to take discriminatory legal action rather than to adopt proven public health interventions that stress education and behavior modification. For a compendium of specific examples of denial, lack of political commitment, and repressive measures undertaken by countries at all levels of development, see Garrett (1994).

5. The OED review of UNAIDS (Lele and others 2004) relied extensively on analysis from the *Five-Year Evaluation of UNAIDS* (Poate and others 2002).

6. OED has an ongoing evaluation of the Bank's assistance to primary education. Evaluations have been

completed on social funds (Carvalho and others 2002), social development (Parker 2004), and gender (Gopal and others 2001), for example.

7. The only previous review of the effectiveness of the Bank's HIV/AIDS assistance was a desk review by Dayton (1998) covering projects completed through mid-1997. At that time, only 8 projects had been completed, of which only one was free standing (Zaire AIDS), and only one had been rated by OED.

Chapter 2

1. The full amount of an approved loan, credit, or grant in figure 2.1 is attributed to the year of project approval, but the resources for each of these commitments were disbursed over the life of the project. A list of AIDS projects and components over US\$1 million is in Appendix C.

2. Figure 2.2 is based on the inventory of analytic work summarized in Appendix E and posted on the evaluation Web site (<www.worldbank.org/oed/aids>). Because of the irregular reporting conventions and recall biases that can be expected, the inventory is an indicative rather than definitive list of the Bank's analytic work (see Chapter 3).

3. It was not until 1994 that the median time between infection and AIDS was found to be on the order of 10 years (Hessol and others 1994). When *AIDS in the World II* was published in 1996, the prevailing view was that the incubation period in developing countries was much shorter (Mulder 1996). It was later found that this was not the case. Characteristics such as the incubation period and infectiousness are key in modeling the epidemiological spread of HIV and its impact on mortality, from which estimates of impact are derived.

4. Improved treatment of conventional sexually transmitted diseases (STDs) was a major programmatic recommendation for HIV prevention and one in which the Bank invested heavily. However, the results of ran-

domized controlled trials of the impact of STD treatment on HIV incidence differed according to the research site. A randomized community trial in Mwanza, Tanzania, found that better treatment of symptomatic STDs through the health system reduced incidence of HIV by more than 40 percent (Grosskurth and others 1995). Three years later, a randomized trial of mass treatment of the population for STDs in Rakai District of Uganda, found no effect on HIV incidence (Wawer and others 1998). Many explanations have been offered for the diverging results—the stage of the epidemic, baseline levels of sexual behavior and STD prevalence, and others (Hitchcock and Fransen 1999; Grosskurth and others 2000; Orroth and others 2003; White and others 2004; Korenromp and others 2005). STD treatment remains in the prevention portfolio, but other approaches are now receiving greater prominence.

5. Mann, Tarantola, and Netter 1992. The human immunodeficiency virus was not isolated until 1984 and the first blood tests for HIV were licensed for production in the US in 1985 (see Appendix C.3).

6. By the end of fiscal year 1985, only 18 health projects had been approved Bankwide, of which 7 were in Sub-Saharan Africa. None had closed. By the end of fiscal 1989, a total of 45 health projects had been approved (22 in Africa), of which only 5 had closed (none in Africa) (OED 1998).

7. As reported in World Bank 1988; OED was unable to locate the original documents from 1986.

8. “We will support the World Health Organization’s worldwide effort to combat AIDS, a disease that has potentially grave consequences for some countries in Africa” (Conable 1987).

9. According to interviews, the first of these strategies was reviewed by the “President’s Council” under President Conable but was never formally adopted by top Bank management. It was disseminated in the form of a working paper, however, and served as a guide for the Africa Region. The 1996 strategy was finalized just as the Africa Region underwent a reorganization that dissolved the technical department, which had been coordinating the AIDS response. It became a formal “gray cover” report of the Bank, but respondents reported that it was not disseminated by the incoming Africa AIDS coordinator, who launched development of a new strategy in 1998.

10. For the first two years, she was financed by the U.S. Centers for Disease Control and Prevention, after which the Bank was able to create a new position.

11. The CAS sets out a selective program of Bank support linked to each country’s development strategy and based on the Bank Group’s comparative advantage in the context of other donor activities. The starting point is the country’s own vision for its development, as defined in a Poverty Reduction Strategy Paper (PRSP) or other country-owned process. The CAS includes a comprehensive diagnosis of the development challenges facing the country, including the incidence, trends, and causes of poverty and is developed in consultation with country authorities, civil society organizations, development partners, and other stakeholders. The CAS identifies the areas where the Bank Group’s assistance can have the biggest impact on poverty reduction. It includes a framework of targets and indicators to monitor Bank Group and country performance in achieving stated outcomes and is revised about every three years.

12. Lamboray and Elmendorf 1992, World Bank 1995, and interviews conducted for this evaluation. However, at least one country with relatively high commitment (Thailand) declined an offer of World Bank HIV/AIDS lending assistance in 1988, preferring to finance its highly successful AIDS prevention program almost entirely from domestic sources.

13. At the time that the Kenya STIP was approved, government commitment was perceived to be adequate: there were three ongoing Bank projects in health and population and the STIP was complemented by the activities of many partners, including the United Kingdom, Germany, Canada, Belgium, and the United States. Nevertheless, the extent of government commitment to fighting HIV/AIDS was overestimated; project activities in collaboration with other donors effectively raised that commitment by the end of the project.

14. Commitment by the Minister of Health of Zaïre was strong, but not elsewhere in government.

15. OED was unable to document these implementation or effectiveness of these “retrofitted” components in health projects: They were not included in design documents and, because they were generally small, were rarely mentioned in project completion reports.

16. Burden of disease analysis takes into account the existing disease burden of those with AIDS. This type of analysis does not take into account the fact that HIV is an infection whose burden does not occur for many years and that can be prevented most cost-effectively with early action, when the burden is low.

17. The report does offer a few recommendations on AIDS in a box, calling for a public policy response by African governments to start with prevention. Priority is given to carefully targeted public education and condom promotion campaigns and for the detection and treatment of other STDs. The paper also expresses urgency on addressing the needs of the growing number of AIDS patients.

18. Public information on prevention; promotion of condom use; reduction of blood-borne HIV transmission; integration of HIV prevention and STD services; voluntary and anonymous testing; and public health surveillance.

19. The sole mention of AIDS in the main text is in the discussion of global partnerships with UNAIDS and supporting the search for an AIDS vaccine. Mention of HIV/AIDS as a health problem is embedded in Annex C, "Essential Health, Nutrition, and Population Services," in a brief section on "Re-emerging or New Communicable Diseases." Noting the "increased threats" from TB, malaria, and AIDS, the Annex states that "Prevention and treatment policies must be adapted to keep up with these trends" (World Bank 1997b, p. 64).

20. UNAIDS came into existence in January 1996, replacing GPA. The other five original co-sponsors were WHO, UNDP, UNFPA, UNICEF, and UNESCO.

21. World Bank 1997a. The European Commission and UNAIDS provided support and input for the report.

22. *Confronting AIDS* was launched by the Bank's Senior Vice President and Chief Economist, Joseph Stiglitz, who later that month spoke on the urgency of addressing AIDS in developing countries at a speech to the European Parliament. According to the Bank's External Affairs department, the report received substantial global print and media coverage in late 1997 (Media Relations Division 1997).

23. He urged delegates to "vigorously and straightforwardly pronounce the word 'AIDS' and 'AIDS prevention': AIDS "needs to be put front and center and we need to emphasize prevention" (Wolfensohn 1998).

24. In the speech, he identified a role for donors to keep AIDS on the policy agenda, supplement country resources, "broadly disseminate the latest information... and facilitate cross-country sharing of experience," and facilitate international public goods, like evaluation and vaccine research (Madavo 1998). While saying that the Bank has not done enough, he

referred to the demand problem of the Bank—"Because our resources are loans to governments, we cannot start programs on our own. Governments must first seek our support." Interviews for this evaluation suggest that a turning point in terms of enlisting high-level advocacy from the newly appointed Africa Region vice president was a symposium in January 1998 that highlighted the dramatic decline in life expectancy in the hardest hit countries. Following that meeting, the Regional management team comprising managers from all sectors was directed to address the epidemic.

25. The rules for approval of subsequent individual operations within the overall funding envelope are based on Board procedures for Adaptable Program Loans (APLs). The individual operations within the MAP envelope are technically classified as APLs, but they are not individually adaptable program loans and in practice resemble standard investment projects.

26. In the next IDA replenishment (IDA 14), grants will no longer be targeted to HIV/AIDS. Instead, all Bank support to countries with the greatest debt problem (most of them in Sub-Saharan Africa) will be in the form of grants, while in the less debt-burdened low-income countries the Bank will offer highly concessional finance.

27. The exception is the Uganda PAPSCA project, which comprised activities to mitigate the impact of AIDS and war on widows and orphans.

28. Projects are classified according to the estimated stage of the epidemic as of the time of project approval. There were 9 projects in 8 countries that could not be classified because of inadequate data availability and are thus classified as "unknown": Bhutan and Sierra Leone (UNAIDS provides no data); Cape Verde, Grenada, St. Kitts and Nevis, and St. Vincent and the Grenadines (not listed in the epidemiological annex of UNAIDS 2004); and Moldova (population prevalence estimated by UNAIDS at 0.2 percent but with no supporting evidence of infection levels in either high- or low-risk groups). This underscores the point made earlier about the extent of uncertainty in which decisions are being made.

29. Bank projects have primarily supported treatment of opportunistic infections (OI) of AIDS patients. These are infections that are held at bay by well-functioning immune systems, but which can kill those whose immune systems are destroyed. The most prevalent OI in developing countries is tuberculosis. Prior to the introduction of highly active antiretroviral ther-

apy (HAART), which directly attacks HIV, the life expectancy of AIDS patients in high-income countries had already increased by about 18 months due to aggressive treatment and prevention of OIs. Even patients on HAART get OIs when there is treatment failure, and most are less expensive to treat.

30. The full set of ratings for each completed project (outcome, sustainability, institutional development impact, Bank performance, borrower performance) are in Appendix C.2.

31. The outcome ratings in figure 3.3 for the projects in Chad, Cambodia, and Uganda (PAPSCA) are based on a field assessment of their AIDS components, not the overall project.

32. The Zimbabwe STI project had no institutional objectives.

Chapter 3

1. In the context of the AIDS epidemic, public goods include measures such as provision of information, evaluation and operational research, epidemiological and behavioral monitoring, blood safety, and the adoption of universal precautions to prevent infection in the health system.

2. Indian government counterpart funds at project closing were \$29.3 million, nearly twice the \$15.6 million agreed to in the credit agreement.

3. In this instance, Bank lending helped to safeguard prevention expenditures during a time of financial crisis (OED 2004b, p. 29).

4. Brazil was already targeting some groups with high-risk behaviors, but the Bank's presence promoted that work and lent legitimacy to controversial activities (Beyrer and others 2004).

5. Initially, State AIDS Control Cells were attached to the Ministries of Health of the states, but by the end of the first project, based on the experience of Tamil Nadu state, most had become semi-autonomous SACS. The autonomy of the SACS significantly helped to facilitate disbursements: under Indian law, societies can receive and disburse funds without going through the government's normal approval process. Core staff was seconded from government ministries, while additional technical staff could be on contract.

6. Prior to the project, the national AIDS program was in a low level in the Ministry of Health, had almost no funds and was marginalized. Most AIDS activities were financed by donors, around the government (OED 2004a).

7. In addition to the Ministry of Health, the project funded six ministries (Defense; Local Government; Gender, Labor, and Social Development; Education; Justice; Agriculture) and the Department of Information in the President's Office.

8. The AIDS activities of non-health sectors have been infrequently evaluated in the countries assessed by OED. An exception is the evaluation of the "Universities Talk AIDS" program in India.

9. This finding is largely based on the experience in countries with concentrated and generalized epidemics, where greater resource and public mobilization is necessary. It is not clear how prominent an AIDS control program must be within the Ministry of Health to be effective in a nascent epidemic.

10. In general usage, the term NGO can be applied to any non-profit organization that is independent from government, whose primary purpose is the design and implementation of development-related projects. The distinction between an NGO and a CBO is that the former is usually a service organization for the benefit of others, while the latter often include project beneficiaries in the organization (Gibbs and others 1999).

11. The Zimbabwe STIP did not have any planned NGO or CBO involvement; it was primarily an STI and opportunistic infection drug procurement operation that was intended to complement the activities of other actors. The extent to which NGOs actually participated in the Zaïre project is unknown.

12. In Indonesia, the capacity of NGOs that would implement the interventions to high-risk groups was not assessed.

13. An exception is the USAID-financed evaluation of the pilot home-based care (HBC) model in Cambodia, which examined its impact and cost-effectiveness (Wilkinson and others 2000).

14. Gibbs and others (1999) also found that the Bank and borrowers give too little attention to the environment for NGOs/CBOs, their capacity, and use of appropriate business practices.

15. Figure 3.2 shows interventions actually implemented, either by government or others (such as NGOs or communities). Some planned interventions were not implemented and some that were implemented were not planned. The interventions in figure 3.2 are the main HIV interventions of these projects but are not exhaustive.

16. The Zimbabwe STIP did not target high-risk groups, on the assumption that this activity would be

financed by other donors. The project primarily supported purchase of drugs to treat STIs, TB, and other opportunistic infections.

17. In Uganda, only the 'organized' risk groups, like the military, police, and prisoners, received services. In Kenya, the failure to activate mechanisms for enlisting NGOs reduced the project's reach to high-risk groups.

18. This lack of emphasis on evaluation is not unique to the Bank; the international HIV/AIDS M&E community has focused largely on monitoring (Rugg and others 2004).

19. Randomized controlled trials have demonstrated the potential efficacy of a handful of interventions in the countries where they were conducted and under the implementation arrangements of the study. The effectiveness of the same intervention when implemented on a national scale through public health systems, subject to the institutional, capacity, and financial constraints, in diverse epidemiological or cultural settings, may be quite different. Further, the ranking of different interventions by their cost-effectiveness should vary considerably across settings.

20. As an exception, home-based care interventions implemented by local NGOs and financed through the Cambodia DCHDP, were formally evaluated before wider replication, financed by USAID (Wilkinson and others 2000).

21. The number of HIV surveillance sites rose from 55 in 1994 to 306 in 2001. Of the 306 sites nationwide in 2001, 163 were among women attending ante-natal clinics (ANC), 121 were in STD clinics, 13 were among IDU, and only 2 sites each were among sex workers and MSM. As of the mid-term review of the second AIDS project in 2003, the number of sites among high-risk groups (17) had not changed.

22. From 1997 to 1999, HIV prevalence was reported twice a year from maternities, emergency rooms, and STD clinics. However, the number of sites fluctuated each year and there was concern that the results from hospital sites that had become reference centers for AIDS treatment might be producing biased estimates. Starting in 2000, national HIV surveillance of pregnant women has been based on a random sample of 150 hospital maternities that have over 500 deliveries per year, with a different random sample of facilities each round. As of the OED evaluation, only two rounds of surveillance had been completed, in 2000 and 2003. Traditionally, Brazil's surveillance has

focused heavily on AIDS cases and AIDS incidence. In that sense, introduction of systematic HIV and behavioral surveillance of any type has been an important accomplishment.

23. Three studies of about 850,000 army recruits provided data on behavior, but the indicators collected in each of the surveys were different, so trends cannot be tracked.

24. HIV prevalence in Burkina Faso, for example, had previously been estimated at 6–7 percent of the population based on results from women attending ANC. The 2003 DHS, conducted in a representative sample of the population, found HIV prevalence of only 1.8 percent. In Kenya, HIV prevalence had been estimated by UNAIDS at 15 percent in 2001 (UNAIDS 2002b); the population-based prevalence survey conducted by DHS in 2003 found a rate of 7 percent.

25. In countries like Uganda and Thailand, evidence on changes in HIV incidence has been primarily gleaned from the results of academic research, yet public research budgets in other countries reviewed by OED are not being brought to bear on this issue.

26. After failing to ask questions on AIDS knowledge and sexual behavior in the first National Health Survey (NHS 1998), which was to be a baseline, the end-of-project national survey (2002) used a different, non-representative sampling frame that made the results fundamentally not comparable either to the baseline or to the 2000 DHS. The NHS was financed by the Asian Development Bank, the 2000 DHS was financed by UNFPA, UNICEF, and USAID, and the 2002 final evaluation survey by the DCHDP. In the first two, the sampling frame was nationally representative (although some provinces were excluded in 1998 due to conflict); in 2002 the sampling frame was nationally representative of communities covered by fully functioning health centers.

27. Data from the 1996/97 DHS, the 2000 UNICEF Multiple Indicator Survey (MICS), and the 2003 Knowledge, Attitude and Practices (KAP) Survey were not consistent in the phrasing of questions and variables collected, making it impossible to discern trends in knowledge or sexual behavior. The 1996/97 DHS and the 2003 KAP were financed by Bank projects.

28. The reference periods for reporting non-spousal/cohabiting sexual partners were different in the 1995 (6 months) and 2000 (12 months) Uganda DHS, so changes in these partnerships cannot be tracked.

29. In some cases, the comparability problems are a simple matter of presentation. For example, the 2003 DHS Final Reports for Burkina Faso and Kenya present only the results of prompted questions on knowledge of HIV transmission, even though open-ended (unprompted) questions were also asked and would have been comparable with the results from the 1998 surveys in these countries.

30. The Uganda STIP financed the national AIDS program throughout the 1990s when several key behaviors changed in the population. However, the completion report was unable to quantify most of the project's outputs. Thus, it is unclear to what extent any of these changes could be plausibly attributed to the Bank-financed government AIDS program.

31. The Bank was the major external sponsor of government AIDS programs in Brazil, India (AIDS I), and Chad.

32. Unprompted questions ask the respondent to name all of the ways that AIDS can be avoided. Prompted questions ask the respondent directly whether (in this instance) AIDS can be avoided by condom use. Answers to the prompted and unprompted questions are not directly comparable; in surveys where they are asked both ways, the answers to prompted questions yield higher results.

33. This result should not necessarily be attributed to any particular message (on abstinence, for example) of the AIDS control programs, without further evidence of what messages were delivered and to whom. Such trends can be influenced by economic factors as well as any increase in social conservatism.

34. OED 2003, Annex D. These results are for married women of reproductive age; results for high-risk groups, which received targeted IEC during the project, are not available. The 2001 BSS found that 40 percent of women of reproductive age in Tamil Nadu and 35 percent in Maharashtra knew that condoms prevent AIDS, but the questions and skip patterns were different from the NFHS so results are not strictly comparable.

35. During the 1990s the World Bank was the major funder of the Indian Government's national AIDS Control Program. Other donors had significant bilateral assistance in a number of the states

36. The source for these statistics and those that follow is the 1993 and 1998 DHS and a knowledge, attitude, and practices survey conducted by Population Services International in 2000, as cited in OED 2002,

Annex B. As there were a number of donor activities going on concurrently, these trends in condom use and behavior cannot be linked to the activities of a single contributor but may reflect the effect of the combined inputs of government and donors.

37. These data were provided by the USAID-sponsored AIDS Prevention and Care (APAC) project in Tamil Nadu, which conducted annual behavioral surveillance surveys of risk groups in urban areas between 1996 and 2001. APAC sponsored targeted interventions, but they were not launched until 1997–98. Thus, the declines in risk behavior for 1996–98 are plausibly attributable in part to state or national-level awareness-raising activities, although general media coverage of the AIDS issue may also have contributed. Similar positive trends were found for condom use by sex workers and truck drivers with non-regular sexual partners. There is no information for earlier years (the project was launched in 1992). Source: APAC 2002, as cited in OED 2003.

38. Indeed, research points to substantial variation in the efficacy of STD treatment in reducing the incidence of HIV (Grosskurth and others 1995; Wawer and others 1998).

39. Two key actions were to: (a) “collect and disseminate information and documentation throughout the Bank and externally at central and country levels to inform staff and others of intervention tools and success” and (b) “develop and maintain Web pages to provide up-to-date information and best practices on HIV/AIDS and serve as a resource to Bank staff throughout the world” (World Bank 2000a, p. 32).

40. The two Web sites with the largest collection are the Bank's HIV/AIDS Web site (<www.worldbank.org/aids>) and the International AIDS Economics Network (IAEN) Web site (<www.iaen.org>). Some of the older documents do not exist in electronic form and in some cases OED found only references to the documents, not the documents themselves. There is no central repository for this material.

41. The respondents represented about a third of Bank staff working in human development (44 percent of HNP staff, and a quarter each of education and social protection staff). OED asked about 18 prominent global, sectoral, and Regional analytic outputs and 7 toolkits, all conducted, financed, or managed by the Bank.

42. The survey of ICASA delegates should not be considered representative of responses in other Re-

gions, which could not be surveyed. The ICASA delegates represented government, academia, donors, and civil society. Ninety-four percent were living in Africa, representing about 6 to 8 percent of those attending the conference. OED asked about 12 prominent analytic outputs in addition to questions on access to the Internet. The survey questionnaire was dual language—in English and French—although only some of the analytic work had been translated into French.

43. The ratings for technical quality were: very low, low, average, high, very high. The ratings for usefulness were: not useful, useful, very useful, one of the most useful I've ever read.

44. Note, however, that some of the task team leaders were not from the Africa Region.

45. Thailand Social Monitor (65 percent), *Confronting AIDS* (51 percent), and *Averting an AIDS Crisis in Eastern Europe* (50 percent).

Chapter 4

1. This chapter deals only with the Africa MAP. Eight country-level projects had also been approved for the \$155 million Caribbean MAP by June 2004, of which \$14.5 million had been disbursed. As of April 30, 2005, total disbursements for the Africa MAP projects approved by June 2004 had risen to \$450 million.

2. See the findings from the self-administered questionnaires in Appendix H.

3. World Bank 2000b, p. 10. The definition of “scaling up” is not provided in the MAP appraisal document. The Five-Year Evaluation of UNAIDS points out half a dozen interpretations of scaling up, including replication, expansion of scale, and institutionalizing (Poate and others 2002, p. 64). In the evaluation they use the term to denote an increase from small to large impact. The MAP operations manual issued in 2004 describes scaling up as “the process of expanding the scale of activities and institutions with the ultimate objective of increasing the numbers of people reached and/or the impact on HIV/AIDS. Scaling up may entail: expanding coverage, altering the type or intensity of coverage, increasing impact, or improving quality. While there is no precise definition, scaled-up programs usually reach (or provide access for) substantially more of the targeted population within a specified area” (Brown and others 2004, p. 12).

4. In contrast, the objectives of the Caribbean MAP reflect content and some degree of prioritization: “To assist ... countries in (i) preventing the spread of

HIV/AIDS by reducing transmission among high-risk groups; (ii) improving access of PLWHA to care that is effective, affordable, and equitable within the context of government health policy; (iii) strengthening their institutional capacity to respond to HIV/AIDS in a sustainable way” (World Bank 2001a).

5. Table is a construct for evaluative purposes; it was not a formal part of the MAP appraisal document.

6. Seven MAP projects have separate components for the Ministry of Health, however: Cameroon, Eritrea, Gambia, Mauritania, Mozambique, Rwanda, and Sierra Leone.

7. The detailed risks include: low commitment and denial by government and civil society; low capacity of governments, decentralized implementation entities, and communities; slow disbursements due to limited capacity for financial management and procurement, and processing of sub-projects; poor intersectoral collaboration; and unmanageable fiduciary problems, including misuse of funds.

8. The Uganda AIDS Commission had already been in place for several years before the approval of the Uganda STIP; however, the project was managed by the Ministry of Health because of that institution's relatively greater capacity.

9. If the M&E had been completely and correctly implemented, there would be better evidence on the ultimate impact of these outputs.

10. This is not to say that AIDS activities in other sectors could not have been enhanced or coordination improved.

11. A recent OED evaluation of *World Bank Support for Capacity Building in Africa* (OED 2005b) found that the Bank's traditional tools—technical assistance and training—have often proved ineffective in helping to build sustained public sector capacity; economic and sector work could contribute much more. It also found that most capacity-building activities lack standard quality assurance processes at the design stage, and are not routinely tracked, monitored, or evaluated. A key recommendation is that Regional Senior management ensure that all operations aiming to build public sector capacity are based on adequate assessments of capacity needs and have ways to monitor and evaluate the results.

12. Evidence cited from task team leader and country director interviews is as of August 2004.

13. “The emphasis [of the MAP]... is on speed, scaling up existing programs, building capacity, ‘learning by doing,’ and continuous project re-work, rather

than an up-front technical analysis of individual interventions” (Brown and others 2004).

14. World Bank 2000b, p.31. “Supervision budgets will be considerably larger than the norm.”

15. OED compared actual supervision expenditure of MAP I and health projects controlling for the time since effectiveness in eight countries (Benin, Ethiopia, Eritrea, Gambia, Ghana, Kenya, Madagascar, Uganda). One year after project effectiveness, actual supervision expenditure was 39 percent higher for the health than the MAP projects (\$110,500 for health versus \$79,750 for MAP). By 24 months after effectiveness, cumulative health project supervision costs (\$198,600) were still 10 percent higher than for the MAP (\$181,250). According to the first Progress Review of the MAP (World Bank 2001d, p. 25), the Africa Regional Leadership Team instructed that as much as \$200,000 be allocated from the Bank’s budget for supervision of the first year and \$150,000 for supervision of follow-on years for each MAP—or \$350,000 for the first 24 months. The statistics on actual supervision expenditure fall far short of that objective.

16. The scatter plot in figure 4.1 shows data points representing the disbursement rate (percentage of funds disbursed charted against the percent of total project time elapsed) for each project at annual intervals following effectiveness. The share of total project time elapsed is calculated based on the original planned length of the project, excluding extensions. The figure includes data points for 25 projects—11 MAP I and 14 HNP projects in the same countries. At the time of this analysis, none of the MAP projects had been completed, so the number of data points at high elapsed times is relatively scarce.

17. Over the range of elapsed time that they could be compared, MAP projects disbursed faster than the health projects in Benin, Burkina Faso, Cameroon, Eritrea, Ghana, and Madagascar. MAP and HNP projects disbursed at similar rates in Kenya and Nigeria. In Ethiopia, the MAP disbursed faster early, then there was little difference; in Gambia the HNP project disbursed faster early in the project but the MAP disbursed faster after the mid-point; and in Uganda there was little difference until after the mid-point, at which time the MAP disbursed at a faster rate.

18. Bakilana and others 2005. While supervision of both was found to be weak, the study noted that AIDS components of education loans are typically prepared with greater rigor than education sector requests for MAP resources.

19. The number of NGOs and CBOs is higher in MAP I than MAP II projects because the latter were more recently approved. All are still active and these numbers will increase before the projects close.

20. Task team leaders for 92 percent of MAP projects reported policy dialogue with the government during project preparation. All of the country directors reported engaging in dialogue on HIV/AIDS; in five cases, the country directors mentioned the participation of the Africa Regional vice president or the president of the Bank (see Appendices H and J).

21. These resources include direct support from ACT*africa* and the Global HIV/AIDS Program specialists; field visits from technical support teams to unblock implementation; workshops for task team leaders, country-level staff, and civil society; and an Implementation Acceleration Team, created in January 2003.

22. Team leaders of the projects for 8 of 19 countries reported that there is no prioritization process by the government. Any activity from a list of allowable activities (or not on the list of what cannot be funded) can be funded. In four countries, prioritization is encouraged by MAP project components on targeted interventions, orphans, treatment, or workplace interventions. In three countries, priorities for the project are set as a function of what other donors are not doing. The Ethiopia case study found that the 2000–04 strategic plan did not prioritize activities and there was no link to HIV epidemiology. The plan was costed at \$245 million, but no constraints to implementation were acknowledged.

23. For example, the strategic plan for Mauritania, which has a nascent epidemic, includes psychosocial and medical care (including antiretroviral therapy), community care, and economic support for PLWHA, orphans, widows, and affected families, even though it is unlikely that there are many individuals needing these services.

24. According to information provided by 18 NACs in mid-2004 to ACT*africa*, a third of the countries reported allocating 5 percent or more of the project budget for M&E, a third have allocated from 2–5 percent and a third less than 2 percent (Nadeem Mohammed, ACT*africa*, personal communication). The statistics provided by the NACs are of unknown accuracy; actual M&E expenditures have not been centrally monitored.

25. World Bank 2001c. The Progress Review visited Ethiopia, Kenya, and Uganda.

26. In addition to providing support to capacity building to many of the African countries with MAPs, GAMET has piloted innovative monitoring approaches in several countries. These include the Rapid Results Initiative (RRI), implemented in Eritrea, Gambia, and Mozambique, and the application of Lot Quality Assurance Sampling (LQAS) in Uganda and Kenya. Both aim to produce real-time data for use in management decisions at the periphery. GAMET's activities and effectiveness have not been evaluated in this OED report.

27. World Bank 2004. The *Interim Review* was a self-evaluation by the MAP unit that made field visits to Benin, Burkina Faso, Ghana, Malawi, Mozambique, and Sierra Leone. The *Review* notes that field visits were rapid (one week in each country), that no formal analysis was commissioned, and that the findings are "informed judgments of the team, grounded in examples from the review" (p. 4). Unfortunately, while some information was systematically collected in each of the six countries, almost none is referenced in the evaluation report. Thus, the evidence behind the conclusions is not presented.

28. Data in this and the next sentence are based on data from the *HIV/AIDS Survey Indicator Database* (www.measuredhs.com/hivdata/). This pertains to national surveys of both HIV/AIDS knowledge and risk behavior among men and women.

29. OED did not collect systematic data on supervision of AIDS activities in non-health ministries sponsored by the MAP, but it is an issue that warrants further investigation. A review by the Bank's education sector of AIDS and education found that the supervision of allocations to Ministries of Education through the MAP is inadequate (Bakilana and others 2005).

30. These per capita civil society expenditures amount to a quarter of per capita health spending in Mauritania and half in Eritrea (World Bank 2003a).

31. Seven of the 19 task team leaders surveyed did not answer this question.

32. CCISD 2001, p. iv. The efficacy, cost-effectiveness, and impact of the pilot were never assessed before it was adopted on a larger scale by the MAP (including in Burkina Faso). "In the planning and execution, the sustainability of the actions, as well as the efficiency of intervention, did not seem to be a dominant preoccupation among the promoters of the project. The administrative modalities have often predominated in the development orientation." (CCISD,

p. iv). The authors also noted that the community activities were primarily awareness-raising and that alternative approaches—such as use of the radio—might be equally effective at meeting that objective (CCISD, p. xv).

33. The MAP operations manual published in 2004 suggests that empowering communities is one rationale, but that additional objectives are creating "AIDS-competent communities," changing norms and values, and providing key AIDS services (Brown and others 2004, p. 45). However, it notes that "The first priority is mobilization. ... At first, mobilizing communities is more important than determining specifically what should be done" (p. 46).

34. OED 2005a. The OED evaluation defines community development as the universe of participatory projects involving communities, either through community-based development (CBD) or community-driven development (CDD). CDD projects support the empowerment of the poor by giving communities control over subproject resources and decisions, while CBD gives communities less direct responsibility and emphasizes collaboration, consultation, or sharing information with them on project activities.

Chapter 5

1. In Indonesia, Zaïre, and Zimbabwe, emergency preparation led to delayed implementation. More recently, the Bangladesh AIDS prevention project (for a nascent epidemic) was rushed through preparation on the assumption that detailed implementation plans would be developed in the first year of the project. Two years after approval, implementation had hardly begun and only 7 percent of the credit had been disbursed. The *Interim Review of the MAP* (World Bank 2004) concluded that in some cases implementation might have been quicker had the standard preparation activities taken place, but at an accelerated pace.

2. An important exception is in the Caribbean, where another Multi-Country AIDS Program was an important signaling device for raising political commitment.

3. This is the 2-year approved maximum; the 5-year maximum for AIDS is \$5 billion. Source: GFATM Web site, accessed February 21, 2005.

4. Recurrent public expenditures on health in 2002 in Rwanda were the equivalent of \$8.43 million, compared with a two-year commitment of GFATM to government of \$23.2 million for AIDS and TB. The GFATM

two-year commitment to the government of Uganda of \$106 million for AIDS is substantially more on an annual basis than the government's fiscal year 1999/2000 recurrent health budget of \$37.1 million. In 2004, PEPFAR disbursed an additional \$80.5 million in AIDS assistance to Uganda (GFATM Web site, accessed November 8, 2004, total approved proposals to government, years 1 and 2; World Bank 2001c); PEPFAR data/Washington, D.C.

Chapter 6

1. This would include, for example, impact evaluation of alternative approaches to achieving selected outcomes.

2. This would include, for example, cross-national analysis of AIDS determinants, the effectiveness of interventions, and impacts.

Appendix D

1. In a number of cases, HIV/AIDS was mentioned in the general discussion on the political, economic, and social context, but was not identified as an issue to be specifically included on the development agenda.

2. (i) Bangladesh, Belarus, Bhutan, El Salvador, Ethiopia, Ghana, Guyana, India, Latvia, Mozambique, Pakistan, Romania, and Russia; (ii) Cambodia, Tanzania, Uganda, and Zambia.

3. Of these, 8 led to actual loans or credits, as of December 2002.

4. Burkina Faso, Gambia, Honduras, Mozambique, Niger, Tanzania, Uganda, Vietnam, and Zambia.

Appendix F

1. The registration packets were given to fully paid delegates, scholarship recipients, ICASA committee members, and ICASA-accredited media persons and VIPs. According to the Secretariat, there were 7,230 total registrants. However, it is not known how many of these individuals were delegates and actually attended the conference. Often some registered individuals do not show up. The response rate is therefore approximate: the rate of 7.6 percent is computed over the total number of questionnaires distributed; when computed over all conference registrants, the response rate is 6.4 percent.

2. Note that "Breaking the Silence" was also the theme of the International AIDS Conference in 2000 in Durban, South Africa. This could lead to inflated estimates of recognition of that article.

Appendix H

1. The TTLs reported their years of experience with HIV/AIDS as of the date of the questionnaire, in June 2004, not as of the date that they became involved in the project. Thus, the mean years of experience includes the time that they spent managing the project. Since most of the MAP I projects were approved between 2000 and 2001, it would be appropriate to subtract 3 years for MAP I TTLs as an estimate of their experience at time of preparation. The 12 MAP II projects were approved from 2002 to mid-2003, so it would be appropriate to subtract about a year and a half. When this is taken into account, the level of experience is roughly similar.

2. In a few cases, the project did not conduct these preparatory studies because another donor had undertaken them. Those done by others have been included, when cited.

3. Source: Business Warehouse. The MAP II statistics apply only to the projects reviewed here. MAP I projects were more likely to take place in countries that had had previous Bank HIV/AIDS lending—Kenya and Uganda (with former STI projects and Uganda with the PAPSCA), Burkina Faso (with an AIDS and population control project), and Benin, Cameroon, Eritrea, Ethiopia, Gambia, Madagascar, and Nigeria (with AIDS components of health projects).

4. Six countries are excluded because: (i) the TTL did not complete the questionnaire (one country); (ii) the project was not yet effective (one country); (iii) parallel health projects financed major public health AIDS activities (two countries); (iv) the project was too recently launched and has not initiated many activities (two countries).

5. Citing statistics for those projects in which the number of NGOs and CBOs were separately cited by TTLs; in three cases, the number included both.

6. The breakdown of the 23 cited pilot projects that had been evaluated, according to TTLs: CDD (5); care and treatment (4); voluntary counseling and testing (2); condoms (2); decentralized health care, orphan day clinics, prevention of MTCT, drug prophylaxis, peer education, AIDS education in the schools, and migrant interventions (1 each).

Appendix I

1. The Cameroon and CAR projects share the same TTL.

2. An additional 9 MAP projects were approved by the end of fiscal year 2004 but had not been effective for at least a year.

3. According to the Business Warehouse, the following countries had ongoing health projects at the time of preparation: MAP I: Benin, Burkina Faso, Cameroon, Eritrea, Ethiopia, Gambia, Ghana, Madagascar, Uganda; MAP II: Burundi, Mauritania, Mozambique (2003), Niger, Rwanda, Senegal, Sierra Leone, Tanzania. The following had ongoing AIDS projects at preparation (all MAP I): Burkina Faso, Kenya, Uganda. The following had an ongoing population project (no other health) (MAP II): Guinea. The following had no active health project at the time of preparation: MAP I: CAR, Nigeria; MAP II: Cape Verde, Zambia (though there had been one previously).

4. In one of these 9 countries, the TTL noted no prioritization in the civil society component; it is not clear whether there's prioritization in the other components.

5. Not sure that this really qualifies as a political commitment strategy—it was in the template.

6. Of these seven countries, all but Cape Verde and Zambia had health projects during preparation. Also, Nigeria, which had two concurrent health projects, had no health projects at preparation. The failure to renew a health project (and to substitute a MAP, based not in MOH but elsewhere) has been cited as a reason for MOH disengagement.

7. One TTL cited a 'leveling off' of HIV prevalence and another a decline in HIV prevalence, but these can arise from the natural evolution of an epidemic and do not serve as evidence of a decline in the rate of new infections.

8. Looking to the follow-on question, three additional TTLs advocated that the criteria be adapted to the country context and, in the last question, two other TTLs complained about the excessive haste to

get the projects approved. Lack of content was highlighted by two TTLs.

Appendix J

1. The country coverage is in Appendix I.

2. The open-ended format of the interview led respondents to mention the most prominent achievements for each country. This is not to say that the same achievements are not present in other countries, just that they were less prominent and not mentioned.

3. In one case, the respondent cited an absolute drop in HIV prevalence. However, prevalence can decline only when mortality outstrips the number of new infections; it is not clear whether the country directors fully understand the relationship between the number of new infections (incidence) and HIV prevalence (which is affected by past infections, new infections, and mortality) and how trends should be interpreted.

4. Note, however, that the rationale for higher supervision resources for MAP projects during implementation was not related to these factors. Rather, it was because the rapid preparation of the projects left relatively more of the detailed implementation plan to be worked out after the projects were approved.

Appendix M

1. The "Three Ones" refer to: (i) One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners; (ii) One National AIDS Coordinating Authority, with a broad-based multi-sectoral mandate; and (iii) One agreed country-level monitoring and evaluation system.