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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARDE	Annual Review of Development Effectiveness
CAS	Country Assistance Strategy
CDF	Country Development Framework
DFID	Department for International Development
ESW	Economic and Sector work
FP	Family Planning
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition and Population
HSR	Health Sector Reform
MAP	Multi-Country HIV/AIDS Programme
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organisation
OED	Operations Evaluation Department
PA	Poverty Assessment
PRSP	Poverty Reduction Strategy Paper
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation

Executive summary

Tom Stoddart/IPG/ActionAid

UNAIDS estimated that in Africa in 2003, more than 2.3 million people died from AIDS, 3 million were newly infected and a total of 12 million children were orphaned. Antiretroviral drugs are reaching a mere 50,000 of those with AIDS in developing countries. The HIV/AIDS pandemic is clearly a human and developmental disaster.

This paper looks at the response to the HIV/AIDS crisis by the World Bank as a key member of the international donor/lending community, a leader in the international health community, and as Africa's principal development partner. In its seminal document, *Intensifying Action Against HIV/AIDS*, the World Bank acknowledges both its special leadership role in fighting HIV/AIDS and the need that it be held accountable for its stewardship.

It states: **"those who look back on this era will judge our institution in large measure by whether we recognised this wildfire that is raging across Africa for the development threat that it is, and did our utmost to put it out. They will be right to do so."**

This paper assesses what the Bank did in response to the epidemic, whether it could have done things differently, and given this, what should happen now. The main findings are as follows.

The World Bank failed the poor. It failed to protect social spending during its structural adjustment operations in the 1980s and 1990s, and this led to the deterioration of basic services – including those needed for the prevention and control of HIV/AIDS. It failed to consider the impact of its policies on the poor, who are already vulnerable to HIV, have less access to safe-sex information, are less likely to use condoms and have fewer STI/HIV services. The Bank failed to consider the possibility that its policies would reduce the safety of health systems and become a source of HIV, especially at the periphery of health systems.

In the 1990s, the World Bank failed to adequately invest in the fight against HIV/AIDS and the few investments it did make were ill chosen. For example, World Bank lending for the period 1986-96 was a paltry US$552 million, which was inequitably distributed across regions. Brazil, for instance, a middle-income country with a low prevalence rate (less than one per cent), received US$160 million compared with US$274 million for all of Africa, where some least developed countries, such as Zambia and Lesotho (with prevalence rates of 20 per cent), were largely ignored until 2000. The Bank's own data show that from a public health perspective, less than 25 per cent of its projects met its own criteria for good investment in sexual health interventions. From a public economics perspective, the Bank failed its basic mandate – to provide protection for the poorest groups in society from contracting HIV and its consequences, and to target those most likely to contract and transmit HIV.

Instead of focusing on HIV/AIDS, the World Bank sought improvements in the way goods and services were provided and financed through health sector reforms, such as user fees, privatisation, decentralisation and integration of services. These reforms frequently had the unintended effect of reducing access to effective health care, including services aimed at the prevention and control of HIV/AIDS.

At the heart of the Bank's overall failure to respond adequately to Africa's health challenges over the last two decades is the critique that, rather than relying on public health principles, it operated mainly as a 'bank', with its core business processes and incentives focused on lending money, rather than achieving health impact. It failed to place sufficient emphasis on addressing determinants of health that lie outside the medical care system. Consequently, it focused on HIV/AIDS as a narrow health sector problem, rather than a multi-sectoral problem. No mechanism existed for staff to

discuss and review progress on the HIV/AIDS crisis, or recognise and reward progress on public health investments. Because the Bank typically focused on providing inputs, its monitoring and evaluation systems were too weak to assess performance and alter course. This is key to understanding why misconceived policies and strategies tended to go unchecked while the epidemic spread. This isolation from reality on the ground was exacerbated because the Bank tended not to consult or co-ordinate with other stakeholders. As an institution, it lacked the strategic and flexible approaches needed to support the development of intellectual consensus and broad-based coalitions necessary to tackle HIV/AIDS.

Over the last three years, the Bank has dramatically improved its approach to the HIV/AIDS crisis: increasing resources available; putting emphases on a multi-sectoral approach; working extensively at the community level with local organisations; building up institutional capacity; and developing partnerships with government, community groups and financing partners. Nevertheless, preliminary evaluation of the Bank's US$500 million Multi-Country HIV/AIDS Programme (MAP) for Africa, annual review of its development effectiveness (2003) and comprehensive development framework, show that the institutional weaknesses described in this report persist, and may take years to correct.

This report recommends that the Bank carefully assess its stewardship over the last 15 years. Its acknowledged failure to protect public health spending and basic services, and take proactive steps to protect poor households during its structural operations, has huge implications on the spread of HIV. This is because vulnerable populations lost the access to the health care needed for the prevention and treatment of HIV/AIDS. Furthermore, the link between the decline in quality and safety of health care, and the spread of HIV through the medical system deserves attention.

This report recommends that, as an institution taking leadership on HIV/AIDS, the Bank would benefit from improved levels of accountability and oversight. The establishment of an external supervisory board of independent HIV/AIDS and public health specialists to provide direction and guidance to the World Bank would be a positive step in the right direction. Further recommendations are that the Bank: develops and implements institutional and programmatic mechanisms to ensure that a non-formulaic and multi-sectoral view is taken in all Bank funded HIV/AIDS work, especially MAP; places emphasis on evaluating impact and outcomes of HIV/AIDS initiatives, rather than focusing on inputs; ensures that its HIV/AIDS policies and programming are rooted in a sound poverty reduction strategy, taking into account inequalities within countries and specifically targets poor and vulnerable groups through genuinely involving civil society in decision making processes; "mainstreams" HIV/AIDS into its policy processes and development initiatives; ensures that its HIV/AIDS interventions such as MAP and other poverty reduction initiatives are not undermined by previous (though still influential)and current wider Bank policies, and implements mechanisms to protect poor and vulnerable populations from user fees; promotes the integration of HIV/AIDS services into FP activities services, with the recognition for the additional need for separate HIV/AIDS services that can target at-risk groups not likely to use FP services, such as men, sex workers, and men who have sex with men.

The report recommends that DFID undertake a "bench-marking" review of Bank HIV/AIDS work (particularly through MAP), using a monitoring and evaluation framework similar to that which it has proposed for the Global Fund to Fight AIDS, TB and Malaria. It also recommends that NGOs monitor MAP funding flows to both civil society groups and government, and endeavour to provide feedback on project successes and failures; and that NGOs monitor and make known inconsistencies between overarching or wider Bank policies and MAP aims and objectives.

Introduction

Gideon Mendel/ActionAid

According to UNAIDS,[1] in 2003, more than three million people are estimated to have died from AIDS and another five million became infected with HIV. Sub-Saharan Africa (SSA) accounted for three million of these new infections, and 2.3 million of the AIDS deaths. UNAIDS reports that the breadth of the epidemic in SSA **"indicates that HIV/AIDS has a firm hold on most countries in the region".**[2] In Southern Africa, where 20 per cent of the population is believed infected, the rate of AIDS mortality equals the rate of new infections in several countries, **"creating a cycle of illness and death due in great part to the almost complete absence of large scale HIV prevention or antiretroviral treatment programmes".**[3] More than 20 million Africans are now estimated to have died from AIDS and left 12 million children orphaned.[4]

This paper looks at the response to the HIV/AIDS crisis by the World Bank, as a key member of the international donor/lending community, a leader in the international health community and, as the Bank describes itself, Africa's principal development partner. The World Bank is also the second largest recipient of multilateral funding from the UK government's Department for International Development (DFID). In 2002/03, DFID's contribution to the World Bank amounted to just under £250 million,[5] roughly 17 per cent of DFID's total multilateral expenditure, and equivalent to three quarters of the £336 million reported as total DFID HIV/AIDS expenditure over the same period.[6]

In its seminal document, *Intensifying Action Against HIV/AIDS*, the World Bank acknowledges both its special leadership role in fighting HIV/AIDS, and the need for it to be held accountable for its stewardship. It states that:

"Those who look back on this era will judge our institution in large measure by whether we recognised this wildfire that is raging across Africa for the development threat that it is, and did our utmost to put it out. They will be right to do so."[7]

This paper's purpose is to assess what the Bank did in response to the epidemic, whether it could have done things differently, and given this, what should happen now. It begins by identifying what the Bank appears to have done wrong. First, data describe how the Bank failed to: protect social spending during crisis and adjustment, which led to deterioration and then collapse in basic services; assess the impact of this on the poor; and consider the possibility that this deterioration made the health system itself a source of HIV infection.

Second, investments made by the World Bank that targeted HIV/AIDS and sexually transmitted infections (STIs) in the 1980s and 1990s, are examined both from a public health point of view and a public economics perspective. An analysis of a wide range of documentation from this same period describing the Bank's economic and sector work (ESW) is also reviewed. Third, until recently the World Bank's main priority in the health sector has not been HIV/AIDS, but rather improvement in the way health services are delivered and financed through health sector reforms (HSR). Because of this, data are examined that describe the influence initiatives such as cost recovery, privatisation, integration and decentralisation of service delivery may have had on access to effective health care, including the prevention and control of HIV/AIDS.

The paper then examines why the Bank failed. Failures common to both its reform initiatives and HIV/AIDS investments suggest not only weaknesses in policy and programme, but institutional constraints as well. A discussion follows of the weaknesses that underlie the Bank's failure to: take a multi-sectoral approach to health issues; consult openly and transparently with other stakeholders, including the poor; undertake the adequate economic and sector work needed to develop country-specific responses; and adequately monitor and evaluate (M&E) the impact on system performance and health status. Finally, whether the Bank has learned lessons, and whether its HIV/AIDS programmes are now working, is considered. Limited data are available that directly describe the relevance and effectiveness of the World Bank's HIV/AIDS investments since 2000. This includes an interim report on the Bank's currently operational Multi-Country HIV/AIDS Programme (MAP-I): for Africa, and Country Assistance Strategies (CASs). MAP is the first phase of the Bank's long-term response to the HIV/AIDS epidemic in Africa. In addition, extensive assessment data available from systematic analyses, published in 2003, of World Bank activities in terms of development effectiveness, provide insight into whether the Bank has learnt lessons from the decade.

The paper concludes with recommendations for the World Bank MAP. Recommendations are also given for non-governmental organisations working in the HIV/AIDS area and for DFID.

Section **1**

What the World Bank did wrong i:

Failing the poor [8]

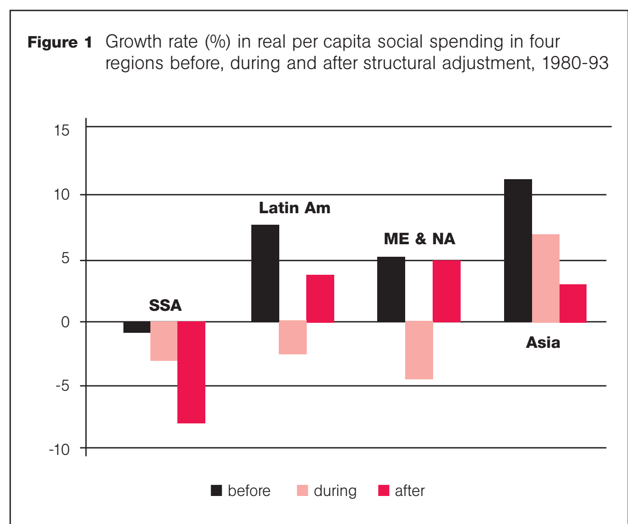
The collapse of public health delivery systems in many developing countries had its roots in the economic crisis of the 1980s and the structural adjustment policies which attempted to deal with the crisis. This collapse had a detrimental impact on such governments' ability to respond to the HIV/AIDS epidemic, as effective prevention and control of HIV/AIDS presume a robust health system. Some evidence suggests that the deterioration of quality health care has reached the point where health systems themselves have become an important source of HIV infection. International financial institutions may bear a large portion of the responsibility for the gap between needs and capacity to respond.

For more than two decades, structural adjustment programmes have been highly contentious, with International Monetary Fund (IMF) and World Bank critics claiming such programmes placed undue burden on the poor. In the 1990s, the World Bank and the IMF made two important concessions to their critics that reversed earlier positions held about structural adjustment. First, social spending did decline in developing countries due to fiscal austerity measures associated with structural adjustment policies, and this was done without protecting (through conditionality) basic services such as primary health care, that tend to benefit the poor. Second, by the end of the 1990s, both institutions acknowledged that they had not taken the proper steps to understand the impact of their policies on the livelihoods of the poor, and that consequently this population suffered disproportionately. This section discusses these two points and shows their relevance to the spread of HIV/AIDS.

1. The Bank failed to protect social spending during crisis and adjustment and this led to deterioration of basic services

In order to assess whether structural adjustment had an adverse effect on public spending on the social sectors, the World Bank's Operations Evaluation Department (OED) evaluated 114 adjustment operations in 53 countries for the period 1980 to 1993.[9] Using what it calls **"the most relevant indicator of the fiscal impact of adjustment"**– per capita social spending – it found that spending fell in 60 per cent of cases and in three of the four country groupings (increasing only in Asia, while declining in the Middle East and North Africa, Latin America and SSA). Reductions in social spending were most severe in SSA, where **"during adjustment"** per capita social spending declined to 76 per cent of 1981 levels, and **"after adjustment"** it declined to 68 per cent of 1981 levels. Figure 1 shows the very large decline in real per capita social spending in four developing regions during adjustment.

Figure 1 Growth rate (%) in real per capita social spending in four regions before, during and after structural adjustment, 1980-93



Source *Data from "Social Dimensions of Adjustment", World Bank, 1996*

"After a decade and a half of structural adjustment, there seem to be too few positive and sustainable results, particularly in sub-Saharan Africa."

During these cuts in social spending, few proactive steps were taken to protect vulnerable populations. In retrospect, the Bank says this was a mistake. For example, it concludes from events in Zambia that:

"Structural adjustment programmes of the 1980s paid little or no attention to the situation in the social sectors...It has been the experience in Zambia that structural adjustment programmes need to address poverty issues directly."[10]

In its analysis of the 114 adjustment operations in 53 countries during the period 1980-93, it reaches similar conclusions: **"Few of the Bank's early adjustment loans provided for safety net programmes. Experience stresses the need for the Bank to deal explicitly with the social dimensions of adjustment."**[11] Did the World Bank follow its own advice? The authors of the Bank's recent *Zambia Country Assistance Evaluation* (CAE) point out that virtually every structural adjustment loan refers to this need to improve social safety nets, yet (with one exception):

"The Bank has not supported direct targeting of households or individuals in Zambia – i.e., social safety net programmes that transfer income to the poor in order to meet basic needs."[12]

Many observers have described the subsequent collapse of basic services and the impact on health status indicators.[13] A recent review of maternal health programmes in 46 countries showed that with only a 56 per cent likelihood that a typical service is adequate, programme and service efforts are seriously deficient.[14] Based on this study, in rural areas only 39 per cent of women had access to effective health care (as opposed to 68 per cent in urban areas). In this respect, regions such as sub-Saharan Africa are significantly worse. In 2003 the World Bank acknowledged that by the late 1990s:

"…concerns were growing about how aid was being used and managed, and about the disappointing impact it was having. The concerns were widespread – at the World Bank and other multilateral agencies, and among bilateral aid agencies, non-governmental organisations (NGOs), and developing country governments. After a decade and a half of structural adjustment, there seem to be too few positive and sustainable results, particularly in sub-Saharan Africa."[15]

2. The Bank failed to consider the impact of its policies on the poor

While cuts in public health expenditure were leading to deterioration of basic services, the World Bank failed to take measures that would have helped it understand the impact their policies were having on the lives of poor and vulnerable people, and enable it to take effective steps to ameliorate these unintended consequences.

In the health sector, little was known about the impact of macro-economic policies on the coping mechanisms of the poor when incomes fall, services collapse or costs of care rise. During the 1980s and 1990s, even the most fundamental questions were not asked. For example: What happens at the household level when care cannot be obtained? Why do households adopt different coping strategies and responses? How does severity of illness influence the responses adopted? What is the trigger or threshold point that forces households into strategies with more serious consequences, such as sale of productive assets or the abandonment of treatment? How do households respond to the combined impact of fees and rising levels of poverty and other economic stress?[16]

"PAs add little to our understanding of poverty or what to do about it, [they are] rather, a reflection of the shortcomings of the Bank's approach."

Liba Taylor/ActionAid

Throughout the 1990s, the World Bank had, by its own account, a poor grasp of poverty and the impact of its policies on the livelihoods of ordinary people.[17] In an attempt to understand 'who' the poor are, why they are poor and what to do about it, it made large investments in most borrowing countries in Poverty Assessments (PA). In a review undertaken in consultation with the World Bank, it was shown that these surveys tended to demonstrate what the World Bank did not know about the poor rather than what it did.[18] By defining poverty by income only, by arbitrarily setting a poverty line, by giving no consideration to household economies of scale and scarcely considering household composition, the resulting conceptual and technical problems meant that **"the PAs add little to our understanding of poverty or what to do about it, [they are] rather, a reflection of the shortcomings of the Bank's approach."**[19]

The decline in social spending, the collapse of basic services, and the failure to take proactive measures to protect vulnerable populations has a direct bearing on the spread of HIV. This is because its prevention and control require a robust system of health service delivery – for example, to inform the citizenry about HIV/AIDS through health education programmes and to treat sexually transmitted infections – a cofactor for the spread of HIV. The interplay between poverty and the epidemic makes the poor especially vulnerable to HIV/AIDS. One analyst points out for instance:

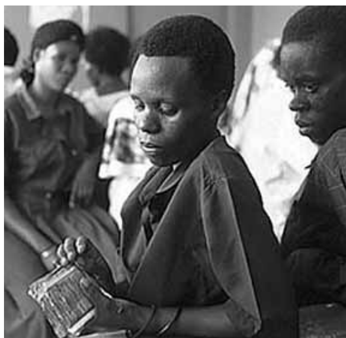
"The decline of health, education, and other social services implies a loss of opportunities for HIV prevention. People with little or no education have poor access to safe-sex information. For instance, condom use is associated with higher levels of education. Reduced provision of quality health services also represents a loss of opportunities to control other sexually-transmitted infections, offer reproductive health services, and provide quality care for people infected with HIV-1."[20]

The collapse of health delivery systems would have hit basic community services hard with respect to treatment of STIs and health education programmes needed for the prevention of HIV transmission.

A study in Mwanza, Tanzania[21] found that only eight per cent of symptomatic sexually transmitted diseases were being cured by the primary health care services and that other st udies in Senegal[22]and South Africa[23] showed that these low cured rates "were not exceptional."

3. The Bank failed to consider the possibility that its policies would reduce the safety of health systems and become a source of HIV

Reduced access to quality health care not only undermines the prevention and control of HIV/AIDS, but the deterioration in certain management functions – such as supervision, monitoring, training and logistics – has made some medical practices unsafe and a source of HIV transmission. In an editorial of The Bulletin of the World Health Organisation focusing on injection safety, the editors wrote that **"as we review the successes and failures in global health at the end of the twentieth century, an alarming pattern emerges suggesting that the 'first do no harm' principle may be being violated on a grand scale as a result of unsafe injection practices".**[24]


Jenny Matthews/Network/ActionAid

"As we review the successes and failures in global health at the end of the twentieth century, an alarming pattern emerges suggesting that the 'first do no harm' principle may be being violated on a grand scale as a result of unsafe injection practices."

Looking at the scale of the problem, another study reviews research into safe injection practices in 19 countries and finds that in 14 of these, at least 50 per cent of injections were unsafe; of the remaining five countries, rates varied between 21 per cent and 30 per cent; three countries had no documented problems. Conservative estimates were based on such information as: **"each syringe was routinely used on three to ten patients before discarding/sterilising".**[25] Another study that sought to estimate the contribution of unsafe injections to the transmission of HIV suggests that 80,000-160,000 infections may result annually – possibly two million infections over the last 14 years.[26]

However, more recently, an important review of existing research claimed that the conventional view that two per cent of HIV transmission is due to unsafe injection practices is an underestimation of the problem, and that in fact, HIV is more likely to be spread through unsafe medical practice than unsafe sex – the latter it claimed might only explain 33 per cent of transmissions.[27] It is rightly pointed out that over the last 20 years, investigations into iatrogenic[i] transmission have disappeared from the HIV research agenda,[28] while existing evidence suggesting that exposure to medical care may be an important source of HIV transmission in developing countries, has been largely ignored. At a meeting held by the World Health Organisation (WHO) and UNAIDS to discuss these controversial findings with the researchers, modeling techniques tended to undermine the new findings:

"The prevailing view was that sexual transmission was responsible for the large majority of HIV infections", although it was agreed **"better data on the possible role of unsafe injections, and other health care practices, in HIV transmission are needed to more definitively determine their role in HIV transmission".**[29] While these new data overstate the iatrogenic effect of 'sharps' on HIV transmission, nevertheless, an accepted view is that in the poorest countries – particularly at the periphery where health spending cutbacks have led to deterioration in supervision, monitoring, training and logistics – unsafe medical practices are an important source of HIV transmission. This, of course, has implications for the World Bank, which failed to take adequate measures to protect access to effective health care by the poor in the 1980s and 1990s.

[i] Iatrogenic (from the Greek, iatros = physician; genic = induced), commonly means adverse affect associated with practitioner, treatment or medical system.

Section 2

What the World Bank did wrong ii:

HIV/AIDS and sexual health projects

The World Bank has been assisting governments in the fight against HIV/AIDS since 1986, through freestanding HIV/AIDS-focused projects and projects with an HIV/AIDS component. This section reviews data produced by the World Bank OED that describe the effectiveness and relevance of investments that targeted HIV/AIDS and sexually transmitted infections in the 1980s and 1990s – first from a public health point of view, and then from a public economics perspective.

1. Public Health Perspective[30]

Evaluation of the World Bank's Health, Nutrition and Population (HNP) portfolio from a public health point of view looks at its investment in "the best buys in public health and clinical services" for the period 1993-99, using the widely understood criteria of effectiveness, affordability, quality and relevance to the health status of the poor. The best buys for HIV/AIDS prevention were identified as education on safe behaviour, condom promotion, STI treatment, and safe blood supply. For the treatment of STIs, they were case management using syndromic diagnosis and standard treatment algorithm.[ii] Results of analysis of HIV/AIDS investments show that of the total 152 HNP projects undertaken, 44 (29 per cent) addressed HIV/AIDS, out of which only 10 (23 per cent) met the quality criteria of "best buys". For STIs, 51 of the 152 HNP projects (34 per cent) supported STI treatment of which only seven (14 per cent) met the criteria for best buys. Possibly more worrying is the finding that, while the World Bank acknowledges that HIV/AIDS is a multi-sectoral problem and opportunities existed for interventions in other sectors, there is little evidence that this occurred.

2. Public Economics Perspective[31]

From a public economics perspective there are two reasons why the World Bank supports government intervention in HIV/AIDS: to maximise total social well-being, and to promote a more equitable distribution of well-being among social groups. An analysis of the World Bank's HIV/AIDS activities between 1986 and 1996 looks at 10 stand-alone HIV projects, 51 projects with an HIV component in 27 countries, and a wide range of documentation that describes the Bank's economic and sector work. In addition to "information collection", the World Bank identified two priority areas for government support:

1. promotion of safer behaviour among those most likely to contract and transmit HIV; and
2. protection for the poorest groups in society from contracting HIV.

The study found that while all 10 of the stand alone HIV/AIDS projects financed surveillance of HIV and other STIs,

"only a few had indicated a plan to focus these activities on the population groups most at risk in the country".[32]

About 60 per cent of the 51 projects contracted NGOs to provide outreach services to high-risk groups, but

"there is very limited discussion of how these groups had been identified or what additional information was needed to reach them effectively".[33]

Only four of the 10 projects supported condom promotion programmes targeted to high-risk groups. While all 10 financed STI treatment, only one explicitly

[ii] When someone is infected with a sexually transmitted disease (STD) they are more likely to become infected with HIV through sexual contact. Proper treatment of STDs can reduce HIV transmission, and therefore AIDS, by nearly one half. The syndromic approach to STDs is a simple, rapid, effective way of diagnosing and treating clients who show signs of having one or more STDs. STDs are treated with drugs at the primary level of care without costly laboratory tests or referral.

Liba Taylor/ActionAid

Brazil, for example, a middle-income country with a low prevalence rate (less than one per cent), received US$160 million compared with US$274 million for all of Africa, where some countries, such as Zambia (with a prevalence rate of 20 per cent), were ignored until 2000.

planned to focus these services on those most at risk. In terms of the poor, only one project provided support for efforts to protect the poorest groups in society from HIV infection, or for programmes to mitigate the negative consequences of HIV/AIDS among those groups. Most of the projects were not based on strong economic analysis. The 51 projects with an HIV/AIDS component largely ignored any ex-ante economic analysis of the proposed AIDS interventions. While the freestanding HIV/AIDS projects included some ex-ante economic analysis, only three prepared an adequate cost-benefit analysis. Ex-post evaluations were only available for four of the eight completed projects, only one of which was classified as "satisfactory". The OED provides some regional and country expenditure data on HIV/AIDS. However, none of these adequately explain the low levels of World Bank lending (US$552 million over 11 years) and its inequitable distribution across regions. Brazil, for example, a middle-income country with a low prevalence rate (less than one per cent), received US$160 million compared with US$274 million for all of Africa, where some countries, such as Zambia (with a prevalence rate of 20 per cent), were ignored until 2000.

Section 3

What the World Bank did wrong iii: promoting reform instead of services

At about the same time the World Bank began making HIV/AIDS investments (1986), it embarked upon its main policy priority of the next decade: reform of health service delivery systems. Through improvements in the way goods and services were provided and financed, it sought to address the low supply-low utilisation paradigm that typified most service delivery systems in Africa – the result of prolonged cuts in public health spending in the 1980s. The following paragraphs look at the impact these reforms may have had on access to services needed for the prevention and care of HIV/AIDS.

1. User fees

The World Bank (1987[34], 1993[35]) recommended user fees as a means to put the health sector on a more sustainable footing. For reasons of equity and public health, it is widely understood that the poor and certain health services[iii] should be exempt from these charges. In terms of equity, the World Bank's own data show that in the 1990s, while

"asserting that the poor should be protected from fee increases, the Bank has often failed to propose administratively feasible methods to protect the poor".[36]

In terms of public health priorities, there is no evidence that HIV-related services somehow escaped the imposition of user fees: even key services aimed at the prevention and control of HIV/AIDS including the diagnosis and treatment of STIs,[37,38] blood transfusion schemes,[39] and voluntary HIV/AIDS counselling and testing (VCT),[40] are sometimes considered as legitimate targets for cost recovery. Early research in Kenya showed that after the implementation of user fees at STI referral services, the average monthly attendance of men decreased significantly to 64 per cent of the pre-user-charge level.[41] Although there is a scarcity of other research into the impact of fees on the use of STI clinics and related goods and services (a concern in itself), numerous studies draw attention to the prevalence of charges at STI clinics and their detrimental effect. For example, a WHO review of integrating STI management into family planning services found that: **"several projects reported that consumer fees were introduced to pay for services and drugs…Often this led to a significant drop in clinic attendance as services became unaffordable."** [42] Elsewhere, a WHO review of adolescent-friendly health services found that for reproductive health care aimed mainly at HIV testing, STIs and pregnancy, 42 per cent of adolescents were put off by user fees that were too high.[43] Another study of integrating STI/HIV services into existing family planning (FP) services found that caseloads decreased because consumer fees were introduced to cover drug costs.[44] A WHO/UNAIDS paper on developing HIV/AIDS surveillance systems at sentinel sites warns that site populations may not be representative of the general population, because the introduction of user fees may dissuade poor women from using services.[45] In Zimbabwe the OED cites the implementation of cost recovery and waiver systems as an example of the World Bank doing "the right thing" but "the wrong way".[46]

2. Privatisation

The encouragement of privatisation of health care by the World Bank is another reform policy designed to address the low supply of quality health care seen in many African countries where public health infrastructure is limited. An extensive body of research describes large deficiencies in the quality of private

[iii] Including sexual health provision, emergency services and basic services aimed at young children such as immunisation.

Jenny Matthews/Network/ActionAid

"In practice, World Bank OED data show that the Bank promoted decentralisation without sufficient regard for the administrative or political implications, or without giving the necessary attention to determining what responsibilities should be devolved."

sector STI management, particularly at the more informal end of the range of providers.[47,48,49,50] One study in Mwanza, Tanzania, for example, noted that only about eight to ten per cent of patients were receiving effective diagnosis and treatment of STIs. Privatisation is sharply criticised because it was introduced without concurrent improvements in regulation, better implementation of existing regulation, and training.[51] Even if effective treatment was available, according to the WHO the public health implications are enormous if a comprehensive approach is not taken, including: treatment of partners, recommending counselling, testing, condom use and so forth.[52] In reality, **"the private sector generally focuses on the treatment of symptoms. The World Bank OED finds that private providers have few incentives to provide preventive care,"** and that **"the Bank has neglected these issues in its projects and policy dialogue."**[53]

3. Integration

The horizontal integration of vertical programmes was another key component of the World Bank's 1993 package designed to address systemic constraints and improve economic efficiency. OED data suggest that, in view of the epidemic, this reform initiative may have been fundamentally inappropriate because HIV/AIDS

"called for an intensive, emergency campaign at a time when disease specific vertical programmes were being dismantled in favour of integrated care."[54]

It led to recommendations for the integration of HIV/STI programmes with FP at the 1994 International Conference on Population and Development (ICPD). The idea was that multifunctional workers would provide – in addition to family planning services – counselling and behaviour change communication, and attend clinical procedures and the delivery of medications and commodities. Doubts were raised from the outset about how realistic integration plans were, given the financial, administrative and technical constraints typical of most African countries.[55,56] A review of cross-country data from studies undertaken in Ghana, Kenya, Zambia and South Africa, shows that combining these services with FP was misconceived, because they are used mainly by married women – not other groups that are particularly vulnerable to HIV infection.[57] A review of concrete experiences with integrated services based on consultations with 62 key informants, shows that integration does not lead to increased access to STI care via cross-utilisation of services.[58] Another study reached similar conclusions, arguing that the delivery and management of HIV/STI and FP may simply not be operationally compatible and, because in many African settings men are disinclined to use what are perceived to be female reproductive health services, integration was unworkable.[59] Many researchers, dismayed by these results, draw attention to the need for better consultation with those who are to implement and provide integrated services[60] and greater emphasis on country-specific and multi-dimensional frameworks.[61,62]

4. Decentralisation

As a mainstay of health sector reform, decentralisation (or devolution of responsibilities from the centre to the local level) can support HIV/STI health care by improving community participation, ownership, resource allocation and overall efficiency.[63] In practice, World Bank OED data show that the Bank

"promoted decentralisation without sufficient regard for the administrative or political implications, or without giving the necessary attention to determining what responsibilities should be devolved".[64]

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Analyses indicate that in Ghana, Kenya, Zambia, and generally throughout Africa, poor management and low capacity led to the confusion of responsibilities and deterioration of services. Frequently, a lack of general capacity at the local level to manage reproductive health care, and a reluctance at the central level to transfer power to the localities, undermined decentralisation.[65,66] The OED reports that

"the Bank has tended to underestimate the training and technical support needed to help districts undertake their new responsibilities".[67]

An assessment in Tanzania examined HIV/AIDS commodity needs and logistics capacity and found that the decentralisation of responsibilities for the management and the provision of HIV/AIDS health services to the districts increased the workload beyond existing human resource capacity. The assessment also found that quality of care was undermined by inadequate training, monitoring and supervision, to the point that health workers were unable to "protect themselves and patients from the risk of infection" and were actually contributing "to the spread of the infectious disease."[68] Although overstated, the WHO[69] and other data[70] show that the health system itself has become an important source of HIV transmission. This is the logical outcome of prolonged cuts in public health spending, and the chaos associated with poorly planned and implemented decentralisation and other reform strategies.

In summary, the Bank, by its own account, was not very effective in fulfilling its new role of promoting health sector reforms. The OED states that

"the Bank may have been excessive in its encouragement of overly ambitious reforms" and that **"the Bank is doing more of what it has done least well in the past".** It reports that:

"the Bank has been more successful at expanding health service delivery systems than in improving service quality and efficiency or promoting institutional change. The Bank is often better at specifying what practices need to be changed than how to change them or why change is difficult."[71]

For example, in SSA in the 1990s, the OED reports that **"only 10 per cent of [HNP] projects and only five per cent in the area of basic health had a substantial impact on institutional development".**[72]

However, what is particularly striking about these findings is that from the outset data were available showing that: user fees reduced utilisation of STI services; integrated STI and FP services were not capturing high risk groups; unfettered privatisation meant ineffective diagnosis and treatment of STIs; and, poorly planned and resourced decentralisation measures reduced access to HIV/AIDS commodities and services. Moreover, data shows that poor households with little or no education – already more vulnerable to HIV – were less likely to use condoms and had fewer services needed for the prevention and control of HIV/STI. This group was losing a disproportionate share of access as services retracted from the periphery and user charges became commonplace. Such data were largely ignored. These points raise questions not only as to why poorly conceived reforms would have been recommended in the first place, but more disturbingly, why immediate measures were not taken to modify or adjust reforms once their negative effects became evident.

Section

4 Why did the Bank fail?

When analytic data describing World Bank-financed HIV/AIDS projects are considered together with assessments of health sector reform initiatives, a particularly notable finding is that the weaknesses of the two seem to mirror one another. In terms of outputs, for example, in the same way that the Bank's HIV/AIDS activities were not aimed at populations most at risk for infection, integration of reproductive health services based on the Bank's 1993 formula also failed to reach the main transmitters of HIV. Similarly, Bank data showing that its HIV/AIDS investments did not provide protection and support for the poorest groups in society, resonate with data showing that privatisation, user fees and the chaos associated with decentralisation, hit the poor's access to effective health care. These 'mirrored' weaknesses suggest not only flawed policy and programme initiatives, but also institutional constraints that may have rendered the World Bank incapable of responding to the challenge of the HIV epidemic in a timely and robust manner.

One set of institutional factors that may underlie misconceived policies and strategies relates to the critique that the World Bank's agenda is driven by ideological, political and economic factors, rather than public health principles: the Bank has focused attention on cost-effectiveness and efficiency associated with a narrow definition of health as the absence of disease, and fails to take into account **"broader policy objectives concerned with better health through democratic devolution and inter-sectoral activity".**[73] Data already presented supports the notion that the Bank takes a narrow view of health and public health problems. OED data show, for example, "little evidence" that the Bank took the opportunity to treat HIV/AIDS as a multi-sectoral problem between the years 1993 and 1999.[74]

This is consistent with OED assessment data on a full range of activities in the health sector, showing that as a rule, the Bank **"has not placed sufficient emphasis on addressing determinants of health that lie outside the medical care system including behavioural change and cross-sectoral interventions".**[75]

This assessment notes that **"case studies and portfolio review found that the Bank investments and policy advice tend to focus on the medical care system while greater aggregate health improvements may be achieved through health education and behavioural change or through inter-sectoral interventions such as water and sanitation."**[76]

More worrying is the finding that the Bank was not capable of generating a multi-sectoral approach because **"the incentives and mechanisms for inter-sectoral approaches are weak both within the Bank and in borrower governments".**[77]

Another set of factors partially explaining why policies and strategies were misconceived – as well as why they have tended to endure – is the lack of dialogue, good communication and consultation between the World Bank and other stakeholders. A study that analyses in detail the lack of dialogue between reformers and interventionists in their efforts to combine reproductive health and HIV/STI services and what to do about it, notes that

"to some extent the constraints on dialogue arise from basic differences between disciplines i.e., cost-centred efficiency and management driven systems versus concepts of equitable health for all. They also arise from the differential involvement and acceptance of groups at the level of policy influence, differences in global and national policy-making contexts and weak institutional frameworks that impede dialogue and linkage."[78]

The OED reports that the Bank lacks **"strategic and flexible approaches to support the development of intellectual consensus and broad-based coalitions necessary for change".**[79] Both the success of HIV/AIDS and reform initiatives depends on stakeholders outside ministries of health.

"Activities supported by the Bank have not been well focused on the groups in the population most at risk for HIV infection."

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The OED reports that

"in practice the Bank has primarily focused on dialogue with government officials, particularly within ministries of health, without taking advantage of its convening role to build consensus among stakeholders… In addition, the Bank has frequently failed to develop sufficient understanding to anticipate responses to reform, including which measures are likely to be adopted, which may be resisted, and possible changes in content that may be made in the course of policy debate and implementation." [80]

An aspect of inadequate consultation and dialogue by the Bank with other stakeholders that has received substantial attention is the lack of inclusion and participation by the poor and vulnerable in the formulation of policy and its implementation. Descriptive data from the OED show that

"activities supported by the Bank have not been well focused on the groups in the population most at risk for HIV infection", [81] while efforts to integrate HIV/AIDS services with reproductive health based on the Bank's 1993 formula, also failed to reach **"the main infection transmitters – men and sexually active unmarried women".** [82] Because the Bank seldom involves poor and vulnerable people in policy or programme formulation, or takes into account beneficiaries' perceptions of health services, or how these services relate to their daily lives, or even whether they use them or not, policies and strategies may often be lacking precisely what is needed to make them effective and relevant. The OED reports that

"notably lacking in most Bank analysis is an adequate assessment of demand for services. [Only] a minority of design and completion projects provides basic data on current levels of service utilisation (in both public and private sectors) or consumer satisfaction. Overall, only 40 per cent of all project design documents provided evidence on consumer demand and only two per cent estimated consumer response to the proposed intervention. Although beneficiary surveys and consultations have become more common, only 4 of 224 projects documented the presence of beneficiary decision making power in project design." [83]

Elsewhere, the OED points out that from an institutional perspective, there is a need by the Bank to **"reduce constraints and improve institutional support for participation".** [84] In terms of consulting with NGOs, beneficiaries' interest groups and civil society generally in the formulation and implementation of policy and strategies, the Bank reports that it **"is still in a tentative, experimental mode in actively seeking their increased involvement".** [85]

These findings suggest that for nearly a decade integrated HIV/STI services were in many cases unnecessarily reaching the wrong target population for want of better dialogue.

The quality of Bank policies and strategies is also undermined by failure to encourage inclusion of, and consultation with, the poor. The impact of HIV/AIDS is greater on the poor **"who are less educated about prevention and more vulnerable to rising health care costs and loss of income".** [86] OED data showing that the Bank's HIV/AIDS investments failed to provide **"protection for the poorest groups in society from contracting HIV and support to mitigate the negative consequences of HIV/AIDS among those groups"** [87] resonate with data presented previously, showing that ineffective reform policies may reduce the poor's access to effective health care. The OED reports that

"although the Bank usually focuses on poor regions, or diseases that most affect the poor, it has been weaker in analysing the factors that lead to ill health among the poor and in selecting interventions that are likely to achieve the maximum impact on their overall disease burden". [88]

In fact, data presented in Section Two showing that the Bank made few serious efforts at protecting low-income households from the unintended consequences of stabilisation and adjustment programmes, are somehow consistent with OED data showing the Bank's lack of sincerity towards the poor in the design of HNP projects. The OED reports that

"project design documents typically describe the disease burden, list project activities and then assert that significant improvements in health outcomes will be achieved. Design documents seldom present a coherent analysis of how project interventions will translate into improved health outcomes for the poor"[89] – a finding that contributes to the overall impression that the Bank's pro-poor stance is largely rhetorical.

Another set of factors that would have led to misconceived policies and strategies is that Bank initiatives tend to be formulaic and not tailored to local situations. The perception that the Bank's 1993 prescription for HSR is a "packaged" one-size-fits-all approach and not "country-specific" strikes a chord with the OED finding that

"few of the HIV/AIDS Bank projects base support for interventions explicitly on the principles of public economics or have relied on sound economic analysis in ex-ante or ex-post evaluation".[90] The OED reports that: **"Bank policy advice and reform strategy are too often insufficiently grounded in empirical evidence or institutional analysis of the country context. The Bank has been better at specifying what needs to be done rather than why problems persist and how to address them. As a result the Bank has a tendency to promote standard solutions to health system problems without giving sufficient attention to local institutions or details of implementation."**[91]

Further, it reports that **"resources for economic and sector work have declined in the past five years relative to the lending portfolio. This has placed the Bank in the position of embarking on ambitious sector reforms in many countries without first establishing a strong empirical foundation to guide the process".**[92]

In addition to this formulaic approach and poor communication by the Bank with other stakeholders, several other factors help explain why immediate measures were not taken to modify or adjust poorly conceived policies and strategies. One key factor is the failure by the Bank to monitor and evaluate outcomes and maintain a consistent process. The OED reports that

"the Bank typically focuses on providing inputs rather than clearly defining and monitoring progress towards HNP development objectives. Because of weak incentives and underdeveloped systems for monitoring and evaluation (M&E), both within the Bank and borrowing governments, there is little evidence regarding the impact of Bank investments on system performance or health outcomes. The Bank, therefore, has not used its lending portfolio to systematically collect evidence on what works, what does not, and why. Methodological challenges can make it difficult to conclusively link project interventions with changes in HNP outcome and system performance. Yet, experience shows that effective M&E design – including the selection of a limited number of appropriate indicators, attention to responsibilities and capacity for data collection and analysis – enhances the focus on results and increases the likelihood of achieving developmental impact" – a startling admission that would have had enormous implications for investments aimed at the prevention of HIV/AIDS.[93]

"Because of weak incentives and underdeveloped systems for monitoring and evaluation (M&E), both within the Bank and borrowing governments, there is little evidence regarding the impact of Bank investments on system performance or health outcomes. The Bank, therefore, has not used its lending portfolio to systematically collect evidence on what works, what does not, and why."

However, a factor contributing to the endurance of badly conceived policies that seems to underlie all others, is the hard-to-prove but oft heard critique that the World Bank is first and foremost a "bank" that measures its success by its disbursements. Remarkably, the OED reports that throughout the 1990s, the Bank's **"core business processes and incentives remained focused on lending money rather than achieving impact. Forums for staff to discuss and review progress towards development objectives, or recognise and reward evidence of HNP development impact, are lacking. Staff still perceived that rewards were linked primarily to project approval and disbursement."** [94]

Furthermore, **"low priority is given to M&E by Bank management and there is little incentive for staff to become involved. Many staff report that their managers rarely express interest in reviewing developmental progress."** [95] This assessment suggests that, not only was the Bank constrained by institutional weakness that led to policies and strategies that may not have been helpful in the fight against HIV/AIDS, but it was directed by an ethos that lacked the wherewithal to take on board the public health threat posed by HIV/AIDS.

Section 5

Has the Bank learned the lessons?

Given its enormous policy and financial leverage in the region, the World Bank might have easily met the challenge of the HIV/AIDS crisis in Africa had it not been encumbered by the institutional weakness described above. In 1998, key epidemiologists and demographers from the international health community confronted the World Bank in a two-day meeting in Washington, with detailed evidence on the nature and extent of the epidemic. This led the next year to publication by the Bank of its seminal document, *Intensifying Action Against HIVAIDS in Africa: Responding to a Developmental Crisis.*[96] It declared that the epidemic was the main development challenge facing Africa today and that it intended to launch a radically new and intensified response. Built on the four pillars of knowledge management, advocacy, resource development and mainstreaming/capacity building, the World Bank committed itself to doing "business unusual", by greatly increasing resources available, placing emphases on a multi-sectoral approach, working extensively at the community level with local organisations, building up institutional capacity and developing partnerships with government, community organisations and financing partners. Other initiatives such as PRSPs, the Millennium Development Goals (MDGs) and the Bank's own Comprehensive Development Framework (CDF), have helped place HIV/AIDS, in all its aspects, at the top of the international agenda.

An important part of the World Bank's response to the epidemic is the Multi-Country HIV/AIDS Programmes for Africa. With nearly US$1 billion committed to 24 countries, MAP represents the first phase of a long-term World Bank plan to fight HIV/AIDS in Africa. The Bank describes it as **"unprecedented in design and flexibility", with its emphasis on "speed, scaling-up existing programmes, building capacity, 'learning by doing' and continuous project rework".**[97] It relies upon immediate monitoring and evaluation of programmes to determine which activities are efficient and effective and would benefit from capacity building.

1. Are Bank HIV/AIDS projects now working?

A progress report of MAP I undertaken in June/July 2001, covering the period September 2000 to July 2001, showed that the approach was indeed bold and innovative and described factors that made programmes successful.[98] However, it also identified several constraints, many of which have been previously described. The report found, perhaps predictably, that **"most MAP projects have not yet started systematic programmes building capacity"**[99] and that **"Task Team Leaders and Managers in the Bank substantially underestimate the complexity and scope of the supervision effort needed".**[100] More worrying though is the finding that there is **"insufficient partnership or evidence of co-ordinated collective action among key multilateral, bilateral and the UN Theme Group".**[101] It also found **"limited sharing of lessons and experiences among both Bank staff and counterpart teams alike".**[102] It concluded that in view of the fact that **"'learning by doing' underlies the entire approach, a more effective means of sharing MAP experiences is critical".**[103] It found that **"MAP projects did not have appropriately designed M&E."**[104] It warned that since the scaling up of existing programmes is a key objective, **"early and comprehensive results from M&E are critical to determine which programmes are successful".**[105]

Few other data describe the relevance and effectiveness of the World Bank's investments since 1999. Its OED has established a special HIV/AIDS unit focused on the Bank's HIV/AIDS assistance at the country level, the purpose of which is to assess the effectiveness of its investments and distil lessons to be learned. Assessments of HIV/AIDS projects have been completed in Kenya[106] and India[107] and are forthcoming in Cambodia, Zimbabwe, Chad and Brazil. But thus far, they do not provide data on projects initiated since 1999.

2. Have the Bank's institutional weaknesses been resolved?

Extensive assessment data on World Bank activities are available from systematic analyses done by the Bank in 2003, including: *the Annual Review of Development Effectiveness*[108] (ARDE); *Toward Country-Led Development: A Multi-Partner Evaluation of Country Development Framework,*[109] and *Strategy Sharing: Innovations and Remaining Challenges.*[110] These data describe institutional factors that influence the effectiveness and relevance of World Bank programmes, some of which are disquieting in that they are repetitions of the very weaknesses that undermined HIV/AIDS investments in the 1990s. They include:

a. Multi-sectoral approaches to development

According to ARDE, the Millennium Development Goals' (MDGs) focus on outcomes rather than inputs and outputs has drawn the Bank's attention to the multi-sectoral determinants of outcomes. The Bank, however, has not advanced much further than this. ARDE reports that **"Bank programmes need now to take the next step of developing and implementing cross-sectoral strategies. [This] will require that the country and sector units co-operate to design and implement outcome-based, cross-sectoral country strategies. A more effective institutional mechanism is needed to foster the design and implementation of cross-sectoral strategies to deliver specific development outcomes."**[111] The CDF Synthesis Report recommends that **"a conscious effort is needed to reform organisational arrangements that discourage cross-sectoral collaboration and to develop more effective institutional mechanisms for designing and implementing cross-sectoral programmes".**[112]

b. Country-specific solutions

OED evaluations show that throughout the 1990s the Bank tended to promote standard solutions, rather than undertaking adequate economic and sector work to support a coherent CAS tailored to the country situation. This remains a problem. According to ARDE, global MDG targets (such as stopping and reversing HIV/AIDS trends) **"must be localised".**[113] **"The Bank needs to develop more coherent CASs grounded in specific objectives and national targets and based on a realistic assessment of capacity and resources, and to monitor progress systematically."**[114] It stressed that better analytical work was needed to strengthen both the Bank's country and sector programmes. The OED's evaluation of the Bank's efforts to make itself the "knowledge bank" noted that while its partners described Bank technical information as unrivalled, they **"were often critical of the Bank's ability to provide information that is realistic in light of local circumstances and responsive to local needs. Many insisted that technical soundness is meaningless apart from applicability to the local context."**[115]

c. Monitoring and Evaluation

The finding that HIV/AIDS investments were undermined in the 1990s by the Bank's failure to **"systematically collect evidence on what works, what does not, and why"** continues to undermine programmes. ARDE reports on a series of studies that identify serious weakness in M&E. It reports that **"Bank analysis confirms that monitoring and evaluation remains one of the weakest areas of CAS".** It notes that while there have been improvements, **"only about 40 per cent of recent CAS are satisfactory or better; about 50 per cent do not contain core targets; and about 60 per cent do not distinguish between country and Bank performance targets."** Recent initiatives to

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"The lack of access to adequate poverty data remains an issue and has been noted in many CASs."

improve M&E are likely to improve the situation, but **"cannot be expected to bear fruit easily or swiftly".**[116] Similarly, the CDF evaluation draws attention to the need to enhance Bank capacity to track and analyse implementation and impact.

d. Poverty Data

Failure by HIV/STI investments to target or consult with the poor reduced the effectiveness of programmes. ARDE reports that **"poverty-related analytical work underlying country programmes needs strengthening. The analysis, data and projections that underpin the Bank's programmes could be further improved. Quality Assurance Group (QAG) reviews of economic and sector work confirm that there is room to enhance the quality of the Bank's ESW relating to poverty reduction strategies, poverty-related analysis to poor policy environments and, to fiduciary issues… The lack of access to adequate poverty data remains an issue and has been noted in many CASs."** [117]

While initiatives such as the PRSPs, the MDGs and the Bank's CDF have helped place HIV/AIDS at the top of the international agenda and improve the quality of programmes, it is clear that institutional weaknesses need to be addressed and that they will take time. In the meantime, WHO and UNAIDS are reporting that 40 million people are infected with HIV and that 8,000 people are dying each day.[118] At the end of 2003, one indicator of the quality of the international community's response to the crisis is its failure to provide access to antiretroviral (ARV) drugs to those who need it most. With fewer than 300,000 being treated globally in developing countries, and only 50,000 in sub-Saharan Africa where most of those infected live, this crisis represents a global health emergency.[119] The data presented in this paper suggest that as an institution taking the leadership on HIV/AIDS, the World Bank would benefit from improved levels of accountability and oversight. The relevance to the UK, and in particular DFID, is reflected in the fact that DFID has contributed over £1.3 billion to the World Bank since 1997. [120, 121] Establishment of an external supervisory board of independent HIV/AIDS and public health specialists to provide direction and guidance to the World Bank would be a positive step in the right direction. The prospect of an organisation that does not yet have the institutional arrangements to ensure a multi-dimensional approach to its prevention and control, systematically track what works and doesn't work, and undertake adequate ESW to ensure the relevance of its programmes – effectively addressing the epidemic without outside, independent guidance – seems unlikely. The World Bank should take the opportunity to increase the effectiveness and relevance of its HIV/AIDS initiatives by welcoming outside and independent professional support.

Recommendations

1. World Bank

As mentioned previously, the World Bank could benefit from the establishment of an external supervisory board of independent HIV/AIDS and public health specialists. Further recommendations are:

- That the Bank develops and implements institutional and programmatic mechanisms to ensure that a non-formulaic and multi-sectoral view is taken in all Bank funded HIV/AIDS work, especially MAP. Such a view should recognise that successful HIV/AIDS interventions take into account local capacities and cultural contexts.
- That the Bank places emphasis on evaluating impact and outcomes of HIV/AIDS initiatives, rather than focusing on inputs. The scale of the epidemic necessitates a swift, informed response that effectively incorporates lessons learned from previous work.
- That the Bank ensures that its HIV/AIDS policies and programming are rooted in a sound poverty reduction strategy. The synergistic relationship between HIV/AIDS and poverty requires that Bank HIV/AIDS funding takes into account inequalities within countries and specifically targets poor and vulnerable groups. Such targeting should be supported through genuinely involving civil society, in particular the poor and those living with HIV/AIDS, in decision making processes.
- That the Bank, through further development of institutional mechanisms, "mainstreams" HIV/AIDS into its policy processes and development initiatives. Consideration and documentation of the potential impact on the epidemic should form an integral component in the development and implementation of all Bank policies and projects.
- That the Bank ensures that Bank HIV/AIDS interventions such as MAP and other poverty reduction initiatives are not undermined by previous (though still influential) and current wider Bank policies. For example:
    - The Bank could work with funding recipient countries to develop and implement administratively feasible mechanisms to ensure that poor and vulnerable populations accessing HIV/AIDS-related services are protected from user fees.
    - Promotion of the integration of HIV/AIDS services into FP activities services with the recognition for the additional need for separate HIV/AIDS services that can target at-risk groups not likely to use FP services, such as men, sex workers, and men who have sex with men.

2. DFID

- That DFID, given that the World Bank is the second largest recipient of DFID multilateral funding, undertake a "bench-marking" review of World Bank HIV/AIDS work (particularly through MAP), using a monitoring and evaluation framework similar to that which it has proposed for the Global Fund to Fight AIDS, TB and Malaria.

3. Civil Society

- That NGOs monitor MAP funding flows to both civil society groups and government, and endeavor to provide feedback on project successes and failures.
- That NGOs monitor and make known inconsistencies between overarching or wider Bank policies and MAP aims and objectives.

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