Global health

The World Bank and sub-Saharan Africa's HIV/AIDS crisis

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Between the early 1980s and 2000 the prevalence rate of HIV infection in sub-Saharan Africa increased from less than 1% to 12%,[1] as illustrated in the prevalence maps in Fig. 1. This represents an increase in the number of people living with HIV infection from less than 1 million to 22 million.[1] During this period, neither African governments nor the international donor community sufficiently prioritized HIV/AIDS or allocated adequate resources to help prevent and control its spread. In sub-Saharan Africa, the total amount of official development assistance actually declined in the 1990s, to about $3 per HIV-infected person by 1999.[3] By this time, the international donor community had begun to focus on the HIV/AIDS pandemic and in 2000 began to send billions of dollars to sub-Saharan Africa to tackle the crisis. These investments appear to have had a positive effect: between 2000 and December 2005, HIV prevalence rates among adults were reported to have decreased in more than two-thirds of the countries in sub-Saharan Africa, falling from a mean rate of 10% to 7.5%.[1]

Although ultimate responsibility for responding to the HIV/AIDS crisis in a timely and effective manner rests with African governments, in reality it was the international donor community that determined Africa's health priorities, agendas and strategies over the last 40 years.[4] It typically contributed about 20% of the funds needed to cover public health expenditures, and sometimes up to 30%–80% in the poorest countries.[5] The World Bank was the pivotal player in the international donor community in the 1990s. With a general mandate to reduce poverty and improve living standards, and a remit to promote access to essential services in the health sector, the World Bank exercised enormous fiscal and policy leverage over governments and the other members of the donor community. This influence was due to the fact that (a) the World Bank was sub-Saharan Africa's main development partner; (b) it was the lead donor in terms of finance and policy in Africa's health sector; (c) it often acted as the "umbrella funder," designing and implementing integrated health strategies to which other donors would contribute; (d) it attached "con-

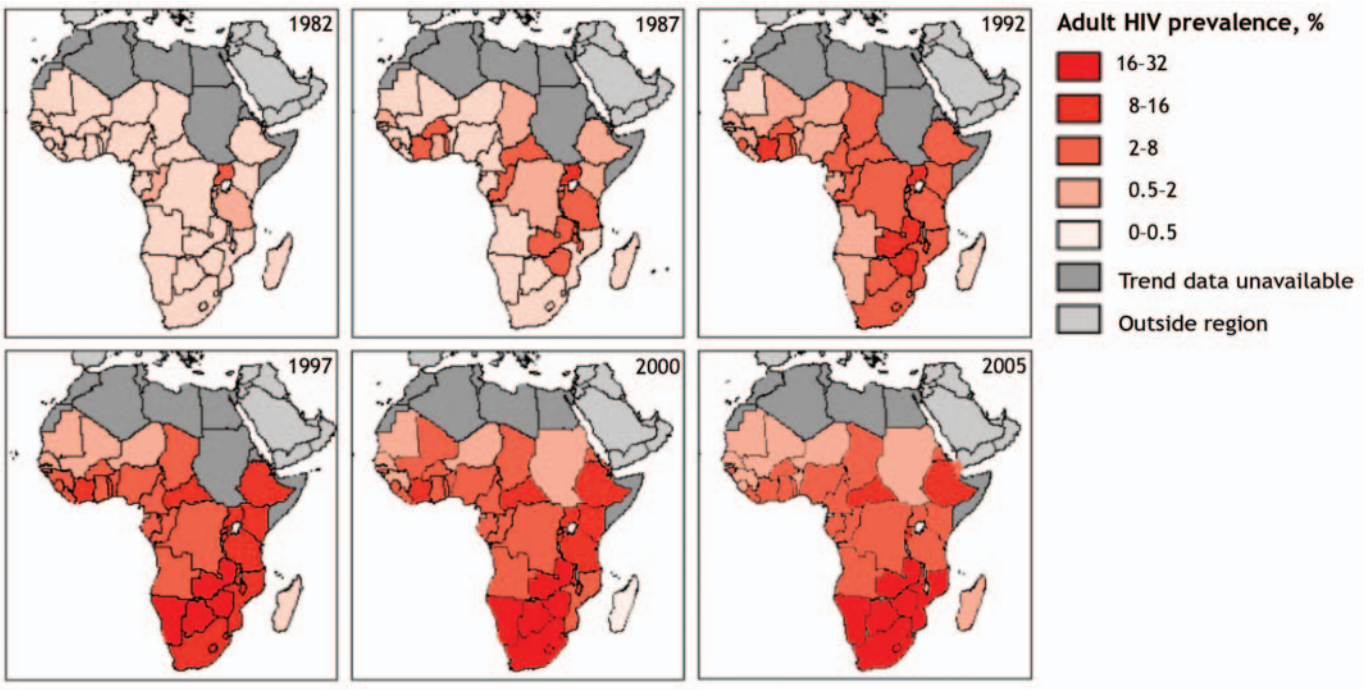

Fig. 1: Prevalence of HIV infection among adults in sub-Saharan Africa from 1982 to 2005. The first 5 maps show the dramatic rise in the prevalence of HIV infection among adults between 1982 and 1997; the remaining map and the map in Fig. 2 depict some of the improvements realized since 2000. [The first 4 maps were reproduced, with permission, from the 1998 UNAIDS report on the global AIDS epidemic;[2] the last 2 maps were redrawn using UNAIDS data.]

ditionalities" to loans that needed to be met by borrowing governments for the release of funds; and (e) it acted in concert with the International Monetary Fund, which also had great monetary and fiscal influence. Indeed, the World Bank frequently draws attention to its influence, citing its comparative advantage in dealing with governments through dialogue, analysis and lending. In its seminal document, *Intensifying Action Against HIV/AIDS in Africa*, it acknowledged its de facto leadership role and implied responsibilities, stating that "those who look back on this era will judge our institution in large measure by whether we recognized 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."[6]

As the largest contributor to HIV/AIDS intervention activities, the World Bank lent US$552 million globally between 1986 and 1996. However, these resources were inequitably distributed across regions. For example, Brazil, a relatively well-off country with a low HIV prevalence rate (less than 1%), received US$160 million, compared with US$274 million given to all of Africa, where many countries were virtually ignored until 2000.[7] By 1999, the World Bank's Health, Nutrition and Population Unit had only 3 substantial AIDS projects in Africa, all of which were winding down, with no new projects in the offing.[8]

Its own Operations Evaluation Department, whose mandate is to provide independent evaluations, analyzed what HIV/AIDS investments the World Bank did make. It found that, from public health and public economics perspectives, the World Bank failed to meets its own criteria. The 10 standalone HIV projects and the 51 projects with an HIV component initiated between 1986 and 1996 lacked economic analyses of expected and actual results. In general, they also failed to focus on population groups at highest risk.[7] In an internal analysis of the World Bank's investment in "best buys in public health and clinical services" for the period 1993–1999, Claeson and colleagues assessed the extent of investment in essential public health and clinical services.[9] (These services were identified as essential in the 1993 World Development Report on the basis of disability-adjusted life-years averted and on available efficacy, effectiveness and cost data.[10]) The authors found that 44 (29%) of the 152 projects undertaken by the Health, Nutrition and Population Unit during 1993–1999 addressed HIV/AIDS. Of those 44 projects, only 10 (23%) met the strict criteria used to define quality interventions in this domain (i.e., education on safe behaviour, condom promotion, treatment of sexually transmitted infections, and safe blood supply).[9] In short, less than one quarter of the interventions met the World Bank's own quality indicators.

In reality, the World Bank in the 1990s was actually focused on health sector reform, not on HIV/AIDS. A review of key World Bank documents showed that it sought repeatedly and explicitly to deprioritize the HIV/AIDS crisis in favour of health sector reform.[11] The review revealed that, in 1992, the World Bank had warned that, "an expanded role of the Bank in AIDS should not be allowed to overtake the critical agenda for strengthening health systems."[12] The remarkable conclusion reached was that, as the decade progressed, increasingly "AIDS was even less strategically prominent in the Bank's

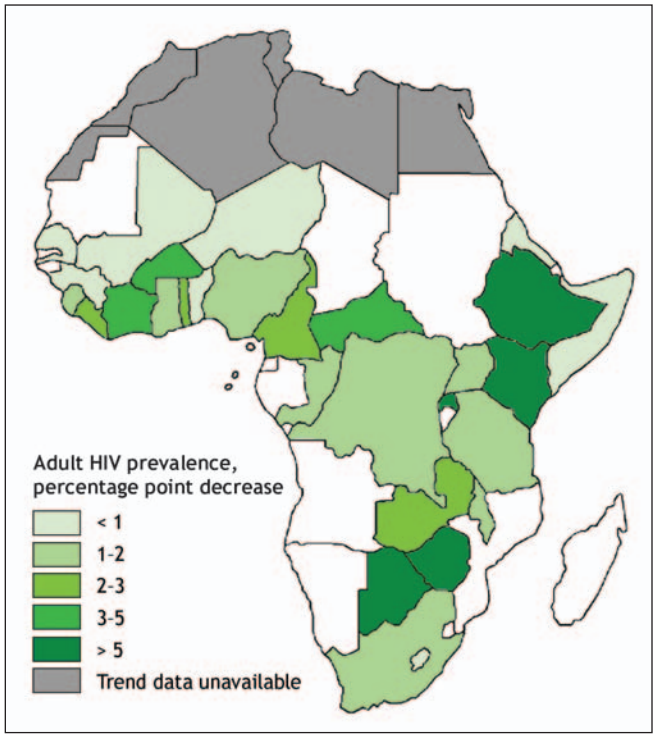

Fig. 2: Sub-Saharan countries in which the prevalence of HIV infection among adults decreased between 2000 and 2005. Source: UNAIDS data.

health sector strategy."[12] To make matters worse, extensive data show that these very reforms, however badly needed, were poorly planned and underfunded and frequently had the effect of reducing access to effective health care, including services aimed at the prevention and control of HIV/AIDS. For example, with the promotion of cost recovery, it became commonplace to charge users for key HIV-related services, including the diagnosis and treatment of sexually transmitted infections, blood transfusion schemes, voluntary counselling and testing, and antiretroviral therapy.[4]

A series of institutional weaknesses identified in a review of the World Bank's investing activities in the health sector in the 1990s[13] suggests that an effective response to the HIV/AIDS pandemic by the World Bank was an unlikely prospect from the outset. First, the World Bank operated as a bank and kept its core business processes and incentives "focused on lending money rather than achieving impact." Second, it had weak incentives and underdeveloped systems for monitoring and evaluation and therefore did not use its lending portfolio to systematically collect evidence on what works, what doesn't and why. Third, the World Bank failed to develop good dialogue and consultation with its partners and local stakeholders — often preferring to "go it alone." Fourth, it took a "one size fits all" approach to country's situations that was insufficiently grounded in empirical evidence or institutional analysis of the local context. Fifth, it seldom placed sufficient emphasis on addressing determinants of health that lie outside the medical care system. Any one of these weaknesses would have severely undercut the effectiveness of the World Bank's

Key institutional weaknesses of the World Bank's investing activities in the health sector in the 1990s

- Bank-like operations focused on lending money rather than on achieving impact
- Weak incentives and underdeveloped systems for monitoring and evaluation
- Lack of development of good dialogue and consultation with partners and local stakeholders
- "One size fits all" approach to countries' situations that was insufficiently grounded in empirical evidence or institutional analysis of the local context
- Insufficient emphasis placed on addressing determinants of health that lie outside the medical care system

Source: Johnston and Stout.[12]

response to the HIV/AIDS crisis. Collectively, they suggest the unchecked proliferation of ill-conceived, blueprint responses over a prolonged period from an institution out of touch with events on the ground. For example, upon reviewing levels of official development assistance targeting HIV/AIDS (about $10 per HIV-infected person globally and $3 in sub-Saharan Africa), the World Bank in 1997 concluded that "these allocations are remarkably large relative to national spending on the same problem and probably in comparison with international spending on any other disease. Perhaps only the international campaign to eradicate smallpox in the 1970s benefited from such a large preponderance of donor funds."[14]

In fairness, bilateral and multilateral agencies were generally no more effective than the World Bank in their response to the HIV/AIDS pandemic. However, none of these agencies was in comparable positions of leadership or influence. Furthermore, none of this critique removes the onus from African governments to do more: Uganda and Senegal have shown what can be achieved when there is strong political will, just as South Africa has shown the consequences of its absence.

Since 2000, the World Bank has made large investments in sub-Saharan Africa to tackle HIV/AIDS and has addressed some of its institutional weaknesses, the most obvious being that it offers grants rather than bank loans to finance interventions. A recent review of the World Bank's development effectiveness[11] showed that 3 characteristics were good predictors of success: first, country assistance was focused and was in support of a country-owned program; second, the program was carefully aligned with government capacity; and third, strategies were based on analytical work that helped tailor them to a country's conditions. However, evaluation of the World Bank's HIV programs,[15] while confirming substantial improvements in aid effectiveness, has identified areas that require immediate attention by the World Bank — the need to target HIV/AIDS intervention strategies at high-risk groups, to improve analysis of country-specific issues and to improve monitoring and evaluation of research activities — if it is to meet current challenges presented by the HIV/AIDS crisis in sub-Saharan Africa.

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