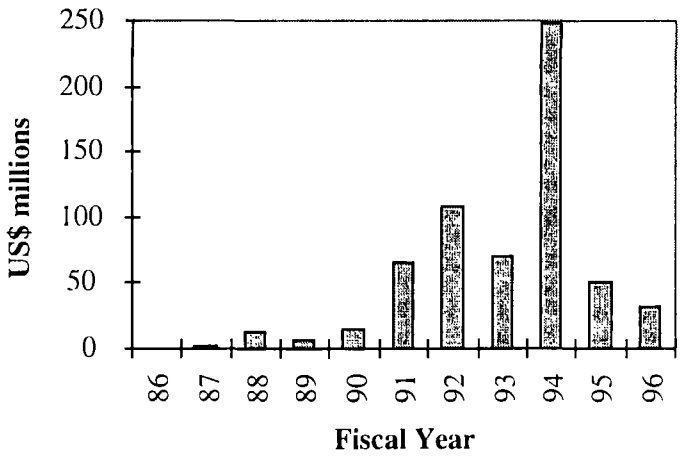
**Figure 2: World Bank Lending for HIV/AIDS Interventions by Fiscal Year, 1986-96**




Source: Author's calculations

One-third of the projects with HIV/AIDS components (21 project) and about the same proportion of lending (US$ 202 million) was for countries with a generalized epidemic (Table 2). Over half of the lending (US$ 291 million) was for the 26 projects in countries with a concentrated epidemic. Total lending for countries with generalized epidemics was less than lending to countries with concentrated epidemics, because the former are mostly in Sub-Saharan Africa where loan sizes are smaller on average. The remaining US$ 59 million was lent for 13 project in countries with a nascent epidemic or for which the stage of the epidemic is unknown.

**Table 2: Bank Lending for HIV/AIDS Interventions**

| ***Stage of the Epidemic*** | *Number of Projects* | *Number of Countries* | *Total Lending for HIV/AIDS Components (US $ millions)* |
|---|---|---|---|
| Generalized | 21 | 14 | 202 |
| Concentrated | 26 | 16 | 291 |
| Nascent | 8 | 6 | 36 |
| **Stage unknown** | **5** | **5** | **23** |
| **TOTAL** | **60** | **41** | **552** |

Source: Appendix C

**World Bank projects focusing primarily on HIV/AIDS**

An in-depth review of the ten Bank HIV/AIDS-focused projects (including Argentina) evaluated the extent to which the Bank has supported interventions in three priority areas. These areas, which were identified in *Confronting AIDS*, include:

1. Information collection (including level and trends of HIV/other STDs, prevalence of high-risk behavior and characteristics of those who practice it, cost of interventions and their impact on HIV incidence)
2. Promoting safer behavior among those most likely to contract HIV (including lowering costs of condom use, lowering costs of safe injecting behavior, treating STDs, working with NGOs, and improving the status of women)
3. Promoting equitable access for the poor to prevention and treatment.

Generally speaking, it was not possible to evaluate the exact allocation of funds to these areas, as project documents rarely disaggregated spending along the same categories. A rough approximation was possible for only two projects, Indonesia and Kenya (Box 3).

**Box 3: Spending Allocations for Priority Interventions for Two Bank Projects**

What share of Bank project funds support interventions in the three priority areas? This question is answered for the two HIV/AIDS-focused projects for which this information was available in the Staff Appraisal Reports. (Other Bank projects did not disaggregate spending along similar lines.) These projects are not necessarily representative of the Bank's entire lending portfolio; it would be helpful to collect this type of information on all Bank projects with HIV/AIDS components to indentify patterns in spending.

The Indonesia HIV/AIDS and STDs Prevention and Management Project devoted about 40 percent of project base costs for interventions in the three priority areas. This included: 5 percent for targeted IEC, 23 percent for STD services, and 12 percent for surveillance. In addition, 27 percent of project base costs financed other types of IEC, including mass media programming and campaigns in the workplace, schools and universities and among health providers. Another 22 percent of the base cost financed the improvement of laboratory services.

In the Kenya Sexually Transmitted Infections Project, 42 percent of total project costs (US$ 42.7 million) have been allocated to interventions in the three priority areas. This includes support for surveillance, operational research, monitoring and evaluation, condom promotion, treatment for STDs, and support for innovative NGO outreach activities to target high-risk groups. The rest of the project finances other activities such as mass media, programs to build national and district capacity, project management, activities to care for HIV/AIDS patients and efforts to improve occupational safety.

Source: Staff Appraisal Reports

One issue that complicates the evaluation of Bank loans is that they often provide financial support for interventions not already being financed from other sources. In some situations, therefore, the Bank does not support priority interventions because these have already received adequate support from government agencies or other donors. To take this into account,

this review also looked at the extent to which the project documentation discussed the role of other donors and organizations and efforts to collaborate with them.

### *Providing information*

The Bank provided strong support for surveillance of HIV and other STDs. All 10 projects supported activities to improve national surveillance systems. The India project has financed sentinel surveillance among high-risk groups (sex workers, IDUs, truck drivers and TB patients). The Burkina Faso Population and AIDS Control Project is supporting special prevalence studies among miners, prisoners, migrants, TB patients, and pregnant women. The Argentina AIDS and STD Control Project plans to establish HIV and STD surveillance system with about 20 sentinel centers, although it is not clear whether these will focus on high-risk groups.

Most of the projects supported behavior studies, but only two identified the specific need to focus on groups most likely to engage in high-risk behavior. Studies are planned on the behavioral risk factors of IDUs in Brazil and on the commercial sex industry in Indonesia. All projects support at least one study of cost-effectiveness or the economic impact of AIDS.

### *Promoting safer behavior among those most likely to contract and spread HIV*

Seven of the 10 projects (those for Argentina, Burkina Faso, India, Indonesia, Kenya, Uganda, Democratic Republic of Congo) had some discussion of the need to target prevention services to the highest risk groups. Project documentation included limited discussion about how these groups were identified, how they would be reached, or what additional information was needed to reach them effectively. Eight of 10 projects planned to contract NGOs to provide outreach services to high-risk groups. The projects in Burkina Faso, Chad and Kenya have established separate funds to support innovative NGO activities.

Four projects discussed efforts to target condom promotion to high-risk groups. In Brazil, the project supported an intervention to promote condoms among IDUs. The project in Burkina Faso subsidized condoms for those at highest risk. The project for Uganda also promoted condoms with an emphasis on expanding access for high risk groups. The project for Democratic Republic of Congo promoted condom distribution at non-traditional distribution

points such as bars, nightclubs, and hotels, as well as promoting condom high-risk groups, including sex workers. Students and employees were also identified by the SAR as high-risk groups, although no evidences was provided to support this claim.

Only the Brazil project discussed specific efforts to lower costs of safe injecting behavior. This included outreach efforts to promote and distribute products for needle cleansing, experimentation with syringe distribution and the distribution of 2.5 million condoms to IDUs. We might have also expected this type of programmatic support in India or Indonesia. These two projects provided targeted IEC for IDUs but had no support for behavioral interventions to lower risk.

All ten projects supported STD treatment services, but only the Kenya project documentation discussed specific efforts to target these services to those most at risk. There was a special emphasis on reaching those at increased risk: youth, men living away from home, truck drivers, and sex workers. One project supported efforts to improve the status of women. The Burkina Faso project provides support for enhancing public understanding of women's rights and problems, including financing seminars and international study tours.

***Promoting equitable access for the poor to prevention and treatment.*** The Argentina project will establish entities to provide medical care to those without insurance and for care for AIDS orphans and hospice care. Several of the projects support various types of treatment, but do not focus these efforts towards the most disadvantaged.

***Collaboration with other donors.*** The degree of collaboration with other donor organizations varied substantially across the projects. The projects for Burkina Faso, Chad, Uganda were jointly financed with others donors and the project documentation discussed a well-coordinated effort. The project for Indonesia, although financed solely by the World Bank, included an extensive discussion of the project would complements efforts of other organizations. In Argentina and Brazil, there was no discussion of the HIV/AIDS programs that already exist in country or of efforts to collaborate with other donors. Other project documents had very limited discussion of the roles of other donors, and it was therefore difficult to know if they supported priority interventions.

**HIV/AIDS interventions supported by other Bank projects**

Among the 51 projects with a component for HIV/AIDS-related activities, most projects supported four types of interventions: (i) operational research, surveillance, and monitoring; (ii) information, education and communication (IEC) regarding HIV/AIDS awareness; (iii) treatment of STDs; and (iv) condom promotion (Appendix C). The provision of information (i) is always a priority, although operational research is most useful when it focuses on groups at highest risk for contracting and transmitting HIV. Interventions in the other three categories are appropriate when they reach groups at highest risk.

Over half of the 51 projects (57 percent) funded operational research, surveillance, and/or monitoring and evaluation activities. Projects in countries with a concentrated epidemic were more likely to support operational research and surveillance (68 percent) than were projects in other countries. Operational research addressed topics such as measuring the cost effectiveness of various interventions, assessing the economic impact of AIDS and program monitoring and evaluation (see Box 3). Most of these projects also finance epidemiological surveillance of HIV, and some of them also support surveillance of other STDs. Almost half of the operations (43 percent) funded mass-media education for the population at-large. Fewer projects (about 33 percent) supported IEC targeted to high-risk groups, although these types of interventions are likely to be much more effective than mass-media campaigns in reducing HIV transmission.

Half of the projects financed assistance for the treatment of STDs, including support for developing protocols for treating STDs, training health care providers on how to diagnose and treat STDs, providing drugs to treat the STDs, and paying the full costs of STD treatment. It is not clear the extent to which these interventions targeted groups at highest risk for infection, although expanding treatment for these groups is most important.

About a third of the projects also support treatment for HIV/AIDS patients such as treating opportunistic infections (especially TB), providing drugs and counseling, designing protocols for treatment and training medical staff on appropriate treatment. The Uganda Sexually Transmitted Infections Prevention and Control Project, for example, supports all of these as well as financing community and home-based health care and social support for people with AIDS.

About half of the projects promote condom use and/or finance the provision of condoms. For example, the project in Guinea Bissau support the social marketing of condoms. The extent to which Bank support was focussed on the highest-risk groups was difficult to establish, but not enough project documents discussed which groups were at highest risk for sexual transmission and how to best reach them.

**Box 4: The Socioeconomic Impact of AIDS in Madagascar**

As of 1995, only 20 cases of AIDS had been reported in Madagascar. Yet, a combination of factors could cause the epidemic to explode in the near future. These include: high levels of STDs, extensive prostitution and promiscuity, low use of condoms, high rates of poverty, and an increase in the dislocation of the family and internal migration. Nevertheless, Madagascar has the opportunity to control the spread of HIV.

In support of efforts to control the spread of AIDS, the Bank's Economic Management and Social Action Project sponsored operational research to estimate the potential growth of the epidemic and on the socio-economic impact of AIDS in Madagascar. Although only 20 cases of AIDS had been reported, it is estimated that at least an additional 130 cases are unreported. About 5,000 individuals are estimated to be infected with HIV. Two future scenarios were modeled: a controlled epidemic resembling that of Thailand and a rapid growth epidemic like that being experienced by Kenya. In the slow-growth scenario, HIV prevalence would reach 3 percent of the general population in 2015, and in the full-blown scenario, HIV prevalence would reach 15 percent by 2015.

The direct costs of caring for AIDS patients in 2015 will be between US$ 10.75 and 52.75 millions (1996 dollars at 4000 FMG/dollar), depending on the severity of the epidemic. These figures are likely to be on the low side as they do not include the costs of treating opportunistic infections. The analysis considers the burden on public health expenditures and concludes that at the present rates of growth of the Ministry of Health budget, the sector will not be able to absorb these costs, particularly the high scenario. A range of indirect costs are also considered but not estimated. By 2015, there will be between 107,000 and 548,000 AIDS orphans.

Source: Etude de l'impact socio-economic du VIH/SIDA a Madagascar (Juin 1996)

## IV. Ex-ante and ex-post project evaluation

Two recent studies have shown that good economic analysis leads to better projects. Analysis by Belli and Pritchett (1995) found that projects with poor economic analysis were 7 times more likely to perform poorly than were projects with good economic analysis. Belli (1996) repeated the analysis an additional (fourth) year of project performance rating and found that the relationship holds even stronger. In a separate analysis, Robert Schneider (World Bank 1995) measured the intensity of sector work in the three years preceding a project and found that the more sector work done, the higher the probability of success. This section assesses the quality of the economic analysis in project preparation, and Box 6 discusses the available evidence from ex-post evaluation. An analysis of the link between economic and sector analysis and project success is presented in Appendix D.

Devarajan, Squire and Suthiwart-Narueput (1995) identified ways in which the World Bank can improve the economic analysis of its projects. Hammer (1996) applied their approach to the project analysis in the health sector. He proposed four aspects of economic analysis that should be covered in health project evaluation, which are outlined in Box 5.

**Box 5: Desiderata for Project Analysis in the Health Sector**

1. Establish a firm justification for public involvement. This usually involves identifying market failures and discussing how and why public intervention is appropriate.
2. Examine the counterfactual. What would happen with and without the project?
3. Determine the fiscal effect of the project. In the health sector, this usually involves discussing the appropriate level of user fees.
4. Acknowledge the fungibility of project resources and examine the incentives facing public servants.

Source: Hammer (1996)

With a very few exceptions, only the free-standing AIDS-focused projects included economic analysis related to the AIDS interventions. For this reason, this section is limited to the nine completed or ongoing projects that address AIDS as their primary focus. Table 3 discusses the projects in terms of the desiderata identified by Hammer (1996). The first, rationale for public involvement, was almost never explicitly discussed, but rather implicit in the project document. An exception is the Brazil AIDS and STD Control Project, which cited the large negative externalities to the AIDS epidemic and the problems with imperfect information.

Two forecasting models were utilized. The WHO epidemiological model developed by Chin and Sato was used in the analyses for the projects in Brazil, India and Democratic Republic of Congo (which only forecasted future AIDS incidence, without estimating the project impact). The InterAgency Working Group-AIDS model developed by the US Census Bureau was used for Indonesia. The assumptions listed in Table 7 indicate wide variation from project to project. The fact that no assumptions were discussed for several of the projects suggests that future project analysis should carefully document the assumptions under which the calculations were made, as they can dramatically affect the results.

Only three of the nine projects identified a counterfactual for the project and presented cost-benefit or cost-effectiveness analysis comparing the various options. The project analyses

for Brazil, India and Indonesia provided extensive analysis of the alternatives. The Brazil project used the WHO epidemiological model to estimate the future incidence of HIV/AIDS in the presence and absence of the project. The analysis then calculated the direct and indirect costs saved with the project in place. Both the India and Indonesia project analyses included the 'without project' scenario and three possible 'with project' scenarios, which varied according to the effectiveness of the project interventions. For example, the three scenarios in the analysis for India were reducing the incidence of HIV/AIDS by 20, 30 or 40 percent. The 30 percent scenario (considered by the authors to be conservative) was then used to calculate the direct and indirect costs saved by the project. The analysis also calculates the internal rate of return on government direct costs, which was estimated to be 26.7 percent. None of the project analyses estimate the impact separately for each component of the projects.

Among the other six projects, direct and indirect benefits were only estimated partially. For the projects in Burkina Faso and Democratic Republic of Congo, direct and indirect costs per AIDS case were calculated, but the number of cases averted as result of the project was not estimated.[5] The analysis for Chad, Kenya, Uganda and Zimbabwe did the opposite: they estimated how many people would be reached by the project (although not how many AIDS cases would be averted), but did not estimate the indirect or direct costs saved by the project.

With respect to the last two desiderata, only a few of the projects discuss the fiscal impact of the project, mostly raising cost recovery issues and estimating the impact of the project on recurrent costs. Problems related to fungibility were rarely discussed.

[5] The project for Burkina Faso estimates how many couples will be using condoms and assumes 90 percent efficacy of condoms use. It then estimates the direct costs saved, assuming that all of these couples would become HIV-positive without wearing condoms. According to epidemiological trends in HIV/AIDS, this last assumption is completely unreasonable.

## Table 3: Economic Analysis for Nine AIDS-focused Projects

| *Project* | *Rationale for Public Involvement* | *Analysis of Costs, Benefits and Counterfactuals* | | | | | | *Fiscal Impact* | *Fungibility* |
|---|---|---|---|---|---|---|---|---|---|
| | | *Assumptions* | *Model* | *Costs Considered* | *Counter-factual ?* | *Benefits* | | | |
| | | | | | | **Direct** | **Indirect** | | |
| Brazil AIDS and STD Control<br>Four components:<br>(i) prevention through IEC and medical staff training;<br>(ii) treatment services;<br>(iii) institutional development to build capacity to deal with HIV/AIDS (mainly training and upgrading of laboratories);<br>(iv) surveillance, research and evaluation. | Imperfect information; externalities | Two sets of assumptions:<br>1.(i) as of 1991, 425,000 people currently infected; (ii) widespread transmission began in 1980; (iii) annual incidence of HIV continues to increase until 1999.<br>2. (i) and (ii) same as above, plus (iii) incidence increases only until 1995 and then decrease | WHO Expanded Program of Immunization model | IBRD and government costs considered | Yes, 2 scenarios | 300,000 lives saved by 2001, equaling $US 594 million in direct treatment costs (present value in 1992) | Indirect plus direct costs estimated at US$1.2 billion (present value in 1992) | Incremental recurrent cost estimated at US$ 150.3 million | |
| Burkina Faso Population and AIDS Control<br>Three components:<br>(i) family planning;<br>(ii) STD/HIV/AIDS prevention and treatment;<br>(iii) grants for private sector. | Not explicitly discussed | 1. a loss per AIDS death of 43 yrs for men and 49 yrs per woman<br>2. incidence rate of .173 per thousand<br>3. discount rate of 3 percent | None | Bank, other donors, and government costs calculated | 1992 scenario (pre-project) is the only one considered | Ambulatory treatment and hospitalization cost $US 416 (1992) per case.<br><br>Costs averted by project not accurately calculated. | Cost per AIDS case = $US 7,488 (1992).<br><br>Project benefits not calculated. | | |
| Chad Population and AIDS Control<br>Four components:<br>(i) reinforce implementation of natl population policy<br>(ii) HIV/AIDS/STDs prevention<br>(iii) social marketing of condoms;<br>(iv) promoting participation of private sector and NGOs | Not explicitly discussed | None given | None specified | IDA, other donor, government and community costs are analyzed | No | Project would 'alleviate the burden' of HIV/AIDS on about 12,000 AIDS patients, 21,000 families, 45,000 orphans and the nation. IEC and social marketing are expected to produce behavioral changes among 415,000 high risk people. Benefits of project not valued in monetary terms. | None given | Very limited incremental effect on recurrent costs | Not discussed |

## Table 3 (continued): Economic Analysis for Nine AIDS-focused projects

| *Project* | *Rationale for Public Involvement* | *Analysis of Costs, Benefits and Counterfactuals* | | | | | | *Fiscal Impact* | *Fungibility* |
|---|---|---|---|---|---|---|---|---|---|
| | | *Assumptions* | *Model* | *Costs Considered* | *Counter-factual ?* | *Benefits* | | | |
| | | | | | | *Direct* | *Indirect* | | |
| India National AIDS Control Project<br><br>Five components:<br>(i) promote public awareness and community support<br>(ii) improve blood safety<br>(iii) build surveillance and clinical management capacity<br>(iv) Improve STD clinical services<br>(v) strengthen management capacity at national and state levels | Not explicitly discussed | 1. 1991 underlying prevalence of 200,000 HIV + in risk groups and 200.000 people in the general population<br>2. 8 percent discount rate<br>3. each AIDS case is associated with 30 related illnesses, or which 20 will incur medical care at US$ 10 per illness (1992 $), increasing 8 percent/yr.<br>4. every patient with AIDS will require 250 days of care, of which 25 will require hospital care at US$30/day | WHO Expanded Program of Immunization Model | IDA, other donors and government costs considered | Yes, without project and three 'with project' scenarios – AIDS reduced by 20 percent, 30 percent or 40 percent as a result of the project | By 2000, AIDS incidence would be 500,000/yr without the project and 100.000, 150,000, or 200,000 in each of the AIDS scenarios.<br><br>Direct cost savings at current prices for the 30 percent scenario would total US$388.4 million for the govt, and US$ 100.4 in private costs.<br>Internal rate of return on govt direct costs = 26.7 percent | By 2000, loss to national income avoided US$2.5-3.0 billion | Recurrent costs implications are small but costs of dealing with AIDS patients will likely escalate | |
| Indonesia HIV/AIDS and STDs Prevention and Management<br><br>(i) two pilot programs for IEC and strengthening of STD care<br>(ii) central activities to improve STD delivery, surveillance, laboratory improvements, and IEC | Not explicitly discussed | 1. demographics based on 1980 and 1990 censuses<br>2. host/virus contact:<br>(i) HIV 'seed' was 1000 in 1990:<br>(ii) STD and circumcision rates assumed<br>3. Sexual mixing patterns based on census and community surveys<br>4. Mode of transmission: 95 percent sexual contact | InterAgency Working Group AIDS model | IBRD and government costs considered | Yes, 4 total (baseline plus three) | 5000 fewer AIDS cases by 2005: 22,500 by 2010.<br><br>Present value of direct treatment costs in Jakarta US$6.3 for 2005 and US$19.2 for 2010 | Total: US$140 million by 2005 and US$551 million by 2010 | Impact on government recurrent costs not evaluated | Not discussed |

## Table 3 (continued): Economic Analysis for Nine AIDS-focused projects

| *Project* | *Rationale for Public Involvement* | *Analysis of Costs, Benefits and Counterfactuals* | | | | | | *Fiscal Impact* | *Fungibility* |
|---|---|---|---|---|---|---|---|---|---|
| | | *Assumptions* | *Model* | *Costs Considered* | *Counter-factual ?* | *Benefits* | | | |
| | | | | | | *Direct* | *Indirect* | | |
| Kenya STI Project<br><br>Three components:<br>(i) strengthen institutional capacity<br>(ii) prevention of STIs<br>(iii) address social and economic consequences, including drugs for opportunistic infections and support to NGOs. | Not explicitly discussed | None given | None presented | IDA, other donors and govt costs are considered | No | Evidence on the success in lowering transmission of AIDS and cost-effectiveness of treating STDs in a core group in Nairobi.<br><br>Condoms will be distributed to 5 million people. 1.7 million people will receive care for infections.<br><br>Direct cost of project not calculated. | Total direct and indirect costs of AIDS to the country could reach 15 percent of GDP by the year 2000 (about $US 19.000 per AIDS case).<br><br>Indirect costs saved from project not calculated. | Recurrent cost implications are estimated to be small | Risk that broad government support may not materialize and govt capacity may be too weak to implement |
| Uganda STI Project<br><br>Three components:<br>(i) prevent sexual transmission of AIDS & other STDs<br>(ii) mitigation of personal impact of AIDS<br>(iii) institutional development | Not explicitly discussed | None | None | IDA, other donors and govt costs are considered | No | 6650 TB patients will be treated: Condoms will be distributed to 4 million people; 1.9 million people with HIV will receive care for infections: 7.000 health workers will receive protective supplies.<br><br>Direct costs saved are not estimated. | None | Recurrent cost implications are estimated to be small | Risk that broad government support may not materialize and govt capacity may be too weak to implement |

## Table 3 (continued): Economic Analysis for Nine AIDS-focused projects

| *Project* | *Rationale for Public Involvement* | *Analysis of Costs, Benefits and Counterfactuals* | | | | | | *Fiscal Impact* | *Fungibility* |
|---|---|---|---|---|---|---|---|---|---|
| | | *Assumptions* | *Model* | *Costs Considered* | *Counter-factual ?* | *Benefits* | | | |
| | | | | | | *Direct* | *Indirect* | | |
| Democratic Republic of Congo National AIDS Control<br><br>Four components:<br>(i) IEC and condom distribution<br>(ii) integration of AIDS control activities<br>(iii) operational research<br>(iv) institutional strengthening | Not explicitly discussed | 1. current level of infection of 6 percent in urban and 1 percent in rural areas<br>2. conversion rate o f 4 percent/year<br>3. seroprevalence stays at 2 per 1000<br>4. estimates of the number of treated cases base on projected health coverage. | WHO model | IDA, other donors, government and beneficiary costs considered | No, scenario without project is the only one considered | Direct costs of AIDS presented for each year 89-93 and for 2000 and 2010. The average cost of each AIDS patient (per year -- on average patients die within the year after clinical manifestations of the disease) is US$ 229 in constant 1986 dollars.<br><br>Direct benefits of project not calculated. | Healthy life years saved per case of infection would be 6.2 and based on annual incomes in Democratic Republic of Congo. this is equivalent to US$5,512 in urban areas and US$ 893 in rural areas. The average would be about US$4.600, which is about 20 times higher that the direct costs of AIDS.<br><br>Benefits of project not estimated. | Cost recovery assessed and project affordability compared with other health interventions | Poor managerial capability is a project risk |
| Zimbabwe STI Prevention and Care<br><br>Five components:<br>(i) condom provision<br>(ii) STD treatment<br>(iii) drugs for opportunistic infections<br>(iv) supplies for HIV diagnosis and blood screening<br>(v) biomedical security supplies | Not explicitly discussed | None given | None | IDA, other donor and govt costs considered | Only current costs considered | 65.000 TB patients will receive treatment; condoms will be distributed to 700,000 people; 180.000 people with HIV will receive care; 5.000 health care workers will have protective supplies; and 575.000 people will be tested.<br><br>Direct benefits of project not calculated. | Indirect costs are about 20 times direct costs -- as much as US$21.300 per case.<br><br>Benefits of project not estimated. | Cost recovery discussed | |

Source: Project Staff Appraisal Reports.

## Box 6: Lessons Learned from Completed Projects

Eight projects with AIDS components have been completed, including one free-standing AIDS project (Democratic Republic of Congo). The four available completion reports indicate mixed results (see table below). Two of the four project outcomes (Democratic Republic of Congo and Cameroon) were rated as unsatisfactory by both the task manager (ICR in table) and the operations evaluation department (EVM in table). In both cases the project had only modest impact and was not considered to be sustainable in the future. Weak project management and limited government commitment were cited as reasons for poor performance in both projects. Most of the four project completion reports identified similar factors (not limited to the AIDS-related intervention) that contributed to poor project implementation, suggesting priorities for future projects:

- ***A strong government commitment is key***: The Niger project credited government commitment as the main reason for project success and the other three projects indicated that lack of commitment to the goals of the project hindered project implementation.
- ***Simple project design is best***: 'Simple' is broadly defined as supporting few interventions, that are easily implemented and working with a limited number of implementing agencies. Both the Gambia and Cameroon projects found that the complex design of several of their components hindered project implementation.
- ***Strengthening management capacity is important:*** All four projects cited poor management capacity, especially financial management, as an impetus to effective project implementation.
- ***Appraisal must be thorough:*** Weak project appraisal was cited as one of the main reasons for poor project implementation in Cameroon. The Democratic Republic of Congo project did not adequately consider the possibilities of rapid macroeconomics change, which led to severe project implementation problems.

Additional project experience on AIDS intervention (World Bank 1996) provided the following additional lessons:

- Interventions in the earlier stages of the epidemic have a greater impact and a higher benefit-cost ration that interventions at a later stage.
- Large-scale condom promotion and marketing has resulted in large observed changes in sexual behavior and significant increases in condom use.
- Efforts to control STDs should be integrated with AIDS prevention efforts.
- NGOs can play an important role on reaching high risk groups.

**Project Ratings for 4 completed projects**

| *Project: (rating source)* | *Outcome* | *Sustainability* | *Institutional. Development* | *US$ Committed* | *Percent Canceled* |
|---|---|---|---|---|---|
| Cameroon SDA(ICR) | unsatisfactory | uncertain | modest | 21.5 million | 81.7 |
| (EVM) | unsatisfactory | unlikely | negligible | | |
| Gambia Hlth Dev (ICR) | | | | 4.7 million | 6.9 |
| Niger 1st Health (ICR) | satisfactory | likely | partial | 25.1 million | 1.3 |
| Democratic Republic of Congo AIDS (ICR) | unsatisfactory | unlikely | negligible | 8.1 million | 60.9 |

Notes: ICR= implementation completion report (prepared by task manager); PCR=project completion report (prepared by task manager); EVM=evaluative memorandum (prepared by OED).
The possible ratings are: (i) outcome: highly satisfactory, satisfactory, unsatisfactory, highly unsatisfactory; (ii) sustainability: likely, unlikely, uncertain; (iii) institutional development: substantial, partial, and negligible.

Source: World Bank project completion reports

## V. Conclusions

Between 1986 and 1996, over US $ 550 million in World Bank loans has supported interventions specifically aimed at preventing HIV/AIDS and mitigating its effects. This paper reviews Bank activities in all regions of the world from a public economics perspective. The paper focuses on the Bank's lending program, although the conclusion presented here also draw on review of the Bank Country Assistance Strategies and country economic and sector work (Appendices A and B, respectively).

The recent World Bank Policy Research Report, *Confronting AIDS: Public Priorities in a Global Epidemic*, identified three priority areas for government support: (i) information collection; (ii) promotion of safer behavior among those most likely to contract and transmit HIV; and (iii) and protection for the poorest groups in society from contracting HIV and support to mitigate the negative consequences of HIV/AIDS among these groups. Bank projects are evaluated based on the extent to which they supported interventions in these areas.

The Bank provided extensive assistance for efforts to collect information. All ten of the HIV/AIDS-focused projects financed surveillance of HIV and other STDs. Most of them also supported behavior studies, and all ten had plans for at least one cost-effectiveness study. Only a few, however, indicated a plan to focus these activities on the population groups most at risk in the country. About 60 percent of the 51 projects with an HIV/AIDS component supported operational research, surveillance, evaluation and monitoring activities, although the focus on groups at highest risk was limited.

Support for interventions to reduce risky behavior among those most likely to contract and transmit HIV was less extensive. Most of the ten HIV/AIDS-focused projects contracted NGOs to provide outreach services to high risk groups, but there was very limited discussion of how these groups had been identified or what additional information was needed to reach them effectively. Four projects supported condom promotion programs targeted to high-risk groups. Only the Brazil project provided specific support for interventions to support safe injecting behavior. All ten projects financed STD treatment, but only one planned to focus these services on those most at risk. Finally, only one project provided support for efforts to protect the poorest groups in society from contracting HIV or programs to mitigate the negative consequences of HIV/AIDS among these groups.

Most of the projects were not based on strong economic analysis. With a very few exceptions, only the free-standing AIDS-focused projects included any ex-ante economic analysis of the proposed AIDS interventions. Only one-third of these projects, however, prepared adequate cost-benefit or cost-effectiveness analysis. As of October, 1996, ex-post evaluations were only available for four of the eight completed projects and their assessment was generally unsatisfactory.

Country Assistance Strategies and sector analyses, have only addressed HIV/AIDS issues in limited manner. Consideration of the AIDS epidemic was not central in most of the Country Assistance Strategies, the principle strategic planning documents, although coverage was most extensive in countries with generalized epidemics. The best documents discussed how the development strategy would affect the HIV/AIDS epidemic, or vice-versa, and what the government was doing about this problem. Most of the sector analysis of HIV/AIDS was in health sector reports, and very few reports estimated the economic effects of AIDS. The coverage and quality varied, and few reports provided estimates of the potential public (and/or private) costs of AIDS for the health sector or the cost-effectiveness of the various health interventions. Analysis of the broader consequences of AIDS such as its relationship with poverty, and its effects on other sectors and the macroeconomy was limited.

This reviews the extensive support provided by the World Bank for a wide-range of HIV/AIDS interventions. It also identifies a weakness in the Bank's lending program: many of the activities supported by the Bank have not been well-focused on the groups in the population most at risk for HIV infection. Few of the HIV/AIDS Bank projects based support for interventions explicitly on the principles of public economics or have relied on sound economic analysis in ex-ante or ex-post evaluation. Thus, the two primary challenges for the Bank are to provide more support for prevention activities that focus on the groups at highest risk for contracting and spreading HIV and to improve the ex-ante and ex-post economic evaluation of HIV/AIDS projects.

## Appendix A: Country assistance strategies and HIV/AIDS

The Country Assistance Strategy (CAS) is the central planning document guiding World Bank activities in each borrowing country. It is prepared by World Bank staff and consists of a short, concise discussion of the major developmental challenges facing the country, the Government's economic development plan, and the World Bank's strategy to support government efforts. It includes a description of the current and future lending program and the plan for analytical work.

How do the CASs incorporate concerns about the AIDS epidemic and what sorts of strategies do they recommend for dealing with the epidemic? (Box A1 provides general guidelines for incorporating AIDS issues in CASs.) A review of the CASs for 25 countries[6] found that coping with AIDS was not central to any of the country strategies. The AIDS epidemic was not discussed in 11 of the 25 CASs, including those for Haiti, where the incidence of AIDS is relatively high, and in Viet Nam, where the disease is spreading quickly (Table A1). An additional seven CASs briefly mentioned AIDS as a health issue, but did not describe the problem or how to address it in any detail. The remaining seven CASs included a more extensive discussion of AIDS issues.

### Box A1: When Should a CAS Discuss AIDS?

At a minimum all CASs for countries with a mature or developing AIDS epidemic should consider AIDS issues in the CAS. First, the CAS should discuss whether the development strategy proposed by the country and the Bank has either (a) the potential to exacerbate the epidemic or conversely, (b) whether the presence of the epidemic could hamper the achievement of the development objectives. To the extent that there are such effects, the document should say what the government is doing to address them.

Second, the Bank's overarching objective is to help countries to reduce poverty. In countries with a severe epidemic, the epidemic is likely to impoverish many and push the already-poor deeper into poverty. When this is the case, the CAS should include some discussion of the implications of the AIDS epidemic on the poverty reduction strategy in the country. How do AIDS survivors fit into the current safety nets? Are they only candidates if otherwise poor (usually the best policy)? If there is no safety net, is the country really too poor to afford one? Is the government doing all it can to promote, rather than hamper, private assistance efforts by NGOs and/or communities?

The degree to which AIDS issues were addressed in the CAS varied by stage of the epidemic. Those countries with a high HIV prevalence (over 5 percent of the general adult population, according to WHO estimates) included a more in-depth discussion of the AIDS

[6] There is no CAS for Botswana or Central African Republic.

epidemic. They discussed the incidence or prevalence of the disease, in some cases indicating changes over time and the main modes of transmission. For example, the CAS for Malawi asserted that AIDS is spreading in epidemic proportions, with HIV infection in the 15-19 age group estimated at about 20 percent in urban and 8 percent in rural areas. Life expectancy in Malawi has declined from 46 years in 1980 to 44 in 1993 as a result of AIDS mortality. Two of the CASs, those for Tanzania and Uganda, also considered problems with the spread of other STDs.

**Table A1: Selected HIV/AIDS Issues covered in 25 Country Assistance Strategies**

| *Country* | *Describes Incidence/ Prevalence or Means of Transmission of HIV/AIDS* | *Recommends Analysis of HIV/AIDS* | *Recommends STD/AIDS Prevention (✓) or Care (+)* | *Recommends Targeted Programs for Vulnerable Groups (e.g. aid for widows & orphans)* |
|---|---|---|---|---|
| | | *Generalized Epidemic* | | |
| Burkina Faso | ✓ | ✓ | ✓ | |
| Burundi | ✓ | | ✓ | ✓ |
| Congo, Democratic Republic of | ✓ | | | |
| Côte d'Ivoire | | | | |
| Haiti | | | | |
| Kenya | | | | |
| Malawi | ✓ | | ✓ | |
| Rwanda | ✓ | | | |
| Tanzania | | ✓ | | |
| Uganda | ✓ | ✓ | + | ✓ |
| Zambia | | ✓ | | |
| Zimbabwe | | | ✓+ | |
| | | *Concentrated Epidemic* | | |
| Brazil | | | | |
| China | | | | |
| Honduras | ✓ | | | |
| India | | | | |
| Thailand | | ✓ | | |
| Vietnam | | | | |
| | | *Nascent Epidemic (or * for stage not known)* | | |
| Indonesia | | | | |
| Kyrgyz Republic* | | | | |
| Mexico | | | | |
| Morocco | | | | |
| Philippines | | | | |
| Romania* | | | | |
| Yemen | | | | |
| Total: 25 | 7 | 5 | 5 | 1 |

Note: There is no CASs for Botswana or Central African Republic.
Source: Author's review

Few of the documents communicated a country strategy for dealing with HIV/AIDS. Only ten CASs discussed any actions taken by the Government or the Bank to fight the HIV/AIDS epidemic, and all of these were for countries with either high or medium prevalence rates. These CASs included five countries that proposed STD and/or AIDS prevention or care, five that reported plans for analysis of HIV/AIDS and six that mentioned other HIV/AIDS interventions in a very general way. The Burundi CAS, after identifying the 'looming threat of AIDS' as a key constraint to economic development, mentioned that the Government is supporting education campaigns and the promotion of condoms to help slow the spread of STDs and HIV/AIDS. It did not, however, detail the Bank's support for these efforts except to mention that an AIDS rapid assessment survey was on-going.

Research from the Kegara region of Tanzania indicated that the poor and other vulnerable groups are the most severely affected by a death from AIDS of an adult in the household. These findings suggested that targeted programs for the poor are likely to be effective in mitigating the affects of AIDS (Over et al, forthcoming). This suggests the need for strong links between targeted poverty programs and AIDS mitigation efforts. The CASs for Burundi and Uganda were the only ones to make this link when they identify plans for specific targeted programs. The Uganda CAS, which indicated the need for specific targeted programs for vulnerable groups such as AIDS patients and AIDS widows and orphans, describes how two Bank projects will support the areas in Uganda most devastated by the AIDS epidemic.

Educating girls and other interventions to raise the status of women are additional ways in which governments can help to slow the spread of AIDS. About half of the 25 CASs discuss the poor status of women and/or the low educational enrollment rates of girls. Almost all of these CASs also outline measures supported by the Bank to improve the status of women or expand education for girls. Yet none of them made the link between support for these measures and potentially lowering the transmission of HIV/AIDS.

There are several other issues related to HIV/AIDS that one might have expected to see discussed in the CASs. The financial impact of the epidemic on the health sector and recommended policies to mitigate it has traditionally been one of the first policy considerations. Only two of the CASs (Côte d'Ivoire and Tanzania) alluded to this issue generally, but neither provided actual estimates of the cost of the impact. The effects on labor force productivity or on macroeconomic indicators could have been covered in some of the countries with high HIV

prevalence, but they were not. The relationship between the AIDS epidemic and family planning activities was not discussed in any of the CASs.

## Appendix B: Analysis of HIV/AIDS in World Bank economic and sector work

This section discusses the coverage of AIDS in World Bank economic and sector work from 1990 to the present for the 27 selected countries. A previous review (World Bank 1996) of the sector work completed since 1991 for 12 African countries found that consideration of AIDS was greatest in poverty assessments, policy framework papers, and country assistance strategies, and least in public expenditure reviews and country economic memorandums. As a follow-up to that study, this paper reviews the following for each country (when available): country economic memorandum (CEM), poverty assessment, public expenditure review (PER), health sector reviews and gender analysis.

When the analysis for each country is considered as a whole, the economic and sector work for countries at an advanced stage of the AIDS epidemic included more extensive analysis of AIDS issues than did the sector work for countries where AIDS is less widespread (Table B1). The sector work for four (Malawi, Tanzania, Uganda, and Zambia) of the countries with a mature AIDS epidemic included economic analysis of the epidemic, in addition to a summary of trends in incidence and/or prevalence. In particular, the CEMs and poverty assessments for these countries considered the impact of AIDS on the economy at large, or on efforts to reduce poverty. Consideration of the effects of the epidemic on the macroeconomy has been most comprehensive for Tanzania, Zambia, and Uganda, and the main findings of the analysis are presented in Box B1. Overall, however, the inclusion of economic analysis of the AIDS epidemic was very limited in the reports reviewed and, with the above exceptions, AIDS was almost always considered in the more narrow context of a health sector issue.

Among the report types, the health sector analysis and joint CEM/Poverty assessment documents contained the most extensive economic analysis of AIDS. The most comprehensive analysis in the joint CEM/poverty assessments was highlighted above. Three-fourths of the health/social sector analyses reviewed included substantial coverage of AIDS issues. The most in-depth analysis is presented in the Tanzania AIDS Assessment and Planning Study, which includes analysis of incidence and prevalence of the epidemic, the likely demographic impact,

and economic analysis of the costs of the epidemic and possible sectoral and macroeconomic effects.[7] The Malawi Population Sector Study contains extensive modeling of the potential demographic impacts of HIV/AIDS, considering several scenarios depending on the severity of the AIDS epidemic.

Discussion of AIDS was generally absent among the stand-alone CEMs, with the exception of the reports for Côte d'Ivoire, Indonesia and Zambia. The Côte d'Ivoire CEM draws on analysis done for other countries to predict how the epidemic is likely to affect the Ivoirian economy. Based on this analysis, the report lays out priority activities that should be part of a comprehensive government strategy. The Indonesia CEM highlighted the fact that STDs are becoming a more serious health problem and considers the per capita costs of several basic health care interventions, including those for TB and STD care and AIDS prevention. The Zambia CEM considered various ways in which the AIDS epidemic threatens to undermine prospects for economic growth, as discussed in Box B1.

Among the poverty assessments, analysis of AIDS issues varied. The reports for Côte d'Ivoire, Kenya and Malawi focused on how AIDS increased poverty by imposing additional costs on an already impoverished society. The report for Zimbabwe asserted that the AIDS crisis is exacerbated by the poverty situation. Poor men often go to urban areas to seek work, leaving the wife and family at home, and are at higher risk of sexual encounters outside of marriage and of infecting their family. In addition, the burden of caring for AIDS patients is often left to women in rural areas. The report suggests that a systematic and vigorous IEC campaign, along with affordable and easy access to condoms are needed to reduce transmission of AIDS.

[7] Eight more AIDS assessments are at various stages of preparation.

## Table B1: AIDS Analysis in World Bank Economic and Sector Work, 1990-96

| *Country* | *CEM* | *Poverty Assessment* | *PER* | *Health Sector Work* |
|---|---|---|---|---|
| | | ***Generalized Epidemic*** | | |
| Botswana | | | | |
| Burkina Faso | | | - | |
| Burundi | | ++R* | - | |
| Central African Republic | | ++R | | |
| Congo, Democratic Republic | | | | |
| Côte d'Ivoire | ++R | ++R | - | - |
| Haiti | | | | |
| Kenya | - | ++ | | |
| Malawi | | +++ | - | ++R |
| Rwanda | | ++R* | | |
| Tanzania | | ++R* | +R | +++R |
| Uganda | | +++R* | + | +++R |
| Zambia | +++ | +++R | R | |
| Zimbabwe | | ++R* | | + |
| | | ***Concentrated Epidemic*** | | |
| Brazil | - | - | | |
| China | - | - | | - |
| Honduras | + | | | |
| India | - | - | - | ++R |
| Mexico | - | - | | |
| Thailand | - | - | | |
| Vietnam | | + | | - |
| | | ***Nascent Epidemic or Unknown Stage*** | | |
| Indonesia | +++ | - | +R | + |
| Kyrgyz Republic | - | - | - | |
| Morocco | - | | | - |
| Philippines | - | | +R | |
| Romania | | | | |
| Yemen | - | - | | - |

* Joint PER/Poverty Assessment.

***Legend:***

| | |
|---|---|
| | A blank indicates that there was no recent report to review |
| - | no discussion of HIV/AIDS |
| + | a brief mention of HIV/AIDS, but no in-depth discussion |
| ++ | incidence and/or prevalence rates discussed |
| +++ | incidence and/or prevalence rates discussed , plus economic analysis, including cost analysis and/or macro/sectoral analysis |
| R | policy recommendations given |

Source: Author's review

This review confirms the finding in the World Bank report (1996) that PERs generally included very little analysis of the AIDS epidemic and its potential impact on the public budget or civil service. A few of the PERs did, however, provide a discussion of the public economics rationale for government intervention in the health sector, often finding a role for the government in fighting AIDS. For example, the Indonesia PER outlines three economic rationales for public involvement in the health sector: public good, equity and market failures. It cites communicable disease control and epidemiological surveillance as two types of public goods that should be publicly supported. Treating STDs, including AIDS, should be publicly supported because of their equity implications, as the report asserts (without evidence) that the poor are more likely to get these diseases. The PER for the Philippines asks the question: What can national government do that will not be done by the people themselves or by the local government? The main candidates are infectious disease control and health education campaigns of various types (smoking, HIV prevention, and nutrition), where many of the benefits of the activity will accrue to people outside the jurisdiction in which the health expenditures are borne. Local government may underprovide these policies, either because effects directly transcend political boundaries or because migration spreads the effects of interventions across jurisdictions. None of the PERs reviewed, however, took the next logical step of analyzing costs of the alternative public interventions to fight AIDS.

## Box B1: Analysis of the Impact of AIDS on Growth and Macroeconomic Projections

***Tanzania***. The rising prevalence of AIDS can be expected to affect the macroeconomy through a number of channels, which can be grouped into two broad categories. First, declines in 'healthiness' have four effects: reduced labor productivity; increased health care expenditures; reduced savings; and reduced human capital investments. Second, rising mortality rates, particularly among children and sexually active adults, reduce the population growth rate and change the age structure.

A modeling exercise that took into account these effects, estimated that the presence of AIDS reduced the average real GDP growth rate in the 1985-2010 period by between 15 and 28 percent, from 4.0 percent per annum to 2.9-3.4 percent per year (depending on the productivity and savings parameters chosen). Over a 25 year period this decreases potential output by between (1980) Tsh 15 billion to Tsh 25 billion. The impact on growth of potential per capita GDP is more moderate, decreasing it by only 12 percent in the worst case scenario. Under the simulation, per capita GDP growth is forecast to grow an average annual rate of 0.7 percent in the hypothetical situation without AIDS, while with AIDS growth rates range between 0.3 and 0.8 percent per annum. (Tanzania AIDS Assessment and Planning Study, World Bank, 1992)

***Zambia.*** It is not easy to separate the impact of AIDS from the impact of other factors on such important variables as fertility rates and birth control practices, but recent research suggests that the impact of AIDS on population growth rates will be larger than earlier estimated. From an aggregate level of well over 3 percent in the 1980s, the current population growth rate is estimated at 2.8 percent. Estimates from various sources for the rate of population growth in 2005 vary from 1.7 to 2.3 percent.

It is even more difficult to assess the impact on GDP projections. In some areas, such as cotton, it is not likely to have much direct effect, but for domestic food crops, such as maize, one would expect a proportionate reduction. Looking at the economy as a whole, the impact of AIDS on total output depends on the extent to which the impact is disproportionately on the more highly skilled workers, the degree of incapacity to work of AIDS patients, and the substitutability of unemployed workers for AIDS victims. One estimate using cross sectional production functions suggests that with prevalence rates of 20 percent, a two to one ratio of skilled incidence to unskilled incidence, and assuming that 50 percent of the direct AIDS costs come out of direct savings, the impact on per capita output is a negative 0.2 percent per year. In other words, if using these assumptions AIDS decreases annual population growth rates by one percentage point, AIDS would decrease output growth rates by 1.2 percentage points. (Zambia Country Economic Memorandum, World Bank, 1996)

***Uganda***: Prospects for accelerated growth are likely to be adversely affected by the AIDS epidemic. WHO projects that the number of HIV-infected people could increase to more that 1.9 percent by 1998. In 1993-98, 565,000 adults and 250,000 children will die from AIDS. HIV prevalence is found to be higher in urban areas and among the more educated occupational groups in Uganda. Instead of the labor force growing from 400,000 to 1.1 million by 2010, it is estimated to reach only 740,000 because of deaths among workers between the ages of 35 and 50.

Studies on the economic impact of AIDS are less conclusive. Nonetheless, private savings and investment, labor supply, and hence growth are likely to be adversely affected by the epidemic. In the hard-hit areas, less land is under cultivation and farmers have shifted to less-labor intensive crops (no specific evidence is cited to support these assertions). Interest in long-term planning and investments has decreased. Health expenditures per capita are likely to go up, but as resources are limited, the time required to care for the sick may further reduce labor input and hence growth. (Uganda: The Challenge of Growth and Poverty Reduction, World Bank, 1996)

Appendix C: World Bank Projects with an HIV/AIDS Component

| | | *PRIORITY INTERVENTIONS (when targeted to high-risk groups)* | | | | | *OTHER INTERVENTIONS* | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ***Country*** | *Project* | ***Condom Promotion*** | ***STD Treatment*** | ***Targeted IEC*** | ***Operational Research, Surveillance, Evaluation,*** *and Monitoring* | ***Mass-media IEC*** | ***Treatment of AIDS and Operational Infections*** | ***Blood Safety (equipment supplies and training)*** | ***HIV Testing and Counseling*** | ***Total Bank*** | ***Amount for HIV/AIDS*** |
| | | | | | | | | | | *(US $ millions)* | |
| ***Generalized Epidemic*** | | | | | | | | | | | |
| Benin | Health Services | | | | | 1 | | | | 18.60 | 0.60 |
| Benin | Health and Population | 1 | 1 | 1 | 1 | 1 | 1 | ? | | 27.80 | 1.20 |
| Burundi | Population and Health | | | | 1 | 1 | 1 | | 1 | 14.00 | 1.20 |
| Côte d'Ivoire | Integrated Health Services | 1 | 1 | 1 | | 1 | 1 | | | 40.00 | 3.00 |
| Guinea-Bissau | Social and Infrastructure | | 1 | | | | 1 | 1 | | 5.00 | 0.05 |
| Guinea-Bissau | Social Sector | | | 1 | | 1 | | | | 8.80 | 1.00 |
| Haiti | First Health | | | | 1 | | | | 1 | 28.20 | 1.70 |
| Kenya | Third Population | | 1 | | | | | | | 12.20 | 7.00 |
| Kenya | Fourth Population | | | | 1 | | | | | 35.00 | 5.00 |
| Kenya | Health Rehabilitation | | 1 | | 1 | | | 1 | | 31.00 | 1.00 |
| Lesotho | Second PHN | | 1 | 1 | 1 | 1 | 1 | | 1 | 12.10 | 0.90 |
| Malawi | PHN | | | 1 | | | 1 | 1 | | 55.50 | 0.23 |
| Rwanda | First Population | 1 | | | 1 | | | | ? | 19.60 | 2.40 |
| Tanzania | Health and Nutrition | | 1 | | | | | | | 47.60 | 5.00 |
| Uganda | First Health | | | 1 | 1 | 1 | 1 | 1 | | 52.50 | 1.66 |
| Uganda | Transport | | | 1 | | | | | | 75.00 | 0.50 |
| Zambia | Health Sector | | 1 | 1 | 1 | 1 | | | | 56.00 | tbd |
| Sub-total | | 3 | 8 | 8 | 9 | 8 | 7 | 4 | 3 | 538.90 | 32.44 |
| Share | | 18 % | 47 % | 47 % | 53 % | 47 % | 41 % | 24 % | 18 % | | |
| ***Concentrated epidemic*** | | | | | | | | | | | |
| Angola | Health | 1 | | | 1 | | | | | 19.90 | 0.75 |
| Brazil | NE Endemic Disease | | | | 1 | 1 | 1 | | 1 | 109.00 | 6.60 |
| Cameroon | SDA | | 1 | | 1 | 1 | 1 | | 1 | 21.50 | 0.40 |
| Cameroon | Health, Fertility, and Nutrition | 1 | 1 | | | 1 | | | | 43.00 | 0.40 |
| Chad | Health and Safe Motherhood | | 1 | | 1 | 1 | | | | 18.50 | 0.10 |
| China | Infectious and Endemic Disease | | 1 | | 1 | | | | | 90.00 | 0.48 |
| China | Comprehensive Maternal and Child | | 1 | | | | | | | 100.00 | 0.40 |
| China | Disease Prevention | 1 | 1 | 1 | 1 | 1 | | | | 129.60 | 0.48 |
| Gambia | National Health Development | 1 | 1 | | 1 | | | | | 5.60 | 0.10 |
| Guinea | Health Services | 1 | | 1 | | | | | | 19.70 | 1.00 |
| Guinea | Health and Nutrition | | 1 | | 1 | 1 | | | | 24.60 | tbd |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Honduras | Nutrition and Health | | 1 | 1 | 1 | | 1 | 1 | 1 | 25.00 | 0.67 |
| Malaysia | Health Development | | | | | | 1 | 1 | | 50.00 | 16.00 |
| Mali | 2nd Pop and Rural Water | 1 | | | | | | | | 26.60 | 1.40 |
| Niger | Health | 1 | 1 | 1 | ? | | | ? | | 27.80 | 0.35 |
| Niger | Population | 1 | | 1 | | 1 | | | | 17.60 | 0.60 |
| Niger | Health II | 1 | 1 | | 1 | 1 | 1 | 1 | | 40.00 | 1.70 |
| Nigeria | National Population | 1 | | | 1 | 1 | | | | 78.50 | tbd |
| Nigeria | Imo Health and Population | 1 | | | 1 | 1 | | 1 | | 27.60 | 1.00 |
| Nigeria | Health System | 1 | | | 1 | | | | | 70.00 | tbd |
| Senegal | Human Resources Development | 1 | | 1 | 1 | | | | | 35.00 | 0.60 |
| Togo | Population and Health | 1 | 1 | | 1 | 1 | 1 | 1 | | 14.20 | 1.00 |
| Sub-total | | 14 | 12 | 6 | 15 | 11 | 6 | 5 | 3 | 993.70 | 34.03 |
| Share | | 64 % | 55 % | 27 % | 68 % | 50 % | 27% | 23% | 14% | | |
| ***Nascent Epidemic*** | | | | | | | | | | | |
| Madagascar | Economic Management and Social Action | | | | 1 | | | | | 22.10 | 0.43 |
| Madagascar | Health Sector Improvement | | 1 | 1 | 1 | 1 | | | | 31.00 | 1.60 |
| Mauritania | Health and Population | 1 | | | 1 | | | | | 15.70 | 0.20 |
| Morocco | Social Priorities-Basic Health | 1 | 1 | | | 1 | 1 | | | 68.00 | tbd |
| Morocco | Second Health | | | | | | | | | 104.00 | 8.00 |
| Papua New Guinea | Pop and Family Planning | 1 | 1 | 1 | 1? | | | | | 6.90 | 0.66 |
| Yemen | Family Health | 1? | | 1? | 1? | 1? | | | | 36.60 | 0.25 |
| Sub-total | | 3 | 3 | 2 | 3 | 2 | 1 | 0 | 0 | 284.30 | 11.14 |
| Share | | 43% | 43% | 29% | 43% | 29% | 14% | 0% | 0% | | |
| ***Stage of epidemic unknown*** | | | | | | | | | | | |
| Comoros | Population and Human Resources | | | 1 | 1 | | | | 1 | 13.00 | 0.29 |
| Equatorial Guinea | Health Improvement | | 1 | | 1 | | | | | 5.50 | 0.23 |
| Kyrgyz Republic | Health Sector Reform | | 1 | | | | 1 | | | 18.50 | 0.50 |
| Macedonia, FYR | Health Sector | | | | | | | 1? | 1 | 16.90 | 0.77 |
| Romania | Health Services | | | | | 1 | | 1 | | 150.00 | 21.50 |
| Sub-total | | 1 | 2 | 1 | 2 | 1 | 1 | 1 | 2 | 203.90 | 23.29 |
| Share | | 20% | 40% | 20% | 40% | 20% | 20% | 20% | 40% | | |
| Grand Total | | 21 | 25 | 17 | 29 | 22 | 15 | 10 | 8 | 2020.80 | 100.90 |
| Share | | 41% | 49% | 33% | 57% | 43% | 29% | 20% | 16% | | |

Notes: A question mark (?) indicates the SAR was ambiguous regarding this intervention; tbd = to be determined.

Source: Author's review

## Appendix D: The link between economic and sector analysis and project success

The relationship between the amount of sector work prepared prior to the project and project success was investigated following a method similar to the one used in World Bank (1995). 'Project success' was measured using the average project implementation rating from project supervision reports (as reported in the MIS), evaluated on a four-scale criteria: high satisfactory (1), satisfactory (2), unsatisfactory (3), and unsatisfactory (4). The average project implementation rating was 'satisfactory ' (2) and there was very little variation by region (Table D-1).

The amount of high quality sector work was measured by the number of sector reports completed in the three years preceding the project, as documented in the World Bank Reports database.[8] Another measure of the amount of sector work is the number of staff weeks dedicated to sector analysis during the three years preceding project approval, although this measure does not take into account the quality of the analysis.[9] Projects in Sub-Saharan Africa had the fewest average number of completed health sector reports per project (0.5 per project). In contrast, projects in South Asia were most likely to have more completed sector work – an average of almost 1 completed report per project—although the countries in this region seemed to have spent more staff weeks preparing sector work.

Neither of these variables was significant in predicting project success, nor were they significantly related to the measure of project success.[10] This may be due to the small sample size (53 projects were include in the analysis) or the limited variation in project implementation ratings (almost all project received a '2').

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[8] The assumption is that reports must be of a sufficiently high quality to be recorded in this database.

[9] The source for this information is the MIS.

[10] Regressing the project implementation rating on the number of reports completed and, separately, the number of staff weeks both yielded statistically insignificant results (N=53). The Pearson's correlation between project success and number of reports completed was 0.07 (, p=-.75) and between project success and staff weeks of sector work was 0.08, (p=0.56). The correlation between staff weeks spent health sector analysis and reports completed was also insignificant (Pearson's correlation 0.19, p=.15), suggesting that these two indicators are not measuring the same thing and are not good proxies for each other.

**Table D-1: Implementation Ratings and Previous Health Sector Work for Projects with AIDS components, by Region**

| *Region* | *Average Implementation Rating*[1] | *Number of Completed Health Sector Reports in Previous 3 Fiscal Years* | *Staff Weeks Spent on Health Sector Work in Previous 3 Fiscal Years* |
|---|---|---|---|
| Sub-Saharan Africa | 2.0 | 0.5 | 44.4 |
| South and East Asia | 2.1 | 0.9 | 212.5 |
| Latin America | 2.0 | 0.8 | 33.0 |
| Other regions | 1.8 | 0.6 | 30.9 |
| **Average of all projects** | **2.0** | **0.6** | **45.8** |

[1] The average of all supervision implementation ratings as of 10/31/96. Scale: 1=highly satisfactory; 2=satisfactory; 3=unsatisfactory; 4=highly unsatisfactory.
Source: World Bank MIS reports

The nine projects that focused primarily on AIDS prevention and mitigation tend to perform the same as the overall average (1.9 compared with 2.0) (Table D-2). A higher average number of sector reports was completed (0.9 per project) and the average staff weeks spent on health sector work during the previous three years was over twice as high as the average for all projects – 111.6 compared with 45.8. Based on previous analysis (World Bank 1995), we would expect these projects to have a higher probability of success than the other AIDS related projects.

**Table D-2: Implementation Ratings and Sector Work Preceding Project for the Nine Free-standing AIDS Projects**

| *Project* | *Average Implementation Rating* [1] | *Number of Completed Health Sector Reports in Previous 3 Fiscal Years* | *Staff Weeks Spent on Health Sector Work in Previous 3 Fiscal Years* |
|---|---|---|---|
| Brazil AIDS and STD Control | 2 | 2 | 54.3 |
| Burkina Faso Population and AIDS Control | 2 | 0 | 10.9 |
| Chad Population and AIDS Control | 1 | 1 | 45.4 |
| India National AIDS Control | 2 | 2 | 212.5 |
| Indonesia HIV/AIDS and STD | 2 | 1 | |
| Kenya STI | 2 | 0 | 195.8 |
| Uganda STI | 2 | 0 | 205.3 |
| Democratic Republic of Congo National AIDS Control | 2 | 0 | 76.7 |
| Zimbabwe STI Prevention and Care | 2 | 2 | 91.6 |
| Average | 1.9 | 0.9 | 111.6 |

Source: World Bank MIS tables

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**The World Bank**
Washington, D.C. 20433
U.S.A.

JAMES D. WOLFENSOHN
President

October 7, 1999

The Honorable Sandy Thurman
National AIDS Policy
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Ms. Thurman,

As was discussed at the White House during the First Lady's Meeting on AIDS (September 7, 1999), the World Bank has recently published its Strategic Plan on HIV/AIDS in Africa.

Titled *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis*, this strategy book outlines important information on the current state of HIV/AIDS in Sub-Saharan Africa and details the strategic measures being enacted by the World Bank to respond to this critical issue.

I have included a copy of this strategy book as promised during the meeting. If you have any questions about this publication or need additional information, please contact Dr. Debrework Zewdie at the World Bank's AIDS Campaign Team for Africa (ACT*africa*) at 202-458-0606.

Sincerely yours,

James D. Wolfensohn
(Dictated by Mr. Wolfensohn
and signed in his absence)

cc: Ms. Jan Piercy, Executive Director

**The World Bank**
Washington, D.C. 20433
U.S.A.

JAN PIERCY
U.S. Executive Director

4/4

Sandy –

I much enjoyed lunch & apologize that I had to run – I see I left most handing over this paper to be discussed by Ministers (eg Larry Summers, for U.S.) at the World Bank Spring meetings.

Regards,

Jan

Sandy Shuman

DEVELOPMENT COMMITTEE
(Joint Ministerial Committee
of the
Boards of Governors of the Bank and the Fund
on the
Transfer of Real Resources to Developing Countries)

**FOR OFFICIAL USE ONLY**

**DC/2000-02**

**March 24, 2000**

# INTENSIFYING ACTION AGAINST HIV/AIDS: RESPONDING TO A DEVELOPMENT CRISIS

Attached for the April 17, 2000 meeting of the Development Committee is an issues note on Intensifying Action against HIV/AIDS: Responding to a Development Crisis prepared by World Bank Staff as background to item 1.A of the Provisional Agenda.

* * *

# INTENSIFYING ACTION AGAINST HIV/AIDS: RESPONDING TO A DEVELOPMENT CRISIS

DEVELOPMENT COMMITTEE

APRIL 17, 2000

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# INTENSIFYING ACTION AGAINST HIV/AIDS: RESPONDING TO A DEVELOPMENT CRISIS

*HIV/AIDS represents a serious crisis for development in large parts of the developing world, where it is rapidly reversing the social and economic achievements of the past half century. The epidemic now poses the foremost threat to development in Sub-Saharan Africa, a growing threat in Asia and the Caribbean, and a probable threat in some Eastern European countries. This paper summarizes the impact of HIV/AIDS, explains the importance of acting fast, and seeks the engagement of Development Committee members in a strategy by which the international community could help stop the further spread of the epidemic while alleviating its effects.*

## The Explosive Epidemic of HIV/AIDS

1. The HIV/AIDS epidemic has spread with ferocious speed. Virtually unknown 20 years ago, HIV has now infected 50 million people worldwide. More than 16 million have died—2.6 million in 1999 alone. Today, 34 million people are living with HIV/AIDS, over 95 percent of them in developing countries. AIDS is already the fourth-leading cause of death in the world, and the leading cause in Sub-Saharan Africa. Yet despite heightened awareness and a mounting death toll, the growth of the epidemic continues unabated. Each day, over 15,000 people—approximately half between the ages of 15 and 24—are newly infected.

2. The effect on social outcomes has already been extensive. In the most-affected countries, HIV/AIDS is swiftly dismantling the development achievements of the past 50 years. *Life expectancy* is now declining in a host of countries after decades of progress. In several nations it is already 10 years shorter because of HIV/AIDS. In the hardest-hit countries such as Botswana and Zimbabwe, it will soon be 17 years shorter than it would otherwise have been. *Adult mortality rates* have risen by 50 percent in many countries and 100 percent in those most affected by AIDS. *Child mortality rates* in many countries have doubled, and could double again if HIV/AIDS continues unchecked. And the rapid rise in adult deaths is leaving an unprecedented number of *orphans*—11.2 million worldwide, 10.7 million of them in Africa alone. Before AIDS, one in 50 children in the developing world was an orphan. Today as a result of AIDS, in some countries the rate is one in ten.

3. ***AIDS is a global epidemic***. In 1982, there was only one country (Uganda) with an HIV prevalence rate[1] as high as two percent in the general population, along with a much higher rate in certain "at-risk" population groups (*e.g.* commercial sex workers, truckers). Today there are 21 countries with prevalence rates of more than seven percent, and many other developing and transition economies are now where Uganda was in the 1980s—at the dangerous early stage of the epidemic. The behavior of HIV is such that once the prevalence rate reaches around five percent in the general population, the virus spreads very fast. What has happened in these 21 countries now threatens to happen in many other developing and transition economies if action is not taken while the epidemic is young.

4. ***Sub-Saharan Africa*** has experienced the most severe impact so far. The 13.7 million Africans who have died account for 85 percent of the global toll from AIDS, and another 23.3 million are living

[1] The HIV prevalence rate refers to the percentage of all adults age 15-49 who are HIV-positive, which is the standard definition for the scope of the epidemic in a country. In this paper, the terms "HIV prevalence," "HIV rate" and "adult HIV rate" are used interchangeably.

with HIV/AIDS. In at least five countries, more than 20 percent of adults have HIV. Africa's burden has resulted from conditions that allow the virus to spread—notably poverty, dilapidated health systems, and a high level of untreated sexually transmitted infections. But *inaction* has also played a crucial role. Although prevention strategies were known years ago and many measures were taken on a small scale, very few countries or their international partners have taken sufficient action to slow the spread of HIV. The lessons from Africa, both positive and negative, now urgently need to be applied to the other regions where HIV/AIDS is rapidly advancing.

5. ***South and Southeast Asia*** is the second most-affected region. HIV/AIDS came relatively late to the area, but has already killed more than one million people. India has the largest number of persons living with HIV/AIDS—nearly four million—and the virus has appeared in new Indian states in the past two years. HIV rates in Cambodia now exceed two percent among adults and 40 percent among commercial sex workers (a key leading indicator of rates in the general population). In Myanmar, the adult HIV rate is approaching two percent and has already surpassed 20 percent among commercial sex workers. Leading indicators are also troubling in Bangladesh and Vietnam.

6. ***Eastern Europe and Central Asia*** show the most worrisome trend. Half the people now living with HIV/AIDS in this region have been infected in the past two years alone. In 1999, the fastest growth of HIV anywhere took place in Russia. Unlike in Africa and Asia, intravenous drug use (IDU) is the primary mode of transmission in this region for now. Typically, however, IDU fuels the early growth of the virus, which then becomes sexually transmitted and spreads among the general population. The fact that HIV has grown so rapidly in a region where awareness is high underscores that awareness alone is insufficient; support for behavior change must follow.

## The Economic and Social Impact of HIV/AIDS

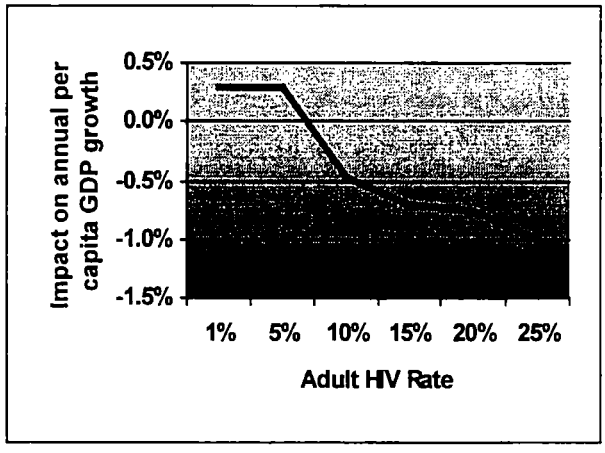
7. The epidemic poses a great threat not only to public health, but to development itself. The World Bank has identified the following factors (among others) to be essential in promoting development and poverty reduction: macroeconomic growth; good governance; human capital development; a favorable climate for private investment; and growth in labor productivity. By undermining each of these, HIV/AIDS is increasingly impeding development. In the worst-hit countries, otherwise sound public and private investments are already proving uneconomic and unsustainable as a result of the epidemic. While many other diseases also kill millions, HIV/AIDS is virtually unique in its impact on the economic and demographic underpinnings of development. Because it weakens and kills adults in the prime of their lives as workers and parents, it erodes productivity, decimates the workforce, depletes the skills base, consumes savings, orphans millions and changes the very structure of households. Many of the following examples come from Africa, because that is where the epidemic and its impact are most advanced. But they are indications of what could happen across the developing world if HIV/AIDS continues to spread.

8. ***AIDS and the economy***. Recent World Bank estimates suggest that HIV/AIDS has a substantial negative impact on economic growth. This relationship was difficult to discern when rates were lower, but it now appears that the economic impact grows as the epidemic advances.[2] Figure 1 shows the most conservative estimate of the epidemic's impact on economic growth in 75 countries; the actual impact may well be greater. As long as prevalence remains below about five percent, annual per capita economic growth is minimally affected. As prevalence rises, per capita growth can be expected to decline. When HIV prevalence reaches eight percent—about where it is in 21 African countries today—the cost in per

[2] This result is derived from cross-country regressions of GDP growth rates as a function of country-specific policy ratings and other parameters, including life expectancy, to control for the different starting conditions of each country. Combining these results with demographic projections of the impact of AIDS on life expectancy and population growth yields the estimated impact on per capita growth.

capita growth is estimated to be about 0.4 percentage points per year. Compared to historical performance in Africa, such losses are significant. Annual per capita growth in Africa as a whole for the past three years has been about 1.2 percent, for instance. In countries such as Zimbabwe where the HIV rate exceeds 25 percent, annual per capita growth is at least a full percentage point lower than it otherwise would be, because of HIV/AIDS.

**Figure 1.** ***Estimated impact of AIDS on annual per capita growth, 1990-97 (75 countries)***




9. The fiscal cost of HIV/AIDS is also significant. One year of basic treatment for a person with AIDS costs an estimated two to three times per capita GDP in *medical* costs alone. Most of these costs are typically borne by the public sector, which faces difficult choices. As the number of AIDS cases increases, so does the cost. In a country with HIV prevalence of 15 percent, the estimated budgetary cost of prevention and basic care could rise from 2.5 percent of GDP today to 6.0 percent by 2010. For most countries, this would imply a substantial worsening of the fiscal deficit.

10. ***AIDS and the production sectors***. In general, it is the 15-49 age group that is disproportionately affected by the HIV/AIDS epidemic. Through its impact on the labor force, HIV/AIDS diminishes productivity just as developing countries need to become more competitive to cope with rapid globalization. All sectors are affected. For example:

- Agriculture. HIV/AIDS reduces investments in irrigation, soil enhancements, and other capital improvements, thereby inhibiting agricultural production. Households are shifting from more nutritious foods to less nourishing but less labor-intensive crops. The epidemic is forcing families to make irreversible decisions to sell livestock, equipment, and land to cover AIDS-related costs. HIV/AIDS illness and care also siphon time away from vital farm work.

- Private sector development. HIV/AIDS is undermining private sector development by removing skilled labor, increasing expenditures, and reducing revenues. Nearly 19 percent of all skilled laborers in South Africa will have HIV by 2015, according to a new report by ING Barings. On one sugar estate in Kenya where 25 percent of the workforce was HIV-positive, company spending on funerals increased 500 percent and direct health expenditures rose 1,000 percent in eight years. At the same time, productivity fell by half in four years. In Madras, India, a study of large industries projected that absenteeism would likely double over the next two years because of sexually transmitted infections and HIV/AIDS. At the firm level, higher labor costs are diminishing scope and incentive to invest in training.

11. ***AIDS and the social sectors***. AIDS overtaxes social systems and aborts the health and educational development that the poor (especially children) need to escape poverty:

- Education. Across Africa, HIV/AIDS has drained skilled manpower in every sector, which was scarce to begin with. Teachers and students are dying or leaving school because they can no longer afford it, have fallen ill, or because they are needed at home to work or care for the sick. Illness and deaths of students and teachers will reduce both the quality and efficiency of educational systems. In some countries more than 30 percent of teachers are living with HIV/AIDS, and more now die each year than graduate from teacher training programs. Moreover, faltering education also diminishes

human capital for the future in every other sector. Girls' education—a critical factor in development—is particularly vulnerable to HIV/AIDS.

- Health. Health care systems in many countries are stretched beyond their limits as they deal with a growing number of AIDS patients and the loss of health personnel to illness and death. Once HIV prevalence reaches five percent, demand for medical care is estimated to rise by at least 25 percent and to increase faster than government is able to supply it. In Cote d'Ivoire, Kenya, Zambia, and Zimbabwe, HIV-infected patients occupy 50-80 percent of all beds in urban hospitals, crowding out other patients and consuming scarce health care resources. AIDS also has large negative externalities for people who are HIV-negative. The epidemic has already sparked a resurgence in tuberculosis (TB) in Africa after years of decline. In some countries, TB cases have risen 500 percent from where they stood before HIV/AIDS.

12. ***AIDS and governance.*** Many developing countries depend crucially on a small number of policy makers and managers for the overall operation of government. Tax and customs administration, legal systems, central banks, finance ministries, schools, hospitals, public utilities and sectoral planning departments all rely on such officials, whose skills are typically scarce. Such personnel are now being rapidly depleted by HIV/AIDS. In South Africa, for instance, 15 percent of civil servants are living with HIV/AIDS. The loss of these key officials is further reducing capacity, which is weakening the prospects for good governance while raising the costs of recruitment, training, benefits, and replacements.

13. ***AIDS and gender.*** Women in general, and girls in particular, are biologically and socially more vulnerable to HIV/AIDS and are disproportionately infected and affected by the epidemic. In some countries, for every 15-19 year-old boy who is infected, there are six girls infected in the same age group. Women and girls also bear the greatest burden of care; families often take girls out of school to care for sick relatives or assume family responsibilities, jeopardizing recent gains in health, nutrition and girls' education. This has an especially detrimental impact on girls' development, which in turn makes them more vulnerable to HIV infection. Girls out of school are less likely to obtain the earning power to increase their economic independence, and more likely to have to resort to commercial sex work. They are also less likely to develop the confidence and knowledge to make sound decisions about their sexual health.

14. ***AIDS and poverty.*** HIV/AIDS particularly targets the poor. The epidemic has overwhelmingly hit the world's poorest countries and those with the greatest disparities of income. Although people at all income levels are vulnerable to HIV, the poor have suffered the most economically, as the costs of care, foregone income and funerals are substantial. The poor also have less access to basic health care and are more likely to have to resort to commercial sex and other survival strategies that put them at risk for HIV. The epidemic has been found to exacerbate both income inequality and absolute poverty.

## The Importance of Acting Fast

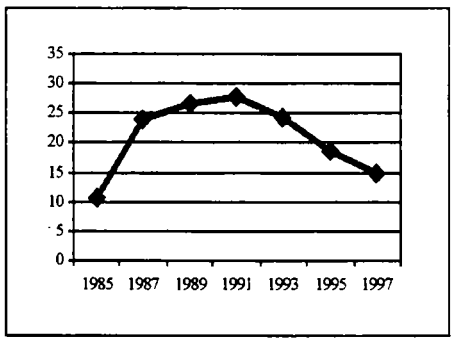
15. The tragedy of this epidemic is compounded by the fact that it is preventable. Despite the lack of a vaccine, behavior change has been proven a highly effective means of reducing HIV transmission. Young people (particularly under age 15) are especially receptive to learning safe behavior messages and skills. Since very few persons at this age are infected, they represent a window of opportunity to prevent HIV/AIDS from afflicting future generations. There is broad consensus and abundant evidence on the impact of behavior change. Early and aggressive action against the epidemic has paid dividends in several settings:

- In Uganda, where the government has led a strong campaign, HIV fell significantly among pregnant women and young people ages 15-24 in urban and peri-urban areas.

- In Senegal, enlisting all key actors in a timely prevention campaign has helped maintain one of the lowest HIV infection rates in Sub-Saharan Africa.

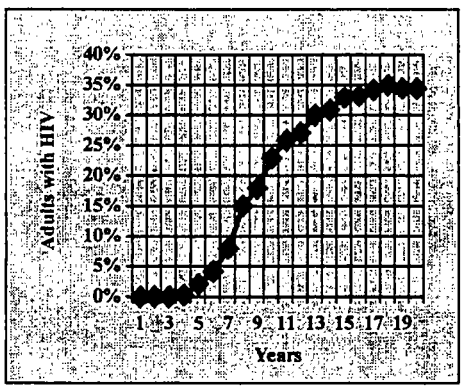
- Asian countries have mounted some of the most effective prevention programs. Rates among pregnant women and military conscripts in northern Thailand fell sharply in four years following concerted prevention efforts. The Indian state of Tamil Nadu launched a safe behavior campaign and saw steep reductions in risky behavior in two years.

**Figure 2.** ***HIV rates in urban Uganda fell sharply after preventive programs were put in place***




16. Prevention not only averts suffering and death, but pays vast dividends in future savings to the health system and the public sector at large. Cost-effective interventions such as greater use of condoms, public information programs, and treatment of sexually transmitted infections cost as little as $8 per infection averted, compared to the hundreds of dollars that each case of AIDS costs to treat.

**Figure 3.** ***Typical spread of HIV in a southern African country***




17. Early action is vital. Once it passes a certain threshold, HIV spreads extremely fast. As Figure 3 illustrates, it can increase tenfold in five years, as it has in several southern African countries. The more widely HIV/AIDS spreads, the more difficult and costly prevention and treatment become. In Sub-Saharan Africa, it is estimated that a national program would cost less than $3 per capita while prevalence remained below five percent. Once rates reach 15 percent, however, program costs could be $12 per capita or more. The longer the introduction of programs is delayed, the greater the likelihood that the epidemic will grow exponentially.

18. Countries therefore face two policy options: (1) delay while prevalence remains low and face far higher expenses once it is widespread; or (2) take comprehensive action early on. Since a strong HIV/AIDS program would be multisectoral, the costs could be spread among several ministries, agencies, civil society, and private actors.

## Building an Effective National Response

19. Every nation threatened by HIV/AIDS must lead its own response. There is no substitute for strong national commitment and ownership. Building an effective national response requires an enabling environment and the necessary resources to bring proven interventions quickly up to nationwide scale. In many countries, it is government that creates such an environment so that all sectors of society can contribute. Many governments have initiated a limited response to HIV/AIDS. Few, however, have brought it to the nationwide necessary. Governments of all vulnerable countries (with their partners) need to expand and intensify their responses rapidly, and to address HIV/AIDS as a multisectoral development issue—not only a health concern.

20. In too many countries, however, there is still official denial or silence surrounding the epidemic. Some governments are unwilling to acknowledge that certain practices such as commercial sex work and intravenous drug use exist in their country. Some are reluctant to tamper with practices that are part of "cultural norms," such as female genital mutilation, even when these place people at higher risk of HIV infection. Some will not address sensitive issues such as sexual behavior by adolescents because of traditions and fears. Since these concerns arise from particular cultural contexts, they can only be overcome by customizing strategies to be culturally appropriate. Governments need to lead a major change in attitudes, to break the conspiracy of silence, and to scale up national responses. Seven actions are fundamental:

21. ***Increase Government Commitment, Attention, and Funding***. Strong government commitment has proved essential in every country that has made headway against the epidemic. This calls for bold political action and leadership, not merely tacit approval of public HIV/AIDS interventions. Leaders need to speak openly about HIV/AIDS, overcome taboos, and place the epidemic at the center of their development agendas. Each country at risk needs a multisectoral national program with adequate funding. To ensure such funding, governments need to re-examine spending priorities in light of the rapidly growing costs of AIDS, and reallocate accordingly. But government can also leverage existing programs (*e.g.* education, agricultural extension) by integrating HIV/AIDS into them at modest cost. Management of national programs belongs in the highest office of government to ensure the power, resources, flexibility, and effective coordination to act multisectorally.

22. ***Scale Up Prevention Activities***. Governments and their partners need to expand proven interventions to a scale large enough to reach all vulnerable individuals. Because of scarce resources, this calls for setting priorities and focusing on a core set of activities that have proven effective and feasible, including: *behavior-change communications* that move audiences from awareness to risk-reducing behavior; making *condoms, treatment of sexually transmitted infections, and voluntary counseling and testing* more accessible; ensuring a *safe blood supply*; and reducing HIV *transmission from mother to child*. Gender-sensitive programs need to be developed to build women's awareness and empowerment. To ensure effectiveness, governments need to work in partnership with persons living with HIV/AIDS, community groups, religious organizations, NGOs, health professionals, and the private sector.

23. ***Scale Up Care Activities***. Governments also need to develop strategies to care for and support the vast numbers of people who are infected and/or affected by HIV/AIDS. Given that the costs of life-prolonging triple-drug therapy are currently out of reach for virtually all developing countries, governments will need to focus on effective treatment for the opportunistic infections that afflict persons living with AIDS. In addition, governments and their partners need to mount programs to care for the millions of orphans and other vulnerable children where extended families can no longer bear the load.

24. ***Support Community-Level Prevention, Care and Support.*** In many countries, the scale of the epidemic exceeds government's capacity to address it. In all countries, communities play a decisive role against HIV/AIDS because of their capacity for social mobilization, their awareness of the local cultural and social context, and their daily influence on the lives of their members. Communities, NGOs and community-based organizations (CBOs) therefore need to receive direct financial support to act at the local level, where the public sector is often less effective. Communities also have a vital role to play in HIV/AIDS care, since long-term hospital care is not affordable or even possible in most developing countries. Strategies to provide high-quality community and home-based care need to be developed. Since it is usually in the best interests of orphans to remain in their extended family or community, innovative support to communities will be important in this respect as well.

25. ***Integrate HIV/AIDS into Poverty Reduction Strategies***. Poverty and HIV/AIDS form a vicious circle. Poverty can drive people to leave their families to find work or into commercial sex for economic

survival, placing them at high risk for HIV infection. HIV/AIDS, in turn, can drive a household deeper into poverty. It is therefore important to address the socioeconomic factors that make people vulnerable to HIV and to mitigate the impact of AIDS on poor households. Poverty reduction policies and programs can prevent people from adopting risky survival strategies and mitigate the financial impact of HIV/AIDS. Poverty Reduction Strategy Papers (PRSPs) need to address the structural factors that have been found to increase people's vulnerability to HIV/AIDS.

26. ***Support More Research.*** Continued research is needed into the cost of HIV/AIDS treatment and care alternatives, the sectoral impact and costs of the epidemic, and the effectiveness of existing prevention tools in different cultural and infrastructure settings. Leaders in each sector will continue to view HIV/AIDS as a health issue unless they see the potential impact on their sector and the comparatively low cost of intervention.

27. ***Make Policy Changes to Mitigate Public and Private Impact.*** AIDS is shrinking capacity in the public sector and imposing new social welfare burdens as families collapse. Countries need to explore innovative ways of rebuilding capacity in government, as well as changes in labor and social legislation and new means of delivering social services to aid the growing number of households headed by orphans.

## Building an Effective International Response

28. Developing country governments cannot overcome the HIV/AIDS challenge alone. Given the scope of the epidemic, its costs, widespread denial, and sensitivities, sustained support from all development partners will be required. Two overarching goals should guide this support. For the present, the goal is to replicate what has been proven to work—that is, *to help every country at risk to establish an appropriate national HIV/AIDS program comprising basic prevention, basic treatment, basic care, and mitigation tools*. This is the minimum needed to prevent the epidemic from spreading further and to begin reversing it where it is already widespread. For the future, the goal is an effective HIV vaccine. Because such a vaccine will not likely be available for at least 10-15 years, however, no country can afford to delay strengthening its prevention and care programs. To help achieve these goals, no single step will suffice. What is needed is a balanced combination of advocacy, incentives, disincentives, funding, and policy support. This will call on the international community for strong partnerships and coordinated action.

29. The international effort is led by the Joint United Nations Programme on HIV/AIDS (UNAIDS), which comprises seven UN cosponsors.[3] With the guidance of the UNAIDS Secretariat, the cosponsors coordinate their assistance to countries addressing the epidemic. This division of labor allows each cosponsor to focus on its comparative advantages and thereby hastens and strengthens international support. The UNAIDS cosponsors have also launched the broader International Partnership Against HIV/AIDS in Africa. This Partnership joins the UNAIDS cosponsors with African governments, donor countries, the private sector, NGOs, and people living with HIV/AIDS. Its goal is to help all African countries put comprehensive national programs in place within a few years under the leadership of the government.

30. **The Role of the World Bank.** The World Bank brings four primary comparative advantages to UNAIDS and the Partnership: (1) Strong influence on the global development agenda; (2) Involvement in virtually all sectors; (3) Ability to support large scaling-up of effective programs; (4) Economic expertise. The Bank has recently adopted a comprehensive new approach to bring each of these strengths to bear on

[3] The UN International Drug Control Programme (UNDCP), the UN Development Programme (UNDP), the UN Educational, Scientific, and Cultural Organization (UNESCO), the UN Population Fund (UNFPA), the UN Children's Fund (UNICEF), the World Health Organization (WHO), and the World Bank. See Annex 1 for more details.

HIV/AIDS. In full collaboration with the UNAIDS Secretariat, the Bank is treating HIV/AIDS as a multisectoral development issue and according it top priority in development policy, dialogue with all sectors of government, planning, analysis, and lending. The Bank's president has corresponded with heads of state on HIV/AIDS. The Bank's senior managers have begun highlighting the issue in some high-level appearances and meetings. Administrative resources have been reallocated, and HIV/AIDS projects have been put on a fast track. From a corporate perspective, the Bank will review the situation every six months to maintain momentum and focus corporate interest continually on the issue.

31. The Bank is acting at both regional and corporate levels to strengthen its support to prevention, care and research. At the regional level, it is taking several steps to integrate HIV/AIDS into both lending and non-lending services. The Africa region is retrofitting its current portfolio to include prevention and mitigation components in as many sectors and projects as possible. A multisectoral AIDS Campaign Team for Africa (ACT*africa*) has been established under the office of the Africa Regional Vice Presidents. ACT*africa* is designing a flagship regional IDA operation to expedite support to HIV/AIDS programs throughout Africa, including innovative forms of funding which will put resources directly in the hands of communities. This operation should reach the Board in the first half of fiscal year 2001. ACT*africa* is also spearheading the incorporation of an AIDS impact assessment module into the Bank's environmental assessment process, and HIV prevention requirements into the Bank's standard procurement requirements for civil works. Economic work is underway to better assess the macro and micro impacts of the epidemic at various stages. Africa country teams are incorporating HIV/AIDS into development planning, HIPC, PRSPs, Country Assistance Strategies, and into projects such as social funds and community action projects. And they are rapidly identifying opportunities to support more comprehensive AIDS programs wherever possible.

32. While the Bank will continue to regard Africa as a funding priority, it is also boosting its support to other regions. Last fiscal year, the Bank approved major HIV/AIDS projects in India and Brazil as a follow-up to earlier projects, and is now developing projects in Russia and Ukraine.

33. At the corporate level, the Bank is using its knowledge and influence to help provide more tools against the epidemic. For instance, the Bank is part of a UNAIDS task force mandated to work with pharmaceutical companies to find ways of making anti-retroviral drugs more available in the developing world. The development of an HIV/AIDS vaccine would produce immense benefits, particularly for the poor and the developing world. As an international public good, however, such a vaccine is unlikely to come to market without concerted action by international donors. Accordingly, the Bank has been an active member of the Global Alliance for Vaccines and Immunizations (GAVI)—a network comprising interested governments, UNICEF, WHO, bilateral agencies, the Gates Foundation, the Rockefeller Foundation and other partners to complement the work of the International AIDS Vaccine Initiative (IAVI). Over the past year, GAVI has met with 180 individuals and institutions to ascertain the pharmaceutical industry's views on HIV vaccine research and development, potential demand, and institutional responses that could be used to ensure future markets for a vaccine in developing countries.

34. ***The international community*** has also intensified attention to the epidemic. Several bilateral donors have recently stepped up their efforts, and the UN Security Council has held a historic session on HIV/AIDS. This reflects the growing consensus and alarm over HIV/AIDS. To convert this consensus into an effective response to HIV/AIDS *as a development issue*, there are six specific actions the international community needs to take:

(1) **Mainstream HIV/AIDS into the development agenda and aid programs**. Donors and international agencies need to make HIV/AIDS a standard element of the core development and aid agenda. The far-reaching ramifications of the epidemic have to be integrated into both macro and sector planning and analyses, as well as in PRSPs and the HIPC Initiative.

Countries with high HIV rates (*i.e.* greater than five percent) will need help preparing to cope with the social challenge that care will pose. Capacity will need to be sustained and frequently replenished, and means found to maintain human capital. The regressive impact of HIV/AIDS will present new challenges for anti-poverty policies. Countries with lower HIV rates (*i.e.* less than five percent) will need help in mounting programs beyond the health sector and in keeping tight surveillance.

(2) **Enhance and sustain advocacy for action on HIV/AIDS**. The international community must use its collective voice to encourage greater attention and action on the epidemic. Advocacy at the global level can help position HIV/AIDS as a development issue, raise more resources for the effort, improve the international policy framework on issues such as procurement and pharmaceuticals, and encourage greater private sector participation. External actors can also stress the importance of national leadership in the HIV/AIDS effort. In developing countries where the response is sound but small, advocacy can accelerate scaling up of the many interventions known to work. In countries where government remains reluctant to address HIV/AIDS, partners can use their development dialogue to encourage greater commitment. In countries where the HIV rate remains low, advocacy can help stimulate early action to keep it that way.

(3) **Build capacity of developing and transition economies to prevent HIV, to care for persons living with AIDS, and to care for orphans.** The impact of the epidemic will be felt for at least a generation to come. Building the capacity of health, education and social support systems to cope over the long term and replacing the skilled manpower that is being eroded will be essential to limiting the consequences of HIV/AIDS. Capacity building will need to focus on the public sector, private sector, and civil society alike.

(4) **Leverage more resources for the HIV/AIDS effort at national *and* community levels.** While funding alone will not stop the epidemic, the resources currently dedicated to HIV/AIDS are far too limited to support expansion to the scale required. In 1997, external support for HIV/AIDS in the developing world amounted to $300 million, or 0.7 percent of all development assistance. The total estimated annual cost for basic prevention in Sub-Saharan Africa would be approximately $1.0-2.3 billion. Both financial and technical resources need to increase substantially. Concessional and grant funds will be especially important to avoid adding to the debt burden of affected countries. Technical resources will also be needed to help countries build expertise in research, planning, implementation, and evaluation. A larger share of HIV/AIDS funding needs to be allocated directly to communities and local NGOs, which are doing some of the best work in HIV/AIDS and will play an indispensable role, especially in caring for the infected and for orphans. Global agencies can also help by harmonizing administrative arrangements and simplifying procurement, disbursement, and accounting. At the same time, even the resources currently available have not been used to the extent possible. There is no shortage of IDA funds, for instance, but demand for HIV/AIDS support from IDA has been modest at best. Developing countries need to reallocate more of their own resources, increase the effectiveness of current HIV/AIDS assistance, and make greater use of current resources.

(5) **Stimulate the development of vaccines and microbicides**. Current market incentives may not be enough to induce industry to develop vaccines that will be affordable and effective in developing countries. To address this, the International AIDS Vaccine Initiative, GAVI and others have been exploring ways of accelerating development of an AIDS vaccine for developing countries. To succeed, this effort may ultimately require innovative financial instruments as well as legal and institutional policy changes. Although an effective vaccine

is probably years away, research is far more advanced on microbicides (substances to kill sexually transmitted infections on contact). Since far more women are infected than men in Sub-Saharan Africa, woman-controlled methods of HIV prevention could reduce both overall infections and the disproportionate burden of infection on women. The international community needs to give priority to enhance the development, clinical testing and accessibility of microbicides and female condoms to help women protect themselves from HIV.

(6) **Strengthen partnerships**. Because HIV/AIDS affects so many aspects of development, external actors must work in unprecedented partnerships with civil society and the private sector under the leadership of governments to exploit the comparative advantage of each. Support must be well-planned and coordinated to enhance synergy and avoid duplication of effort. Bureaucracy should be minimized and processing of aid dramatically accelerated. Most of all, a concerted effort to break the silence surrounding HIV/AIDS needs to be made and consolidated action taken very early in the epidemic.

**Issues for Committee Consideration**

- *Ministers may wish to comment on the development impact of HIV/AIDS in their own countries' experiences.*

- *What advice do ministers have on how governments can help to change attitudes and increase awareness? Do ministers also have advice on how best to help bring about the coordinated action within governments needed to overcome this epidemic? Are there important issues and differing viewpoints not addressed in this short paper which ministers must confront?*

- *What priority would ministers assign to the different actions set out in the paper, and what activities do they think governments should scale back to make room for more action on HIV/AIDS?*

- *Do ministers generally agree with the six priority actions for international action as set forth above? Do they have suggestions for other steps which should be taken to intensify action against HIV/AIDS? Would they support the adoption of specific goals or outcome indicators by the international community as targets for HIV/AIDS efforts?*

- *What do ministers see as the priority actions for the World Bank to pursue on HIV/AIDS?*

Sandy — further re AIDS in India. Mieko is regional VP & — as you'll see in reading this she is remarkable.

**MIEKO NISHIMIZU**
04/04/2000 11:11 PM

Extn: 80600 SARVP
Subject: Re: India Country Assistance Evaluation

Jan

Thanks very much for your note to Ed, to which I am sure he would respond. I have shared your note with Richard Skolnik, as you mentioned HIV/AIDs. Your attention to this topic of global import is much appreciated.

Just so you are aware, the Prime Minister of India himself champions the nation's fight against HIV/AIDS. Richard can share more with you about what India has been doing, with donor support including ours. He can also share with you what the counterfactuals of HIV/AIDS epidemic could have been today, had the nation not begun to act some years back -- a point often missed since India's size captures everyone's attention (as it should).

Meanwhile, the attached two pieces contain some information, including those from the grass roots of South Asia, which might be of some interest to you.

Warm regards,

Mieko -.

**"Fighting AIDS, Mobilizing Everyone"**

**Opening Remarks**
**World AIDS Day**
**The World Bank, November 29, 1999**

**Mieko Nishimizu**
**Vice President, South Asia Region**

- There is a highway in India that begins at its southern end.
  It runs north along the west coast, and splits into two about 500km north of Madras (Chennai).
  One branch heads straight east through the guts of the subcontinent, via Hyderabad to Bombay.
  The other keeps along the west coast, all the way to Calcutta, and fans out.
  A branch heads further west to Bangladesh.
  Others head northward to the Himalayas, to Nepal and to Bhutan.
  Yes another turns northeast, through New Delhi to Amritsar, and to Pakistan.

- On the night of November 10, I stood on that National Highway V totally speechless.
  I was at a truckers' stop called the Red Hills, north of the Chennai city limits,
  not far from Tamil Nadu's state border with Andhra Pradesh.
  The highway was literally a thundering river of trucks, roaring north- and south-bound.
  7,000 trucks per day, 3 men to a truck, 21,000 men per day -- I was told.
  That's the HIV risk group on that spot, picking up village women turned commercial sex workers along the way.
  I was simply overwhelmed.
  21,000 men per day -- how could anyone possibly think of changing the behavior of such a risk group?

- But, there they were ... workers of the Santoshi Social Service Research and Welfare Society.
  With a network of other NGOs along the Highway, they cater truckers pulling off the road

for rest and respite.

And they double as peer educators.

They teach the truckers and local sex workers about HIV/AIDS, and give counseling and referrals.

They motivate the high-risk groups to change their behavior and practice safe sex.

- These workers are former truck drivers and commercial sex workers.

  They used to be beaten up by the truckers, and spat at by the sex workers.

  But, they said it's up to us, and kept going.

  Today, it's not just the Tamil Nadu State Government and IDA who support them.

  All India Truckers Union embraces and support their work.

  The Union said count us in, because we have the strength in unity.

  The union truckers display this shield on their trucks ("Prevention along the highway"), and honk at others who do the same.

- One small condoms manufacturer also said count us in, because we care and it's good for business.

  The company mobilized pan shop owners of Tamil Nadu, the main outlet of their products.

  Together, they developed marketing strategies, to break the dark image of taboo and stigma.

  They designed beautiful and fun packages for condoms.

  They designed open and welcoming pan shop displays.

  Today, the company is the industry leader, and still keep investing in training pan shop owners.

- Tamil Nadu's HIV/AIDS prevention strategy is the true stuff of CDF.

  Of social transformation, rooted in self-empowerment and social mobilization of communities.

  People of leadership qualities said it's up to us and nobody else.

  They are inspiring and organizing their communities, large or small, to find strength in unity & participation.

They have invited those with knowledge and funds, like us, to work with them.
These are leaders in politics, government, NGOs, medical community, and the private sector.
They are also leaders of high risk groups, be they commercial sex workers, truckers, or drug addicts, themselves.
Leadership of the Positive Network, a national organization of HIV-positive Indians, hails from Tamil Nadu.

- It has taken India nearly a decade to create islands of success like Tamil Nadu and others, and to do things like achieving 95% clean blood supply in the nation from 0%.
  I know what the counterfactuals of the epidemic could have been, without them.
  Today, there is a consortium of donors supporting India's national HIV/AIDS control program.
  Our strategy for the coming decade is to help nurture and spread the islands of success throughout India,
  and beyond its borders to all South Asian countries.

- My colleagues and counterparts taught me this: fighting HIV/AIDS is a huge engagement of social transformation.
  It is an engagement that must move all leaders in government and civil society to act.
  An engagement that wants all citizens of all nations to mobilize.
  It is an awesome engagement.
  But, I am now convinced that the Bank has the corporate talent, strength and comparative advantage
  to play a critical part in this global engagement -- to make a difference.
  And I am proud to have colleagues, like Richard Skolnik, who said it's up to us & count us in,
  more than 10 years ago when an enabling environment like this today did not exist in the Bank or in India.

- "The Bank" is nobody else but us.

It is up to each and every one of us, no matter what our job is, to find a part to play in this fight against HIV/AIDS.

**"AIDS and Development"**

**Plenary Address**
**Fifth International Conference on AIDS in Asia**
**Kuala Lumpur, Malaysia**
**October 24, 1999**

**Mieko Nishimizu**
**Vice President, South Asia**
**The World Bank**

**Imagine a world free of poverty.** A world, where quality of life guarantees human dignity. A world, where everyone exercises basic human rights. A world, where all children will live to their fullest potential. That is the dream the World Bank shares with all member nations. That is why we remain impressed by Asia's achievements in social, economic and human development. But, that is also why I am here to talk about AIDS.

**AIDS threatens Asia.** AIDS threatens to reduce, halt and even reverse economic growth of Asia. It threatens to kill the people of Asia at the prime of their productive years. It threatens to tear apart the very social fabric of Asia. Ultimately, but without exaggeration, AIDS threatens the security and stability of nation states. It is unlike any other disease. It is decidedly not just a public health matter. It is a singularly most critical socio-economic development issue.

**AIDS threatens Asia, today.** Not in generations, not in decades, not in

years, but now -- today. At least 33 million people are infected worldwide. One quarter, or about 8 million, of them are here in Asia, and most likely more. Yes, already spreading silently here in Asia, where a lion's share of the world's population live.

**Preventing AIDS epidemic is, therefore, not the agenda of Asia alone.** The highest absolute number of the poor live in Asia still. The majority of our world's children belong to Asia. AIDS's threat to Asia is a threat to the world. To void Asia's hard-earned economic and social achievements is a global threat. To deny the people of Asia the dream of the world without poverty is to deny that dream for the entire world. Preventing the epidemic in Asia is, indeed, a global development agenda.

**We can be part of the problem or part of the solution.** The World Bank is prepared to be part of the solution. But, it must be Asia's own solution, to protect your society, economy, proud nationhood -- all that you have, all that you want, all that you dream of. It has to be Asia's own commitment, starting at the top political leadership and throughout the civil society everywhere. It must be Asia's own will to act, with governments and non-government organizations united as true partners under one common cause.

For leaders both in government and in civil society to choose not to act --

knowing fully the consequences -- is unethical and a betrayal of their people. To focus the might of leadership everywhere on the problem, orchestrating all the change agents throughout the society, is at the heart of the solution. Asia's future is in our hands. The choice, is ours.

* * * * *

**What do I -- just another macroeconomist -- know about AIDS?** Am I just reading off a speech my public health colleagues wrote? Am I here just to do what I was told to do? No. Hear me out, please.

I spent one day in July deep inside the old city of Dhaka, Bangladesh, where I saw the dream of poverty reduction and the threat of AIDS that could shutter it at the same time. I spent that day with commercial sex workers. Not at high-class brothels or middle-class ones, but at a rest house for street workers run by two non-government organizations. A house, where these workers come in off the streets each morning, to wash, rest and to receive medical care.

The most remarkable group of women I have ever met. Their shining faces spoke the power of self-empowerment they discovered. Their beaming eyes showed that leadership stuff they are made of. They have mobilized themselves into a self-help group, with membership fees and saving schemes-- to look after the old and the sick among them, to learn new occupational skills to "get out of this

darkness", to take marshal arts lessons to defend themselves from abuse, to send their fatherless children to school, and to secure an old-age pension for themselves.

Nadia, their leader, said to me: "Sister, you must learn about AIDS to protect yourself from ruins." She and her fellow workers taught me, patiently, what the disease is, how it is transmitted, and what methods they use to avoid infection. They showed me a range of condoms they sell, for a small profit margin going to the savings group. They laughed at me when I confessed I have never seen a female condom in my life. As I bid farewell, Nadia took my hands into hers, and said in her firm, confident, voice: "Remember, younger sister, knowledge is your power to a better life." That day, I could almost smell, taste, and touch the dream of a world free of poverty.

A day like that ought to make me feel elated and renew my resolve to go on, *"to fight poverty with passion and professionalism for lasting results" (Mission Statement, the World Bank Group)*. At the end of the day, instead, I was thrown into the deepest despair I ever knew. I possessed one knowledge that they did not: that many of these sisters were already infected. It was too late, and they did not know it yet. Their empowerment, mobilization, and hard work for the dream -- to get out of the destitute poverty -- was already denied to many of them.

On the way back, with a heavy heart, I stared at a crazy Dhaka traffic. I remembered that Bangladesh has the world's highest death tolls from road accidents. Suddenly, a chill ran though my spine. What if I get into an accident? What if I am taken to a hospital? What if I receive injection with an unclean needle? What if I need a blood transfusion? What if? What if?

For the first time on that day, the threat of AIDS I thought I knew became a threat I truly knew -- one that I share with the commercial sex workers of Dhaka, all the poor of Bangladesh and beyond, and the rest of mankind, personally and professionally.

* * * * *

**AIDS -- a single fatal infectious disease -- is indeed touching every one of us, in ways totally unlike any other disease.** The HIV virus is already present in all countries of Asia. Whether or not we want to admit it, there are people engaged in high risk behaviors everywhere. There are people who inject drugs. There is commercial sex. People engage in unsafe sexual practices. In most countries, the blood supply is not free of HIV and infection control procedures are poor, posing risks for health workers, patients, the general public -- you, and me, alike.

**AIDS can shrink economies, as it threatens people in their most**

**productive years.** In the hardest-hit Africa, life expectancy is 10-20 years lower today than it would have been, because of AIDS. The harder-hit, moreover, are those who are contributing to their economy -- at the prime of their productive lives. Just search for any Nairobi newspapers on the internet, and open the obituary section. Page after page of young beautiful faces -- full of hope and vitality. Cause of death: "unknown." Page, after page, after page ... every day.

The worst-hit countries in East Asia are feeling a similar impact. Cambodia, Myanmar, and Thailand have lost 2-3 years of life expectancy to AIDS, and the majority of those infected are not yet showing signs of illness. Since 1970, life expectancy in nine East Asian nations rose by 10 years or more. In South Asia, countries such as Bangladesh, Bhutan, India, and Nepal raised it by 14 years or more. Impressive gains. But, AIDS can cancel and reverse this progress, with significant impact on the growth and size of economies. It will cancel and reverse the progress, if we do not act now.

**The AIDS epidemic will overwhelm health finances. But, it will not stop there -- the entire public finances will come under an enormous pressure.** To project this is not rocket science. AIDS patients require a variety of medical care, as they cope with repeated bouts of infection and tuberculosis. This raises health-care costs, even in places that cannot afford expensive drug therapy.

India has been fighting the spread of HIV/AIDS for almost a decade now, but she already has the largest number of infected people of any country in the world. Suppose the infection rate rises to 5 percent of adult Indian population. The nation's public health budget could swell by at least 30 percent. Average treatment expenditure per year on each and every AIDS case costs more than educating 10 primary school students in India -- without counting expensive therapies.

Larger health expenditure from an AIDS epidemic will force very hard trade-offs in public finances. Here, I am on a safer ground. Every time I look at such financial projections, I shudder. We economists are not good at making impossible, unethical, financial trade-offs. I do not wish such nightmares on anyone, including and especially Finance Ministers. But, they will be the reality one day, if we do not act now.

**But, AIDS threatens things we value more than finances.** It destroys families. It intrudes in the most intimate relations between people. It erodes our trust in each other. It devalues our basic right to procreate. It spreads silently. It kills. It tears at the very fabric of society. It is like no other disease. In a fundamental sense, it is a threat to the security of societies and of nation states. That threat is here today. It will strike if we do not act now.

* * * * *

**Asian governments must act now**. In all nations of Asia, preventing the AIDS epidemic and mitigating its impact must be at the center of development policies and programs.

**Denial is pointless.** In every country with a serious AIDS epidemic today, people once said: "It can't happen here. We don't have the behaviors that spread AIDS." They were wrong. It is too easy to be complacent, when no one appears visibly sick with AIDS. It is too easy to look the other way, when thousands are dying of other afflictions.

But, HIV/AIDS respects no international borders. It does not discriminate by nationality, race, gender, or religion. And, I repeat, human behaviors and social conditions that spread the virus are present in all countries. Internal and international migration, or political and social upheavals, also facilitate the spread of the virus. By the time hospitals are seized by AIDS patients, it is too late. The virus will already have spread to epidemic proportions.

**Asia can learn from the Asian experience.** Thailand offers an outstanding example of how to slow down the spread of HIV by enabling people to adopt safer behavior. The nation's vigorous response worked -- program promoting 100% condom use in commercial sex, public information campaign about HIV/AIDS,

and various other prevention measures. The number of STD patients is one-tenth its former level. Infection rates among army conscripts have halved. Such achievements are tribute to Thailand's government and civil-society leaderships, working together.

Thailand teaches us to act forcefully. But she also teaches us to act immediately -- in spite of her tremendous success, the virus has now infected nearly 1 million people of Thailand.

**Today, Asia has a golden opportunity to act early.** Asia does have pockets of concentrated epidemics. Nearly 600 million Asians live in countries with such pockets. The success of Thailand, and others such as India, teach us that concentrated epidemics can be contained, that one can slow down the spread of HIV, by enabling those with the greatest risk to protect themselves and others.

Asia is fortunate. To date, there are no Asian nations with "generalized" epidemic -- where HIV has spread to more than 5 percent of the population. Three-quarters of the people of Asia live in countries or states or provinces where HIV/AIDS is not widespread -- such as many states of India, much of China, Indonesia, the Philippines, Korea, Bangladesh, Bhutan, Sri Lanka. Africa and some Caribbean nations were not so fortunate. By the time scientists understood how HIV was transmitted, it was too late.

Asia has a small gift of time. Time to act. Time to act early. Time to prevent a generalized epidemic. Use it, before it turns against you.

* * * * *

**Before closing, I want to tell you about Sonagachi.** In the Sonagachi red-light district of Calcutta, sex workers are leading the war against HIV/AIDS. They have organized themselves into a crusading force to promote the use of condoms. With support of the government, non-government organizations, and international agencies, the Sonagachi women raised condom use from 3% in 1992 to over 90% in 1998. HIV infection is held to about 5% there, compared to more than 50% among sex workers of Bombay.

But, the impact of this program have gone well beyond HIV prevention to development -- economic, social and human development. Like those sisters in Dhaka, they too have their own financial cooperatives. They are becoming literate, have organized to demand protection from police abuse, and are preventing child prostitution.

Confronting AIDS is not easy. Acting to fight it is even tougher. But, engagements like the Sonagachi and Dhaka ones can prevent AIDS epidemic. They jump-start sustained social transformation that is development -- grass-roots social mobilization with empowerment, human dignity, and visible shifts in the

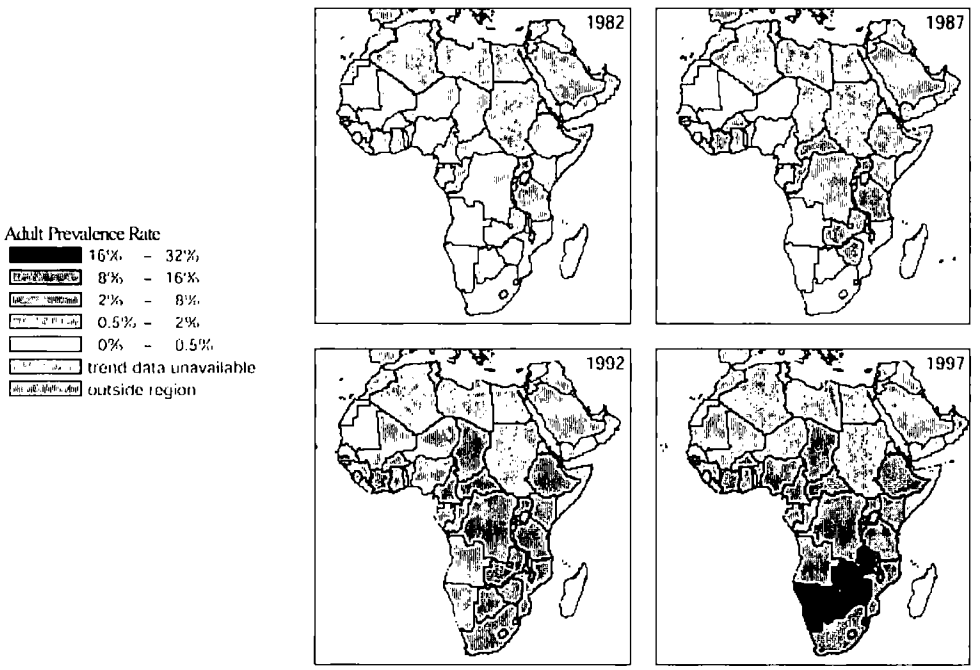
quality of life. Early and enlightened government actions like these -- in true partnerships with non-government organizations and the civil society -- can shift the paradigm, the path and outcomes of nation building in Asia, and the rest of the world beyond.

I end my remarks with a favorite passage of mine, from the Koran: "*Verily never will God change the condition of a people until they change it themselves, with their own souls.*" I call on all leaders of Asia, in governments and in civil societies, and all change agents amongst the people of Asia, to act, act forcefully, and act now.

To: Jan Piercy Eds
cc: Richard Lee Skolnik
Edwin Lim
Joelle Chassard

# Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis

**The Cost of Inaction:**
**Spread of HIV over time in Sub-Saharan Africa, 1982–1997**




*Africa Region*
*The World Bank*

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## ACRONYMS

| | |
|---|---|
| ACT*africa* | AIDS Campaign Team for Africa |
| AIDS | Acquired immunodeficiency syndrome |
| ARV | Antiretroviral therapy |
| CAS | Country assistance strategy |
| CBO | Community-based organization |
| CILSS | Comité Inter-Etats de Lutte Contre la Séchéresse dans le Sahel |
| ESW | Economic and sector work |
| HIPC | Heavily indebted poor countries |
| HIV | Human immunodeficiency virus |
| IAVI | International AIDS Vaccine Initiative |
| IBRD | International Bank for Reconstruction and Development |
| IDA | International Development Association |
| MTCT | Mother-to-child transmission |
| NGO | Nongovernmental organization |
| OAU | Organization for African Unity |
| OD | Operational directive |
| OP | Operational policy |
| SADC | Southern Africa Development Community |
| SSA | Sub-Saharan Africa |
| STI | Sexually transmitted infection |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| UNDP | United Nations Development Programme |
| UNESCO | United Nations Education, Scientific, and Cultural Organization |
| UNFPA | United Nations Population Fund |
| VCT | Voluntary counseling and testing |
| WHO | World Health Organization |

## FOREWORD

HIV/AIDS has spread with ferocious speed. Nearly 34 million people in the world are currently living with HIV/AIDS, one-third of whom are young people between the ages of 10 and 24. The epidemic continues to grow, as 16,000 people worldwide become newly infected each day. AIDS already accounts for 9 percent of adult deaths from infectious disease in the developing world, a share that is expected to quadruple by 2020.

Nowhere has the impact of HIV/AIDS been more severe than Sub-Saharan Africa. All but unknown a generation ago, today it poses the foremost threat to development in the region. By any measure, and at all levels, its impact is simply staggering:

- At the regional level, more than 11 million Africans have already died, and another 22 million are now living with HIV/AIDS. That is two-thirds of all the cases presently on earth.

- At the national level, the 21 countries with the highest HIV prevalence are in Africa. In Botswana and Zimbabwe, one in four adults is infected. In at least 10 other African countries, prevalence rates among adults exceed 10 percent.

- At the individual level, the arithmetic of risk is horrific. A child born in Zambia or Zimbabwe today is more likely than not to die of AIDS. In many other African countries, the lifetime risk of dying of AIDS is greater than one in three.

In short, as a result of the HIV/AIDS epidemic, much of Africa will enter the 21st century watching the gains of the 20th evaporate.

Tragically, mass killers are nothing new in Africa. Malaria still claims about as many African lives as AIDS, and preventable childhood diseases kill millions of others. What sets AIDS apart, however, is its unprecedented impact on regional development. Because it kills so many adults in the prime of their working and parenting lives, it decimates the workforce, fractures and impoverishes families, orphans millions, and shreds the fabric of communities. The costs it imposes force countries to make heartbreaking choices between today's and future lives, and between health and dozens of other vital investments for development. Given these realities, African governments and their partners must act now to prevent further HIV infections and to care for and support the millions of Africans already infected and affected.

The World Bank can and will play a stronger role in this effort. This document, *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis*, introduces the Bank's new strategy to combat the epidemic in partnership with African governments and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The strategy, approved by the Regional Leadership Team in May 1999, stands on four pillars:

- Advocacy to position HIV/AIDS as a central development issue and to increase and sustain an intensified response.

- Increased resources and technical support for African partners and Bank country teams to main-stream HIV/AIDS activities in all sectors.

- Prevention efforts targeted to both general and specific audiences, and activities to enhance HIV/AIDS treatment and care.

- Expanded knowledge base to help countries design and manage prevention, care, and treatment programs based on epidemic trends, impact forecasts, and identified best practices.

(An ideal national program that incorporates these four pillars is presented as a case study in Annex 1.)

To stimulate and support implementation of the strategy, the Bank has established a multisectoral AIDS Campaign Team for Africa (ACT*africa*), which will be based in the Office of the Regional Vice Presidents. The high-level placement of ACT*africa* underscores the Bank's commitment to HIV/AIDS prevention and care and will enable the team to maximize collaboration among the sector families. Most of ACT*africa*'s work will be demand-driven and funded from country budgets. The team will serve as the region's focal point and clearinghouse on HIV/AIDS and will provide a variety of services, including:

- Equipping and supporting Bank country teams to mobilize African leaders, civil society, and the private sector to intensify action against HIV/AIDS.

- Retrofitting projects with HIV/AIDS components where possible, assisting in the development of new dedicated HIV/AIDS projects, and building AIDS-mitigation measures into other projects where necessary.

- Supporting Bank country teams in addressing HIV/AIDS in their country assistance strategies.

- Exploring the feasibility of building an AIDS impact assessment module into existing environmental and/or social assessment processes.

- Collecting and disseminating information on the progress of the epidemics, country-by-country statistics, and best practices.

- Strengthening and expanding the Bank's partnership with UNAIDS, as well as with key agencies, nongovernmental organizations, and interested bilaterals.

The strategic plan detailed herein represents the Bank's next important step in the fight against HIV/AIDS in Africa. By its terms, we will now place HIV/AIDS at the center of our development agenda, and mainstream it in all aspects of our work in Africa and in all channels of our dialogue. We will help our clients intensify and expand their national responses, and help build capacity among our staff in all sectors to factor HIV/AIDS into policies and projects. We will establish HIV/AIDS as both a corporate priority and our primary partnership issue. Finally,

we will ensure that Sub-Saharan Africa realizes the full potential of our strategic partnership with UNAIDS.

It is easy to despair of AIDS. But let us bear in mind the many formidable challenges that Africa has already faced and overcome: wars of independence, global economic upheaval, droughts, floods. Then let us remember that unlike any of these, ***AIDS is completely preventable***.

Recently, a history of the World Bank's first 50 years was published. In its more than 1,900 pages, including a 100-page chapter on Africa, the word "AIDS" barely appears. A generation from now, when the next such history is written, we can be certain that the pandemic will play a far more prominent role. 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.

Let's get to work.

Callisto Madavo
Jean-Louis Sarbib

Vice Presidents
Africa Region

June 1999

## ACKNOWLEDGMENTS

This strategic plan was prepared by a team led by Debrework Zewdie[1], comprising Sheila Mitchell and Sheila Dutta. Birger Fredriksen (Director, Human Development, Africa Region) and Ruth Kagia (Sector Manager, Human Development I, Africa Region) provided overall guidance.

The personal commitment of the Regional Vice Presidents, Callisto Madavo and Jean-Louis Sarbib, enabled the Regional Leadership Team to place HIV/AIDS at the center of the strategic agenda for Africa.

This document benefited from the invaluable guidance provided by the Intensifying Action Against HIV/AIDS Steering Committee: Hans Binswanger, Robert Calderisi, Abdou Salaam Drabo, Jacob Gayle, Salim Habayeb, Demissie Habte, Keith Hansen, Ohene Owusu Nyanin, A. Mead Over, Ok Pannenborg, and Albertus Voetberg. Of this group, Hans Binswanger, Robert Calderisi, Keith Hansen, and Albertus Voetberg prepared sections of the document. A review committee consisting of Pamela Cox, Alan Gelb, Letitia Obeng, and Hasan Tuluy provided valuable comments.

We also thank the many other Bank staff, the UNAIDS Secretariat and Cosponsoring Agencies, and the HNP External Advisory Panel for sharing their insights. The assistance of the UNAIDS Secretariat in providing us with data and the included maps is gratefully acknowledged.

We also would like to thank Robert Ritzenthaler for his assistance in editing this document.

A grant from the Norwegian Royal Ministry of Foreign Affairs enabled the preparation of this strategic plan.

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# I. EXECUTIVE SUMMARY

Two-thirds of the world's HIV/AIDS epidemic is in Africa. Last year alone, the disease killed 1.5 million people. They were not statistics. They were fathers and mothers, brothers and sisters, doctors and nurses, primary school teachers, electrical engineers, community leaders, finance managers, entrepreneurs, students, researchers, and farmers trying to lift their families out of poverty. Their spouses and children are now condemned to new hardship.

These people died because of the unique concentration of HIV in Africa, but also because the continent's leaders—and its international partners—have been slow to respond to the epidemic. Not since the bubonic plague of the European Middle Ages has there been so large a threat to hundreds of millions of people—and to the future of entire economies and societies.

Given the scale of the epidemic, it is no longer just a public health problem. It is a development crisis. And it has been in the making for at least 10 years. But challenges on so many fronts, the lack of knowledge about what to do, and a certain fatalism have overtaken the valiant efforts of a large number of people in Africa to make a dent in the massive infection rates. These people need fresh hope and new resources. Now is the time to act—and to act decisively.

This strategic plan calls on the World Bank, its development partners, and African governments to make a new commitment to saving millions of people from the worst effects of HIV/AIDS. This commitment will need to be as broad as the epidemic itself and intense enough to make up for a late start.

In particular, it calls on African leaders, civil society, and the private sector to put the HIV/AIDS crisis at the center of their national agendas. The Bank can raise the issue in international fora, conduct assessments on the impact of HIV/AIDS on development, sponsor international and regional conferences, and identify credible business leaders who can promote AIDS prevention in the workplace. The Bank can also help by identifying African elders and former statesmen, writers, musicians, artists, and athletes who would be willing to visit the worst-affected countries and dramatize the need for early action—particularly among young people.

The plan calls for building capacity within national and local governments, communities, and the private sector to design and implement effective programs. The Bank can help by providing technical assistance to countries; expanding existing management training programs to include national staff dealing with HIV/AIDS; and modifying existing Bank-financed projects (or developing new ones) to build capacity for HIV/AIDS prevention and care.

The Bank will need to strengthen its own capacity to respond to country requests for support by making HIV/AIDS a central element of its development agenda for Africa; providing timetables and guidance for Bank country teams to address the subject in all their projects and activities; including HIV/AIDS as an aspect of all country assistance strategies (CASs); requiring AIDS impact assessments for all projects; and issuing a Bank operational directive (OD) on the subject.

The Bank must also give its own staff the knowledge, tools, and resources needed to mobilize others by establishing an AIDS Campaign Team, ACT*africa*, to provide operational support in all sectors; expanding such support into Bank country offices; developing analytical tools and briefs for Bank country teams to use with their country counterparts; collecting and disseminating information on intervention options and success stories; providing adequate resources to Bank country teams; and maintaining up-to-date Web pages on best practices.

Equally important will be continued Bank efforts to help countries improve their economic and social circumstances and hence slow the spread of the epidemic by educating girls; reducing poverty; making health sector reform more HIV/AIDS sensitive; expanding gender initiatives; and strengthening capacity building to address the massive loss of skills and experience that has resulted from the epidemic.

The Bank should expand the resources available for fighting HIV/AIDS through increased funding for prevention, care, and treatment; redirecting ongoing project funds; using innovative mechanisms (e.g., social funds) for delivering resources to local governments, communities, and nongovernmental organizations (NGOs); and including HIV/AIDS among activities financed from the Heavily Indebted Poor Countries (HIPC) Trust Fund.

Bank-financed projects can also be retrofitted to reach more vulnerable populations and address long-term needs created by HIV/AIDS by supporting social assessment and impact studies to develop long-range planning; integrating information about HIV/AIDS into existing school and training curricula; and including condom distribution, treatment of sexually transmitted infections (STIs), and care and support into existing projects employing workers vulnerable to the disease.

The Bank must also mobilize additional resources from the international community through high-level meetings; better collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS), other United Nations agencies, and international donors; and greater engagement with the international private sector.

Finally, the Bank should identify new ways of financing the development of affordable vaccines and other prevention options, such as microbicides, and support research efforts to provide decision-makers with the data and tools they need to intensify their efforts against the epidemic.

HIV/AIDS has already reversed 30 years of hard-won social progress in some countries. Now is the time for Africa—and the world—to fight back.

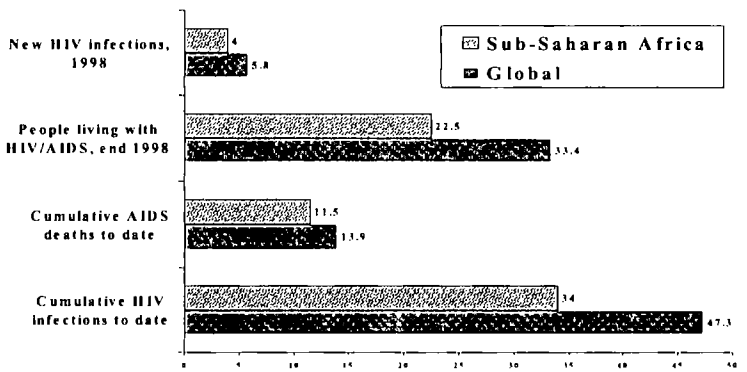
## II. THE GATHERING STORM

### The Rapidly Growing HIV/AIDS Epidemic

The spread of HIV/AIDS has exceeded the worst projections by far. Nearly 34 million people in the world are currently living with HIV/AIDS, and one-third of these are young people between the ages of 10 and 24. The epidemic continues to grow, as 16,000 people worldwide become newly infected each day. Fourteen million adults and children have already lost their lives to this devastating disease, and the death toll rises each year (UNAIDS, 1998e). Despite these alarming figures, AIDS is still an emerging and growing epidemic.

The region most affected has been Sub-Saharan Africa[2] (SSA). At the end of 1998, 22.5 million people, including 1 million children, were living with HIV/AIDS in SSA, two-thirds of the worldwide total (Figure 1). At least 4 million Africans were newly infected with the virus in 1998. HIV does not respect borders, and its transmission is often facilitated by subregional trade routes and other migration patterns common throughout the continent. In Botswana, Namibia, Zambia, and Zimbabwe, between 20 and 26 percent of people ages 15 to 49 are infected. In 12 other SSA countries, including Ethiopia, Kenya, Mozambique, South Africa, and Tanzania, 9 to 20 percent of adults are infected (UNAIDS, 1998a; Annex 2). Some countries in West and Central Africa have been less affected and have been able to maintain low and stable HIV infection rates. This is due, in part, to an early response to the threat of the epidemic in some countries, and in part because a less virulent HIV strain (HIV-2) predominates in these countries. However, there is no single factor or clear-cut group of factors that determines the severity of a country's HIV/AIDS epidemic.

**Figure 1. Global and Sub-Saharan Africa Disease Burden, December 1998**




*Source*: UNAIDS, 1998c.

[2]In this document, "Africa" and "Sub-Saharan Africa" are used interchangeably.

Deaths due to HIV/AIDS in Africa will soon surpass the 20 million Europeans killed by the plague epidemic of 1347–1351 (Decosas and Adrien, 1999).

It is estimated that only 10 percent of the illness and death that this epidemic will bring has been seen. The real impact on people, communities, and economies is still to come. There is no affordable cure or vaccine likely to be available in developing countries for a decade or more. The only options are to prevent further spread of the epidemic, minimize its impact, and provide a caring and compassionate environment for those infected and affected. This crisis calls for an expanded and intensified response to mobilize governments, civil society, the private sector, and the international community to take action, increase resources, and build capacity to sustain efforts to slow the spread of the epidemic.

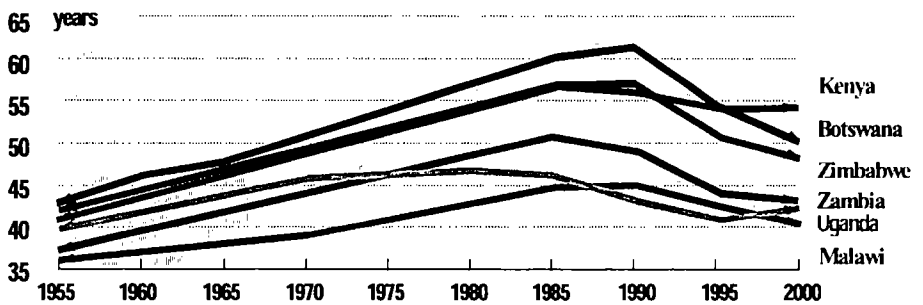
### HIV/AIDS' Devastating Impact on Development

The HIV/AIDS epidemic is not only the most important public health problem affecting large parts of SSA, but is an unprecedented threat to the region's development. It is, therefore, a development crisis.

The most disturbing long-term feature of the HIV/AIDS epidemic is its impact on life expectancy, making HIV an unprecedented catastrophe in the world's history. Among 18 countries in SSA that experienced a declining or stagnating life expectancy during 1990-1995, all but one (Togo) were described as having a generalized HIV/AIDS epidemic, that is, an HIV prevalence of more than 5 percent in the adult population. Conversely, of 29 countries that experienced an improvement in life expectancy, only two, Mozambique and Lesotho, had a generalized epidemic (World Bank, 1999).

In nine African countries with adult prevalence of 10 percent or more, HIV/AIDS will erase 17 years of potential gains in life expectancy, meaning that instead of reaching 64 years, by 2010-2015 life expectancy in these countries will *regress* to an average of just 47 years; this represents a reversal of most development gains of the past 30 years—affecting an entire generation (UNAIDS, 1998e). Figure 2 indicates estimated life expectancy in selected African countries.

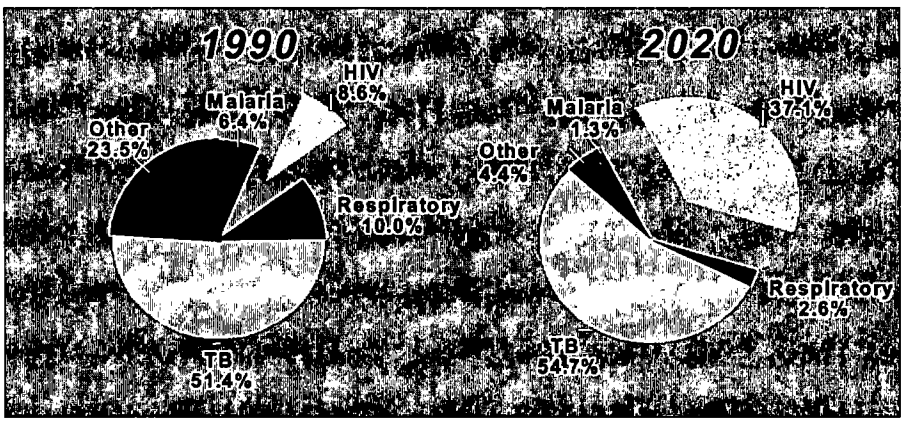
**Figure 2. Estimated Life Expectancy at Birth: Selected African Countries, 1955-2000**




*Source:* UNAIDS, 1998a.

HIV/AIDS is also surpassing malaria as the leading cause of death in many countries (Figure 3).

**Figure 3. Adult Deaths from Infectious Diseases in the Developing World, 1990 and 2020.**




*Source*: World Bank, 1997a.

Demographic projections vary in predicting the effects of the epidemic on population growth. However, all agree that there will be a decrease in annual population growth in the region by 2010. It is unlikely that the epidemic in any country will reach proportions severe enough and cause a rapid enough decline in fertility to exhibit a negative population growth due to HIV (Decosas and Adrien, 1999).

*Child mortality is rising.* In 1998, about 530,000 HIV-infected children were born in SSA, about 90 percent of the world total. By 2005–2010, infant mortality in South Africa will be 60 percent higher than it would have been without HIV/AIDS (61 deaths per 1,000 infants born rather than 38 per 1,000 in the absence of AIDS). In Zambia and Zimbabwe, 25 percent more infants are already dying than would be the case without HIV. By 2010, Zimbabwe's infant and child mortality rates will have doubled (UNAIDS, 1998e).

*Young people are disproportionately affected.* Worldwide, about half of all new HIV infections occur in young people ages 15-24. In 1998, nearly 3 million young people became infected with the virus, equivalent to more than five young men and women every minute of the day, every day of the year (UNAIDS, 1998a). Girls become infected younger and die earlier than boys due to age asymmetry in sexual partnerships. In countries such as Ethiopia, Malawi, Tanzania, Zambia, and Zimbabwe, for every 15-19-year-old boy who is infected, there are five to six girls infected in the same age group.

*The disease mainly strikes people in their prime years.* Worldwide, AIDS hits people hardest in their most productive years. This profoundly disrupts the economic and social bases of families. When a family loses its primary income earner, its very survival is threatened. It sells assets and exhausts savings to pay for health care and funerals.

*Children are being orphaned in huge numbers.* In 1997, approximately 1.5 million children in SSA were orphaned[3] by the disease. To date, there are 7.8 million AIDS orphans in this region alone. In some hard-hit cities, orphans comprise 15 percent of all children (UNAIDS, 1998a). Care for these orphans often falls on extended families, stretching the capacity of these social safety nets. Many orphans are now heading households. They are far less likely to attend school, more likely to be undernourished, less likely to receive immunizations or health care, and usually very poor. Orphans often end up on the streets, where they pursue survival strategies that put them at great risk of contracting HIV themselves (USAID, 1997).

*National income is affected.* The illness and impending death of up to 25 percent of all adults in some countries will have an enormous impact on national productivity and earnings. Labor productivity is likely to drop, the benefits of education will be lost, and resources that would have been used for investments will be used for health care, orphan care, and funerals. Savings rates will decline, and the loss of human capital will affect production and the quality of life for years to come. Countries need to plan for the human resource needs that will result from the millions of premature deaths.

*The epidemic is having a tremendous subregional impact.* Southern Africa has one of the world's most rapidly spreading HIV/AIDS epidemics. The eight countries with the highest prevalence rates in the world (see Annex 2), ranging from 12 to 25 percent of the adult population, are in Southern Africa. Zimbabwe is especially hard hit with up to 50 percent of pregnant women in some sites infected. In Botswana, Namibia, and Zambia, the prevalence rates among pregnant women are between 20 and 40 percent. South Africa trailed behind many of its neighbors in 1990 but is rapidly catching up. In 1998, South Africa accounted for over half of all new infections in Southern Africa and for one in seven new infections in SSA. The socioeconomic costs of South Africa's HIV/AIDS epidemic are critical not just within the country itself, but for its neighbors as well, given the interconnectedness of many economies to that of South Africa and the high degree of movement among countries in the subregion.

**Impact of the Epidemic on Various Sectors**

Many studies have tried to demonstrate the macroeconomic impact of the HIV/AIDS epidemic, but the interaction between the epidemic and economic performance is complex (Decosas and Adrien, 1999). Other studies have been able to provide a more detailed view of the economic consequences of the epidemic in the industry and economic sectors, geographic regions, and on specific demographic groups.

*Social safety nets and impact on households.* The HIV/AIDS epidemic is stretching the capacity of social safety nets to the limit. The numbers of AIDS patients, widows, and orphans are growing rapidly. The household impacts begin as soon as a member of the household starts to suffer from HIV-related illness. This results in loss of income of the patient, a substantial increase in household expenditures for medical expenses, and other members of the household, usually daughters and wives, missing school or work to care for the sick person. Death results not only in additional expenses for funeral and mourning costs, but in a permanent loss of income from less labor on the farm or from lower remittances. Poor households are more

[3]UNAIDS has defined orphans as children under 15 who have lost their mother or both parents to AIDS.

vulnerable to the impact of an AIDS death, which significantly affects food expenditure and consumption and ultimately impacts childhood nutrition (World Bank, 1997a). Death of a parent often results in removal of children from school to save educational expenses and increase household labor, resulting in a severe loss of future earning potential. Widows in particular may have no means to support themselves after their husbands die, often forcing them into commercial sex work and increasing their risk of infection. The large number of orphans in Africa is not only a major development problem; the increasing number of children-headed households is creating a new social system with inherent problems that societies have yet to address. This growing crisis is putting pressure on governments to increasingly support safety nets where they exist or create effective social safety nets where they do not. Greater investment in social programs and strengthening of institutions to deal with these growing needs will help construct these social safety nets.

*Health care.* Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce, which, in turn, is essential for economic development. The countries most affected by AIDS are often those least able to afford increased costs of health care. Health care systems are stretched beyond their limits as they not only deal with a growing number of AIDS patients and the loss of health personnel due to death and illness, but also cope with rising cases of tuberculosis, the most common opportunistic infection associated with AIDS. Tuberculosis adds to the burden of illness and shortens life expectancy (UNAIDS, 1997b). In Côte d'Ivoire, Zambia, and Zimbabwe, HIV-infected patients occupy 50 to 80 percent of all beds in urban hospitals. The services provided meet only a fraction of the needs. Yet spending on AIDS care is crowding out spending on other life-saving, cost-effective programs. On average, treating an AIDS patient for one year is about as expensive as educating 10 primary school students for one year (World Bank, 1997a). There is little hope that any development goals for health (e.g., reduced infant, child, and maternal mortality; reduced mortality from malaria) can be achieved in the face of AIDS. The motivation and incentive system for health workers needs to be reviewed from the perspectives of both service delivery and overall sectoral objectives. AIDS also poses significant challenges for health sector reform and is dramatically changing the disease burden profile in many countries (UNAIDS, 1998c). It is bound to change the components of essential health care packages as well. Effective strategies are needed to find and strengthen alternatives to hospital care for patients suffering from AIDS as well as to assist in procuring much-needed drugs and supplies for treatment.

*Education.* AIDS is reducing the hard-won returns on investment in education and exacting a staggering human cost. Scarce resources spent on education will be lost if teachers and students die of AIDS—the more skilled, the greater the economic loss. Millions of teachers and students are dying or leaving school for economic reasons, because of illness or to care for family members, reducing both the demand for education and the supply of teachers. Over 30 percent of teachers in Malawi and Zambia are already infected (UNAIDS, 1998b). Infected parents keep children (especially girls) out of school for economic and social reasons, presenting an increasing challenge to reach these out-of-school youth with effective AIDS-prevention programs. Young girls are particularly at risk of contracting HIV, undermining their hopes for education. The resulting lower female education will undermine recent gains in health, nutrition, and family planning. AIDS also affects education at higher levels. Firms grow reluctant to invest in training as the turnover among workers rapidly rises. The education sector has a key

role in promoting and maintaining the critical behavior-change agenda and must take these factors into account when planning. Educators must seek every opportunity to include HIV/AIDS prevention in school and training curricula at all levels.

*Agriculture.* Agriculture is the largest sector in most African economies, accounting for a large portion of production and employing the majority of workers. Many of the countries most affected by HIV/AIDS are heavily reliant on agriculture and agricultural exports to pay for raw materials and essential imports for development. Coping strategies developed by rural communities affected by HIV can lead to greater poverty and increased vulnerability. The loss of adults to AIDS often leads to a shift in cropping patterns. In many cases, this means switching from cash crops to subsistence farming. It can also reduce investments in soil enhancements, irrigation, and other capital improvements, which have long-term impacts on output. AIDS forces families to make irreversible decisions to sell livestock, equipment, and land to cover AIDS-related expenses, leaving surviving family members in poverty, from which it is hard to escape (Topouzis, 1998). In addition, agricultural knowledge and management skills are being lost. A study conducted with the Zimbabwe Farmers Union showed that the death of a breadwinner due to AIDS will cut the production of maize in small-scale farming and communal areas by 61 percent (The Policy Project, 1999). In Malawi, where 10 percent of gross domestic product comes from estate agriculture, the strongest effect of HIV/AIDS will be the negative impact on the supply of skilled labor (The Policy Project, 1999). Bank country teams must examine the long-term impact of AIDS as it spreads to rural areas and address these issues now in long-term planning and resource development. Proven HIV/AIDS-prevention tools can be incorporated into agriculture training programs and extended through existing mechanisms such as extension agents to reach the many rural people who are vulnerable to the epidemic.

*Infrastructure and mining.* Mining and construction of roads, dams, bridges, and other infrastructure often take workers away from their families. This increases the risk of HIV infection for both workers and people living near the construction sites. A study in Ghana has found prevalence of HIV infection to be 5 to 10 percent higher in a rural district where the Akosomo hydroelectric dam was under construction than in neighboring districts. Not only did construction of the dam draw workers away from their families and increase commercial sex work in the area, but it displaced 80,000 inhabitants (Decosas, 1996). The potential for infrastructure projects to contribute to the spread of AIDS needs to be considered in project design whereby these projects are used as an opportunity to extend HIV-prevention efforts. AIDS prevention and care for workers, their families, and the surrounding communities must be incorporated into all infrastructure and mining projects to reduce potential impact and expand prevention coverage. The World Bank and others can play an important role in enlisting the private sector to accept this responsibility.

*Private sector firms.* AIDS-related illnesses and deaths to employees affect private sector firms by increasing expenditures and reducing revenues. Industries relying on a high level of skilled labor and in an environment of high HIV prevalence are most vulnerable. The main effect of HIV on industry is through increased labor costs and decreased availability of skilled labor (Decosas and Adrien, 1999). Numerous countries in Africa are facing the prospect of significant increases in staff costs arising from absenteeism (due to illness and family bereavements), higher labor turnover (due to illness and deaths), and increasing recruitment,

training, and staff welfare costs (medical insurance, medical expenses, and benefits to employees).

A study examining several firms in Botswana and Kenya demonstrated that the most significant factors in increased labor costs were absenteeism due to HIV/AIDS and increased burial costs (Roberts and Rau, 1997). HIV/AIDS is costing Kenyan companies an average of US$25 per employee annually. These costs, which result from absenteeism and increased expenditures for medical and other benefits, are expected to increase to an average of US$56 by 2005 if the rate of HIV incidence continues unchecked. Conversely, a comprehensive prevention program in Kenya would cost an estimated US$15 per employee annually (UNAIDS, 1998e). It is critical to convince the private sector to join the national response to the epidemic and address these issues in their planning, as well as take responsibility for prevention and care of their workers.

**The Imperative of Urgent Action**

*The cost of inaction.* Although prevention strategies were known early in the course of the epidemic and many interventions have been implemented on a limited scale, only a few countries have taken sufficient action to curtail the spread of HIV/AIDS. Inaction to date has resulted in millions of new infections and unnecessary deaths, leading to the current crisis situation that will require considerable effort and resources to bring the epidemic under control.

In 1982, there was only one country in Africa, Uganda, with an adult HIV prevalence rate higher than 2 percent. Today there are 21 countries in Africa with prevalence rates of more than 7 percent. Since 1985, the prevalence of HIV in urban antenatal women in Blantyre, Malawi, has increased from less than 5 percent to over 30 percent. In Francistown, Botswana, reported rates in antenatal women were less than 10 percent as recently as 1991, but rose to 43 percent in 1997 (U.S. Bureau of the Census, 1998). In Ethiopia, the proportion of adults infected with HIV increased from less than 1 percent to nearly 10 percent between 1987 and 1997. These alarming figures illustrate how quickly the epidemic can spread out of control.

The cost of delaying an intensified response is monumental. More than 4 million people in SSA were newly infected in 1998, and the numbers are certain to grow in 1999. Most of these people will die within the next decade, leaving millions of orphans. The resulting social decay and breakdown will threaten socioeconomic development for decades to come.

*The benefit of action.* Despite the mounting crisis, the situation is far from hopeless. Although HIV prevalence rates are high, more than 200 million adults in Africa are not yet infected. However, many are vulnerable and will be infected and die unless action is taken now.

Studies have shown that specific interventions using voluntary counseling and testing (VCT), condom social marketing, peer education, and treatment of sexually transmitted infections (STIs) can change behaviors and reduce the risk of HIV. Modeling has shown that the synergistic effect of combining these interventions reduces the risks even further. The following pilot projects were carefully evaluated and demonstrate the effect these specific interventions can have on changing behavior and reducing transmission of STIs, including HIV:

- Results of a Rwandan study on the impact of preventive counseling and testing indicated that for women whose partners were also tested and counseled, the annual incidence of new HIV infections decreased from 4.1 percent to 1.8 percent. Among women who were HIV-positive, the prevalence of gonorrhea decreased from 13 percent to 6 percent, with the greatest reduction in those using condoms (Allen et al., 1992). The estimated cost of VCT programs in SSA is US$4.40 per person counseled and tested.[4]

- An intervention in the Democratic Republic of Congo targeted education, STI treatment, and condoms to commercial sex workers, resulting in an increase in regular condom use with clients from 10 to 68 percent in three years. The incidence of HIV dropped from 11.7 to 4.4 per 100 woman years of observation, and there was a decline in the incidence of treatable STIs (Laga et al., 1994). The estimated cost of STI treatment is approximately US$2.33 per case.

- A condom social marketing program in Brazil resulted in a reduction in the price of condoms from US$.075 to US$.020. Under this program, the total market volume for condoms more than tripled from 45 million to 168 million in four years (World Bank, 1997a). It is estimated that each condom distributed through a social marketing program in SSA costs approximately US$0.25 to $0.34.

- A project in Kenya distributed condoms and educational materials and provided STI treatment to male truck drivers through a workplace intervention. After one year, there was a reported 13 percent decrease in extramarital sex (49 to 36 percent) and a 6 percent decrease in visits to commercial sex workers (12 to 6 percent). There was also a decline in STIs (Jackson et al., 1997). Other studies have estimated the cost of a workplace intervention focusing only on education to be US$0.50 per worker reached. The costs of STI treatment and condoms would be similar to those noted above.

- Studies in Mwanza, Tanzania, show that early, continuous treatment of STIs in a rural community was associated with a 42 percent decline in newly acquired HIV infections at a cost of US$10 per person treated (Grosskurth et al., 1995). More recent evidence indicates that STI control may be most effective in the early phase of an HIV epidemic (Wawer et al., 1999).

The challenge is to incorporate these and other effective interventions into a comprehensive national program, bring them to scale, and sustain them. By so doing, certain countries have been able to slow the epidemic and minimize its impact. These countries have been able to change social norms to help people lower their risk of HIV and have significantly reduced the number of new infections. The active response and success of HIV-prevention efforts in these countries provide reason for hope:

[4]The cost estimates provided in these examples are not specific to these studies but were compiled from the literature on costs of interventions throughout SSA and represent a medium-cost scenario (Kumaranayake and Watts, 1999).

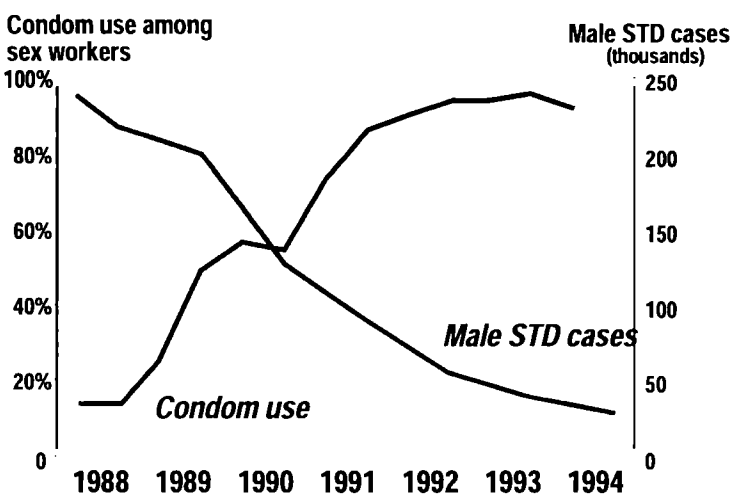
- There were significant decreases in HIV prevalence among women attending prenatal clinics in certain regions of Uganda between 1990-93 and 1994-95. These were noted particularly among women ages 15-24 (Wawer et al., 1999). Strong, high-level, national leadership and effective partnerships with civil society facilitated the changes leading to this decrease.

- The leadership of Senegal chose not to deny the existence of the epidemic, but to face the challenge from the start. Enlisting all key actors as allies in a timely and aggressive prevention campaign has helped the country maintain one of the lowest HIV-infection rates in SSA (1.77 percent). The small number of HIV-positive individuals allows the government to consider utilizing treatment schedules that otherwise would not have been affordable (UNAIDS, 1998e).

- Numerous Western countries have established and sustained comprehensive HIV/AIDS-prevention efforts that have greatly reduced the spread of the epidemic. The most notable features of the Australian response to HIV/AIDS are support from all political parties and strong partnerships among community groups, government officials, health workers, the private sector, and researchers (National Centre in HIV Epidemiology and Clinical Research, 1997). The Swiss strategy highlights the vitality of developing strong working partnerships with people living with HIV/AIDS, local and regional officials, and nongovernmental organizations (Swiss Federal Office of Public Health, 1999). The response to HIV/AIDS in the Netherlands has been comprehensive and progressive, particularly with respect to its community-based outreach programs and partnerships with groups at increased risk of HIV infection.

- In Thailand, concerted government prevention efforts at the national and regional levels led to a rapid and sharp decline in new HIV and sexually transmitted infections. As can be seen in Figure 4, the number of male STI cases decreased dramatically as condom use among sex workers rose.

**Figure 4. The Impact of Rising Condom Use in Thailand**




*Source:* Rojanapithayakorn and Hanenberg, 1996.

## III. BUILDING AN EFFECTIVE RESPONSE

Governments must rally and invest early in the epidemic recognizing the unique epidemic characteristics in each country and the determinants of epidemic spread. Prevention is much less expensive than treatment and avoids the sickness, death, and socioeconomic impact that will ultimately result (World Bank, 1997a). Although AIDS has already resulted in severe deterioration in the economic and social conditions of many SSA countries, there is much that can be done now to halt the epidemic and mitigate its impact. Necessary responses include the following:

### Intensify, Expand, and Improve the National Response

An expanded, multisectoral, and national response will extend the reach of current prevention efforts to those who are vulnerable and will reduce the impact of the epidemic on all sectors. It will address the biological, behavioral, and social factors that determine the profile of the epidemic in each country. The key components of effective HIV-prevention programs include changing individual behavior and social norms to reduce risk, making condoms available and affordable, providing effective diagnosis and treatment of STIs, ensuring a safe blood supply, and supporting affordable interventions to reduce transmission from mother to child. Focusing comprehensive efforts on the groups most at risk of contracting and spreading HIV has been necessary and cost-effective in all successful efforts. These components must be integrated into activities in all sectors. World Bank country teams must help countries understand the impact this epidemic will have on all sectors and adjust programs and project designs to take these fully into account.

### Address the Root Causes of Vulnerability

Two major factors render a society vulnerable to a major HIV epidemic: 1) social destructuring as experienced during war, rapid economic or political changes, or massive migration; and 2) low social cohesion, which is a measure of a society's ability to cope with stress (Decosas and Adrien, 1999).

The HIV/AIDS epidemic disproportionately affects women, especially young girls, and the poor. The impact of AIDS on households can be reduced to some extent by putting programs in place to address specific problems. For example:

- Improved economic opportunities, gender-sensitive legal and regulatory frameworks, and elimination of harmful and discriminatory practices will improve the status of women and help them avoid infection.

- Educating children, especially girls, will enhance their ability to avoid infection.

- Reduced school fees can help children from poor families and AIDS orphans stay in school longer.

- Establishing outreach programs for street children and other out-of-school youth will help reduce HIV infection among this vulnerable group.

- Creative incentives for training can encourage firms to maintain worker productivity despite the loss of experienced workers.

- Home care for HIV/AIDS patients and support for basic needs of households can help families cope.

- Foster care for orphans, food programs for children, and support for educational expenses can help families and children survive some of the consequences of the epidemic.

- Social funds can help grassroots organizations cope.

**Assess the Impact of Development Projects on HIV/AIDS**

Major development projects may inadvertently facilitate the spread of HIV. For example, major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for men to purchase commercial sex and to an increased likelihood that women left behind may resort to it for economic survival. These projects can be designed or retrofitted to reduce these risks by providing innovative means to keep families together, reduce mobility, generate income, and provide strong prevention programs.

**Learn from Experience**

Successful programs from Uganda to Australia and from Senegal to Thailand have shown that government commitment to creating an enabling environment for all partners is key. This is supported by a strong alliance with the private sector, communities, NGOs, and people infected and affected by HIV who have been leading the fight so far. Although much has been learned about how to curtail the epidemic, most countries are slow to act and have not been able to scale up successful interventions to reach all at-risk individuals. Governments must take the lead to scale up and intensify actions to a national level.

Worldwide, youth are disproportionately affected by this epidemic. This large and growing segment of the population also has been the most responsive to behavior-change interventions. Studies have shown that youth programs can make a significant and sustainable impact on this impressionable audience. A global assessment of school-based programs found that sexual health education and AIDS prevention incorporated into school-based programs not only delayed the start of sexual activity but reduced the number of sexual partners and raised contraceptive use among those who became sexually active (UNAIDS, 1997a).

Public economics and epidemiologic principles argue strongly to intervene early and prevent infections among those most likely to catch and spread the virus to avert the largest number of new infections (World Bank, 1997a). The need to prioritize and effectively use scarce resources becomes even more important when a country brings successful interventions to national scale. To put effective programs in place, SSA countries have been divided into two major categories:[5]

1. *Countries with adult HIV prevalence rates of 7 percent or more.* Twenty-one (21) countries meet this criterion. In these countries, a strategy is required that continues to strengthen interventions targeted to groups at highest risk, and at the same time will lead to rapid coverage of all vulnerable groups in all urban areas and rural districts. These countries must also move rapidly beyond prevention to provide care and mitigate the impact of the epidemic.

2. *Countries with adult HIV prevalence rates of less than 7 percent.* Twenty-three (23) countries fall in this category. HIV in these countries remains predominantly in groups whose behavior places them at high risk but has the potential to spread rapidly to the general population. To contain the spread of the epidemic in these countries, priority should be given to changing the behavior of those at highest risk of contracting and spreading HIV. This sharply targeted effort needs to be national in scope and be quickly followed by broader approaches to reach other vulnerable groups such as women and youth.

A strategy, national in scope, is therefore required in all countries. The strategy is initially more focused on prevention and on groups at highest risk in the low-prevalence countries. In the high-prevalence countries, the program must address wider objectives and reach all vulnerable groups while reinforcing sustainable behavior change among those at highest risk.

*What works?* Successful national HIV/AIDS programs have many things in common:

- They have government commitment at the highest level and multiple partnerships at all levels with civil society and the private sector.
- They invest early in effective prevention efforts.
- They require cooperation and collaboration among many different groups and sectors: those who are most affected by the epidemic, religious and community leaders, NGOs, researchers and health professionals, and the private sector.
- They are decentralized and use participatory approaches to bring prevention and care programs to truly national scale.

[5]National HIV/AIDS prevalence rates are not known for the following four countries in SSA and have consequently not been included: Cape Verde, Sao Tome and Principe, Seychelles, and Sudan.

- The response is forward-looking, comprehensive, and multisectoral; addresses the socioeconomic determinants that make people vulnerable to infection; and targets prevention interventions and care and treatment support to them.

- They are characterized by community participation in government policymaking as well as design and implementation of programs; many of these are implemented by people living with HIV/AIDS, NGOs, civil society, and the private sector.

These national programs all focus on a core set of interventions that have been proven on a small scale to change behavior, to reduce the risk of HIV transmission, and to be cost-effective. These interventions can all be implemented through a strong partnership with the government, NGOs, civil society, people living with HIV/AIDS, and the private sector. They include:

- Changing behavior to reduce risks through communication, including mass media, peer education, theater, and counseling, especially among youth.

- Making STI diagnosis and treatment readily available and affordable.

- Treating opportunistic infections, including tuberculosis.

- Making condoms affordable and widely accessible.

- Ensuring a safe blood supply.

- Making VCT available and affordable.

- Preventing transmission from mother to child (see Annex 4).

An ideal program that incorporates these interventions is presented as a case study in Annex 1.

As the epidemic progresses, with over 22 million Africans already infected, the need to strengthen care, treatment, and social support becomes a high priority. Programs are needed to finance and implement home-, hospice-, and hospital-based care; treatment for opportunistic infections and STIs; and social support for those affected by AIDS, including widows and orphans. These strategies can help families, communities, and nations cope. Experience demonstrates that communities are often in the best position to launch a response to the epidemic and take care of their own. All they need are the enabling environment, the tools, and the resources.

*What does not work?* Many years of experience have shown that the following strategies do not work and that some can actually be damaging to program efforts:

- Expecting health-oriented national AIDS committees to lead an intensified response to the epidemic in the absence of adequate, sustained and high-level government support.

- Undertaking centralized programs, led by ministries of health, primarily focusing on the health aspects of the epidemic.

- Inadequately targeting interventions to small sections of populations at increased risk of both HIV infection and transmission.

- Withholding knowledge from young people that would protect them from infection, under the guise of "cultural and social norms."

- Targeting the vulnerable, especially women and young girls, without addressing the root causes of their vulnerability.

- Stigmatizing and marginalizing those infected and affected by this epidemic.

- Investing in expensive pilot studies that have no chance of being sustained, replicated, or expanded.

- Building plans and programs that are externally driven based on available funding or donor interest rather than well-coordinated programs based on need and proven strategies.

- Designing programs without community involvement.

Sporadic or isolated activities are ineffective unless they are evaluated as pilot activities and revised and expanded based on what has been learned. To maximize their impact, programs should be implemented for long periods based on need rather than funding cycles.

Focusing on information and education is not enough to reduce people's risk; it is essential to foster an environment that facilitates changes in social norms, address poverty, and provide the tools for people to change their behavior.

*What does an ideal program look like and how much does it cost?* A fully costed case study of an ideal national program is presented in Annex 1. The cost estimates are based on a costing model developed specifically for this strategy (Kumaranayake and Watts, 1999). Similar estimates have been developed for 24 countries in SSA and will soon be published under separate cover.

## IV. STRATEGIC PLAN FOR INTENSIFYING ACTION AGAINST AIDS IN AFRICA

This strategic plan builds upon the important partnerships of the World Bank with African countries, UNAIDS, the private sector, and donor agencies and summarizes the World Bank's contribution to the common framework for action agreed upon by UNAIDS. In this strategy, the Bank addresses the HIV/AIDS epidemic as a major development threat to SSA and defines the actions the Bank will take in support of the International Partnership Against HIV/AIDS in Africa (see Annex 3).

## Goal

The goal is to urgently assist African governments and mobilize the Bank, development partners, the private sector, and civil society to intensify action on multisectoral and sustainable policies and programs to address the compelling and evolving implications of the HIV/AIDS epidemic to halt further reversal of human, social, and economic development in Africa.

## Approach

Together with UNAIDS, the Bank will intensify its actions against HIV/AIDS in Africa by providing the necessary resources and technical support to country teams to mainstream HIV/AIDS activities in all sectors. To reach the stated goal, the Bank's approach will stand on the following four pillars: advocacy; increased resources; programs for prevention, care, and treatment; and knowledge.

- Advocacy efforts targeted to policymakers at the national and international levels will increase and sustain the demand for an intensified action. These efforts will increase awareness within the Bank and globally to position HIV/AIDS as a development issue and mobilize additional resources.

- Bank lending and economic and sector work (ESW) for HIV/AIDS have diminished to a trickle in recent years. This stems from the lack of progressive programs at the country level as well as from the narrowness of the Bank's present approaches to AIDS. To reverse this trend, the Bank needs to take a broader, more strategic, and more timely approach to integrating HIV/AIDS into existing activities. In collaboration with UNAIDS, the Bank will intensify its actions against AIDS in Africa by providing the necessary resources and technical support to Bank country teams to mainstream HIV/AIDS activities in all sectors.

- In countries with a more generalized epidemic (those with HIV prevalence rates of 7 percent or higher), the highest priority will be to increase the scale of prevention efforts to reach all people who are vulnerable and to rapidly build capabilities to provide care and treatment. In countries with relatively low prevalence rates (less than 7 percent), the highest priority will be to bring prevention efforts to a national scale, focusing on those whose behavior puts them at higher risk, and to identify and reinforce the social norms that seem to be preventing epidemic spread. To accomplish this, the Bank and its partners will provide Bank country teams with tools and financial resources to assess needs and provide support to their countries.

- There is a continuing need for information and data to increase the Bank's knowledge base. The response to this epidemic must evolve based on new information and solid data for decision-making. While expanding the global knowledge base is the responsibility of UNAIDS, this strategy will help expand the knowledge base of Bank staff to help countries design and manage prevention, care, and treatment programs based on epidemic trends, impact forecasts, and identified best practices. This information and data will also be used to inform leaders and motivate them to take action.

This strategy is a guiding document for the Bank's work in the Africa region. It is based on the comparative advantages of the Bank to lead efforts in advocacy, financing, and analysis in partnership with other development partners and in support of the UNAIDS International Partnership Against HIV/AIDS in Africa. This is a regional strategy involving multiple partners that provides the overarching framework for customizing involvement at the country level.

**Overcoming Barriers**

There is little disagreement about what works to slow the HIV/AIDS epidemic. The challenge is to create the enabling environment and mobilize the resources to quickly bring them to scale. This strategy addresses the following constraints and provides the tools to overcome them:

- *Lack of strong political commitment.* Not all African leaders and development agencies are convinced of the seriousness of the epidemic nor do they realize the potential impact it will have on their countries. Because of this, they have not made HIV/AIDS a high priority. A strong political commitment to the fight against AIDS is crucial to provide the needed resources, strong leadership, and enabling environment that are critical to controlling epidemic spread and caring for the nation. Accurate and relevant data are a powerful tool to convince leaders to increase their commitment to confronting this epidemic. These data are even more powerful when presented by respected international and regional peers. This strategy will primarily target countries that lack sufficient commitment and other key elements to mobilize them to take action.

- *Competing priorities.* Most countries in Africa must simultaneously address multiple serious health, political, economic, and social problems. Some leaders see HIV/AIDS as only an additional issue requiring more resources. Because the real impact of AIDS is not felt immediately, leaders find it difficult to respond effectively until it is almost too late. Appropriate use of relevant data and modeling techniques is critical to helping leaders visualize the impact the epidemic will have on all sectors and to placing it within the context of the competing priorities.

- *Insufficient resources and inadequate capacity to mount the necessary level of response.* Although the epidemic is generalized in most African countries and reaching well beyond those groups with high-risk behaviors, most current programs are not reaching nearly enough people in rural areas, especially youth and women. Few countries have sufficient human and financial resources to mount a full-scale program. Governments must work with their partners to leverage additional funding and continually build and replenish capacity within their countries to sustain an expanded response. Governments must also give support to NGOs, community groups, and people living with HIV/AIDS to expand their capacity.

- *"Cultural norms" or religious beliefs.* Some countries are reluctant to acknowledge that certain practices, such as commercial sex work and intravenous drug use, exist in their country and will not address the serious risks that these practices pose. Some are reluctant to change behaviors that are part of the "cultural norms," such as female genital mutilation,

even when these behaviors place people at risk of HIV infection. And yet others will not address sensitive issues such as sexual health of adolescents because of strong traditions and irrational fears. The approach to mobilizing leaders in these countries is to customize the strategies, bringing religious and traditional leaders on board, to gradually address the obstacles and build a positive response. Countries can learn from others with similar cultural or religious constraints and conduct operations research and pilot studies to evaluate new approaches.

**Actions**

The following actions describe the substance of what the Bank will do in collaboration with its partners to fight the HIV/AIDS epidemic during the next five years. A detailed implementation plan will be developed within the next six months that will describe how to bring these actions to scale and present various financing options. Detailed descriptions of activities at the international, regional, and country levels are presented below.

The Bank and its partners will be able to initiate these actions only if countries in SSA are willing to lead the intensified action and request assistance. Only then will this strategy effectively be supporting sustainable programs owned by the countries themselves.

**1. Increase Demand to Intensify Action**

**1.a. Assist African Leaders to Mobilize Civil Society and the Private Sector to Intensify Action against AIDS within Their Countries**

The leadership for intensified action against HIV/AIDS must come from the countries themselves. The governments of these countries should foster a strong alliance with civil society and the private sector to ensure that the response is truly effective and sustainable. The Bank can assist in mobilizing African nations to intensify their action against HIV/AIDS through a variety of measures.

- *Identify influential leaders to mobilize others.* The Bank has access to the highest-level decision-makers in SSA and should use this access to persuade leaders to take action. Apart from the Bank's president, regional vice presidents, and executive directors, it can organize teams comprising African elders, former statesmen), opinion leaders, and friends of Africa that will visit countries that request assistance and demonstrate readiness to intensify their response to HIV/AIDS. The teams will meet with high-level government officials, UNAIDS Theme Groups, leaders of civil society organizations, NGOs, people living with HIV/AIDS, and donors to discuss the socioeconomic costs of the epidemic, examine best practices, propose specific solutions, and work to reach consensus on future activities. These meetings will be high profile and will be covered by the press. The teams will offer to work more intensively with governments that demonstrate commitment to developing a joint program of future activities. Celebrities such as football stars or musicians can also be engaged to appear on television and radio and at public rallies to mobilize civil society. The press will be heavily involved to raise the profile of these events.