THE WORLD BANK'S COMMITMENT TO

HIV/AIDS IN AFRICA

OUR AGENDA FOR ACTION, 2007–2011

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1 2 3 4 11 10 09 08

English:	French:	Portuguese:
ISBN: 978-0-8213-7448-1	ISBN: 978-0-8213-7464-1	ISBN: 978-0-8213-7466-5
eISBN: 978-0-8213-7449-8	eISBN: 978-0-8213-7465-8	eISBN: 978-0-8213-7467-2
DOI: 10.1596/978-0-8213-7448-1	DOI: 10.1596/978-0-8213-7464-1	DOI: 10.1596/978-0-8213-7466-5

Cover design: Naylor Design, Inc.
Cover photos: Curt Carnemark/World Bank (left & right); Robert T. Schreiber (middle).

Library of Congress Cataloging-in-Publication Data
World Bank.
The World Bank's commitment to HIV/AIDS in Africa : our agenda for action, 2007-2011.
p. ; cm.
March 2008.
Includes bibliographical references and index.
ISBN-13: 978-0-8213-7448-1 (alk. paper)
ISBN-10: 0-8213-7448-6 (alk. paper)
1. World Bank. 2. AIDS (Disease)—Africa, Sub-Saharan—Prevention—Finance. 3. AIDS (Disease)—Africa, Sub-Saharan—International cooperation. 4. AIDS (Disease)—Economic aspects—Africa, Sub-Saharan. I. Title.
[DNLM: 1. World Bank. 2. Acquired Immunodeficiency Syndrome—economics—Africa—Tables. 3. HIV Infections—economics—Africa—Tables. 4. Acquired Immunodeficiency Syndrome—prevention & control— Africa—Tables. 5. HIV Infections—prevention & control—Africa—Tables. 6. International Agencies—Africa—Tables. 7. International Cooperation—Africa—Tables. 8. Regional Health Planning—Africa—Tables. WC 503 W9273w 2008]

RA643.86.A357W67 2008
362.196'979200967—dc22

2007051390

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Foreword

HIV/AIDS poses an unprecedented development and human challenge, especially in Africa. In many countries, the epidemic has cut life expectancy and robbed society of millions of people in their prime working years. It has dimmed the hope of living full and productive lives for unimaginable numbers of infants, children, and young adults.

The World Bank, an institution dedicated to the reduction of poverty worldwide, was one of the first organizations to respond to the HIV/AIDS emergency. Since 2000, it has provided more than $1.5 billion to more than 30 countries in Sub-Saharan Africa to combat the epidemic. The World Bank has helped put in place the foundations of an effective response—a governance structure; a strategic direction; a multisectoral approach; community engagement; and programs for prevention, treatment, and care. World Bank support has also helped mobilize significant new funding for HIV/AIDS and engendered collaboration among donors.

Today, we have a better understanding of the epidemic and its transmission than at any time in the past. We now know that it is not one but several different epidemics. We are more conscious that this horrific scourge has disproportionately hit women and young girls, who need the legal, social, and economic power to protect themselves, access treatment and care, reverse infection, and stem stigmatization. And we have seen funding for HIV/AIDS dramatically increase. HIV/AIDS remains, however, the leading cause of premature death and is a major threat to development in Africa.

The World Bank is vigorously working together with the peoples of Africa—the communities, their national leaders, and external partners—to find solutions to this scourge, which is an attack on our common humanity. For this reason, the Bank rededicates itself to a long-term engagement in fighting HIV/AIDS in Africa. The title of this report is appropriate: *The World Bank's Commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007–2011.*

This Agenda for Action reaffirms the Bank's determination to remain a full partner in the fight against HIV/AIDS through the provision of funding, analytical support, capacity development, and knowledge sharing. The Bank will use its convening power and other technical resources to combat

the epidemic, including in the countries of southern Africa—the epicenter of HIV/AIDS—that are not eligible for IDA assistance. The Bank will also focus on the strategic response, monitoring and evaluation to enhance effectiveness, the multisectoral approach, and harmonization with other development partners.

Together—as governments, communities, individuals, the private sector, development partners, and donors—we must halt and begin to reverse the spread of HIV/AIDS.

Let me end by thanking the many colleagues and partners around the world who have contributed their ideas and suggestions to shape the Agenda for Action. Let me also thank the staff of the Bank, ACT*africa*, the Global HIV/AIDS Program (World Bank), and the Africa Region for their persistence and patience in articulating this agenda. Along with the Africa Action Plan, the World Bank Global HIV/AIDS Program of Action, and the Bank's Strategy for Health, Nutrition, and Population Results (*Healthy Development*), this Africa Region HIV/AIDS Agenda for Action will help focus our efforts, reaffirm the Bank's determination, and contribute to the dream of an Africa liberated from the devastation of AIDS.

Obiageli Katryn Ezekwesili
Vice President, Africa Region

Acknowledgments

The HIV/AIDS Agenda for Action (AFA) team was led by Elizabeth Lule, manager of the AIDS Campaign Team for Africa (ACT*africa*), and included Daniel Ritchie, Richard Seifman, Antonio C. David, Albertus Voetberg, Sangeeta Raja, Cassandra De Souza, Carolyn Shelton, Nadeem Mohammad, John Nyaga, and Frode Davanger. Support was provided by Annette Minott, Mohammad Javed Karimullah, and Therese Cruz. AFA was prepared under the guidance of John Page (chief economist, AFRCE), Gerard Byam (director, AFTQK), Yaw Ansu (sector director, AFTHD), and Debrework Zewdie (director, HDNGA).

The HIV/AIDS AFA could not have moved forward without the leadership of the regional vice president, Obiageli Katryn Ezekwesili. We would also like to thank former regional vice presidents, Callisto Madavo and Gobind Nankani, who enabled the Bank's continued commitment to place HIV/AIDS at the center of the strategic development agenda for Africa.

Several individuals contributed to the development of AFA, and all are thanked generously for committing their time, effort, ideas, and experience. Consultations were held with a broad constituency over several months, including governments and country counterparts, civil society, and people living with HIV/AIDS (PLWHAs) (Nairobi, May 2006); bilateral donors (London, October 2006); the international HIV/AIDS community (Toronto, August 2006); multilateral development partners (New York, September 2006; Geneva, October 2006; Johannesburg, November 2006; Dakar, January 2007); World Bank managers and staff (Washington, D.C., September–December 2006); GFATM managers and staff (Geneva, September 2006); and country counterparts and youth (Johannesburg, February 2007).

Well over a thousand people from more than 35 countries and many institutions participated in the AFA deliberative process. The lion's share of participants was provided by our client countries in Sub-Saharan Africa. They were representatives, at all levels, of their communities, faith-based organizations, local nongovernmental organizations (NGOs), research institutes, universities, the private sector, labor federations, trade unions, local and national governments, and PLWHA. People representing the entire gamut of age, profession, and gender spoke to us knowledgeably,

frankly, and with passion about the role of the Bank and their battles to overcome HIV/AIDS.

We are very grateful for the inputs received from our external partners and the valuable insights provided by representatives of UNAIDS and its cosponsors, other international organizations, bilateral and multilateral donors, governments of recipient countries, faith-based and civil society organizations, PLWHA, youth, international and national NGOs, foundations, research institutions, and the private sector. The consultations encompassed participants from many partner institutions, including Christopher Armstrong (Canadian International Development Agency), Chris Austin (DFID, UK), Andrew Ball (WHO), Mazewa Banda (WHO), Ellie Bard (DFID, UK), Christophe Benn (GFATM), Andrew Berg (IMF), Jochen Bohmer (Ministry of Economic Development, Germany), Reina Buijs (DSI, the Netherlands), Clement Chan-Kam (WHO), Thea Christiansen (Ministry of Foreign Affairs, Denmark), Veronique Collard (WHO), Akinyele Dairo (UNFPA), Benedict David (DFID, UK), Jean Christophe Deberre (Ministry of Foreign Affairs, France), Mario Dolpoz (WHO), Norbert Dreesch (WHO), Duncan Earle (GFATM), Emma Fraser (DFID, UK), Robin Gorna (DFID, UK), Frederik Goyet (Ministry of Foreign Affairs, France), Lennarth Hjelmaker (Ministry of Foreign Affairs, Sweden), Lisa Kaalund-Jorgensen (Ministry of Foreign Affairs, Denmark), Alan Leather (Global Unions AIDS Programme), Louisiana Lush (DFID, UK), Amal Medani (GFATM), Jane Miller (DFID, UK), Asha Mohamud (UNFPA), Nosa Orobaton (GFATM), Mary Otieno (UNFPA), Mark Pearson (HLSP, UK), Sue Perez (RESULTS, US), Tim Poletti (AusAID, Australia), Jo Ruwende (DFID, UK), Daisuke Sakai (Japanese Embassy, London), Anita Sandstrom (Swedish Embassy), Mark Schreiner (UNFPA), Bernard Schwartzlander (GFATM), Clare Shakya (DFID, UK), Anne Skjelmerud (NORAD, Norway), Paul Spiegel (UNHCR), Mats Svensson (Sida, Sweden), Lia von Wantoch (U.S. Embassy, London), Bruce Waring (HLSP, UK), Sibili Yelibi (UNFPA), and Paul Zeitz (Global AIDS Alliance, US).

A concept note was developed and reviewed by a team of World Bank staff in July 2006. In addition, a preliminary draft was circulated and reviewed at a decision meeting in April 2007. We especially thank the participants at these meetings in Washington, D.C., who took time to provide numerous comments and inputs that helped shape the final draft of the document.

The following internal and external peer reviewers deserve particular praise for their commitment, insightful suggestions, and attention to detail when analyzing previous drafts of AFA. From the World Bank Group staff, the reviewers included Cristian Baeza (HDNHE), Hartwig Schafer (AFRVP), Christopher Walker (AFTH1), and Irene Xenakis (AFRVP). External peer reviewers were Fama Ba (UNFPA), Geeta Rao Gupta (ICRW), Sigrun Mogedal (Ministry of Foreign Affairs, Norway), Babatunde Osotimehin (NACA, Nigeria), Kristan Schoultz (UNDP), and Michel Sidibe (UNAIDS).

We also thank the following colleagues from within the Bank as well as other institutions for their contributions and valuable feedback at different stages in the elaboration of the document: Martha Ainsworth (IEG), Beldina Auma-Owuor (AFREX), Evelyn Awittor (AFTH2), Mark Blackden (AFTPM), Rene Bonnel (HDNGA), Eduard Bos (HDNHE), Mario Bravo (EXTCD), Jonathan Brown (HDNGA), Donald Bundy (HDNED), Joy de Beyer (HDNGA), Jean Delion (AFTS2), Shantayan Devarajan (SAR), Aissatou Diack (AFTH2), Sheila Dutta (AFTH1), John Elder (AFTH3), Helen Evans (GFATM), Laura Frigenti (AFTH3), Rui Gama Vaz (WHO), Teguest Guerma (WHO), Keith Hansen (LCHH), Astrid Helgeland-Lawson (OPCIL), Janet Leno (HDNGA), John May (AFTH2), Montserrat Meiro-Lorenzo (AFTH3), Michael Mills (AFTH1), Norbert Mugwagwa (AFTHD), Dzingai Mutumbuka (AFTH1), Elizabeth Mziray (HDNGA), Francois Nankobogo (AFTPS), Robert Oelrichs (HDNGA), Judy O'Connor (AFCE1), John Page (AFRCE), Ok Pannenborg (AFTHD), Ritva Reinikka (AFCS1), Khama Rogo (AFTH3), Onno Ruhl (AFTRL), Jocelyn do Sacramento (AFTTR), Miriam Schneidman (AFTH3), Sudhir Shetty (AFTPM), Siele Silue (AFTTR), Bina Valaydon (AFTHV), and Guiseppe Zampaglione (AFTH2).

We are also grateful to those who conducted the analytical work that forms the foundation for the AFA. These thoughtful efforts were our guiding lights during the elaboration of this five-year HIV/AIDS AFA for the Africa Region. In addition to the members of the core team (acknowledged above), the following individuals deserve recognition: Katrine Anderson (PREMGE), Jorge Arbache (AFRCE), Victor Barnes (Corporate Council on Africa), Lori Bollinger (Futures Institute), Esther Dassanou (Corporate Council on Africa), Arunima Dhar (PREMGE), Clare Dickinson (DFID, UK), Ken Grant (DFID, UK), Markus Haacker (IMF), Caroline Hope (Corporate Council on Africa), Paul Jensen (RESULTS), Lucy Keough

(HDNDE), Josette Malley (PREMGE), Lana Moriarty (PREMGE), Waafas Ofosu-Amaah (PREMGE), John Stover (Futures Institute), Katherine Tulenko (ETWWP), Marisa van Saanen (HDNDE), and David Wilson (HDNGA).

We wish to especially acknowledge the generous support of the government of Norway, through the Ministry of Foreign Affairs and the Norwegian Agency for Development Cooperation, for its significant contribution in financing the preparatory process of this AFA.

Abbreviations

AAP	Africa Action Plan
ACGF	Africa Catalytic Growth Fund
ACT*africa*	AIDS Campaign Team for Africa
AFA	Agenda for Action
AFCRI	Africa Regional Integration Department
AFRRMT	Africa Region Management Team
AFTEG	Africa Energy
AFTHD	Africa Region Human Development Department
AFTHV	ACT*africa*
AFTPS	Africa Private Sector
AFTQK	Africa Region Operational Quality and Knowledge Services
AFTTR	Africa Region Transport Group
AFTU	Africa Urban and Water
AIDS	Acquired Immune Deficiency Syndrome
APL	Adaptable Program Loan
ART	Antiretroviral Therapy
ASAP	AIDS Strategy and Action Plan
BCC	Behavior Change Communication
CBO	Community-Based Organization
CDMAP	Capacity Development Management Action Plan
CODE	Committee on Development Effectiveness
CSO	Civil Society Organization
DALY	Disability-Adjusted Life Year
DDP	Development Data Platform
DEC	Development Economics Vice Presidency
FBO	Faith-Based Organization
G-8	Group of Eight
GAMET	Global AIDS Monitoring and Evaluation Team
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GHAP	Global HIV/AIDS Program of Action
GRF	Generic Results Framework
GTT	Global Task Team
HDN	Human Development Network
HDNGA	Global HIV/AIDS Program
HDNHE	Health, Nutrition, and Population Team
HIV	Human Immunodeficiency Virus
HNP	Health, Nutrition, and Population
IBRD	International Bank for Reconstruction and Development

ICRW	International Center for Research on Women
IDA	International Development Association
IDF	Institutional Development Fund
IDP	Internally Displaced Populations
IEC	Information, Education, Communication
IEG	Independent Evaluation Group
IFC	International Finance Corporation
IMF	International Monetary Fund
ISNs	Interim Strategy Notes
ISR	Implementation Status Report
JFC	Joint Facilitation Committee
LEGAF	Africa Legal Department
LOA	Loan Department
MAP	Multi-Country HIV/AIDS Program
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MIC	Middle-Income Country
MOH	Ministry of Health
MSM	Men Who Have Sex with Men
MTEF	Medium-Term Expenditure Framework
NAC	National AIDS Committee/Council
NGO	Nongovernmental Organization
OECD	Organisation for Economic Co-operation and Development
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PREM	Poverty Reduction and Economic Management Network
PMTCT	Prevention of Mother-to-Child Transmission
PRSC	Poverty Reduction Support Credit
PRSP	Poverty Reduction Strategy Paper
RVP	Regional Vice President
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
SWAp	Sector-Wide Approach
TB	Tuberculosis
Three Ones	One national strategic plan, one coordinating body, and one national M&E framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHCR	United Nations High Commission for Refugees

UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WBI	World Bank Institute
WHO	World Health Organization

All dollar amounts are U.S. dollars.

CHAPTER 1

Introduction

The World Bank is committed to support Sub-Saharan Africa in responding to the HIV/AIDS epidemic. This Agenda for Action (AFA) is a road map for the next five years to guide Bank management and staff in fulfilling that commitment. It underscores the lessons learned and outlines a line of action. HIV/AIDS remains—and will remain for the foreseeable future—an enormous economic, social, and human challenge to Sub-Saharan Africa. This region is the global epicenter of the disease. About 22.5 million Africans are HIV positive, and AIDS is the leading cause of premature death on the continent. HIV/AIDS affects young people and women disproportionately. Some 61 percent of those who are HIV positive are women, and young women are three times as likely to be HIV positive than are young men. As a result of the epidemic, an estimated 11.4 million children under age 18 have lost at least one parent. Its impact on households, human capital, the private sector, and the public sector undermines the alleviation of poverty, the Bank's overarching mandate. In sum, HIV/AIDS threatens the development goals in the region unlike anywhere else in the world.

The Agenda for Action

This is not a conventional strategy document. It is deliberately titled *The World Bank's Commitment to HIV/AIDS in Africa: Our Agenda for Action, 2007–2011* to underline the importance of actions the Bank needs to take to continue to play a significant role in combating the HIV/AIDS epidemic in Africa.

HIV/AIDS is not a conventional disease. It is the largest single cause of premature death in Africa. With an average incubation period of eight years, the dimensions and the future consequences of the disease are not well known. Slightly more than a quarter of the Africans requiring treatment are currently being treated, but the promise of universal access to treatment and prevention has major financial and health care implications. Stigma and discrimination remain major obstacles to an effective response.

Africa is also a unique region. National health systems are overwhelmed by numerous health challenges, and the capacity to respond and manage the overall health burden is often extremely limited. Most governments lack the fiscal space to cope with HIV/AIDS program funding in the absence of external financing, which tends to be volatile and unpredictable.

We recognize that strategies are only useful to the extent that they meet three criteria: (i) client demand, (ii) client capacity, and (iii) the ability of the Bank to meet technical and resource demands. From our extensive consultations, we believe there is considerable demand for the Bank's continued active engagement from member countries, other development partners, and service providers, such as civil society organizations. At the same time, we believe the Bank needs to reorient and retool its own effort to ensure it provides effective, efficient, and sustainable support to containing the epidemic in the next five years. The principal audience of this report is the World Bank's Board of Directors, senior management, and staff.

The AFA has four principal objectives:

- *Reaffirm* the World Bank's commitment to long-term support for curbing the spread of HIV/AIDS in Africa;
- *Articulate* the comparative advantages of the Bank in a harmonized international program of support and, consequently, the potential role for the Bank;
- *Identify* priority interventions for the next generation of activity, whether funded by the Bank or others, based on evidence of success and lessons of experience; and
- *Specify* actions the Bank will need to take to ensure it can respond to the demands of member countries and other partners for financial, technical, analytical, and collaborative support.

The AFA articulates a program of support that fits squarely within the Bank corporate strategic priorities, as articulated by World Bank President

Zoellick in October 2007. It honors, reinforces, and translates into discrete actions the six corporate strategic directions of the Bank's Global HIV/AIDS Program of Action (GHAP), the Africa Action Plan (AAP), the Africa Capacity Development Management Action Plan (CDMAP), and Healthy Development: The World Bank's Strategy for Health, Nutrition and Population (HNP) Results. It focuses on mainstreaming HIV/AIDS activities into broader national development agendas as a critical aspect of economic growth and human capacity development. In preparing the AFA, consultations have been carried out over several months with a broad constituency, including countries, donors, communities, civil society, nongovernmental, and nonprofit organizations.[1]

Background

The World Bank launched the first major global response to HIV/AIDS in Sub-Saharan Africa in 1999. It helped put in place the foundations of the response: national strategies, a governance structure, and systems for monitoring and evaluation. It promoted a multisectoral response by focusing on HIV/AIDS as a development issue and by engaging both local communities and the private sector. By November 2007, the Bank had provided $1.5 billion for HIV/AIDS programs in more than 30 countries, including 29 Multi-Country HIV/AIDS Program (MAP) projects for African countries and 5 regional projects to address cross-border issues.

The MAP, approved in 2000, was envisaged as a 15-year commitment by the Bank to be implemented in three stages. The first stage would be an "emergency response," which entails putting in place essential structures, policies, and capacity; working with communities in delivering services; better understanding implementation dynamics; and generally, learning by doing. Stage two would scale up and mainstream prevention, treatment, and care, based on evidence of effective innovation. Stage three would focus on areas or groups where the spread of the disease continued.

During the first phase, the MAP built political commitment and enabled countries to begin implementing decentralized multisectoral national programs while strengthening institutions and accountability. This had an immediate impact on program coverage and paved the way for rapid expansion as other funding became available in later years. The MAP contributed to health-systems strengthening, started several cross-border projects to

address the most at-risk populations, and helped increase access to treatment. Recognizing that HIV requires changes in norms, beliefs, perceptions, and social and individual behavior, the MAP mobilized communities to provide an enabling environment.

Since the MAP was launched, and partly as a result of its implementation, there have been major developments in the global response to the epidemic. Global funding for HIV/AIDS has grown dramatically—from $1.6 billion in 2001 to $8.9 billion in 2006—with the creation of the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria (GFATM), the President's Emergency Plan for AIDS Relief (PEPFAR) initiative, and the involvement of other donors.

In 2005, the Gleneagles Summit endorsed the concept of aiming as close as possible to universal access to treatment and prevention services. Universal access to effective prevention services would reduce the number of new infections from 3.5 million per year to 1.25 million at a cost between $2,000 and $3,000 per infection averted. By continuing to expand access to treatment, almost 1 million deaths will be averted annually by 2011. Conversely, inaction will have devastating consequences: 10 million new deaths and 14 million newly infected persons by 2011, an increase of 50 percent from 2006. There are positive indications of future increases in donor commitments to work toward achieving the universal access goal. Nevertheless, an estimated $18 billion is needed to combat the disease in 2007 alone, with much of that funding needed for Sub-Saharan Africa. Moreover, the GFATM, PEPFAR, and other donor institutions, including the International Development Association (IDA), are dependent on replenishments, with no certainty about the levels of future funding.

Access to treatment has expanded, thanks in part to a reduction in the costs of antiretroviral drugs. Today, slightly more than one-quarter of Africans in need of treatment are on antiretroviral drugs. Efforts to harmonize the international response were intensified under the UNAIDS banner of the "Three Ones."[2] Finally, prevalence rates are declining in some countries and communities.

Continuing Challenges

At the same time, the HIV/AIDS epidemic faces major strategic challenges:

- ensuring an appropriate balance among prevention, treatment, and mitigation interventions;
- addressing human resources shortages and long-term fiscal sustainability of HIV/AIDS programs, especially in light of the commitment to universal access to prevention and treatment;
- tackling the continuing crisis with health systems and linkages with other diseases (such as tuberculosis [TB] and malaria) as well as reproductive health, essential for an effective HIV/AIDS response;
- mitigating gender inequalities that increase the vulnerability and risk of women to HIV; and
- managing the complexity of the global aid architecture for HIV/AIDS.

The first stage envisaged under the MAP has effectively ended. In developing the next phase of support, the Africa Region faces its own challenges in sustaining its engagement. Dedicated grant funding from IDA is no longer available, and the next generation of projects must compete with infrastructure, education, and other national priorities for scarce IDA resources. Moreover, in southern Africa, the epicenter of the disease, most countries are not eligible for IDA funding and are reluctant to borrow on harder International Bank for Reconstruction and Development (IBRD) terms.

While the relative funding role of the World Bank diminishes, other donors, development partners, NGOs, and beneficiaries have cited unique contributions by the Bank to the fight against the epidemic, contributions that they wish to see continued and enhanced. In consultations on the AFA, these groups underscored the Bank's (i) macroeconomic focus, that is, treating HIV/AIDS as a broad development issue; (ii) multisectoral engagement; (iii) capacity-building experience; (iv) convening power; (v) analysis and policy dialogue; and (vi) ability to form partnerships with communities and the private sector. The Bank's challenge now is to shift its emphasis from principal financier to facilitator and knowledge contributor.

One of the explicit future strategic roles of the Bank is in dealing with global public goods; the fight against communicable diseases is a crucial component of this role. In this context lies another reason for continued World Bank engagement in HIV/AIDS. The Bank needs to expand its knowledge base and continue the learning process in how to address global epidemics effectively.

Future Actions for the Bank

The HIV/AIDS Agenda for Action 2007–2011 represents the Africa Region's next stage in its engagement on HIV/AIDS in Africa. The foundation of the AFA is our renewed commitment to remain actively engaged in combating the disease. A principal goal of the AFA is to reaffirm the Bank's promise to devote its resources to help halt and begin to reverse the spread of HIV/AIDS, one of the Millennium Development Goals (MDGs). This reaffirmation would be demonstrated by the endorsement of the AFA by Bank senior management and executive directors. The Bank would commit itself to (i) provide at least $250 million per year for support to HIV/AIDS initiatives, based on client demand; (ii) work to establish an HIV/AIDS grant incentive fund of $5 million annually to promote capacity building, analysis, and HIV/AIDS project components in key sectors such as health, education, transport, public sector management, and other projects as appropriate; and (iii) expand current and find new, innovative ways to engage with middle-income countries (MICs) at the epicenter of the disease in southern Africa, as well as with fragile states and through regional initiatives. The AFA's four strategic objectives are to assist countries to develop long-term, sustainable responses that are integrated into national development agendas; accelerate and improve implementation; strengthen national fiduciary, monitoring and evaluation (M&E), and health systems; and enhance donor coordination and shared learning.

The AFA rests on four pillars that reflect the critical challenges—as much human and institutional as financial—for the next generation of support:

- *Pillar 1: Focus the response, through evidence-based and prioritized HIV/AIDS strategies*. Through its unique analytical and advisory role, the Bank will help embed HIV/AIDS as a development priority; undertake diagnostics of modes of transmission, effective interventions for prevention, and assistance to vulnerable groups; support differentiated responses; recognize the crucial links with the health system as well as TB, malaria, reproductive health, and nutrition; and help integrate these considerations into the HIV/AIDS agenda. This emphasis on "learning and sharing" is reflected in each of this agenda's pillars.
- *Pillar 2: Scale up targeted multisectoral and civil society responses*. The World Bank is uniquely placed to promote the multisectoral response and, working with communities, to address the HIV/AIDS challenge. The

next generation of Bank support will emphasize efforts to strengthen national and health systems, education (especially for orphans and vulnerable children), school-based prevention programs, gender equality, and to foster private-public partnerships.

- *Pillar 3: Deliver more effective results through increased country monitoring and evaluation capacity*. The World Bank will continue to help strengthen M&E frameworks to enhance the efficiency, effectiveness, and transparency of the HIV/AIDS response. This effort will contribute to improving existing structures of governance, public sector management, community-level transparency, and accountability. The Bank will work to assist local and central government structures in improving implementation performance. The results of the Bank's contribution to the HIV campaign also must be measured and reported.
- *Pillar 4: Harmonize donor collaboration*. The Africa Region will work with its key partners to make harmonization and alignment of the global response more effective at the country level in Africa. The Region will carry out joint planning and analytical work and participate in annual joint meetings with UNAIDS and other partners. It will seek to ensure that all partners operate within the framework of the Three Ones.

Building on lessons learned, the AFA will use a more selective, strategic focus. The agenda will center on strong partnerships with governments, communities, the private sector, donors, and other development partners and apply the Bank's unique strengths—its focus on development, multisectoral and civil society engagement, analytical capacity, flexibility, ability to fill gaps, and capacity to serve as a source of long-term, predictable finance.

Implications for the Africa Region Work Program

The actions described above will require a shift over time in the work program of the Africa Region. HIV/AIDS will continue to need greater attention as a development and poverty issue in the Bank's national dialogue with countries and its relevant instruments. Strengthening links with health sector systems, as well as with specific diseases such as TB and malaria, will take on greater priority. Mainstreaming and retrofitting of HIV/AIDS into sec-

toral products will be increasingly important, with analytical support provided by an HIV/AIDS team and resources from the Africa HIV/AIDS incentive fund. Capacity building of national HIV/AIDS authorities to improve fiduciary implementation, and M&E support, will also require heightened attention. What will be required of staff and management is commitment to pursue this AFA. Human and financial resources will also be required to support the HIV/AIDS dedicated team as will be contributions from country and sector units. While the HIV/AIDS team would continue to provide crucial specialized and quality assurance support, the team will also depend on sector specialists and researchers from different units of the Bank to strengthen key sectoral responses.

There are those who say that HIV/AIDS is overfunded relative to other diseases and that the Bank should refocus on other priorities. Others say the Bank has reneged on its commitment to stay engaged until the disease is brought under control. The realities are that the Bank brings to the international response strengths that no other organization possesses, that HIV/AIDS receives less than half the funding needed to meet the commitment to universal access to prevention and treatment, and that HIV/AIDS threatens the well-being of the continent like no other single challenge. For these reasons, the AFA focuses the Bank's engagement on its strategic strengths and helps ensure a harmonized and effective global response.

Notes

1. Countries, civil society, and PLWHAs (Nairobi, May 2006), bilateral donors (London, October 2006), the international HIV/AIDS community (Toronto, August 2006), multilateral development partners (New York, September 2006; Geneva, October 2006; Johannesburg, November 2006, and Dakar, January 2007), World Bank managers and staff (Washington, D.C., September–December 2006), GTAFM managers and staff (Geneva, September 2006), and country counterparts and youth (Johannesburg, February 2007). See appendix 1 for details.
2. One national strategic plan, one coordinating body, and one national monitoring and evaluation framework.

CHAPTER 2

The Diagnosis

Since 1999, when the World Bank published its first call to action, more than 10.5 million people have died from AIDS, erasing many of the development gains of the past generation and now threatening the gains of the next. AIDS also threatens realization of the Millennium Development Goals (MDGs). During the past decade, the disease has evolved, but today it is better understood. We know that it affects women and young people disproportionately in high-prevalence countries. We also know that it is not one but several epidemics. The modes of transmission have been more clearly established and, consequently, the responses more differentiated.

The human tragedy behind the numbers is enormous. In 2006, an estimated 2.2 million children younger than 15 years old were living with HIV and about 11.4 million African children under age 18 were either single or double orphans as a result of parental deaths from AIDS (UNAIDS 2007a). The disease has deprived countries of their scarcest human capital. Zambia, for example, loses half as many teachers annually as it trains (Grassly et al. 2003). Private firms in some countries, especially in southern Africa, recruit two workers for every job in anticipation of loss from the disease. The impact of the epidemic also affects both rural and urban households (UNAIDS 2006).

The 2007 UNAIDS figures show downward trends in HIV prevalence in a number of countries—reflecting improved methodology and data collection—but also progress, where prevention efforts aimed at reducing new HIV infections since 2000 and 2001 are showing results. In most of Sub-Saharan Africa, national HIV prevalence has either stabilized or is showing signs of decline, particularly in urban and rural Kenya; urban areas of Côte d' Ivoire, Malawi, and Zimbabwe; and in rural Botswana (UNAIDS

2007a). Modest prevalence declines among young pregnant women have occurred in urban and rural Burkina Faso, Namibia, and Swaziland, urban Burundi and Rwanda as well as rural areas in Tanzania (UNAIDS 2007a).

The Epidemiology of HIV/AIDS in Sub-Saharan Africa

HIV/AIDS remains an enormous economic and human challenge in Africa. It is the single greatest cause of death in the region, responsible for more than 20 percent of deaths in 2000 (see table 2.1 and World Bank [2006a]).

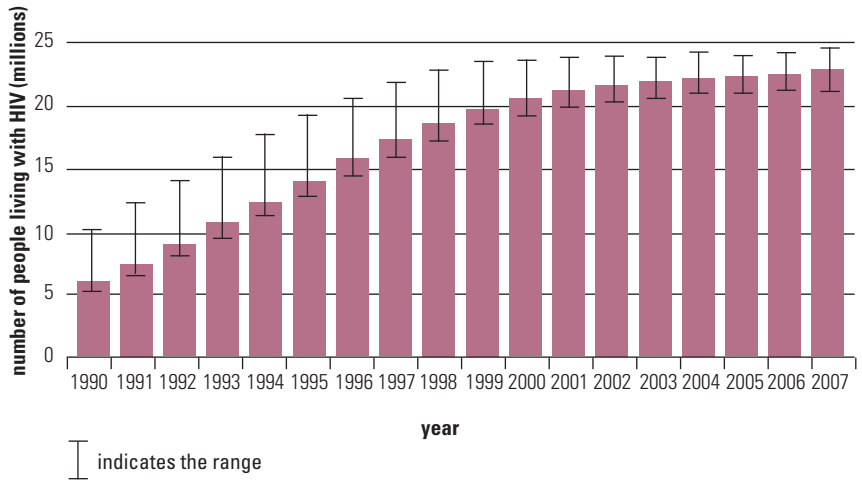
While the 2007 UNAIDS data show that the AIDS epidemic seems to have reached its peak and death rates are falling, more than two-thirds of all people living with HIV reside in Sub-Saharan Africa, where more than three-quarters (76 percent) of all AIDS deaths in 2007 occurred. An estimated 22.5 million Africans are living with HIV/AIDS, the vast majority of them adults in the prime of their working and parenting lives (UNAIDS [2007] and figure 2.1). Despite a peak of new infections and a decline in prevalence in some countries, more than 1.6 million people—about 4,400 per day—died from the disease in 2006 (UNAIDS 2007a).

Table 2.1: Ten Most Common Causes of Mortality and Morbidity in Sub-Saharan Africa

CAUSES OF DEATH	PERCENTAGE OF TOTAL DEATHS, 2000	PERCENTAGE OF TOTAL DISABILITY-ADJUSTED LIFE YEARS, 2001
HIV/AIDS	20.4	17.8
Malaria	10.1	10.3
Lower respiratory infections	9.8	8.4
Diarrheal diseases	6.5	6.1
Perinatal conditions	5.1	6.3
Measles	4.1	4.6
Cerebrovascular disease	3.3	NA
Ischemic heart disease	3.1	NA
Tuberculosis	2.8	2.4
Road traffic accidents	1.8	1.8

Sources: World Bank 2006a; Mathers, Lopez, and Murray 2006.
Note: NA = Not available. Disability-adjusted life years (DALYs) measures population health combined with years of life lost from premature death and years of life lived in less than full health. See Mathers, Lopez, and Murray (2006) for further discussion of DALYs.

Figure 2.1: Estimated Number of People Living with HIV in Sub-Saharan Africa, 1990–2007



Source: UNAIDS 2007.

The feminization of the epidemic

In Africa, HIV/AIDS is predominately a disease of women and young girls. Some 61 percent of those living with HIV/AIDS are women (UNAIDS 2007a), and young women in the 15- to 25-year-old age group are three times more likely to be HIV positive than young men in the same age group (UNAIDS 2006). Because of gender inequalities, women are often more vulnerable. They lack skills or power to negotiate safe sex, including condom use, and have poor access to the means to prevent HIV and other sexually transmitted infections (STIs); they are often prone to other sexual and reproductive-related health threats to themselves or their children. Women are more likely to face stigma and discrimination than men, including harassment, abuse, violence, and lack of rights to productive assets and other property (ICRW 2006). Hence, the issues of gender inequality and vulnerability create a major barrier to effective HIV/AIDS prevention and treatment programs. Improvements in women's legal rights, economic opportunities, and access to productive assets and workloads will need to be better understood and more effectively addressed. Developing individual prevention mechanisms such as vaccines and microbicides will need to be better funded and scaled-up.

The impact on children, the young, and disabled persons

Children continue to be the victims of the disease, particularly in Sub-Saharan Africa, where nearly 90 percent of the world's HIV positive children live (UNAIDS 2007a) and are affected both directly (infected) and indirectly (stigmatization or the loss of a parent). More than 9 percent of children under age 15 have lost at least one parent to AIDS. Orphans are less likely to attend school. In 34 countries in Africa, one survey found orphans were 13 percent less likely to be in school than non-orphans, and primary school completion rates tend to be much lower when a child has lost a parent, especially the mother (Evans and Miguel 2005). Young people in Africa are particularly at risk. Almost half of all new HIV infections occur among youth ages 15 to 24 globally, with an even higher proportion in Africa. Disabled persons are also at increased risk and vulnerability because of their limited access to information and services. People living with HIV/AIDS (PLWHA) are also likely to become disabled.

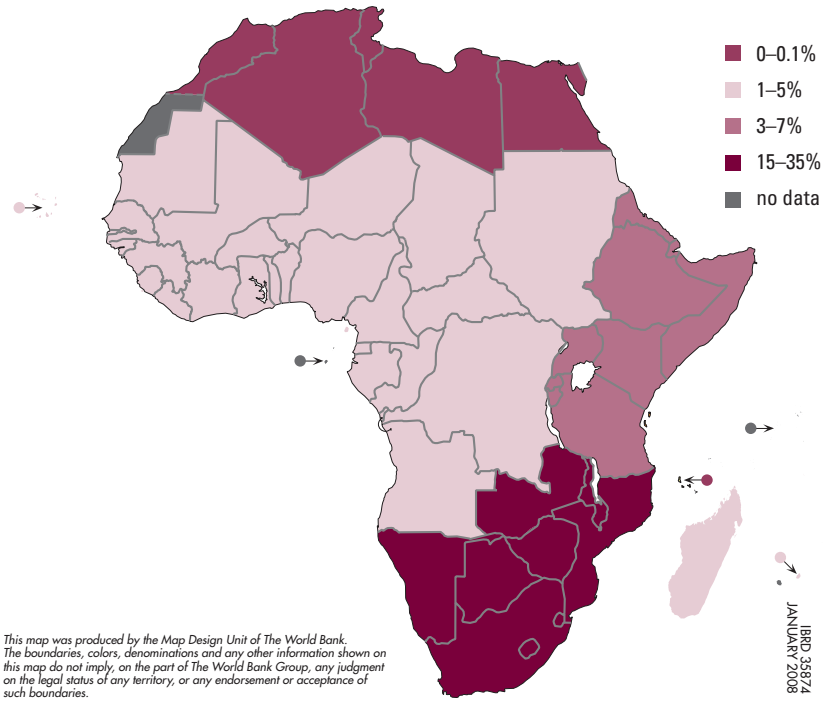
HIV and refugees, internally displaced people, and returnees

At the end of 2005, there were 8.4 million refugees worldwide according to UNHCR (2007), of which 30 percent were in Sub-Saharan Africa. Refugees, internally displaced people, and returnees are potential transmitters of HIV transmission, but also are vulnerable to infection by communities through which they pass toward a safer haven. This increase in vulnerability occurs as income sources disappear, social networks are destroyed, and access to health and education services is reduced. Furthermore, those groups frequently face stigma and are perceived to present higher HIV prevalence rates than host communities.

Not one but several epidemics

The epidemiology of the epidemic is much better understood today than it was six years ago. HIV/AIDS in Africa is not one but several different epidemics among countries and within countries. In Africa, the HIV epidemic is far more heterogeneous than previously recognized. It can be divided into four distinct clusters, as noted in figure 2.2. The epicenter of the epidemic is southern Africa, where HIV prevalence ranges from 15 to 35 percent. The hyper-epidemic of the countries in this epicenter is a continental—and global—exception, unlikely to occur elsewhere. East Africa's epidemics, for

Figure 2.2: The Heterogeneity of HIV Prevalence in Africa



Source: Adapted from Wilson 2006.

Note: Overlaps and gaps in HIV prevalence in the categories above are due to variations in HIV prevalence within countries, or within country clusters.

many years grouped with southern Africa, are far lower, with prevalence ranging from 3 to 7 percent. Prevalence in West Africa, Africa's most populous region, ranges from 1 to 5 percent. In North Africa, prevalence seldom exceeds 0.1 percent (Wilson 2006).

Transmission is better understood

The transmission of HIV is also better understood today than it was a few years ago. Modes of transmission vary significantly among epidemics. In West Africa, more than 75 percent of transmissions are attributable to sex work (Wilson 2006). In the mixed epidemics of East Africa, transmission comes from both HIV-vulnerable groups (sex workers, men who have sex with men [MSM], and injecting drug users) and the general population, while in southern Africa most transmission is driven by sexual behavior in the general population.[1] A better understanding of the modes of transmis-

sion is contributing to an improved response. In 2006, several countries reported reduced HIV prevalence. While not attributable to any single program, the principal elements in this reduction include a decrease in the number of partners among adults—particularly highly sexually active men—followed by deferred sexual inception by young people and increased condom use (Wilson 2006).

The evolution in the understanding of the disease offers opportunities for more focused responses and more effective measures to control its spread, particularly through attention to women, vulnerable and high-risk groups, and, for southern Africa, the general population.

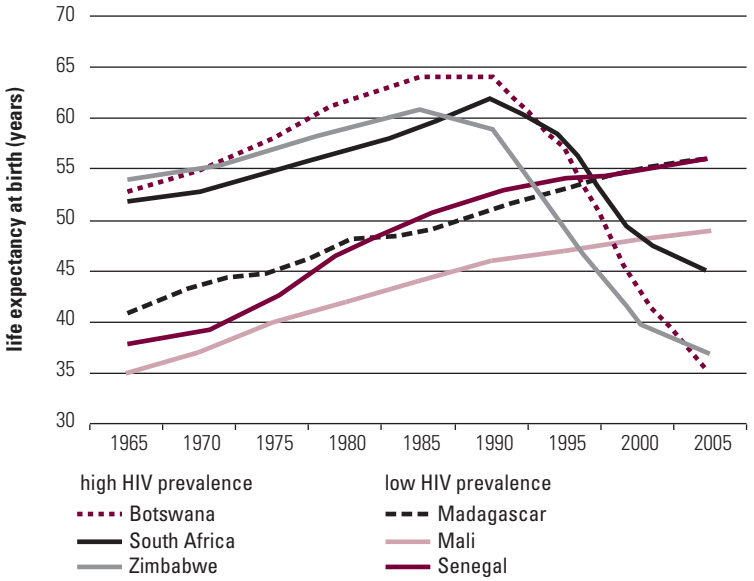
The Development Impact of HIV/AIDS

In addition to continuing human suffering and loss, HIV/AIDS poses an enormous hurdle to the development process in the region. The Bank is dedicated to the reduction of poverty worldwide and HIV/AIDS impacts on national and regional success in achieving poverty reduction goals. The epidemic depletes savings, reduces labor supply, increases households' vulnerabilities to shocks, reduces productivity in the private and public sectors, and negatively affects public finances. Perhaps most worrisome are the significant negative economic impacts that will persist in the long run, as the epidemic leads to increases in the number of orphans and affects human capital accumulation.

The impact on households and welfare

The HIV/AIDS epidemic has an obvious negative impact on welfare from increased mortality rates and reversed gains in life expectancy associated with the disease (see figure 2.3 and appendix 2). Households are directly affected through lost income and decreased labor supply as the health of household members, particularly breadwinners, deteriorates. Where women are the heads of household, often limited empowerment and restricted access to and control over resources, assets, and opportunity compound the impact on the household. In Western Kenya, access to antiretroviral therapy led to a 35 percent increase in weekly hours worked, illustrating the magnitude of the disease's impact on productivity and the potential economic benefits of treatment provision (Thirumurthy, Graff Zivin, and

Figure 2.3: Changes in Life Expectancy at Birth in Selected African Countries with High and Low HIV Prevalence, 1965–2005



Source: World Bank 2007b.

Goldstein 2005). In addition, increased out-of-pocket expenditures on health care, funerals, and related costs deplete household savings, decrease consumption, and reduce investment opportunities, contributing to the persistence of poverty. Studies in South Africa reveal that HIV/AIDS-related expenditures can amount to up to 25 percent of the income of a household worker in urban households and up to 50 percent of the income of a household worker in rural areas (Salinas and Haacker 2006).

The impact on the private and public sectors

HIV/AIDS leads to decreases in productivity and to increased absenteeism and turnover (with associated costs) of the workforce (Haacker 2004a). In particular, the disease generally affects workers in the most productive years of their lives. In addition, costs of medical and death-related benefits increase. Small and medium businesses as well as the informal sector are likely to suffer more because they lack the resources necessary to mitigate those costs (Corporate Council on Africa 2007). At the same time that the epidemic causes an increase in the demand for government services, it leads

to reductions in public revenues as the tax base decreases and the negative effects of the epidemic on long-run output are felt (Haacker 2004b). Furthermore, there are a number of indirect fiscal costs, as Haacker (2007) highlights, including orphan support, gender-differentiated survivor needs, and pension scheme benefits related to the death of HIV-positive civil servants or eligible individuals, as well as increases in the dependency ratio. Hence, HIV/AIDS puts enormous strains on public and private sector finances.

The impact on human capital and economic growth

HIV/AIDS leads to a direct depletion of the stock of human capital, as skilled workers die prematurely. In addition, the disease contributes to the persistence of poverty because it affects the accumulation of human capital and has adverse effects on the nutritional status of children (especially when the mother is HIV positive), and in particular, of orphans. In fact, when parents die, orphans are threatened by financial distress and lack of care, which leads to increases in the incidence of child labor and reductions in school enrollment and attendance. Graff Zivin, Thirumurthy, and Goldstein (2006) conjecture that the morbidity associated with AIDS may lead to reallocations of time and resources within the household. The potential negative long-run impact of HIV/AIDS on economic development can be quite substantial. Bell, Bruhns, and Gersbach (2006) estimated that in Kenya by 2040, GDP per adult will be 11 percent less than it would have been in the no-AIDS scenario.

Theoretical studies surveyed in Haacker (2004a) typically predict 1.0 percent to 1.5 percent declines in GDP growth rates for the worst affected countries (prevalence rates above 20 percent). Results on the empirical link between the epidemic and economic growth seem to be mixed (Bloom and Mahal 1997; Corrigan Glomm, and Mendez 2005; among others). Because the HIV/AIDS epidemic dramatically affects mortality rates, some authors posit that parents will choose to have more children as an "insurance policy" to guarantee a certain number of survivors. Analysis of evidence for 44 countries in Africa (Kalemli-Ozcan 2006) concluded that HIV/AIDS affects fertility rates positively and school enrollment rates negatively, mitigating the negative effect of the epidemic on population growth and reducing the amount of human capital investment. At the aggregate level, those mechanisms result in slower per capita economic growth.

The Implications for Africa

The epidemiology of HIV in Africa and the effect of the epidemic on development prospects suggest several priorities for the future.

First, given the heterogeneity of the disease, national AIDS programs and strategies will need to focus on a rigorous understanding of HIV transmission dynamics in each context. This, in turn, will require improved surveillance and epidemiological analysis at both the national and subregional levels. Programs will need to focus on major drivers of transmission.

Second, southern Africa will need to be a central focus for HIV/AIDS analysis and investments.

Third, programs will need to target the subgroups heavily affected by the epidemic: women and girls, children, youth, and particularly vulnerable and often stigmatized groups such as sex workers, MSM, prisoners, and disabled persons. Interventions need to be informed by evidence and analysis and a better understanding of underlying root causes of gender inequality and stigmatization.

Finally, because HIV/AIDS directly or indirectly threatens the achievement of many MDGs and perpetuates poverty and deepens inequality, the response to the epidemic needs to be an integral part of the dialogue on poverty reduction with African countries.

Note

1. Injecting drug use is a growing but still less significant factor.

CHAPTER 3

The Bank's Response to Date

As early as 1985 there was growing evidence that a serious HIV/AIDS epidemic of unknown magnitude was spreading across Sub-Saharan Africa, but most governments and the international community were slow to respond. While the World Bank responded to HIV as early as 1986, not until 1999 did the World Bank come to recognize the enormous development threat posed by the disease and prepare a regional HIV/AIDS strategy—*Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis.*

In 2000, the World Bank executive directors approved the Multi-Country HIV/AIDS Program (MAP) for Africa, with a commitment of $500 million as an initial "emergency response." To implement the strategy and provide operational support, an AIDS Campaign Team for Africa (ACT*africa*) was created in the office of the regional vice president (see appendix 3 for a chronology of events).

The MAP was envisaged as a 15-year commitment by the Bank, divided into three stages. The first stage would lay the foundation for an accelerated response, which included involving civil society; putting in place essential structures, strategies, and capacity; and gaining implementation experience. The main goals were to dramatically increase the response in Africa, move governments from denial to commitment and action, build capacity for a broad multisectoral response, and catalyze other resources. Stage two would mainstream innovations that proved effective toward nationwide coverage, and stage three would permit a much sharper focus on areas or groups where spread of the disease continued.

It was clear from the outset that the Bank's standard products would not address the epidemic adequately. Therefore, the MAP adopted a "horizon-

tal Adaptable Program Loan" (APL) approach, allowing rapid responses in many countries using a common framework and promoting a radically different approach, including funding of civil society organizations (CSOs), the private sector, ministries outside the ministries of health, and transboundary populations such as refugees.

The MAP processes were also highly innovative, reflecting the exceptional nature of the HIV/AIDS epidemic. Project design, approval, and implementation focused on speed, flexibility, partnership, "learning by doing," reworking projects as needed, and relying on multisectoral and multiagency implementation mechanisms for the widest possible coverage.

The result was a resounding success in generating support for HIV/AIDS and the national response. In February 2002, the World Bank Board approved an additional $500 million as grant funding from IDA-13, thereby enabling MAP projects in all 29 IDA-eligible countries in Sub-Saharan Africa, funding of several regional programs, and second-generation projects in a number of countries (see appendix 5).

The MAP addressed four pressing country needs:

- strong political and government commitment to respond to HIV;
- a favorable institutional environment with adequate resources and capacity to enable successful HIV and AIDS interventions to be scaled up to a national level;
- a local response that increases community participation in and ownership of HIV and AIDS interventions through providing financial resources and capacity building; and
- a multisectoral approach in which all government sectors are appropriately involved, with improved coordination at the national level and decentralization to subnational government structures.

Many of the hardest-hit countries in southern Africa were not eligible for IDA. To reach these IBRD countries (and IDA countries in arrears), the Bank provided technical support for analytical work and capacity building as well as a regional integration mechanism. HIV/AIDS was made one of the five core categories for support from the Institutional Development Fund (IDF). To date, five IDF grants have been approved for roughly $2.5 million, bringing Bank HIV/AIDS support for the first time to Namibia and Swaziland, as well as to fragile states such as Somalia and Sudan.

The Results

The initial goals of the MAP were to raise political awareness; promote a strategic response; strengthen systems and institutions to help manage that response; mobilize communities to promote activities for prevention, care, mitigation, and treatment; decentralize the response; create mechanisms to monitor and evaluate the results; and stimulate global funding for HIV/AIDS in Africa. The intention was to help lay the foundation for the long-term containment and control of the epidemic. The MAP has achieved many of these goals, including the following (see appendix 6 and Görgens-Albino et al. [2007] for a detailed description of the outputs and results):

- *Political commitment to HIV/AIDS*. A high-level AIDS authority exists in 29 countries, one-third chaired by the president or prime minister and all others by a cabinet minister. In nearly half of the countries all donor financing is coordinated by this high-level national AIDS committee or council (NAC).
- *Active mobilization and engagement of civil society*. In all MAP countries, at least 38 percent of financing is through CSOs. Major scale up of activities in prevention, mitigation, and care has engaged more than 29,000 civil society organizations that are implementing about 60,000 community-level subprojects.
- *Increased funding for HIV/AIDS*. Increased funding for HIV/AIDS from domestic resources provides additional evidence of political commitment. National budget funding in 29 reporting countries reached $757 million in 2006. In addition, with the creation of the GFATM, PEPFAR, and significant other bilateral and foundation funding, global funding has grown by more than 2,000 percent since 2001.
- *Intensified response on prevention*. Bank funding has contributed to the reduction of the risk of mother-to-child transmission (1.5 million women), voluntary testing (7 million people), prevention information (173 million people, vulnerable populations in particular), and condom distribution.
- *Intensified treatment, care, and impact mitigation*. Initially, the Bank provided limited funding for antiretroviral therapy (ART), given its high cost and the intense focus of other agencies on treatment. However, working

with the World Health Organization (WHO) and other partners, it has provided stopgap funding to prevent drug shortages, helped build supply chain systems, and cumulatively supported more than 27,000 persons in need of antiretrovirals. It has also supported mitigation measures for more than a half million adults and 1.8 million children through education, home-based care, and income-generating activities.

- *The multisectoral response*. One of the MAP's most important achievements has been the promotion of the multisectoral response. Recognizing that HIV/AIDS is not solely a health issue, the Bank has taken the lead in involving a broad array of stakeholders, from civil society and the private sector to multiple agencies of government—education, transport, defense, interior, agriculture, gender, social protection, youth, and other ministries.
- *Improved HIV/AIDS systems*. Bank funding has supported training of more than a half million people in service delivery, improved laboratory infrastructure and other health system facilities, provided technical support to more than 41,000 organizations, and reached 2.2 million people with workplace education programs.

The outputs from the MAP have been impressive. Two independent evaluations have commended the overall effort, but suggested that the effectiveness, efficiency, and impact of the program on the disease itself have been difficult to measure. The interim review of the MAP in 2004 endorsed the basic objectives, approach, and design of the program (World Bank 2004). Nevertheless, this review suggested the MAP needed to become more strategic, collaborative, and evidence based. The review particularly noted the lack of functioning M&E systems; problems in governance, implementation, management, and complex procedures; and the generally weak health sector response.

The Operations Evaluation Department (now the Independent Evaluation Group, or IEG) examined the World Bank's global assistance for HIV/AIDS in 2005 and reached many of the same conclusions about the work in Africa (World Bank 2005). The speed with which MAP projects had been developed in response to the emergency did not permit a thorough assessment of the risks associated with a program for which there was little baseline information and few pilot efforts on which to build. While the approach to the emergency nature of the epidemic was to learn by doing and to supervise intensively, the lack of functioning M&E systems limited

knowledge sharing and adaptation. These reports helped focus attention in particular on the need for better M&E systems and evidence-based interventions in the future. Appendix 7 presents actions that are being undertaken to address these recommendations.

Lessons Learned

The key lessons going forward from the MAP experience include the following (see also World Bank [2006]):

- *Recognize that HIV/AIDS is a more formidable challenge than had been realized*. Unrelenting effort is needed to end the epidemic. Uganda, long a beacon of hope against HIV, now offers a warning against complacency. Significant gains against the epidemic were made in Uganda—the first country in Africa to make progress against the disease—reducing prevalence among antenatal clients in Kampala from 30 percent in 1992 to 7 percent by 2001. Now there are worrying signs of rising HIV prevalence, as in Thailand and other "success story" countries.
- *Integrate HIV into the overall development agenda*. HIV/AIDS is a major obstacle to development in many African countries and needs to be treated as a development priority. To address long-term financial sustainability, countries should link their HIV/AIDS strategies and plans to their overall development programs and financing plans as outlined in their Poverty Reduction Strategy Papers (PRSPs) and Medium-Term Expenditure Frameworks (MTEFs).
- *Know the epidemic and invest in results-based M&E*. Successful national and local responses are grounded in understanding and careful analysis of the epidemic and of the behaviors and groups driving infections. This requires investments in surveillance, data collection, and analysis.
- *Integrate HIV/AIDS services with reproductive and maternal health, nutrition, and other diseases such as malaria and TB*. Treating HIV/AIDS as a single disease has been a significant deficiency in national HIV/AIDS programs. The feminization of the epidemic and its links to sexual and reproductive health, and the frequency of co-infection with TB (and the emerging Extensively Drug Resistant TB) and other opportunistic diseases, require providers to offer integrated services.

- *Strengthen administrative and management capacity*. A lack of capacity slows down the scaling up of effective responses and diminishes the national response. Strengthening financial and procurement systems, health care human resources, health facilities, health information systems, and health supply chains is critical to achieving universal access and ensuring good governance, transparency, and accountability.
- *Build strong partnerships*. Donors tend to pull countries in too many different directions, with diverging policies, priorities, and processes that burden countries and undermine program effectiveness. Many donors have agreed to harmonize their support with country strategies, programs, systems, and needs; coordinate their support better; and support the principle of the Three Ones.
- *Focus on engaging stakeholders and working with communities*. Civil society and communities can help strengthen decentralized national responses, lay the foundation for behavior change, scale up mitigation efforts, and contribute to improving health systems at the local level.

CHAPTER 4

Strategic Challenges in the New Environment

Since 1999, there have been major developments in the effort to combat HIV/AIDS in Africa, including increased knowledge of the disease; lessons learned to improve prevention, treatment, and care; and dramatic increases in funding. These developments, in turn, have highlighted significant emerging challenges to the effective control of the epidemic, especially (i) sustainability of funding; (ii) governance and accountability; (iii) the balance among treatment, prevention, and mitigation; (iv) links to sexual reproductive health and other diseases; (v) weak national systems and in particular, health systems; and (vi) the consequences of gender inequality. Such developments have also prompted the World Bank to reconsider its particular strengths in helping to deal with these challenges in the context of an arena much more crowded than in 2001.

Finance, Sustainability, and Accountability

The sources of funds to fight HIV/AIDS, the harmonization of international and national efforts, and the sustainability of, governance of, and accountability for the use of funds all pose challenges to Bank endeavors.

Global funding

Context. The global response to the HIV/AIDS epidemic has been unparalleled. Between 2001 and 2006, worldwide funding has grown from $1.6 billion to $8.9 billion (UNAIDS 2006). Funding to Africa from the three main international sources amounted to $9.9 billion in the period 1997 to 2007 (table 4.1).

Table 4.1: Funding Sources and Commitments

FUNDING SOURCES	COMMITMENTS ($ BILLION)
World Bank (1997–2007)	1.5
PEPFAR (2004–2007)	5.8
GFATM (2003–2007)	2.8
Total	9.9

Sources: Global Fund financing from 2003 through November 2007: www.theglobalfund.org; PEPFAR financing from 2004 through 2007: http://www.pepfar.gov/press/c19558.htm; World Bank financing includes MAP projects approved from 2001 to November 2007 and commitments for subregional projects.

Despite these increases in funding, significant financing gaps remain. Bollinger and Stover (2007) estimate that the resource requirements to achieve universal access to treatment, prevention, and mitigation interventions in Africa alone, in line with international commitments, would amount to more than $41 billion in the period 2007 to 2011 (see table 4.2). This indicates that a significant scale up in the availability of resources is required if the commitments made at the 2005 G-8 summit in Gleneagles and reiterated by the United Nations General Assembly in June 2006 are to be honored.

Challenge. The increase in financial resources presents two major challenges: ensuring the rapid, efficient, and effective use of the available funds, and reducing the continued shortfall between the verbal commitment to universal access and the reality of financial flows. One major concern is the efficiency and effectiveness with which available resources have been used, due in part to deficiencies in national fiduciary and health delivery systems, insufficient planning, leakages, and corruption. An apparent paradox is that despite the increased funding for HIV/AIDS, insufficient resources are devoted to addressing important country needs in the fight against the epidemic, such as recurrent expenditures and institutional capacity building.

Table 4.2: Resource Needs for Universal Access, 2007–2011
($ millions)

	2007	2008	2009	2010	2011
Treatment	1,035	1,467	1,959	2,507	3,153
Prevention	2,768	3,330	3,923	4,544	4,683
Mitigation	1,694	2,056	2,417	2,779	3,141
Total	5,498	6,852	8,300	9,830	10,977

Source: Bollinger and Stover 2007.

Global HIV/AIDS architecture and national institutions

Context. At the global level, several commitments have been made to a more harmonized approach among development partners, embodied in the Monterey, Rome, and Paris Declarations; the New Partnership for Africa's Development; and, for HIV/AIDS, specifically, the Three Ones. Groups have been established to translate these global commitments into concrete action on HIV/AIDS, including the UNAIDS-funded Global AIDS Monitoring and Evaluation Team (GAMET); a country strategy and action plan improvement group (AIDS Strategy and Action Plan, or ASAP); and a procurement process review group. At national levels, the institutional capacity of AIDS authorities is seen as the linchpin for effective utilization of external and internal, and existing and future, resources.

Challenge. Realization of the Three Ones—the UNAIDS-inspired term for the policy of harmonized response among development partners for a single national strategy, a single governance structure, and a single monitoring and evaluation (M&E) system—has proven difficult at the country and institutional levels. Work pressures and internal incentives conspire to keep most managers and staff from focusing on the labor- and time-intensive effort needed to foster genuine collaboration, and information systems at the national level are not geared to adequately track partner efforts. However, basic instruments are in place that could facilitate greater collective effort, such as sector-wide approaches (SWAps), pooled funding, and programmatic lending.

Fiscal sustainability of HIV/AIDS programs

Context. The scale up of efforts to combat the epidemic and the commitment of the major industrial countries to universal access to treatment are welcome. At the same time, these efforts carry implications for macroeconomic and fiscal management in aid-recipient countries and for the effectiveness of public policy initiatives in different sectors. In addition, as discussed in previous sections, HIV/AIDS has significant consequences for the public and private sectors in the affected economies, which can reduce national governments' own abilities to effectively respond to the epidemic.

Most countries in the region are still heavily reliant on external assistance to finance their HIV/AIDS programs. Previous research has indicated that external funding tends to be volatile (Eifert and Gelb 2005). The evolving nature of the epidemic and the availability of lower-cost treatments are con-

verting HIV/AIDS from a death sentence to a chronic disease. Once treatment begins, it is a lifelong commitment to the patient. Suspending or ending treatment for lack of funding would be both a moral and a health hazard. Furthermore, capital investments and recurrent expenditures, such as wages and training for health workers, result in long-term expenditure commitments for governments.

Significant uncertainty surrounds the future costs of treatment because the risks of drug resistance increase as treatment is scaled up. Accordingly, the size of the future fiscal burden on the public sector associated with increased access to treatment in the medium to long term is far from resolved.

Challenge. At the moment, there is a clear mismatch between the erratic character of aid flows and the long-term nature of expenditures on HIV/AIDS treatment and prevention. To address this imbalance effectively, countries need to combine foreign aid with domestic efforts to raise resources to mitigate volatility in financing. The analysis of fiscal space and sustainability issues is inherently country specific, given the role played by local institutions and characteristics in determining outcomes. Nonetheless, from a regional perspective, it seems that in Sub-Saharan Africa the scope for increases in fiscal space through increased indebtedness and seignorage revenues is limited. Efforts to increase the efficiency of expenditures, expand the tax base, and fight leakages linked to corruption and poor governance appear to be more promising avenues to increasing fiscal space (David 2007).

Governance and accountability

Context. Concern has been growing about transparency and integrity in the use of funds. Recent in-depth examinations by the World Bank's Department of Integrity of selected MAP projects in Africa and projects in Asia revealed significant fiduciary risks, resulting in the suspension of disbursements in a health sector project and delaying new commitments for both HIV/AIDS and health sector projects. Similarly, the GFATM has suspended operations in several countries.

Challenge. Working through thousands of communities with many different stakeholders and service providers has proven to be an effective approach to HIV prevention, care, and treatment. At the same time, this decentraliza-

tion of effort carries with it an enhanced risk of fund wasting and leakage. The challenge is to ensure the integrity of financing utilization while promoting the active engagement of many small organizations and the effective flow of funds to areas where the needs are greatest.

Implementation capacity

Context. With the significant infusion of resources, the increased numbers of stakeholders and service providers over a relatively short time frame, and broad acceptance of the notion of universal access to prevention and treatment, the capacity of institutions and entities to effectively perform numerous new tasks represents a major bottleneck, in many instances. Demand for planning, programming, and costing; and provision of service delivery, supervision, M&E, and reporting capacity—whether at community, provincial, or national levels—have outstripped the capability of many of those responsible. The burden on AIDS authorities to provide adequate support for the multifaceted activities provided by many partners is likely to grow as programs extend into universal access.

Challenge. The nature of the HIV/AIDS response, which is principally implemented at the grassroots level as well as in health facilities, encompasses behavioral change as well as provision of medical supplies and treatment. Effective implementation requires systems and skills that are not typically in large supply in many countries. Thus, HIV/AIDS implementation requires appropriate and constant training of those engaged at centralized and decentralized levels, as well as systems that provide key and timely information and communication to authorities who focus on results, transparency, and good governance. Special attention will be required from World Bank staff on the issue of how to effectively conduct capacity development under the umbrella of the Capacity Development Management Action Plan (CDMAP) for priority HIV/AIDS implementation capacity development.

Operational Issues

Bank efforts must be undertaken with an awareness of the numerous intertwined operational issues that HIV/AIDS highlights.

The balance among prevention, treatment, and care

Context. In the past four years, the principal focus of the HIV/AIDS response has been on treatment, partly in response to the priority of the new funders. PEPFAR, for example, follows a policy of distributing 70 percent of funds for treatment and care, and 20 percent for HIV prevention (of which one-third must be spent on abstinence programs), according to UNAIDS (2006). By the end of 2005, the GFATM had spent almost half its HIV/AIDS funds on treatment (47 percent on drugs and commodities, 20 percent on human resources and training, 20 percent on physical infrastructure and administration, and 6 percent on monitoring and evaluation). For various political, cultural, financial, and technical reasons, perhaps related to the difficulties in rigorously evaluating the impact of prevention, many countries have left prevention interventions relatively underfinanced and under-attended. The need to renew the emphasis on prevention was articulated at the XVI International AIDS Conference in Toronto in August 2006, in recognition that an "ounce of prevention is worth many pounds of treatment," particularly given the potential fiscal savings from treatment costs avoided when prevention interventions are effective.

Challenge. Prevention responses cannot be isolated actions nor will one solution work forever. Over the long term, prevention efforts must adapt as the epidemic changes, and respond to different infection patterns and social conditions. Countries in the region have typically implemented generalized prevention programs, which may not have a high impact in low-prevalence countries. The current transmission and infection dynamics of the epidemic require greater focus on prevention interventions targeting:

- women (especially young women) to reduce their vulnerability;
- behavioral change in the general population to reduce multiple concurrent partners in high-prevalence countries;
- men to increase their adoption of prevention mechanisms; and
- vulnerable populations like sex workers, MSM, and injecting drug users, which are the principal modes of transmission in many countries with concentrated epidemics.

In short, prevention efforts need to recognize and adapt to changing infection patterns and focus more on behavior change rather than solely on raising awareness.

Gender inequality

Context. Gender inequalities in status and rights, labor opportunities, access to productive assets, and workloads, as well as gender-based violence are at the core of young girls' and women's greater HIV vulnerability and risk. Scaling up existing tools and methods, in addition to providing innovative and effective prevention tools for women, is needed. Some technological improvements (such as microbicides, which would give women more control over their lives) hold promise, as does the broader application of effective methods, specifically male circumcision, to reduce the risk of HIV transmission from female to male.

Challenge. With the feminization of the HIV epidemic, integration of gender equality into development policy and programs at the country level becomes the highest priority, but the lack of political will, limited capacity, restricted funding, and weak institutions make such integration a major challenge. More in-depth analytical work to shape decision making, provide the basis for training, and integrate gender aspects into operations research, pilot testing, and service delivery would have significant benefits, but requires heightened and sustained focus to alter deeply embedded practices.

Multisectoral engagement

Context. HIV/AIDS touches on virtually all sectors, and warrants response in varying degrees from those in the public sector as well as the direct and indirect beneficiaries of efforts to fight the disease. Agriculture, child welfare, commerce, defense, development, education, finance, health, interior, justice, municipal affairs, social services, trade, transportation, and youth, to name but a few sectors, all justifiably have valid reasons to concern themselves with the national HIV response. In practice, despite rhetorical recognition by civil servants of the relevance of HIV in the workplace and the need to include HIV in the policies they develop and the services they provide to their clients, in most instances the response has been inadequate. The reasons are many, including overburdened agendas; overburdened staff without new resources to take on additional tasks; reluctance to address socially sensitive issues; reluctance to build partnerships with CSOs; lack of leadership; and lack of tools, training, and absorptive capacity.

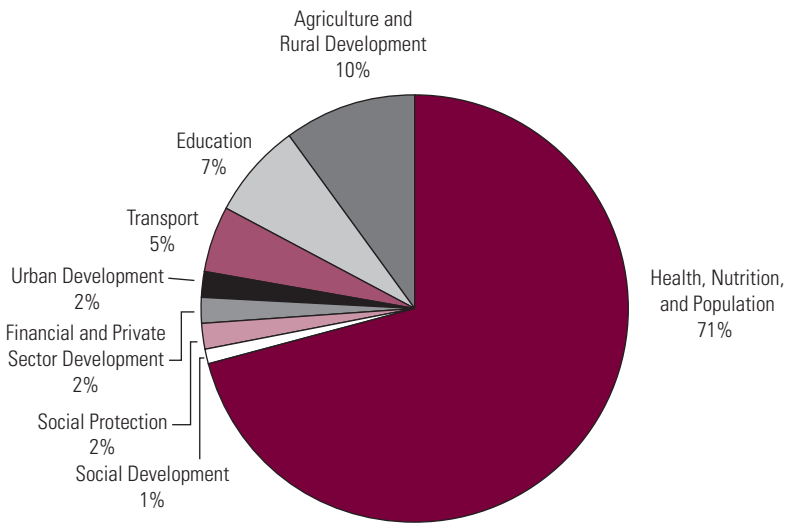
Challenge. Convincing public sector leadership, civil servants, and their intended beneficiaries that HIV is a development problem and not just a health problem—one in which they can effect national success—and a priority for their attention, engagement, and action, is a difficult task. Identifying key sectors on a country-by-country basis, finding receptive individuals, and providing technical and financial support as well as encouragement can be done but will require World Bank sectors to identify such opportunities and draw on regional human and financial resources so that HIV/AIDS becomes an integral part of sectoral programs.

Figure 4.1 illustrates the distribution of active HIV/AIDS commitments across World Bank sectors. While more than half of the portfolio (71 percent) is with the Health, Nutrition, and Population (HNP) sector, continued efforts need to be made to mainstream combating HIV/AIDS into non-health sectors.

Sexual and reproductive health (SRH)

Context. Family planning, maternal and child health, reproductive health, and HIV and sexually transmitted infection (STI) programs are closely

Figure 4.1: Active HIV/AIDS Commitments by World Bank Sector



Source: World Bank Business Warehouse, November 2007.

Note: Data include full commitment amounts for MAP projects and the amount of the HIV/AIDS component for projects with HIV/AIDS components.

interrelated. They are complementary and synergistic; that is, each benefits from the effective performance of the other. Unfortunately, in most Sub-Saharan African countries, they are not dealt with in a mutually reinforcing manner, if they are dealt with at all.

Challenge. Various studies are under way on how best to link SRH with HIV services (Lule 2004). Although such linkages will vary by context, it is also clear that providing family planning services as part of counseling, testing, and prevention of mother-to-child transmission (PMTCT) programs; expanding youth-friendly reproductive health services; sharing facilities and human resources; reducing duplicative tasks; and strengthening community-based services are all promising courses of action. Having national leaders acknowledge SRH and HIV as a priority, and obtaining their commitment to a policy that demands resources, will require a concerted effort by multiple stakeholders.

Links to other diseases, especially tuberculosis

Context. Since 1990, the number of new TB cases has tripled in Africa, and with the emergence of multidrug-resistant TB and extensively drug-resistant TB, the complexity of the interactions between TB and HIV have magnified. Malaria remains a major problem in much of Sub-Saharan Africa, and those who are HIV positive are at greater risk of dying when stricken by malaria and vice versa. Malnutrition is another significant contributor to HIV/AIDS vulnerability, impairing immune systems and heightening mortality.

Challenge. Taking concerted action to deal with relevant research, policy, technological advancements, and their application requires cooperation between donors and national authorities. These national authorities are often overwhelmed by multiple burdens that vastly outstrip resources. External donors need to take into account the larger vulnerability picture in providing financial and technical support.

Health services delivery

Context. The health sector is the one sector that must not fail if there is to be effective HIV/AIDS surveillance, prevention, treatment, and care. Many

health systems in the region lack adequate facilities, outreach capability, and effective systems (such as supply chains and M&E) and face chronic shortages of health workers to respond to the HIV epidemic (Tulenko 2006 and see appendix 2). Indeed, HIV/AIDS imposes a heightened burden for national health systems for retaining health workers, even those who are trained, unless they are provided with the means to protect and treat themselves.

Challenge. While the health system faces a plethora of weaknesses needing attention, from an HIV/AIDS perspective the crucial areas are human resources, laboratory and pharmaceutical capacity, and effective supportive systems such as supply chain management, fiduciary management, and M&E. National health systems and HIV/AIDS strategies and responses must be coordinated, complementary, and supported by national authorities and external partners.

CHAPTER 5

The Agenda for Action 2007–2011

HIV/AIDS remains a fundamental development challenge in many African countries—threatening growth, livelihoods, and human capacity, and inflicting tragedy on millions of families.

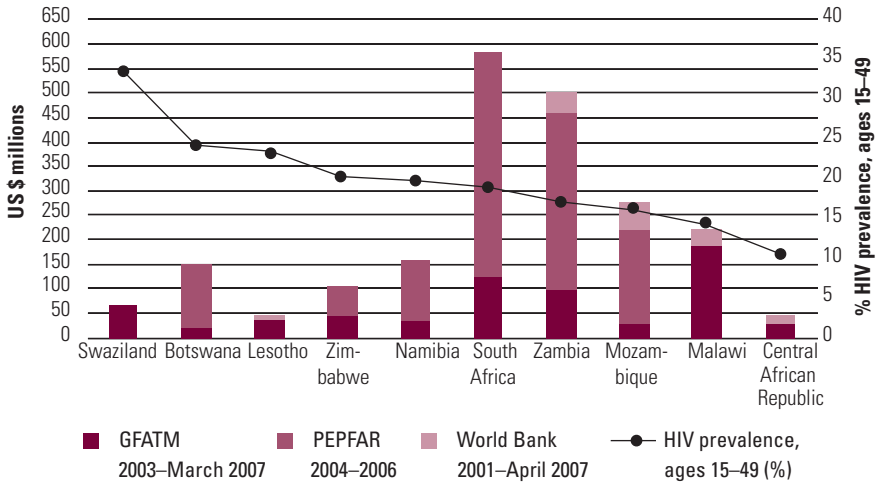
Since the articulation of the first Bank strategy for HIV/AIDS in Africa in 1999, the environment for combating HIV/AIDS has changed dramatically, with new donors, increased funding, more affordable treatment, better understanding of the disease and its transmission, and a new appreciation of gender inequality in the feminization of the disease in Africa.

Despite intensified national and global responses, much remains to be done in strategy development and building the wherewithal to implement a cohesive strategy with sufficient funding, human and institutional capacity, and attention to prevention. The need for continued Bank involvement in Africa is set against this backdrop, drawing on lessons of experience gained over seven years of extensive HIV/AIDS investment, the capacity to adapt to a changing epidemiological environment, and an intention to stay the course with other partners in containing the spread of the disease.

Among the most serious gaps is the absence of sustained international support for HIV/AIDS in the most acutely affected countries, especially in southern Africa, as indicated in figure 5.1 (see also appendix 8).

The role of the World Bank has also changed in the past seven years, from that of the major funder of HIV/AIDS programs in Africa to that of development partner and complementary funder, which is, in many ways, a larger and more complex role. The Bank's financial role has diminished in relative terms, in part because of the absence of IDA grant funds for HIV/AIDS since IDA-13, and in part because of the large infusion of funds

Figure 5.1: Global Funding for HIV/AIDS in the Top 10 High-Prevalence African Countries



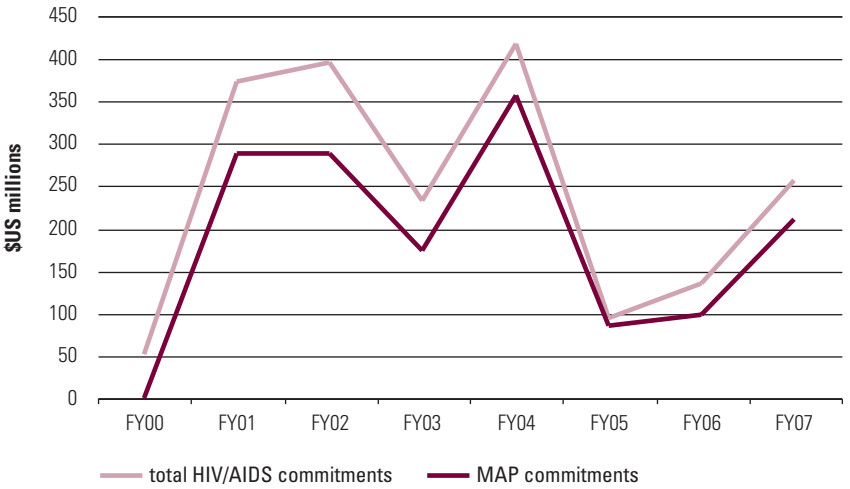
Sources: UNAIDS 2006; Haacker 2007; www.theglobalfund.org; http://www.pepfar.gov/press/c19558.htm and World Bank Business Warehouse. GFATM financing from 2003 through November 2007. PEPFAR financing from 2004 through 2007. World Bank MAP projects approved from 2001 to November 2007.

from the GFATM, PEPFAR, and others. The reduction in the Bank's new commitments from about $250 million per year to about $80 million is pronounced after FY04 (figure 5.2).

In other respects, the demand for the Bank's engagement continues to be very strong. UNAIDS cosponsors specified the World Bank as the lead organization with respect to support to strategic, prioritized, and costed national plans; financial management; human resources; capacity and infrastructure development; impact alleviation; and sectoral work (see appendix 9). Other partners look to the Bank to assist in making their money work more effectively through systems strengthening and institution building. The Bank is also a main partner with the United Nations Development Programme (UNDP) in addressing the broader development, governance, mainstreaming, and gender agendas; with the United Nations Children's Fund (UNICEF) in procurement and supply management; and with the UNAIDS Secretariat in M&E, strategic information, knowledge sharing, and accountability.

Stakeholders consulted for this Agenda for Action (AFA)—including country officials, development partners, donors, and CSOs—articulated roles for the Bank for which it is uniquely qualified, including:

Figure 5.2: World Bank HIV/AIDS Lending[a] in Africa FY00–FY07[b]



Source: World Bank Business Warehouse.

a. Data includes total commitment amounts for MAP projects and the amount of the HIV/AIDS component for projects with HIV/AIDS components.

b. Data as of July 2007.

- macroeconomic and fiscal analysis;
- multisectoral engagement, working in education, transport, agriculture, and other sectors, as well as closely with health;
- institutional and human capacity building for health systems, financial management, and procurement;
- convening power and catalytic role for innovation, for example, in post-conflict countries and in subregional integration;
- partnership building with communities and the private sector; and
- as a source of long-term financial support.

Strategic Objectives

The fundamental purpose of the AFA is to support countries in Sub-Saharan Africa as they strive to reach the sixth Millennium Development Goal (MDG) related to HIV/AIDS—halt and begin to reverse the spread of HIV/AIDS.

The underlying premise of the AFA is that the fundamental obstacles to halting and reversing the spread of the disease in Africa are primarily related to institutional and implementation capacity and human resources, as well as to financial resources. While there remain shortages of funding for universal access and for intensifying the overall response in certain countries, the critical strategic objectives in the next five years are the following:

- *Strengthen the long-term prioritized sustainable response* through incorporating HIV/AIDS more explicitly into national development agendas, focusing the response, articulating realistic strategies built on solid evidence generated by good M&E, and integrating HIV/AIDS efforts with those of other diseases.
- *Intensify and accelerate a targeted multisectoral response* by interventions in education, transport, agriculture, and health; and by working with the private sector, CSOs, and local governments.
- *Build stronger national systems to manage the response effectively and efficiently* in health service delivery, financial management and procurement, supply chain management, human resources, and social services.
- *Strengthen donor coordination* by maintaining the commitment to the Three Ones and working effectively to rationalize the global aid architecture for health.

Pillars of Action

To realize these goals, the AFA rests on four strategic pillars:

- *Pillar 1*. Focus the response through evidence-based and prioritized HIV/AIDS strategies, integrated into national development planning.
- *Pillar 2*. Scale up targeted multisectoral and civil society responses.
- *Pillar 3*. Deliver more effective results through increased country M&E capacity.
- *Pillar 4*. Improve donor harmonization and coordination.

The cornerstone of the AFA

The Bank's commitment to continuing its active engagement in combating HIV/AIDS in Africa will underlie the AFA effort. With constrained country

IDA envelopes, the growing demand for infrastructure and other investment, and the availability of grant resources for HIV/AIDS in several countries from other donors, there is a perception among some development partners that the Bank is receding, if not withdrawing, from its support in the fight against HIV/AIDS. The goal of the AFA is to demonstrate the Bank's determination to continue to play an effective role in combating HIV/AIDS in Africa, through its own actions and through supporting national and regional action.

Overall Conceptual Framework

The conceptual framework for the AFA can be visualized in figure 5.3.

The specific objectives, planned actions, indicators and targets, critical assumptions, timelines, and accountabilities for the AFA are described in the Results Framework and Implementation Plan in appendix 10. The next section summarizes the principal elements of the foundation for the AFA, namely, renewing the commitment, the actions, and the expected results for each of the four pillars.

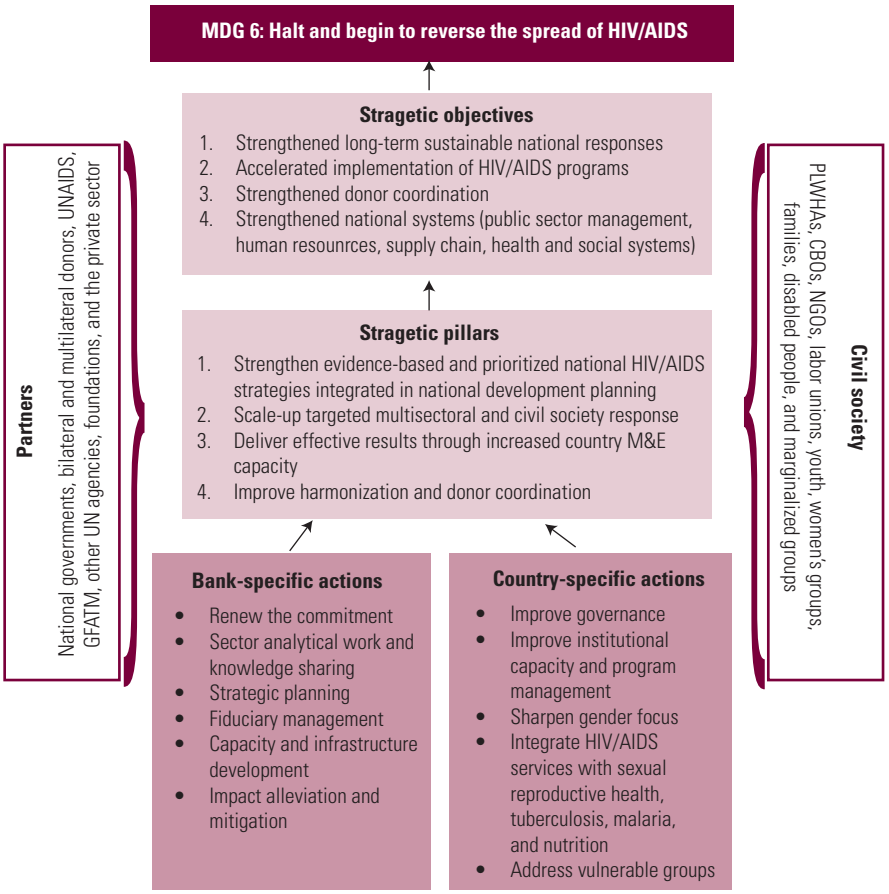
The Foundation: Renew the Commitment

The first goal of the AFA is an explicit reaffirmation of the Bank's long-term commitment to help fight HIV/AIDS in Africa, first articulated in 1999. Moving forward with the AFA by the Bank's senior management and the executive directors would affirm that determination.

The tangible demonstration of the renewed commitment would include the following actions:

- *Commit to remain a source of predictable, flexible, and long-term finance.* The Bank will be prepared to provide at least $250 million annually for HIV/AIDS investments over the next five years, based on the demand from member countries. This commitment is a form of safety net and insurance for borrowers facing issues of fiscal space and the potentially volatile flow of funds from external sources. The funds might support stand-alone HIV/AIDS projects, "hybrid" projects integrated into health sector operations, components of other sector projects, or policy-based loans focused on health expenditures. Financial and program gap studies and the development

Figure 5.3: World Bank HIV/AIDS Agenda for Action in Africa Conceptual Framework



Source: Authors.

Note: CBO = community-based organization; NGO = nongovernmental organization; PLWHA = people living with HIV/AIDS.

of five-year financing plans and financial sustainability studies that incorporate donor and domestic commitments and long-term commitments for treatment would be supported. This would involve pursuing innovative financing routes to respond to HIV/AIDS in Sub-Saharan Africa.

- *Demonstrate the Bank's renewed commitment to combating HIV/AIDS in Africa through participation in all channels of policy dialogue.* Senior management would engage high-level policy makers to advocate for a response to HIV/AIDS. Advocacy by Bank staff would strongly reassert this position.

- *Create an HIV/AIDS incentive fund to enhance the evidence base, promote the multisectoral response, and provide technical support, analysis, and policy advice to countries.* An "incentive fund" with an annual budget of $5 million for five years would promote the analysis and mainstreaming of HIV/AIDS interventions. The fund would (i) help fill major gaps in the understanding of HIV in specific localities and (ii) assist task teams to design HIV/AIDS interventions in sector investment projects for education, transport, rural development, and other key sectors. It would fund critical analysis, policy and program guidance, capacity building, and project and program preparation, in line with the goals of the AAP and the CDMAP. The fund would be available to potential recipients both inside and outside the Bank.
- *Promote work on subregional public goods and cross-boundary issues such as refugees.* Regional efforts are an important complement to national HIV/AIDS programs, and an integral part of Bank corporate strategic priorities. They represent, however, instances in which countries are either reluctant or unable to borrow. Conflict or postconflict situations are common in many subregions, thereby making conventional credit operations infeasible. Grants to deal with refugees, internally displaced populations, transport corridors, and the like are virtually the only option available for responding to such crucial situations. The Bank has greater and more varied experience with HIV/AIDS subregional approaches than other partners.
- *Increase Bank engagement in the epicenter of the epidemic—southern Africa.* The Africa Region must find instruments to support HIV/AIDS programs in countries such as Botswana, Namibia, Swaziland, and South Africa, which are ineligible for IDA funding, either through IBRD "buy-down" collaboration, IBRD grant-funded technical assistance subregional programs, or other mechanisms. The Bank could provide technical support and innovative instruments to assist middle-income countries in southern Africa through IDF financing, analytical work, and policy dialogue.[1]

Pillar 1: Focus the Response through Evidence-Based and Prioritized HIV/AIDS Strategies

The Bank can make a unique contribution to the HIV/AIDS response by helping to incorporate the AIDS program into a country's national development plan, poverty reduction strategy, and MTEF. A prioritized, costed HIV/AIDS

strategy, backed by a realistic annual work plan, is an essential instrument for an effective response. Pillar 1 would help ensure appropriate attention and direction for the national HIV/AIDS program. Its principal elements follow:

- *Embed HIV/AIDS into national development strategies, MTEFs, and poverty reduction programs.* With renewed commitment from Bank and Region management on HIV/AIDS, 6 PRSPs and 10 Country Assistance Strategies (CASs) and Interim Strategic Notes should be reviewed annually to ensure that HIV/AIDS is reflected appropriately in the business plans of the country and the Bank. In the past, tools to help design MTEFs and PRSPs with due consideration for HIV/AIDS have been developed on an ad hoc basis, but now they should be routinely applied.
- *Respond to the specific country epidemics.* The Bank should be prepared to assist countries with financial, technical, and analytical support, depending on their individual circumstances; to understand their specific epidemics; and to establish surveillance systems. A possible typology of responses based on the differentiated epidemics is outlined in tables 5.1 and 5.2.
- *Support and build capacity for the development of prioritized, costed, national HIV/AIDS strategies.* The work of the ASAP group will be directed at approximately 20 Sub-Saharan African countries over the next three years.
- *Integrate HIV/AIDS more fully into programs for health system strengthening, reproductive health, malaria, TB, and nutrition.* Experience has shown that there are programs and diseases that need to be more closely addressed in the context of HIV/AIDS national responses. With its multisectoral capabilities, the Bank will more intensively consider how to do so, whether through HIV/AIDS programs or related investments.
- *Share best practices on what works and what fails in HIV/AIDS programs.* Operations research will be conducted on successes and failures in HIV/AIDS programs to better identify and share best practices.

Pillar 2: Scale Up Targeted Multisectoral and Civil Society Responses

The AFA will support a multisectoral response at the country level and mainstream HIV into the Bank's key sectors. The support will focus on a prioritized multisectoral approach to respond to the complexity of HIV as

Table 5.1: Country Types and HIV/AIDS Typology

COUNTRY TYPES	LOW-LEVEL EPIDEMIC		CONCENTRATED EPIDEMIC		GENERALIZED EPIDEMIC	
	UNDER 1% PREVALENCE IN YOUNG WOMEN AGES 15–24		1–5% PREVALENCE AMONG YOUNG WOMEN AGES 15–24		ABOVE 5% PREVALENCE AMONG YOUNG WOMEN AGES 15–24	
	COUNTRIES	PREVALENCE (%)	COUNTRIES	PREVALENCE (%)	COUNTRIES	PREVALENCE (%)
IDA	Madagascar	0.3	Cameroon	4.9	Lesotho	14.1
	Mauritania	0.5	Tanzania	3.8	Zambia	12.7
	Senegal	0.6	Congo, Rep. of	3.7	Mozambique	10.7
	Niger	0.8	Angola	2.8	Malawi	9.6
			Nigeria	2.7	Central African Rep.	7.3
			Angola	2.5	Kenya	5.2
			Guinea-Bissau	2.5	Uganda	5.0
			Burundi	2.3		
			Congo, Dem. Rep. of	2.2		
			Chad	2.2		
			Rwanda	1.9		
			The Gambia	1.7		
			Eritrea	1.6		
			Burkina Faso	1.4		
			Guinea	1.4		
			Ghana	1.3		
			Mali	1.2		
			Benin	1.1		
			Sierra Leone	1.1		
			Liberia	NA		
			Ethiopia	0.8		
			Sudan	NA		
IDA (conflict and non-accrual)	Somalia	0.6	Togo	2.2	Zimbabwe	14.7
					Côte d'Ivoire	5.1
IBRD						
					Swaziland	22.7
					Botswana	15.3
					S. Africa	14.8
					Namibia	13.4
					Gabon	5.4

Sources: UNAIDS 2006 and extrapolation from Central Statistical Agency [Ethiopia] and ORC Macro, Ethiopia Demographic and Health Survey, 2005.

Note: NA = Not available. This table provides only a broad typology, based on national-level data. Variations in the epidemiology within countries in West Africa and parts of East Africa can be significant (for example, in Kenya, Uganda, and Ghana) and should be taken into consideration when elaborating a locally appropriate response.

Table 5.2: Possible Differentiated Responses

FACTOR	CONCENTRATED EPIDEMIC	MIXED EPIDEMIC	GENERALIZED EPIDEMIC
Geographic area	Parts of West Africa	West Africa and parts of East Africa	Southern Africa
Lending instruments	Focused prevention projects and other sector project components	Hybrid HIV–health projects[a]	Programmatic loans (SWAps)
Investment focus	M&E, stigma reduction, vulnerable groups	Focused interventions on sources of transmission	Behavior change Initiatives for treatment
Analytical focus	HIV mapping, interactions among high-risk groups and general population	Transmission dynamics	Attitude and behavior patterns Human resources for health
Surveillance focus	Sex workers Men who have sex with men	Vulnerable groups and interaction	Population-based surveillance

Source: Wilson 2006.

Note: SWAps = sector-wide approaches.

a. Hybrid projects would include projects such as Burkina Faso (AIDS and health) and the Eritrea projects covering HIV/AIDS/STI, TB, malaria, and reproductive health, which are being replicated in other countries.

a broad development challenge and will focus on sectors that have the greatest potential impact (depending on country context) in partnership with CSOs and private sector entities. To achieve this objective, the AFA will support mainstreaming HIV/AIDS into the overall development and poverty reduction agenda and identify entry points for each sector to incorporate HIV/AIDS. Specifically, the Bank will

- *Encourage HIV/AIDS integration into key sectors.* The Bank will continue and expand its analytical work and investment operations designed to integrate HIV/AIDS policy, programs, and service delivery into priority sectors. This will call for strengthening of sectoral institutional capacity to scale up and supervise activities, in addition to multisectoral prevention operations research, pilot testing of promising approaches, and service delivery. This may involve integrating HIV into new products or retrofitting existing operations.
- *Support CSOs in providing prevention, care, and mitigation services.* Experience gained with the MAP in developing CSO participation and ownership and as service providers for prevention, care, and mitigation shows that civil society is a crucial participant in HIV/AIDS responses. CSOs will continue to be a mainstay of future Africa Region Bank efforts, with new products providing support for, or recognizing the need to significantly engage CSOs as an integral part of, a national solution. CSOs will

also be participants in the M&E approach to provide both realism and accountability.

- *Address gender inequality issues.* Direct and indirect assistance will be needed to address HIV-related gender concerns. Analytical work that leads to greater knowledge of the different effects of HIV on women, resulting in specific actions to change inappropriate gender responses, will be an important part of future efforts. Workshops to build on such findings and train decision makers will be supported. In addition, these results will be integrated into key sectors, and appropriate Bank products will be developed with country teams, task team leaders, and national counterparts.
- *Intensify prevention and support programs for youth and orphans and other vulnerable children.* Each new generation of young women and men must be made aware of, and confront, the risks related to HIV/AIDS. The rapidly growing numbers of orphans and vulnerable children affected or infected by the disease pose a significant social and financial burden to societies. The Bank will contribute to national and external donor responses in conjunction with other lead donor financiers and lead technical partners, including the United Nations Population Fund (UNFPA), the United Nations Educational, Scientific, and Cultural Organization (UNESCO), and UNICEF, in the context of the agreed division of labor among UNAIDS cosponsors.
- *Strengthen health systems.* Taking into account the Bank's 2007 *Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results*, the Africa Region HNP strategy, and the Africa Region health sector portfolio and pipeline, working with Bank health sector specialists, support will be provided to strengthen those elements of the health system that present specific challenges to HIV/AIDS programs, improve service delivery, human resources, and financial sustainability. Particular attention will be paid to ways to multiply results through linkages with TB, malaria, reproductive health, and nutrition.

Pillar 3: Deliver Effective Results through Increased Country M&E Capacity

World Bank support would meet rigorous standards of evidence-informed actions, integrity, and transparency to enhance efficiency, effectiveness, and sustainability. Specifically, the Bank will support countries to:

- *Continue to strengthen M&E frameworks at the country level and tailor the responses.* Monitoring of and technical support to the development and operationalization of M&E systems will be increased, including adoption of a standard "HIV/AIDS Results Scorecard" (see appendix 11) in all projects, development of impact assessment and evaluations, and implementation of an early warning system for project performance. Effective M&E systems can identify epidemic profiles, changing patterns, and contextual areas (including socioeconomic determinants) and develop tailored responses. GAMET, the UNAIDS program housed at the Bank, is charged with helping improve the quality of national M&E systems. Analytical work is also urgently needed to identify specific prevention interventions that will address the feminization of the epidemic and allow women and young girls to better protect themselves.
- *Improve existing governance structures, public sector management, and transparency mechanisms and generate demand at the community level for better accountability.* One of the Bank's most significant advantages lies in helping build national capacity in supervision and fiduciary management—better procurement, financial reporting, and monitoring. Regardless of whether associated with World Bank funding, the Bank has a role to play in helping ensure the integrity of national HIV/AIDS programs, assessing anticorruption practices at all levels, developing guidelines, and building capacity.
- *Support knowledge generation and sharing to improve prioritization, decision making, and program design.* Often, the use of knowledge gained through analytical work is not translated into improved decision making and program design. The Bank will support impact evaluations and project assessments. The Africa Region will pay greater attention to this nexus of knowledge and action.
- *Generate and utilize good practices case studies to support cross-country learning and knowledge sharing*. With its extensive portfolio of varied projects and programs, the Bank is well positioned to identify good practices and share them throughout the Region.

Pillar 4: Harmonize Donor Collaboration

Countries face considerable difficulties in significantly scaling up program implementation. They need technical support that reinforces national own-

ership, addresses immediate needs, and strengthens capacity in a sustainable manner. Strategic planning, integration, and M&E are all vital for "making the money work," that is, improving the efficiency, effectiveness, and sustainability of national HIV/AIDS responses.

The Bank will work with governments and other development partners to honor the concept of the Three Ones and the commitments of the Paris Declaration on aid effectiveness by:

- *Working with key partners to harmonize and strengthen national M&E systems, human resources capacity, procurement, and supply chains.* The Bank will continue to house the multidonor effort to help strengthen M&E systems with support from GAMET. The Bank will also work with lead organizations, as outlined in the UN Technical Support Division of Labor matrix, to address the human resources capacity, procurement, and supply chain management aspects of the HIV/AIDS challenge. Support will be provided to countries and Bank project teams to improve harmonized planning, program design, financial management, rapid and effective disbursement, procurement, and expenditure tracking.
- *Conducting joint planning and analytical work with UNAIDS and other partners.* Taking into account the mandate of ASAP, the Bank will carry out its lead organization responsibilities as specified in the UN Technical Support Division of Labor matrix regarding strategic planning, financial management, human resources, capacity and infrastructure development, impact evaluation, and sector work.
- *Participating in joint annual partner meetings.* The Bank will actively seek to harmonize and align its work with other partners for greater aid effectiveness. It will participate or organize collaborative partnership information-sharing and action events.
- *Strengthening and harmonizing national coordinating institutions.* The Bank will conduct institutional assessments with a view toward identifying key constraints and will provide the tools and training to effectively deal with the multiple stakeholders engaged in the HIV response.

Anticipated Results

The AFA will help produce a stronger policy, institutional, and human capacity framework, which, in turn, will strengthen the HIV/AIDS

response. Over time, it will contribute to a reduction of new infections, reduced prevalence, and improved life expectancy. Within 10 years, it will have helped realize the MDG to halt and begin to reverse the spread of HIV/AIDS.

The expected principal outputs from the AFA over the next five years are contained in tables 5.3 through 5.7.

The Potential Impact and Consequences of Inaction

If universal access to treatment and prevention becomes a reality by 2011 as envisaged by the G-8 countries, the impact on Africa will be significant. According to the analysis discussed in detail in appendix 4, universal access to effective prevention services would reduce the number of new infections from 3.5 million per year to 1.25 million at a cost between $2,000 to $3,000 per infection averted. In addition, these prevention interventions would result in savings for avoided treatment cost alone of about $6,570 per HIV infection averted. With continued expanded access to treatment, almost a million deaths will be averted annually by 2011. In contrast, the consequences of inaction are frightening: new infections would continue to increase, and deaths from HIV/AIDS would grow from the 2005 level of 1.9

Table 5.3: Foundation

OBJECTIVE	ANTICIPATED RESULTS	BY WHOM	BY WHEN
Country demands for predictable, flexible, and sustainable IDA financing for HIV/AIDS receive responses	Countries' access to predictable, flexible, and sustainable financing for HIV/AIDS provided	AFRRMT	FY08–FY11
Support for subregional and cross-border initiatives provided	Support continued to subregional operations to address cross-border issues At least two new subregional operations	AFRRMT AFTHV AFTHD	FY08–FY11
Africa HIV incentive fund (to provide support for project and program development, policy advice, and capacity building) created	Incentive fund finances five technical support products per year	CDMAP AFTHV	FY08–FY10

Source: Authors.

Note: AFRRMT = Africa Region Management Team; AFTHD = Africa Region Human Development Department; AFTHV = ACT*africa*.

Table 5.4: Pillar 1: Focus the Response through Evidence-Based and Prioritized HIV/AIDS Strategies

OBJECTIVE	ANTICIPATED RESULTS	BY WHOM	BY WHEN
Appropriate HIV/AIDS efforts integrated into countries' development agendas and Bank instruments (policy procedures)	HIV/AIDS addressed appropriately through countries' and Bank development agenda	AFTHV, AFRRMT, PREM, WBI, HDNGA, UNDP, IMF.	FY08–FY11
Bank support in capacity building to develop prioritized, and costed, national strategies and action plans provided	Strengthened capacity to develop prioritized and costed national action plans in 20 countries	HDNGA, ASAP, UNAIDS, AFTHV.	FY08–FY11
Integration of TB, malaria, reproductive health, and nutrition into World Bank HIV/AIDS products ensured	Bank projects addressing HIV/AIDS integrate TB, malaria, reproductive health, and nutrition when appropriate to epidemiological context	HDNGA, AFTHV, AFTHD, WHO, UNFPA, UNICEF.	FY08–FY11

Source: Authors.
Note: HDNGA = Global HIV/AIDS Program; IMF = International Monetary Fund; PREM = Poverty Reduction and Economic Management network; WBI = World Bank Institute; WHO = World Health Organization.

Table 5.5: Pillar 2: Scale Up Targeted Multisectoral and Civil Society Responses

OBJECTIVE	ANTICIPATED RESULTS	BY WHOM	BY WHEN
HIV/AIDS policy, programs, and service delivery integrated into priority sectors (dependent upon country context)	Improved country capacity in key sectors to implement multisectoral approaches Increased commitment in key Bank sectors to include HIV/AIDS component or subcomponents in lending and nonlending activities, including adequate resources	HDN, AFTHD, PREM, IFC, AFTHV, AFTPS, AFTEG, AFTTR, AFTU, AFTRL.	FY08–FY11
Support to strengthen elements of the health system that challenge HIV/AIDS programs provided	Improved synergy between HNP and HIV/AIDS operations	HDNHE, AFTHD, AFTHV, WHO, UNFPA, UNICEF.	FY08–FY11

Source: Authors.
Note: AFTEG = Africa Energy; AFTPS = Africa Private Sector; AFTTR = Africa Region Transport Group; AFTU = Africa Urban and Water; HDN = Human Development Network; HDNHE = Health, Nutrition, and Population Team; IFC = International Finance Corporation; JFC = Joint Facilitation Committee.

Table 5.6: Pillar 3: Deliver Effective Results through Increased Country M&E Capacity

OBJECTIVE	ANTICIPATED RESULTS	BY WHOM	BY WHEN
Harmonized M&E frameworks at the country level strengthened	Bank to continue to play leading role (through GAMET) in supporting countries All countries have a functional, harmonized M&E system reporting and using data	HDNGA, AFTHV, GAMET, UNAIDS.	FY08–FY11
Knowledge generation and sharing to improve prioritization, decision making, and program design supported	Design and impact of HIV/AIDS investments based on knowledge sharing Countries and partners fully engaged in knowledge generation and sharing	HDNGA, AFTHV, GAMET, AFTQK, DEC.	FY08–FY11

Source: Authors.
Note: AFTQK = Africa Region Operational Quality and Knowledge Services; DEC = Development Economics Vice Presidency.

Table 5.7: Pillar 4: Harmonize Donor Collaboration

OBJECTIVE	ANTICIPATED RESULTS	BY WHOM	BY WHEN
Collaboration with key partners to harmonize and strengthen national M&E systems, human resources capacity, procurement, and supply chains strengthened	GAMET continues to support countries to strengthen M&E in close collaboration with other partners Better implementation of the global division of labor	HDNGA, AFTHV, PREM, GAMET, AFTQK, UNAIDS, GFATM, PEPFAR.	FY08–FY11
Joint planning and analytical work with UNAIDS and other partners increased	More efficient, effective, and sustainable HIV/AIDS resource allocation	HDNGA, WBI, AFTQK, AFTHV, UNAIDS, GFATM, PEPFAR.	FY08–FY11

Source: Authors.

million. The cumulative effect of no scaled-up effort over the next five years would be close to 10 million deaths and 14 million newly infected persons (an increase of 50 percent from 2006).

Note

1. The Bank currently supports analytical and advisory services and provides IDF grants for capacity building in Swaziland and Namibia.

CHAPTER 6

Operational Implications for the Bank

The role for the Bank in the coming five years in supporting Africa's fight against the HIV/AIDS epidemic will be no less challenging than it was in the past five years. With the absence of IDA grant funding for HIV/AIDS, the demand for IDA credits is likely to be reduced and hence the traditional mechanism of engagement—MAP investment projects—will be less readily available. The principal responsibility for integrating HIV/AIDS into the development agenda and managing the multisectoral response in education, transport, and other sectors does not rest with ACT*africa* or with the HNP team, but with other units in the Bank. And the most critical role for the Bank might shift from financier to facilitator in some countries that have financing from other donors, with consequences for budgeting, work program agreements, and internal incentives.

As indicated in chapter 5, other stakeholders consulted for the AFA consider the "soft" role to be no less critical than the financial role to an effective HIV/AIDS response. They cited attributes they felt were in some cases unique to the Bank:

- *A potentially stable and predictable source of long-term financial support.* Relative to other international financial partners, the Bank's presence in Africa for more than 50 years demonstrates that it has been a stable and predictable source of finance. In a sense, it is an "insurance policy" so that treatment, care, prevention, and mitigation programs, once scaled up, will not fall victim to unpredictable and volatile external funding, especially with the moral and health consequences of a start-and-stop regime for treatment.
- *A catalytic role in core economic and fiscal policy, and treatment of HIV/AIDS as a development as well as a health issue.* The Bank is uniquely positioned

to place the HIV/AIDS epidemic within a macroeconomic framework and within PRSPs, MTEFs, and other mechanisms of national economic and fiscal policy.

- *Experience in dealing with communities and with the private sector.* Much of the work on prevention, treatment, care, and mitigation interventions can be more effectively managed by private employers and workers, and by community-level organizations. The Bank has unique experience in working with these groups.
- *The multisectoral role.* The Bank is active in the sectors that have critical roles in managing the HIV/AIDS epidemic, including education, transport, rural development, defense, and health, as well as in the private sector.
- *Analytical expertise.* The Bank has the analytical capacity—one of its core competencies—to support research and analysis to better understand the epidemic and the most effective means to change attitudes and behaviors.
- *Experience in developing institutional capacity.* Bank support of national and decentralized HIV/AIDS institutions has been and will continue to be important. The Bank's knowledge and reputation in fiduciary management strengthening is widely seen as critical to implementing multisectoral programs.
- *Convener and catalyst*. In the complexity of the global aid architecture for HIV/AIDS, the Bank's traditional role in convening partners to address common issues at both the country and global levels is particularly valued.

At the same time, the consultation process identified areas where development partners felt the Bank had been less effective. A number of stakeholders and partners perceive a decline in the Bank's corporate commitment to HIV/AIDS in Sub-Saharan Africa. They also believe that the Bank's limited country presence weakens its capacity to help harmonize the HIV/AIDS response and broader health responses at the local level. Another shortcoming relates to the Bank's limited ability to operate in the epicenter of the epidemic, that is, in the middle-income countries of southern Africa. Finally, the Bank is perceived to have been slow to put into practice lessons learned from the MAP, to measure the program's impact, and to apply these lessons to the next generation of efforts to fight the disease.

Work Program Implications for the Africa Region

The four pillars of the AFA will require that the Africa Region and ACT*africa* design and develop a program of work very different from the one that drove the first phase of the MAP. New skills, an intensified focus on building and maintaining relationships inside and outside the Bank, new incentives and rewards to recognize the value of partnerships, and a new commitment to working across institutional boundaries will be needed. In particular, the Bank will need to:

- *Focus national development strategies on the role of HIV/AIDS as a development and poverty issue.* The Bank can play a major role in incorporating HIV/AIDS into PRSPs and Poverty Reduction Support Credits (PRSCs), and in helping to design prioritized and costed national HIV/AIDS strategies.
- *Ensure Bank CASs reflect appropriate attention to HIV/AIDS.* A recent review of 34 current CASs for IDA countries in Africa indicated only 24 percent made HIV/AIDS a strategic priority. Few CASs analyzed the nature of the epidemic or assessed government strategy. Almost none identified what other partners were doing and how the Bank initiatives fit into the international response.
- *Help to develop a new generation of HIV/AIDS strategies and action plans based on evidence and focused on critical, cost-effective interventions, and fund them where demand exists.* New projects have been approved in seven of the nine countries where MAP projects have been completed. Under the AFA, the Bank will be prepared to provide funding of at least $250 million per year for projects in the Region.
- *Support the inclusion and design of HIV/AIDS-related components in other sector projects, SWAps, and policy lending.* The next generation of HIV/AIDS-related projects is likely to be concentrated in sectors such as education, social protection, transport, infrastructure, agriculture, and capacity building for health and fiduciary systems. ACT*africa* can provide expertise and operational support where requested for both new products and for retrofitting existing ones. The proposed incentive fund will provide funding to develop HIV/AIDS components in sector projects and analytical support on the epidemic for SWAps and policy loans.
- *Intensify implementation support.* Many of the current projects in the HIV/AIDS portfolio are being reviewed and, where necessary, an inten-

sive program of retrofitting outputs and enhanced supervision for enhanced results is being initiated, in collaboration with our partner countries. The Global Implementation and Support Team will continue to promote problem solving among development partners.

- *Continue to support capacity building for HIV/AIDS governance, especially at the local level, for M&E, and for good governance.* Specialized units such as GAMET for M&E and ASAP for strategic planning may be expanded with heightened attention to Sub-Saharan Africa.
- *Promote harmonization among development partners.* By virtue of the Bank's pledge to the UNAIDS Three Ones principles, work on HIV/AIDS represents a model of the harmonization effort commitment under the Paris Declaration.

These principal areas of work—analysis, strategic development, project design, component design, implementation support, capacity building, and partnership management—are spelled out in the proposed Results Framework and Implementation Plan presented in appendix 10.

An HIV/AIDS Support Program for FY2007–FY2011

Although it is difficult to predict the sources of future demand, the relatively underserved countries of Central and West Africa (that have no or limited PEPFAR funding and relatively modest GFATM support) and the Low-Income Countries Under Stress and postconflict countries with large refugee populations, may be the most likely claimants of Bank funding. Epicenter countries such as Botswana, Namibia, South Africa, and Swaziland may also consider funding from the IBRD, while the Bank explores innovative instruments for this purpose.

Implications for Staffing and Budgeting

Implementing the AFA will require both human and financial resources from the Africa Region to support the HIV/AIDS specialized dedicated team, contributions from country and sector units, and specialists to take on their share of the responsibilities to mainstream HIV/AIDS.

The functions of the current dedicated specialized multisectoral team ACT*africa* would require its transition from essentially an emergency response team carrying out the full gamut of advocacy, national project design, and implementation supervision to one with greater focus on strategic planning; financing and program gap analysis and long-term financial sustainability; macroeconomic and social analysis; fiduciary system strengthening; results monitoring and evaluation; knowledge generation and knowledge sharing; operational and technical support facilitation to Bank teams, countries, and partners; partnership coordination; and regional and cross-border efforts. In addition, we envisage an evolution of the skills requirements over time based on these functions and emerging demands.

While the dedicated team would continue to provide key specialized and quality assurance support across sectors, it will also depend on other Bank staff in the Africa Region, external partners, and cosponsored operations such as GAMET and ASAP to provide substantial time to strengthen key sectoral responses. The dedicated unit would draw on specialized expertise from other Bank operations such as DEC, the WBI, and the IFC. Additional skills and support would be drawn from the Global AIDS Program of the World Bank.

The cost of the unit will involve a modest increase in the current base budget for ACT*africa*. This modest increase would allow the unit to reconfigure its staff over time, take the substantive lead where appropriate, and provide both direct and indirect technical, facilitation, and supplemental support for others in the Region with HIV/AIDS tasks, as described in the Results Framework. While the team will serve as the Region's focal point and information clearing house on AIDS and continue to build internal capacity, most of its work will be demand driven and funded from country budgets.

CHAPTER 7

Conclusion

We have sought to present a convincing case for the Bank's continued engagement in Africa's struggle to overcome HIV and the suffering of its people. We have provided the best available information on the epidemiology, the impact, the Bank's efforts to date, and its future role.

As development practitioners, we know that HIV/AIDS threatens the realization of the MDGs and has long-term economic and human impacts on the Region. The changing environment for HIV/AIDS—including the better understanding of the diversity of the epidemic, the drivers of transmission, and the relative cost effectiveness of different interventions, as well as the growth of funding—has resulted in new challenges for African countries and for the World Bank. The AFA responds to these challenges and to the priorities of the World Bank in Sub-Saharan Africa through the AAP, the World Bank's Global HIV/AIDS Program of Action, CDMAP, and the World Bank HNP strategy.

Using knowledge gained from experience, the AFA is to be demand driven, evidence based, and results oriented. It will build capacity for M&E and epidemiological surveillance, and will continue the process of learning by doing and knowledge creation and sharing. For the Bank's Africa Region, this AFA will reinvigorate its engagement in the fight against HIV/AIDS.

While its funding role is likely to be modest in relative terms, the Bank's investments would remain significant in that it would be the lender of last—and sometimes first—resort. Its involvement would be significant in analyzing, generating, and disseminating evidence; continuing the learning-by-doing process; building capacity for national, effective, sustainable HIV/AIDS responses; strengthening health and fiduciary systems; generating high-quality, prioritized strategic programs and action plans at the

national level; and harmonizing the international response. Above all, the World Bank would provide a critical safety net for a sustained program of prevention, treatment, care, mitigation, and support across the continent to cushion the possible impact of volatile international funding over time.

The AFA will be implemented through partnerships across Bank units and other sectors working closely with partner countries. It will collaborate with and complement the work of UNAIDS, its cosponsors, GFATM, and other development partners to scale up a multisectoral response, mainstream HIV/AIDS in development agendas, build capacity, and, with the IMF, address fiscal space and long-term sustainability issues.

In 2000, the World Bank made a commitment to remain actively involved in combating the HIV/AIDS epidemic in Sub-Saharan Africa for a generation. The AFA provides a program of strategic direction and effort to honor that pledge. This commitment has been reiterated on many occasions by Bank leadership and staff in numerous forums. Standing by this commitment through the unanticipated trials and tribulations of its partner countries will reinforce Bank credibility as a reliable partner, but more importantly, it will further our goal of alleviating poverty.

Appendixes

APPENDIX 1

Agenda for Action Consultations

Table A1.1: Agenda for Action Consultations

EVENT	OVERVIEW	BROAD PRIORITY AREAS	BANK COMPARATIVE ADVANTAGE
Toronto stakeholder consultations with panelists (August 13, 2006)	• HIV/AIDS a development issue and a priority • MDG responsibilities • Multisectoral engagement	• Three Ones support • Alignment and harmonization with other partners	• Multiyear, sustainable financing
ASAP consultations with UNAIDS (August 17, 2006)		• Alignment and harmonization with other partners	
Task Team Leader consultations (September 18, 2006)	• MDG responsibilities • Multisectoral engagement • Knowledge management and analytical capacity • Convening power	• Alignment and harmonization with other partners	• Africa-wide MAP experience • Multisectoral approach • National capacity-strengthening experience
UNAIDS/East and Southern Africa (September 23, 2006)	• Macroeconomic access and dialogue • Knowledge management and analytical capacity • Convening power	• Three Ones commitment • Alignment and harmonization with other partners • Fulfill donor of last resort to inadequately treated and/or sensitive issues and marginalized groups	• Multiyear, sustainable financing • National capacity-strengthening experience

SPECIFIC THEMES FOR BANK	BANK RESOURCES AND INSTITUTIONAL STRUCTURE	BANK WEAKNESSES
• Local response and prevention experience • Integrated health sector engagement • National capacity strengthening • Regional programs and emergency responses • Analytical capacity	• "Financial gap" provider, using its various financing response instruments • Headquarters and field presence to support national HIV/AIDS deliberation and response	• Apparent insufficient commitment and priority by Bank to long-term HIV/AIDS effort • Inadequate coordination with health and other sectors • Neither mainstreaming nor budget support translating into HIV/AIDS resources
• National capacity strengthening	• Headquarters and field presence to support national HIV/AIDS deliberation and response	• Absence of engaged field presence, technical expertise
• Local response and prevention experience • Integrated health sector engagement • Scaling up good practices	• "Financial gap" provider, using its various financing response instruments • Headquarters and field presence to support national HIV/AIDS deliberation and response	• Apparent insufficient commitment and priority by Bank to long-term HIV/AIDS effort • Absence of engaged field presence, technical expertise • Insufficient Bank staff incentives to pursue HIV/AIDS track • Neither mainstreaming nor budget support translating into HIV/AIDS resources • Absence of "ring-fenced financing" and Bank Budget support results in reduction of Bank HIV/AIDS support • Insufficient awareness of reputational risks and governance considerations
• Local response and prevention experience • Regional programs and emergency responses	• "Financial gap" provider, using its various financing response instruments	• Absence of engaged field presence, technical expertise • Rigidity of fiduciary rules • Need for a significant presence in southern Africa

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Table A1.1: Agenda for Action Consultations (continued)

EVENT	OVERVIEW	BROAD PRIORITY AREAS	BANK COMPARATIVE ADVANTAGE
UN agencies with New York headquarters (September 28, 2006)	• MDG responsibilities • Macroeconomic access and dialogue • Convening power	• Fulfill donor of last resort to address inadequately treated and/or sensitive issues and marginalized groups	• Africa-wide MAP experience • National capacity-strengthening experience
GFATM (Geneva, October 2, 2006)	• MDG responsibilities • Macroeconomic access and dialogue • Knowledge management and analytical capacity	• Alignment and harmonization with other partners	• Fiduciary expertise • National capacity-strengthening experience • Support to national AIDS institutions, especially in costing, fiduciary, and M&E
UNAIDS (Geneva, October 2, 2006)	• Macroeconomic access and dialogue • Multisectoral engagement • Convening power	• Alignment and harmonization with other partners (contribute to it becoming a reality via support for independent monitoring of organization behaviors)	• Fiduciary expertise • Multiyear, sustainable financing
WHO (Geneva, October 3, 2006)	• Macroeconomic access and dialogue • Multisectoral dimension of engagement • MDG responsibilities (coupled with concern for equity in access and treatment)	• Discard notion of dichotomy between vertical versus horizontal programs, and invest in both in a mutually reinforcing manner	• National capacity-strengthening experience • Multiyear, sustainable financing • Fiduciary expertise
UNHCR (Geneva, October 3, 2006)	• Multisectoral engagement • Convening power, especially in inherently risky countries and environments	• Alignment and harmonization with other partners	• Multiyear, sustainable financing
Nairobi regional consultations on civil society response (May 8–11, 2006)	• Multisectoral dimension of engagement • Macroeconomic access and dialogue • Knowledge management and analytical capacity	• Alignment and harmonization with other partners, especially in the health sector • Three Ones commitment (but adapt M&E to the reality of each country)	• Multiyear, sustainable financing • National capacity-strengthening experience, including strategic plans and action plans

SPECIFIC THEMES FOR BANK	BANK RESOURCES AND INSTITUTIONAL STRUCTURE	BANK WEAKNESSES
• Local response and prevention experience • Integrated health sector engagement • Regional programs and emergency responses	• Financial gap provider, using its various financing response instruments	• Absence of engaged field presence, with technical expertise • Rigidity of fiduciary rules • Need for a significant presence in southern Africa
• Local response and prevention experience • Integrated health sector engagement		• Rigidity of fiduciary rules
• Analytical work (including analysis of the financial consequences of "universal access") • Local response and prevention experience, including the private sector • National capacity strengthening and need to do more at subnational levels		• Apparent insufficient commitment and priority by Bank to long-term HIV/AIDS effort • Absence of engaged field presence, with technical expertise, and continuity • Lack of vision in integrating HIV/AIDS and health systems • M&E effort needs to be better coordinated (GAMET and UNAIDS)
• Integrated health sector engagement		• Rigidity of fiduciary rules • Africa MAP was isolated from other partner efforts
• Regional programs and emergency responses • Local response and prevention experience, in particular in income-generation activities		• Apparent insufficient commitment and priority by Bank to long-term HIV/AIDS effort in refugee environments
• Scaling up good practices • Local response and prevention experience • Regional programs and emergency responses • Integrated health sector engagement	• Financial gap provider, using its various financing response instruments, particularly for civil society • Headquarters and field presence to support national HIV/AIDS deliberation and response	• Apparent insufficient commitment and priority by Bank to long-term HIV/AIDS effort • Rigidity of fiduciary rules • Absence of engaged field presence, with technical expertise, and continuity • Need for a significant presence in southern Africa

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Table A1.1: Agenda for Action Consultations (continued)

EVENT	OVERVIEW	BROAD PRIORITY AREAS	BANK COMPARATIVE ADVANTAGE
Donor consultations (London, October 23, 2006)	• Convening power • Macroeconomic access and dialogue (PRSP, MTEF) • Knowledge management and analytical capacity • Capacity to consider the multi-sectoral dimensions of engagement	• Alignment and harmonization with other partners, particularly with the the GFATM, and especially in the health sector	• National capacity-strengthening experience, including technical assistance and training, in various aspects, including strategic plans and action plans • Support to national AIDS institutions, especially in costing, fiduciary, and M&E • Multisectoral approach via mainstreaming or integrating HIV/AIDS into sector policies and programs, and development of sectoral or topic-specific guidelines
Countries and youth (Johannesburg, February 2007)	• Accelerating attention to and implementation of youth activities • Improved integration of adolescent HIV and sexual reproductive health services • Multisectoral engagement	• Effective approaches and partnerships for addressing youth • Strengthen linkages between adolescent reproductive health and HIV services • Strengthen M&E and the evidence base for youth-friendly services and interventions • Alignment and harmonization with other partners	• Advocate for mainstreaming of youth in government budget lines and national frameworks • Be a knowledge bank • Convening authority for dialogue with development partners and government • Work with regional establishments

SPECIFIC THEMES FOR BANK	BANK RESOURCES AND INSTITUTIONAL STRUCTURE	BANK WEAKNESSES
• Analytical work (including analysis of the financial consequences of "universal access") • Scaling up good practices • Local response (civil society, private sector, NGOs) and prevention experience • Regional programs and emergency responses • Integrated health sector engagement	• As an important financer, use its various financing response instruments, particularly for civil society • IDA-15 represents an opportunity to revisit the ways and means to maintain Bank involvement and momentum in responding to HIV/AIDS	• Apparent insufficient commitment and priority by Bank to long-term HIV/AIDS effort, coupled with current absence of key management leadership • Absence of engaged field presence, with technical expertise, and continuity to engage in country dialogue • Uncertain extent to which GTT recommendations have been adopted and embedded in Bank approach • Need for a significant presence in southern Africa • Neither mainstreaming nor budget support translating into HIV/AIDS resources • Absence of "ring-fenced financing" and Bank Budget support results in reduction of Bank HIV/AIDS support
• Enhance youth capacity on development concepts, agendas, and frameworks, for example, PRSPs, budgeting, monitoring, and accountability • Advocate flexibility in registration and mechanisms for youths to access resources • Take leadership to bring key groups together and give a voice to youth • Intensify analytical work, document and disseminate best practices and lessons learned		• Lack of specific focus on youth HIV interventions • Lack of segmentation catering to varying needs of different youth groups; limited attention to rural youth and gender differentiation • Inadequate consideration of the 10–14 age group • Weak youth participation in policy and programming decisions

APPENDIX 2

HIV Indicators for Sub-Saharan Africa

Table A2.1: HIV Prevalence, Income, Access to Treatment, and Quality of Health Services in Sub-Saharan Africa, 2006

COUNTRY	GDP PER CAPITA ($)	HIV PREVALENCE, AGES 15–49 (PERCENT)	ACCESS TO TREATMENT (PERCENT)	POPULATION PER PHYSICIAN (UNITS)	POPULATION PER NURSE (UNITS)	PLWHA PER PHYSICIAN (UNITS)	PLWHA PER NURSE (UNITS)
Angola	1,873	3.7	6	12,993	871	363	24
Benin	595	1.8	33	22,244	1,195	280	15
Botswana	5,829	24.1	85	2,510	378	378	57
Burkina Faso	438	2.0	24	16,975	2,427	190	27
Burundi	107	3.3	14	35,340	5,243	750	111
Cameroon	952	5.4	22	5,216	626	163	20
Central African Republic	336	10.7	3	11,819	3,293	755	210
Chad	601	3.5	17	25,664	3,709	522	75
Congo, Dem. Rep. of	119	3.2	4	9,339	1,890	172	35
Congo, Rep. of	1,751	5.3	17	5,050	1,040	159	33
Côte d'Ivoire	850	7.1	17	8,120	1,660	360	74
Equatorial Guinea	5,934	3.2	0	3,314	2,224	58	39
Eritrea	206	2.4	5	19,986	1,715	274	24
Ethiopia	153	0.9 – 3.5	7	36,507	4,746	NA	NA
Gabon	6,538	7.9	23	3,420	194	152	9
Gambia, The	304	2.4	10	9,141	830	128	12
Ghana	512	2.3	7	6,598	1,085	99	16
Guinea	355	1.5	9	8,734	1,812	86	18
Guinea-Bissau	181	3.8	1	8,181	1,483	170	31
Kenya	574	6.1	24	7,195	874	289	35
Lesotho	537	23.2	14	20,247	1,605	3,034	240
Madagascar	263	0.5	0	3,442	3,162	9	9
Malawi	161	14.1	20	46,380	1,698	3,534	129
Mali	421	1.7	32	12,734	2,051	123	20
Mauritius	5,058	0.6	NA	946	271	3	1

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Table A2.1: HIV Prevalence, Income, Access to Treatment, and Quality of Health Services in Sub-Saharan Africa, 2006 (continued)

COUNTRY	GDP PER CAPITA ($)	HIV PREVALENCE, AGES 15–49 (PERCENT)	ACCESS TO TREATMENT (PERCENT)	POPULATION PER PHYSICIAN (UNITS)	POPULATION PER NURSE (UNITS)	PLWHA PER PHYSICIAN (UNITS)	PLWHA PER NURSE (UNITS)
Mozambique	346	16.1	9	37,319	4,851	3,502	455
Namibia	2,870	19.6	71	3,363	327	385	37
Niger	278	1.1	5	32,931	4,571	210	29
Nigeria	678	3.9	7	3,551	590	83	14
Rwanda	242	3.1	39	21,150	2,360	474	53
Senegal	715	0.9	47	17,406	3,145	103	19
Sierra Leone	219	1.6	2	30,762	2,807	286	26
South Africa	5,100	18.8	21	1,298	245	158	30
Sudan	783	1.6	1	NA	NA	NA	NA
Swaziland	2,323	33.4	31	6,333	159	1,287	32
Tanzania, United Republic of	324	6.5	7	22,298	2,343	6,222	654
Togo	378	3.2	27	12,086	1,646	50	7
Uganda	326	6.7	51	44,131	2,729	1,217	75
Zambia	609	17.0	27	8,642	575	870	58
Zimbabwe	383	20.1	8	6,199	1,382	815	182

Source: Haacker 2007.

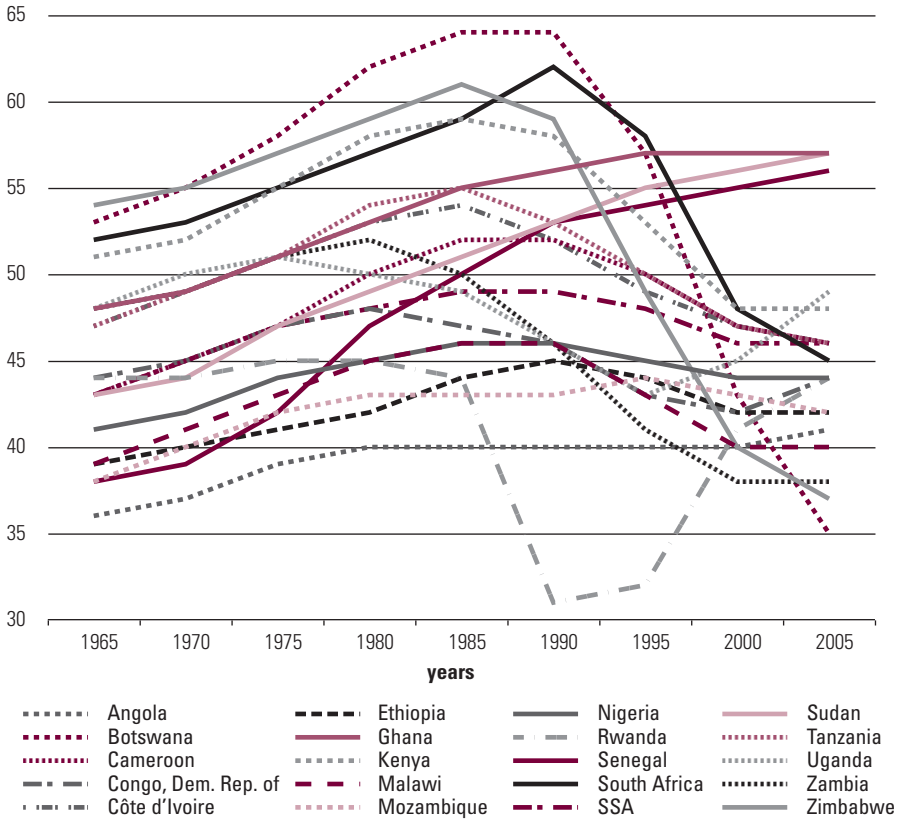
Note: NA = not available. Country HIV prevalence data is the most recent at the time of this publication. The UNAIDS publication of 2007 country estimates are expected in July 2008.

Table A2.2: Life Expectancy at Birth for Selected Sub-Saharan African Countries, 1965–2005 (years)

COUNTRY	1965	1970	1975	1980	1985	1990	1995	2000	2005
Sub-Saharan Africa region	43	45	47	48	49	49	48	46	46
Angola	36	37	39	40	40	40	40	40	41
Botswana	53	55	58	62	64	64	57	43	35
Cameroon	43	45	47	50	52	52	50	47	46
Congo, Dem. Rep. of	44	45	47	48	47	46	43	42	44
Côte d'Ivoire	47	49	51	53	54	52	49	47	46
Ethiopia	39	40	41	42	44	45	44	42	42
Ghana	48	49	51	53	55	56	57	57	57
Kenya	51	52	55	58	59	58	53	48	48
Malawi	39	41	43	45	46	46	43	40	40
Mozambique	38	40	42	43	43	43	44	43	42
Nigeria	41	42	44	45	46	46	45	44	44
Rwanda	44	44	45	45	44	31	32	41	44
Senegal	38	39	42	47	50	53	54	55	56
South Africa	52	53	55	57	59	62	58	48	45
Sudan	43	44	47	49	51	53	55	56	57
Tanzania	47	49	51	54	55	53	50	47	46
Uganda	48	50	51	50	49	46	43	45	49
Zambia	48	49	51	52	50	46	41	38	38
Zimbabwe	54	55	57	59	61	59	49	40	37

Source: World Bank's Development Data Platform (DDP) database.

Figure A2.1: Life Expectancy at Birth for Selected Sub-Saharan African Countries, 1965–2005



Source: World Bank's Development Data Platform (DDP).

APPENDIX 3

Bank Response to HIV/AIDS: A Chronology of Events

Table A3.1: Bank Response to HIV/AIDS: A Chronology of Events

TIMELINE	ACTION TAKEN
Pre-1997	The Bank's response was constrained internally and externally by low demand for Bank's assistance and Bank's internal focus on health sector reforms during this period.
1997	The HNP strategy contained no discussion of AIDS except in a remote annex in the context of emerging diseases. A Bank policy research report, *Confronting AIDS: Public Priorities in a Global Epidemic,* highlighted the economic impact of AIDS.
1998	The Africa Regional Vice President (RVP) called for a new Regional strategy in light of emerging data on the development impact of AIDS.
July 1999	ACT*africa* was established to support and coordinate the Bank's multisectoral response. The unit was placed in the office of the RVP and staffed with seconded multisectoral staff. Weekly Regional Leadership Team meetings regularly discussed AIDS. Accountability mechanisms were established requiring country directors to report regularly on AIDS activities. AIDS was incorporated in Bank instruments and procedures, such as safeguards.
1999	The Bank adopted *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis* to address the growing HIV/AIDS epidemic in Africa.
1999	AIDS activities were added to existing projects in country portfolios and sectors other than health, such as education, transport, rural development, and social protection. Retrofitting had mixed results because the commitment amounts were often too small to affect the spreading epidemic.
January 2000	The World Bank president addressed the UN Security Council and called for a "War on AIDS."
April 2000	ACT*africa* published its cross-country analysis of economic impact, which was picked up by "Economics Focus" in the Economist. AIDS was the top agenda item for the Bank's Spring Meetings.
September 2000	The Bank's Board approved a Multi-Country HIV/AIDS Program (MAP), a 10–15 year program to intensify multisector action against AIDS and build political commitment. The MAP defined eligibility criteria to raise political commitment and mobilization at the country level.
February 2002	MAP 2 was approved with $500 million funding to pilot test ART and support cross-border initiatives. IDA-13 provided grants in support of HIV/AIDS.
January 2003	An Implementation Acceleration Team was established to address slow implementation and low coverage and strengthen institutional capacity as well as facilitate learning by doing. Higher supervision budgets were provided to MAP projects.
October 2004	ACT*africa* commissioned an *Interim Review of MAP*, which basically confirmed validity of the MAP approach, highlighted progress made and suitability of interventions, and identified ways for future improvement.

(*continues on the following page*)

Table A3.1: Bank Response to HIV/AIDS: A Chronology of Events (continued)

TIMELINE	ACTION TAKEN
July 2004	ACT*africa* moved to AFTQK for mainstreaming with quality assurance of HIV operations and knowledge generation and sharing.
2005	OED evaluated the World Bank's global assistance for HIV/AIDS and issued its report.
2005	AFTQK established an escrow account to support problem projects and encouraged all HIV projects to use this fund to address challenges.
April 2006	The Africa Region reviewed all active HIV projects in collaboration with HDNGA, AFTHD, and LEGAF to assess implementation risks and opportunities to incorporate recommendations from the MAP interim review and OED evaluation.
May 2006	ACT*africa* and HDNGA conducted MAP task team leader training on M&E and appropriate indicators.
August 2006	The Africa Region established a core team to review and lead the work on restructuring (retrofitting) projects for improved performance and incorporate recommendations from the MAP interim review and OED evaluation. Led by ACT*africa* and AFTHD, the core team includes LEGAF, Loan Department (LOA), HDNGA (GAMET), and AFTRL.
October 2006	The Africa Region and HDNGA (GAMET) finalized a Generic Results Framework (GRF) and Results Scorecard for all HIV projects inclusive of IDA-14 and UNGASS indicators, AAP indicators, and indicators from national M&E plans.
2006 – Ongoing	ACT*africa* intensified technical assistance to operations by supporting project supervision, portfolio monitoring, and ISR reviews and by extending both financial and technical support to problem projects. HDNGA/ACT*africa* further intensified M&E assistance in support of donor harmonization and alignment and strengthening of national AIDS strategies and plans through ASAP.
2006 – Present	The Africa Region began updating its 1999 HIV/AIDS strategy and developing an "Africa HIV/AIDS Agenda for Action, 2007–2011." Consultations were held with civil society, donors, stakeholders and countries, trade unions, UN agencies, private sector, youth, women's groups, and global health partners working on sexual and reproductive health, TB, and malaria.
February 2007	An umbrella restructuring proposal of MAP projects was presented to the Bank's Executive Board. The proposed restructuring took into account the findings from the MAP interim review, OED/IEG evaluation of global HIV projects, latest scientific evidence on prevalence, changed global financial architecture, as well as agreement on the Three Ones by the global development community and governments on HIV and AIDS.
April 2007	Progress on "Africa HIV/AIDS Agenda for Action 2007–2011" was presented as part of the AAP update during Annual Spring Meetings.
November 2007	"Africa HIV/AIDS Agenda for Action 2007–2011" was discussed and endorsed by the Board at an informal meeting.

APPENDIX 4

The Potential Impact of HIV/AIDS Interventions: Methodology and Simulations

This appendix discusses the simulations of the impact and costs of HIV/AIDS prevention, care, and mitigation interventions in Sub-Saharan Africa (Bollinger and Stover 2007). The presented results were based on models used for simulations published in Science and by UNAIDS.

Methodology and the Consequences of Inaction

Bollinger and Stover (2007) examined the consequences of three different scenarios regarding HIV/AIDS policies in the region: (i) a "Base Scenario" where coverage rates for prevention, treatment, and mitigation interventions remain at current levels; (ii) a universal access to treatment scenario ("Treatment Scenario"), where treatment services are scaled up to reach at least 80 percent of those in need by 2010, but other interventions remain constant; and (iii) a universal access to treatment and prevention scenario ("Prevention Scenario"), where prevention interventions are also scaled up.

The results are divided into three different subregions—East Africa, southern Africa, and Central/West Africa—to reflect the different natures of the epidemic in those areas. In the Base Scenario, new infections would continue to increase and deaths from HIV/AIDS would grow from the 2005 level of 1.9 million. The cumulative effect of no scaled-up effort over the next five years would be close to 10 million deaths and 14 million newly infected persons (an increase of 50 percent from 2006).

The second case—the Treatment Scenario—consists of increasing coverage from the current levels that are in the Base Scenario to reach universal access to treatment by 2010 (defined as covering 80 percent of adults and children in

need of ART). Annual costs of care and treatment are based on data from Khayelitsha, South Africa, and include data on costs of and progression to first-line and second-line therapies, incidence and treatment of opportunistic infections, and configuration of palliative care. Costs of ART are based on the assumption that, on average, each person receives 7.5 years of ART.

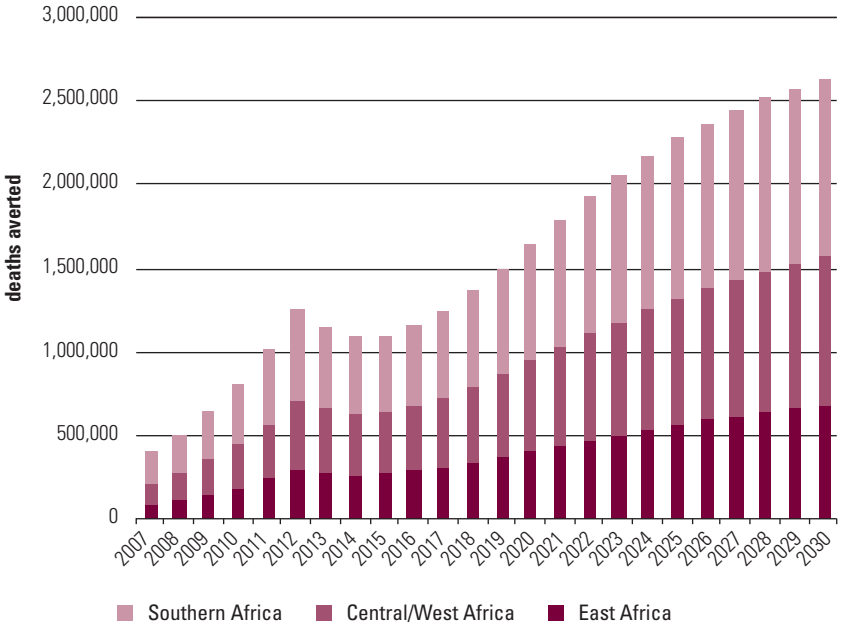
The third case—the Prevention Scenario—builds on the Treatment Scenario and assumes that prevention interventions are scaled up in a linear fashion from the existing 2005 levels to coverage levels of 80 to 100 percent by 2010. The impact of this increase in coverage on HIV infections averted is then calculated by: (i) predicting the change in behavior that is due to this increased coverage; (ii) estimating the impact of this behavior change on HIV incidence; and (iii) examining the consequences of the changes in incidence.

Changes in behavior are predicted based on an impact matrix that estimates the effect of the various prevention interventions on specific behaviors. The values of the matrix were derived from a review of the literature on approximately 100 impact studies. These behavior changes were then fed through an HIV/STI transmission equation to calculate new HIV infections. This equation calculates the probability of infection as a function of HIV prevalence in the partner population, the transmissibility of HIV, the impact of an STI on HIV transmissibility, the proportion of the population with STIs, condom use, number of partners per year, and number of sexual contacts with each partner. Finally, the Spectrum Model is used to relate the changes in HIV incidence to other variables of interest.

Impact of Universal Access to Treatment

If the Treatment Scenario occurs, by 2010 more than 5 million people would be on treatment. The impact of scaling up treatment is immediate and dramatic. In 2007 alone, approximately 400,000 deaths would be averted and by 2011, the number of deaths averted annually rises to almost a million (figure A4.1). The overall cost per AIDS death averted varies between $2,500 and $3,500, depending on the subregion. There are a number of positive and negative external effects to a scale up of treatment, such as benefits from orphan-life-years averted, emergence of drug-resistant strains of the virus, reduction in HIV transmission associated with lower viral loads, or increases in transmission resulting from longer duration of infectivity (Revenga et al. 2006).

Figure A4.1: Universal Access to Treatment: Number of Deaths Averted, 2007–2030



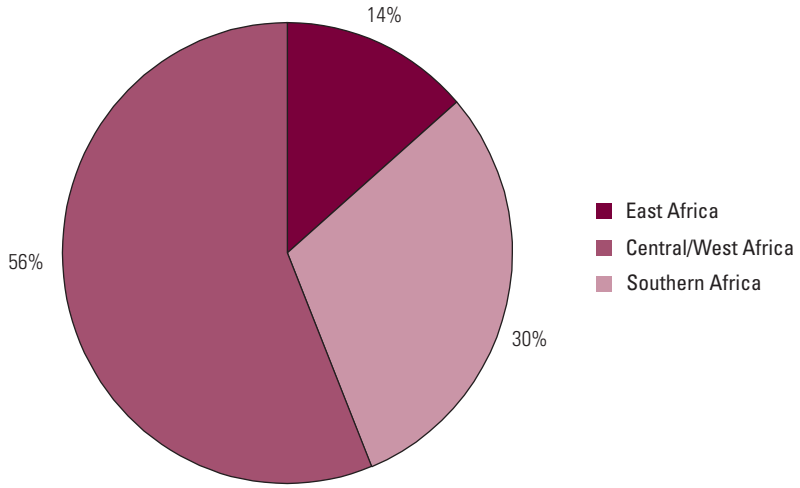
Source: Bollinger and Stover 2007.

Another way to look at the impact of the increase in access to treatment is to calculate the amount of life years gained relative to the Base Scenario. In total, almost 14 million life years will be gained relative to the Base Scenario (see figure A4.2) at a cost of approximately $1,400 per life year in East Africa and approximately $600 per life year in southern Africa and Central/West Africa.

Impact of Universal Access to Prevention

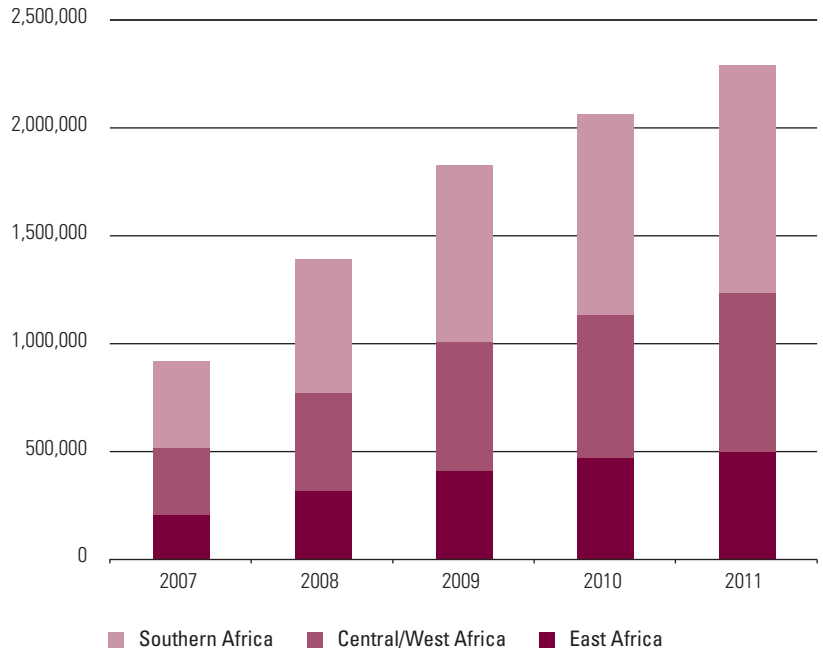
The Prevention Scenario assumes scaling up of prevention efforts to reach target levels set by UNAIDS by 2010. The number of annual new infections would be reduced from more than 3.5 million to approximately 1.25 million by 2011. The total number of HIV-positive people would decline from 28 million to 22 million (see figure A4.3). The cost per infection averted decreases significantly between 2007 and 2011. Overall, the average cost per HIV infection averted in Sub-Saharan Africa drops from about $3,000 in

Figure A4.2: Universal Access to Treatment: Cumulative Number of Life Years Gained in Sub-Saharan Africa, 2007–2011



Source: Bollinger and Stover 2007.

Figure A4.3: Infections Averted Due to Prevention Efforts in Sub-Saharan Africa, 2007–2011



Source: Bollinger and Stover 2007.

2007 to about $2,000 by 2011. (See below for more on the cost effectiveness of different prevention interventions.) It is also crucial to note that prevention interventions result in large benefits in treatment costs avoided. In fact, Bollinger and Stover (2007) estimate overall cost savings of $6,570 per HIV infection averted in the region. Some authors have discussed the possibility of increased risky behavior due to "complacency" effects associated with treatment availability (Revenga et al. 2006).

Cost Effectiveness of Prevention Interventions

Results from 10 different country-specific applications of the Goals Model (Futures Group 2005) were used to calculate unweighted average impacts for 11 different interventions: community mobilization, mass media, voluntary counseling and testing (VCT), interventions for sex workers (SWs), interventions for men who have sex with men (MSM), in-school youth programs (Education), blood safety, condom distribution, STI treatment, workplace programs, and programs for prevention of mother-to-child transmission (PMTCT). These interventions were selected because they have the most robust results when calculating their impact coefficients. For each country, the full program of prevention interventions was scaled up to reach universal access targets by 2010, with the resulting number of total HIV infections averted calculated. After this, the funding was taken away from each of the 10 interventions one at a time (and subsequently replaced), so that the marginal impact of the intervention could be measured.

Table A4.1 classifies interventions by their relative cost-effectiveness ratios, as well as by their relative impact measured by percentage of total infections averted. There are three categories of cost per infection averted: Low (< $1,000), Medium ($1,000 to $3,000), and High (> $3,000); and three categories for impact: Low (0–10 percent of total infections averted), Medium (10–20 percent of total infections averted), and High (> 20 percent of total infections averted). These cost-effectiveness estimates should also be analyzed in light of monetary benefits associated with averted treatment costs for extended periods.

Table A4.1: Cross-Classification of Interventions by Cost Effectiveness and Impact

A. EAST AND SOUTHERN AFRICA				B. CENTRAL AND WEST AFRICA			
	IMPACT (% OF INFECTIONS AVERTED)				IMPACT (% OF INFECTIONS AVERTED)		
Cost per infection averted	Low (0–10)	Medium (10–20)	High (> 20)	Cost per infection averted	Low (0–10)	Medium (10–20)	High (> 20)
Low (< $1,000)	SW MSM	PMTCT	Blood safety	Low (< $1,000)	MSM	SW	
Medium ($1,000 – $3,000)	Community mobilization VCT Education	Condom distribution		Medium ($1,000 – $3,000)	Blood safety Condom distribution	PMTCT Workplace programs	
High (> $3,000)	Mass media STI treatment Workplace programs			High (> $3,000)	Community mobilization Mass media STI treatment Education		

Source: Bollinger and Stover 2007.

Both tables indicate that interventions targeting SWs across all of Sub-Saharan Africa are very cost effective, with costs per infection averted of less than $1,000. Interventions for SWs have a much smaller target population, yet because the HIV-prevalence rate in that group is usually quite high, a large number of infections can be averted.

PMTCT and blood-safety programs are also very cost effective in East and southern Africa, where HIV prevalence rates are higher and have a substantial impact on the number of total infections averted. In Central and West Africa, these two interventions are classified in the medium cost per infection averted category, and PMTCT contributes a substantial proportion of all infections averted.

Finally, those interventions with the highest cost per infection averted in East and southern Africa are mass media, STI treatment,[1] and workplace programs, while the corresponding interventions in Central and West Africa are community mobilization, mass media, STI treatment, and education for youth. Hence, it seems that four interventions are particularly highly cost effective for Sub-Saharan Africa: PMTCT, blood-safety programs, and outreach programs for SWs and for MSM. Table A4.2 presents a summary of other studies on the cost effectiveness of HIV prevention interventions in the region that broadly corroborates the results outlined here. Caution should be exercised when analyzing the results, because pre-

Table A4.2: Studies of Cost Effectiveness of HIV/AIDS Interventions in Sub-Saharan Africa

INTERVENTION	COST EFFECTIVENESS IN 2001 DOLLARS	
	PER HIV INFECTION	PER DALY
VCT (Kenya and Tanzania)	270–376	14–19
VCT (Chad)	891–5,213	45–261
Peer-based programs (Cameroon)	67–137	3–7
Condom distribution and IEC (South Africa)	378–4,094	19–205
Condom social marketing (Chad)	77	4
STI treatment (Kenya)	11–16	1
STI treatment (Tanzania)	326	16
STI treatment (South Africa)	2,093	105
STI treatment (Chad)	1,675	84
ART for PMTCT: Nevirapine (Sub-Saharan Africa)	142–306	6–12
Blood safety (Chad)	75–151	4–8
Blood safety (Zimbabwe)	166–1,010	8–51
Blood safety (Zambia)	215–262	11–13
Sterile injection (Africa)	—	91–230

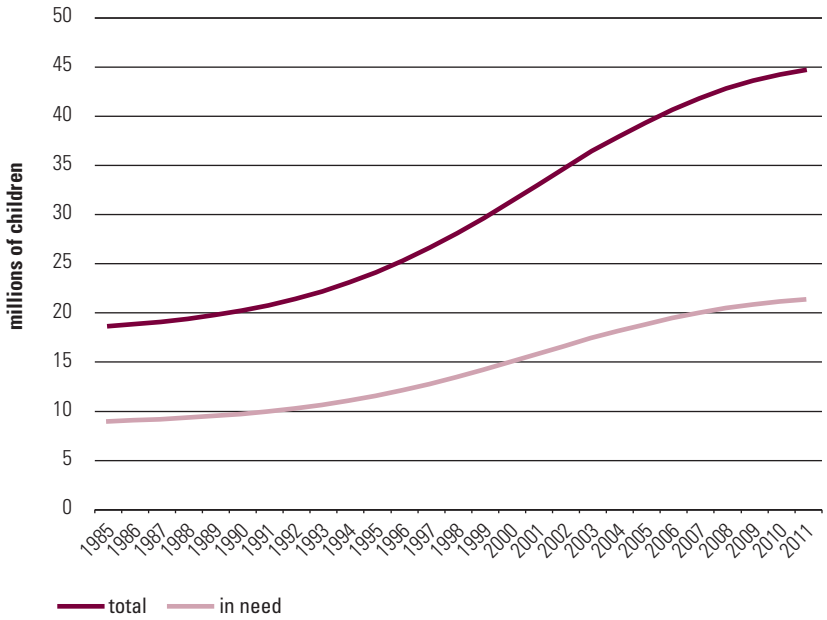
Source: Bertozzi et al. 2006.
Note: — = not available; DALYs = disability-adjusted life years; IEC = information, education, and communication.

vention interventions should not be considered in isolation. It is more useful to think in terms of packages of interventions, particularly interventions that are mutually supportive and complementary.

Mitigation

HIV/AIDS is responsible for a significant part of the increase in the number of orphans and vulnerable children (OVC) in Sub-Saharan Africa. This puts strains on traditional coping mechanisms (such as the extended family) and highlights the need to provide additional support to those groups. Bollinger and Stover (2007) provide simulations of the impact of HIV/AIDS on the number of OVC from 2007 to 2011, as well as projections of the number of those in need of assistance.[2] According to figure A4.4, the number of OVC in need would increase from about 19 million in 2006 to more than 21 million in 2011. It is important to note that there is a global consensus that all OVC in need should be supported, not only those whose parents have died of AIDS, to mitigate any stigma that might develop otherwise.

Figure A4.4: Number of OVC in Sub-Saharan Africa



Source: Bollinger and Stover 2007.

Notes

1. Note that the cost of STI considered here does not reflect the cost of STI treatment per se, but rather the cost of outreach programs.
2. The population in need is defined as all double orphans and vulnerable children, along with half of single orphans, who live in households below the poverty line.

APPENDIX 5

World Bank HIV/AIDS Portfolio for Africa, FY1989–FY2007

Table A5.1: Closed MAP and Standalone Projects, and Closed Projects with HIV/AIDS Components

COUNTRY	PROJECT ID	PROJECT TITLE	FY APPROVED	FY CLOSED	CLOSING DATE	COMMITTED[a]
CLOSED MAP AND STANDALONE PROJECTS						
Congo, Dem. Rep. of	P003116	National AIDS Control Program	1989	1995	12/31/1994	8.1
Zimbabwe	P003333	Sexually Transmitted Infections	1993	2001	12/31/2000	64.5
Uganda	P002963	Sexually Transmitted Infections	1994	2003	12/31/2002	50.0
Kenya	P001333	SEXUALLY TRANSMITTED Infections Project	1995	2001	6/30/2001	40.0
Eritrea	P065713	ER-AIDS, Mal, STD, TB Cntrl APL (FY01)	2001	2006	3/31/2006	40.0
Ethiopia	P069886	ET-MAP (FY01)	2001	2007	12/31/2006	59.7
Gambia, The	P060329	GM-HIV/AIDS Rapid Response (FY01)	2001	2007	12/31/2006	15.0
Ghana	P071617	GH-AIDS GARFUND Response Proj (FY01)	2001	2006	12/31/2005	25.0
Kenya	P070920	KE-HIV/AIDS Disaster Resp (FY01)	2001	2006	12/31/2005	50.0
Uganda	P072482	UG-HIV/AIDS Control SIL (FY01)	2001	2007	12/31/2006	47.5
Cameroon	P073065	CM-MultiSecal HIV/AIDS SIL (FY01)	2001	2007	6/30/2007	50.0
Benin	P073118	BJ-HIV/AIDS Multi-Sec APL (FY02)	2002	2007	9/15/2006	23.0
Burkina Faso	P071433	BF-HIV/AIDS Disaster Response APL (FY02)	2002	2007	6/30/2007	27.0
Madagascar	P072987	MG-MultiSec STI/HIV/AIDS Prev APL (FY02)	2002	2008	12/31/2007	20.0
Sierra Leone	P073883	SL-HIV/AIDS Response (FY02)	2002	2008	12/31/2007	15.0
Subregional	P074850	3A-HIV/AIDS Abidjan Lagos Trnspt (FY04)	2004	2008	12/31/2007	16.6
Subtotal						551.4
CLOSED PROJECTS WITH HIV/AIDS COMPONENTS[b]						
Angola	P000048	HEALTH	1993	2000	12/31/1999	6.8
Burkina Faso	P000308	POPULATION/AIDS CONTROL	1994	2002	9/30/2001	8.2
Comoros	P000596	POP & HUMAN RESOURCE	1994	2000	6/30/2000	2.2
Chad	P035601	POPULATION & AIDS CONTROL	1995	2002	12/31/2001	6.9
Côte d'Ivoire	P001214	CI-Integ Health Serv Deliv (FY96)	1996	2005	12/31/2004	6.2
Eritrea	P043124	National Health Devl.	1998	2005	12/31/2004	4.6

(*continues on the following page*)

Table A5.1: Closed MAP and Stand-Alone Projects, and Closed Projects with HIV/AIDS Components (continued)

COUNTRY	PROJECT ID	PROJECT TITLE	FY APPROVED	FY CLOSED	CLOSING DATE	COMMITTED[a]
Gambia, The	P000825	GM-Participatory HNP SIL (FY98)	1998	2005	6/30/2005	3.1
Guinea-Bissau	P035688	National Health Development Prog	1998	2008	12/31/2007	2.2
Malawi	P001670	MW-Secondary Education (Fy98)	1998	2006	12/31/2005	6.3
Guinea	P041568	Pop. & Reprod. Health	1999	2004	12/31/2003	2.3
Lesotho	P056416	2nd Education Sector Dev. Proj (Phase 1)	1999	2004	12/31/2003	2.7
Malawi	P036038	Pop./Family Planning	1999	2004	12/31/2003	1.0
Burundi	P064556	Emergency Economic Recovery Credit	2000	2003	10/30/2002	6.0
Cameroon	P048204	CM-CAPECE Env Oil TA (FY00)	2000	2008	11/30/2007	0.8
Lesotho	P053200	Health Sector Reform	2000	2005	6/30/2005	2.1
Nigeria	P066571	2nd Primary Educ.	2000	2005	12/31/2004	9.4
Tanzania	P058627	Health Sector Development Program	2000	2004	12/31/2003	6.4
Zambia	P063584	ZM-ZAMSIF (FY00)	2000	2006	12/31/2005	12.9
Zambia	P064064	ZM-Mine Township Srvc SIL (FY00)	2000	2006	12/31/2005	4.9
Burundi	P064961	BI-Pub Works & Employ Creation (FY01)	2001	2008	12/31/2007	16.2
Mali	P040650	Edu Sec Exp Prgm APL (FY01) - (PISE)	2001	2007	12/31/2006	6.3
Kenya	P066486	KE-Decentr Reprod Hlth & HIV/AIDS (FY01)	2001	2007	6/30/2007	37.1
Congo, Rep. of	P074006	CG-Emerg Infrast Rehab & Living Cond Imp	2002	2007	1/31/2007	5.2
Mozambique	P001785	MZ-Roads & Bridges MMP (FY02)	2002	2007	6/30/2007	22.7
Ghana	P073649	GH-Health Sec Prgm Supt 2 (FY03)	2003	2007	6/30/2007	15.2
Nigeria	P071494	NG-Univ Basic Edu (FY03)	2003	2006	6/30/2006	10.0
Malawi	P072395	MW-FIMAG SAL (FY04)	2004	2006	6/30/2006	7.0
Cameroon	P100965	CM-Debt Relief Grant DPL (FY06)	2006	2007	12/30/2006	4.4
Subtotal						219.1
Total closed projects						770.5

Source: World Bank Business Warehouse.

a. Commitment amounts are in the dollar value at the time of approval.

b. Commitment amounts for projects with HIV/AIDS components reflect the HIV/AIDS component amount, not the entire project amount.

Table A5.2: Active MAP and Stand-Alone HIV/AIDS Projects, and Active Projects with HIV/AIDS Components

COUNTRY	PROJECT ID	PROJECT TITLE	FY APPROVED	APPROVAL DATE	CLOSING DATE	COMMITTED[a]
ACTIVE MAP AND STANDALONE HIV/AIDS PROJECTS						
Burundi	P071371	BI-MultiSec HIV/AIDS & Orph APL (FY02)	2002	6/27/2002	11/30/2008	36.0
Cape Verde	P074249	CV-HIV/AIDS APL (FY02)	2002	3/28/2002	12/31/2008	9.0
Central African Republic	P073525	CF-HIV/AIDS (FY02)	2002	12/14/2001	9/30/2010	17.0
Chad	P072226	TD-Pop & AIDS 2 (FY02)	2002	7/12/2001	1/31/2008	24.6
Nigeria	P070291	NG-HIV/AIDS Prog Dev (FY02)	2002	7/6/2001	6/30/2009	90.3
Senegal	P074059	SN-HIV/AIDS Prevent & Control APL (FY02)	2002	2/7/2002	9/30/2008	30.0
Guinea	P073378	GN-Multisectoral AIDS SIL (FY03)	2003	12/13/2002	7/31/2008	20.3
Mozambique	P078053	MZ-HIV/AIDS Response SIL (FY03)	2003	3/28/2003	12/31/2008	55.0

Table A5.2: Active MAP and Stand-Alone HIV/AIDS Projects, and Active Projects with HIV/AIDS Components (continued)

COUNTRY	PROJECT ID	PROJECT TITLE	FY APPROVED	APPROVAL DATE	CLOSING DATE	COMMITTED[a]
Niger	P071612	NE-MultiSec STI/HIV/AIDS 2 (FY03)	2003	4/4/2003	6/30/2009	25.0
Rwanda	P071374	RW-MultiSec HIV/AIDS (FY03)	2003	3/31/2003	10/30/2008	30.5
Zambia	P003248	ZM-Zanara HIV/AIDS APL (FY03)	2003	12/30/2002	2/28/2008	42.0
Congo, Dem. Rep. of	P082516	ZR Multisectoral HIV/AIDS	2004	3/26/2004	1/31/2011	102.0
Congo, Rep. of	P077513	CG-HIV/AIDS & Health SIL (FY04)	2004	4/20/2004	6/30/2009	19.0
Guinea-Bissau	P073442	GW-HIV/AIDS Global Mitigation Sup (FY04)	2004	6/2/2004	12/31/2008	7.0
Malawi	P073821	MW-Multisectoral AIDS - MAP (FY04)	2004	8/25/2003	12/31/2008	35.0
Mali	P082957	ML-HIV/AIDS MAP (FY04)	2004	6/17/2004	7/31/2009	25.5
Mauritania	P078368	MR-HIV/AIDS MultiSec Cntrl (FY04)-(PMLS)	2004	7/7/2003	3/31/2009	21.0
Subregional	P082613	3A-Regional HIVAIDS Treatment Prj (FY04)	2004	6/17/2004	9/30/2008	59.8
Tanzania	P071014	TZ-HIV/AIDS APL (FY04)	2004	7/7/2003	9/30/2009	70.0
Angola	P083180	AO-HAMSET SIL (FY05)	2005	12/21/2004	6/30/2010	21.0
Eritrea	P094694	ER-HIV/AIDS/STI/TB/Malaria/RH SIL (FY05)	2005	6/30/2005	6/30/2010	24.0
Lesotho	P087843	LS-HIV/AIDS Cap Bldg TAL (FY05)	2005	7/6/2004	12/31/2008	5.0
Subregional	P080406	3A- African Regional Capacity Building Network for HIV/AIDS Prevention, Treatment, and Care (FY05)	2005	9/22/2004	6/30/2009	10.0
Subregional	P080413	3A-HIV/AIDs Great Lakes Init APL (FY05)	2005	3/15/2005	3/31/2009	20.0
Burkina Faso	P093987	BF Health Sector Sup. & AIDS Proj (FY06)	2006	4/27/2006	6/30/2010	47.7
Ghana	P088797	GH-Multi-Sector HIV/AIDS - M-SHAP (FY06)	2006	11/15/2005	6/30/2011	20.0
Madagascar	P090615	MG-MultiSec STI/HIV/AIDS 2 (FY06)	2006	7/12/2005	12/31/2009	30.0
Benin	P096056	BJ-HIV/AIDS SIL 2 (FY07)	2007	4/5/2007	12/31/2011	35.0
Cape Verde	P101950	CV-HIV/AIDS MAP - Additional Financing (FY07)	2007	12/19/2006	12/31/2008	5.0
Ethiopia	P098031	ET-2nd Multisectoral HIV/AIDS (FY07)	2007	3/8/2007	6/30/2010	30.0
Kenya	P081712	KE-Total War Against HIV/AIDS (TOWA)	2007	06/26/2007	12/31/2011	80.0
Nigeria	P105097	NG-HIV/AIDS APL - Additional Financing (FY07)	2007	5/22/2007	6/30/2009	50.0
Rwanda	P104189	RW-MultiSec HIV/AIDS - Additional Financing (FY07)	2007	2/1/2007	10/30/2008	10.0
Subtotal						1,106.7
ACTIVE PROJECTS WITH HIV/AIDS COMPONENTS[b]						
Rwanda	P045091	RW-Human Res Dev (FY00)	2000	6/6/2000	6/30/2008	8.0
Chad	P035672	TD-Natl Transp Prgm Supt SIL (FY01)	2001	10/26/2000	1/31/2008	13.4
Zambia	P057167	ZM-TEVET SIM (FY01)	2001	6/14/2001	12/30/2008	3.5
Burkina Faso	P000309	BF-Basic Edu Sec SIL (FY02)	2002	1/22/2002	6/30/2008	4.2
Congo, Rep. of	P073507	CG-Transp & Gov CB (FY02)	2002	2/7/2002	6/30/2010	1.0
Eritrea	P073604	ER-Emerg Demob & Reint ERL (FY02)	2002	5/16/2002	12/31/2008	7.8
Guinea	P050046	GN-Education for All APL (FY02)	2002	7/24/2001	12/31/2008	15.4

(*continues on the following page*)

Table A5.2: Active MAP and Stand-Alone HIV/AIDS Projects, and Active Projects with HIV/AIDS Components (continued)

COUNTRY	PROJECT ID	PROJECT TITLE	FY APPROVED	APPROVAL DATE	CLOSING DATE	COMMITTED[a]
Mozambique	P069824	MZ Higher Education SIM (FY02)	2002	3/7/2002	6/30/2009	8.4
Nigeria	P069901	NG-Com Based Urb Dev (FY02)	2002	6/6/2002	6/30/2009	14.3
Rwanda	P075129	RW-Emerg Demobiliz & Reintegr (FY02)	2002	4/25/2002	12/31/2008	3.3
Tanzania	P047762	TZ-Rural Water Sply (FY02)	2002	3/26/2002	6/30/2008	4.4
Angola	P078288	AO-Emerg Demob & Reinteg ERL (FY03)	2003	3/27/2003	12/31/2008	4.6
Chad	P000527	TD-Edu Sec Reform (FY03)	2003	3/18/2003	6/30/2009	5.9
Ethiopia	P044613	ET-Road Sector Development Phase 2 (FY03)	2003	6/17/2003	6/30/2009	17.8
Burundi	P064876	BI-Road Sec Dev SIM (FY04)	2004	3/18/2004	12/31/2009	7.2
Burundi	P081964	BI-Demobilization & Reint Prj (FY04)	2004	3/18/2004	12/31/2008	4.6
Congo, Dem. Rep. of	P078658	CD-Emerg Demob Reintegr ERL (FY04)	2004	5/25/2004	3/31/2008	14.0
Ghana	P050620	GH-Edu Sec SIL (FY04)	2004	3/9/2004	10/31/2009	15.6
Lesotho	P081269	LS-Second Education Sector Development (Phase 2)	2004	7/17/2003	12/31/2008	4.2
São Tomé and Principe	P075979	ST Social Sector Support	2004	5/18/2004	6/30/2009	1.1
Zambia	P071985	ZM-Road Rehab Maintenance Prj (FY04)	2004	3/9/2004	6/30/2010	6.5
Angola	P083333	AO-Emerg MS Recovery ERL (FY05)	2005	2/17/2005	12/31/2009	8.6
Congo, Dem. Rep. of	P088751	CD-Health Sec Rehab Supt (FY06)	2006	9/1/2005	6/30/2010	19.5
Ethiopia	P079275	ET- Cap. Building for Agric. Serv (FY06)	2006	6/22/2006	10/31/2011	7.6
Lesotho	P076658	LS-Health Sec Reform Phase 2 APL (FY06)	2006	10/13/2005	3/31/2009	1.0
Mozambique	P087347	MZ Tech & Voc Edu & Training (FY06)	2006	3/21/2006	10/31/2011	4.2
Mali	P090075	ML-Transp Sec SIL 2 (FY07)	2007	5/24/2007	12/31/2011	12.6
Kenya	P087479	KE-Edu Sec Sup Project (FY07)	2007	11/7/2006	12/31/2010	12.8
Namibia	P086875	NA-Education & Training DPL (FY07)	2007	5/24/2007	12/31/2008	1.3
Tanzania	P102262	TZ-Zanzibar Basic Educ. SIL (FY07)	2007	4/24/2007	7/31/2013	8.4
Subtotal						241.2
Total active HIV/AIDS projects						1,347.9

Source: World Bank Business Warehouse.

a. Commitment amounts are in the dollar value at the time of approval.

b. Commitment amounts for projects with HIV/AIDS components reflect the HIV/AIDS component amount, not the entire project amount.

APPENDIX 6

MAP Achievements

Table A6.1: Results in Countries in Africa with MAPs

SYSTEMS STRENGTHENING	
Percentage increase in development partner funding	2,240%
MAP management integrated into NAC functions	59%
OUTPUTS TO WHICH THE MAP CONTRIBUTED	
Number of persons trained with MAP funds	562,366 (23 countries)
Number of decentralized government structures that have implemented HIV work plans	10,938 (25 countries)
Employees reached with workplace HIV programs	2,258,844 (23 countries)
Number of organizations provided with technical support	41,107 (25 countries)
GFATM and MAP coordinated from one unit	38% of NACs
HIV PREVENTION	
Number of women enrolled in PMTCT since start of MAP	1,546,388 (23 countries)
Number of VCT sites in all MAP countries	8,812 (23 countries)
Number of new VCT sites that MAP helped to establish	1,512 (17 countries)
Number of persons who have received HIV test results	6,999,528 (25 countries)
Number of male condoms distributed	1,294,369,023 (25 countries)
Number of female condoms distributed	4,041,973 (15 countries)
Number of persons reached with IEC/BCC programs	173,333,043 (21 countries)
Number of IEC/BCC events	726,876 (20 countries)
HIV CARE AND TREATMENT	
Number of sites providing ART	3,012 (26 countries)
Total number of people on ART (26,699 with MAP funding)	554,648 in total (27 countries)
Number of PLWHA treated for opportunistic infections	287,805 (20 countries)
IMPACT MITIGATION	
Number of infected or affected persons receiving support	502,958 (21 countries)
Number of vulnerable children receiving support	1,779,872 (22 countries)
Number of income-generating activities supported	32,854 (18 countries)
MONITORING AND EVALUATION (M&E)	
Average number of surveys/surveillance per country before MAP	2
Current average number of surveys/surveillance	4

Source: Görgens-Albino et al. 2007.

Note: BCC = Behavior change communication.

Table A6.2: Outcome-Level Results to Which MAP Has Contributed

SYSTEMS STRENGTHENING
The MAP has contributed to increased political commitment at the highest government level.
The MAP gave countries a head start in achieving the Three Ones.
The MAP contributed toward institution building and strengthening of the NACs.
MAP funding helped mobilize additional government resources for HIV.
The MAP was a catalyst for increased international funding.
The MAP sparked a quantum increase in the scale of country action on HIV.
The MAP has contributed toward improved legislation related to HIV and AIDS.
The MAP has succeeded in promoting and facilitating a multisectoral response.
MAP funding has supported the decentralization of the HIV response.
The MAP supported improved coordination of the HIV response by NACs and at decentralized levels.
The MAP has supported international partnerships on HIV at the country level.
The MAP built capacity to plan, coordinate, monitor, evaluate, and implement HIV services.
HIV PREVENTION
The MAP has increased the number of women who have accessed PMTCT services.
The MAP has supported HIV education in schools and HIV testing among education sector staff.
The MAP has contributed to increased knowledge about how HIV can be transmitted.
The MAP has contributed to reductions in higher-risk sex in some countries.
There is some evidence of the MAP focusing on the most vulnerable and at-risk populations.
The MAP has contributed to an increase in condom use.
The MAP has ensured that more people know their HIV status.
The MAP has helped prevent transmission of HIV in health care settings.
HIV CARE AND TREATMENT
MAP funding has set up facilities that provide ART and expanded access to ART.
The MAP has strengthened infrastructure for delivering health services.
IMPACT MITIGATION
The MAP supported and promoted school attendance for orphans and vulnerable children.
The MAP increased access to good quality psychosocial care for affected households and children.
The MAP contributed to sustainable community-level care.
MONITORING AND EVALUATION (M&E)
In most countries, there is an M&E unit with an approved budget as a result of the MAP.
Most countries also have an M&E Task Team that meets at least quarterly.
Most countries have developed M&E training materials.
Most countries have an approved M&E framework or strategy, with indicators agreed on by all partners.
Many countries have a detailed M&E work plan, although only some are costed.
Most countries have begun to build an HIV/AIDS database, but ministry of health data collection is still weak.
Strategic information is flowing better than before.
There is some evidence of data use.

Source: Görgens-Albino et al. 2007.

APPENDIX 7

MAP Challenges and Improving Performance of the MAP for Africa

Challenges

In 2004, ACT*africa* initiated an interim review of the MAP to review the validity of the MAP approach, highlight progress made, review the suitability of interventions, and identify lessons learned. The review concluded that the MAP objectives were still appropriate, highlighted implementation challenges, and recommended that the MAP needed to become more strategic, collaborative, and evidence based.

In 2005, OED (which became today's IEG) conducted a separate independent assessment of the Bank's global HIV assistance to examine the assumptions, design, and implementation of 24 country-level AIDS projects. The OED report recommended a focus on capacity building, developing strong national and subnational institutions, investing strategically in public goods and activities likely to have the largest impact, creating incentives for M&E, and using local evidence to improve performance. From these assessments, the Bank's Committee on Development Effectiveness (CODE) recognized the achievements made in HIV/AIDS (MAP) programs and approved key recommendations for further improvement in all future HIV operations. CODE reaffirmed the Bank's role, together with other development partners, in responding to the complex and pressing issues of HIV/AIDS; the need for bold, innovative, and flexible responses; and reconfirmed the need for a multisectoral approach to this development challenge.

Table A7.1 provides an overview of the key recommendations from the MAP interim review report (World Bank 2004), the OED report (World Bank 2005) and CODE response (appendix M to World Bank 2005), and actions taken by the Africa Region.

Table A7.1: Overview of the Key Recommendations

	RECOMMENDATIONS	MEASURES UNDERTAKEN BY THE AFRICA REGION
(i)	Integrate HIV/AIDS into development planning, PRSs, budget allocation strategies, and mainstream in CASs.	IBRD and WBI in collaboration with UNDP have held two regional workshops to build capacity of country officials to integrate HIV/AIDS into PRSPs and MTEF. ACT*africa* will also continue to ensure that HIV/AIDS is sufficiently incorporated in the CAS.
(ii)	Support the development of prioritized, nationally owned strategies with a nuanced understanding of the country epidemic, identification of cultural and social factors contributing to the spread, and assist governments to be selective and prioritize activities that achieve the greatest impact.	The Bank and other partners (UNAIDS and UNDP) have rolled out the ASAP[a] program to provide direct technical support to countries on a demand-driven basis in reviewing and producing evidence-based, prioritized, and costed strategies and annual programs.
(iii)	Adopt targeted approach in all next-generation projects in low-prevalence countries.	Adopted as a criteria for all second-generation projects. Bank and UNAIDS collaborated on a regional conference on targeting vulnerable groups. ACT*africa* is also assessing the effectiveness of good practices targeting vulnerable groups.
(iv)	Improve governance and accountability measures within projects to mitigate misuse of project funds and ensure that funds are utilized for the intended beneficiaries.	The Region continues to build capacity on improved fiduciary management and has developed a Guidance Note on Disbursement in HIV/AIDS projects to assist in determining the appropriate fiduciary steps for various levels. ACT*africa* is initiating a study on governance and anticorruption practices at the community level by engaging grassroots-level women's groups in several countries and will develop guidelines for civil society organizations and local government authorities in addressing governance and corruption.
(v)	Ensure the development of a common, functioning M&E system at country level working with other partners, develop clear criteria and outcome indicators for improved data collection, and improve the evidence base for decision makers through local capacity building and rigorous analytic work.	GAMET has significantly increased its efforts to help countries build both their clinical and nonclinical indicators and data collection mechanisms, and all repeater MAPs include more attention and financing for scaling up M&E activities in partnership with UNAIDS and other donors. Ongoing MAP operations are also providing increased financing for M&E implementation. GAMET and ACT*africa* developed a generic HIV/AIDS Results Scorecard in October 2006.
(vi)	Improve donor coordination and harmonization efforts to avoid duplication of efforts with the multitude of actors.	A Global Task Team (GTT) comprising key UN agencies and development partners agreed on a division of labor for all agencies that countries can use in identifying technical support needs. Several countries have adopted joint annual reviews to encourage more harmonization of activities.
(vii)	Encourage performance-based disbursements.	Ongoing discussions with TTLs on methods for integrating this into HIV projects without hindering access to services.

Table A7.1: Overview of the Key Recommendations (continued)

	RECOMMENDATIONS	MEASURES UNDERTAKEN BY THE AFRICA REGION
(viii)	Continue to fully support the community response, which is an important stakeholder group activity, by engaging them in the design of interventions and improved procedures for financing but also evaluate the effectiveness of the community response.	Civil society organizations are more actively involved than before in HIV activities. The Africa Region plans to carry out a situation analysis of civil society engagement. ACT*africa* hosted a consultation with civil society representatives from all MAP countries to brainstorm the roles, responsibilities, and partnerships of civil society organizations in responding to HIV. These recommendations are being incorporated in the revision of the Bank strategy for HIV/AIDS in Africa (2007–2011).
(ix)	Prioritized multisectoral approach to respond to the complexity of HIV as a broad development challenge and focus on sectors that have the greatest potential impact such as health, education, transport, military, and others depending on the country context.	MAPs continue to use the multisectoral approach and address HIV/AIDS as a broad development issue. ACT*africa* will ensure that this continues to be reflected in the CASs. Second-generation MAPs will focus on sectors with the greatest potential within each country setting.
(x)	Clarify the role of the Ministry of Health (MoH) to ensure that they are a principal partner in the national response and build MOH capacity while continuing to work with other sectors.	MoH is engaged in all MAP projects as is evident from the MoH being the second largest beneficiary of MAP financing after the civil society component. All next-generation MAP projects will clarify the roles and responsibilities of MoH as well as address issues related to strengthening health systems that can be integrated into HIV projects.
(xi)	Ensure consistency with Bank commitments to other global initiatives and partners and improve donor collaboration.	The Bank is fully engaged with the GTT and will continue its close partnership with UNAIDS. The Bank has also taken the lead in collaborating with the GFATM, PEPFAR, and other development partners and held a meeting in January 2006 to improve coordination.

Source: Compiled by authors.

a. UNAIDS has raised $5 million to finance these activities, which include workshops and direct assistance from the Bank and UNDP.

APPENDIX 8

HIV Prevalence and Global Financing

Table A8.1: HIV Prevalence and Financing, by Country

COUNTRY	HIV PREVALENCE, AGES 15–49 (%)	GFATM 2003–NOVEMBER 2007 ($ MILLION)	PEPFAR 2004–2007 ($ MILLION)	WORLD BANK 2001–DECEMBER 2007 ($ MILLION)	TOTAL FUNDS AVAILABLE ($ MILLION)
Comoros	0.1	1.1	0.0	0.0	1.1
Madagascar	0.5	21.0	0.0	50.0	71.0
Mauritania	0.5	6.6	0.0	21.0	27.6
Mauritius	0.6	0.0	0.0	0.0	0.0
Cape Verde	0.8	0.0	0.0	14.0	14.0
Ethiopia	0.9–3.5	541.3	496.6	89.7	1,127.6
Senegal	0.9	23.5	0.0	30.0	53.5
Niger	1.1	10.7	0.0	25.0	35.7
Guinea	1.5	14.2	0.0	20.3	34.5
Sierra Leone	1.6	18.2	0.0	15.0	33.2
Sudan	1.6	58.9	0.0	0.0	58.9
Mali	1.7	52.3	0.0	25.5	77.8
Benin	1.8	40.7	0.0	58.0	98.7
Burkina Faso	2.0	47.1	0.0	74.7	121.8
Liberia	2.0–5.0	19.7	0.0	0.0	19.7
Ghana	2.3	45.8	0.0	45.0	90.8
Eritrea	2.4	30.5	0.0	64.0	94.5
Gambia, The	2.4	14.6	0.0	15.0	29.6
Rwanda	3.1	117.2	271.2	40.5	428.9
Congo, Dem. Rep. of	3.2	48.7	0.0	102.0	150.7
Equatorial Guinea	3.2	4.4	0.0	0.0	4.4
Togo	3.2	44.7	0.0	0.0	44.7
Burundi	3.3	21.7	0.0	36.0	57.7
Chad	3.5	7.4	0.0	24.6	31.9
Angola	3.7	27.7	0.0	21.0	48.7
Guinea-Bissau	2.8	3.4	0.0	7.0	10.4
Nigeria	3.9	74.4	649.7	140.3	864.4

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Table A8.1: HIV Prevalence and Financing by Country (continued)

COUNTRY	HIV PREVALENCE, AGES 15–49 (%)	GFATM 2003–NOVEMBER 2007 ($ MILLION)	PEPFAR 2004–2007 ($ MILLION)	WORLD BANK 2001–DECEMBER 2007 ($ MILLION)	TOTAL FUNDS AVAILABLE ($ MILLION)
Congo, Rep. of	5.3	12.0	0.0	19.0	31.0
Cameroon	5.4	76.0	0.0	50.0	126.0
Kenya	6.1	109.7	811.8	130.0	1,051.5
Tanzania	6.5	192.1	515.0	70.0	777.1
Uganda	6.7	106.7	645.7	47.5	799.9
Côte D'Ivoire	7.1	51.1	199.7	0.0	250.8
Gabon	7.9	5.2	0.0	0.0	5.2
Central African Rep.	10.7	29.6	0.0	17.0	46.6
Malawi	14.1	209.0	0.0	35.0	244.0
Mozambique	16.1	121.1	354.1	55.0	530.2
Zambia	17.0	117.1	576.8	42.0	735.9
South Africa	18.8	177.0	856.8	0.0	1033.8
Namibia	19.6	104.0	215.5	0.0	319.5
Zimbabwe	20.1	50.0	0.0	0.0	50.0
Lesotho	23.2	39.3	0.0	5.0	44.3
Botswana	24.1	18.6	207.3	0.0	225.9
Swaziland	33.4	68.9	0.0	0.0	68.9
Total financing by donor		2,783.2	5,800.2	1,389.1	9,972.5

Sources: Prevalence: UNAIDS 2006; Haacker 2007. Financing: GFATM financing from 2003 through November 2007, www.theglobalfund.org; PEPFAR financing 2004–2007 http://www.pepfar.gov/press/c19558.htm. World Bank financing includes MAP projects approved from 2001 to December 2007 and does not include commitments for subregional projects. World Bank Business Warehouse.

Note: Country HIV prevalence data is the most recent at the time of this publication. The UNAIDS publication of 2007 country estimates are expected in July 2008.

APPENDIX 9

The Bank's Role in the UNAIDS Division of Labor

Table A9.1: World Bank Role in UNAIDS' Technical Support Division of Labor

TECHNICAL SUPPORT AREAS	LEAD ORGANIZATION	MAIN PARTNERS
1. Strategic planning, governance, and financial management	World Bank	ILO, UNAIDS, UNDP, UNESCO, UNICEF, WHO
• Support to strategic, prioritized, and costed national plans; financial management, human resources; capacity and infrastructure development; impact alleviation and sectoral work		
• HIV/AIDS, development, governance, and mainstreaming, including instruments such as PRSPs and enabling legislation, human rights, and gender	UNDP	ILO, UNAIDS, UNESCO, UNICEF, WHO, World Bank, UNFPA, UNHCR
• Procurement and supply management, including training	UNICEF	UNDP, UNFPA, WHO, World Bank
2. Scaling up interventions		
• Overall policy, monitoring, and coordination on prevention	UNAIDS	All cosponsors
3. M&E, strategic information, knowledge sharing, and accountability		
• Strategic information, knowledge sharing, accountability, coordination of national efforts, partnership building, advocacy, and M&E	UNAIDS	World Bank, ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO

Source: Global Task Team 2005.

APPENDIX 10

Agenda for Action: Implementation Plan and Results Framework

Table A10.1: The Foundation: Renew the Commitment

SPECIFIC OBJECTIVES	SPECIFIC ACTIONS
0.1. Respond to country demand for predictable, flexible, and sustainable IDA financing for HIV/AIDS	0.1.1 Sustained support for HIV/AIDS to fill financial gaps for the next five years 0.1.2 Provide safety net financing for countries in the context of creating fiscal space for HIV/AIDS
0.2. High-burdened, middle-income countries' access to technical or financial assistance, or both, increased	0.2.1 Provide innovative financing, for example, buydowns to IBRD countries 0.2.2 IDF grant financing provided for capacity building 0.2.3 Analytical work on macro impact and regional and cross-border issues 0.2.4 Conduct strategic analysis to identify new lending instruments that are attractive to IBRD countries and focused on increasing lending for HIV/AIDS

INDICATORS	ANTICIPATED RESULTS	CRITICAL RISKS	ACCOUNTABILITY
• At least $250 million committed annually for the next five years, including IDA, PRSCs, ACGF, and IDF • Financing gap studies completed in at least 10 countries (IDA and non-IDA)	• Predictable, flexible, and sustainable IDA financing for HIV/AIDS provided	• Availability of IDA financing • Financing from other development partners remains unpredictable and volatile • Low country demand for IDA financing due to competing priorities	AFRRMT, HDNGA, ACT*africa* PREM, IMF
• Number of countries where the Bank responds to country demands and supports AIDS responses through grants, loans, blended instruments, or knowledge support, policy dialogue, and capacity building • Number of analytical studies completed	• Technical and financial assistance accessible to high-burdened, middle-income countries • Effective policy dialogue • Effective partnerships • Cross-regional, cross-country learning	• Lack of instruments to engage high-burdened, middle-income countries • Weak donor commitment to support innovative financing in middle-income countries • Continued scarce financing from other donors in middle-income countries	AFRRMT, ACT*africa*

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Table A10.1: The Foundation: Renew the Commitment (continued)

SPECIFIC OBJECTIVES	SPECIFIC ACTIONS
0.3. Support to subregional and cross-border initiatives provided	0.3.1 Provide financing to countries, including postconflict countries, for regional HIV/AIDS response 0.3.2 Design regional cross-border projects that address vulnerable populations, for example, refugees and IDPs
0.4. Africa HIV incentive fund to provide support for project and program development, policy advice, and capacity building created	0.4.1 Obtain financing for Africa HIV/AIDS incentive fund for analysis, policy advice, and capacity building in project and program preparation 0.4.2 Use the funds to conduct policy dialogue, analytical work, and capacity building in line with the AAP and CDMAP 0.4.3 Assist teams to design HIV/AIDS interventions in sectoral investments
0.5. Bank's senior management commitment to HIV/AIDS renewed through inclusion and action in all channels of policy dialogue	0.5.1 Bank's senior management reiterates commitment through speeches, memos, and discussions with partners 0.5.2 HIV/AIDS continues to be a flagship program in the AAP 0.5.3 Engage high-level policy makers to advocate for HIV/AIDS response

INDICATORS	ANTICIPATED RESULTS	CRITICAL RISKS	ACCOUNTABILITY
• At least two new subregional operations approved in the next five years	• Improved HIV/AIDS awareness and prevention efforts through subregional and cross-border initiatives • Realization of externalities • Positive spillover effects for more effective customs procedures and clearances	• Lack of grant financing • Weak institutional capacity at regional level • Lack of commitment to subregional initiatives	AFRRMT, ACT*africa*, AFTHD, Africa Regional Integration (AFCRI)
• Incentive fund finances five technical support products per year • Mainstreaming guidelines developed for different sectors • Number of sectoral projects with HIV/AIDS components	• Critical analysis and policy guidance achieved • Scaled-up multisectoral responses in key sectors	• Lack of grant funding • Weak Bank commitment • Lack of commitment to a multisectoral response	ACT*africa*, CDMAP
• HIV/AIDS included in senior management speeches and discussions with partners	• Senior management speeches related to the Bank's commitment to combating HIV/AIDS reflected in national and international media	• Competing priorities • Senior management fails to enforce commitment through regular reporting from CMUs on how HIV/AIDS is being addressed and on harmonizing HIV/AIDS efforts	AFRRMT, External Affairs, WBI, UNDP, UNAIDS

Table A10.2: Pillar 1: Strengthened Long-Term Sustainable National Response

PILLAR 1	SPECIFIC OBJECTIVES	SPECIFIC ACTIONS
Focus the response through evidence-based and prioritized HIV/AIDS strategies	1.1. Appropriate HIV/AIDS efforts integrated into countries' development agendas and Bank instruments (policy procedures)	1.1.1 Review at least 10 CASs and ISNs and 6 PRSPs to ensure HIV/AIDS is appropriately addressed 1.1.2 Ensure appropriate priority to HIV/AIDS in PRSPs 1.1.3 Bank support to incorporate HIV/AIDS into guidelines and processes for preparing MTEFs and annual budgets
	1.2. Bank support to developing prioritized responses to diverse epidemics provided	1.2.1 Assist countries to analyze epidemics and optimal responses 1.2.2 Provide financial, technical, and analytical support to countries to understand country epidemics, including the drivers of the epidemic, and to establish surveillance systems 1.2.3 Conduct subregional epidemiological studies
	1.3. Bank support in capacity building to develop prioritized, and costed, national strategies and action plans provided	1.3.1 Support and build capacity in 20 countries to develop prioritized, costed national strategies and annual action plans 1.3.2 Provide technical support to countries for developing national strategic planning 1.3.3 Provide technical, financial, and analytical support for better country-specific HIV/AIDS program planning
Focus the response through evidence-based and prioritized HIV/AIDS strategies	1.4. Integration of TB, malaria, reproductive health, and nutrition into World Bank HIV/AIDS products ensured	1.4.1 Conduct operations research on integrating services within epidemiological context 1.4.2 Ensure that the Bank HIV/AIDS products address integration of TB, malaria, reproductive health, and nutrition 1.4.3 Actively participate in interagency working groups on integrating HIV and reproductive health, and HIV and TB
	1.5. Good practices in HIV/AIDS programs based on operations research shared	1.5.1 Conduct operations research, including cost-effectiveness studies, on success and failures in HIV/AIDS programs

INDICATORS	ANTICIPATED RESULTS	CRITICAL RISKS	Accountability
• HIV/AIDS included in all PRSCs • HIV/AIDS integrated into at least 75 percent of PRSPs, CASs, and ISNs prepared each year • Develop relevant tools to design MTEF	• HIV/AIDS addressed appropriately through countries' and Bank development agendas	• Lack of management leadership • Declining political commitment • Fiscal space issues and long-term financial sustainability issues not adequately addressed • Poor coordination between IDA and IMF	AFRRMT, ACT*africa*, WBI, UNDP, HDNGA, PREM, IMF
• Five countries where epidemiological studies have been conducted and potential responses formulated	• Improved evidence-based country responses to differing epidemics	• Lack of country-level and Bank expertise in supporting analytical work, as well as an adequate budget	ACT*africa*, AFTHD, HDNGA
• 20 countries over the next five years have the capacity to develop prioritized and costed strategies	• Strengthened capacity to develop prioritized and costed national action plans in 20 countries	• Unpredictable donor financing to support national programs • Lack of expertise for strategic planning and costing work • Weak capacity for planning and program design	HDNGA, ASAP, UNAIDS, ACT*africa*
• At least 60 percent of new HIV/AIDS operations have an integrated approach to SRH, TB, and malaria • Three country assessments would be conducted and action plans to integrate TB, malaria, and HIV developed • Intensify efforts in nine high TB-burden countries as well as high-burden HIV/AIDS countries • Good practices on integration will be documented and disseminated	• World Bank projects addressing HIV/AIDS integrate TB, malaria, reproductive health, and nutrition when appropriate to epidemiological context	• Lack of technical expertise and incentives to integrate • Institutional structures with different vertical units in ministries of health • Donor procedures that hinder integration	HDNGA, ACT*africa*, AFTHD, WHO, UNFPA, UNICEF
• At least five operations studies over the next five years	• Operations research and documentation of good practices in HIV/AIDS programs widely shared with countries and development partners	• Lack of financing to conduct operations research	AFTHD, AFTQK, ACT*africa*, HDNGA

Table A10.3: Pillar 2: Accelerated Implementation of HIV/AIDS Programs

PILLAR 2	SPECIFIC OBJECTIVES	SPECIFIC ACTIONS
Scale up targeted multisectoral and civil society response	2.1 HIV/AIDS policy, programs, and service delivery integrated into priority sectors (dependent upon country context)	2.1.1 Strengthen sectoral institutional capacity to scale up and supervise HIV/AIDS-related activities 2.1.2 Conduct operations research on multisectoral prevention, including pilot testing of promising approaches 2.1.3 In collaboration with the IFC, support capacity building in the private sector to scale up its response
	2.2 Bank support to care and mitigation services through civil society organizations continued	2.2.1 Support care and mitigation service providers through CSOs and build capacity of NGOs
	2.3 Bank support to address HIV-related gender-inequality issues	2.3.1 Support analytical work to identify specific actions that would contribute to changing inappropriate gender responses to the epidemic 2.3.2 Conduct knowledge-sharing workshops to build on analytical work findings and to build capacity among decision makers to address gender and legal dimensions of HIV/AIDS among law, justice, medical, and health professionals
Scale up targeted multisectoral and civil society response	2.4. Bank support to prevention and programs for youth and OVC intensified	2.4.1 Strengthen programs to increase access to school of HIV/AIDS orphans. Address stigma in school-based programs and learning. Strengthen school health programs; disseminate good practice examples in school-based prevention programs; continue to improve the role of teachers in addressing HIV/AIDS; coordinate with partners and local experts. 2.4.2 Collaborate with the Bank's social protection sector to scale up mitigation efforts and conduct analytical work on orphans and affected families

INDICATORS	ANTICIPATED RESULTS	CRITICAL RISKS	ACCOUNTABILITY
• Number of countries where Bank supports institutional capacity-building activities in priority sectors • At least two operations research studies documenting promising approaches to multisectoral prevention interventions	• Improved country capacity in key sectors to implement multisectoral approaches • Increased commitment in key Bank sectors to include HIV/AIDS component or subcomponents in lending and nonlending activities, including adequate resources	• Lack of country commitment from key sectors, including inadequate resources • Lack of clarity and guidance from management as well as adequate budget to integrate HIV into sectoral activities • Limited funds to conduct adequate supervision of HIV/AIDS components in other projects	HDN, AFTHD, PREM, IFC, ACT*africa*, AFTPS, AFTEG, AFTTR, AFTU, AFTRL
• Number of countries where HIV/AIDS care and mitigation services are supported by civil society	• Capacity of NGOs and CBOs strengthened • Civil society continues to be an integral part of the national solution to address HIV/AIDS	• Lack of government interest to engage civil society	ACT*africa*, CMUs, AFTHD, other donors
• Five pieces of analytical work • At least two knowledge-sharing events conducted on the gender dimensions of HIV/AIDS • Develop appropriate M&E indicators	• Increased awareness of specific steps to designing and implementing gender-appropriate HIV interventions • Analytical work in the sectors address gender inequalities	• Lack of country commitment to implementing specific actions to address HIV-related gender inequalities • Lack of support from Bank management to dedicate time and resources to operations research or implementation of gender-specific responses	PREMGE, AFTPM, ACT*africa*, AFTQK, HDNGA, AFTHD, WBI IFC, AFTPS, AFTEG, AFTTR, AFTU, AFTRL
• Number of countries where Bank supports youth and OVC	• All education and social protection sector investments include HIV/AIDS prevention, mitigation, social protection, and support activities	• Lack of country leadership in the education sector • Stigma continues	HDNED, ACT*africa*, AFTSP, HDNSP Children and Youth Group, UNFPA, UNESCO, UNICEF, UNAIDS

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Table A10.3: Pillar 2: Accelerated Implementation of HIV/AIDS Programs (continued)

PILLAR 2	SPECIFIC OBJECTIVES	SPECIFIC ACTIONS
	2.5 Support to strengthen elements of the health system that challenge HIV/AIDS programs	2.5.1 Through the implementation of the 2007 HNP strategy to strengthen health systems, support provided to improve service delivery, human resources, and financial sustainability.
Scale up targeted multisectoral and civil society response	2.6 Bank support to known multisectoral prevention approaches and tools increased	2.6.1 Support the inclusion of HIV/AIDS components in Transport and Infrastructure sectors, including the preparation of an HIV/AIDS transport corridor project in southern Africa. Require construction contracts to include HIV/AIDS-prevention activities. 2.6.2 Urban: continue efforts to support local governments' responses to HIV/AIDS, including developing and updating monitoring and training tools and incorporating HIV/AIDS components in urban operations
	2.7 Strengthen community response and evaluate its effectiveness	2.7.1 Provide technical support to HIV/AIDS projects to strengthen, simplify, and focus community-level interventions 2.7.2 Conduct social assessments and impact evaluation studies on community-based HIV/AIDS interventions, including identification of good practices

INDICATORS	ANTICIPATED RESULTS	CRITICAL RISKS	ACCOUNTABILITY
• At least 50 percent of new HIV/AIDS operations address and support health system challenges vis-à-vis HIV/AIDS • 60 percent of HNP operations address health system challenges	• Improved synergy between HNP and HIV/AIDS operations	• Lack of collaboration between ministries of health and NACs on resource allocation for health systems • Agreement on a clear division of labor within the Bank as well as with its partners • Health systems do not adequately address all implementation constraints, for example, fiduciary and supply chain management	HDNHE, AFTHD, WHO, UNFPA, UNICEF, ACT*africa*
• Number of key sector projects with AIDS components	• Prioritized support to key public sector and nonpublic sector entities having maximum impact on the ground	• Lack of adequate technical resources to prepare and supervise AIDS components • Sector focal persons not identified	ACT*africa*, IFC, AFTPS, AFTEG, AFTTR, AFTU, AFTHD, AFTRL
• Number of countries with revised and simplified community HIV/AIDS response guidelines and trained personnel • Number of social/behavioral assessments and impact evaluations regarding the effectiveness of community-based HIV/AIDS interventions	• Capacity strengthened in designing and implementing decentralized multisectoral responses • More effective community responses	• Lack of absorptive capacity at the community level • High fiscal costs and sustainability concerns • National governments unwilling to directly fund communities • Lack of capacity at national and regional levels to train and support communities	ACT*africa*, HDNGA, DEC, Environment and Socially Sustainable Development in Africa (AFTSD)

Table A10.4: Pillar 3: Strengthened National Systems for Financial Management, Human Resources, Procurement, Supply Chains, and Health and Social Systems

PILLAR 3	SPECIFIC OBJECTIVES	SPECIFIC ACTIONS
Deliver effective results through increased country M&E capacity	3.1. Ongoing HIV/AIDS projects retrofitted with realistic goals and indicators	3.1.1 Complete restructuring of MAP project development objectives and performance indicators. Technical support teams to support country project teams
	3.2. Harmonized M&E frameworks at the country level strengthened	3.2.1 Assist countries to establish monitoring systems 3.2.2 Develop and implement project performance early warning system 3.2.3 Institutionalize the use of HIV/AIDS Results Scorecard 3.2.4 Conduct regional and national M&E training courses 3.2.5 Train M&E specialists, building national capacity, gradually reducing the need for external support
	3.3. Countries' surveillance systems strengthened and epidemiologic studies conducted	3.3.1 Conduct country epidemiology studies
	3.4. Bank studies of vulnerable groups in countries conducted	3.4.1 Conduct analytical work and operations research on vulnerable population needs with the aim of informing policy dialogue 3.4.2 Sharpen HIV/AIDS support to ensure that vulnerable groups are appropriately targeted and their networks strengthened
Deliver effective results through increased country M&E capacity	3.5. Countries' existing governance structures, public sector management, and transparency mechanisms improved with demand for accountability at the community level generated	3.5.1 Improve existing governance structures, public sector management, and transparency mechanisms and generate demand for better accountability at the community level 3.5.2 Assist countries to strengthen fiduciary capacity 3.5.3 Assist countries to streamline administrative structures 3.5.4 Integrate governance, accountability, and anticorruption into all new HIV/AIDS operations in collaboration with WBI
	3.6. Knowledge generation and sharing to improve prioritization, decision making, and program design supported	3.6.1 Provide operational support in design and impact of HIV/AIDS interventions in sector investments 3.6.2 Engage countries and partners in knowledge generation and sharing
	3.7. Good practice case studies to support cross-country learning and knowledge sharing generated	3.7.1 Prepare good practice notes that highlight examples of promising national responses to HIV/AIDS 3.7.2 Develop and promote good practice guidelines by using selected case studies that illustrate common implementation constraints 3.7.3 Support networks of program practitioners to exchange experiences, knowledge, and practical advice on general operational issues

INDICATORS	ANTICIPATED RESULTS	CRITICAL RISKS	ACCOUNTABILITY
• 13 ongoing projects reviewed and adjusted to realistic objectives and goals	• Improved HIV/AIDS portfolio • MAP projects evaluated on realistic goals and indicators	• IEG and Africa Region methodology in assessing project successes • Weak country support to restructure	ACT*africa*, AFTQK
• Eight additional countries supported over five years to establish a harmonized HIV/AIDS monitoring system	• In the next five years, all countries have a functional, harmonized M&E system reporting and using data • Bank to continue to play a leading role (GAMET) in supporting countries	• Availability of resources to provide technical support • Willingness of countries and partners to reduce number of indicators and implement the principle of the Three Ones	HDNGA, ACT*africa*, GAMET, UNAIDS
• Five country epidemiology studies conducted over five years	• National systems strengthened for improved understanding of the drivers of the epidemic	• Country commitment and demand for capacity building to strengthen surveillance	ACT*africa*, HDNGA
• Three analytical studies or operations research completed on best practices and cost-effective interventions • Support three regional meetings with groups working with vulnerable groups • Three operations research studies	• Evidence-based responses developed • Best practices disseminated • Vulnerable group networks strengthened	• Weak country commitment to work with vulnerable groups • Weak capacity • Stigma of vulnerable groups continues	ACT*africa*, HDNGA
• Assessment of selected MAP projects on governance and accountability completed • Institutional assessments conducted in three counties • Training activities conducted in collaboration with WBI	• Governance and accountability improved • Demand for accountability generated at the grassroots level • Improved institutional capacity and governance structures	• Inadequate financial and technical resources • Lack of country commitment to address corruption	PREM, AFTQK, HDNGA, ACT*africa*, WBI, OPCS, Department of Institutional Integrity (INT)
• One regional consultation per year to encourage cross-country learning • Macroeconomic analytical work and financial sustainability studies conducted	• Design and impact of HIV/AIDS investments based on knowledge sharing • Countries and partners fully engaged in knowledge generation and sharing	• Continued financing for annual knowledge learning events in the region • Coordination with other development partners	HDNGA, GAMET, ACT*africa*, AFTQK, DEC, WBI
• Five good practice notes on national responses • Two workshops to share experiences	• Improved country and cross-country learning	• Available resources to identify good practices and disseminate them	GAMET, ACT*africa*, AFTQK, AFTHD, TTLs, WBI

Table A10.5: Pillar 4: Strengthened Donor Coordination

PILLAR 4	SPECIFIC OBJECTIVES	SPECIFIC ACTIONS
Harmonize donor collaboration	4.1. Collaboration with key partners to harmonize and strengthen national M&E systems, human resources capacity, procurement, and supply chains strengthened	4.1.1 Support countries extensively in areas where Bank is designated lead technical organization 4.1.2 Work with key partners to harmonize and strengthen national M&E systems, procurement, and supply chains 4.1.3 Work with countries and Bank project teams to improve planning, budgeting, program design, financial management, disbursement, procurement, and expenditure tracking
	4.2. Joint planning and analytical work with UNAIDS and other partners increased	4.2.1 Conduct joint planning and analytical work with UNAIDS and other partners 4.2.2 Conduct strategic planning training courses to train national counterparts, Bank staff, development partners, and consultants in strategic planning 4.2.3 Support country practitioners' networks to contribute to strategic planning
	4.3. Bank's participation in joint annual planning with partners increased	4.3.1 Advocate and assist practitioners' networks to contribute to strategic planning 4.3.2 Participate in joint annual partner meetings

INDICATORS	ANTICIPATED RESULTS	CRITICAL RISKS	ACCOUNTABILITY
• Comply with and report on Paris Declaration indicators • Number of Public Expenditure Reviews conducted that include an HIV/AIDS component • Public sector management conducted • Proportion of countries with performance-based procedures	• Better implementation of the global division of labor • GAMET to continue to support countries to strengthen M&E in close collaboration with other partners	• Partners' readiness to take actions to align and harmonize M&E processes	HDNGA, ACT*africa*, GAMET, AFTQK, PREM network, UNAIDS, GFATM, PEPFAR
• All countries moved toward joint annual national program reviews and planning	• More efficient, effective, and sustainable HIV/AIDS resource allocation	• Lack of country ownership in enforcing partners to move in this direction • Lack of donor commitment to harmonize	HDNGA, ACT*africa*, WBI, AFTQK, UNAIDS, GFATM, PEPFAR
• At least 10 joint missions • At least eight countries have a strengthened single coordinating body	• Harmonized planning and implementation	• Willingness of Bank units to participate • Inability of donors to schedule joint activities	WBI, HDNGA, ACT*africa*, GAMET, UNAIDS, GFATM, PEPFA

APPENDIX 11

The HIV/AIDS Results Scorecard

The Africa Region, in collaboration with GAMET, has developed a toolkit to support the countries in preparing their project-specific results frameworks. This toolkit, the HIV/AIDS Results Scorecard, has been discussed and shared with countries, other development partners, and project task teams. The Scorecard is based on: (i) the indicators selected from globally agreed HIV indicators for prevention, care, treatment, and mitigation required by UNGASS, the MDGs, and IDA; (ii) the fact that several countries have the capacity to report on the indicators; and (iii) the OECD's Paris Declaration on harmonization and minimizing data requirements. The Scorecard proposes indicators for groups of countries where the epidemic has reached the general population and for the countries where it is still within concentrated populations. All Scorecard indicators are not mandatory. The Scorecard is a tool for task teams to use as a baseline for developing or updating a project's specific results framework.

A small set of mandatory indicators have, however, been extracted to measure the overall progress of the HIV response to which the World Bank contributed in the Africa Region. The Scorecard will therefore be used to measure progress under the AAP as well as on IDA financing. It contains indicators for measuring long-term results at the regional level, and indicators for measuring results to which specific Bank-funded HIV assistance projects have contributed. Two types of data sources will be used to determine the values of the two types of Scorecard indicators on an annual basis: (i) regional level data will be extracted from international reports and verified data sources with the support of GAMET and UNAIDS; and (ii) project-level data will be reported by all HIV projects using the project ISRs and by ACT*africa* through its annual MAP questionnaire.

Adopting the Scorecard in all ongoing and future HIV operations will reduce the burden on the countries and the task teams in reporting progress. It will also enable the Region to report on the aggregate achievements under IDA financing. The indicators, when fully adopted in all ongoing and future HIV operations, would be a major step toward achieving harmonization and alignment on M&E at the country, regional, and global levels.

The Scorecard indicators have been harmonized, where possible, with the indicator sets of other major partners in HIV/AIDS (PEPFAR indicators and the GFTAM's list of "Top Ten" indicators). The Scorecard indicators are not based on attribution, but rather on contribution. The Scorecard therefore does not suggest that a separate Bank HIV M&E system is required for a project; on the contrary, it suggests that indicator data from the national HIV M&E framework be reported to the Bank on a regular basis.

Table A11.1 presents the HIV/AIDS Results Scorecard for the Africa Region. Indicators 4–13 in the Scorecard are mandatory for all ongoing, pipeline, and future HIV operations in the Region, for reporting through the project ISRs.

Key benefits of the scorecard include: (i) compliance with the Paris Declaration (to reduce burden on the countries); (ii) harmonization with UNAIDS (UNGASS) indicators and those of other key financers (such as GFATM and PEPFAR) in reporting on HIV/AIDS; (iii) support for regional IDA financing and the AAP; and (iv) use of existing country capacity in data collection and reporting.

Scorecard data will be collected through the following arrangements:

	DATA SOURCES
A – Demographics	WDI
B – Development challenge indicators	UNAIDS and WHO global reports
C – Intermediate results indicators	UNAIDS and WHO global reports
D – Output indicators	Annual ACT*africa* MAP questionnaire and ISRs
E – Financing indicators	Client Connection, donor Web sites, and their focal points

Scorecard responsibility will be shared as follows:

- All country project teams.
- GAMET will provide technical assistance to the project teams.

- GAMET and ACT*africa* will gather data from the sources identified above as well as from UNAIDS, and will update the AAP progress reporting system.
- Task Team Leaders need to ensure that the scorecard is agreed upon with their counterparts, with support from ACT*africa* and GAMET.

GAMET will provide technical support to country project teams and to Task Team Leaders in getting agreement with counterparts, and ACT*africa* will provide support in integrating the scorecard into the Bank system.

The Africa Region HIV/AIDS Results Scorecard in table A11.1 uses the new UNGASS wording in line with the new 2008 UNGASS guidelines, released April 2007 (UNAIDS 2007b).

Table A11.1: The HIV/AIDS Results Scorecard

INDICATOR	INDICATOR ORIGIN	UNIT	DATA SOURCE
A. Demographics			
1. Total population (million)	World Bank	number	WDI database
B. Challenge: To understand the overall development challenge created by HIV in the Region			
2. Estimated number of adults and children living with HIV	UNAIDS	number	UNAIDS Global Report
3a. Men and women ages 15–24 who are living with HIV (may need to be estimated from antenatal data)	UNGASS, IDA-14, AAP	percentage	UNAIDS Global Report, WHO estimate
3b. Most-at-risk populations who are living with HIV	UNGASS	percentage	UNAIDS Global Report, WHO estimate
C. Intermediate results: To measure results contributed by Bank-funded projects			
4a. *Condom use.* Women and men ages 15–49 who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	UNGASS, AAP	percentage	ISR (extracted from country UNGASS report)
4b. *Condom use.* Female and male SWs who report using a condom with their most recent client (of those surveyed having sex with any clients in the last 12 months)	UNGASS, AAP	percentage	ISR (extracted from country UNGASS report)
5. Women and men ages 15–24 who have had sex with more than one partner in the last 12 months	UNGASS, AAP	percentage	ISR (extracted from country UNGASS report)
6. Adults and children with advanced HIV infection receiving antiretroviral combination therapy	UNGASS	number	ISR (extracted from country UNGASS report)
		percentage	ISR (extracted from country UNGASS report)

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Table A11.1: The HIV/AIDS Results Scorecard (continued)

INDICATOR	INDICATOR ORIGIN	UNIT	DATA SOURCE
7. Pregnant women living with HIV who received antiretrovirals to reduce the risk of mother to child transmission	UNGASS, AAP	number	ISR (extracted from country UNGASS report)
		percentage	ISR (extracted from country UNGASS report)
8. Orphaned and vulnerable children ages 0–17 whose households received free basic external support in caring for the child in the past 12 months	UNGASS	number	ISR (extracted from country UNGASS report)
		percentage	ISR (extracted from country UNGASS report)
D. Outputs: To measure results contributed by Bank-funded projects			
9. Persons ages 15 and older who received counseling and testing for HIV and received their test results	World Bank	number	ISR (from country M&E system)
		percentage	ISR (from country M&E system)
10. Male and female condoms distributed	World Bank	number	ISR (from country M&E system)
11. CSOs supported for subprojects (includes NGO, CBO, FBO)	World Bank	number	ISR (from country M&E system)
		amount	ISR (from country M&E system)
12. Public sector organizations supported	World Bank	number	ISR (from country M&E system)
		amount	ISR (from country M&E system)
13. National AIDS Coordinating Authorities that report annually on at least 75 percent of the indicators in their national HIV M&E frameworks and that disseminate the report to national-level leaders in at least three public sector organizations, national civil society leaders, and business leaders in the private sector	World Bank	percentage	ISR (from country M&E system)
E. Financing: To quantify funding provided by the Bank, government, and other partners to respond to the challenge and achieve the outputs and intermediate results			
14. Estimated investment requirements for HIV/AIDS ($ million)	World Bank	amount	UNAIDS global data
15. Total financial commitments for HIV/AIDS ($ million)	World Bank	amount	Calculation (15a + 15b + 15c)
15a. Country commitments for HIV/AIDS ($ million)	World Bank	amount	ISR (extracted from country UNGASS report)

INDICATOR	INDICATOR ORIGIN	UNIT	DATA SOURCE
15b. World Bank commitments for HIV/AIDS ($ million)	World Bank	amount	World Bank Business Warehouse
15c. Other development partner commitments for HIV/AIDS ($ million)	World Bank	amount	Development partner Web sites
16. Financing gap to reach HIV/AIDS targets ($ million)	World Bank	amount	Calculation (14 - 15)
17. World Bank financial disbursements for HIV/AIDS ($ million)	World Bank	amount	World Bank Client Connection

Note: All of the indicators in the Scorecard are based on the latest international thinking about indicator wording. Because efforts are under way to harmonize indicators, the indicators in the Scorecard may be slightly revised in 2008, when the harmonization process will be complete. Detailed indicator definitions will be released once the global indicator registry has been developed. Projects are only required to report on indicators 9–13.

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Note: Boxes, figures, and tables are indicated by *b*, *f*, and *t*, respectively.

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