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# Our Commitment: The World Bank's Africa Region HIV/AIDS Agenda for Action 2007–2011

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AIDS Campaign Team for Africa (ACT*africa*)  
Africa Region



Document of the World Bank

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## ACRONYMS AND ABBREVIATIONS

<b>AAP</b>	Africa Action Plan	<b>M&amp;E</b>	Monitoring and evaluation
<b>ACT<sub>africa</sub></b>	AIDS Campaign Team for Africa	<b>MAP</b>	Multi-Country HIV/AIDS Program for Africa
<b>AFA</b>	World Bank's Africa Region HIV/AIDS Agenda for Action	<b>MDG</b>	Millennium Development Goal
<b>AIDS</b>	Acquired Immuno-Deficiency Syndrome	<b>MIC</b>	Middle-income country
<b>ART</b>	Antiretroviral therapy	<b>MOH</b>	Ministry of Health
<b>ARV</b>	Antiretroviral drug	<b>MSM</b>	Males Having Sex with Males
<b>ASAP</b>	AIDS Strategy and Action Plan	<b>MTEF</b>	Medium-Term Expenditure Framework
<b>CAS</b>	Country Assistance Strategy	<b>NAC</b>	National AIDS Committee/Council
<b>CCM</b>	Country Co-ordination Mechanism	<b>NGO</b>	Non-Governmental Organization
<b>CDMAP</b>	Africa Capacity Development Management Action Plan	<b>OECD</b>	Organization for Economic Co-operation and Development
<b>DEC</b>	Development Economics Vice-Presidency, World Bank Group	<b>OED</b>	World Bank's Operations and Evaluation Department
<b>DFID</b>	Department for International Development, United Kingdom	<b>OVC</b>	Orphans and Vulnerable Children
<b>GFATM</b>	Global Fund to Fight AIDS, Tuberculosis and Malaria	<b>PEPFAR</b>	President's Emergency Plan for AIDS Relief
<b>GHAPA</b>	Global HIV/AIDS Program of Action	<b>PER</b>	Public Expenditure Review
<b>GIST</b>	Global Implementation and Service Team	<b>PLWHA</b>	People Living with HIV/AIDS
<b>HD</b>	Human Development	<b>PREM</b>	Poverty Reduction and Economic Management Network
<b>HIV</b>	Human Immuno-Deficiency Virus	<b>PMTCT</b>	Prevention of Mother to Child Transmission.
<b>HNP</b>	Health, Nutrition, and Population	<b>PRSC</b>	Poverty Reduction Strategy Credit
<b>HR</b>	Human Resources	<b>PRSP</b>	Poverty Reduction Strategy Paper
<b>IBRD</b>	International Bank for Reconstruction and Development, World Bank Group	<b>SRH</b>	Sexual and Reproductive Health
<b>ICR</b>	Implementation Completion Report	<b>SWAp</b>	Sector-Wide Approach
<b>IDA</b>	International Development Association, World Bank Group	<b>TA</b>	Technical Assistance
<b>IDF</b>	Institutional Development Plan	<b>TB</b>	Tuberculosis
<b>IDP</b>	Internally Displaced Populations	<b>UNAIDS</b>	Joint United Nations Program on HIV/AIDS
<b>IEC</b>	Information, Education, Communication	<b>UNDP</b>	United Nations Development Program
<b>IFC</b>	International Finance Corporation, World Bank Group	<b>UNHCR</b>	United Nations High Commission on Refugees
<b>ISR</b>	Implementation Status Report	<b>UNICEF</b>	United Nations Children's Fund
		<b>USAID</b>	United States Agency for International Development
		<b>WBI</b>	World Bank Institute
		<b>WHO</b>	World Health Organization

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## EXECUTIVE SUMMARY

The World Bank is committed to support sub-Saharan Africa in responding to the HIV/AIDS epidemic. This Agenda for Action is a road map for Bank management and staff over the next five years to fulfill 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. More than 25 million Africans are HIV positive, and AIDS is the leading cause of premature death on that Continent. HIV/AIDS affects young people and women disproportionately. Young women are three times as likely to be infected as young men. Due to the pandemic, there are an estimated 12 million children under the age of 18 who have lost at least one parent. Its impact on households, human capital, the private sector and 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 Background

The World Bank launched the first major global response to the disease in 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 multi-sectoral response by focusing on HIV/AIDS as a development issue and by engaging both local communities and the private sector. By May 2007, the Bank had provided US\$1.4 billion for HIV/AIDS programs in over 30 countries, including 29 Multi-country HIV/AIDS Program for Africa (MAP) countries and 4 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 multi-sectoral 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 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 due to its implementation, there have been major developments in the global response to the pandemic. Global funding for HIV/AIDS has grown dramatically—from US\$1.6 billion in 2001 to US\$8.9 billion in 2006 globally—with the creation of the



Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), the US 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. 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 US\$2,000 to US\$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 towards achieving the universal access goal. Nevertheless, an estimated US\$18 billion is needed to combat the disease in 2007 alone, with much of that funding needed for sub-Saharan Africa.

Moreover, the Global Fund, PEPFAR, and other donor institutions, including the International Development Association (IDA), are dependent on replenishments, with no certainty about the levels of future funding. Furthermore, access to treatment has expanded, thanks in part to a reduction in the costs of ARV drugs. Today, about one-quarter of Africans in need of treatment are on ARVs. Efforts to harmonize the international response were intensified under the UNAIDS banner of the "Three Ones".<sup>1</sup> Finally, prevalence rates are declining in some countries and communities.

## Continuing Challenges

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

- ensuring an appropriate balance between prevention, treatment and mitigation interventions,
- addressing human resource 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 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 program 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 (currently about 7 percent of new funding for HIV/AIDS in Africa) 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 Agenda for Action, these groups underscored

<sup>1</sup> One national strategic plan, one coordinating body and one M&E national framework.



the Bank's (i) macroeconomic focus, i.e., treating HIV/AIDS as a development issue, (ii) multi-sectoral engagement, (iii) capacity-building experience, (iv) convening power, and (v) 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 emerging 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 effectively address global epidemics.

## 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. This reaffirmation would be demonstrated by the endorsement of the AFA by the Bank senior management and Executive Directors. The Bank would commit itself to (i) provide at least US\$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 education, transport and other projects; and (iii) expand its engagement in IBRD countries at the epicenter of the disease in southern Africa.

The Agenda 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 linkages with TB, reproductive health, malaria 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 multi-sectoral and civil society responses.** The World Bank is uniquely placed to promote the multi-sectoral response and, working with communities, to address the HIV/AIDS challenge. The next generation of Bank support will emphasize efforts to strengthen health systems, education (especially for orphans and vulnerable children), school-based prevention programs, and gender inequality, and to foster private-public partnerships.
- **Pillar 3: Deliver more effective results through increased country M&E capacity.** The World Bank will continue to help strengthen M&E frameworks in the effort 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.



- **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 Agenda for Action 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—focus on development, multi-sectoral 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 Region. There will be a need to continue to give greater attention to HIV/AIDS as a development and poverty issue in the Bank's national dialogue with countries and in the relevant instruments. Mainstreaming of HIV/AIDS in sectoral products will be of increasing importance, with analytical support provided by an HIV/AIDS team and the Africa HIV/AIDS Incentive Fund. Capacity building of national HIV/AIDS authorities to improve fiduciary implementation, and monitoring and evaluation support will also require heightened attention. What will be required of staff and management is commitment to pursue this Agenda for Action. Human and financial resources will also be required to support the HIV/AIDS specialized dedicated team as well as contributions from country and sector units. While the dedicated team would continue to provide key 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 over-funded 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, and that HIV/AIDS threatens the well-being of the Continent like no other single challenge. For these reasons, the Agenda for Action focuses the Bank's engagement on its strategic strengths and helps ensure a harmonized and effective global response. The audience of the report is the World Bank's Board of Directors, senior management and staff of the Africa Region.



# 1. INTRODUCTION

- 1.1. This is not a conventional strategy document. We have deliberately titled it **Our Commitment: World Bank Africa Region HIV/AIDS 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.
- 1.2. 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. Less 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.
- 1.3. Nor is Africa a conventional 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 the funding of HIV/AIDS programs in the absence of external finance, which tends to be volatile and unpredictable.
- 1.4. We recognize that strategies are only useful to the extent that they meet three criteria: client demand, client capacity, and the ability of the Bank to meet those 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 audience of the report is the World Bank's Board of Directors, senior management and staff.
- 1.5. The Agenda for Action (hereafter “the AFA”) has four principal objectives:
  - **Reaffirm** the World Bank's commitment to long-term support for HIV/AIDS control 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
  - **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
- 1.6. The AFA articulates a program of support that honors, reinforces and translates into discrete actions the strategic directions of the Bank's Global HIV/AIDS Program of Action, the Africa



- 1.7. Action Plan (AAP), the Africa Capacity Development Management Action Plan (CDMAP), and Healthy Development: The World Bank's Strategy for Health, Nutrition and Population Results (HNP). 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 Agenda for Action, consultations have been carried out over several months with a broad constituency, including countries, donors, communities and non-profit organizations<sup>2</sup>.

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<sup>2</sup> Countries, civil society and PLWHAs (Kenya, May 2006), bilateral donors (UK, 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 (September-December 2006), GTAFM managers and staff (Geneva, September 2006), and Countries and Youth (Johannesburg, February 2007). See Annex 5 for details.



## 2. THE DIAGNOSIS

### The Epidemiology of HIV/AIDS in sub-Saharan Africa

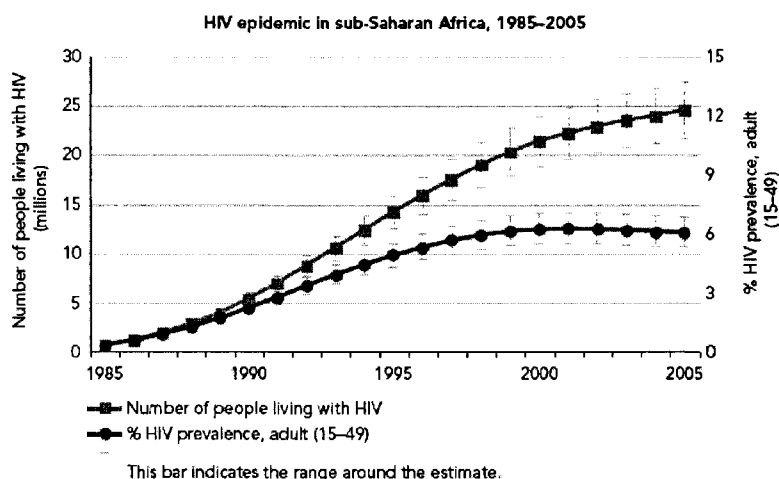
- 2.1. HIV/AIDS remains an enormous economic and human challenge in Africa. It is the single greatest cause of death in the Region, responsible for more than 20 percent of total deaths in 2000 (see Table 1 and World Bank, 2006a).
- 2.2. Nearly 25 million Africans are living with HIV/AIDS, the vast majority of them adults in the prime of their working and parenting lives (UNAIDS, 2006 and Figure 1). Despite a peaking of new infections and a decline in prevalence in some countries, more than two million people—about 5000 per day—died from the disease in 2005 (UNAIDS, *ibid.*).

**Table 1: Ten Most Common Causes of Mortality and Morbidity in sub-Saharan Africa**

The 10 Most Common Causes of Death	% of Total Deaths in 2000	% of Total Disability-Adjusted Life Years for the Region in 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	Not available
Ischemic heart disease	3.1	Not available
Tuberculosis	2.8	2.4
Road traffic accidents	1.8	1.8

Source: World Bank (2006a) and Mathers et al. (2006)

**Figure 1: Increasing number of persons living with HIV, especially in Sub Saharan Africa**



Source: UNAIDS (2006)



- 2.3. 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 the realization of the Millennium Development Goals. During the past decade, the disease has evolved and is today better understood. We know that it affects women and young people disproportionately. We also know that it is not one but several epidemics. The means of transmission have been more clearly established and, consequently, the responses more differentiated.
- 2.4. The human tragedy behind the numbers is enormous. In 2005, an estimated 2 million children younger than 15 years of age were infected with HIV (UNAIDS, 2006) and about 12 million African children under the age of 18 were either single or double orphans due to parental deaths from AIDS. The disease has deprived countries of their scarcest human capital. Zambia, for example, loses half as many teachers annually as it trains (Grassley et al, 2003). Private firms in some countries, especially in Southern Africa, recruit two workers for every job in anticipation of the loss due to the disease. The impact of the epidemic is countrywide, affecting both rural and urban households (UNAIDS, 2006).

#### ***The feminization of the epidemic***

- 2.5. In Africa, HIV/AIDS is predominately a disease of women and young girls. They are infected more often and earlier in their lives than men. Young women in the 15-25 year old age group are three times more likely to be infected than young men in the same age group (UNAIDS, 2006). Because of gender inequalities, women are often more vulnerable. They cannot negotiate safe sex or condom use and lack the means to prevent HIV and other sexually transmitted infections (STIs) as well as 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, physical assault and loss of home (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, opportunities, access to productive assets, workload and individual prevention mechanisms such as vaccines or microbicides will need to be addressed.

#### ***The impact on children, the young and disabled persons***

- 2.6. Children continue to be the victims of the disease both directly (infected) and indirectly (stigmatization or the loss of a parent). Over 9 percent of children under the age of 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 & 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. Disabled persons are also at increasing risk and vulnerability due to 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***

- 2.7. 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 vectors of transmission of HIV, but equally are vulnerable to infection by communities through which they pass towards a safer haven. This increase in vulnerability occurs as income sources disappear, social networks are destroyed and access to health and education services is

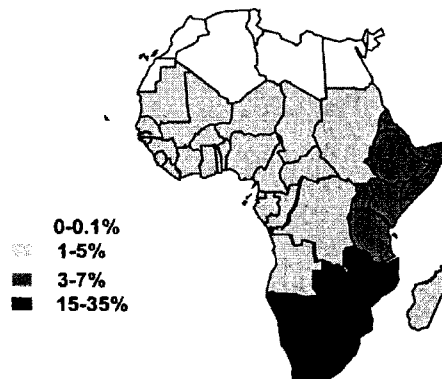


reduced. Furthermore, those groups frequently face stigma and are perceived to present higher HIV prevalence rates than host communities.

### ***Not one but several epidemics***

- 2.8. 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. 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 many years grouped with southern Africa, are far lower, ranging from 2 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).

**Figure 2: The Heterogeneity of HIV in Africa**



Source: Adapted from Wilson (2006).

### ***Transmission is better understood***

- 2.9. 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, *ibid.*). In the mixed epidemics of East Africa, transmission comes from both HIV-vulnerable groups (sex workers, men who have sex with men, and injecting drug users) and the general population, while in southern Africa most transmission is driven by sexual behavior in the general population<sup>3</sup>. The better understanding of the means of transmission is contributing to the 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).
- 2.10. The evolution in the understanding of the disease offers opportunities for more focused responses and more effective measures to control the spread of the disease, particularly in terms of attention to women, vulnerable groups and, as far as southern Africa is concerned, the general population.

<sup>3</sup> Injecting drug use is a growing but still less significant factor.



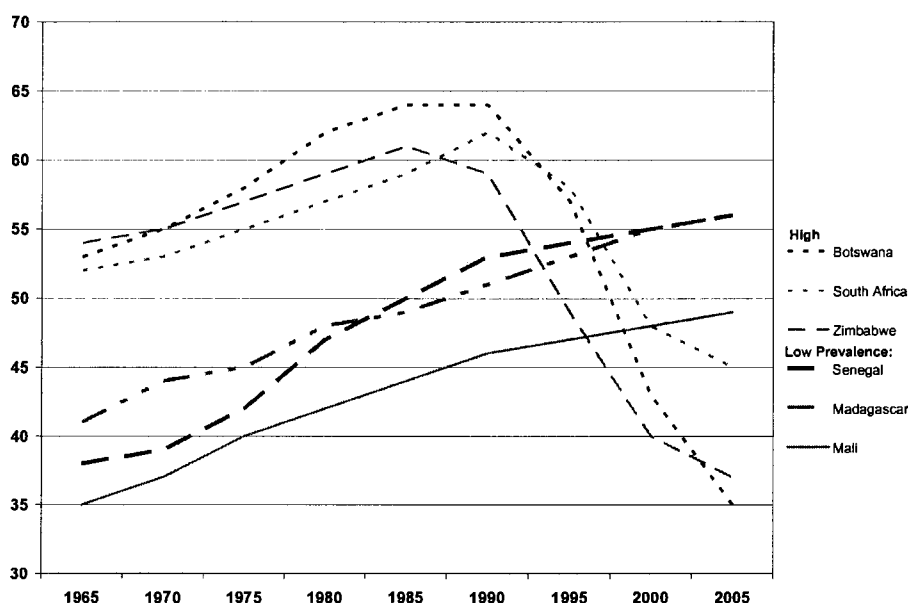
## The Development Impact of HIV/AIDS

- 2.11. In addition to the continuing human suffering and loss, HIV/AIDS represents 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 pandemic 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 is the fact that it has 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*

- 2.12. The HIV/AIDS pandemic has an obvious negative impact on welfare due to the increases in mortality rates and reversed gains in life expectancy associated with the disease (see Figure 3 and Annex 1). Households are directly affected through lost income and decreased labor supply as the health of household members, particularly "breadwinners," deteriorates. For instance, in Western Kenya access to antiretroviral therapy (ART) led to a 35 percent increase in weekly hours worked, thus illustrating the magnitude of the disease's impact on productivity and the potential economic benefits of treatment provision (Thirumurthy et al., 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 for 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 & Haacker, 2006).

**Figure 3: Changes in life expectancy at birth in selected African countries with high and low HIV prevalence: 1965-2005**



Source: World Development Indicators 2007



### ***The impact on the private and public sectors***

- 2.13. HIV/AIDS leads to decreases in productivity and to increased absenteeism and turn-over (with associated costs) of the work force (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, as 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 is felt (Haacker, 2004b). Furthermore, there are a number of indirect fiscal costs, as Haacker (2007) highlights, including orphan support and disbursements of pension scheme benefits related to the death of infected civil servants or eligible individuals, as well as increases in the dependency ratio. Hence, HIV/AIDS puts enormous strains on public finances

### ***The impact on human capital and economic growth***

- 2.14. 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 as it affects the accumulation of human capital and has adverse effects on the nutritional status of children, in particular 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/or reductions in school enrollment/attendance. Zivin et al. (2006) consider 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 et al. (2006) estimated that in Kenya by 2040, Gross Domestic Product (GDP) per adult will be 11 percent less than it would have been in the No-AIDS Scenario.
- 2.15. Theoretical studies surveyed in Haacker (2004a) typically predict 1 percent to 1.5 percent declines in GDP growth rates for the worst affected countries (prevalence rates >20 percent). Results on the empirical link between the epidemic and economic growth seem to be mixed (see Bloom et al, 1997, Corrigan et al, 2005, among others). As the HIV/AIDS pandemic 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. For instance, Kalemli-Ozcan (2006) analyzes evidence for 44 countries in Africa and concludes 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***

- 2.16. The epidemiology of HIV in Africa and the effect of the pandemic on development prospects suggest several priorities for the future.
- 2.17. 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 sub-regional levels. Programs will need to focus on major drivers of transmission.



- 2.18. Second, southern Africa will need to be a central focus for HIV/AIDS analysis and investments.
- 2.19. Third, programs will need to target the sub-groups heavily impacted by the epidemic: women and girls, children, youth and particularly vulnerable and often stigmatized groups such as sex workers, men having sex with men, 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.
- 2.20. Finally, because HIV/AIDS threatens the achievement of the Millennium Development Goals and perpetuates poverty and deepens inequality, the response to the pandemic needs to be an integral part of the dialogue on poverty reduction with African countries.



## 3. THE BANK'S RESPONSE TO DATE

### The Africa Region's Response to HIV/AIDS

- 3.1. 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. It was only in 1999 that the World Bank came to recognize the enormous development threat posed by the disease and prepared a regional HIV/AIDS strategy—*Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis*.
- 3.2. In 2000, the World Bank Executive Directors approved the Multi-Country HIV/AIDS Program (MAP) for Africa, with a commitment of US\$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 Annex 4 for a chronology of events).
- 3.3. The MAP Program 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 multi-sectoral response, and catalyze other resources. Stage two would mainstream innovations that have proved effective towards nationwide coverage, and stage three would permit a much sharper focus on areas or groups where spread of the disease continued.
- 3.4. It was clear from the outset that the Bank's standard products would not address the epidemic adequately. Therefore, the MAP Program adopted a “horizontal Adaptable Program Loan” (APL) approach, allowing a rapid response in many countries using a common framework and promoting a radically different response, including funding of civil society organizations, the private sector, ministries outside the Ministry of Health and trans-boundary populations such as refugees.
- 3.5. 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 the multi-sectoral and multi-agency implementation mechanisms for the widest possible coverage.
- 3.6. 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 US\$500 million as grant funding from IDA-13, thereby enabling MAP projects in all 29 IDA-eligible countries in sub-Saharan Africa, commitments of US\$1.4 billion, funding of several regional programs, and second-generation projects in a number of countries (see Annex 7).
- 3.7. The MAP Program addressed four pressing country needs:
  - strong political and government commitment to respond to HIV;



- a conducive 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 is increasing community participation in and ownership of HIV and AIDS interventions through providing financial resources and capacity building; and
  - a multi-sectoral approach in which all government sectors are appropriately involved, with improved coordination at the national level and decentralization to the sub-national government structures.
- 3.8. 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). So far, five IDF grants have been approved for roughly US\$2.5 million, bringing Bank HIV/AIDS support for the first time to Namibia, Somalia, Sudan, and Swaziland.

## The Results

- 3.9. The initial goals of the MAP program 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 program has achieved many of these goals, including the following (see Annex 3 and Grgens-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 AIDS authority (NAC).
  - **Active mobilization and engagement of Civil Society.** In all MAP countries, at least 38 percent of financing is through the civil society organizations. Major scale up of activities in the areas of prevention, mitigation and care has engaged over 29,000 civil society organizations who are implementing about 60,000 community level subprojects.
  - **Increased funding for HIV/AIDS.** Additional evidence of political commitment is the increased funding for HIV/AIDS from domestic resources. National budget funding in 29 reporting countries has reached \$757 million in 2006. In addition—with the creation of the Global Fund, the US PEPFAR program and significant other bi-lateral and foundation funding—global funding has grown by more than 2000 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, especially vulnerable populations) and condom distribution.
  - **Intensified treatment, care and impact mitigation.** Initially, the Bank provided limited funding for ARV treatment, 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 ARVs. It has also supported mitigation measures for more than 500,000 adults and 1.8 million children through education, home-based care and income-generating activities.

- **The multi-sectoral response.** One of the MAP Program's most important achievements has been the promotion of the multi-sectoral response. Recognizing that HIV/AIDS is not only 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, youth and other ministries.
  - **Improved HIV/AIDS systems.** Bank funding has supported training of over a half million people in service delivery, improved laboratory infrastructure, provided technical support to over 41,000 organizations, and reached 2.2 million people with workplace education programs.
- 3.10. The outputs from the MAP program 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 program in 2004 endorsed the basic objectives, approach and design of the program (World Bank, 2004). Nevertheless, this review suggested the MAP program 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.
- 3.11. The Operations Evaluation Department (now Independent Evaluation Group - 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 (see 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 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. Annex 10 presented actions that are being undertaken to address the recommendations.

## Lessons Learned

- 3.12. The key lessons going forward from the MAP experience include the following (see also World Bank, 2006b):
- ***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. It was the first country in Africa to make significant gains against the epidemic, reducing prevalence among antenatal clients in Kampala from 30 percent in 1992 to 7 percent by 2001. Now there are worrying signs of HIV prevalence rising again, as it is 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 as outlined in the Poverty Reduction Strategy Papers (PRSPs) and Medium-Term Expenditure Frameworks (MTEFs).
- ***Know the epidemic/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 tuberculosis.*** Treating HIV/AIDS as a single disease has been a significant deficiency of national HIV/AIDS programs. The feminization of the epidemic and its linkages to sexual and reproductive health, the often co-infection with TB (and the emerging XDR TB), as well as 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 systems, health information systems and 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.



## 4. STRATEGIC CHALLENGES IN THE NEW ENVIRONMENT

- 4.1. Since 1999, there have been major developments in the effort to combat HIV/AIDS in Africa, including the 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 and to national systems including health systems, and (v) 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 a much more crowded arena than in 2001.

### Finance, Sustainability and Accountability

#### (i) Global funding

- 4.2. **Context:** The global response to the HIV/AIDS epidemic has been unparalleled. Between 2001 and 2006, worldwide funding has grown fourfold—from US\$1.6 billion to S\$8.9 billion (UNAIDS, 2006). Funding to MAP countries in Africa from the three main international sources amounted to US\$5.9 billion in the period from 1997 to 2006 (Table 2).

**Table 2: Funding Sources and Commitments to MAP Countries**

Funding Sources	Commitments to MAP Countries (in US\$ billion)
World Bank (1997-2006)	1.3
PEPFAR (2004-2006)	1.9
Global Fund (2003-2006)	2.6
Total	5.9

Source: World Bank (2006b), PEPFAR (<http://www.pepfar.gov/press/c19558.htm>), GFATM ([www.theglobalfund.org/en/funds\\_raised/commitments/](http://www.theglobalfund.org/en/funds_raised/commitments/))

- 4.3. 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 over US\$41 billion in the period from 2007 to 2011 (see table below). 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.

**Table 3: Resource Needs for Universal Access in Millions of US\$ (2007-2011)**

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

Source: Bollinger and Stover (2007)

- 4.4. **Challenge:** The increase in financial resources presents two major challenges: ensuring the 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 shortcomings in national fiduciary and health delivery systems, insufficient planning, leakages and corruption. An apparent paradox is that despite the increased funding for HIV/AIDS, there is frequently a shortage of resources devoted to addressing important country needs in the fight against the epidemic, such as recurrent expenditures and institutional capacity building.

**(ii) Global HIV/AIDS architecture and national institutions**

- 4.5. **Context:** At the global level, there have been several commitments to a more harmonized approach among development partners, embodied in the Monterey, Rome and Paris Declarations, the New Partnership for Africa's Development (NEPAD) and, for HIV/AIDS specifically, the "Three Ones." Groups have been established to translate the global commitment to concrete action on HIV/AIDS, including a multi-institutional Global Task Team (GTT) responsible for creating a regular coordination and problem-solving mechanism, the Global Implementation and Service Team (GIST), a UNAIDS-funded Global Monitoring and Evaluation Team (GAMEI), a country strategy/action plan improvement group (ASAP), and a procurement process review group. At national levels, the institutional capacity of AIDS authorities is seen as a crucial linchpin in effective utilization of external and internal, existing and future resources.
- 4.6. **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 level. 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.

**(iii) Fiscal sustainability of HIV/AIDS programs**

- 4.7. **Context:** The scale-up in 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.

- 4.8. Most countries in the region are still heavily reliant on external assistance to finance their HIV/AIDS programs. Previous research has indicated that this source of funding tends to be volatile (Eifert & Gelb, 2005). The evolving nature of the epidemic and the availability of lower-cost treatments are converting HIV/AIDS from a death sentence to a chronic disease. Once treatment begins, it is a life-long commitment. 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.
- 4.9. There is significant uncertainty regarding the future costs of treatment as 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.
- 4.10. **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 effectively address this imbalance, 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).

#### **(iv) Governance and accountability**

- 4.11. **Context:** There has been growing concern 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.
- 4.12. **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 decentralization of effort carries with it an enhanced risk of fund wastage and leakage. The challenge is to ensure the integrity of fund use while promoting the active engagement of many small organizations and the effective flow of funds to where the needs are the greatest.

#### **(v) Implementation Capacity**

- 4.13. **Context:** With the significant infusion of resources, increased numbers of stakeholders and service providers over a relatively short time frame, and broad acceptance of the notion of universal access, the capacity of institutions and entities to effectively perform the variety of new tasks represents a major bottleneck, in many instances. Demand for planning, programming and costing, provision of service delivery, supervision, monitoring and evaluation and reporting capacity—whether at



community, provincial or national levels—have outstripped the capability of many of those responsible. The burdens on AIDS authorities to provide adequate support for the multifaceted activities provided by many partners is only likely to grow as programs extend into universal access.

- 4.14. **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 country situations. 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 access the CDMAP for priority HIV/AIDS implementation capacity development.

## Operational Issues

### (i) The balance between prevention, treatment and care

- 4.15. **Context:** In the past four years, the principal focus of the HIV/AIDS response has been on treatment, due in part 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 Global Fund 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 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.
- 4.16. **Challenge:** Prevention responses cannot be “one-off” actions nor will one solution work forever. Over the long term, prevention efforts must adapt as the epidemic changes, responding to different infection patterns and social conditions. Countries in the Region have typically implemented generalized prevention programs, which may not have 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, men having sex with men, injecting drug users, the principal vectors of transmission in many countries with concentrated epidemics.



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

### **(ii) Gender inequality**

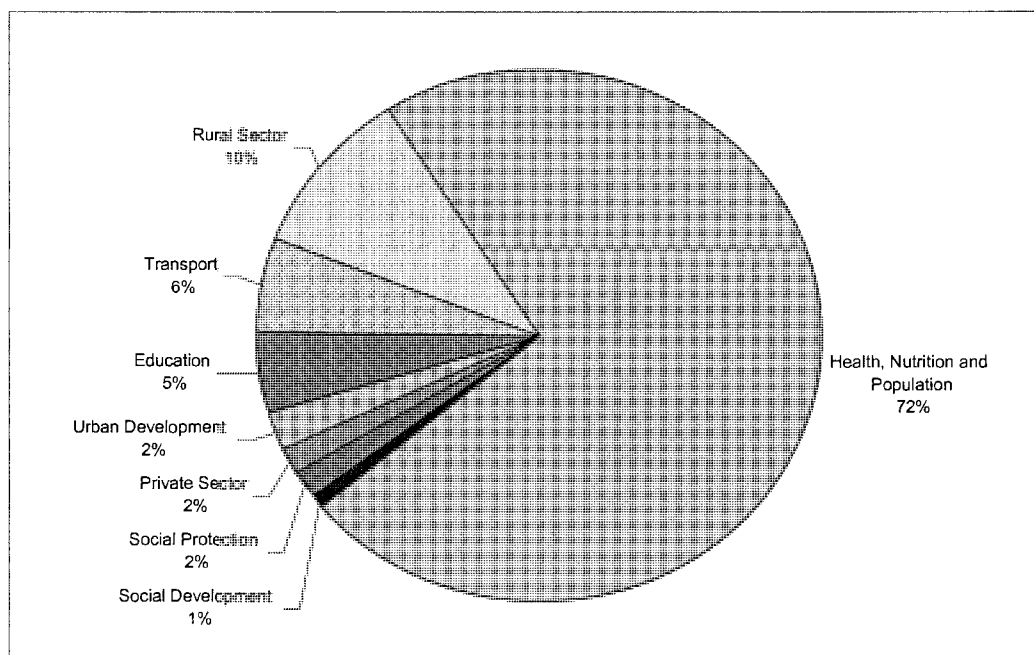
- 4.18. **Context:** Gender inequalities in status and rights, gender-based violence, labor opportunities, access to productive assets, and workloads are at the core of young girls and women's greater HIV vulnerability and risk. Scaling up existing tools and methods, as well as providing innovative and 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 traditional methods, specifically male circumcision, to reduce the risk of HIV transmission from female to male.
- 4.19. **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 operational research, pilot testing and service delivery would have significant benefits, but requires heightened and sustained focus to alter deeply embedded practices.

### **(iii) Multi-sectoral Engagement**

- 4.20. **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, Municipal Affairs, Social Services, Trade, Transportation, Youth to name but a few sectors, all justifiably have valid reasons to concern themselves with the national HIV response. In practice, while there is rhetorical recognition by civil servants of the relevance of HIV to 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 partnership with civil society organizations, lack of leadership, and lack of tools, training and absorptive capacity.
- 4.21. **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 affect national success—and a priority for their attention, engagement, and action is a difficult task. Identifying the key sectors on a country-by-country basis, finding receptive individuals, and providing the 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.
- 4.22. Figure 4 illustrates the distribution of active HIV/AIDS commitments across the World Bank's sectors. While more than half of the portfolio (77 percent) is managed by the Health, Nutrition and Population (HNP) sector, continued efforts need to be made to mainstream combating HIV/AIDS into non-health sectors.



**Figure 4: Active HIV/AIDS Commitments by Sector Board**



Source: Business Warehouse, May 2007. Data includes full commitment amounts for MAP projects and coded amounts for projects with HIV/AIDS components.

**(iv) Sexual and reproductive health (SRH)**

- 4.23. **Context:** Family planning, maternal and child health, reproductive health and HIV/STI programs are closely inter-related. 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.
- 4.24. **Challenge:** Various studies are underway on how best to link sexual and reproductive health with HIV services (see Lule, 2004). Although such linkages will vary from context to context, it is also clear that providing family planning services as part of counseling and testing and PMTCT, expanding youth-friendly reproductive 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 is a priority, but obtaining their commitment to a policy that necessitates resources will require a concerted effort by many stakeholders.

**(v) Links to other diseases, especially Tuberculosis**

- 4.25. **Context:** Since 1990, the number of new TB cases has tripled in Africa and with the emergence of Multi-Drug Resistant Tuberculosis (MDR TB) and Extensively Drug Resistant Tuberculosis (XDR TB), the complexity of the interactions between TB and HIV have been magnified. Malaria remains a major problem in much of sub-Saharan Africa, and those infected by HIV are at greater risk of



dying when stricken by malaria and vice versa. Malnutrition is another of the significant contributors to HIV/AIDS vulnerability, impairing immune systems and heightening mortality.

- 4.26. **Challenge:** Taking concerted action to deal with relevant research, policy, technological advancements and their application requires cooperation among 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.

**(vi) Health services delivery**

- 4.27. **Context:** The health sector is the one sector that cannot fail if there is to be effective HIV/AIDS surveillance, prevention, treatment, and care. Many health systems in the Region lack adequate facilities and outreach capability and effective systems (such as supply chains and monitoring and evaluation). They face chronic shortages of health workers to respond to the HIV pandemic (see Tulenko, 2006). Indeed, HIV/AIDS represents a heightened burden for national health systems in retaining health workers, even those who are trained, unless they are provided with the means to protect and treat themselves.
- 4.28. **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 monitoring and evaluation.

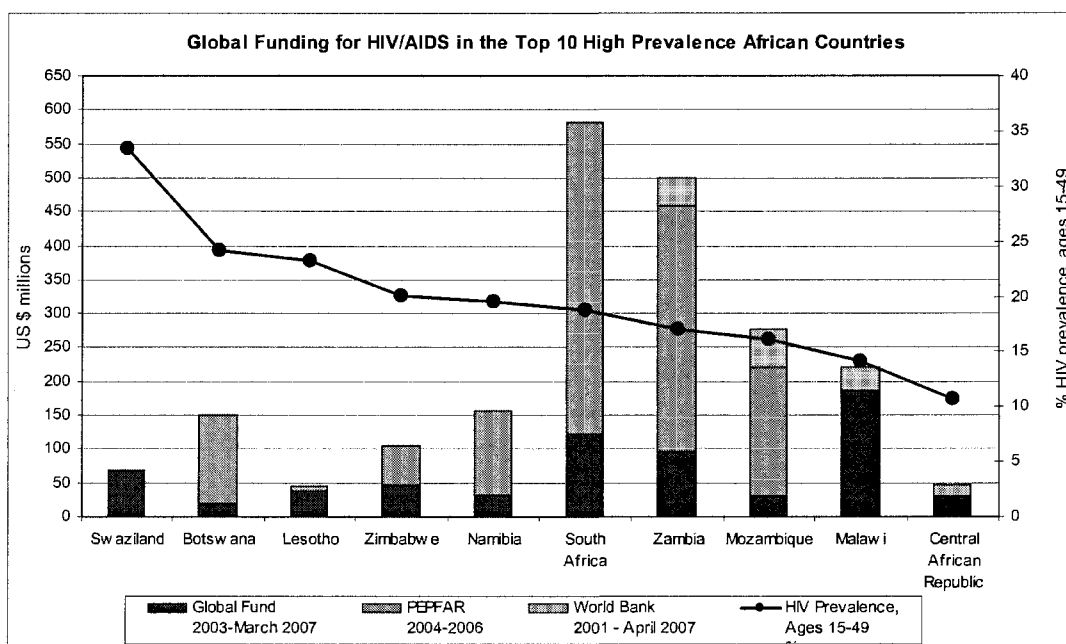


## 5. THE AGENDA FOR ACTION 2007-2011

### The Rationale for an Agenda for Action

- 5.1. HIV/AIDS remains a fundamental development challenge in many African countries—threatening growth, livelihoods and human capacity and representing a tragedy for millions of families.
- 5.2. 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, a better appreciation of the disease and its transmission, and new appreciation of gender inequality in the feminization of the disease in Africa.
- 5.3. Despite intensified national and global responses, much remains to be done in terms of strategy and the wherewithal to implement a cohesive strategy, 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, a capacity to adapt to a changing epidemiological environment, and an intention to stay the course with other partners in containing the spread of the virus.
- 5.4. Among the most serious gaps is the absence of sustained international support for HIV/AIDS in the most seriously affected countries, especially in southern Africa, as indicated in Figure 5 (see also Annex 11).

**Figure 5: Global Funding for HIV/AIDS in the Top 10 High Prevalence African Countries**

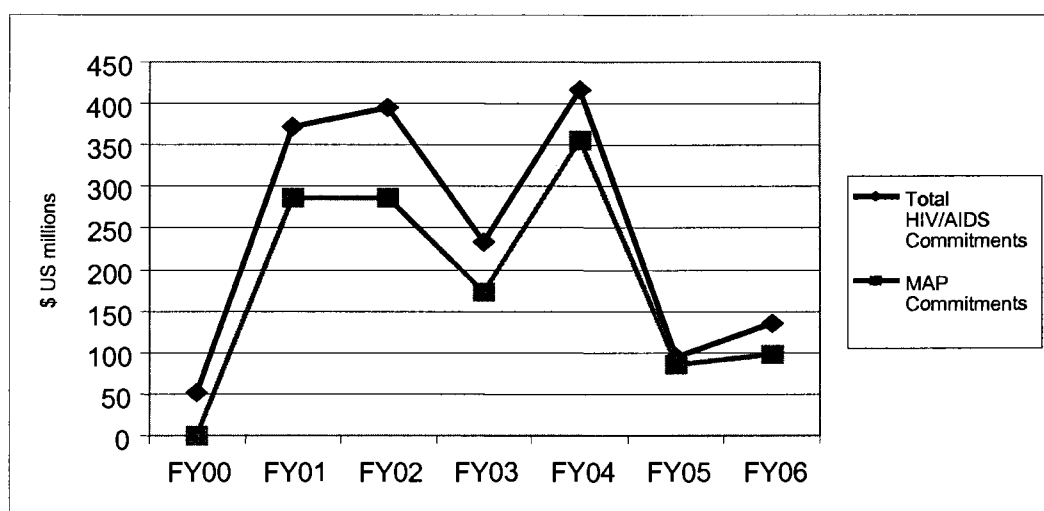


Sources: UNAIDS, 2006; Haacker, 2007; [www.theglobalfund.org](http://www.theglobalfund.org); and [www.pepfar.gov/pepfar/press/81902.htm](http://www.pepfar.gov/pepfar/press/81902.htm). Data for World Bank MAP projects includes approvals from 2001 to April 2007 and does not include \$106 million in allocations for sub-regional MAP projects.



- 5.5. 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. Its 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 from the Global Fund, PEPFAR and others. The reduction in the Bank's new commitments from about US\$250 million per year to about US\$80 million is pronounced after FY04 (Figure 6).

**Figure 6: World Bank HIV/AIDS Lending\* in Africa FY00-FY06\*\***



\*Data includes total commitment amounts for MAP projects and coded amounts for projects with HIV/AIDS components

\*\* Data as of April 2007

Source: World Bank Business Warehouse

- 5.6. In other respects, the demand for the Bank's engagement continues to be very strong. UNAIDS co-sponsors specified the World Bank as 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 Annex 9). The Bank is also a main partner with UNDP in addressing the broader development, governance, mainstreaming, and gender agendas; with UNICEF in procurement and supply management; and with the UNAIDS Secretariat in monitoring and evaluation, strategic information, knowledge sharing and accountability.
- 5.7. Stakeholders consulted for this Agenda for Action—including country officials, development partners, donors and civil society organizations—articulated roles for the Bank for which it was uniquely qualified (some of which were described as "core competencies" in the previous section), including:

- macroeconomic and fiscal analysis



- multi-sectoral engagement, working in education, transport, agriculture and other sectors as well as health
- institutional and human capacity-building for health systems, financial management and procurement
- “convening power”
- partnership with communities and the private sector
- source of long-term financial support

## Strategic Objectives

- 5.8. The fundamental purpose of the AFA is to support countries in sub-Saharan Africa to realize the Millennium Development Goal related to HIV/AIDS—halt and begin to reverse the spread of HIV/AIDS.
- 5.9. 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 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 to:
- **Strengthen the long-term prioritized sustainable response** through incorporating HIV/AIDS more explicitly into the national development agenda, focusing the response, articulating realistic strategies built on solid evidence generated by good monitoring and evaluation (M&E), and integrating HIV/AIDS efforts with those of other diseases;
  - **Intensify and accelerate a targeted multi-sectoral response** by interventions in education, transport, agriculture and health, by working with the private sector, with civil society organizations 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; and
  - **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

- 5.10. 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 multi-sectoral and civil society responses
  - **Pillar 3:** Deliver more effective results through increased country M&E capacity
  - **Pillar 4:** Improve donor harmonization and coordination



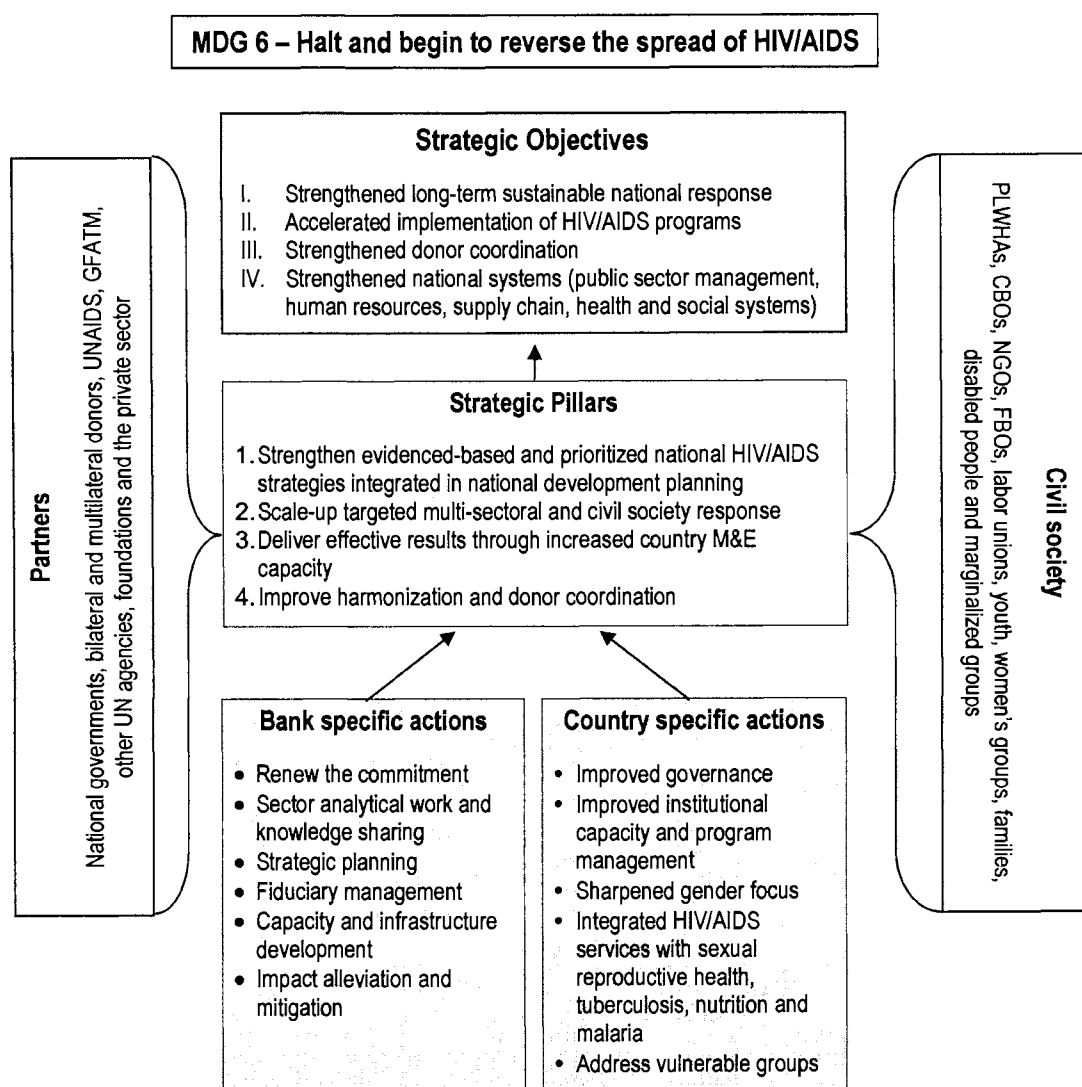
## The Cornerstone of the AFA

- 5.11. The Bank's **commitment** to continuing its active engagement in combating HIV/AIDS in Africa will underlie the AFA effort. With constrained budgets for IDA, the growing demand for infrastructure and other investment, and the availability of grant resources 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

- 5.12. The conceptual framework for the AFA can be visualized in Figure 7:

**Figure 7: World Bank HIV/AIDS Agenda for Action in Africa Conceptual Framework**





- 5.13. 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 attached as Annex 6. The following section summarizes the principal elements of the Foundation for the AFA, namely renewing the commitment and the actions and expected results for each of the four pillars.

## The Foundation: Renew the Commitment

- 5.14. 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. The approval of the AFA by the Bank's senior management and the Executive Directors would affirm that determination.
- 5.15. The tangible demonstration of the renewed commitment would include the following:
- **Commit to remain a source of predictable, flexible and long-term finance.** The Bank will be prepared to provide at least US\$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 of five-year financing plans and financial sustainability studies that incorporate donor and domestic commitments and long term commitments for treatment would be supported.
  - **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 Incentives Fund to enhance the evidence base, promote the multi-sectoral response and provide technical support, analysis and policy advice to countries.** An "Incentive Fund" with an annual budget of US\$5 million for five years would promote the analysis of 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 guidance, capacity building and project/program preparation, in line with the goals of the AAP and the Capacity Development Management Action Plan (CDMAP). The Fund would be available to potential recipients both inside and outside the Bank.
  - **Promote work on sub-regional public goods and cross-boundary issues such as refugees.** Regional efforts are important to complement national HIV/AIDS programs. They represent, however, instances in which countries are either reluctant or unable to borrow. Conflict or post-conflict situations are common in many sub-regions, thereby making conventional credit operations unfeasible. Grants to deal with refugees, Internally Displaced Populations (IDPs), transport corridors and the like are virtually the only option available to respond to such crucial situations. The Bank has larger and more varied experience with HIV/AIDS sub-regional approaches than others.



- **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, whether through IBRD “buy-down” collaboration, grant-funded technical assistance sub-regional programs, or other mechanisms. The Bank could provide technical support and innovative instruments to assist middle-income countries (MICs) in southern Africa through Institutional Development Plans (IDFs), financing, analytical work and policy dialogue<sup>4</sup>.

## **Pillar 1: Focus the Response Through Evidence-Based and Prioritized HIV/AIDS Strategies**

5.16. 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 medium-term expenditure framework. 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 are as follows:

- **Embed HIV/AIDS into national development strategies, medium-term expenditure frameworks and poverty-reduction programs.** With the renewed commitment from Bank and Regional management on HIV/AIDS, 6 PRSPs and 10 CASs and Interim Strategic Notes (ISNs) 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 4 and 5 on the following pages:

<sup>4</sup> The Bank currently supports analytical and advisory services and provided IDF grants for capacity building in Swaziland and Namibia.

**Table 4: Country Types and HIV/AIDS Typology**

Country Types	Low-level Epidemic		Concentrated Epidemic		Generalized Epidemic	
	Under 1% prevalence in young women (15-24)		Between 1-5% prevalence among young women (15-24).		Above 5% prevalence among young women (15-24)	
IDA	<b>Countries</b>	<b>Prev.</b>	<b>Countries</b>	<b>Prev.</b>	<b>Countries</b>	<b>Prev.</b>
	Madagascar	0.3%	Cameroon	4.9%	Lesotho	14.1%
	Mauritania	0.5%	Tanzania	3.8%	Zambia	12.7%
	Senegal	0.6%	Congo, Rep	3.7%	Mozambique	10.7%
	Niger	0.8%	Angola	2.8%	Malawi	9.6%
			Nigeria	2.7%	CAR	7.3%
			Angola	2.5%	Kenya	5.2%
			Guinea-B	2.5%	Uganda	5.0%
			Burundi	2.3%		
			DRC	2.2%		
			Chad	2.2%		
			Rwanda	1.9%		
			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%		
IDA (conflict and non-accrual)	<b>Countries</b>	<b>Prev.</b>	<b>Countries</b>	<b>Prev.</b>	<b>Countries</b>	<b>Prev.</b>
	Somalia	0.6%	Togo	2.2%	Zimbabwe	14.7%
					Cote d'Ivoire	5.1%
IBRD					<b>Countries</b>	<b>Prev.</b>
					Swaziland	22.7%
					Botswana	15.3%
					S. Africa	14.8%
					Namibia	13.4%
					Gabon	5.4%

Source: UNAIDS (2006). This table provides only a broad typology, based on national-level data. The variations in the epidemiology within countries in West Africa and parts of East Africa can be significant (e.g. Kenya, Uganda, Ghana) and should be taken into consideration when elaborating a locally appropriate response.

**Table 5: Possible Differentiated Responses**

Factor	Concentrated	Mixed	Generalized
<b>Geographic areas</b>	Parts of West Africa	West Africa and parts of East Africa	Southern Africa
<b>Lending Instruments</b>	Focused prevention projects/other sector project components	Hybrid* HIV/health projects	Programmatic loans (SWAps)
<b>Investment Focus</b>	M&E, stigma reduction, vulnerable groups	Focused interventions on sources of transmission	Behavior change Initiatives/treatment
<b>Analytical focus</b>	HIV mapping, interactions among high-risk groups and general population	Transmission dynamics	Attitude and behavior patterns Human resources for health
<b>Surveillance Focus</b>	Sex workers and men having sex with men	Vulnerable groups/interaction	Population-based surveillance

Source: Wilson (2006). \*Hybrid projects would include projects such as the Burkina Faso (half AIDS, half health) and the Eritrea projects covering HIV/AIDS/STI, TB, malaria and reproductive health, which are being replicated in other countries.

- **Support and build capacity for the development of prioritized, costed national HIV/AIDS strategies.** The work of the recently established AIDS Strategy and Action Plan (ASAP) will be directed at approximately 20 sub-Saharan African countries over the next three years.
- **Integrate HIV/AIDS more fully into programs on reproductive health, malaria, TB and nutrition.** Experience has shown that there are diseases and programs which need to be more closely addressed in the context of HIV/AIDS national responses. With its multi-sectoral capabilities, the Bank will more intensively consider how to do so, whether through HIV/AIDS 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 Multi-sectoral and Civil Society Responses**

5.17. The Agenda for Action will support a multi-sectoral response at the country level and mainstream HIV in the Bank's key operations. The support will focus on a prioritized multi-sectoral approach to respond to the complexity of HIV as a broad development challenge and focus on sectors that have the greatest potential impact (depending on country context) in partnership with the civil society organizations and private sector entities. To achieve this objective, the Agenda for Action will support mainstreaming HIV/AIDS in the overall development and poverty reduction agenda and identify entry points for each sector to mainstream HIV/AIDS. Specifically, the Bank will:

- **Encourage HIV/AIDS integration in key sectors.** The Bank will continue and expand its analytical work and investment operations designed to integrate HIV/AIDS policy, programs and service delivery in priority sectors. This will entail strengthening sectoral institutional



capacity to scale up and supervise activities, as well as multi-sectoral prevention operations research, pilot testing of promising approaches and service delivery.

- **Support civil society organizations 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. Civil society organizations 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 which leads to specific actions to change inappropriate gender responses will be an important part of future actions. Workshops to build on such findings and train decision makers will be supported. In addition, these results will be integrated in 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 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 virus represent a significant social and financial burden to societies. The Bank will contribute to the national and external donor response in conjunction with other lead donor financiers and lead technical partners, including UNFPA, UNESCO, and UNICEF, in the context of the agreed division of labor among UNAIDS cosponsors.
- **Strengthen health systems.** Taking into account the April 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, such as human resources, supply chain and monitoring and evaluation systems, and health facility infrastructure, especially laboratory and pharmaceutical services. Particular attention will be paid to ways to multiply results through linkages with tuberculosis, malaria, reproductive health and nutrition.

### **Pillar 3: Deliver Effective Results Through Increased Country M&E Capacity**

5.18. The 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 monitoring and evaluation frameworks at the country level and tailor the responses.** Monitoring and technical support to the development and operationalization of M&E systems—including adopting a standard “HIV/AIDS Results Scorecard” (see Annex 8) in all projects and developing impact assessment and evaluations and implementation of an early warning system for project performance—will be increased. Effective M&E systems can identify epidemic profiles and changing patterns and contextual



areas (including socio-economic determinants) and develop tailored responses. GAMET, the UNAIDS program housed in 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. Whether associated with World Bank funding or not, 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**

- 5.19. Countries face considerable difficulties in significantly scaling up program implementation. They need technical support that reinforces national ownership, addresses immediate needs and strengthens capacity in a sustainable manner. Areas of strategic planning, integration and M&E are all vital for “making the money work,” that is, improving the efficiency, effectiveness and sustainability of national AIDS responses.
- 5.20. 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:
  - **Work with key partners to harmonize and strengthen national M&E systems, human resource capacity, procurement and supply chains.** The Bank will continue to house the multi-donor effort to help strengthen M&E systems with support from GAMET. It will work with the lead organizations, as outlined in the UN Technical Support Division of Labor matrix, to address the human resource 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, disbursement, procurement and expenditure tracking.
  - **Conduct joint planning and analytical work with UNAIDS and other partners.** Taking into account the mandate of AIDS Strategy and Action Plans (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.



- **Participate 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.
- **Strengthen and harmonize national coordinating institutions.** The Bank will conduct institutional assessments with a view to identifying key constraints and provide the tools and training to effectively deal with the multiple stakeholders engaged in the HIV response.

## Anticipated Results

5.21. 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 ten years, it will have helped realize the Millennium Development Goals goal to halt and begin to reverse the spread of HIV/AIDS.

5.22. The principal outputs from the AFA over the next five years are expected to be the following:

**Table 6: Foundation**

Objective	Anticipated Results	By Whom	By When
Respond to country demand for predictable, flexible and sustainable IDA financing for HIV/AIDS.	Countries' access to predictable, flexible and sustainable financing for HIV/AIDS provided.	AFRLT.	FY08-FY11
Support for sub-regional and cross-border initiatives provided.	Support continued to sub-regional operations to address cross-border issues. At least 2 new sub-regional operations.	AFRLT, AFTHV, AFTHD.	FY08-FY11
Africa HIV Incentive Fund to provide support for project/program development, policy advice and capacity building created.	Incentive fund finances 5 technical support products per year.	CDMAP, AFTHV.	FY08-FY10

**Table 7: 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, AFRLT, 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, reproductive health, malaria and nutrition into World Bank HIV/AIDS products ensured.	• World Bank projects addressing HIV/AIDS integrate TB, reproductive health, malaria and nutrition when appropriate to epidemiological context.	HDNGA, AFTHV, AFTHD, WHO, UNFPA, UNICEF.	FY08-FY11

**Table 8: Pillar 2 - Scale Up Targeted Multi-sectoral and Civil Society Responses**

Objective	Anticipated Results	By Whom	By When
HIV/AIDS policy, programs and service delivery integrated in priority sectors (dependent upon country context).	<ul style="list-style-type: none"> <li>Improved country capacity in key sectors to implement multi-sectoral approaches.</li> <li>Increased commitment in key Bank sectors to include HIV/AIDS component or sub-components in lending and non-lending activities, including adequate resources.</li> </ul>	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.	<ul style="list-style-type: none"> <li>Improved synergy between HNP and HIV/AIDS operations.</li> </ul>	HDNHE, AFTHD, AFTHV, WHO, UNFPA, UNICEF.	FY08-FY11

**Table 9: 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.	<ul style="list-style-type: none"> <li>Bank to continue to play leading role (GAMET) in supporting countries.</li> <li>All countries have a functional harmonized M&amp;E system reporting and using data.</li> </ul>	HDNGA, AFTHV, GAMET, UNAIDS.	FY08-FY11
Knowledge generation and sharing to improve prioritization, decision-making and program design supported.	<ul style="list-style-type: none"> <li>Design and impact of HIV/AIDS investments based on knowledge sharing.</li> <li>Countries and partners fully engaged in knowledge generation and sharing.</li> </ul>	HDNGA, AFTHV, GAMET, AFTQK, DEC	FY08-FY11

**Table 10: Pillar 4 - Harmonize Donor Collaboration**

Objective	Anticipated Results	By Whom	By When
Collaboration with key partners to harmonize and strengthen national M&E systems, HR capacity, procurement and supply chains strengthened.	<ul style="list-style-type: none"> <li>GAMET to continue to support countries to strengthen M&amp;E in close collaboration with other partners.</li> <li>Better implementation of the global division of labor.</li> </ul>	HDNGA, AFTHV, PREM, GAMET, AFTQK, UNAIDS, GFATM, PEPFAR.	FY08-FY11
Joint planning and analytical work with UNAIDS and other partners increased.	<ul style="list-style-type: none"> <li>More efficient, effective and sustainable HIV/AIDS resource allocation.</li> </ul>	HDNGA, WBI, AFTQK, AFTHV, UNAIDS, GFATM, PEPFAR.	FY08-FY11



## **The Potential Impact and Consequences of Inaction**

- 5.23. Should universal access to treatment and prevention become a reality by 2011 as envisaged by the G-8 industrial countries, the impact on Africa would be significant. According to the analysis discussed in detail in Annex 2, 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 US\$2,000 to US\$3,000 per infection averted. In addition, these prevention interventions would entail savings in terms of treatment cost avoided alone in the order of US\$6,570 per HIV infection averted. With continued expanded access to treatment, almost 1,000,000 deaths will be averted annually by 2011. In contrast, the consequences of inaction are frightening: new infections would continue to increase, and deaths due to HIV/AIDS would grow from the 2005 level of 1.9 million. The cumulative affect 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).



## 6. OPERATIONAL IMPLICATIONS FOR THE BANK

- 6.1. 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 has been in the past five years. With the absence of grant funding, 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 multi-sectoral response in education, transport and other sectors does not rest with *ACTAfrica* or with the Health, Nutrition and Population (HNP) family, but with other units in the Bank. And the most critical role for the Bank might shift from financier to facilitator in some countries with other donor financing, with consequences for budgeting, work program agreements and internal incentives.
- 6.2. As indicated in Part 6, other stakeholders consulted for the AFA consider the “soft” role as 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 over 50 years demonstrates that it is 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 health issue.** The Bank is considered to be uniquely positioned to place the HIV/AIDS epidemic within a macro-economic 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 multi-sectoral 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 the private sector.
  - **Analytical expertise.** The Bank has the analytical capacity, as 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 multi-sectoral programs.



- **The Bank as “convener.”** 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 level is particularly valued.
- 6.3. 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 and broader health response at the local level. Another shortfall 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 as having been slow to put into practice lessons learned from the MAP program, 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

- 6.4. The four pillars of the AFA will require that the Africa Region and the ACT*africa* team design and develop a program of work very different from the one which drove the first phase of the MAP program. There will need to be 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. 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 PRSCs, and in helping to design prioritized and costed national HIV/AIDS strategies.
  - **Ensure Bank country assistance strategies reflect the 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 funding them where demand exists.** New projects are being prepared or have been approved in 8 of the 14 countries where MAP projects have been completed. Under the AFA, the Bank will be prepared to fund projects in the Region at least US\$250 million per year.
  - **Support the 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 and capacity building for health and fiduciary systems. ACT*africa* can provide expertise and operational support where requested. 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 intensive program of retro-fitting



outputs and enhanced supervision for enhanced results is being initiated. GIST will continue to promote problem-solving among development partners.

- **Continue to support capacity building for HIV/AIDS governance, especially at the local level, M&E and 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 pledge to the UNAIDS “Three Ones” principles, HIV/AIDS represents a model of the harmonization effort commitment under the Paris Declaration.
- 6.5. 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 Annex 6.

## **An HIV/AIDS Support Program for FY07-11**

- 6.6. While 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 LICUS and post-conflict countries with large refugee populations may be the most likely claimants of Bank funding. Epicenter countries such as Botswana, Namibia, Lesotho, Swaziland and South Africa may also consider funding from the IBRD.

## **Implications for Staffing and Budgeting**

- 6.7. Implementing the AFA will require both human and financial resources from the Africa Region to support the HIV/AIDS specialized dedicated team as well as contributions from country and sector units, and specialists to take on their share of the responsibilities to mainstream HIV/AIDS.
- 6.8. The functions of the current dedicated specialized multi-sectoral team (*ACTafrica*) 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; macro-economic 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/cross-border efforts. In addition, we envisage an evolution of the skills requirements over time based on the functions above and emerging demands.
- 6.9. While the dedicated team would continue to provide key specialized and quality assurance support across the sectors, it will also depend on Bank staff in the Region, other external partners, and co-sponsored 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 World Bank Institute and the International Finance Corporation. Additional skills and support would be drawn from the Global AIDS Program of the World Bank.



- 6.10. The cost of the dedicated specialized unit will involve a modest increase in the current base budget for *ACTAfrica*. Such a 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 as well.



## 7. CONCLUSION

- 7.1. We have sought to present a convincing case for the Bank's future continued engagement in Africa's struggle to overcome the HIV virus and the suffering of its people. We provided the best available information on the epidemiology, the impact, what the Bank has done to date, and its future role.
- 7.2. As development practitioners, we know that HIV/AIDS threatens the realization of the Millennium Development Goals 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 Agenda for Action responds to these challenges and to the priorities of the World Bank in sub-Saharan Africa through the Africa Action Plan, the World Bank's Global HIV/AIDS Program of Action, CDMAP and the World Bank HNP strategy.
- 7.3. Using knowledge gained from experience, the Agenda for Action is to be demand-driven, evidence-based and results-oriented. It will build capacity for monitoring and evaluation and epidemiological surveillance, and will continue the process of learning by doing and knowledge creation and sharing. For the Bank's Africa Region, this Agenda for Action would reinvigorate its engagement in the fight against HIV/AIDS.
- 7.4. While its funding role is likely to be modest in relative terms, the Bank's investments would remain significant in terms of being 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 HIV/AIDS, 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 and mitigation and support across the Continent to cushion the possible impact of volatile international funding over time.
- 7.5. The Agenda for Action will be implemented through partnerships across Bank units and other sectors working closely with client countries. It will collaborate and complement the work of UNAIDS, its co-sponsors, GFATM and other development partners to scale up a multi-sectoral response, mainstream HIV/AIDS in development agendas, build capacity, and, with the IMF, address fiscal space and long-term sustainability issues.
- 7.6. In 2000, the World Bank made a commitment to remain actively involved in combating the HIV/AIDS pandemic in sub-Saharan Africa for a generation. The Agenda for Action 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 for a. Standing by this commitment through the unanticipated trials and tribulations of its clients will reinforce Bank credibility as a reliable partner, but more importantly, it will further our goal of alleviating poverty.



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## **9. ANNEXES**



## ANNEX 1 – HIV Prevalence, Income, Access to Treatment and Quality of Health Services in sub-Saharan Africa in 2006

**Table 11: HIV Prevalence, Income, Access to Treatment and Quality of Health**

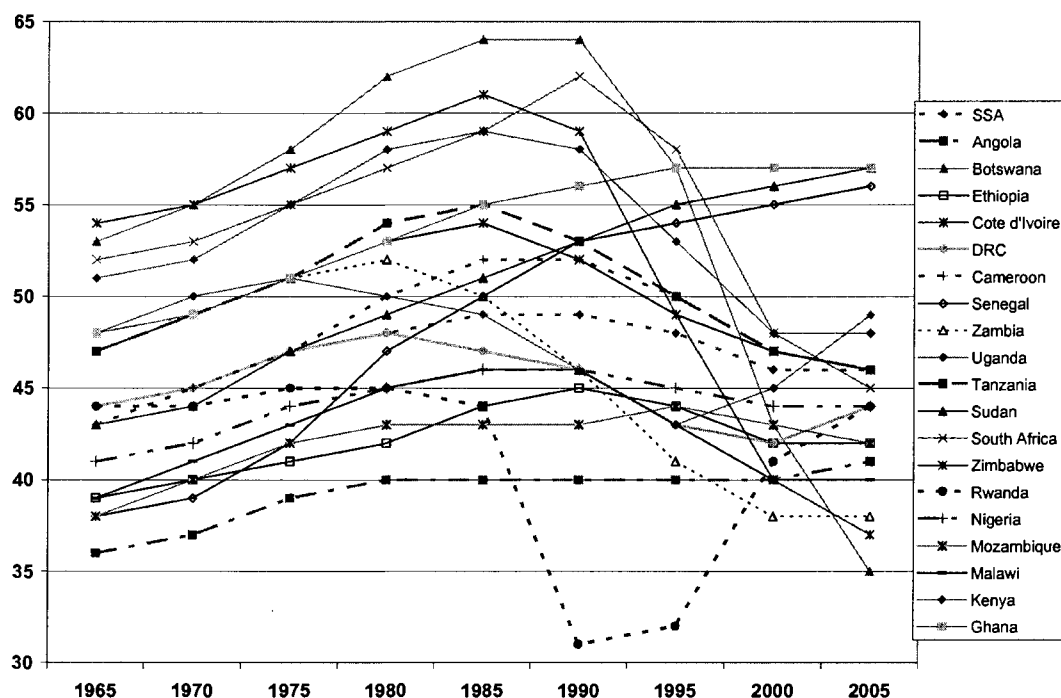
HIV Prevalence, Income, Access to Treatment and Quality of Health Services in sub-Saharan Africa in 2006							
Country	GDP per capita (U.S.\$)	HIV Prevalence, Ages 15-49 (Percent)	Access to treatment (Percent)	Population per Physician (Units)	Population per Nurse (Units)	PLWH per Physician (Units)	PLWH 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	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	1,751	5.3	17	5,050	1,040	159	33
Côte d'Ivoire	850	7.1	17	8,120	1,660	360	74
Dem. Republic of Congo	119	3.2	4	9,339	1,890	172	35
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	n.a.	n.a.
Gabon	6,538	7.9	23	3,420	194	152	9
Gambia	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	n.a.	946	271	3	1
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	n.a.	n.a.	n.a.	n.a.
Swaziland	2,323	33.4	31	6,333	159	1,287	32
Togo	378	3.2	27	12,086	1,646	50	7
Uganda	326	6.7	51	44,131	2,729	1,217	75
United Republic of Tanzania	324	6.5	7	22,298	2,343	6,222	654
Zambia	609	17	27	8,642	575	870	58
Zimbabwe	383	20.1	8	6,199	1,382	815	182

Source: Haacker (2007)

**Table 12: Life Expectancy at Birth for Selected sub-Saharan African Countries (1965-2005)**

Country	1965	1970	1975	1980	1985	1990	1995	2000	2005
SSA	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
Ethiopia	39	40	41	42	44	45	44	42	42
Cote d'Ivoire	47	49	51	53	54	52	49	47	46
DRC	44	45	47	48	47	46	43	42	44
Cameroon	43	45	47	50	52	52	50	47	46
Senegal	38	39	42	47	50	53	54	55	56
Zambia	48	49	51	52	50	46	41	38	38
Uganda	48	50	51	50	49	46	43	45	49
Tanzania	47	49	51	54	55	53	50	47	46
Sudan	43	44	47	49	51	53	55	56	57
South Africa	52	53	55	57	59	62	58	48	45
Zimbabwe	54	55	57	59	61	59	49	40	37
Rwanda	44	44	45	45	44	31	32	41	44
Nigeria	41	42	44	45	46	46	45	44	44
Mozambique	38	40	42	43	43	43	44	43	42
Malawi	39	41	43	45	46	46	43	40	40
Kenya	51	52	55	58	59	58	53	48	48
Ghana	48	49	51	53	55	56	57	57	57

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

**Figure 8: Life Expectancy at Birth for Selected sub-Saharan African Countries (1965-2005)**

Source: World Bank's DPP Database.



## **ANNEX 2 – The Potential Impact of HIV/AIDS Interventions: Methodology and Simulations**

This annex discusses the simulations on the impact and costs of HIV/AIDS prevention, care and mitigation interventions in sub-Saharan Africa (Bollinger & Stover, 2007). The results presented 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 baseline scenario where coverage rates for prevention, treatment and mitigation interventions remain at current levels, (ii) a universal access to 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, where prevention interventions are also scaled up.

The results presented were divided into three different sub-regions: East Africa, Southern Africa and Central/West Africa, in order to reflect the different nature of the epidemic in those areas. In the Base Scenario, new infections would continue to increase and deaths due to HIV/AIDS would grow from the 2005 level of 1.9 million. The cumulative affect 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 Treatment Scenario consists of increasing coverage from the current levels that are in the Base Scenario to reach universal access 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, including 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 Prevention Scenario builds on the previous 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 (1) predicting the change in behavior that is due to this increased coverage; (2) estimating the impact of this behavior change on HIV incidence; and (3) examining the consequences of the changes in incidence.

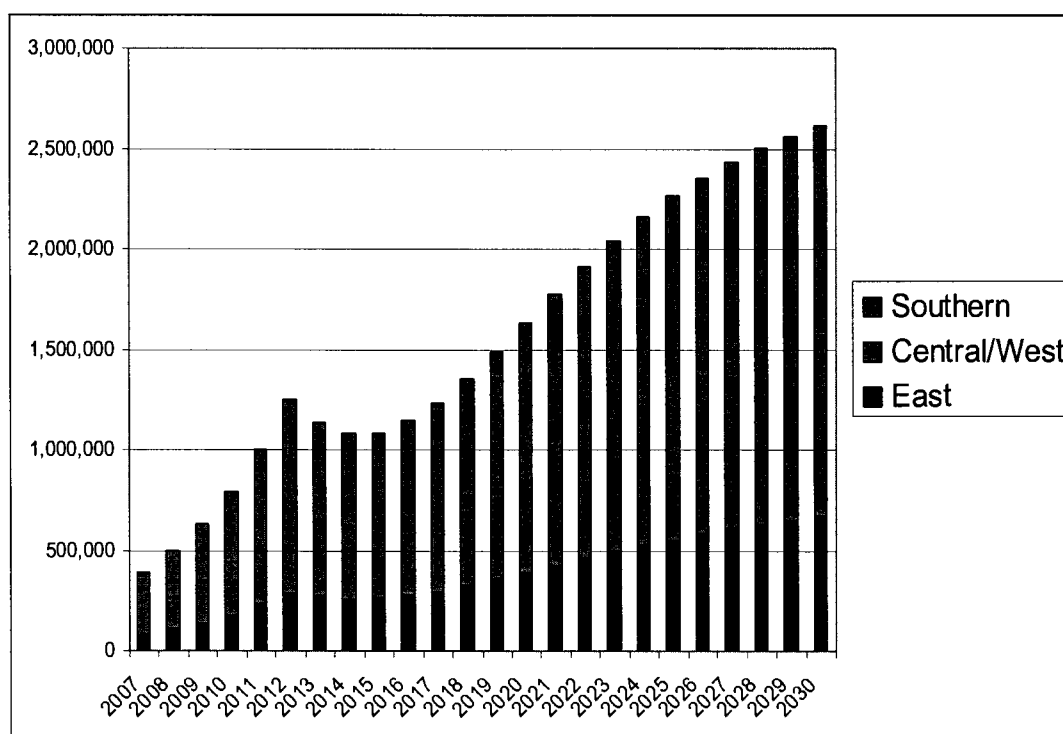
Changes in behavior are predicted based on an impact matrix that estimates the effect of the various prevention interventions on specific behaviors. The values of the matrix are derived from a review of the literature on approximately 100 impact studies. These behavior changes are then fed through an 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 a sexually transmitted infection on HIV transmissibility, the proportion of the population with sexually transmitted infections, condom use, numbers 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 universal access to 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 1,000,000. The overall cost per AIDS death averted varies between US\$2,500 and US\$3,500, depending on the sub-region. One should note that 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 due to longer duration of infectivity (Revenga et al., 2006).

**Figure 9: Universal Access to Treatment Number of Deaths Averted (2007-2030)**

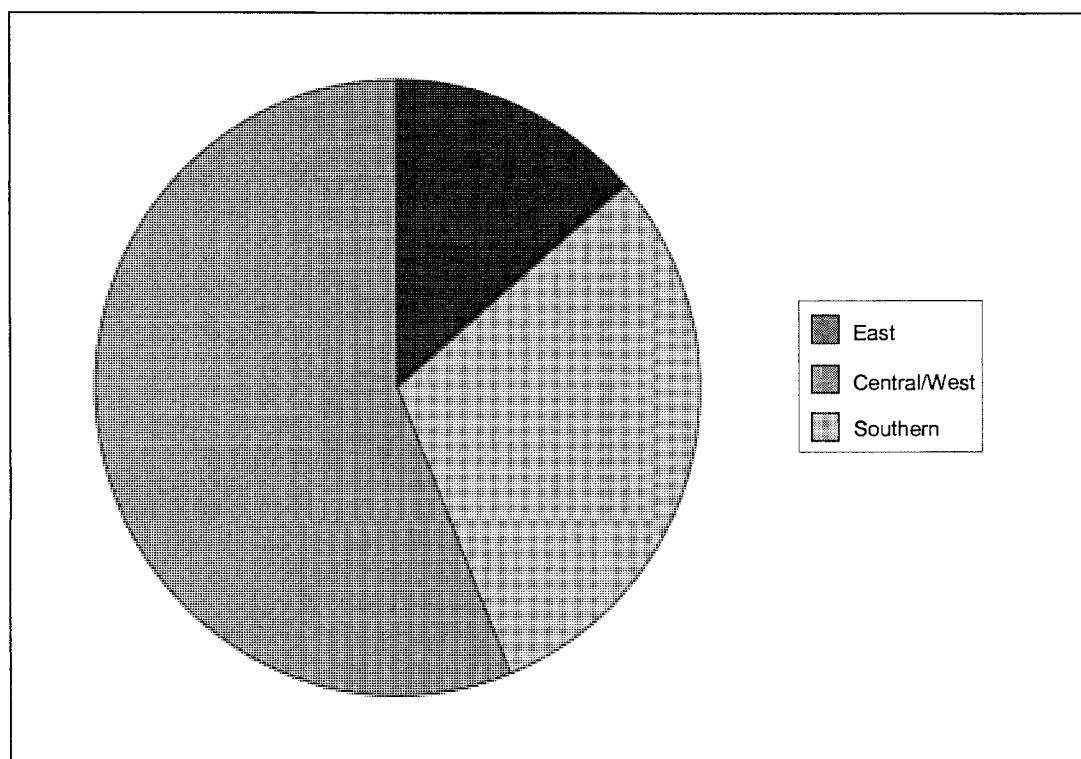


Source: Bollinger and Stover (2007)

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 no-scale-up scenario. In total, almost 14 million life years will be gained relative to the Base Scenario (see figure below) at a cost of approximately US\$1,400 per life year in East Africa and approximately US\$600 per life year in Southern Africa and Central/West Africa



**Figure 10: Universal Access to Treatment:  
Cumulative Number of Life Years Gained in Sub-Saharan Africa 2007-2011**



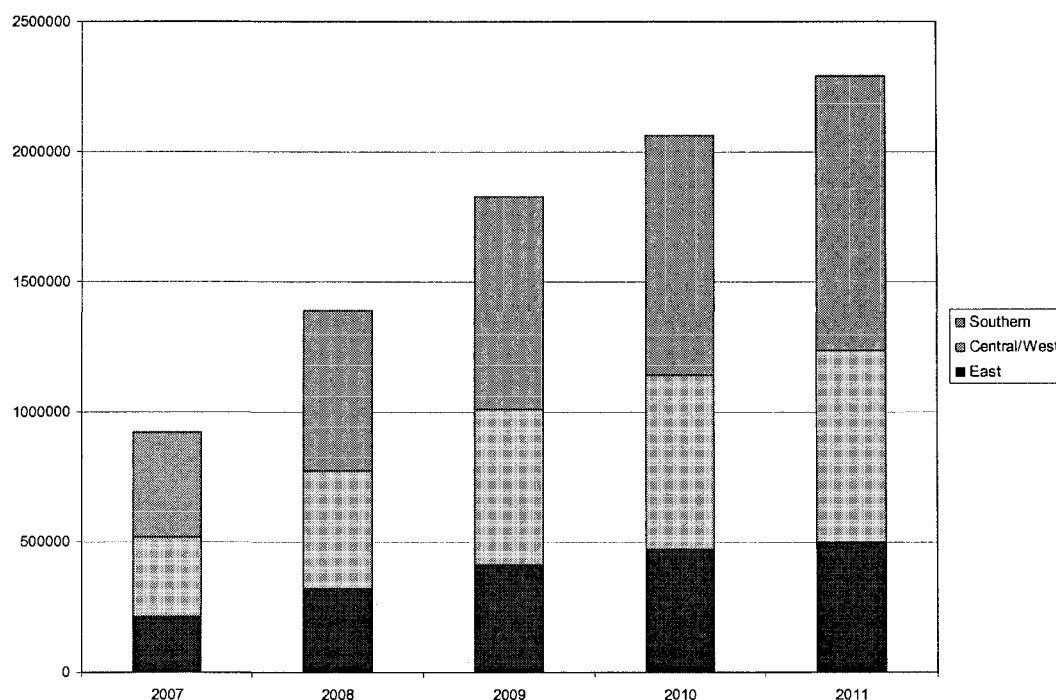
Source: Bollinger and Stover (2007)

### 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 over 3.5 million to approximately 1.25 million by 2011. The total numbers of HIV-positive people would decline from 28 million to 22 million. 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 US\$3,000 in 2007 to about US\$2,000 by 2011 (more on the cost effectiveness of different prevention interventions below). It is also crucial to note that prevention interventions entail large benefits in terms of treatment costs avoided. In fact, Bollinger and Stover (2007) estimate overall cost savings of US\$6,570 per HIV infection averted in the Region. Some authors have discussed the possibility of increased risk behavior due to “complacency” effects associated with treatment availability (Revenge et al., 2006).



**Figure 11: Infections Averted Due to Prevention Efforts in sub-Saharan Africa 2007-2011**



Source: Bollinger and Stover (2007)

## Cost Effectiveness of Prevention Interventions

Results from ten different country-specific applications of the Goals model were used to calculate (unweighted) average impacts for ten different interventions: community mobilization, mass media, voluntary counseling and testing (VCT), interventions for sex workers, interventions for men who have sex with men (MSM), in-school youth programs (Education), blood safety, condom distribution, STI treatment, workplace programs, and programs to prevent 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 ten interventions listed one at a time (and subsequently replaced), so that the marginal impact of the intervention could be measured.

The tables below classify interventions by their relative cost-effectiveness ratios, as well as by their relative impact in terms of percentage of total infections averted. There are three categories of cost per infection averted: Low (<US\$1,000), Medium (US\$1,000 – US\$3,000), and High (>US\$3,000) and three categories for impact: Low (0-10% of total infections averted), Medium (10-20% of total infections averted), and High (>20% 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 of time.

**Table 13 & 14: Cross-classification of Interventions by Cost-effectiveness and Impact**

Cross-classification of Interventions by Cost-effectiveness and Impact For East/Southern Africa			
	Impact (% of infections averted)		
Cost per infection averted	Low (0-10%)	Medium (10-20%)	High (>20%)
Low (< \$1,000)	CSW MSM	PMTCT	Blood
Medium (\$1,000 - \$3,000)	Comm. Mobilization VCT Education	Condom Dbn	
High (> \$3,000)	Mass Media STI Treatment Workplace		

Source: Bollinger &amp; Stover (2007)

Cross-classification of Interventions by Cost-effectiveness and Impact For Central/West Africa			
	Impact (% of infections averted)		
Cost per infection averted	Low (0-10%)	Medium (10-20%)	High (>20%)
Low (< \$1,000)	CSW MSM	PMTCT	Blood
Medium (\$1,000 - \$3,000)	Comm. Mobilization VCT Education	Condom Dbn	
High (> \$3,000)	Mass Media STI Treatment Workplace		

Source: Bollinger &amp; Stover (2007)

Both tables indicate that interventions targeting sex workers across all of sub-Saharan Africa are very cost-effective, with costs per infection averted of less than US\$1,000. Interventions for sex workers 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/Southern Africa, where HIV prevalence rates are higher and have a substantial impact on the number of total infections averted. In Central/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/Southern Africa are mass media, STI treatment<sup>5</sup>, and workplace programs, while the corresponding interventions in Central/West Africa are community mobilization, mass media, sexually transmitted infections 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 sex workers and men who have sex with men (MSM). The table below presents a summary of other studies on the cost effectiveness of HIV prevention interventions in the region that broadly corroborates the results previously outlined. One should be careful when analyzing the results presented, as they do not imply that prevention interventions should be considered in an isolated way. It is more useful to think in terms of packages of interventions, in particular, interventions that are mutually supportive and present complementarities.

<sup>5</sup> 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.



**Table 15: Summary of Studies on Cost Effectiveness of HIV/AIDS Interventions in sub-Saharan Africa**

Intervention	Cost Effectiveness in 2001 US\$
VCT (Kenya and Tanzania)	270 to 376/HIV Infection 14 to 19 per DALY*
VCT (Chad)	891 to 5,213 / Infection 45 to 261 per DALY
Peer-Based Programs (Cameroon)	67 to 137/HIV Infection 3 to 7 per DALY
Condom Distribution and IEC (South Africa)	378 to 4,094/Infection 19 to 205 per DALY
Condom Social Marketing (Chad)	77 per HIV Infection 4 per DALY
STI Treatment (Kenya)	11 to 16 per HIV Infection 1 per DALY
STI Treatment (Tanzania)	326 per HIV Infection 16 per DALY
STI Treatment (South Africa)	2,093 per HIV Infection 105 per DALY
STI Treatment (Chad)	1,675 per HIV Infection 84 per DALY
ART for MTCT: Nevirapine (sub-Saharan Africa)	142 to 306/HIV Infection 6 to 12 per DALY
Blood Safety (Chad)	75 to 151/HIV Infection 4 to 8 per DALY
Blood Safety (Zimbabwe)	166 to 1,010/ Infection 8 to 51 per DALY
Blood Safety (Zambia)	215 to 262 /HIV Infection 11 to 13 per DALY
Sterile Injection (Africa)	91 to 230 per DALY

\*DALY: Disability Adjusted Life Years. Source: Bertozzi, S. et al. (2006)

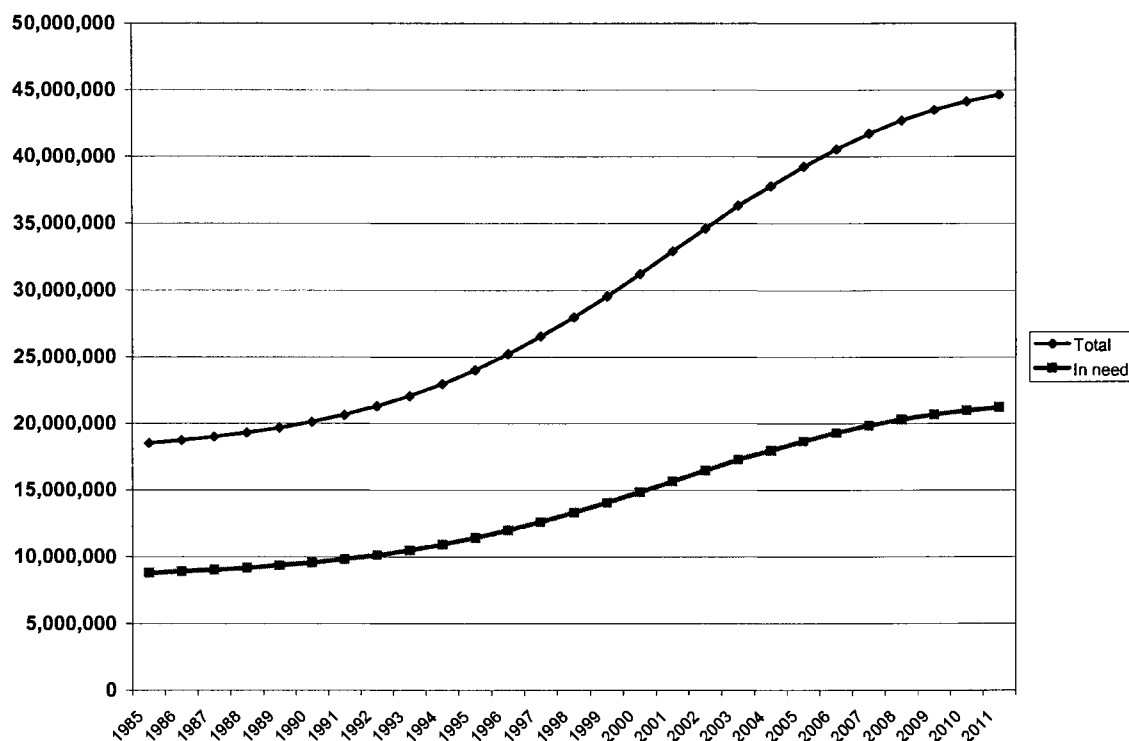
## Mitigation

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 poses 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 on the number of those in need of assistance<sup>6</sup>. According to the figure below, the number of OVC in need would increase from about 19 million in 2006 to over 21 million in 2011. It is important to note that there is a global consensus that all orphans and vulnerable children in need should be supported, not only those whose parents have died of AIDS, to mitigate any stigma that might develop otherwise.

<sup>6</sup> The population in need is defined as all double orphans and vulnerable children, along with half of single orphans, who live in households under the poverty line.



**Figure 12: Number of OVC in sub-Saharan Africa**



Source: Bollinger and Stover (2007)

## References

Bertozi, S. et al. (2006) "HIV/AIDS Prevention and Treatment" in Jamison et al. (eds.) "Disease Control Priorities in Developing Countries" 2nd Edition World Bank and Oxford University Press, New York: NY.

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## ANNEX 3 – MAP Achievements

*Table 16: Systems Strengthening*

<b>SYSTEMS STRENGTHENING</b>	
Percentage increase in development partner funding	2,240%
MAP management integrated into NAC functions	59%
<b>Outputs to which MAP Contributed</b>	
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
<b>HIV PREVENTION</b>	
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)
<b>HIV CARE AND TREATMENT</b>	
Number of sites providing ART	3,012 (26 countries)
Total # of people on ART	554,648 in total (27 countries) (26,699 with MAP funding)
Number of PLWH treated for opportunistic infections	287,805 (20 countries)
<b>IMPACT MITIGATION</b>	
Number of infected/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)
<b>MONITORING AND EVALUATION (M&amp;E)</b>	
Average number of surveys/surveillance per country before MAP	2
Current average number of surveys/surveillance	4

Source: Görgens-Albino et al. (2007) "The Africa Multi-Country AIDS Program 2000-2006: Results of the World Bank's response to a development crisis" World Bank, May Washington: DC

**Table 17: Outcome Level Results to which MAP Has Contributed**

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

Source: Görgens-Albino et al. (2007) "The Africa Multi-Country AIDS Program 2000-2006: Results of the World Bank's response to a development crisis" World Bank, May Washington: DC



## ANNEX 4 – Africa Response to HIV/AIDS: A Chronology of Events

**Table 18: Africa Response to HIV/AIDS, A Chronology of Events**

Timeline	Action Taken
<b>Pre-1997</b>	Bank's response constrained internally and externally by low demand for Bank's assistance and Bank's internal focus on health sector reforms during this period.
<b>1997</b>	The HNP strategy contained no discussion of AIDS except in a remote annex in the context of emerging diseases. A Bank policy research report, <i>Confronting AIDS: Public Priorities in a Global Epidemic</i> , highlighted the economic impact of AIDS.
<b>1998</b>	Africa RVPs called for new strategy for region in light of emerging data on development impact of AIDS.
<b>July 1999</b>	AIDS Campaign Team for Africa (ACTafrica) established to support and coordinate the Bank's multi-sectoral response. It was placed in the office of the RVP and staffed with seconded multi-sectoral staff. Weekly Regional Leadership Team meetings regularly discussed AIDS. Accountability mechanisms were established requiring Country Directors to report regularly on AIDS activities. AIDS incorporated in Bank's instruments and procedures such as safeguards.
<b>1999</b>	The Bank adopted <i>Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis</i> to address the growing HIV/AIDS epidemic in Africa.
<b>1999</b>	AIDS activities added to existing projects in country portfolios and sectors other than health, such as education, transport, rural development, social protection. Retrofitting had mixed results because amounts were often too small to impact the spreading epidemic.
<b>January 2000</b>	World Bank President addressed the UN Security Council and called for a "War on AIDS."
<b>April 2000</b>	ACTafrica published its cross country analysis of economic impact, which was picked up by "Economics Focus" in the Economist. AIDS was top agenda item for the Spring Meetings.
<b>September 2000</b>	The Bank's Board approved a Multi-Country AIDS Program for Africa (MAP), a 10-15 year program to intensify multi-sector action against AIDS and build political commitment. MAP defined eligibility criteria to raise political commitment and mobilization at country level.
<b>February 2002</b>	MAP 2 approved with \$500 million funding to pilot test antiretroviral therapy and support cross-border initiatives. IDA 13 provided grants in support of HIV/AIDS.
<b>January 2003</b>	Implementation Acceleration Team 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.
<b>October 2004</b>	ACTafrica commissioned an <i>Interim Review of MAP</i> which basically confirmed validity of the MAP approach, highlighted progress made and suitability of interventions, and identified ways for future improvement.
<b>July 2004</b>	ACTafrica moved to AFTQK for mainstreaming with quality assurance of HIV operations and knowledge generation and sharing.
<b>2005</b>	OED evaluated the World Bank's global assistance for HIV/AIDS and issued its report.
<b>2005</b>	AFTQK established an escrow account to support problem projects and encouraged all HIV projects to utilize this fund to address challenges.
<b>April 2006</b>	The Africa Region reviewed all active HIV projects in collaboration with HDNGA, AFTHD, LEGAF, and HDNGA to assess implementation risks and opportunities to incorporate recommendations from the MAP interim review and OED evaluation.
<b>May 2006</b>	ACTafrica and HDNGA conducted MAP TTL training on monitoring and evaluation and appropriate indicators.
<b>August 2006</b>	The Africa Region established a core team to review and lead the work on restructuring (retrofitting) projects for improved performance and incorporate recommendations from MAP interim review and OED evaluation. Led by ACTafrica and AFTHD, the core team includes LEGAF, LOA, HDNGA (GAMET) and AFTRL.



Timeline	Action Taken
<b>October 2006</b>	Africa Region and HDNGA (GAMET) finalized a Generic Results Framework (GRF) and Results Score Card for all HIV projects inclusive of IDA-14 and UNGASS indicators, Africa Action Plan indicators and indicators from national M&E plans.
<b>2006 - Ongoing</b>	ACTafrica 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/ACTafrica further intensified monitoring and evaluation assistance in support of donor harmonization and alignment and strengthening of national AIDS strategies and plans through ASAP.
<b>2006 - Present</b>	Africa Region began updating its 1999 HIV/AIDS strategy and developing an <i>Africa AIDS Agenda for Action for 2007-2011</i> . Consultations are ongoing with civil society, donors, stakeholders and countries, trade unions, UN agencies, private sector, youth, women's groups, global health partners working on sexual and reproductive health and Tuberculosis and Malaria.
<b>February 2007</b>	Umbrella restructuring proposal of MAP projects was presented to the 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.
<b>April 2007</b>	Progress on <i>Africa AIDS Agenda for Action 2007-2011</i> was presented as part of the Africa Action Plan update during Annual Spring meetings.

## ANNEX 5 – Agenda for Action Consultations

Table 19: Agenda for Action Consultations

Event	Overview	Broad Priority Areas	Bank Comparative Advantage	Specific Themes For Bank	Bank Resources And Institutional Structure	Bank Weaknesses
<b>Toronto Stakeholder Consultations with Panelists (August 13, 2006)</b>	HIV/AIDS a development issue and a priority MDG responsibilities Multi-sectoral engagement	"Three Ones" support Alignment and harmonization with other partners	Multi-year, sustainable financing	Local response and prevention experience Integrated health sector engagement National capacity strengthening Regional programs and emergency responses Analytical capacity	"Financial gap" provider, utilizing its various financing response instruments HQ and field presence to support national HIV/AIDS deliberation and response	Apparent insufficient commitment/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
<b>ASAP Consultations with UNAIDS (August 17, 2006)</b>		Alignment and harmonization with other partners		National capacity strengthening	HQ and field presence to support national HIV/AIDS deliberation and response	Absence of engaged field presence, technical expertise
<b>TTL Consultations (September 18, 2006)</b>	MDG responsibilities Multi-sectoral engagement Knowledge management and analytical capacity Convening power	Alignment and harmonization with other partners	Africa-wide MAP experience Multi-sectoral approach National capacity strengthening experience	Local response and prevention experience Integrated health sector engagement Scaling up good practices	"Financial gap" provider, utilizing its various financing response instruments HQ and field presence to support national HIV/AIDS deliberation and response	Apparent insufficient commitment/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 BB support results in reduction of Bank HIV/AIDS support Insufficient awareness of reputational risks and governance considerations





Event	Overview	Broad Priority Areas	Bank Comparative Advantage	Specific Themes For Bank	Bank Resources And Institutional Structure	Bank Weaknesses
UNAIDS/East and Central Africa (September 23, 2006)	Macro-economic access and dialogue Knowledge management and analytical capacity Convening power	*Three Ones* commitment Alignment and harmonization with other partners Fulfill donor of last resort as to inadequately treated and/or sensitive issues and marginalized groups	Multi-year, sustainable financing National capacity strengthening experience	Local response and prevention experience Regional programs and emergency responses Analytical work	Financial gap provider, utilizing its various financing response instruments	Absence of engaged field presence, technical expertise Rigidity of fiduciary rules Need for a significant presence in southern Africa
UN Agencies with NY HQ (September 28, 2006)	MDG responsibilities Macro-economic access and dialogue Convening power	Fulfill donor of last resort as to inadequately treated and/or sensitive issues and marginalized groups	Africa-wide MAP experience National capacity strengthening experience	Local response and prevention experience Integrated health sector engagement Regional programs and emergency responses	Financial gap provider, utilizing 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
GFATM/Geneva (October 2, 2006)	MDG responsibilities Macro-economic 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	Local response and prevention experience Integrated health sector engagement		Rigidity of fiduciary rules
UNAIDS/Geneva a (October 2, 2006)	Macro-economic access and dialogue Multi-sectoral 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 Multi-year, sustainable financing	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 sub-national levels		Apparent insufficient commitment/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)

Event	Overview	Broad Priority Areas	Bank Comparative Advantage	Specific Themes For Bank	Bank Resources And Institutional Structure	Bank Weaknesses
<b>WHO/Geneva (October 3, 2006)</b>	Macro-economic access and dialogue Multi-sectoral/dimension 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 Multi-year, sustainable financing Fiduciary expertise	Integrated health sector engagement		Rigidity of fiduciary rules Africa MAP was isolated from other partner efforts
<b>UNHCR/Geneva (October 3, 2006)</b>	Multi-sectoral engagement Convening Power, especially in inherently risky countries and environments	Alignment and harmonization with other partners	Multi-year, sustainable financing	Regional programs and emergency responses Local response and prevention experience, in particular in income generation activities		Apparent insufficient commitment/priority by Bank to long-term HIV/AIDS effort in refugee environments
<b>Nairobi Regional Consultations on Civil Society Response (May 8-11, 2006)</b>	Multi-sectoral/dimension engagement Macro-economic 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)	Multi-year, sustainable financing National capacity strengthening experience, including strategic plans and action plans	Scaling up good practices Local response and prevention experience Regional programs and emergency responses Integrated health sector engagement	Financial gap provider, utilizing its various financing response instruments, particularly for civil society HQ and field presence to support national HIV/AIDS deliberation and response	Apparent insufficient commitment/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.





Event	Overview	Broad Priority Areas	Bank Comparative Advantage	Specific Themes For Bank	Bank Resources And Institutional Structure	Bank Weaknesses
<b>Donor Consultations (London, October 23, 2006)</b>	<p>Convening power</p> <p>Macro-economic access and dialogue (PRSP, MTEF)</p> <p>Knowledge management and analytical capacity</p> <p>Capacity to consider the multi-sectoral dimensions/engagement</p>	<p>Alignment and harmonization with other partners, particularly with the GFATM, and especially in the health sector</p>	<p>National capacity strengthening experience, including technical assistance and training, in various aspects, including strategic plans and action plans</p> <p>Support to national AIDS institutions, especially in costing, fiduciary and M&amp;E</p> <p>Multi-sectoral approach via mainstreaming or integrating HIV/AIDS into sector policies and programs, and development of sectoral or topic specific guidelines</p>	<p>Analytical work (including analysis of the financial consequences of "universal access")</p> <p>Scaling up good practices</p> <p>Local response (civil society, private sector, NGOs)</p> <p>and prevention experience</p> <p>Regional programs and emergency responses</p> <p>Integrated health sector engagement</p>	<p>As an important financier, utilize its various financing response instruments, particularly for civil society</p> <p>IDA-15 represents an opportunity to revisit the ways and means to maintain Bank involvement and momentum in responding to HIV/AIDS</p>	<p>Apparent insufficient commitment/priority by Bank to long-term HIV/AIDS effort, coupled with current absence of key management leadership</p> <p>Absence of engaged field presence, with technical expertise, and continuity to engage in country dialogue</p> <p>Uncertain extent to which GTT recommendations have been adopted/embedded in Bank approach</p> <p>Need for a significant presence in Southern Africa</p> <p>Neither mainstreaming nor budget support translating into HIV/AIDS resources</p> <p>Absence of "ring-fenced financing" and BB support results in reduction of Bank HIV/AIDS support</p>

Event	Overview	Broad Priority Areas	Bank Comparative Advantage	Specific Themes For Bank	Bank Resources And Institutional Structure	Bank Weaknesses
<b>Countries and Youth (Johannesburg, February 2007)</b>	<p>Accelerating attention to and implementation of youth activities</p> <p>Improved integration of adolescent HIV and sexual reproductive health services</p> <p>Multi-sectoral engagement</p>	<p>Effective approaches and partnerships for addressing youth</p> <p>Strengthen linkages between adolescent reproductive health and HIV services</p> <p>Strengthen M&amp;E and the evidence base for youth-friendly services and interventions</p> <p>Alignment and harmonization with other partners</p>	<p>Advocate for mainstreaming of youth in government budget lines and national frameworks</p> <p>Be a knowledge bank</p> <p>Convening authority for dialogue with development partners and government</p> <p>Work with regional establishments</p>	<p>Enhance youth capacity on development concepts, agendas, and frameworks e.g., PRSPs, budgeting, monitoring and accountability</p> <p>Advocate flexibility in registration and mechanisms for youths to access resources</p> <p>Take leadership to bring key groups together and give a voice to youth</p> <p>Intensify analytical work, document and disseminate best practices and lessons learned</p>		<p>Lack of specific focus on youth HIV interventions</p> <p>Lack of segmentation catering to varying needs of different youth groups – limited attention to rural youth and gender differentiation</p> <p>Inadequate consideration of the 10-14 age group</p> <p>Weak youth participation in policy and programming decisions</p>



## ANNEX 6 – Agenda for Action: Implementation Plan and Results Framework

Table 20: The Foundation - Renew the Commitment

The Foundation: Renew the Commitment					
Specific Objectives	Specific Actions	Indicators	Anticipated Results	Critical Risks	Accountability <sup>7</sup>
<b>0.1. Respond to country demand for predictable, flexible and sustainable IDA financing for HIV/AIDS.</b>	<p><b>0.1.1</b> Sustained support for HIV/AIDS to fill financial gaps for the next five years.</p> <p><b>0.1.2</b> Provide safety net financing for countries in the context of creating fiscal space for HIV/AIDS.</p>	<ul style="list-style-type: none"> <li>• At least \$250 million committed annually for the next 5 years, including IDA, PRSCs, ACGF, and IDF</li> <li>• Financing gap studies completed in at least 10 countries (IDA and non-IDA)</li> </ul>	<ul style="list-style-type: none"> <li>• Predictable, flexible and sustainable IDA financing for HIV/AIDS provided</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of IDA financing</li> <li>• Financing from other development partners remains unpredictable and volatile</li> <li>• Low country demand for IDA financing due to competing priorities</li> </ul>	AFRLT (Regional Leadership Team), HDNGA, ACTafrica PREM, IMF
<b>0.2. High-burdened middle-income countries' access to technical and/or financial assistance increased.</b>	<p><b>0.2.1</b> Provide innovative financing to IBRD countries e.g., buydowns.</p> <p><b>0.2.2</b> IDF grant financing provided for capacity building.</p> <p><b>0.2.3</b> Analytical work on macro impact and regional and cross-border issues.</p> <p><b>0.2.4</b> Conduct strategic analysis to identify new lending instruments that are attractive to IBRD countries and focused on increasing lending for HIV/AIDS.</p>	<ul style="list-style-type: none"> <li>• Number of countries where the Bank responds to country demands and supports AIDS responses through grants, loans, blended instruments and/or knowledge support, policy dialogue and capacity building</li> <li>• Number of analytical studies completed</li> </ul>	<ul style="list-style-type: none"> <li>• Technical and financial assistance accessible to high-burdened middle-income countries</li> <li>• Effective policy dialogue</li> <li>• Effective partnerships</li> <li>• Cross regional/country learning</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of instruments to engage high-burdened MICs</li> <li>• Weak donor commitment to support innovative financing in middle income countries</li> <li>• Continued scarce financing from other donors in MICs</li> </ul>	AFRLT, ACTafrica

<sup>7</sup> World Bank Unit acronym definitions available on request.



The Foundation: Renew the Commitment					
Specific Objectives	Specific Actions	Indicators	Anticipated Results	Critical Risks	Accountability <sup>7</sup>
<b>0.3. Support to sub-regional and cross-border initiatives provided.</b>	<p><b>0.3.1</b> Provide financing to countries, including post-conflict countries, for regional HIV/AIDS response.</p> <p><b>0.3.2</b> Design regional cross-border projects that address vulnerable populations, e.g., refugees and IDPs.</p>	<ul style="list-style-type: none"> <li>At least 2 new sub-regional operations approved in the next 5 years</li> </ul>	<ul style="list-style-type: none"> <li>Improved HIV/AIDS awareness and prevention efforts through sub-regional and cross-border initiatives</li> <li>Realization of externalities</li> <li>Positive spill over effects for more effective customs procedures and clearances</li> </ul>	<ul style="list-style-type: none"> <li>Lack of grant financing</li> <li>Weak institutional capacity at regional level</li> <li>Lack of commitment to sub-regional initiatives</li> </ul>	AFRLT, ACTafrica, AFTHD AFCRI
<b>0.4. Africa HIV Incentive Fund to provide support for project/program development, policy advice and capacity building created.</b>	<p><b>0.4.1</b> Obtain financing for Africa HIV/AIDS incentive fund for analysis, policy advice and capacity building in project/program preparation.</p> <p><b>0.4.2</b> Use the funds to conduct policy dialogue, analytical work and capacity building in line with the AAP and CDMAP. Assist teams to design HIV/AIDS interventions in sectoral investments.</p>	<ul style="list-style-type: none"> <li>Incentive fund finances 5 technical support products per year</li> <li>Mainstreaming guidelines developed for different sectors</li> <li>Number of sectoral projects with HIV/AIDS components</li> </ul>	<ul style="list-style-type: none"> <li>Critical analysis and policy guidance achieved</li> <li>Scaled-up multi-sectoral responses in key sectors</li> </ul>	<ul style="list-style-type: none"> <li>Lack of grant funding</li> <li>Weak Bank commitment</li> <li>Lack of commitment to a multi-sectoral response</li> </ul>	ACTafrica, CDMAP
<b>0.5. Bank's senior management commitment to HIV/AIDS renewed through inclusion and action in all channels of policy dialogue.</b>	<p><b>0.5.1</b> Bank's senior management reiterates commitment through speeches, memos and discussions with partners.</p> <p><b>0.5.2</b> HIV/AIDS continues to be a flagship program in the Africa Action Plan.</p> <p><b>0.5.3</b> Engage high-level policy makers to advocate for HIV/AIDS response.</p>	<ul style="list-style-type: none"> <li>HIV/AIDS included in senior management speeches and discussions with partners</li> </ul>	<ul style="list-style-type: none"> <li>Senior Management speeches related to the Bank's commitment to combating HIV/AIDS reflected in national and/or international media</li> </ul>	<ul style="list-style-type: none"> <li>Competing priorities</li> <li>Senior management fails to enforce commitment through regular reporting from CMUs on how HIV/AIDS is being addressed and on harmonizing HIV/AIDS efforts</li> </ul>	AFRLT, EXT, WBI, UNDP, UNAIDS



Table 21: Pillar 1 -Strengthened Long-Term Sustainable National Response

Pillar I: Strengthened Long-Term Sustainable National Response						
Pillar I:	Specific Objectives	Specific Actions	Indicators	Anticipated Results	Critical Risks	Accountability
<b>Focus the Response, through Evidence-Based and Prioritized HIV/AIDS Strategies</b>	<b>1.1. Appropriate HIV/AIDS efforts integrated into countries' development agendas and Bank instruments (policy procedures).</b>	<b>1.1.1</b> Review at least 10 CASS and ISNs and 6 PRSPs to ensure HIV/AIDS is appropriately addressed. <b>1.1.2</b> Assure appropriate priority to HIV/AIDS in PRSPs. <b>1.1.3</b> Bank support to incorporate HIV/AIDS into guidelines and processes for preparing Medium-Term Expenditure Frameworks and annual budgets.	<ul style="list-style-type: none"> <li>HIV/AIDS included in all PRSCs</li> <li>HIV/AIDS integrated into at least 75% of PRSPs, CASS and ISNs prepared each year</li> <li>Develop relevant tools to design MTEF</li> </ul>	<ul style="list-style-type: none"> <li>HIV/AIDS addressed appropriately through countries' and Bank development agenda</li> </ul>	<ul style="list-style-type: none"> <li>Lack of management leadership</li> <li>Declining political commitment</li> <li>Fiscal space issues and long-term financial sustainability issues not adequately addressed.</li> <li>Poor coordination between IDA and IMF</li> </ul>	AFRLT, ACTafrica, WBI, UNDP, HDNGA, PREM, IMF
	<b>1.2. Bank support to developing prioritized responses to diverse epidemics provided.</b>	<b>1.2.1</b> Assist countries to analyze epidemics and optimal responses. <b>1.2.2</b> Provide financial, technical and analytical support to countries to understand country epidemics, including the drivers of the epidemic and to establish surveillance systems. <b>1.2.3</b> Conduct sub-regional epidemiological studies.	<ul style="list-style-type: none"> <li>5 countries where epidemiological studies have been conducted and potential responses formulated</li> </ul>	<ul style="list-style-type: none"> <li>Improved evidence-based country responses to differing epidemics</li> </ul>	<ul style="list-style-type: none"> <li>Lack of country level and Bank expertise in supporting analytical work, as well as an adequate budget</li> </ul>	ACTafrica, AFTHD, HDNGA
	<b>1.3. Bank support in capacity building to develop prioritized, and costed national strategies and action plans provided.</b>	<b>1.3.1</b> Support and build capacity in 20 countries to develop prioritized, costed national strategies and annual action plans. <b>1.3.2</b> Provide technical support to countries for developing national strategic planning. <b>1.3.3</b> Provide technical, financial and analytical support for better country-specific HIV/AIDS program planning.	<ul style="list-style-type: none"> <li>20 countries over the next 5 years have the capacity to develop prioritized and costed strategies</li> </ul>	<ul style="list-style-type: none"> <li>Strengthened capacity to develop prioritized and costed national action plans in 20 countries</li> </ul>	<ul style="list-style-type: none"> <li>Unpredictable donor financing to support national programs</li> <li>Lack of expertise for strategic planning and costing work</li> <li>Weak capacity for planning and program design</li> </ul>	HDNGA, ASAP, UNAIDS, ACTafrica



Pillar I: Strengthened Long-Term Sustainable National Response						
Pillar I:	Specific Objectives	Specific Actions	Indicators	Anticipated Results	Critical Risks	Accountability
<b>Focus the Response, through Evidence-Based and Prioritized HIV/AIDS Strategies</b>	<b>1.4. Integration of TB, reproductive health, malaria and nutrition into World Bank HIV/AIDS products ensured.</b>	<b>1.4.1</b> Conduct operational research on integrating services within epidemiological context. <b>1.4.2</b> Ensure that the WB HIV/AIDS products address integration of TB reproductive health, malaria and nutrition. <b>1.4.3</b> Actively participate in inter-agency working groups on integrating HIV and RH, and HIV and TB.	<ul style="list-style-type: none"> <li>At least 60% of new HIV/AIDS operations have an integrated approach to SRH, TB and malaria</li> <li>3 country assessments would be conducted and action plans to integrate TB, malaria and HIV developed</li> <li>Intensify efforts in 9 high-TB-burden countries as well as high-burden HIV/AIDS countries</li> <li>Good practices on integration will be documented and disseminated</li> </ul>	<ul style="list-style-type: none"> <li>World Bank projects addressing HIV/AIDS integrate TB, reproductive health, malaria and nutrition when appropriate to epidemiological context</li> </ul>	<ul style="list-style-type: none"> <li>Lack of technical expertise and/or incentives to integrate</li> <li>Institutional structures with different vertical units in MOH</li> <li>Donor procedures that hinder integration</li> </ul>	HDNGA, ACT <i>africa</i> , AFTHD, WHO, UNFPA, UNICEF
	<b>1.5. Good practices in HIV/AIDS programs based on operational research shared.</b>	<b>1.5.1</b> Conduct operations research, including cost-effectiveness studies, on success and failures in HIV/AIDS programs.	<ul style="list-style-type: none"> <li>At least 5 operational studies over the next five years</li> </ul>	<ul style="list-style-type: none"> <li>Operational research and documentation of good practices in HIV/AIDS programs widely shared with countries and development partners</li> </ul>	<ul style="list-style-type: none"> <li>Lack of financing to conduct operations research</li> </ul>	AFTHD, AFTQK, ACT <i>africa</i> , HDNGA



Table 22: Pillar II - Accelerated Implementation of HIV/AIDS Programs

Pillar II: Accelerated Implementation of HIV/AIDS Programs						
Pillar II:	Specific Objectives	Specific Actions	Indicators	Anticipated Results	Critical Risks	Accountability
Scale-up targeted multi-sectoral and civil society response	<b>2.1 HIV/AIDS policy, programs and service delivery integrated in priority sectors (dependent upon country context).</b>	<p><b>2.1.1</b> Strengthen sectoral institutional capacity to scale up and supervise HIV/AIDS-related activities.</p> <p><b>2.1.2</b> Conduct operational research on multi-sectoral prevention, including pilot testing of promising approaches.</p> <p><b>2.1.3</b> In collaboration with the IFC, support capacity building in the private sector to scale up its response.</p>	<ul style="list-style-type: none"> <li>Number of countries where Bank supports institutional capacity building activities in priority sectors</li> <li>At least 2 operational research studies documenting promising approaches to on multi-sectoral prevention</li> </ul>	<ul style="list-style-type: none"> <li>Improved country capacity in key sectors to implement multi-sectoral approaches</li> <li>Increased commitment in key Bank sectors to include HIV/AIDS component or sub-components in lending and non-lending activities, including adequate resources</li> </ul>	<ul style="list-style-type: none"> <li>Lack of country commitment from key sectors, including inadequate resources</li> <li>Lack of clarity and guidance from Management as well as adequate budget to integrate HIV into sectoral activities</li> <li>Limited funds to conduct adequate supervision of HIV/AIDS components in other projects</li> </ul>	HDN, AFTHD, PREM, IFC, ACTAfrica, AFTPS, AFTEG, AFTTR, AFTU, AFTRL
	<b>2.2 Bank support to care and mitigation services through civil society organizations continued.</b>	<b>2.2.1</b> Support care and mitigation service providers through civil society organizations and build capacity of NGOs.	<ul style="list-style-type: none"> <li>Number of countries where HIV/AIDS care and mitigation services are supported by civil society</li> </ul>	<ul style="list-style-type: none"> <li>Capacity of NGOs and CBOs strengthened</li> <li>Civil society continues to be an integral part of the national solution to address HIV/AIDS</li> </ul>	<ul style="list-style-type: none"> <li>Lack of government interest to engage civil society</li> </ul>	ACTAfrica, CMUs, AFTHD, Other donors
	<b>2.3 Bank support to address HIV-related gender inequality issues.</b>	<p><b>2.3.1</b> Support analytical work to identify specific actions which would contribute to changing inappropriate gender responses to the epidemic.</p> <p><b>2.3.2</b> 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.</p>	<ul style="list-style-type: none"> <li>5 pieces of analytical work</li> <li>At least two knowledge-sharing events conducted on the gender dimensions of HIV/AIDS</li> <li>Develop appropriate M&amp;E indicators</li> </ul>	<ul style="list-style-type: none"> <li>Increased awareness of specific steps to designing and implementing gender-appropriate HIV interventions</li> <li>Analytical work in the sectors address gender inequalities</li> </ul>	<ul style="list-style-type: none"> <li>Lack of country commitment to implementing specific actions to address HIV-related gender inequalities</li> <li>Lack of support from Bank management to dedicate time and resources to operational research or implementation of gender-specific responses</li> </ul>	PREMGE, AFTPM, ACTAfrica, AFTQK, HDNGA, AFTHD, WBI IFC, AFTPS, AFTEG, AFTTR, AFTU, AFTRL



Pillar II: Accelerated Implementation of HIV/AIDS Programs						
Pillar II:	Specific Objectives	Specific Actions	Indicators	Anticipated Results	Critical Risks	Accountability
<b>Scale-up targeted multi-sectoral and civil society response</b>	<b>2.4. Bank support to prevention and programs for youth and OVCs intensified.</b>	<p><b>2.4.1</b> 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.</p> <p><b>2.4.2</b> Collaborate with the Bank's Social Protection sector to scale up mitigation efforts and conduct analytical work on orphans and affected families.</p>	<ul style="list-style-type: none"> <li>Number of countries where Bank supports youth and OVCs</li> </ul>	<ul style="list-style-type: none"> <li>All education and social protection sector investments include HIV/AIDS prevention, mitigation, social protection and support activities</li> </ul>	<ul style="list-style-type: none"> <li>Lack of country leadership in the education sector</li> <li>Stigma continues</li> </ul>	HDNED, ACTafrica, AFTSP, HDNSP Children and Youth Group, UNFPA, UNESCO, UNICE, UNAIDS
	<b>2.5 Support to strengthen elements of the health system that challenge HIV/AIDS programs.</b>	<b>2.5.1</b> Through the implementation of the 2007 HNP strategy to strengthen health systems, support provided to human resources, supply chain management, M&E, and health infrastructure, especially laboratory and pharmaceutical services.	<ul style="list-style-type: none"> <li>At least 50% of new HIV/AIDS operations address and support health system challenges vis-à-vis HIV/AIDS</li> <li>60% of HNP operations address health system challenges</li> </ul>	<ul style="list-style-type: none"> <li>Improved synergy between HNP and HIV/AIDS operations</li> </ul>	<ul style="list-style-type: none"> <li>Lack of collaboration between MOH and National AIDS Commissions on resource allocation for health systems</li> <li>Agreement on a clear division of labor within the Bank as well as with its partners.</li> <li>Health systems do not adequately address all implementation constraints, e.g., fiduciary and supply chain management</li> </ul>	HDNHE, AFTHD WHO UNFPA, UNICEF, ACTafrica



Pillar II: Accelerated Implementation of HIV/AIDS Programs						
Pillar II:	Specific Objectives	Specific Actions	Indicators	Anticipated Results	Critical Risks	Accountability
Scale-up targeted multi-sectoral and civil society response	2.6 Bank support to known multi-sectoral prevention approaches and tools increased.	<p>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.</p> <p>2.6.2 Urban: continue efforts to support local governments' response to HIV/AIDS, including developing and updating monitoring and training tools and incorporating HIV/AIDS components in urban operations.</p>	<ul style="list-style-type: none"> <li>Number of key sector projects with AIDS components</li> </ul>	<ul style="list-style-type: none"> <li>Prioritized support to key public sector and non-public sector entities having maximum impact on the ground</li> </ul>	<ul style="list-style-type: none"> <li>Lack of adequate and technical resources to prepare and supervise AIDS components</li> <li>Sector Focal persons not identified</li> </ul>	ACTAfrica, IFC, AFTPS, AFTEG, AFTTR, AFTU, AFTHD, AFTRL
	2.7 Strengthen community response and evaluate its effectiveness.	<p>2.7.1 Provide technical support to HIV/AIDS projects to strengthen, simplify and focus community level interventions.</p> <p>2.7.2 Conduct social assessments and impact evaluation studies on community-based HIV/AIDS interventions, including identification of good practices.</p>	<ul style="list-style-type: none"> <li>Number of countries with revised and simplified community HIV/AIDS response guidelines and trained personnel</li> <li>Number of social/behavioral assessments and impact evaluations regarding the effectiveness of community based HIV/AIDS interventions</li> </ul>	<ul style="list-style-type: none"> <li>Capacity strengthened in designing and implementing decentralized multi-sectoral responses</li> <li>More effective community responses</li> </ul>	<ul style="list-style-type: none"> <li>Lack of absorptive capacity at the community level</li> <li>High fiscal costs and sustainability concerns</li> <li>National governments unwilling to directly fund communities.</li> <li>Lack of capacity at national and regional levels to train and support communities</li> </ul>	ACTAfrica, HDNGA, DEC, AFTSD



**Table 23: Pillar III - Strengthened National Systems**

<b>Pillar III: Strengthened National Systems</b> (Financial Management, Human Resources, Procurement, Supply Chains, Health And Social Systems)						
<b>Pillar III:</b>	<b>Specific Objectives</b>	<b>Specific Actions</b>	<b>Indicators</b>	<b>Anticipated Results</b>	<b>Critical Risks</b>	<b>Accountability</b>
<b>Deliver Effective Results through increased country M&amp;E capacity</b>	<b>3.1. Ongoing HIV/AIDS projects retrofitted with realistic goals and indicators.</b>	<b>3.1.1</b> Complete restructuring of MAP project development objectives and performance indicators. Technical support teams to support country project teams.	<ul style="list-style-type: none"> <li>13 ongoing projects reviewed and adjusted to realistic objectives and goals</li> </ul>	<ul style="list-style-type: none"> <li>Improved HIV/AIDS portfolio</li> <li>MAP projects evaluated on realistic goals and indicators</li> </ul>	<ul style="list-style-type: none"> <li>IEG and Africa region methodology in assessing project successes</li> <li>Weak country support to restructure</li> </ul>	ACTafrica, AFTQK
	<b>3.2. Harmonized M&amp;E frameworks at the country level strengthened.</b>	<b>3.2.1</b> Assist countries to establish monitoring systems. <b>3.2.2</b> Develop and implement project performance early warning system. <b>3.2.3</b> Institutionalize the use of HIV/AIDS Results Scorecard. <b>3.2.4</b> Conduct regional and national M&E training courses. <b>3.2.5</b> Train M&E specialists, building national capacity, gradually reducing the need for external support.	<ul style="list-style-type: none"> <li>8 additional countries supported over five years to establish a harmonized HIV/AIDS monitoring system</li> </ul>	<ul style="list-style-type: none"> <li>In the next 5 years, all countries have a functional, harmonized M&amp;E system reporting and using data</li> <li>Bank to continue to play a leading role (GAMET) in supporting countries</li> </ul>	<ul style="list-style-type: none"> <li>Availability of resources to support technical support</li> <li>Willingness of countries and partners to reduce number of indicators and implement the principle of the "Three Ones"</li> </ul>	HDNGA, ACTafrica, GAMET, UNAIDS
	<b>3.3. Countries' surveillance systems strengthened and epidemiologic studies conducted.</b>	<b>3.3.1</b> Conduct country epidemiology studies.	<ul style="list-style-type: none"> <li>5 country epidemiology studies conducted over five years</li> </ul>	<ul style="list-style-type: none"> <li>National systems strengthened for improved understanding of the drivers of the epidemic</li> </ul>	<ul style="list-style-type: none"> <li>Country commitment and demand for capacity building to strengthen surveillance</li> </ul>	ACTafrica, HDNGA
	<b>3.4. Bank studies of vulnerable groups in countries conducted.</b>	<b>3.4.1</b> Conduct analytical work and operations research on vulnerable population needs with the aim of informing policy dialogue. <b>3.4.2</b> Sharpen the HIV/AIDS support to ensure that vulnerable groups are appropriately targeted and their networks strengthened.	<ul style="list-style-type: none"> <li>3 analytical studies/operations research completed on best practices and cost-effective interventions</li> <li>Support 3 regional meetings with groups working with vulnerable groups</li> <li>3 operations research studies</li> </ul>	<ul style="list-style-type: none"> <li>Evidence-based responses developed</li> <li>Best practices disseminated</li> <li>Vulnerable group networks strengthened</li> </ul>	<ul style="list-style-type: none"> <li>Weak country commitment to work with vulnerable groups</li> <li>Weak capacity</li> <li>Stigma of vulnerable groups continues</li> </ul>	ACTafrica, HDNGA



<b>Pillar III: Strengthened National Systems</b> (Financial Management, Human Resources, Procurement, Supply Chains, Health And Social Systems)						
<b>Pillar III:</b>	<b>Specific Objectives</b>	<b>Specific Actions</b>	<b>Indicators</b>	<b>Anticipated Results</b>	<b>Critical Risks</b>	<b>Accountability</b>
67	<b>Deliver Effective Results through increased country M&amp;E capacity</b>	<b>3.5. Countries' existing governance structures, public sector management, and transparency mechanisms improved with demand for accountability at the community level generated.</b>  <b>3.5.1</b> Improve existing governance structures, public sector management and transparency mechanisms and generate demand for better accountability at the community level. <b>3.5.2</b> Assist countries strengthen fiduciary capacity. <b>3.5.3</b> Assist countries streamline administrative structures. <b>3.5.4</b> Integrate governance, accountability and anticorruption (GAC) into all new HIV/AIDS operations in collaboration with WBI.	<ul style="list-style-type: none"> <li>Assessment of select MAP projects on governance and accountability completed</li> <li>Institutional assessments conducted in 3 countries</li> <li>Training activities conducted in collaboration with WBI</li> </ul>	<ul style="list-style-type: none"> <li>Governance and accountability improved</li> <li>Demand for accountability generated at the grass roots</li> <li>Improved institutional capacity and governance structures</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate financial and technical resources</li> <li>Lack of country commitment to address corruption</li> </ul>	PREM, INT, AFTQK, HDNGA, ACTafrica, WBI, OPCS
	<b>3.6. Knowledge generation and sharing to improve prioritization, decision-making and program design supported.</b>	<b>3.6.1</b> Provide operational support in design and impact of HIV/AIDS interventions in sector investments. <b>3.6.2</b> Engage countries and partners in knowledge generation and sharing.	<ul style="list-style-type: none"> <li>One regional consultation per year to encourage cross-country learning</li> <li>Macro- economic analytical work and financial sustainability studies conducted</li> </ul>	<ul style="list-style-type: none"> <li>Design and impact of HIV/AIDS investments based on knowledge sharing</li> <li>Countries and partners fully engaged in knowledge generation and sharing</li> </ul>	<ul style="list-style-type: none"> <li>Continued financing for annual knowledge learning events in the region</li> <li>Coordination with other development partners.</li> </ul>	HDNGA, GAMET, ACTafrica, AFTQK, DEC, WBI
	<b>3.7. Good practice case studies to support cross country learning and knowledge sharing generated.</b>	<b>3.7.1</b> Prepare good practice notes that highlight examples of promising national responses to HIV/AIDS. <b>3.7.2</b> Develop and promote good practice guidelines by using selected case studies that illustrate common implementation constraints. <b>3.7.3</b> Support networks of program practitioners to exchange experiences, knowledge and practical advice on general operational issues.	<ul style="list-style-type: none"> <li>5 good practices notes on national responses</li> <li>2 workshops to share experiences</li> </ul>	<ul style="list-style-type: none"> <li>Improved country and cross-country learning</li> </ul>	<ul style="list-style-type: none"> <li>Available resources to identify good practices and disseminate them.</li> </ul>	GAMET, ACTafrica, AFTQK, AFTHD, TTLs, WBI



Table 24: Pillar IV - Strengthened Donor Coordination

Pillar IV: Strengthened Donor Coordination						
Strategic Pillar IV:	Specific Objectives	Specific Actions	Indicators	Anticipated Results	Critical Risks	Accountability
Harmonize Donor Collaboration	4.1. Collaboration with key partners to harmonize and strengthen national M&E systems, HR capacity, procurement and supply chains strengthened.	<p>4.1.1 Support countries extensively in areas where WB is designated lead technical organization.</p> <p>4.1.2 Work with key partners to harmonize and strengthen national M&amp;E systems, procurement and supply chains.</p> <p>4.1.3 Work with countries and Bank project teams to improve planning, budgeting, program design, financial management, disbursement, procurement and expenditure tracking.</p>	<ul style="list-style-type: none"> <li>• Comply with and report on Paris Declaration indicators</li> <li>• Number of PERs conducted which include an HIV/AIDS component.</li> <li>• Public sector management conducted</li> <li>• Proportion of countries with performance-based procedures</li> </ul>	<ul style="list-style-type: none"> <li>• Better implementation of the global division of labor</li> <li>• GAMET to continue to support countries to strengthen M&amp;E in close collaboration with other partners</li> </ul>	<ul style="list-style-type: none"> <li>• Partners' readiness to take actions to align and harmonize M&amp;E processes</li> </ul>	HDNGA, ACTAfrica, GAMET, AFTQK, PREM network, UNAIDS, GFATM, PEPFAR
	4.2. Joint planning and analytical work with UNAIDS and other partners increased.	<p>4.2.1 Conduct joint planning and analytical work with UNAIDS and other partners.</p> <p>4.2.2 Conduct strategic planning training courses to train national counterparts, Bank staff, development partners and consultants in strategic planning.</p> <p>4.2.3 Support country practitioners' networks to contribute to strategic planning.</p>	<ul style="list-style-type: none"> <li>• All countries moved towards joint annual national program reviews and planning</li> </ul>	<ul style="list-style-type: none"> <li>• More efficient, effective and sustainable HIV/AIDS resource allocation</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of country ownership in enforcing partners to move in this direction</li> <li>• Lack of donor commitment to harmonize</li> </ul>	HDNGA, ACTAfrica, WBI, AFTQK, UNAIDS, GFATM, PEPFAR
	4.3. Bank's participation in joint annual planning with partners increased.	<p>4.3.1 Advocate and assist practitioners' networks to contribute to strategic planning.</p> <p>4.3.2 Participate in joint annual partner meetings.</p>	<ul style="list-style-type: none"> <li>• Number of joint missions</li> <li>• Number of countries with one coordinating body</li> </ul>	<ul style="list-style-type: none"> <li>• Harmonized planning and implementation</li> </ul>	<ul style="list-style-type: none"> <li>• Willingness of Bank units to participate</li> <li>• Inability of donors to schedule joint activities</li> </ul>	WBI, HDNGA, ACTAfrica, GAMET, UNAIDS, GFATM, PEPFAR



## ANNEX 7 – HIV/AIDS Portfolio for Africa (1989-2007)

Table 25: Closed MAP and Stand Alone Projects

CLOSED MAP and STAND-ALONE PROJECTS						
Country	Project ID	Project Title	FY Approved	FY Closed	Closing Date	Committed*
Congo, DR	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
Benin	P073118	BJ-HIV/AIDS Multi-Sec APL (FY02)	2002	2007	9/15/2006	23.0
SUBTOTAL						422.8

Table 26: Closed Projects with HIV/AIDS Components

CLOSED PROJECTS WITH HIV/AIDS COMPONENTS**						
Country	Project ID	Project Title	FY Approved	FY Closed	Closing Date	Committed*
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
Cote 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
Gambia, The	P000825	GM-Participatory HNP SIL (FY98)	1998	2005	6/30/2005	3.1
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





CLOSED PROJECTS WITH HIV/AIDS COMPONENTS**						
Country	Project ID	Project Title	FY Approved	FY Closed	Closing Date	Committed*
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
Mali	P040650	Edu Sec Exp Prgm APL (FY01) - (PISE)	2001	2007	12/31/2006	6.3
Congo Republic	P074006	CG-Emerg Infrast Rehab & Living Cond Imp	2002	2007	1/31/2007	5.2
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						124.8
TOTAL CLOSED PROJECTS						547.6
NOTES:						
*Commitment amounts are in the dollar value at the time of approval.						
**Commitment amounts for projects with HIV/AIDS components reflect the HIV/AIDS component amount, not the entire project amount.						

Table 27: Active MAP and Stand Alone HIV/AIDS Projects

ACTIVE MAP and STAND-ALONE HIV/AIDS PROJECTS						
Country	Project ID	Project Title	Approval FY	Approval Date	Closing Date	Commitment*
Cameroon	P073065	CM-MultiSecal HIV/AIDS SIL (FY01)	2001	1/12/2001	6/30/2007	50.0
Kenya	P066486	KE-Decentr Reprod Hlth & HIV/AIDS (FY01)	2001	12/12/2000	6/30/2007	50.0
Burkina Faso	P071433	BF-HIV/AIDS Disaster Response APL (FY02)	2002	7/6/2001	6/30/2007	22.0
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	6/30/2007	17.0
Chad	P072226	TD-Pop & AIDS 2 (FY02)	2002	7/12/2001	9/30/2007	24.6
Madagascar	P072987	MG-MultiSec STI/HIV/AIDS Prev APL (FY02)	2002	12/14/2001	12/31/2007	20.0
Nigeria	P070291	NG-HIV/AIDS Prog Dev (FY02)	2002	7/6/2001	6/30/2007	90.3
Senegal	P074059	SN-HIV/AIDS Prevent & Control APL (FY02)	2002	2/7/2002	9/30/2007	30.0
Sierra Leone	P073883	SL-HIV/AIDS Response (FY02)	2002	3/26/2002	12/31/2007	15.0
Guinea	P073378	GN-Multi-Sectoral 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
Niger	P071612	NE-MultiSec STI/HIV/AIDS 2 (FY03)	2003	4/4/2003	6/30/2008	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, DR	P082516	ZR Multi-sectoral HIV/AIDS	2004	3/26/2004	1/31/2011	102.0
Congo Republic	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	12/31/2007	7.0
Malawi	P073821	MW-Multi-sectoral 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
Sub-Regional	P074850	3A-HIV/AIDS Abidjan Lagos Trnspt (FY04)	2004	11/13/2003	7/1/2007	16.6
Sub-Regional	P082613	3A-Regional HIV/AIDS Treatment Prj (FY04)	2004	6/17/2004	9/30/2007	59.8
Tanzania	P071014	TZ-HIV/AIDS APL (FY04)	2004	7/7/2003	9/30/2008	70.0
Angola	P083180	AO-HAMSET SIL (FY05)	2005	12/21/2004	6/30/2010	21.0
Burkina Faso	P088879	HIV/AIDS Disaster Response Supplement	2005	5/3/2005		5.0
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
Sub-Regional	P080406	3A-ARCAN SIL (FY05)	2005	9/22/2004	6/30/2009	10.0
Sub-Regional	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



ACTIVE MAP and STAND-ALONE HIV/AIDS PROJECTS						
Country	Project ID	Project Title	Approval FY	Approval Date	Closing Date	Commitment*
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		5.0
Ethiopia	P098031	ET-2nd Multi-Sectoral HIV/AIDS (FY07)	2007	3/8/2007	3/8/2007	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		50.0
Rwanda	P104189	RW-MultiSec HIV/AIDS - Additional Financing (FY07)	2007	2/1/2007		10.0
SUB-TOTAL						1,205.3

Table 28: Active Projects with HIV/AIDS Components\*\*

ACTIVE PROJECTS WITH HIV/AIDS COMPONENTS**						
Country	Project ID	Project Title	Approval FY	Approval Date	Closing Date	Commitment*
Guinea-Bissau	P035688	National Health Development Prog	1998	11/25/1997	12/31/2007	2.2
Cameroon	P048204	CM-CAPECE Env Oil TA (FY00)	2000	6/6/2000	11/30/2007	0.8
Rwanda	P045091	RW-Human Res Dev (FY00)	2000	6/6/2000	6/30/2008	8.0
Burundi	P064961	BI-Pub Works & Employ Creation (FY01)	2001	1/23/2001	12/31/2007	16.2
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 Republic	P073507	CG-Transp & Gov CB (FY02)	2002	2/7/2002	12/31/2007	1.0
Eritrea	P073604	ER-Emerg Demob & Reint ERL (FY02)	2002	5/16/2002	12/31/2007	7.8
Guinea	P050046	GN-Education for All APL (FY02)	2002	7/24/2001	12/31/2007	15.4
Mozambique	P001785	MZ-Roads & Bridges MMP (FY02)	2002	7/19/2001	6/30/2007	22.7
Mozambique	P069824	MZ Higher Education SIM (FY02)	2002	3/7/2002	12/31/2007	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	12/31/2007	3.3
Tanzania	P047762	TZ-Rural Water Sply (FY02)	2002	3/26/2002	12/31/2007	4.4
Angola	P078288	AO-Emerg Demob & Reintegr ERL (FY03)	2003	3/27/2003	12/31/2008	4.6
Chad	P000527	TD-Edu Sec Reform (FY03)	2003	3/18/2003	6/30/2007	5.9





ACTIVE PROJECTS WITH HIV/AIDS COMPONENTS**						
Country	Project ID	Project Title	Approval FY	Approval Date	Closing Date	Commitment*
Ethiopia	P044613	ET-RSDP APL1 (FY03)	2003	6/17/2003	6/30/2009	17.8
Ghana	P073649	GH-Health Sec Prgm Supt 2 (FY03)	2003	2/6/2003	6/30/2007	15.2
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, DR	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-ESDP II APL - Phase 2 (FY04)	2004	7/17/2003	12/31/2007	4.2
Sao Tome 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	6/30/2008	6.5
Angola	P083333	AO-Emerg MS Recovery ERL (FY05)	2005	2/17/2005	12/31/2007	8.6
Congo, DR	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
SUB-TOTAL						275.9
TOTAL ACTIVE HIV/AIDS PROJECTS						1,481.1
NOTES:						
*Commitment amounts are in the dollar value at the time of approval.						
**Commitment amounts for projects with HIV/AIDS components reflect the HIV/AIDS component amount, not the entire project amount.						



## ANNEX 8 – The HIV/AIDS Results Scorecard

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

A small set of mandatory indicators have, however, been extracted from the GRF to measure the overall progress with the HIV response to which the World Bank contributed in the Africa region. The Scorecard will therefore be used to measure progress under the Africa Action Plan as well as on IDA financing. The Scorecard contains both 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 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; (ii) project level data will need to 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 terms of 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 towards achieving harmonization and alignment on M&E at the country, regional and global levels. These indicators are selected from globally agreed UNGASS, MDG and IDA indicators and are based on reporting capacities of the countries, availability of baseline data and agreement of our key partners such as UNAIDS and within the OECD's Paris declaration on harmonization and minimizing data requirements.

The indicators in the Scorecard have been harmonized, where possible, with the indicator sets of other major partners in HIV/AIDS (US government's PEPFAR indicators and the Global Fund's list of "Top Ten" indicators). Neither the GRF indicators nor the Scorecard indicators are based on attribution, but rather on contribution. The scorecard and GRF therefore does not suggest that a separate World 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 World Bank on a regular basis.

Table 1 presents the HIV Scorecard for the Africa Region. Indicators 4 to 13 in the Scorecard is mandatory for all for all ongoing, pipeline and future HIV operations in the region to report on through the project Implementation Status and Results Reporting system (ISRs).

**Key benefits of the Scorecard** include: (a) Compliance with the Paris Declaration (to reduce burden on the countries); (b) Harmonization with UNAIDS (UNGASS) indicators and other key financiers (such as Global Fund and PEPFAR in reporting on HIV/AIDS); (c) Support for regional IDA



financing and the Africa Action Plan; and (d) Utilization of existing country capacities in data collection and reporting.

**The Scorecard data will be collected** through the following arrangements (per Africa Action Plan's 6 standard reporting sections:

	How Data will be Collected?
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 ACTafrica MAP questionnaire and ISRs
E – Financing indicators	Client Connection, donor websites and their focal points

**The responsibility to report** on the Scorecard will be by: (a) All country project teams; (b) GAMET will provide technical assistance to the Project teams; (c) GAMET and ACTafrica will gather data from the sources identified above, as well as from UNAIDS and update the Africa Action Plan progress reporting system; (d) TTLs need to assure that the Scorecard is agreed upon with their counterpart, with support from ACTafrica and GAMET. GAMET will provide technical support to country project teams and to TTLs in getting agreement with counterparts, and ACTafrica will provide support in integrating the Scorecard into the Bank system.

**Table 29: The HIV/AIDS Results Scorecard**

*Note: The Africa region HIV scorecard uses the new UNGASS wording in line with the new 2008 UNGASS guidelines (released April 2007).*

INDICATOR	INDICATOR ORIGIN	UNIT	DATA SOURCE
<b>A. Demographics</b>			
1. Total population (million)	World Bank	Number	WDI database
<b>B. Challenge - to understand the overall development challenge created by HIV in the region</b>			
2. Estimated number of adults and children living with HIV	UNAIDS	Number	UNAIDS Global Report
3a. Men and women aged 15-24 who are living with HIV <small>(may need to be estimated from antenatal data)</small>	UNGASS, IDA14, AAP	Percentage	UNAIDS Global Report / WHO est.
3b. Most-at-risk populations who are living with HIV	UNGASS	Percentage	UNAIDS Global Report / WHO est.
<b>C. Intermediate Results - to measure results contributed by Bank-funded projects</b>			
4a. <u>Condom use</u> : Women and men aged 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. <u>Condom use</u> : Female and male sex workers 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 aged 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)



INDICATOR		INDICATOR ORIGIN	UNIT	DATA SOURCE
			Percentage	ISR (extracted from country UNGASS report)
7.	Pregnant women living with HIV who received antiretrovirals to reduce the risk of MTCT	UNGASS, AAP	Number	ISR (extracted from country UNGASS report)
			Percentage	ISR (extracted from country UNGASS report)
8.	Orphaned and vulnerable children aged 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 aged 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.	Civil Society Organizations 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 Authority that report annually on at least 75% of the indicators in its national HIV M&E framework and that disseminates 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 intermediary results				
14.	Estimated investment requirements for HIV/AIDS, USD million	World Bank	Amount	UNAIDS global data
15.	Total financial commitments for HIV/AIDS, USD million	World Bank	Amount	Calculation (15a + 15b + 15c)
15a. Country commitments for HIV/AIDS, USD million		World Bank	Amount	ISR (extracted from country UNGASS report)
15b. World Bank commitments for HIV/AIDS, USD million		World Bank	Amount	World Bank Business Warehouse
15c. Other development partner commitments for HIV/AIDS, USD million		World Bank	Amount	Development partner websites
16.	Financing gap to reach HIV/AIDS targets, USD million	World Bank	Amount	Calculation (14 - 15)
17.	World Bank financial disbursements for HIV/AIDS, USD million	World Bank	Amount	World Bank Client Connection

**Notes:**

- A: All of the indicators in the scorecard are based on the latest international thinking in terms of indicator wording. As there are currently efforts underway to harmonize indicators, the indicators in the scorecard may be slightly revised in 2008, when the harmonization process will be complete.
- B: Detailed indicator definitions will be released once the global indicator registry has been developed
- C: Projects are only required to report on indicators 9 to 13.



## ANNEX 9 – The Bank's Role in the UNAIDS Division of Labor

**Table 30: World Bank Role in UNAIDS' Technical Support Division of Labor**

Technical Support Areas	Lead Organization	Main Partners
<b>1. Strategic Planning, Governance and Financial Management</b>		
<ul style="list-style-type: none"> <li>Support to strategic, prioritized and costed national plans; financial management, human resources; capacity and infrastructure development; impact alleviation and sectoral work.</li> </ul>	<b>World Bank</b>	ILO, UNAIDS, UNDP, UNESCO, UNICEF, WHO
<ul style="list-style-type: none"> <li>HIV/AIDS, development, governance and mainstreaming, including instruments such as PRSPs and enabling legislation, human rights and gender.</li> </ul>	UNDP	ILO, UNAIDS, UNESCO, UNICEF, WHO, <b>World Bank</b> , UNFPA, UNHCR
<ul style="list-style-type: none"> <li>Procurement and supply management, including training.</li> </ul>	UNICEF	UNDP, UNFPA, WHO, <b>World Bank</b>
<b>2. Scaling Up Interventions</b>		
<ul style="list-style-type: none"> <li>Overall policy, monitoring and coordination on prevention.</li> </ul>	UNAIDS	<b>All Cosponsors</b>
<b>3. M&amp;E, Strategic Information, Knowledge Sharing and Accountability</b>		
<ul style="list-style-type: none"> <li>Strategic information, knowledge sharing and accountability, coordination of national efforts, partnership building, advocacy and M&amp;E.</li> </ul>	UNAIDS	<b>World Bank</b> , ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO

Source: Global Task Team Report on Improving AIDS Coordination among Multilateral Institutions and International Donors, June 2005.



## **ANNEX 10 – MAP challenges and Improving Performance of the Multi-Country AIDS Program (MAP) for Africa**

### **Challenges**

In 2004, ACTafrica initiated an Interim Review of MAP to review the validity of the MAP approach, highlight progress made, the suitability of interventions and to 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 (now named 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 sub-national institutions, investing strategically in public goods and activities likely to have the largest impact, creating incentives for monitoring and evaluation, and using local evidence to improve performance. From these assessments, the Committee on Development Effectiveness (CODE) has 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 issue of HIV/AIDS, the need for bold, innovative, and flexible responses, and also reconfirmed the need for a multi-sectoral approach to this development challenge.

**Table 1** provides a brief overview of the key recommendations from the MAP Interim Review report (October 2004), OED/IEG Report<sup>8</sup>, and CODE<sup>9</sup> response and actions taken by the Africa region.

**Table 31: Overview of the Key Recommendations**

Recommendations	Measures undertaken by the Africa region
(i) Integrate HIV/AIDS in development planning, poverty reduction strategies, budget allocation strategies and mainstream in the country assistance strategies	IBRD and WBI in collaboration with UNDP have held two regional workshops to build capacity of country officials to integrate HIV/AIDS in PRSPs, MTEF. ACTafrica 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 AIDS Strategy and Action Planning (ASAP <sup>10</sup> ) 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. ACTafrica is also assessing the effectiveness of good practices targeting vulnerable groups.

<sup>8</sup> "Committing to Results: Improving the Effectiveness of HIV/AIDS Assistance – An OED Evaluation of the World Bank's Assistance for HIV/AIDS Control," July 2005.

<sup>9</sup> Committee on Development Effectiveness (CODE), Chairman's Summary, Appendix M to OED/IEG Report

<sup>10</sup> UNAIDS has raised US\$5 million to finance these activities, which include workshops and direct assistance from the Bank and UNDP.



Recommendations	Measures undertaken by the Africa region
(iv) Improve governance and accountability measures within projects to mitigate misuse of project funds and ensure that funds are utilized for the intended beneficiaries.	<p>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.</p> <p>ACTafrica is initiating a study on governance and anticorruption practices at the community level by engaging grassroots level women groups in several countries and will develop guidelines for civil society organizations and local government authorities in addressing governance and corruption.</p>
(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.	<p>GAMET<sup>11</sup> has significantly increased their efforts to help countries build both their clinical and non-clinical indicators and data collection mechanisms, and all repeater MAPs include more attention and financing for scaling up M&amp;E activities in partnership with UNAIDS and other donors. Ongoing MAP operations are also providing increased financing for M&amp;E implementation. GAMET and ACTafrica developed a generic in October 2006.</p>
(vi) Improve donor coordination and harmonization efforts to avoid duplication of efforts with the multitude of actors.	<p>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.</p>
(vii) Encourage performance-based disbursements.	<p>On going discussions with TTLs on methods for integrating this into HIV projects without hindering access to services.</p>
(viii) Continue to fully support the community response, which is an important stakeholder group, by engaging them in the design of interventions and improved procedures for financing but also evaluate the effectiveness of the community response.	<p>Civil Society organizations are more actively involved than before in HIV activities. The Africa region plans to carry out a situation analysis of CS engagement. ACTafrica hosted a consultation with civil society representatives from all MAP countries to brainstorm the roles, responsibilities and partnerships of CSO in responding to HIV. These recommendations are being incorporated in the revision of the Bank strategy for HIV/AIDS in Africa (2007-2011).</p>
(ix) Prioritized multi-sectoral 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	<p>MAPs continue to use the multi-sectoral approach and address HIV/AIDS as a broad development issue. ACTafrica 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.</p>
(x) Clarify the role of the Ministry of Health to ensure that they are a principal partner in the national response and build MOH capacity while continuing to work with other sectors.	<p>MOH is engaged in all MAP projects as 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 role and responsibilities of MOH as well as address issues related to strengthening health systems that can be integrated into HIV projects.</p>

<sup>11</sup> Global AIDS Monitoring and Evaluation Team (GAMET), hosted by the Bank on behalf of the Bank and UNAIDS.



Recommendations	Measures undertaken by the Africa region
(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 Global Fund, PEPFAR, and other development partners and held a meeting in January 2006 to improve coordination.



## ANNEX 11 – HIV Prevalence and Financing

Table 32: HIV Prevalence and Financing by Country

HIV Prevalence* and Financing** by Country					
Country	HIV Prevalence, Ages 15-49 %	Global Fund 2003-March 2007	PEPFAR 2004-2006	World Bank 2001 – May 2007	TOTAL Funds Available
Comoros	0.1	0.7	0.0	0.0	0.7
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	14.0
Cape Verde	0.8	0.0	0.0	14.0	14.0
Ethiopia	0.9-3.5	181.2	254.8	89.7	527.7
Senegal	0.9	8.8	0.0	30.0	38.8
Niger	1.1	8.5	0.0	25.0	33.5
Guinea	1.5	9.7	0.0	20.3	30.0
Sierra Leone	1.6	8.6	0.0	15.0	23.6
Sudan	1.6	46.1	0.0	0.0	46.1
Mali	1.7	23.5	0.0	25.5	49.0
Benin	1.8	39.0	0.0	58.0	97.0
Burkina Faso	2.0	10.6	0.0	74.7	85.3
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	30.4	0.0	64.0	94.4
Gambia	2.4	14.6	0.0	15.0	29.6
Rwanda	3.1	56.6	168.2	40.5	265.3
Dem. Rep. of Congo	3.2	34.8	0.0	102.0	136.8
Equatorial Guinea	3.2	4.4	0.0	0.0	4.4
Togo	3.2	25.7	0.0	0.0	25.7
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	26.7	0.0	21.0	47.7
Guinea-Bissau	2.8	1.2	0.0	7.0	8.2
Nigeria	3.9	74.4	344.8	140.3	559.5
Congo Republic	5.3	12.0	0.0	19.0	31.0
Cameroon	5.4	75.9	0.0	50.0	125.9
Kenya	6.1	109.6	443.7	50.0	603.3
Tanzania	6.5	134.8	309.5	70	514.3
Uganda	6.7	106.6	409.1	47.5	563.2
Cote D'Ivoire	7.1	51.0	115.3	0.0	166.3
Gabon	7.9	5.2	0.0	0.0	5.2
Central Africa Republic	10.7	29.6	0.0	17.0	46.6
Malawi	14.1	186.3	0.0	35.0	221.3
Mozambique	16.1	29.7	192.1	55.0	276.8
Zambia	17.0	97.3	360.8	42.0	500.1
South Africa	18.8	121.9	459.0	0.0	580.9
Namibia	19.6	31.3	124.3	0.0	155.6
Zimbabwe	20.1	46.2	59.4	0.0	105.6
Lesotho	23.2	39.3	0.0	5.0	44.3
Botswana	24.1	18.6	131.1	0.0	149.7
Swaziland	33.4	68.9	0.0	0.0	68.9
<b>TOTAL FINANCING BY DONOR</b>		<b>1891.4</b>	<b>3372.1</b>	<b>1309.1</b>	<b>6572.5</b>
*UNAIDS, 2006. Haacker 2007 ** Global Fund Financing from 2003 - March 2007. <a href="http://www.theglobalfund.org">www.theglobalfund.org</a> (March 31, 2007) PEPFAR financing from 2004-2006: <a href="http://www.pepfar.gov/pepfar/press/81902.htm">www.pepfar.gov/pepfar/press/81902.htm</a> World Bank MAP projects approved from 2001 to May 2007. Does not include \$106m for sub-regional MAP projects					

