AFRICAN DEVELOPMENT BANK **AFRICAN DEVELOPMENT FUND**

HIV/AIDS STRATEGY PAPER FOR BANK GROUP OPERATIONS

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TABLE OF CONTENTS

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GLOSSARY

Azido-Thymidime (AZT)

AZT is one of the antiretroviral (ARV) drugs recognized as capable of slowing down the development of the HIV infection into AIDS because it reduces the quantity of the virus in the blood. It is also used in association with other ARV drugs to reduce the risk of parent-to child-transmission (PTCT) of the infection.

Immunodeficiency or immuno-depression

Inability of the immune system to resist infection. In the case of AIDS and HIV-related diseases, this situation is due to the immuno-suppression caused by the action of the HIV virus.

Levirate

An institution that recommends or imposes the marriage of a widow to a close relative of her deceased husband.

Opportunistic diseases

These are the infections or tumours that appear because the deficient immune system can no longer combat them. In general, these diseases do not affect people whose immune system is intact.

Sororate

Traditional practice that compels a widower to marry the younger sister or younger cousin of his deceased wife.

Acquired immunodeficiency syndrome (AIDS)

This clinical manifestation of HIV infection is usually associated with loss of capacity to fight infections and manifested by frequent and repeated opportunistic infections. For an AIDS diagnosis, the patient should show clinical signs of AIDS, usually with one or several of the major opportunistic diseases associated with a HIV-positive serology.

Tri-therapy or multi-therapy

Therapy involving two or more drugs used in combination or alternatively in order to obtain optimum results.

Human immunodeficiency virus (HIV)

Human retrovirus considered by most specialists as the primary cause of AIDS.

People's competence *vis-à-vis* HIV/AIDS

Capacity to understand the reality of HIV/AIDS, to analyse the personal and collective (community) risk and vulnerability factors and to work towards eliminating those factors.

ACRONYMS AND ABBREVIATIONS

ADB	African Development Bank
ATF	AIDS Task Force
CBO	Community-based organizations
CPA	Country Programme Adviser
CSP	Country Strategy Paper
ECA	Economic Commission for Africa
ECOWAS	Economic Community of West African States
UNFPA	United Nations Fund for Population Activities
GPA	Global Programme on AIDS
HDI	Human Development Index
HIPC	Highly indebted poor countries
IMF	International Monetary Fund
ICT	Inter-Country Teams
MCH	Maternal and child health
MTP	Medium-Term Plan
NACP	National AIDS Control Programme
OAU	Organisation of African Unity
PRSP	Poverty Reduction Strategy Paper
RMCs	Regional Member Countries
SADC	Southern African Development Community
STD/STI	Sexually transmitted diseases/sexually transmitted infections
TRIPS	Trade-Related aspects of Intellectual Property rights
UEMOA	West African Monetary Union
UNDCP	United Nations Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organizations
UNICEF	United Nations International Children's Emergency Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

1. In December 2001 the total number of people living with HIV throughout the world was estimated at 40 million, of whom almost 28.1 million (i.e. 70%) live in Africa, south of the Sahara—a region that accounts for barely 10% of the world's population. The HIV/AIDS prevalence rate has been increasing at an alarming speed and the epidemic has become the leading cause of adult mortality in sub-Saharan Africa. Several important meetings have been held at the continental and global levels to discuss the issue and, as a result, the fight against the epidemic as been identified as Africa's topmost priority.

2. Conscious of the devastating impact of this epidemic on the development of the continent and in order to steer its operations to meet the expectations of the Regional Member Countries (RMCs), the Bank set up an AIDS Task Force (ATF) in February 1994. The duties of the ATF include, *inter alia*, the preparation of a HIV/AIDS strategy paper for Bank Group operations in the RMCs and the formulation of a Bank Group policy document on HIV/AIDS in the work place.

3. The strategy on HIV/AIDS is elaborated to define the Bank's support to RMCs in the fight against the epidemic. It is set against a background description of the complexity of the epidemic, which resides in the nature of HIV and its consequences at the country level be they demographic, macroeconomic or sectoral. The indicators such as life expectancy at birth or infant mortality rate are considerably affected by the epidemic. All the development sectors, particularly the social (health and education), agricultural and infrastructure sectors are affected by this epidemic.

4. The strategy also reflects the declarations and resolutions of the international community and is based on the recommendations made at the consultative meeting organized by the Bank in Yamoussoukro in April 2000. It takes into account the achievements made in the fight against the epidemic to date and focuses on the priorities defined by the RMCs, in the drive to complement the efforts undertaken by organizations specializing in HIV/AIDS control.

5. Therefore, the objectives of the Bank with regard to HIV/AIDS control are to: i) assist RMCs in their efforts to develop and implement multisectoral HIV/AIDS control activities and ii) support the programmes prepared and led by the UN specialized agencies and other partners in the fight against HIV/AIDS in Africa.

6. The Bank has provided responses against the epidemic both at policy and operational level. It has taken into account HIV/AIDS in its sectoral policies, e.g. agriculture, education, health, integrated water resources management, gender, population, etc. At the operational level, the Bank has integrated HIV/AIDS control activities into the social, agricultural and transport sector. Drawing on the lessons learnt from experience and to enhance complementarity of its interventions with national and international actors involved in the fight against the epidemic, the Bank will intervene in selected priority areas of HIV/AIDS**,** namely: i) promotion of political commitment at all levels; ii) support to sectoral responses promoting decentralization, community participation and ownership; and iii) the strengthening of coordination to promote greater synergy in HIV/AIDS control.

7. In order to attain the objectives, the Bank Group will focus on the following strategies at the Bank and national levels, and with other development partners:

Advocacy and policy dialogue in RMCs: The Bank will enhance advocacy to position HIV/AIDS as a central development issue and to promote multisectoral HIV/AIDS responses through its policy dialogue with governments and other stakeholders, via its CSP operation. In this regard:

- The Bank's advocacy and policy dialogue with RMCs will attempt to bring the political leadership to focus on: i) comprehensive multisectoral national strategic plans; ii) laws or measures against traditional and cultural practices that increase the risk of infection to vulnerable groups (women, children, youth); iii) promotion of the use of ARV therapy and prophylaxis among pregnant women and children to prevent mother-to-child transmission and ensure survival of mothers; iv) allocation of adequate resources to finance HIV/AIDS activities; and v) actions for greater involvement of people living with HIV/AIDS.
- The Bank will promote advocacy on accountability, the transparency of HIV/AIDS operations and the full participation of people living with HIV/AIDS.
- The Bank will support policies and mechanisms that allow the population to acquire the necessary knowledge on the dynamics of the epidemic and encourage greater commitment of civil society leaders including CBOs, NGOs, and religious and traditional groups.
- The Bank will support the decentralization of HIV/AIDS responses that allow participatory approach with broad stakeholder involvement and promote community ownership.

Mainstreaming of HIV/AIDS in Bank operations: The Bank's HIV/AIDS control strategy will continue to be reflected in sectoral policies and operations, CSPs, and project preparation through a mainstreaming mechanism involving the consideration of the sensitivity and vulnerability of the different sectors to HIV/AIDS. This will entail that:

- *Bank sectoral operations* incorporate appropriate HIV/AIDS prevention, care and impact mitigation activities that especially target the youth, women and other disadvantaged groups of society. In mainstreaming HIV/AIDS, priority will be given to the social (health, education, etc.), agricultural and infrastructure sectors. It will also focus on trans-sectoral issues such as poverty reduction, good governance, gender and population;
- *Bank sectoral policy papers* continue to be updated to take into account the HIV/AIDS dimension;
- *Bank Country Strategy Papers (CSPs)* and Poverty Reduction Strategy Papers (PRSPs) will include analyses of the HIV/AIDS situation. In the same vein, the HIV/AIDS problems will be taken into account during the preparation of *Bank projects.*

Partnership development: The Bank supports the strategic partnerships nurtured by UNAIDS under the International Partnership against AIDS in Africa (IPAA)—the coalition that works under the leadership of African governments to harness the resources of the United Nations, donors, and the private and community sectors. The Bank's collaboration with UN specialized agencies on HIV/AIDS will be that of supporting HIV/AIDS control interventions within the framework of IPAA. Similarly, close

cooperation will be fostered with existing regional and subregional organizations and institutions such as the OAU, ECA, ECOWAS, UEMOA and SADC. The strategic partnership with the World Bank will continue to be pursued to intensify HIV/AIDS control activities. The Bank will also coordinate its activities with bilateral institutions, civil society and the private sector.

8. Implementation of the Bank's HIV/AIDS control strategy will be facilitated by the following institutional and operational measures, as well as resource mobilization efforts:

(a) Institutional measures:

- The Country Departments will take primary responsibility for the mainstreaming of HIV/AIDS into Bank Group operations. These activities will be coordinated by a focal point to be established within the Central Operations Department (OCOD). The focal point will also be responsible for the policy dimensions, and for liaison and collaboration with partner institutions. It will also prepare an annual progress report to the Boards of Directors;

- The Bank's internal capacity on HIV/AIDS will be strengthened through staff training and sensitization programmes, as well as the recruitment of specialists for project design and implementation;

    - Special measures will also be taken to ensure that HIV/AIDS issues are taken into account in the policy dialogue with RMCs and in the formulation of the Bank's Country Strategy Papers (CSPs). These issues should also be given priority attention by countries themselves, especially in the preparation of their own Poverty Reduction Strategy Papers (PRSPs).

(b) Operational measures

The mainstreaming of HIV/AIDS into Bank Group operations will involve the following measures:

i) Project preparation and design

The HIV/AIDS dimensions will be taken into account from the beginning of the Bank's project preparation phase, and will influence project design. The Bank Group intervention will include HIV/AIDS control components or stand-alone HIV/AIDS projects and programmes.

ii) Monitoring and evaluation

Monitoring and evaluation of the implementation of the Bank's strategy will be undertaken in order to learn from its successes and failures. The activities will be carried out with the technical support of the UN specialized agencies and other partners, as necessary.

iii) Research

In order to expand the knowledge base on local circumstances and best practices, the Bank will support operational research in socio-cultural and behavioural area and other

socioeconomic domains relevant for the control of HIV/AIDS in Africa. The Bank will also lend its support to research on HIV/AIDS epidemiological surveillance systems, on the development of vaccines and therapeutic medicines, including those based on plants (Bank Group Health policy, 4.1.4), and on the cost-effectiveness of the wider availability of drugs to treat opportunistic infections.

(c) Resource mobilization

The primary challenge in the fight against HIV/AIDS is to mobilize the resources to meet the scale and devastating impact of the epidemic. The mobilization of additional resources for HIV/AIDS assistance will be achieved by mainstreaming HIV/AIDS into all Bank activities, in particular the integration of HIV/AIDS components in Bank-financed projects and programmes as well as in Bank-assisted PRSPs. The Bank would also ensure that priority is given to the social sectors with a special focus on HIV/AIDS and communicable diseases in the use of the debt relief assistance provided under the HIPC initiative. More grant resources are needed to meet the funding gap in priority areas, including: i) institutional capacity-building and support for community-based local responses to develop competency for sustainable prevention and care; ii) operational research to expand the knowledge base of the design and management of comprehensive programms based on local circumstances and best practices; iii) supporting prevention and care measures including treatment of HIV-positive pregnant women and children with ARV therapy to prevent MTCT; and iv) partnership development activities with development partners such as the UN specialized agencies, the World Bank and regional institutions.

9) HIV/AIDS is both a development and human problem affecting every sector. The close relationship between the epidemic and most sectors of society makes it necessary to adopt a multisectoral approach, which is the main focus of the Bank's strategy. The priority areas of intervention and the strategic options allow the Bank to promote HIV/AIDS control activities within its regular sectoral operations and contribute to the fight against HIV/AIDS in Africa.

CHAPTER I: INTRODUCTION

1.1. HIV/AIDS: ONE MORE CHALLENGE FOR AFRICA

1.1.1 In December 2001, it was estimated that a total of 40 million people worldwide were living with HIV/AIDS. Almost 28.1 million—70% of all HIV-positive people—live in Africa south of the Sahara, a region that accounts for barely 10% of the world population (see Annex 1). Most of the infected people will die in the next 10 years, adding to the 19 million Africans who have already died from the epidemic, and leaving behind devastated families and compromised development prospects.

1.1.2 Several important meetings, at the continental and global levels, have been held on the issue. Thus, during the 28th Summit of the Organisation of African Unity (OAU), held in Dakar in July 1992, the Heads of State and Government signed a *Declaration on the AIDS Epidemic in Africa*, in keeping with which they decided to give absolute priority to the fight against AIDS. At the 29th OUA Summit held in Cairo, in June 1993, a plan of action was defined. The Resolution adopted at the end of this Summit strongly urged the United Nations, the African Development Bank (ADB) and other organizations to support Africa in its fight against AIDS. The 1998 OAU Summit held in Ouagadougou reiterated this call. The United Nations Security Council devoted its meeting of 10 January 2000 to AIDS in Africa and declared the fight against AIDS as the topmost priority in Africa.

1.1.3 The African Development Forum, held in December 2000, and the Abuja Summit on HIV/AIDS, TB and Other Infectious Diseases, held in April 2001, brought together African Heads of State and leaders of United Nations organizations, and multilateral and bilateral institutions to mobilize political commitment and leadership at the highest level and use the momentum gained in this respect to embark on a massive mobilization of resources to intensify the fight against the epidemic. According to UNAIDS, although the total amount necessary for AIDS prevention in Africa stands at US$1–3 billion, only 160 million dollars were mobilized for the continent in 1999. Subsequent to these meetings, the UN General Assembly Special Session on HIV/AIDS (UNGASS), held in June 2001 in New York, stressed the crucial role of resources and partnership in the fight against the epidemic. These three meetings made headway in providing leadership and demonstrating a lot of good will towards addressing the problem of resources. Among the concrete proposals made in this regard are: the pledge by African Heads of State to allocate at least 15% of the annual national budget to the improvement of the health sector to help address the HIV/AIDS epidemic, the establishment of the Global Funds for AIDS, Tuberculosis and Malaria (GFATM), and the adoption of the Declaration of Commitment drawn up at UNGASS.

1.1.4 Africa has been unable to fight a plague that threatens its very survival. In the absence of a vaccine to prevent the disease and drugs to cure it, and devoid of the financial resources needed to gain access to available technological and preventive therapy, Africa lives with AIDS as a new and insurmountable challenge. AIDS is a major obstacle to economic growth, a serious impediment to development, and a considerable public health problem because it has become the primary cause of death among adults. For these three reasons, the Bank is called to support its Regional Member Countries (RMCs) in combating the HIV/AIDS epidemic by playing a supportive and complementary role to the efforts being developed by the UN specialized agencies and other organizations involved in the fight against HIV/AIDS.

1.1.5 In order to direct its operations to meet the expectations of RMCs, the Bank set up a permanent AIDS Task Force (ATF) in February 1994. The duties of the ATF include**,** *inter alia*, the preparation of a HIV/AIDS strategy document for Bank Group operations in the RMCs and the formulation of a Bank Group policy paper on HIV/AIDS in the work place.

1.1.6 This strategy reflects the declarations and resolutions of the international community during the different meetings initiated by the UN and the OAU. It also draws from the recommendations made by the participants at the consultative meeting organized by the Bank in Yamoussoukro from 17 to 18 April 2000 (see box below) and experience gathered in HIV/AIDS control in the RMCs.

WORKSHOP ON THE HIV/AIDS STRATEGY FOR BANK GROUP OPERATIONS IN THE REGIONAL MEMBER COUNTRIES

1. The African Development Bank organized a consultative workshop on the Bank's HIV/AIDS Strategy Paper on 17 and 18 April 2000 in Yamoussoukro, Republic of Côte d'Ivoire. This workshop**,** organized as part of the Bank's participatory policy process, brought together 78 participants representing the RMCs, NGOs and associations, bilateral and multilateral cooperation agencies, including the specialized agencies of the United Nations system (WHO, UNDP, UNFPA and the UNAIDS Secretariat). The primary objective of the workshop was to enhance stakeholders' participation in the elaboration of the Bank's Strategy and to ensure that it is in line with the expectations of its partners and beneficiaries.

2. The workshop met in plenary sessions, and working groups on (i) Advocacy and Strategic Planning; (ii) Decentralization and Community Response to the HIV/AIDS Problem; and (iii) Partnership and Coordination. The deliberations focused on poverty and the shortcomings of the African States in the area of governance. It also emphasized the need to underscore the capacity of the communities to face up to the HIV/AIDS problem, to address (from the gender point of view) the causes of the vulnerability of the population and to find solutions to problems of access to antiretroviral drugs.

3. Participants to the workshop recommended (i) advocacy and policy dialogue to mobilize political commitment at the highest level; ii) mainstreaming HIV/AIDS into Bank operations; (iii) promotion of community responses against the epidemic; and (iv) coordination of activities with development partners. They also recommended that the Bank mobilize grant resources to support prevention and care activities by grass-roots communities and civil society targeting vulnerable groups such as women, youth, people living with HIV/AIDS, and orphans. The workshop concluded by appreciating the Bank's stakeholders participatory process in the elaboration of its strategy and recommended expediting the implementation of the same.

1.2 THE BANK'S HIV/AIDS CONTROL EXPERIENCE

Aware of the devastating impact of HIV/AIDS on Africa's development, the African Development Bank Group began addressing the problem at the end of the 1980s. To this end, an AIDS Study Group, comprising several departments of the Bank, was set up in July 1987. The group was commissioned to study the progression of the epidemic in Africa and to propose activities that the Bank should support. As of then, the ADB undertook two main activities:

- Financing HIV/AIDS control activities: The Bank's experience in matters of HIV/AIDS is limited to HIV/AIDS control operations in selected RMCs. These operations include projects devoted entirely to the fight against HIV/AIDS and components or subcomponents of projects or programmes in the social, agricultural and infrastructure sectors. The total cost of operations financed by the Bank Group in this area amount to UA 150 million (see Annex 2). These operations concern primarily: (i) institution-building to enable countries to diagnose and study the disease (training of managers and the construction/equipment of laboratories); (ii) enhancing the safety of blood transfusion (construction and equipment of blood transfusion centres); (iii) improving access of the sick to therapy; and (iv) sensitizing and educating the population through IEC activities.

- Enhancing advocacy for political commitment: In May 1993, the Bank organized a symposium on HIV/AIDS and its implications in Africa, within the context of its annual meeting seminars on the Major Problems of Economic and Social Development in Africa. On this occasion, the RMCs were sensitized on the magnitude of the HIV/AIDS problem and its socioeconomic impact in Africa. The symposium confirmed that effective AIDS control requires: (i) political commitment at all levels; (ii) availability of substantial human and financial resources; and (iii) coordinated actions.

1.3 STRUCTURE OF THE DOCUMENT

The rest of the document is structured as follows: Chapter II describes the epidemiological situation and the impact of HIV/AIDS on the Bank's areas of intervention, its risk and vulnerability factors, as well as the response and lessons learnt with regard to HIV/AIDS in Africa; Chapter III defines the objectives of the Bank Group strategy on HIV/AIDS, sets forth the guiding principles and specifies the Bank's future HIV/AIDS control operations; Chapter IV describes the administrative and operational measures to be taken by the Bank in order to create an enabling environment for the implementation of this strategy; and Chapter V is devoted to the conclusion. The annexes include a guide for effectively taking HIV/AIDS into account in the Bank's operations in the RMCs and an outline of the draft action plan for the strategy's implementation.

CHAPTER II: THE HIV/AIDS PROBLEM IN AFRICA

2.1 MAGNITUDE OF THE EPIDEMIC IN AFRICA

2.1.1 Epidemiological situation

2.1.1.1 As indicated earlier, by December 2001, there were about 28.1million HIV-positive people in Africa. The Southern and Eastern regions are the most affected regions, with prevalence rates among people aged 15–49 in 2000 varying from 35.8% in Botswana to 8% in Tanzania. In the Central and Western regions, with the exception of the Central African Republic (13.8%) and Côte d'Ivoire (10.7%), the prevalence rates vary from 6.4% in Burkina Faso to 1.3% in Niger. In North Africa, the prevalence rates range from 0.9% in Sudan to 0.02% in Egypt. These prevalence rates are listed by country in Annex 3.

2.1.1.2 AIDS has become the primary cause of death among adults in sub-Saharan Africa. Indeed, in 1998, UNAIDS observed that, in 1954, malaria caused the death of millions of people, at a time when AIDS was unknown. Today, according to recent WHO estimates, malaria kills more than 1 million people every year, whereas, in 2001, a total of 3.0 million died of AIDS. These two diseases are among the five leading causes of death in the world. Even though HIV infection is on the increase, countries such as Senegal, Uganda and, recently, Zambia have demonstrated that it is possible to check the spread of new infections through prevention programmes, strong political leadership and civil society participation.

2.1.2 Impact of AIDS

2.1.2.1 The rapid worsening of the epidemiological situation of HIV/AIDS in Africa has underscored its impact at all levels and in all the development sectors. The complexity of the epidemic resides in the nature of HIV and the magnitude of its effects. It is worth distinguishing the effects on the infected person from the effects on the family, the community, including in the work place, and on the entire country, be they demographic, macroeconomic or sectoral. Sectoral effects will be considered from the viewpoint of the sector's sensitivity and vulnerability. The sector's sensitivity is defined as the probability of infection of the population working in the sector, whereas vulnerability corresponds to the probability of the more or less severe impact of the epidemic on the sector.

The Impact of AIDS on HIV-positive individuals

2.1.2.2 The *impact of AIDS on HIV-positive individuals* translates into a deterioration of the person's physical and mental health, a declining quality of life and, ultimately, death. Opportunistic infections are frequent at the AIDS stage and often require hospitalization and temporary absence from work. Psychologically affected by his/her HIV-positive status and the absence of any cure, the patient lives in constant fear of the deterioration of his/her state of health and, ultimately, of death. His/her mental state is affected by the lack of access to treatment, frequent absences from work, the risk of losing his/her job and the likelihood that the situation of his/her family will become precarious.

Impact of AIDS on the family and community

2.1.2.3 The *impact of AIDS on the family* of the person living with HIV is multifaceted. It includes the time spent by the still healthy (or apparently healthy) spouse in caring for the sick spouse and increased spending on health care at a time when savings are dwindling and the risk of job loss is looming. Often, both husband and wife are infected by HIV/AIDS and sometimes, at least, one of the children is also HIV-positive. Such situations lead to a dislocation of the family in the event of the demise of the parents. According to UNAIDS estimates, by the end of 2000, about 12.1 million children under 15 had been orphaned by AIDS in sub-Saharan Africa, representing 95% of the global AIDS orphans. Dislocated families contribute to the emergence of generations of street children and the worsening of social problems such as begging, theft, delinquency, violence, alcoholism, drugs, commercial sex work and rape, which in turn favour the propagation of HIV/AIDS. Furthermore, social solidarity savings, which makes it possible to attend to the needs of other members of the extended family in the community, is discontinued, resulting in greater precariousness and poverty within the affected communities. The resurgence of tuberculosis (TB) among HIV-positive as well as HIV-negative individuals due to increased TB exposure is becoming a great social and economic burden to families and communities.

Impact of AIDS on business

2.1.2.4 HIV/AIDS mainly affects people between 15 and 49 years of age, who constitute a country's labour force. The impact of the disease is illustrated by absenteeism, declining efficiency and productivity of the sick employee, an increase in health expenditure, salaries paid to employees who are on sick leave, replacement of qualified staff and an increase in training costs. Furthermore, ostracism, often related to ignorance of the nature of HIV/AIDS, and fear create a social environment hardly conducive to productive work and, in time, there is a decline in the overall performance of the company. The most affected are labour-intensive enterprises (e.g. transport companies) and those employing migrant workers (e.g. mines). HIV/AIDS has an adverse effect on private sector development—a core element in the development strategies of RMCs.

Impact of AIDS countrywide

2.1.2.5 *Macroeconomic impact*: The World Bank model developed in 1993 to calculate the macroeconomic impact of the AIDS epidemic showed that countries lose on average 0.5% to 1.2% on their GDP growth figures each year. For a developing country such as Kenya, the loss in GDP growth calculated according to the model would be about 14.5% between 1995 and 2005. The Human Development Index (HDI), an indicator of the level of development of a country, has shown a decrease in some countries hard hit by the epidemic. In Namibia and South Africa, forecasts indicate a decrease in HDI of about 10% in 2006 and around 15% in 2010 as a result of AIDS. The HIV/AIDS situation is worsened by poverty in these countries, which, in itself, is a factor that favours the propagation of the epidemic.

2.1.2.6 *Demographic impact*: *Life expectancy at birth* is an important human development index. In Southern Africa, it rose from 44 years at the beginning of the 1950s to 59 years at the beginning of the 1990s. Due to the high HIV/AIDS prevalence rates in these countries, life expectancy will decrease to almost 45 years between 2005 and 2010. In the absence of AIDS, life expectancy would have gone up to about 64 years by the years 2010 to 2015. It has also been proven that women living with HIV/AIDS gradually become *less fertile* and their chances of reproducing decrease by around 20% as the disease develops.

Furthermore, AIDS reduces the chances of survival of the child who, most often, is infected through vertical transmission from mother to child. Not only does the epidemic contribute to infant mortality, it also cancels out the achievements of other health programmes such as the extended vaccination programme. Young people aged between 15 and 24 represent the age group mostly affected by the epidemic. Due to precocious sexual relations, biological reasons and gender roles, girls are more exposed to HIV than boys. The deaths of young adults modify the age pyramid and increase the dependency index.

2.1.2.7 *Impact on the health sector*: The health sector is the first to feel the effects of AIDS, not only because of the loss of health professionals (doctors, nurses, midwives), but also due to the high occupancy rates of hospital beds by AIDS patients, over-worked health staff, the evident incapacity of the health systems to meet hospital admission and health-care requirements and to cater for a higher number of deaths. Because of AIDS, not only is the attainment of health programme objectives compromised but even the achievements of these programmes are totally or partially lost. At the financial level, all the impact studies have made very pessimistic forecasts with respect to the magnitude of costs relating to HIV/AIDS in the health sector budgets of African countries.

2.1.2.8 *Impact on the education sector*: This sector is sensitive to HIV as teachers and students are particularly exposed to the risk and vulnerability factors. The impact of AIDS on teachers is reflected in the mortality rates, productivity figures, costs and stress. There is a considerable loss in teaching time because of the prolonged illness of many teachers who continue to receive their salaries. There is also a decrease in enrolment rates. The high number of deaths among children and youths, the rise in the number of orphans and the number of children who drop out to care for their sick parents, or who no longer have the means to pay school fees, increase the dropout rates. As a privileged medium for reaching the youths, the education sector has an important role to play in HIV/AIDS control, particularly in disseminating information and messages on prevention.

2.1.2.9 *Impact on the agricultural sector*: In spite of sprawling urbanization, the majority of Africans still live in rural areas and are employed in agriculture, and the latter should be the starting point of any action aimed at stimulating overall growth and improving living conditions on the continent. The agricultural sector is sensitive and vulnerable to HIV/AIDS. The impact of the disease and HIV/AIDS-related deaths affect the able-bodied people employed in subsistence farming as well as the balance of manpower available for cash cropping. The survival strategies adopted by rural communities where HIV/AIDS is widespread can worsen the poverty of these communities and render them more vulnerable. HIV/AIDS compels families to take the irreversible decision to sell their cattle, equipment and land to meet the costs of HIV/AIDS-related health care. However, considering the human potential it mobilizes and the networks it creates, the agricultural sector can play a leading role in controlling the epidemic.

2.1.2.10 *Impact on the infrastructure and industrial sector*: The labour-intensive infrastructure sector that includes transport and public utilities, as well as the industrial sector, encourage mobility of labourers. By enhancing population movements that cause family separation, these sectors facilitate the propagation of HIV. Both sectors experience decline in performance due to the HIV/AIDS-related morbidity and mortality of the work force. The industry sector faces severe adverse effects from HIV/AIDS in terms of declining performance because of the fact that it employs qualified manpower that, in general, is difficult and expensive to replace.

2 .1.2.11 *Impact on crosscutting issues*: The quality and efficiency of the national response to HIV/AIDS depends on the quality of governance. Decentralization, effective participation of the population and the existence of an enabling legal and ethical framework are vital in the fight against HIV/AIDS. Gender issues are also important aspects of HIV/AIDS control. Women play significant roles in agriculture, industry, trade, the social sector and environmental protection. Moreover, women are particularly vulnerable for biological, economic and social reasons. Women of childbearing age and sex workers are most exposed to HIV.

2.2 DETERMINANTS IN THE SPREAD OF THE EPIDEMIC IN AFRICA

In Africa, HIV is mainly transmitted through sexual contact and particularly through heterosexual relations (roughly 80–90% of cases). Transmission from mother to child (5–10% of cases) and through blood (again 5–10% of cases) also occurs. The latter is often related to shortcomings in the methods used for ensuring the safety of blood and blood transfusion. Accidental transmission in the medical environment is quite rare. Certain traditional practices, such as excision and tattooing, are said to contribute to the propagation of the infection but this is yet to be proven. With respect to the sexual mode of transmission, there are risk factors that the individual can control and vulnerability factors that are beyond his/her control. The probability of HIV infection, or the risk of spreading the AIDS epidemic, depends on the capacities of individuals, communities and countries to manage these risk and vulnerability factors.

2.2.1 Risk factors in HIV transmission

The key factors for spreading HIV infection are behavioural factors, such as unprotected sex, casual sex, and multiple sexual partners and early sexual contact. Medical and health factors such as the presence of an STI and ignorance of the sero status, often due to the withholding of the results of a positive test, can favour HIV transmission. *Ignorance* of the modes of HIV transmission often leads to fear of being infected in day-to-day activities and this can result in ostracism and stigmatization of people living with HIV. This *stigmatization* often compels people living with HIV to conceal their HIV-positive status and live clandestinely with their predicament, which hinders HIV/AIDS prevention efforts.

2.2.2 Factors of vulnerability with regard to HIV transmission

2.2.2.1 Nowadays, prevention should focus on risk reduction and, particularly, on reduction of a population's vulnerability. Vulnerability is due to socio-cultural factors such as early marriages imposed on young girls, the loss of social standards and etiquette, rape, the inferior status of women in certain African societies, certain harmful traditional practices such as genital mutilation, levirate and sororate. Socioeconomic factors, such as a precarious, financial situation, unemployment and poverty, and political factors, such as an inappropriate legal framework with regard to HIV/AIDS as well as bad governance, create and/or aggravate situations of vulnerability.

2.2.2.2 Internal and international migration results in people moving away from their habitual environment and remaining beyond the social control and regulatory mechanisms of their community. Thus, the relative freedom of movement, solitude, temptation, easy access to casual sexual partners and the aggressive sexual advances they are subjected to, contribute to making them particularly vulnerable. The military constitutes a very mobile population

with a behaviour that involves a high risk of HIV infection. Drivers and temporary labourers employed in work sites and in the transport sector are equally high-risk groups.

2.2.2.3 Social and political conflict that increases the number of *displaced people* and *refugees* living in camps, where promiscuity, rape, commercial sex and insecurity are rampant, make individuals particularly vulnerable to HIV infection. Unemployment and *idleness* in countries that offer no prospects to young people are major factors associated with vulnerability. They lead the individual to adopt risky behaviour such as drinking, drug use and unsafe sex, sometimes compelling them to emigrate. Making a living from commercial sex can be to the result of extreme economic and financial problems. Often, it is women heading families, with no source of income, who resort to this activity. Ignorance of the nature of HIV/AIDS and other sexually transmitted infections, of the seriousness of the complications related to these infections and of the means for self-preservation place individuals in a vulnerable situation with regard to HIV infection.

2.2.2.4 Poverty and socioeconomic precariousness are factors that make people particularly vulnerable in Africa where the solidarity mechanisms are gradually being lost. These factors lead to commercial sex and migration and can result in social conflicts if they attain intolerable levels. Poverty breeds AIDS and AIDS breeds poverty. On the other hand, wealth, which facilitates access to the pleasures of life, including commercial sex, has proved to be a vulnerability factor.

2.2.2.5 Risk and vulnerability factors are almost the same in all African countries. Depending on the geographical and cultural considerations, sexual practices may differ and certain factors may be more dominant than others. Depending on whether the country is at war or in peace, and depending on job opportunities, population movements can be more intensive in one location than another. These differences partly explain the disparities in prevalence from region to region as well as the rapidity and appropriateness of the response required.

2.3 Response to The Epidemic

2.3.1 Response at the country level

2.3.1.1 For most sub-Saharan Africa countries, the first cases of AIDS appeared at the beginning of the 1980s, and the end of the 1980s in the case of North Africa. Governments that reacted at the time set up National AIDS Control Programmes (NACP) within the Ministries of Health. The major task of the NACPs was to determine the magnitude of the problem and monitor its development.

2.3.1.2 Most countries affected by HIV/AIDS prepared a short-term AIDS control plan (STP) between 1986 and 1988, followed by a first mid-term plan (MTP1) between 1988–1989 and 1992–1993. These plans focused on (i) epidemiological surveillance; (ii) the prevention of HIV transmission through sexual contact and safe blood transfusion; and (iii) mother-to-child transmission. The first-generation plans helped to enhance knowledge of the epidemic and achieved a certain degree of success in reducing new infections through sensitization and health measures. However, the weakness of these first plans resided in the fact that they approached HIV/AIDS as a health issue only.

2.3.1.3 The second-generation mid-term plans (MTP2) ran from 1993–1994 to 1998–1999; some were extended to the year 2000. The MTP2s stress the need to involve sectors

other than the health sector and to reduce the impact of the epidemic. The multisector responses to the epidemic that included decentralization of the National Aids Control Programmes (NACPs), voluntary testing and counselling, health care for persons living with HIV/AIDS and the lessening of the effects of HIV/AIDS were the major strategic focus of the second-generation mid-term plans. Prevention was essentially based on the control of sexual transmission risks and safe blood transfusion. The promotion of voluntary testing and counselling contributed considerably to prevention in general and the prevention of mother-to-child transmission in particular.

2.3.1.4 Since 1998, countries have been engaged in the strategic planning process in order to prepare a third-generation national plan (MTP3). The plan emphasizes the analysis of the HIV/AIDS situation in the country and provides a critical review of the response to the epidemic. Such analysis helps to identify risk and vulnerability factors so as to attack the problem at its roots, identify the obstacles hindering HIV/AIDS control activities and highlight the opportunities for enhancing or strengthening thes activities.

2.3.1.5 While progress was made in strategic planning process to target appropriate actions against the epidemic, political commitment at the highest level which is a pre-condition for the successful implementation of HIV/AIDS control programmes was missing in most of the countries until recently. Political commitment should be reflected in concrete measures and actions that go beyond simple declarations. This commitment could be in the form of domestic resource mobilization or the inclusion of HIV/AIDS-related issues in school programmes or messages broadcast by State media.

2.3.1.6 The nongovernmental response to the AIDS epidemic has generally been very strong in most African countries. In Uganda, the involvement of NGOs and community-based organizations (CBOs) in prevention activities and in the provision of effective psychological and social care to people living with HIV/AIDS significantly contributed towards bringing down the adult HIV prevalence rate from 14% in 1995 to 8% in 2000. In Senegal, due to intensified community responses, the HIV prevalence rate in the population has been stabilized at around 1.7%. Civil societies in general and political and religious leaders in particular have been mobilized and original mechanisms for financing community initiatives against HIV/AIDS have been gradually set up. In these two countries, NGOs and community-based organizations (CBOs) have been organized into associations and networks that allow them to provide effective outreach services in awareness building and information dissemination, much of it focusing on youth. The relative success of these experiences suggests that, in the majority of countries, the Coordination Bureau of the NACPs should establish close collaboration with these NGOs and CBOs, which have demonstrated their capacity to mobilize communities and promote local response in the fight against HIV/AIDS (see Annex 4). In the same vein, mobilization of the private sector in HIV/AIDS control is promising and should be encouraged.

2.3.2 Response at the continental and Subregional levels

2.3.2.1 Relatively few initiatives in the form of regional or subregional programmes to address the HIV/AIDS epidemic have been undertaken. Regional and subregional institutions such as the ECA, OAU, ECOWAS, SADC and UEMOA have shown their commitment in the struggle against HIV/AIDS through the organization of conferences and meetings on HIV/AIDS and related issues to increase awareness and mobilize political commitment in RMCs. A commitment was made at the Economic Summit of Heads of State, organized by the IMF, the World Bank and the ADB in January 2000, in Libreville (Gabon),

to use the funds freed through the debt relief exercise under the Highly Indebted Poor Countries (HIPC) Initiative, to finance the social sectors, including HIV/AIDS control activities. Subsequently, a number of countries that have benefited from the Bank Group debt relief under the enhanced HIPC framework incorporated HIV/AIDS control as one of the priority issues in their I-PRSPs.

2.3.2.2 The African Development Forum on HIV/AIDS: The Greatest Development Challenge, organized by ECA in December 2000 and the OAU Heads of State Summit on HIV/AIDS, Tuberculosis and Other Infectious Diseases organized by the OAU in April 2001 are two important regional efforts that brought political leadership to focus on the strategy for mobilization of additional financial resources to fight the scourge of the epidemic in Africa. At the Abuja Summit, African leaders pledged to devote 15% of their national annual budget towards health, particularly towards the fight against HIV/AIDS.

2.3.2.3 UNAIDS, for its part, has put in place Inter-Country Teams (ICT) in Abidjan and Pretoria to support initiatives involving inter-country partnership within the region, as well as to assist the creation of technical resource networks in the fields of management, operations and research.

2.3.3 Response at the international level

2.3.3.1 There has been a lot of effort and good will from international organizations and multilateral institutions to contribute towards the fight against HIV/AIDS in Africa. However, there is a need to translate this commitment and good will into concrete actions in critical areas such as: i) promotion of leadership and coordination; ii) alleviation of the social and economic impact of the epidemic; and iii) reduction of vulnerability. Over time, the majority of the United Nations specialized agencies are embarking on HIV/AIDS control activities.

- The United Nations Joint Programme on AIDS (UNAIDS), cosponsored by the United Nations and the World Bank, was created in January 1996 and replaced the Global Programme on AIDS (GPA). The mission assigned to UNAIDS is to steer, strengthen and support extended action to prevent the spread of HIV, provide health care and support to persons living with and affected by HIV/AIDS, reduce the vulnerability of individuals and communities to HIV and lessen the human and socioeconomic impact of the epidemic.UNAIDS and its sponsoring agencies, meeting in Annapolis (Maryland, United States of America), in January 1999, decided to collaborate as a matter of urgency in setting up an international partnership against AIDS in Africa **(**IPAA). This international partnership, which extends beyond the UN system, constitutes a coordination framework for mobilizing human and financial resources and for creating the necessary synergies to intensify the fight against HIV/AIDS in Africa (see Annex 5).

- The World Bank considers HIV/AIDS control a development priority and allocates considerable resources towards the fight against the epidemic in Africa. Its Multi-Country HIV/AIDS Programme (MAP), with objectives to scale up prevention, care and support and treatment programmes, has already been launched in some African countries.

- The UN specialized agencies such as the UNDP, UNFPA, UNICEF, WHO, ILO, UNESCO and others are also engaged in HIV/AIDS control activities focusing on their specialized areas of mandate; e.g. UNDP in poverty, UNFPA in reproductive health (RH); UNICEF in MTCT; WHO in health; ILO in labour and employment, etc. Similarly, international NGOs and bilateral donors are also continuing to support Africa in the fight against the epidemic.

2.3.3.2 Recently, important initiatives and decisions were taken by the international community to mark its commitment towards HIV/AIDS control.

- The Millennium Initiative on Vaccine and Health, launched in April 2000, called upon multilateral development banks to mobilize resources in the fight against transmissible diseases, including HIV/AIDS.

- The XIIIth International AIDS Conference held in Durban (South Africa), in July 2000, laid the groundwork for negotiations between agencies of the United Nations system and pharmaceutical companies on issues of access to affordable drugs, including antiretrovirals.

- The continuous advocacy role played by national and international NGOs to make HIV/AIDS drugs accessible recorded a breakthrough by bringing multinational pharmaceutical companies to considerably reduce drug prices and to accept that governments can use measures within the TRIPS agreement, such as parallel importation, generic substitution and compulsory licensing, to make HIV/AIDS drugs accessible to their people.

- The UN General Assembly Special Session on HIV/AIDS, held in June 2001 in New York, represented a landmark event. It resulted in worldwide commitment towards the fight against HIV/AIDS in Africa and elsewhere through the global endorsement of the Declaration of Commitment, and the creation of the Global Fund Against AIDS, Tuberculosis and Malaria (GFATM).

2.3.4 Outcome of response: lessons learnt

2.3.4.1 The response against the HIV/AIDS epidemic has covered areas such as prevention, care (psychological, medical and social), support to those living with and affected by HIV/AIDS, research, and management of HIV/AIDS control programmes. Positive results have been obtained in all areas but HIV infection continues to spread, the AIDS epidemic is progressing and the access of African countries to antiretroviral treatment is far from being a reality.

2.3.4.2 The prevention of HIV/AIDS transmission seeks primarily to change high-risk sexual behaviour. It is based on information, sensitization in favour of abstinence or fidelity, the promotion of the use of the condom, the early treatment of STIs, counselling and voluntary testing. The use of communication channels such as the media, peer education, and the incorporation of HIV/AIDS into school curricula, plays and other forms of artistic expression have produced appreciable results at relatively low cost. Special emphasis should be placed on peer education and the development of local and community knowledge on HIV, with the involvement of the public, including persons living with HIV/AIDS.

2.3.4.3 Most of the prevention activities emphasized risk factors, while the reduction of vulnerability, requiring the involvement of sectors (other than the health sector), has not received the attention it deserves. The integrated multisectoral approaches recommended by the second-generation medium-term plans (MTP2) have met with mixed success. In most countries, sectors other than the health sector, which is in charge of HIV/AIDS programmes, did not take an active part in the national response to the epidemic.

2.3.4.4 Inadequate functional health facilities, human and financial resources, equipment and supplies have been the major obstacles for extending HIV/AIDS prevention and care services at the community level. The provision of such services at the level of the community primary health-care system would help control the spread of the epidemic.

2.3.4.5 The mother-to-child transmission risk can be decreased from about 30–35% to around 5%, due to the administration of either of two antiretroviral drugs (AZT or Nevirapine) during a given period at the time of pregnancy and after delivery. In several African countries, studies are under way to identify efficient methods of treatment at an affordable cost. This type of prevention will require of African leaders not only a political commitment but also a financial one.

2.3.4.6 Prevention of HIV transmission via blood transfusions or contaminated medical equipment requires continuous vigilance for safe blood transfusion and compliance with aseptic measures.

2.3.4.7 Medical care is limited to the treatment of opportunistic infections, which often are the cause of death of people living with HIV/AIDS, and the cost of this treatment is usually more affordable than antiretroviral drugs. Tri-therapy considerably prolongs the life of the patient and ensures him/her a good quality of life. Initiatives have been taken by UNAIDS to make the drugs affordable, through pilot projects that are yet to be generalized. All the partners should back these projects and advocacy campaigns aimed at pharmaceutical laboratories, and the private sector involvement should be intensified to ensure that these drugs are affordable to all. It is also necessary to strengthen services such as laboratory monitoring and psychosocial support through counselling.

2.3.4.8 Psychological and social care is generally provided by civil society organizations that take over from health personnel. The associations of persons living with HIV/AIDS and NGOs play a vital role at the community level where they provide home-based care to ensure the continuity of care and lessen the pressure on health facilities.

2.3.4.9 Support to persons living with or affected by HIV/AIDS that encompasses all initiatives seeking to lessen the socioeconomic impact of AIDS, particularly, the measures aimed at making up for the lost income of HIV-positive individuals or of their survivors, and support for orphans and/or widow are provided mainly by civil society organizations, associations, NGOs, the private sector and governments. However, there is a need to scale up such impact-mitigating interventions in order to accommodate the growing number of persons living with or affected by HIV/AIDS.

2.3.4.10 Research on the different issues of HIV/AIDS has helped to improve knowledge about the epidemic with a view to designing better prevention, care and support interventions. However, analytical research on the sociological, anthropological and cultural

issues of HIV/AIDS in the region is not yet well documented. With respect to vaccines, research is under way and tests are being carried out in the United States, Africa and Asia. New drugs are regularly developed by pharmaceutical laboratories and, in Africa, traditional healers are becoming more and more interested in HIV/AIDS. Considering that they are consulted by a large segment of the population, these traditional healers could play a crucial role in prevention as well as in psychological and social care.

2.3.4.11 One of the prerequisites for the success of a National AIDS Control Programme is, first and foremost, a political commitment epitomized by concrete decisions in favour of a strong national response to HIV/AIDS. This political commitment exists at the highest level in an increasing number of African countries; however, such commitment has not yet trickled down to the level of sector ministries and decentralized structures to encourage the full mobilization of sectors other than the health sector. Another condition for success is the commitment of the development partners alongside the countries.

2.3.4.12 The implementation of the National AIDS Control Programmes (NACPs), particularly their financial management, remains centralized. The Coordinating Bureau of NACPs tends to go beyond its catalytic and coordination role and ends up encroaching on implementation activities that disturb those working in the field, thereby considerably limiting the chances of success. In the absence of appropriate decentralization and a clear mechanism for directly financing the community structures, very little or no funding goes to the NGOs, associations and the populations that are expected to benefit from the resources mobilized in the fight against HIV/AIDS**.** Often the existing resources remain unutilized due to the complexity and inflexibility of donor rules and procedures. It is incumbent upon donors, including the Bank, to develop and introduce new financing mechanisms that are best adapted to meet the evolving needs of RMCs.

CHAPTER III: THE BANK'S HIV/AIDS STRATEGY

The Bank's assistance to RMCs for HIV/AIDS prevention and control falls within its mandate for poverty reduction, as articulated in the vision statement approved by the Board of Governors in 1999.

3.1 OBJECTIVES

The objectives of the Bank's HIV/AIDS strategy are to:

- assist the RMCs in their efforts to develop and implement multisectoral HIV/AIDS control activities; and

- within this framework, support the programmes prepared and led by the UN's specialized agencies and other partners in the fight against HIV/AIDS in Africa.

3.2 GUIDING PRINCIPLES

In carrying out the above objectives, the Bank will be guided by the principles laid down by UNAIDS and those of the Dakar Declaration (July 1994) by the African Network on Ethics, Law and HIV.

- Long-term action: HIV/AIDS needs long-term and sustainable action and, to this end, it is essential that individuals and communities work together. It is

therefore necessary to build their capacity, establish HIV-prevention programmes, provide health care and lessen the impact of the epidemic.

- Technical reliability: actions aimed at checking the spread of HIV/AIDS should not only be far-reaching but also improved qualitatively, through the definition of policies and strategies and the use of technically reliable tools and approaches.

- Stressing vulnerability: efficiency in action implies, first and foremost, introducing changes that may reduce the vulnerability of certain population groups, particularly women, youths and migrant workers.

- Principle of empowerment*:* each individual, government, community, institution, private concern and member of the media should be aware of its duties and perform them actively and constantly.

- Support and not rejection: an enabling social, political and legal environment helps individuals to assume their responsibilities, through self-protection and by protecting others from HIV infection.

- Rights of the individual: everyone should enjoy his/her rights without discrimination based particularly on the HIV sero-status; in the same vein, people have the right to health, employment, privacy, freedom from sexual constraints or violence, to information and to the means of preventing infection.

- Participation and partnership: participation of all the communities concerned (including people living with HIV) and partnership provide the most effective mechanisms for conducting a multisectoral HIV/AIDS control action.

- National autonomy: each country has a primary responsibility to design, implement and coordinate its national HIV/AIDS control action. The role of external partners is to support and strengthen actions taken at the national level.

- Avoiding new structure: the focus should be on the strengthening of existing structures for coordination and monitoring of HIV/AIDS activities by increasing the functional effectiveness in order to ensure the optimal use of limited resources in the fight against HIV/AIDS.

3.3 PRIORITY AREAS

The Bank, drawing from past experiences, will contribute to the efforts against HIV/AIDS in the following priority areas:

- Promotion of political commitment at all levels in order to improve the social, ethical, legal and financial environment with respect to HIV/AIDS control;

- Support to sectoral responses for a more efficient focus on vulnerability factors and on efforts to reduce risks**:** promotion of decentralization of responses, community participation and ownership with a view to creating the right conditions for every member of society to have access to knowledge and

the possibility to develop the required competency with regard to HIV/AIDS control; and

- Strengthening of coordination for greater synergy of the HIV/AIDS control actions.

3.4 STRATEGIES

To support RMCs in their HIV/AIDS control efforts, in close collaboration with the ongoing efforts by other partners, the Bank Group will focus on the following strategies:

3.4.1 Advocacy and policy dialogue

3.4.1.1 The Bank's advocacy activities will be geared towards decision-makers, administrators and beneficiaries of National AIDS Control Programmes throughout the RMCs, and with a view to ensuring that the HIV/AIDS dimension is taken into account in the formulation of national development strategies and programmes. The Bank's advocacy and policy dialogue with RMCs will attempt to bring the political leadership to focus on: i) comprehensive multisectoral national strategic plan; ii) laws or measures against traditional and cultural practices that increase the risk of infection to vulnerable groups (women, children, youth); iii) promotion of the use of ARV therapy and prophylaxis among pregnant women and children to prevent mother-to-child transmission and ensure survival of mothers; iv) allocation of adequate resources to finance HIV/AIDS activities; and v) actions for greater involvement of people living with HIV/AIDS.

3.4.1.2 Another important objective will be to sensitize the governments on the need to respect the rights of HIV-positive people and those vulnerable to HIV/AIDS infection, as well as the rights of individuals and communities responding to the epidemic. The Bank will also promote accountability and transparency in the management of HIV/AIDS operations within the full participation of people living with HIV/AIDS. As well, the Bank will promote and support policies and mechanisms that allow the population to acquire the necessary knowledge on the dynamics of the epidemic, efficiency of national responses, mobilization of resources and coordination of activities. The Bank's advocacy efforts will also aim to encourage greater commitment from civil society leaders, including, *inter alia*, community-based organizations (CBOs), NGOs, religious and traditional groups and trade unions, who play a crucial role in social mobilization, sensitization and human resource development in the face of HIV/AIDS.

3.4.1.3 The Country Strategy Paper (CSP), which builds on country-owned Poverty Reduction Strategy Papers (PRSP), remains the principal instrument of policy dialogue with RMCs to position HIV/AIDS as a central development issue and to assist governments in promoting sustainable multisectoral responses against the epidemic. Policy dialogue with RMCs on HIV/AIDS will underscore the importance of monitoring progress towards the attainment of International Development Goals set for 2015, which include targets set for the reduction of HIV/AIDS prevalence rates.

3.4.2 Mainstreaming of HIV/AIDS control in Bank operations

3.4.2.1 Given the crosscutting nature of the HIV/AIDS issue and its impact on the different sectors, the Bank has already taken HIV/AIDS into account in the formulation and/or updating of its sectoral policies for agriculture, health, education, population and gender equality. The incorporation of HIV/AIDS control into the Bank's policy documents will be continued, and emphasis will be placed on vulnerability and sensitivity of the sector in order to determine the level of priority to be given to mainstreaming HIV/AIDS.

3.4.2.2 In mainstreaming HIV/AIDS into the Bank's operations, priority will be given to the social, agricultural and infrastructure sectors. Special attention will also be given to trans-sectoral issues such as poverty reduction, good governance, gender and population. The mainstreaming of HIV/AIDS into the Bank Group operations will be promoted through: i) analysis of HIV/AIDS dimensions in the PRSPs and CSPs; ii) assessment of the impact of HIV/AIDS on key sectors in the context of economic and sector work (ESW); and iii) screening of project and programme proposals so as to ensure that the HIV/AIDS dimensions are fully taken into account and reflected in project design.

3.4.2.3 The Bank will take into account the interventions of other partners in the sector, and the priorities expressed by the beneficiaries, in order to focus its HIV/AIDS control actions**.** The Bank's HIV/AIDS control activities will cover prevention, care and impact-mitigating activities that will target primarily disadvantaged groups such as women and other vulnerable groups of society (e.g. youth, girls, orphans, the disabled etc.). These will include, but not be limited to, the following:

- strengthening of the capacity of primary health centres at the community level to provide services in RH, STI/HIV/AIDS prevention, MCH and nutrition, as well as full implementation of childhood immunization programmes;
- awareness campaigns targeting different groups of the population, with emphasis on harmful practices causing HIV/AIDS;
- voluntary counselling and testing services;
- blood screening services and safe blood provision;
- development of STI/HIV/AIDS prevention programmes in schools;
- provision of prophylaxis and full ARV post-partum treatment to pregnant women and children to prevent MTCT and ensure survival of mothers;
- youth access to health services and development of youth educational programmes for behavioural change;
- support to orphans and families;
- increased educational and employment opportunities for girls and women; and
- human Resource Development in the different areas of HIV/AIDS control

3.4.2.4 In addition, in line with its special mandate to promote regional integration, the Bank will give priority to inter-country, subregional and regional HIV/AIDS

activities. Support in this area will address cross-border issues such as transport corridors, migrant workers and refugees.

3.4.2.5 The mainstreaming of HIV/AIDS into Bank activities and operations offers an opportunity for enhancing decentralization and development of community-based local responses. Effective decentralization and development of local responses can best be achieved where the decentralized structures and entities are autonomous. This, in turn, requires a participatory approach, knowledge development among the community members and organizations involved, and resource management by the decentralized organizations concerned**.**

3.4.2.6 Bank activities will follow a participatory approach that allows the involvement of broad stakeholders at all the stages of planning, implementation, follow-up and evaluation of the decentralized responses, with a view to promoting community ownership of interventions. Community ownership and sustainability of responses will also be promoted b**y** the development of demand-driven proposals with the objective of better targeting local needs. In this framework, the Bank will support capacity-building initiatives for analysis of the risks of, and vulnerability to, HIV infection.

3.4.2.7 An efficient and long-lasting response at the local level implies not only internal skills and know-how, but also internal resources managed directly by each organization. The Bank will assist in the establishment of mechanisms for involving the beneficiaries in the management of resources allocated to HIV/AIDS control and monitoring/evaluation of their utilization. These mechanisms should ensure greater transparency in management and resource allocation to local initiatives, through flexible and direct financing.

3.4.3 Partnership development

3.4.3.1 The Bank supports the strategic partnerships set up to fight HIV/AIDS in Africa—in particular, the International Partnership against HIV/AIDS in Africa (IPAA), established by UNAIDS. The IPAA is a coalition that works under the leadership of African governments to harness the resources of the United Nations, donors, and the private and community sectors. The IPAA is a viable coordination mechanism that will increase the functionality and development effectiveness of responses by different institutions**.** The Bank's involvement and activities in HIV/AIDS will be carried out mainly within the framework of IPAA-sponsored HIV/AIDS control interventions.

3.4.3.2 In the same vein, close cooperation will be maintained with the regional and subregional organizations and institutions, such as the OAU, ECA, ECOWAS, UEMOA and SADC. The strategic partnership with the World Bank, in respect of which a Memorandum of Understanding was signed in March 2000, gives a prominent position to the collaboration between the two Banks on HIV/AIDS control activities in RMCs. Within the context of its cooperation agreements, the Bank will also coordinate its actions with bilateral partners that are not members of the International Partnership against HIV/AIDS in Africa.

CHAPTER IV: IMPLEMENTATION MODALITIES

4.1 INSTITUTIONAL AND POLICY MEASURES

The implementation of the Bank Group HIV/AIDS Strategy will be facilitated by the following actions:

- The Country Departments will have the primary responsibility for the mainstreaming of HIV/AIDS into Bank Group operations. These activities will be coordinated by a focal point to be established within the Central Operations Department (OCOD). The focal point will also be responsible for the policy dimensions, and for liaison and collaboration with partner institutions. It will also prepare an annual progress report to the Boards of Directors;

- There is need to strengthen the internal capacity of the Bank relating to HIV/AIDS, through staff training and sensitization programmes, as well as the recruitment of specialists for project design and implementation;

- Special measures are also needed to ensure that HIV/AIDS-related issues are taken into account in the policy dialogue with RMCs and in the formulation of the Bank's Country Strategy Papers (CSPs). These issues should also be given priority attention by the countries themselves, especially in the preparation of their own Poverty Reduction Strategy Papers (PRSPs).

4.2 OPERATIONAL MEASURES

4.2.1 Operationalization of HIV/AIDS activities

4.2.1.1 In keeping with the priorities identified in the Vision Statement, the Bank's HIV/AIDS activities will give priority to the social (health and education), agricultural and infrastructure sectors. They will also focus on the cross-cutting issues: poverty reduction, good governance, gender and population, which have a major impact on the effectiveness of HIV/AIDS control programmes. A three-year rolling Action Plan will be developed to monitor the implementation schedule of targeted activities defined in line with these priorities. An outline of the Action Plan is presented in Annex 6.

4.2.1.2 The mainstreaming of HIV/AIDS into Bank Group operations will involve the following measures:

i) Project preparation and design

HIV/AIDS will be taken into account from the beginning of the Bank's project preparation phase, in accordance with the practical guidelines presented in Annex 7. During identification and preparation, the project team will analyse the HIV/AIDS situation prevailing in the country or sector concerned; the findings and recommendations of this analysis, as well as consultation with the local partners and civil society representatives, will guide the Bank in

determining its areas of intervention. The HIV/AIDS issues should be systematically discussed in the relevant sections of the project appraisal reports.

The Bank Group intervention will include HIV/AIDS control components or stand-alone HIV/AIDS projects and programmes. HIV/AIDS control activities will be included in the regular Bank-financed projects, with a special focus on: social sector operations, aimed at introducing behavioural change; agricultural and rural development projects, which benefit large and diversified segments of the population with limited knowledge of the risk factors; and infrastructure (particularly transport) projects, facilitating population movements and, consequently, the spread of HIV/AIDS.

ii) Monitoring and evaluation

Monitoring and evaluation of the implementation of the Bank's strategy will be undertaken in order to learn from its successes and failures. Such lessons will contribute towards global knowledge on best practices of HIV/AIDS prevention and impact-mitigation activities. These activities will be carried out with the technical support of the UN specialized agencies and other partners, as necessary.

iii) Research

In order to expand the knowledge base to help countries design and manage comprehensive programs, the Bank will support operational research in socio-cultural and behavioural area and other socioeconomic domains relevant for the control of HIV/AIDS in Africa. The Bank will also lend its support to research on HIV/AIDS epidemiological surveillance system, on the development of vaccines and therapeutic medicines, including those based on plants (Bank Group Health policy, 4.1.4), and on the cost-effectiveness of wider availability of drugs to treat opportunistic infections.

4.2.2 Resource mobilization

4.2.2.1 The primary challenge in the fight against HIV/AIDS is to mobilize the resources to meet the scale and devastating impact of the epidemic. Greatly increased resources are needed to expand national capacities to respond to the epidemic, support essential infrastructure and training, mitigate the social and economic impact, expand successful prevention interventions and implement a broad care and support agenda. Increased investment from donors, domestic budgets and private companies need to be combined with additional funds to meet Africa's resource requirements. The establishment of the UN-sponsored Global Fund Against AIDS, Tuberculosis and Malaria (GFATM) is a step forward in creating a viable mechanism to address this urgent problem of resources.

4.2.2.2 The successful implementation of the Bank's strategic objectives and priorities in HIV/AIDS assistance to RMCs will require the mobilization of additional resources. The mobilization of resources for HIV/AIDS control activities will be achieved through mainstreaming of HIV/AIDS control measures in all Bank activities, in particular by integrating HIV/AIDS components in Bank-financed projects and programmes. Through its

involvement and assistance to RMCs in the preparation of their PRSPs, the Bank would also ensure that priority be given to the social sectors and poverty alleviation efforts in the use of the debt relief assistance provided under the HIPC initiative, with a special focus on HIV/AIDS and communicable diseases. More grant resources are needed to meet the funding gap in priority areas, including: i) institutional capacity-building and support for community-based local responses to develop competency for sustainable prevention and care; ii) operational research to expand the knowledge base of the design and management of comprehensive programmes based on local circumstances and best practices; iii) supporting prevention and care measures, including treatment of HIV-positive pregnant women and children with ARVs to prevent MTCT; and iv) partnership development activities with development partners such as the UN specialized agencies, the World Bank and regional institutions.

5.1 CHAPITER V: CONCLUSION AND RECOMMENDATIONS

5.1.1 HIV/AIDS is both a development and human problem and, as such, it affects every sector. The close relationship between the epidemic and most of the sectors makes it necessary to adopt multisectoral control strategies and to give priority to an integrated participatory approach. More than just a health problem per se, HIV/AIDS is now one of the main challenges to poverty reduction and sustainable development in Africa. Hence the importance of the 'AIDS and Development' issue, which underpins the Bank's strategic options.

5.1.2 Cognisant of its limitations with respect to resources—both human and financial—and confident of the ongoing effort by development partners, the Bank has chosen to intervene in selected priority areas to support RMCs in their battle against the HIV/AIDS epidemic. These are: i) the promotion of political commitment at all levels through advocacy and policy dialogue; ii) back-up of sectoral responses by mainstreaming HIV/AIDS into its operations and promoting decentralization and community-based local responses against the epidemic; and iii) the strengthening of coordination mechanisms in order to obtain greater synergy in HIV/AIDS control by supporting the IPAA and enhancing coordination with regional and subregional institutions, NGOs and the private sector.

5.1.3 The Bank's operational modalities include, *inter alia*, the strengthening of internal capacity of the Bank on HIV/AIDS to guarantee smooth implementation of the strategies, the decentralization of responsibilities for mainstreaming HIV/AIDS activities into departments, and the mobilization of the required resources.

5.1.4 The Bank's strategic options with regard to HIV/AIDS control in the RMCs will allow the Bank to attain its Vision objective of poverty reduction and human capital development, in addition to symbolizing its contribution towards the global fight against HIV/AIDS within the IPAA.

In light of the foregoing, the Board members are invited to approve this strategy for Bank Group assistance to RMCs with regard to HIV/AIDS.

ANNEXES

REGIONAL HIV/AIDS STATISTICS AND FEATURES AS OF END 2001

REGION	BEGINNING OF EPIDEMIC	ADULTS AND CHILDREN LIVING WITH HIV/AIDS	NEW CASES OF HIV INFECTION AMONG ADULTS AND CHILDREN	ADULT PREVALENCE RATE	PERCENTAGE OF HIV-POSITIVE ADULTS WHO ARE WOMEN	MODES OF TRANSMISSION[2] AMONG ADULTS LIVING WITH HIV/AIDS
Sub-Saharan Africa	End 70 Begin. 80	28.1 million	4 million	8.4 %	55 %	Hetero
North Africa & Middle East	End 80	440,000	80,000	0.2 %	40 %	ID, Hetero
Southern & south-east Asia	End 80	6.1 million	800,000	0.6 %	35 %	Hetero, ID
East Asia and the Pacific	End 80	1 million	270,000	0.1 %	20 %	ID, Hetero, MSM
Latin America	End 70 Begin. 80	1,4 million	130,000	0.5	30 %	MSM, ID, Hetero
The Caribbean Islands	End 70 Begin. 80	420,000	60,000	2.2 %	50 %	Hetero, MSM
Eastern Europe and Central Asia	Begin. 90s	1 million	250.000	0.5 %	20 %	ID
Western Europe	End 70 Begin. 80	560,000	30.000	0.3 %	25 %	MSM, ID
North America	End 70 Begin. 80	940,000	45.000	0,6 %	20 %	MSM, ID, Hetero
Australia and New Zealand	End 70 Begin. 80	15.000	500	0.1 %	10 %	MSM
TOTAL		**40 million**	**5 million**	**1.2 %**	**48 %**	

For an average prevalence of 1.2% for all the geographical regions worldwide, Africa records 8.4%, followed by the Caribbean Islands with 2.2%; all the other regions are below 1%.

[1]Proportion of adults (aged 15 to 49 years) living with HIV/AIDS in 2000, according to 2000 demographic statistics.

[2]Hetero: heterosexual transmission; MSM: transmission among men who have sex with men; ID: transmission by injecting drugs.

BANK GROUP OPERATIONS IN HIV/AIDS

Country	Project title Loan amount	Date of approval/ status	Details of the components
1. Botswana	*Stockbreeding Improvement Project* (UA 40,000 for HIV/AIDS)	November 2000	- IEC activities
2. Burkina Faso	Burkina Health II (ADF UA 10 million) (UA 1 million. for HIV/AIDS)	1999	- IEC, laboratory equipment - Counselling, - AIDS testing - Sensitization on HIV/AIDS and STI
3. Burundi	Health: Rehabilitation Project (ADF UA 7.9 million) (TAF UA 0.7 million)	1998	- Rehabilitation of the blood testing laboratory; - Supply of laboratory equipment - Staff training
4. Chad	Programme in Support of the Strengthening of the National HIV/AIDS and STI Control system (TAF UA 1 million) (ADF UA 5 million)	2001	- Construction, equipment of the National and Regional Blood Transfusion Centre - Basic supply of pharmaceutical products and consumables, Antiretroviral drugs - IEC - Construction and equipment of the National Centre and 3 psychomedico-social support units. - Staff training - Support for the preparation of the inter-regional HIV/AIDS control initiative
5. Côte d'Ivoire	Project for the Rehabilitation of Hospital Infrastructure and Support to the Basic Health Care Services. (ADF: UA 7.3 million) (ADB: UA 4.05 million HIV/AIDS Component: UA 529,000)	1990 (Ongoing)	- Construction, equipment of a Regional Blood Transfusion Centre in Daloa - 4 blood banks and 4 regional hospitals
6. Djibouti	Strengthening of the Health Services (UA 1 million for HIV/AIDS	2001	- Capacity-building for the National AIDS Control programme
7. D.R.C. (ex-Zaire)	Strengthening of the Immunology Laboratory of the University of Kinshasa	1988	- Medical equipment for laboratories - Construction of premises for testing on animals - Training
8. Gabon	Health: Rehabilitation Project (ADF UA 10 million)	1999	Rehabilitation of the blood testing laboratory; Supply of laboratory equipment - Staff training
9. Gabon	Support to HIV/AIDS and STI Control. ADB: UA 5.0 million	2001	- Development of safe blood transfusion system - Staff training; - IEC on HIV/AIDS and STI
10. Guinea	Strengthening of the Health System (ADF: UA 300,000 for HIV/AIDS)	2000	- Capacity-building - Sensitization programme on HIV/AIDS and STI

11. Kenya	Health II (SWAP: UA 2.34 million for HIV/AIDS)	1998	- Capacity-building - Sensitization on HIV/AIDS and STI - RH/HIV/AIDS/STI component
12. Lesotho	Project for the Improvement of Natural Resources and Rural Income (40,000 UA for HIV/AIDS)	2000	- Support to the HIV/AIDS Control and Prevention Programme.
13. Lesotho	Health V (UA 0.5 million)	2001	- Capacity-building - Support to the National HIV/AIDS Control and Prevention Programme
14. Mauritania	Sector Investment Programme (0.5 million UA)	1998	- Support to the National STI/HIV/AIDS Programme; - Equipment and supplies ; - Staff training - Procurement of pharmaceuticals including ARVs
15. Malawi	Support to the National AIDS Control Programme (TAF grant: about UA 1 million.	1999	- Capacity-building
16. Malawi	Health III (UA 1,300,000 for HIV/AIDS)	2000	- IEC - Equipment and supplies
17. Mali	Support to PRODESS (SIP) (UA 1.0 million)	For 2001	- Regional STI and HIV/AIDS Control Initiative (Sikasso Region); - IEC, reinforcement of laboratories - Blood bank - Provision of medical supplies including ARVs to children, widows, migrants
18. Mali	Support to community food security in Mopti (UA 0.05 million)	2001	- IEC
19 .Morocco	Project for the Strengthening of Basic Health Care in the Rural Areas (ADF UA 18,5 million) (BAD UA 18,42 million)	1992	- Support to the National STI/HIV/AIDS Programme; - Supplies; - Staff training; - Procurement of pharmaceuticals including ARVs.
20. Mozambique	Improvement in Family Income (UA 40,000 for HIV/AIDS)	2000	- IEC
21. Mozambique	Health Project II (UA 1,000,000 for HIV/AIDS)	December 2000	- IEC - Capacity-building to National AIDS Control Programme
22. Mozambique	Integrated Water and Sanitation Programme (UA 140,000 for HIV/AIDS)	December 2000	- Sensitization and awareness campaign
23. Mozambique	Road Rehabilitation (UA 50,000 for HIV/AIDS)	December 2000	- IEC

24. Mozambique Multinational	Technical Assistance to the Southern Africa transport and Communications commission (ADF UA 350,000) (UA 348,000 for HIV/AIDS)	2000	- Sensitization and awareness campaign for control of HIV/AIDS in the transport sector
25. Niger	Health II (ADF 1.14 million UA)	2001	- Blood transfusion - Testing and counselling - Provision of ARVs
26. Nigeria	Project for Poverty Reduction in the Villages. (ADF UA 10.5 million) (UA 1.6 mill. for HIV/AIDS)	December 2000	- Advocacy - Assistance provided by community groups and nongovernmental organizations with respect to preventive measures.
27. Tanzania	Health Rehabilitation Project (ADF UA 0.41 million)	1997	Support to the National STI/HIV/AIDS Programme – IEC and organization of workshops on HIV/AIDS involving the private and commercial sector ; Rehabilitation of laboratories and supply of modern equipment
28. Togo	Project for the Rehabilitation of the Regional Hospitals and Strengthening of the Supply Pharmacy (ADF UA 13 million)	1992	- Laboratory equipment for AIDS and STI testing in the regional hospitals; - Training of medical staff and laboratory technicians; - Sensitization to the HIV/AIDS & STI Programme .
29. Uganda	Health Rehabilitation Project (ADF UA 25.3 million) and NTF UA 5.0 million.	1990	- HIV/AIDS training seminar in the district schools .
30. Uganda	Health Sector Support Project (ADF UA 30 million)	2000	- HIV/AIDS and other communicable diseases.
31. Zambia:	Education II (UA 40000)	1999	- HIV/AIDS seminar
32. Zambia:	Small-Scale Irrigation Project (UA 30,000)	2000	- Institution-building - Sensitization on HIV/AIDS & STI - Staff training
33. Zambia	Central Water Supply Project (UA 550,252 for HIV/AIDS)	December 2000	- IEC on HIV/AIDS
34. Zambia	Support to the National AIDS Control Programme (UA 1 million)	For 2001	- Institution-building
35. Zimbabwe	Support to the National AIDS Control Programme (UA 1 million)	For 2001	- Capacity-building to National AIDS Control Programme

ESTIMATION (%) OF HIV/AIDS PREVALENCE

AMONG ADULTS (15–45 years) BY COUNTRY, 2000

Countries	Rates (%)
1. Algeria	0.07
2. Angola	2.78
3. Benin	2.45
4. Botswana	35.80
5. Burkina Faso	6.44
6. Burundi	11.32
7. Chad	2.69
8. Cameroon	7.73
9. Cape Verde	-
10. Central Africa Republic	13.80
11. Comoros	0.12
12. Congo	6.43
13. Côte d'Ivoire	10.76
14. Djibouti	11.75
15. Egypt	0.02
16. Eritrea	2.87
17. Ethiopia	10.63
18. Gabon	4.16
19. Gambia	1.95
20. Ghana	3.60
21. Guinea	1.54
22. Guinea Bissau	2.50
23. Guinea Equatorial	0.51
24. Kenya	13.95
25. Lesotho	23.57
26. Liberia	2.80
27. Libya	0.05
28. Madagascar	0.15
29. Malawi	15.96
30. Mali	2.03
31. Morocco	0.03
32. Mauritania	0.52
33. Mauritius	0.08
34. Mozambique	13.22
35. Namibia	19.54
36. Niger	1.35
37. Nigeria	5.06
38. Rwanda	11.21
39. Senegal	1.77
40. Seychelles	-
41. Sierra Leone	2.99
42. Somalia	-
43. Sudan	0.99
44. South Africa	19.94
45. Sao Tome & Principe	-
46. Swaziland	25.25
47. Tanzania	8.09
48. Togo	5.98
49. Tunisia	0.04
50. Uganda	8.30
51. Democratic Republic of Congo	5.07
52. Zambia	19.95
53. Zimbabwe	25.06

Source: UNAIDS: Report on the global HIV/AIDS epidemic, June 2000

EXAMPLES OF EFFECTIVE STRATEGIES IN THE RESPONSE TO HIV/AIDS

1. According to the findings of the study conducted in Rwanda on the impact of counselling and preventive testing services, the rate of HIV infection among women dropped from 4.1% to 1.8% and the gonorrhoea prevalence was reduced from 13% to 6% among HIV-positive women (Allen et al., 1992). The estimated cost of the counselling and voluntary testing programmes in sub-Saharan Africa stands at $4.40 per person advised and tested.

2. An operation in the Democratic Republic of Congo, based on education, treatment of STI and the distribution of condoms to sex professionals raised the condom utilization rate from 10% to 68% in three years. The HIV prevalence rate dropped from 11.7% to 4.4%/woman/year of observation and the cost of curable STI stands at about $2.33 per case.

3. Within the context of a project implemented in Kenya through interventions in the work place, truck drivers received condoms and educational materials and they were treated for STI. At the end of one year, there was a 13% reduction in sexual relations outside wedlock (36% instead of 49%) and a 6% reduction in sexual relations with sex professionals (a drop from 12% to 6%). The number of cases of STI also fell (Jackson et al., 1997). Other studies estimate the cost of an intervention at the place of work, focusing only on education, at $0.50 per worker. The costs of condoms and the treatment of STI are about the same as those indicated above.

4. Studies conducted in Mwanza (Tanzania) show that systematic early STI treatment in a rural community reduced by 42% the number of new HIV infections, at a cost of $10 per person treated (Grosskurth et al., 1995). According to more recent data, it is at the stage of a HIV infection that it is more difficult to treat STI (Wawer et al., 1999).

The problem consists of incorporating those operations and other efficient measures into a large-scale national programme, broadening the scope and ensuring their sustainability. Some countries have also succeeded in containing the epidemic and softening its impact. They have also successfully modified the social standards for assisting those at risk from HIV infection and have significantly lowered the number of new cases of infection. The strong measures taken by those countries and the success of their efforts to prevent HIV are grounds for optimism. Some of these successful efforts are:

- UGANDA: Political commitment at the highest level and effective partnership with civil society brought a sharp drop in HIV prevalence among women in some regions of Uganda, between 1990–1993 and 1994–1995, through behavioural change (Wawer et al., 1999).

- SENEGAL: Muslim and Christian leaders, together with other stakeholders, have admited the existence of the epidemic. AIDS education and condom use successfully reduced transmission among sex workers and enabled the country to maintain its HIV prevalence rate at the lowest level—1.77% (UNAIDS 1998).

(Extract from *Intensifying Actions Against HIV/AIDS in Africa*, world Bank, 1999)

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INTERNATIONAL PARTNERSHIP AGAINST AIDS IN AFRICA

ORIENTATION SUMMARY

- The International Partnership against AIDS in Africa is a coordinated counter-attack to the havoc caused by the epidemic in Africa.
- To launch the elaboration process of the action plan, consultations have been initiated with African leaders at the national, subregional and regional levels, with donors and United Nations institutions.
- Focus is mainly at the community, district and country levels, but regional cooperation and coordination are also strengthened.
- A special team in charge of partnership comprising UNAIDS personnel has been formed by the programme's Secretariat. Funds have been re-routed to support the initial activities of partnership.
- The cosponsors of UNAIDS are currently preparing their respective action plans so as to step up their activities in sub-Saharan Africa.

1. AIDS IN AFRICA : AN EMERGING AND COMPLEX DEVELOPMENT CRISIS

- *Has become the leading cause of death in Africa*
- *Is a reality for one-in-four Africans*
- *Is currently eroding the development achievements of the past few decades*
- *Is becoming a major threat to Africa's socioeconomic development*

The actions undertaken now, will, in the years to come, determine the continent's future.

2. WHY ESTABLISH A PARTNERSHIP NOW?

- *Because of the need to enlarge the current response to face the very rapid spread of the epidemic.*
- *We are aware of the best practices and have noted successes at the local level and in some countries through :*
  - *public recognition of AIDS*
  - *the allocation of local resources leading to external financing*
  - *a multisectoral approach and involvement of civil society*

- *A political opportunity emerges: African Heads of State finally break the enforced silence surrounding the epidemic.*

3. A PARTNERSHIP VISION

By the end of the next decade, African countries would have provided large-scale, sustained and more efficient national responses in their efforts against AIDS. Through collaboration, the fostering and protection of human rights, these countries would significantly reduce the number of new cases of HIV infection, provide continuous care to people living with or affected by HIV/AIDS and their families, mobilise communities, NGOs, the private sector and individuals to address the harmful effects of the HIV/AIDS epidemic in Africa.

4. THE PRINCIPLES OF PARTNERSHIP

- *African political leadership have A LEAD ROLE to play*
- *Action is focused at the COUNTRY LEVEL based on priorities defined by the COMMUNITIES*
- *The respect for HUMAN RIGHTS and full participation of HIV-INFECTED INDIVIDUALS*
- *NO RED TAPE! This partnership will be built on existing structures at the international, regional and national levels.*

5. FIVE MAJOR LINES OF ACTION

- *POLITICAL MOBILIZATION AND ADVOCACY: to arouse a large-scale undertaking by mobilizing Heads of State, pan-African organizations, local chiefs and influential leaders in religious community and economic circles;*

- *DEVELOPMENT OF OBJECTIVES AND STRATEGIES: to provide a global action framework comprising clear objectives and follow-up indicators on the impact of partnerships at the local level, as well as technical and financial support;*

- *SUPPORT TO COUNTRIES: assistance in finalizing the implementation of national plans jointly prepared with partners from the different sectors whilet integrating priorities identified at the community level;*

- *FINANCIAL RESOURCES: to increase and re-orient existing resources and mobilize additional resources from non-traditional sectors;*

- *STRENGTHENING OF TECHNICAL RESOURCES: to assist countries in gaining access to technical assistance at the appropriate time, ensure capacity-building and upgrade the quality of interventions.*

THE HIV/AIDS STRATEGY PAPER FOR BANK GROUP OPERATIONS
INDICATIVE PLAN OF ACTION

Strategies and proposed actions	Objective	Time frame	Responsibility	Output	Estimated budget and source
I. **Institutional capacity-building and strategy launching activities**					
- Nomination of a Focal Point;	For effective co-ordination of Bank Group HIV/AIDS activities with partners and follow up of the implementation of the Strategy.	TBD	TBD	Coordination of HIV/AIDS Bank operations; periodic report on Bank HIV/AIDS activities. Follow-up of partnership activities.	NA
- In-house seminar on the Bank Group Strategy	To raise staff awareness about the epidemic and initiation of staff to the Bank's strategy on HIV/AIDS	TBD	OCOD/CADI.	Have a critical mass of staff with some level of knowledge and competency on HIV/AIDS	TBD
- Production of an abridged form of the Strategy document and relevant accompanying leaflets for distribution.	To disseminate the Bank's strategies on HIV/AIDS in RMCs among stakeholder.	TBD	OCOD/COMU/CDs	Advocacy on Bank's HIV/AIDS ongoing and intended activities	TBD
- Seminar/symposium on HIV/AIDS and the official launching of the Strategy;	To disseminate the Bank's strategies on HIV/AIDS in RMCs among stakeholder.	During the 2002 Bank Group annual meeting	OCOD/SEGL/CADI/ COMU	Advocacy for commitment and partnership on HIV/AIDS	TBD
- Signing of an MOU with UNAIDS	To strengthen strategic partnership	December 2001 or during the 2002 annual meeting	OCOD/OCPU/COMU/SEGL	Advocacy for commitment and partnership on HIV/AIDS	TBD

THE HIV/AIDS STRATEGY PAPER FOR BANK GROUP OPERATIONS

INDICATIVE IMPLEMENTATION PLAN OF ACTION

Strategies and proposed actions	Objective	Time frame	Responsibility	Output	Estimated budget and source
II. **Operationalization of the strategy**					
- Consultation with UNAIDS, other partners, and RMCs for selection of Bank Group interventions within the IPAA.	To select priority areas of HIV/AIDS activities within the framework of the IPAA that would be targeted for Bank Group financing for 2001-04	1st Quarter 2002	OCOD/CDs	Projects/programs/studies identified for Bank Group financing	TBD
- Identification of two countries for financing joint HIV/AIDS activities with the World Bank MAP initiative.	To implement the joint action plan drawn between the two institutions within the framework of the strategic partnership.	2002-2003	OCOD/CDs	Two countries identified for launching joint HIV/AIDS operations.	TBD
- Consultation with ECA/OAU and other sub-regional institutions to support regional or sub-regional initiatives.	To identify and launch collaborative cross-boarder major HIV/AIDS control, capacity-building and impact-mitigating activities.	TBD	OCOD/CDs	Regional or subregional programs identified and processed for Bank financing	

THE HIV/AIDS STRATEGY PAPER FOR BANK GROUP OPERATIONS

INDICATIVE IMPLEMENTATION PLAN OF ACTION

Strategies and proposed actions	Objective	Time frame	Responsibility	Output	Estimated budget and source
-Development of sector specific guidelines, tools, and indicators for priority sectors.	To facilitate the implementation of the mainstreaming of HIV/AIDS in Bank sectoral operations and monitor their impact.	2nd Quarter 2002	OCOD/FSPR/CDs/OESU	Operational guidelines and tolls for priority sectors produced	TBD
-Training, seminar, capacity-building and knowledge sharing initiatives on HIV/AIDS and selected development issues;	To strengthen the Bank's and RMCs capacity to respond to the HIV/AIDS epidemic.	2 per year	CADI/JAI/WBI/OCOD.	Competency on HIV/AIDS control among Bank Staff and staff of RMCs increased	TBD
- Development of web page on Bank Group HIV/AIDS activities and other HIV/AIDS-related issues	To promote advocacy among stakeholders; raise Bank internal capacity and level of competency on HIV/AIDS and related issues.	2002	OCOD/CIMM	HIV/AIDS Web pages on the Bank's website created and regularly maintained, and important data and information made available to facilitate the implementation of Bank Strategy on HIV/AIDS.	TBD
Joint partnership activities with development partners (UN Agencies, World Bank, ECA, OAU, etc.) such as joint organization of workshops, round table; panel discussion; etc,	To promote advocacy on key HIV/AIDS issues in the region and strengthen partnership and co-ordination	yearly	OCOD/CADI/OCPU	Coordination and harmonization of Bank Group HIV/AIDS control activities increased.	TBD

A TOOL FOR FACILITATING THE INTEGRATION OF HIV/AIDS IN BANK OPERATIONS IN REGIONAL MEMBER COUNTRIES

1. INTRODUCTION

1.1. The major determinants in the spread of the HIV infection are behavioural factors such as free sex, casual sex, unprotected sex and early sexual contacts. Medical and health factors such as the presence of STI and ignorance of one's sero-status due to withholding of information concerning positive-tested results by health personnel can favour HIV transmission.

1.2 Socioeconomic factors, such as financial instability, unemployment, poverty, and political factors, such as an inappropriate legal framework on HIV/AIDS and bad governance, that create and/or aggravate situations of vulnerability. Vulnerability is caused by:

- Internal and international *migrations* and all other forms of population movement: the 'displaced' and *refugees*.
- Social and political upheavals that plunge most countries into civil war and force the population into situations of vulnerability.
- Unemployment in countries offering no opportunities for young people.
- Commercial sex work.
- Lack of information and knowledge on the nature of HIV/AIDS and its effects
- Poverty and socioeconomic instability.

2. FIELD MISSIONS: IMPORTANT STAGES AND QUESTIONS

For Bank personnel or consultants on mission in member countries and whose terms of reference include HIV/AIDS, it is recommended that systematic reference be made to the existing strategic plan of the country and the need to draw from the experiences and knowledge of UNAIDS.

2.1 Mission preparation

Before leaving the Bank's headquarters, the mission should:

- Be guided by the CSP and PRSP to have a general overview of the magnitude of the HIV/AIDS epidemic and its impact.

- Collect information on the country to be visited and discuss with relevant experts the incorporation of HIV/AIDS-related issues into the project/programme;

- Inform the country of the Bank's intention to integrate HIV/AIDS into the framework of the mission and thereby enable the authorities to take the appropriate measures through local officials and stakeholders involved in the action against AIDS.

2.2 In the field:

1. The mission should firstly carry out a situational review with the ministry in charge of the sector of intervention, discuss the objective of the mission and identify the various current and potential actors in the fight against HIV/AIDS.

2. The mission's work schedule should include meetings with the National AIDS Control Programme (NACP) or similar agency/institution, the UNAIDS thematic group and possibly actors in the field such as NGOs and associations including people living with HIV/AIDS.

2. The questions to be posed to the different key actors include the following :

- What progress has been made in strategic planning? Is the relevant sector of intervention sensitive or vulnerable to HIV/AIDS? Does this sector have an action plan? What persons and institutions in the sector are involved in the fight against HIV/AIDS? How is the NACP organized? What are the management and coordination mechanisms of the NACP? What is the level of decentralization of the NACP? Is the Coordinating Bureau already collaborating with the ADB? What is the structure and functioning of the UNAIDS thematic group in the country?

2.3 Draw conclusions from these consultations

With the help of this information, the mission and national stakeholders can draw some initial conclusions. It can assess the importance to be given to the HIV/AIDS dimension in the Bank, propose possible interventions and the percentage of the project's budget to be earmarked for HIV/AIDS control. This information will be contained in a memorandum to be submitted to the UNAIDS thematic group and to the NACP. In accordance with the MOU between the Bank and UNAIDS, arrangements for co-financing could also be discussed at this point.

3. APPROACH FOR MAINSTREAMING HIV/AIDS INTO THE PROJECT CYCLE

The table below details the key entry points in the different phases of the cycle.

PHASE	CHARACTERISTICS	CONCERNED PARTIES	REFERENCE DOCUMENTS	ENTRY POINTS INTO HIV/AIDS PROBLEM
Elaboration of PRSPS and CSPS	Macroeconomic, social and political setting (governance) sensitivity and vulnerability of sectors to HIV/AIDS, role of sectors in action against HIV/AIDS	Operations department,govern-ment, NACP NGOs, beneficiaries, other development partners	Bank vision, sector policies, ADF VIII/IX, National HIV/AIDS strategic plan or situation analysis report, tools for incorporating HIV/AIDS in PRSPs and CSPs , briefs on HIV/AIDS in the country, mission report	Sector studies, Mission report IPRSP/PRSP/CSP reports
Identification	Requests for projects and programme financing; findings of sector studies; PRSPs and CSPs	Operations departments, concerned ministries (government) NGO, beneficiaries, other development partners	Ditto + tool to facilitate the incorporation of HIV/AIDS into Bank operations, Mission report (terms of reference), feasibility study	Terms of reference, back-to-office reports, identification report,
Preparation	Technical design, definition of indicators, Incorporation of HIV/AIDS (areas and levels of intervention)	Operations department, operations policy/review department/Focal Point on HIV/AIDS, concerned ministries, NACP,NGOs, beneficiaries, other development partners	Identification report, Mission report (terms of reference), sector policies concerned, HIV/AIDS strategy plan	Mission report, Memorandum, preparation report
Appraisal	Importance of project. Programme process (functioning), effectiveness, efficiency, viability and impact place of ??? HIV/AIDS (sensitivity, vulnerability and role of sector), execution (by whom, how, and with whom?) budget, implementation plan	Operations Department,/operations policy/review department/ Focal point on HIV/AIDS, Sectors concerned, NACP, Ministry of Planning and Finance, Beneficiaries, NGOs, other partners	Preparation report Sector policies, Mission report, HIV/AIDS strategy in Bank Group operations	Memorandum, Mission report Appraisal report
Launching & execution	Activities, details of responsibilities and implementation. Follow-up coordination and evaluation mechanisms, action against HIV/AIDS	Beneficiaries, body in charge of execution, Line Ministry, NACP, operations department	Appraisal report Loan Agreement	Mission report, Memorandum, supervision report and mid-term review report.

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