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GLOSSARY

**Anti-Retroviral Therapy** – is treatment with antiretroviral drugs. Antiretroviral drugs are medicines that prevent the reproduction of a type of virus called a retrovirus.

**Burden of Disease** – A measurement of the gap between current health status of a population and an ideal situation where everyone lives into old age free of disease and disability. Designation of high or low burden is disease specific, and may reflect measurements of the quality of life, as exemplified by the **Disability Adjusted Life Year (DALY)** that expresses years of life lost to premature death and years lived with a disability due to a disease. Burden of disease may also reflect the proportion of individuals in a known population living with a specific disease.

**Case Fatality Rate** – The proportion of individuals with a specific communicable disease who die of the illness. A 100% case fatality rate means that the disease is invariably fatal.

**Communicable Diseases** – Infectious diseases that can be transmitted from one person to another. Communicable diseases can be transmitted directly or indirectly and include bacterial, viral and parasitic diseases.

**DOTS Treatment** – Is the internationally recommended TB control strategy that combines the five program elements of political commitment, microscopy services, drug supplies, surveillance and monitoring systems, and use of highly effective clinical regimes with direct observation of treatment.

**Epidemics** – The occurrence of an infectious disease affecting many individuals at the same time.

**Health Education** – Education that increases the awareness and favorably influences the attitudes and knowledge relating to the improvement of health on a personal/community basis.

**Health Impact** – The changes in health risk or health gain attributable to a project. The overall effects, direct or indirect, of a policy, strategy, program or project on the health of a population.

**Health Impact Assessment** – Is a combination of procedures, methods and tools by which a policy, program or project may be judged regarding its potential effects on the health of a population, and the distribution of those effects within the population.

**ICD-10** – The tenth revision of the International statistical classification of diseases and related health problems that started in 1893 as the Bertillon Classification or International List of Causes of Death.

**Incidence of Disease** – Reflects the number of new cases of a specific disease diagnosed during a given period of time.

**Morbidity of Communicable Disease** – Chronic illness after transmission of communicable diseases.

**Mortality of Communicable Disease** – Death from an illness associated with specific or multiple communicable diseases.

**Pandemic** – The occurrence of infectious disease(s) worldwide.
Premature Death – Death that occurs before the age to which the dying person could have expected to survive if he/she was a member of a standardized model population with a life expectancy at birth equal to that of the world’s longest surviving population, Japan.

Prevalence of Disease – Number of existing cases of a disease at a given time. It identifies the level of burden of disease or health-related events on the population and health care system.

Primary Prevention of Diseases – Policies, programs and procedures that aim at preventing the occurrence of new cases of a specific disease. Health education is a very important component of primary prevention.

Secondary Prevention of Diseases – Clinical care management of identified cases of communicable diseases that aim at achieving a cure or the reduction of the signs and symptoms associated with specific diseases. Secondary prevention also includes health education to avoid or significantly reduce future transmission of diseases.

Specialized Agencies – UN Agencies set up to provide specific, specialized services at policy and program levels in most countries. They include the WHO, UNAIDS, UNICEF, UNESCO, UNCHR, and WFP.

Tertiary Prevention of Diseases – The rehabilitation of individuals who have suffered disabilities from their encounters with diseases. These individuals may be living with chronic conditions that require clinical care or may be free of a disease but now live with disabilities from their encounters with specific diseases.

Vulnerable Group – Group of people characterized by a higher risk and reduced ability to cope with adverse impacts, such as disadvantaged ethnic minorities, refugees, displaced people, children, elderly and disabled people. Women and the poor are normally considered independently.
LIST OF ACRONYMS AND ABBREVIATIONS

ADB  African Development Bank
ADP  African Development Fund
ADF-VIII The Eighth Replenishment of the African Development Fund
ADF-IX The Ninth Replenishment of the African Development Fund
AFRO WHO Regional Office for Africa Region
AIDS Acquired Immunodeficiency Syndrome
APOC African Programme for Onchocerciasis
APPR Annual Portfolio Performance Review
AU African Union
CDC Centers for Disease Control and Prevention, Atlanta, USA
CSPs Country Strategy Papers
ECA Economic Commission for Africa
ESW Economic and Sector Work
EU European Union
FAO Food and Agricultural Organization
HIA Health Impact Assessment
HIPC Highly Indebted Poor Countries
HIV Human Immunodeficiency Virus
ICD-10 International Classification of Diseases, 10th revision, WHO
ICT Information and Communication Technologies
IEC Information, Education and Communication
IHR International Health Regulations
ILO International Labor Organization
IMF International Monetary Fund
IPAA International Partnership Against AIDS in Africa
ITMs Insecticide Treated Materials
MDBs Multilateral Development Banks
MDGs Millennium Development Goals
MDT Multi drug Therapy
MoH Ministry of Health
MoU Memorandum of Understanding
MTEF Medium-Term Economic Framework
NEPAD New Partnership for Africa’s Development
NGO Nongovernmental Organization
OAU Organization of African Unity (now defunct)
ODA Official Development Assistance
PBL Policy-Based Loans
PHC Primary Health Care
PLWA People Living with AIDS
POPR Operations Policies and Review Department
PPPs Public-Private Partnerships
PRSPs Poverty Reduction Strategy Papers
RBM Roll Back Malaria
RMCs Regional Member Countries
SARS Severe Acute Respiratory Syndrome
SRF Special Relief Fund
STI Sexually Transmitted Infection
SSP Sector Strategy Papers
<table>
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<tr>
<td>SWAPs</td>
<td>Sector-Wide Approaches</td>
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<tr>
<td>UA</td>
<td>Unit of Account</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>UNESCO</td>
<td>United Nations Education Scientific and Cultural Organization</td>
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<tr>
<td>UNHCR</td>
<td>United Nations High Commission on Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’ Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>USD</td>
<td>United States Dollars</td>
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<td>WB</td>
<td>World Bank</td>
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<td>WFP</td>
<td>World Food Program</td>
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<td>World Health Assembly</td>
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EXECUTIVE SUMMARY

1. Communicable disease are a major cause of morbidity and mortality in Africa, accounting for 63 percent of deaths among children and 48 percent of all premature deaths. They are the principal causes of death among youth (under 21 years of age). HIV/AIDS, tuberculosis (TB) and malaria are the most serious communicable diseases, causing between 5.7-6.0 million annual deaths, mostly in Africa. The impact of other communicable diseases in Africa is also very significant. Diseases such as Onchocerciasis (river blindness), Trypanosomiasis (sleeping sickness), and Dracunculiasis (Guinea worm disease) affect millions of Africans, causing long-term, and sometimes, permanent disabilities.

2. The causal relationships between communicable diseases and economic development reaffirm the strategic importance of tackling communicable diseases within a framework of sustainable development. Communicable diseases, as evidenced from the Millennium Development Goals (MDGs), are overarching issues of sustainable development rather than exclusive health matters. Five out of the eight MDGs relate to communicable diseases reflecting their importance within a multidimensional model of sustainable human development. The increasing burden of HIV/AIDS, Tuberculosis, Malaria and other communicable diseases in RMCs and their negative consequences on poverty reduction and efforts to meet the 2015 MDGs is a major concern for the Bank and development partners alike. In this regard, the Deputies for the ADF-IX Replenishment concluded that HIV/AIDS, Malaria, TB and vaccine-preventable diseases pose serious challenges to the development objectives of African countries and called on Management to prepare operational guidelines on communicable diseases.

3. In developing the Guidelines on communicable diseases, the Bank Group’s long-standing experience in financing health projects in RMCs, including programs that deal directly with communicable diseases, has been reviewed. Between 1967 and 2003, the Bank Group financed over UA 1 billion in health projects, with significant portions specifically supporting communicable disease prevention and control programs. In addition, the Guidelines reflect the institutional priority accorded to the fight against communicable diseases in the Bank Group Strategic Plan 2003-2007. It is set against the background of a strategic review of communicable diseases issues in Africa, including guidelines established by the World Health Organization and experience of other specialized agencies and bilateral and multilateral development partners. It provides an overview of policy and program complexities associated with remedial efforts in RMCs, and the growing influence of creative international alliances emerging in the last few years to address specific diseases, most of which are endemic in Africa. It also reflects conclusions from continental initiatives against communicable diseases.

4. The Bank Group Health Policy (1996) provides a general policy framework for the Bank’s role in financing investments to foster health development in RMCs by supporting both communicable and non-communicable diseases. The Strategies on HIV/AIDS (2001) and on Malaria (2002) both provide specific guidance for promoting Bank support to RMCs in the control of HIV/AIDS and Malaria respectively. Both strategies adopted a single disease approach and support vertical disease control programs. The Guidelines on Communicable Diseases build on these strategies and on the Health Policy, and bring together the major communicable diseases in focus based on WHO’s broad classification for the prioritization of Bank Group responses. In addition, the Guidelines allow a multi-disease approach in the control of communicable diseases to promote synergistic activities that
permit the spillover effect of the control of one disease to boost the control of others. The Guidelines has taken into consideration the growing role of global defense networks against diseases in setting priorities and modalities for interventions.

5. The Bank’s new thrust in communicable diseases control is to promote greater selectivity in operations and strengthen partnership with specialized agencies and other development partners. The Bank’s comparative advantage in the control of communicable diseases lies in project management, infrastructure development, and capacity building as well as in its knowledge of the region’s socio-cultural environment. The Bank will build on its comparative advantage in these areas for increased efficiency of its operations in communicable diseases. The Guidelines recognize the need for (i) prevention of diseases, (ii) timely clinical management of diseases, and (iii) rehabilitation of individuals disabled by communicable diseases.

6. At the core of the Bank’s new thrust on communicable diseases are operational priorities that will guide program planning and implementation. As much as possible, the Bank will carry out its activities in the priority areas in partnership with other development partners. It will also encourage and support public-private partnership in scaling-up communicable disease control activities in RMCs. The Bank’s new operational priorities in communicable diseases are:

(i) **High Mortality Diseases of HIV/AIDS, Malaria and Tuberculosis.** These diseases will be of high priority for Bank investment. Diseases under this category constitute a major threat to human capital development and have a negative impact on poverty reduction. The Bank’s interventions will include advocacy and policy dialogue, prevention, supportive care and treatment, infrastructure development and rehabilitation activities. The Guidelines endorse the priorities and modalities specified in the Bank’s Health Policy, the Bank Group Strategy on HIV/AIDS, and the Malaria Control Strategy concerning Bank support in the control of diseases under this category. While promoting mainstreaming of high mortality diseases in sectoral operations, the Bank continues to support more standalone country specific projects and programs. It also promotes a regional approach to the control of high mortality diseases by providing support to cross-border multinational operations. SWAs, where appropriate, will be used to provide support to RMCs in the control of communicable diseases. The Bank Group operations in high mortality diseases will also encourage participation of other partners in providing technical and/or financial assistance. Emphasis will be placed on reproductive health and family planning infrastructural development, capacity-building and improvement in service delivery as critical areas for prevention and control of high mortality diseases among specific target groups, including the youth and women. The Bank’s interventions in the prevention, control and impact mitigation of the high mortality diseases in RMCs will contribute towards the achievement of the MDGs that are relevant to the diseases in this category. Projects or programs to control diseases under this category will be financed through loans and grants.

(ii) **Neglected but Economically Costly Diseases.** The Bank involvement in the prevention and control of Neglected but economically costly diseases will be subject to the availability of resources and it will mainly focus on mainstreaming of disease control activities in relevant sector projects including agriculture, water and sanitation, and other sector projects and programs. Coordination with other development partners will
be strengthened through Bank’s participation in SWAp that are designed to control neglected and economically costly diseases in RMCs. These diseases have long-term high economic cost and cause serious human suffering and disabilities. Diseases under this category include Onchocerciasis, Schistomiasis, soil Helminthiases, Dracunculiasis, Filariasis, Leishmaniasis, Trypanosomiasis, Buruli ulcer, etc. Most of these diseases are the subject of tightly focused global alliances and partnerships. Hence, as and when the Bank intervenes in the control of diseases within this category, it will provide the necessary support under a partnership framework of global alliances. The Bank’s support in the control of diseases within this category will be funded through loans and grants under co-financing arrangement of specific project or program with the partners involved.

(iii) **Emerging and Epidemic-Prone Diseases.** The Bank’s support in the control of emerging and epidemic-prone diseases that include Yellow Fever, SARS, Cholera, other Food borne diseases, Meningitis, Ebola, influenza, and vaccine preventable diseases, will comprise the provision of timely financial support by forging partnership with more specialized agencies in emergency humanitarian assistance such as WHO, UNHCR, Red Cross and Red Crescent Societies. These diseases are threats to public health and safety, and have vastly increased, causing frequent epidemics. Due to the uncertainties in the type and frequency of occurrence of diseases under this category global responses will be implemented within an emergency humanitarian assistance framework. The Bank will respond to epidemics recognized as such by the WHO and will only support proven or promising interventions that specialized agencies deem feasible.

7. The areas of interventions in communicable diseases control in accordance with the set priorities are as follows:

(i) **Prevention** – Bank prevention activities will comprise: awareness programs for different target groups including school children and youth on prevention and management of diseases; childhood immunization campaigns; production and distribution of condoms, voluntary counselling and testing; blood screening services and safe blood supply systems; malaria prevention and control for children, adults and pregnant women through intermittent preventive treatment; insecticide-treated nets; case management of malaria, and maintenance of quality controls over anti-malaria drugs and other products; promotion of the internationally accepted DOTS strategy for prevention and control of tuberculosis; establishment of surveillance and epidemic intelligence activities for early warning of outbreaks.

(ii) **Care and Treatment** – Providing access to antiretroviral therapy (ART) for pregnant women to prevent PTCT (Parent to child transmission) of HIV, provision of prophylaxis for opportunistic diseases; provision of support/care at home and community settings; access to quality and effective anti-malarial drugs; provision of laboratory support; training of community health workers on malaria control; provision of drugs and highly effective clinical treatment regimes with direct observation of treatment program for TB; support to community directed treatment approach for control of malaria and TB; training of staff on directly observed treatment of TB and laboratory support for monitoring of treatment efficacy.
(iii) **Capacity Building in RMCs** – A large number of RMCs have weak capacity for effective implementation of communicable diseases control programs. Thus, the Bank enhances RMCs capacities to enable them undertake effective and sustainable prevention, care and treatment, and impact mitigation activities in the control of communicable diseases. Capacity building activities include: support to human capital development through training, operational research on intervention strategies; short focused studies to understand certain issues of the epidemic, information and knowledge sharing services for epidemic alert and disease control; raising the institutional capacities of relevant organizations for better implementation of appropriate responses against communicable diseases.

(iv) **Infrastructure Support** – The effective delivery of services for communicable diseases in a number of RMCs require the construction of new facilities or rehabilitation of existing ones. The Bank support in communicable disease prevention and control will also address critical needs for infrastructure support for the delivery of communicable disease services. Activities in this area will include among other things the provision of facilities for voluntary counselling and testing, blood-transfusion and integrated STI/HIV/AIDS services.

(v) **Impact Mitigation** – Providing support to orphans, families and people affected and disabled by communicable diseases and reintegration of those able to work into productive socio-economic life; increasing educational and employment opportunities for empowering vulnerable groups including the youth and the girl child as well as women to protect themselves against communicable diseases; ending social and legal discrimination based on disease status; promoting the development of sentinel sites to estimate the burden of diseases; supporting human resettlements, food security and other development interventions as part of impact mitigation of communicable diseases.

8. The development effectiveness of Bank prevention, care and treatment, and impact mitigation activities depends, among other things, on the expertise and experience of staff, the soundness of the relevant policies and the availability of financial resources. The scaling-up of Bank Group communicable diseases control operations requires an optimal use of Bank’s available human and financial resources. The Bank’s health and related sector experts will take the lead in the implementation of the Guidelines. Sector and country departments will have the primary responsibility for mainstreaming communicable disease control into relevant Bank Group operations. The activities will be financed through loans and grants from the ADF and ADB windows in accordance with the strategic orientation of the present Guidelines.

9. The Guidelines note the growing impact of communicable diseases, especially HIV/AIDS, TB and Malaria in ADB countries. Under present lending guidelines, ADB countries with significant burden of specific diseases such as HIV/AIDS, TB and Malaria do not qualify for Bank’s extended grant assistance. These countries are unlikely to borrow non-concessional loans for communicable disease control. Achieving the national and global objectives on communicable diseases in these countries require new resources and unprecedented levels of cooperation among multilateral agencies, national authorities, communities, and the private sector. The Bank will promote public-private
partnership to mobilize the necessary resources to scale up communicable disease control operations. It will provide resources in the form of ADB loans to countries that are interested to borrow for financing communicable disease control activities.

10. The necessary effective implementation of Bank Group communicable disease control hinges, among others, on institutional strengthening in the Bank, and partnership development.

(i) **Institutional Strengthening in the Bank** - In order to respond effectively to the challenges of communicable diseases as outlined in the guidelines, the Bank needs to strengthen its institutional capacity. The institutional strengthening entails, inter alia, increasing the number of staff and improving the skills mix for analysing multi-sectoral issues of communicable diseases and formulating appropriate responses. It also includes training of staff and supporting research and knowledge-sharing activities through internal exchange of information as well as exchange of information with external partners.

(ii) **Partnership Development** – Partnership provides an appropriate framework for successful implementation of Bank interventions on communicable diseases. The Bank promotes communicable disease control activities by strengthening its existing partnership with UN specialized agencies, the World Bank and other bilateral institutions and NGOs on HIV/AIDS to include other communicable diseases. Existing MoUs with these institutions will serve as a framework for partnership. Communicable disease control through prevention, care and treatment as well as impact mitigation will also be encouraged within existing global and regional frameworks including: International Partnership against AIDS in Africa; Roll Back Malaria; Stop TB; Global AIDS Vaccine Initiative (GAVI); and Commission on HIV/AIDS and Governance in Africa (CHGA). The Bank will reinvigorate its partnership with the AU, the ECA and Regional Economic Communities to promote regional and sub-regional communicable disease control projects and programs within the framework of NEPAD, and to facilitate the monitoring and fast tracking of RMCs performance towards the achievement of the specific MDGs. The Bank will establish new partnerships with the emerging global alliances to support communicable diseases control interventions. It will promote public-private partnership to meet the growing need for scaling-up communicable disease control activities, including the need for appropriate infrastructure development in RMCs. The development of strategic partnerships for the control of communicable diseases allows the Bank to make an optimal use of its limited resources while it creates the opportunity for sharing knowledge and experience as well as for harmonization of procedures.

11. For project cycle activities in communicable diseases, the Guidelines reaffirm that the Bank’s Operations Manual remains valid. It reiterates the importance of mainstreaming prevention and control in relevant Bank projects. It also indicates the importance of the Millennium Development Goals (MDGs) as benchmarks for monitoring and evaluating progress made by countries in communicable diseases control. Monitoring and evaluation will be carried out through regular Bank supervision, mid-term reviews and joint reviews with development partners.
12. Bank Group projects will be required to integrate health impact assessment, in accordance with the procedures stipulated in the Bank Group Environment, Social and Health Impact Assessment for potential risk of spreading communicable diseases on the target population. The systematic application of these procedures on projects and the subsequent classification of these projects in the different categories (Category I to IV)\(^1\) is an essential step towards averting risk of propagation of certain communicable diseases due to development projects.

\(^1\) Category I Projects requiring full environmental, social and health impact assessment (ESHIA), including the preparation of an Environmental and Social Management Plan (ESMP). These projects are likely to induce important adverse or significant environmental, social and Health impacts that are irreversible. Category II Projects requiring the development of an Environmental and Social Management Plan (ESMP). These projects are likely to have detrimental and site-specific environmental and/or social/health impacts that are less adverse than those of Category I projects and that can be minimized by the application of mitigation measures or the incorporation of internationally recognized design criteria and standards. Category III projects that do not require ESHIA. Category IV projects that involve Financial Intermediaries engaged in designing and implementing sub-projects warranting the application of Bank’s ESHIA procedures.
1. INTRODUCTION

1.1 CONTEXT

1.1.1 Africa still suffers from a high number of communicable diseases. Over the last two decades the Continent has been the epicenter of the HIV/AIDS pandemic. More than 90% of all Malaria cases worldwide occur in Africa and at least one-third of all TB patients are Africans. More than 300 million Africans live in the “Meningitis Belt” of Sub-Saharan Africa, and more than half of all cases of childhood Measles occur in Africa. A sizable proportion of the African population is still at risk of contracting Onchocerciasis and Filariasis. These diseases have been by and large fueled by persistent difficult economic conditions. The prevalence of those diseases has been exacerbated by poverty resulting from loss of productivity of the infected persons, loss of productive days and income for families, and disruption of school attendance, which ultimately translate into poor economic performance, and thwart the effort made by RMCs to achieve the Millennium Development Goals (MDGs) (Annex 1).

1.1.2 Communicable diseases are multidimensional development issues with enormous economic and social burden to families and communities. The two way causal relationships between communicable diseases and economic development reaffirm the strategic importance of tackling communicable diseases for ensuring sustainable development. The importance of communicable disease control within a multidimensional model of sustainable human development is reflected in the Millennium Development Goals (MDGs) set at the United Nations in 2000. The MDGs for a large part (5 out of 8 MDGs) relate to communicable diseases directly or indirectly and reflect how communicable diseases have evolved from an exclusive health matter to a multidimensional model of sustainable development. The MDGs include ambitious targets for nutrition, maternal and child health, infectious disease control and access to essential medicines. Evidence suggests that a large number of countries, the majority of which are from sub-Saharan Africa, are far behind in meeting the MDGs for infant mortality and child mortality (73 countries are far behind in meeting the MDGs for infant mortality and 66 are far behind for meeting the MDGs for child mortality). Disease burden from communicable diseases can be brought down to attain the MDGs with bold disease control effort driving the agenda for sustainable development.

1.1.3 Against this background, it has become imperative for the international community to scale up responses to communicable diseases. The Bank’s Vision and Strategic Plan for 2003-2007 underscores the need to control the spread of communicable diseases. In addition, the Deputies during the ADF-IX Replenishment reiterated the need for the Bank’s increased operational focus on communicable diseases and in this regard, called for the preparation of operational guidelines. These Guidelines are a response to the challenges posed by the control of communicable diseases. It builds upon existing Bank Group policies and strategies that provide policy orientations in specific areas of communicable diseases. The Bank Group Health Policy (1996) provides a general policy framework for the Bank’s role in financing projects and programs to foster health development in RMCs by supporting the control of both communicable and non-communicable diseases. The Strategies on HIV/AIDS (2001) and on Malaria (2002) both provide specific guidance for promoting Bank support to RMCs in the control of HIV/AIDS and Malaria respectively. Both strategies adopted a single disease approach and support vertical disease control programs. The Guidelines brings together the major communicable diseases in focus using the WHO broad classification for the prioritization of Bank Group responses in the control of communicable diseases. In the fight against communicable diseases, the Bank Group recognizes the primary role of more specialized agencies such as the World Health Organization. However, as the major development institution for Africa, the Bank Group is mandated to join the fight against communicable diseases and has gained from three decades of considerable knowledge and experience in health projects and programs.
1.2 STRUCTURE OF THE DOCUMENT

The document is organized into 5 chapters. Following an introduction, Chapter II describes the epidemiological situation and socioeconomic impact of communicable diseases on Africa; Chapter III discusses Bank Group and other institutions experiences with communicable diseases and lessons learned; Chapter IV presents the policy framework, the guiding principles, operational priorities and implementation modalities, strategies and operational guidelines, and Chapter V presents the conclusions and recommendations.

2. COMMUNICABLE DISEASES IN AFRICA

2.1 EPIDEMIOLOGICAL SITUATION IN AFRICA

2.1.1 In accordance with the World Health Organization, the epidemiology of communicable diseases has been classified from the perspective of: (i) High mortality diseases; (ii) Neglected diseases; and (iii) Emerging and epidemic-prone diseases.

**High Mortality Diseases**

2.1.2 **HIV/AIDS.** According to the UNAIDS, Africa accounts for nearly 70% of HIV/AIDS worldwide even though the continent represents only 10% of the global population. Southern Africa is home to 30% of Global HIV/AIDS while accounting for only 2% of the global population. Heterosexual transmission of HIV is the main mode of transmission in Africa, with a rate of 90 percent. The highest level of risk for HIV transmission is among women and youth. Africa is the only continent where more women than men live with HIV/AIDS. Adolescent females, ages 15-19 in some regions, have HIV rates that are up to four times that of their male peers. African women account for 95% of all maternal transmission of HIV to newborn babies in the world. More than 11 million African children have lost one or both parents to AIDS, representing nearly 80% of all cases worldwide. Despite the large number of infected persons in Africa, only 1% of Africans living with HIV/AIDS have access to lifesaving antiretroviral (ARV) therapy that is widely available in developed societies. Although the unfolding HIV/AIDS scenario in Africa is frightening, it is important to note that more than 90% of Africans have not contracted HIV.

2.1.3 **Tuberculosis (TB).** TB is one of the most widespread infections in the world. The highest incidence of the disease in the world is in sub-Saharan Africa, with approximately 30% of the global caseload. At least 200 million of the 600 million people in sub-Saharan Africa live with the TB bacillus, with the capacity to infect other people under certain conditions. The major mode of transmission of TB is by close contact with infected persons, who are coughing, especially in crowded and poorly ventilated environments. Men and women are at risk of TB transmission but women are more likely to live with undiagnosed infection. Individuals infected with TB are 30-fold more likely to have been previously infected by HIV, thereby contributing to a dangerous rise in the incidence of these two deadly diseases. Of the 22 countries worldwide, which WHO classified as of “High Burden” TB in 2002, eight are in Africa: Nigeria, South Africa, Democratic Republic of Congo (DRC), Ethiopia, Uganda, Zimbabwe, Mozambique, and Kenya.

2.1.4 **Malaria** is endemic in Africa: at least 45 RMCs have endemic Malaria, with infections occurring year around. WHO estimates that Africa accounts for 90% of the world’s yearly 300 million cases of Malaria and 97% of the one million Malaria deaths every year. Malaria is the leading cause of under-five deaths in Africa, and a significant cause of death among pregnant women, especially would-be first time
mothers. Babies from mothers suffering from Malaria are more likely to have low birth weight compared to Malaria-free mothers. Low birth weight babies have higher rates of developmental and sometimes, life long cognitive problems. Insecticide-treated nets provide high rates of protection for children, yet less than 5% of eligible children have access to these low-cost but lifesaving devices.

**Neglected Diseases**

2.1.5 Neglected diseases include Onchocerciasis, Leprosy, Dracunculiasis, Lymphatic Filariasis, Schistosomiasis and soil-transmitted Helminthiases, African Trypanosomiasis, Human Rabies, Dengue and dengue hemorrhagic fever, Leishmaniasis and Buruli ulcer. These diseases are potentially low prevalence diseases but have very high health impact measured by severe and permanent disabilities and deformities among 1 billion people worldwide. They are also characterized by their predilection for poor people living in rural areas of resource-challenged countries. Although these diseases rarely kill, they cause extraordinary suffering, with long-term disabilities and deformities. These diseases are common in Africa and rarely command the same level of policy and program attention as the higher profile diseases such as HIV/AIDS, TB and malaria. A brief epidemiological overview of each neglected disease is presented hereafter.

2.1.6 **Onchocerciasis** (river blindness) is mostly endemic in Western Africa, causing blindness (in some cases up to 50% of men over the age of 40 years in endemic areas) and other forms of serious visual handicaps. Worldwide, 120 million people are at risk of contracting Onchocerciasis, and 96% of them live in Africa. Onchocerciasis is caused by a parasite that lives in the tissues of the body and transmitted by a blackfly that feeds on the blood of infected individuals. However, Onchocerciasis control is one of the few success stories in Africa. In 1974 a group of international partners launched the Onchocerciasis Control Program in West Africa that reduced the incidence of the disease to almost negligible levels in program areas and allowed residents of deserted homesteads and farmlands to return home and resume normal socioeconomic activities. The program also rehabilitated blind individuals by training them on various vocational skills and ensuring that they have gainful employment. The Bank has been providing support for this initiative. According to WHO, Onchocerciasis is under control in original program areas in West Africa. The current Onchocerciasis Control Program is focusing on 19 endemic African countries, outside of West Africa.

2.1.7 **Leprosy** is one of the diseases slated for elimination by the WHO. The incidence of Leprosy has steadily declined in Africa in recent years. Leprosy causes serious bodily deformities and is associated with unparalleled social stigma. Men and women are at risk of contracting Leprosy and social stigma is associated with both sexes although individuals under treatment quickly lose the ability to transmit the disease. For women diagnosed with Leprosy, marriage and regular interaction with families and friends is rare even after successful treatment because of social stigma. Field diagnoses have steadily improved over the years. Mozambique and Madagascar are the two countries with the highest Leprosy burden on the continent.

2.1.8 **Guinea Worm Disease** (Dracunculiasis) is another disease that has also recorded remedial success as a result of concerted international partnerships. This disease affects mostly poor, rural communities that lack access to safe water supply and have little or no health services. Once a person is infected, the parasite migrates through the body and eventually emerges. 90% of the time from the feet, causing intense painful swelling, a blister and then an ulcer. Guinea worm is truly a disease of the poor since the provision of pipe borne water or clean boreholes can significantly interrupt disease transmission. In hard hit endemic areas, up to 30% of residents may suffer from the disease, and the disease typically
reappears every year during the agricultural season, disrupting farming activities. Actions taken so far aimed at (i) disrupting the transmission patterns, including drinking water sources (ii) treating the ulcers and secondary infections associated with the disease; and (iii) educating the target population on transmission patterns and risk factors. According to WHO, internationally directed remedial efforts reduced the proportion of infections in Africa by 98% in the last decade. Today, the few remaining endemic pockets are located in 13 African countries: Benin, Burkina Faso, Central African Republic, Côte d’Ivoire, Ethiopia, Ghana, Mali, Mauritania, Niger, Nigeria, Sudan, Togo and Uganda. Southern Sudan is believed to harbor 73% of all remaining cases in Africa.

2.1.9 **Lymphatic Filariasis** is known for its grossly enlarged limbs or scrotum (elephantiasis) and is associated with great personal suffering and social stigma. This disease is caused by a parasitic worm and transmitted by mosquitoes. At least 40 million Africans are at risk of contracting the disease and the social stigma associated with enlarged limbs is common to both genders. WHO and a group of international partners advocate yearly mass treatment of at-risk populations with single doses of Albendazole associated with either Ivermectin or Diethylcarbamazine. The filariasis endemic zone runs from Egypt in North Africa through most of Western, Central and Eastern Africa.

2.1.10 **Schistosomiasis** and **soil-transmitted Helminthiasis** are diseases of the poor. According to WHO, 85% of the 200 million people living with Schistosomiasis are Africans. Men and women are both at risk. Children in Africa constitute a significant proportion of soil-contaminated Helminthiasis in the world. Individuals with Schistosomiasis may suffer damage to their livers, kidneys and urinary tracts. Children with helminthiasis suffer chronic anemia, and may have stunted growth and retarded age-appropriate cognitive development. International partnerships that direct remedial efforts aim at using simple doses of cost effective drugs (for example, Praziquantel) to control Schistosomiasis and population-based de-worming programs for school children at risk of Helminthiasis.

2.1.11 **African Trypanosomiasis** or **sleeping sickness** is spread by the Tsetse fly, causing epidemics in humans and domestic cattle. Sleeping sickness is caused by *Trypanosoma brucei gambiense* in West and Central Africa, and *Trypanosoma brucei rhodesiense* in East and Southern Africa. Men and women are at risk of developing sleeping sickness. Current drugs for managing sleeping sickness are becoming less effective because of drug resistance. Hence the best option is the eradication of the Tsetse Fly.

2.1.12 **Human Rabies** is still common in Africa because of stray dogs, human contact with wild animals, and crowded living conditions in urban slums and shanties. Men and women are at risk of infection. Human infection occurs when the viral agent in the saliva of a rabid animal gets into contact with a host through serious bite wounds, open cuts in the skin or exposed mucous membranes. More than 99% of all human deaths from rabies in Africa come from dog bites. Once symptoms develop after a rabid attack, the disease is invariably fatal.

2.1.13 **Other Neglected Diseases** such as Dengue and dengue hemorrhagic fever, Leishmaniasis and Buruli ulcer are often known as “difficult diseases” since there are no vaccines or effective treatment modalities, and they are not headline-grabbing illnesses. Mortality is low but morbidity is high. These conditions remain endemic in various parts of Africa and WHO recommends close attention to supportive remedial efforts.
Emerging and Epidemic-Prone Diseases

2.1.14 The constant evolution and rapid proliferation of infective agents, and the capacity of these agents to quickly develop resistance to available drugs characterize Emerging and Epidemic-prone Diseases. The incidence of emerging and epidemic-prone diseases is rising due to greater mobility of people within and between countries and regions. Lack of resources to prevent or manage ongoing outbreaks represents common features of emerging and epidemic-prone diseases in Africa. WHO strongly supports a global alert network for the prevention and control of emerging and epidemic-prone diseases. Emerging and epidemic-prone diseases include Cholera, epidemic Meningitis, Influenza, Yellow Fever, Vaccine preventable childhood diseases (especially Measles and Poliomyelitis), Rift Valley Fever, Foodborne diseases (E-coli, Salmonellosis, Campylobacteriosis, Cyclosporiasis). These diseases cause epidemic emergencies at regular intervals with serious morbidity and mortality. Cholera transmitted through infected food or water occurs regularly in Africa, killing hundreds of people who are unable to replace the loss of body fluids and nutrients through the gastrointestinal system. Measles is the number one cause of childhood vaccine preventable deaths in Africa, with more than 500,000 annual deaths. Yellow Fever kills 20,000-30,000 people a year in Africa. Epidemic meningitis killed 25,000 people in Africa in 1996. Every person is at risk of food borne illnesses since the causative agents enter the body through ingestion of food. The high prevalence of diarrheal diseases in Africa underscores major underlying food safety problems.

2.2 SOCIO-ECONOMIC IMPACT OF COMMUNICABLE DISEASES

Impact of HIV/AIDS

2.2.1 HIV/AIDS pushes individuals and households into deeper levels of poverty. As families lose their breadwinners to AIDS, disposable family income can fall between 50% and 80% in a relatively short period of time. The Food and Agricultural Organization estimates that Africa has lost at least 7 million agricultural workers to AIDS. The World Bank estimates that GDP growth in 50% of the countries in sub-Saharan Africa is falling by 0.5%-1.2% per year as a direct impact of AIDS. The International Labor Organization estimates that by 2015, 15 African countries will lose 22 million workers to AIDS. HIV/AIDS also exacerbates gender inequalities by further eroding the already low socioeconomic, legal and political status of women. In addition, women are the primary recipients of blood transfusions, especially during and after childbirth. Blood transfusion in many parts of Africa does not meet international safety standards, and the risk of contracting HIV is high. The Bank Group HIV/AIDS Strategy Paper provides detailed information on the socioeconomic impact of HIV/AIDS in Africa.

Impact of Malaria

2.2.2 The Bank Group Strategy on Malaria notes that the disease burden in Africa, at 10.6%, is only second to that of HIV/AIDS (16.6% burden). A malarial attack can cause a loss of up to 10 productive days in an adult. WHO and the Global Fund to Fight HIV/AIDS, TB and Malaria estimate that if the compounding effect of Malaria is factored in for the past 35 years in Africa, the disease is potentially responsible for the continent’s decline in GDP by 32% during the period, equivalent to an annual loss of USD100 billion. Malaria slows economic growth in African countries by 1.3% or more every year. A 10% reduction in Malaria incidence can result in up to 0.3% higher growth rate a year for an affected country.
Impact of Tuberculosis

2.2.3 The Global Fund to Fight AIDS, TB and Malaria indicates that the incidence of TB is on the rise in African countries because of poor economic growth, the spread of HIV/AIDS, and the emergence of multi-drug resistant TB (MDR-TB). More than 75% of TB-related deaths occur among the most economically active segment of the population, 15 to 49 years of age. TB is the leading killer of people living with HIV/AIDS. The average TB patient loses three to four months of work per year as a result of illness. In addition, loss of productivity by infected persons can lead to 30% decline in household income. In some instances, families may lose 100% of their income due to the severity of the disease, number of working breadwinners, and response to DOTS. TB can cause intergenerational poverty by infecting generations of the same family. TB is also a leading cause of death among African women of reproductive age. Women run a higher risk of TB infection, as they are less likely to be tested for TB than men. A major program challenge in TB prevention and control is how to increase case detection. The WHO estimates that current TB programs worldwide detect or refer only 27% of new cases for DOTS.

Impact of Neglected Diseases

2.2.4 The long-term care cost and loss of productivity associated with illness and disability from neglected diseases is high. African Trypanosomiasis accounts for up to USD 4 billion in annual losses in agriculture alone on the continent, according to WHO. Schistosomiasis and Dracunculiasis significantly disrupt school attendance of affected children. It also causes affected adults, mostly male breadwinners, to miss many days or months of productive work. Schistosomiasis, in addition to its effects on adults, can lead to mental retardation among children, even among those medically cured of the disease. The economic costs of Onchocerciasis include potential income loss due to blindness, the deserting of homesteads and farmlands by at-risk populations to avoid the bites of the fly that transmits the disease, and the disruption of schooling activities by children who must serve as guides to their blind parents, older siblings and other relatives. For Leprosy, WHO estimates that savings from treatment protocols that significantly reduce disabilities are significant, and go beyond the usual economic analysis of ill health.

Impact of Emerging and Epidemic-Prone Diseases

2.2.5 The impact of these diseases depend on three unfolding scenarios: the phenomenon of global travel to and from Africa; the emergence of new or more virulent strains of infective organisms; and the growing number of inexpensive anti-microbial medicines that are becoming ineffective against these diseases. WHO notes that Cholera outbreaks frequently disrupt socioeconomic activities in affected areas, and are particularly deadly in conflict situations, as noted in Liberia in 2003. In the first half of 2002, Cholera broke out in Congo, Malawi and Mozambique, causing deaths and disruption of socioeconomic activities. For Epidemic Meningitis, costs associated with permanent brain damage among infected individuals are significant from loss of productive economic life to daily supportive care by family members who may forego their own economic pursuits to provide round-the-clock care. The cost of Human Rabies is also high with almost 100% case fatality rate. For Yellow Fever, with case fatality rates of 50% for adults and 70% for children in endemic areas, nearly 470 million people from at least 33 African countries are at risk of death from an outbreak of the disease.
Country Responses Against Communicable Diseases

2.2.6 Certain socio-cultural factors such as early marriages imposed on young girls, harmful traditional practices including genital mutilation, etc., create risks and increase vulnerability to communicable diseases. There has been an increasing effort by some governments and development partners alike to minimize the impact of these factors through the introduction of appropriate legal frameworks and extensive behavioral change programs.

2.2.7 Some countries have also made progress in preparing strategies against one or more of the major communicable diseases. However, due to lack of political commitment at the highest level as well as poor institutional capacities the strategies have not been fully implemented. The incidence of major communicable diseases in a large number of countries continues to rise. Only in a few countries (Uganda, Senegal, Zambia, Ethiopia), prevention activities of major communicable diseases implemented with the support of NGOs, and donors have shown positive results by bringing down rates of new infections. Among the most important services in the control of communicable diseases, the provision of care and treatment including ARV treatment need to be scaled up in many of the RMCs.

3. BANK GROUP AND OTHER INSTITUTIONS EXPERIENCES

3.1 BANK GROUP EXPERIENCES ON COMMUNICABLE DISEASES

3.1.1 Bank Group experience in communicable diseases comprises operational activities in the form of projects and programs designed to address communicable diseases issues. In addition, the Bank has elaborated appropriate policy and strategic frameworks to guide the Bank’s operational activities in the control of communicable diseases in RMCs. The following is a review of the Bank’s operational activities and policies in this regard.

Operations Activities

3.1.2 The Bank Group’s long-term experience with health sector lending includes infrastructure development, procurement of equipments and public goods, policy development or enhancements, and improved management support for programs. The main thrust of Bank operation in health is to strengthen basic health systems in RMCs, and to mainstream communicable diseases control activities in non-health sector operations. Thirty five social sector projects out of a total of 47 approved (74.4%) in 2002-2003 included communicable diseases control interventions: Education (8), poverty reduction (3) and emergency and humanitarian assistance (14). During the same period eight Health sector projects with specific focus on communicable diseases control and two multinational cross-border communicable diseases control projects (African Program for Onchocerciasis Control (APOC) II, the Congo, Oubangui and Chari Rivers multinational cross-border HIV/AIDS control initiatives) were approved.

3.1.3 A review of the Bank’s social sector approvals for the period 1967 through 2003 show that the health sector accounted for UA1.199 billion worth of approved projects. The Bank Group funding supported: health infrastructure development (hospitals, health centers, clinics, and laboratories); the development and implementation of international collaborative projects against communicable diseases across multiple nations such as the African Program for Onchocerciasis Control (APOC) that started in the 1970’s and enhanced national community-directed treatment programs in 22 countries; the Bilharzias control program in Egypt; and the development and implementation of national health prevention projects
such as the Expanded Program on Immunization (EPI) against deadly but vaccine preventable childhood diseases. The Bank has recently embarked on communicable disease control programs through sector-wide approaches which allow it to adopt common implementation procedures, strengthen closer partnership with its development partners and increase its development effectiveness by providing support in areas where it has comparative advantage. It has also provided timely responses to emergencies for disease outbreaks such as that of Ebola, Cholera and Epidemic Meningitis.

3.1.4 During the period 2002-2003 a total of 4.96 million USD grant resources was made available to 11 countries under emergency assistance. Its support for activities aimed at combating the emergence of new diseases such as HIV/AIDS and the re-emergence of stable diseases such as TB has increased overtime. Its support to communicable disease control comprise institutional strengthening of national and regional institutions such as capacity building support to ministries of health, decentralized health centers and National AIDS Control Programs (National AIDS Control Programs in Malawi, Zambia, Rwanda, Djibouti received such support). Bank projects in this sector also included health systems reforms in RMCs that focus on strengthening management support systems, supervision controls, and partnership and coordination between national health authorities and other development partners.

Policy Setting

3.1.5 The Bank Group experience in the control and prevention of communicable diseases includes, among other things, the appropriate policy frameworks it has put in place to guide its communicable diseases control activities. The Bank Group Health Sector Policy (BGHSP) establishes the strategic framework for priorities and investments in health. Accordingly, it advocates sector-wide, direct interventions and also emphasizes that the focus of Bank’s interventions should be on cost-effective and sustainable health priorities driven by the expressed needs of RMCs.

3.1.6 The HIV/AIDS Strategy Paper defines Bank support to RMCs in the fight against the epidemic, and identifies the priority areas for the Bank’s intervention. These are mainly (i) promotion of political commitment through advocacy and policy dialogue; (ii) support to sectoral responses that promote decentralization, community participation and ownership through mainstreaming HIV/AIDS in Bank operations; and (iii) strengthening of coordinating mechanisms to promote greater synergy in HIV/AIDS control through partnership development.

3.1.7 The Malaria Control Strategy Paper and Operational Guidelines aim at increasing Bank support to RMCs to enhance the formulation and implementation of appropriate and evidence-based Malaria control interventions in various sectors and in emergency assistance. It also aims at ensuring that Bank-financed projects, especially those in non-health sectors (agriculture/rural development and infrastructure, education, private sector) integrate effective and appropriate environment and social management plans to mitigate against the potential impact of Malaria transmission.

3.1.8 The potential for the incorporation of communicable diseases interventions in non-health sectors is outlined in the Agriculture and Rural Development Sector Policy; the Policy for Integrated Water Resources Management; the Education Sector Policy; the Population Policy and the Regional Integration and Economic Cooperation Policy.

3.1.9 The ADF-IX Lending Policy in recognition of the importance of funding HIV/AIDS and other health interventions have allowed for expanded grant resources, representing 18-21 percent of the ADF-IX allocation, to be used for HIV/AIDS and other communicable disease control activities in countries.
The Bank Group Strategic Plan 2003-2007 also identifies communicable diseases as a priority area of investment in RMCs, particularly, trans-boundary, multinational and regional initiatives.

3.2 SELECTED EXPERIENCES OF OTHER INSTITUTIONS

The World Bank

3.2.1 The World Bank supports several types of communicable diseases control in Africa as part of its health, population and nutrition sector projects and program operations. Over the years it has committed to tripling concessional (IDA) support for infectious diseases control including its support to vaccine research for AIDS and Malaria. It provides funding to the Global Fund for AIDS Tuberculosis and Malaria (GFATM).

3.2.2 While its continuous support for the control of communicable diseases is well recognized, the most innovative initiative, which got global recognition, is the Multi-Country HIV/AIDS Program for Africa (MAP). MAP is a disease-specific communicable diseases initiative launched in September 2000. With a current outlay of USD 1 billion the program assists participating countries in scaling up their national response to the epidemic by increasing access to prevention, care and support for individuals and families living with HIV/AIDS. MAP involves a “flexible” and “rapid funding” process to African countries. MAP documented that a strong social mobilization component and a durable partnership are among the most critical issues for program success. The MAP experience also revealed complexities of program supervision, and resource needs that may call for creative solutions.

3.2.3 The Abidjan-Lagos Transport Corridor HIV/AIDS initiative is the World Bank’s current initiative that provides preventive care, treatment and supportive care to high-risk populations in the well-traveled highway of West Africa. The program targets transporters, migrants, commercial sex workers and people living with HIV/AIDS.

The World Health Organization

3.2.4 WHO recognizes the central role of national governments in managing disease outbreaks, in preventing new infections, and in strengthening capacities for future responses. WHO also manages the Global Defense Network against infectious diseases, with more than 110 participating countries. From its initial posture of serving as a technical adviser to RMCs in communicable diseases, it is now taking a more proactive approach of using the opportunity of disease outbreak in any country to take specific steps towards strengthening the capacity of that country to respond to future emergencies and control needs. These steps include training epidemiology and statistics staff on how to recognize emerging epidemics, training laboratory staff to manage reference and field laboratories, strengthening management of communicable diseases control programs and projects, and assisting field staff on modern disease surveillance techniques. To strengthen the reporting mandates of member countries, WHO is currently revising the international health regulations that govern the reporting of communicable diseases worldwide. At the end of the exercise, member countries will increase their capacities to better coordinate their disease responses through worldwide sharing of information and experiences; better management of the protection of national data from confidentiality breaches; and enhancement of capacity to increase the validity and number of diseases reported to WHO instead of the 3 currently mandated diseases (Yellow Fever, Cholera and Plague).
WHO is also providing global leadership by creating alliances with other partners in promoting initiatives that target communicable diseases. The Global Health Security Against Infectious Diseases Framework is an alliance created under the leadership of WHO to marshal a global plan of action against the known communicable diseases. The framework focuses on three interrelated strategies: i) to contain known risks; ii) to respond in a timely fashion to unexpected outbreaks; and iii) to continuously improve the capacity of participating networks and jurisdictions to respond to outbreaks. Within this framework, some of the known initiatives against communicable diseases are:

- **The Global Partnership to Stop TB** (STOP TB initiative). STOP TB has DOTS, as control strategy against TB.

- **The Roll Back Malaria** initiative aims at improving access to affordable and appropriate treatment to at least 60% of those suffering from Malaria.

- **The Africa Programme for Onchocerciasis Control** seeks to deliver the medicine, Ivermectin, in a timely and sustainable manner through community distribution networks in affected communities.

- **The WHO 3 by 5 Initiative on HIV/AIDS** is a new program to provide lifelong antiretroviral treatment to 3 million people living with HIV/AIDS in poor countries by the end of 2005.

**UNAIDS**

UNAIDS is coordinating the global response against HIV/AIDS. It has nine current UN co-sponsors (WHO, UNDP, UNICEF, UNFPA, the World Bank, ILO, UNESCO, IOM, and WFP) who play very active roles in refining the policy and program thrust of the agency. It also manages the International Partnership against AIDS in Africa (IPAA), a coordinated continental effort against HIV/AIDS. UNAIDS has played a key role in advocacy to promote commitment and leadership at the highest level in RMCs and in strengthening the capacity of countries on prevention care and support on HIV/AIDS. Each year, UNAIDS makes available monitoring and evaluation of HIV/AIDS progression in countries as well as the provision of HIV/AIDS prevalence data.

**The Global Fund to Fight AIDS Tuberculosis and Malaria**

The Global Fund to Fight AIDS, TB and Malaria is a creative financing mechanism to fight the 3 diseases that kill more than 6 million people worldwide each year. The Fund, although not under the UN system, works closely with all UN agencies and partners. As of 2002, the Fund had over US$3 billion in funding commitments from governments, private organizations and individuals and has been providing finances to projects tackling HIV/AIDS, TB and Malaria in a number of African countries.

**Continental/Regional Organizations in Africa**

Continental/regional organizations in Africa are responding to specific or various aspects of communicable diseases control and prevention programs. The role of the Bank Group in financing communicable diseases projects in RMCs is a typical example. Another example is the Commission on Governance and HIV/AIDS (CHGA) in which the Bank Group is represented, focusing on governance issues of HIV/AIDS in Africa, and the Pan African Tsetse and Trypanosomiasis Eradication Campaign that include the African Union (AU).
infectious diseases is an important watershed conference that set up the Global Fund to fight HIV/AIDS, TB and Malaria. Committed African leaders pledged to devote 15% or more of their national budget to communicable diseases. The New Partnership for Africa’s Development (NEPAD) is a new continental initiative devised by Africans to take charge of their development strategies and priorities. The NEPAD’s Short Term Action Plan on Health identifies communicable diseases as “first and foremost diseases of poverty”.

Ongoing Public/Private/Civil Society Alliances

3.2.9 Public/private society alliances mobilized against communicable diseases include: The International Coordinating Group on Vaccine Provision for Epidemic Meningitis (ICG); Global Alliance to Eliminate Lymphatic Filariasis; and the Global Alliance for TB Drug Development (TB Alliance) that brings together leaders in the health sector, science and industry to develop a new, affordable drug for TB by 2010, thereby ending a 30-year gap in developing a new drug for TB; Global Alliance for the Elimination of Leprosy that aims to eliminate the disease in all endemic countries by 2005; Medicines for Malaria Venture (MMV), that aim to address the role of market forces in research, development and distribution of new malaria products for low-income populations, mostly in Africa. The MMV functions like a “public venture-capital fund”, enticing the private sector to develop cost-effective anti-malarial products. MMV aims to have its first commercial viable malaria product by 2010.

Other Institutions

3.2.10 The Gates Foundation supports Africa-specific initiatives on HIV/AIDS, TB, Malaria and other communicable diseases. In addition, the Gates Foundation supports global initiatives on diseases endemic in Africa, including an unprecedented USD750 million grant to the Global AIDS Vaccine Initiative (GAVI) to accelerate the immunization of children in 74 countries (mostly in Africa) through the purchase of new vaccines and the USD 243 million support to fight Malaria given to three global organizations. The Gates Foundation also supports Multilateral Development Banks and UN agencies for interventions in communicable diseases.

3.2.11 Some bilateral institutions are supporting Africa in the control of some of the communicable diseases. The Canadian Fund for Africa, a CanD500 million initiative seeks directly to assist Africa in health, education and information technology while the United Kingdom Department of International Development Assistance (DFID) finances projects that address prevention and support issues in HIV/AIDS, TB, and Malaria. The New United States USD 15 billion Five-Year Initiative (2004-2009) aims to combat HIV/AIDS through preventive services, access to treatment, and supportive care to individuals and their families in 12 African countries (Nigeria, South Africa, Uganda, Kenya, Botswana, Zambia, Uganda, Rwanda, Côte d'Ivoire, Ethiopia, Mozambique, Tanzania, and Namibia).

3.3 LESSONS LEARNED

3.3.1 The Bank Group has increased its interventions in communicable diseases control in RMCs by taking into consideration several factors that address: (i) sub-regional disparities in disease prevalence patterns; (ii) weak institutional capacities of RMCs; (iii) inadequate policies and development plans; and (iv) lack of adequate resources for funding communicable disease activities. The Bank Group responds to these varying challenges by developing country-specific and regional operations, and appropriate operational policies as well as enhancing policy dialogue with countries.
3.3.2 New or updated Bank Group sector policies and guidelines have integrated communicable disease control that continue to enhance policy dialogue with RMCs on the importance of control of communicable disease. This process builds upon conscious strategic efforts on the part of the Bank Group to promote support for communicable diseases interventions. Among these policies: (i) the Environment and Population policies highlight communicable diseases as key factors of concerns for sustainable development; (ii) the Economic Cooperation and Regional Integration Policy provides for regional policy coordination on HIV/AIDS and Malaria issues; (iii) the Agriculture and Rural Development Sector Policy recognizes the need to expand access to information and basic health services in rural areas; (iv) the Integrated Water Resources Management policy promotes the establishment of early warning systems for drought, flood and control of certain communicable diseases, increased access to and protection of water resources; and (v) the Education Policy calls for appropriate strategies to expand and enhance learning outcomes as well as increasing the productivity of teachers and school administrators by reducing the impact of diseases such as HIV/AIDS, Malaria and schistosomiasis that affect access to education and learning outcomes in learners.

3.3.3 The Bank’s experience also reaffirms the need to include a discussion of communicable diseases, including prevention and control efforts, in national poverty reduction strategies or other development plans, and in CSPs. In this regard the importance of needs assessment surveys on communicable diseases cannot be overemphasized. A credible national needs assessment of communicable diseases should include baseline and trend data on specific diseases, the risk factors for contracting a specific disease, transmission patterns, occurrence of outbreaks, an inventory of national response capacity for managing disease outbreaks, and an inventory of ongoing programs against specific diseases. The Bank’s experience also validates the need for (i) greater selectivity in interventions on the basis of cost-effectiveness and comparative advantage and tangibility of results; (ii) an enabling environment for better health and sustainability of projects beyond external funding cycles. It also confirms the need to integrate the communicable diseases strategy into overall poverty reduction efforts in RMCs.

3.3.4 At project level, the Bank’s experience with communicable diseases control reveals the continued relevance of primary health care as the basic unit of health services. It underscores the key role of stakeholders in program success through active participation and ownership of project design, implementation, monitoring and evaluation. The Bank’s experience also shows that success of operations in control hinges on (i) timely access to appropriate health services; (ii) a regular supply of medicines and other disease prevention commodities to primary health care centers; (iii) investment in information, education and communication campaigns; and (iv) harmonization of programs and projects at country level to avoid duplication of services and wastage of scarce resources.

3.3.5 An important outcome of the Bank’s increased support in communicable diseases control is its ability of consolidating its experiences in this matter and moving to a new initiative of regional approach to communicable disease control by supporting cross-boarder initiative (Annex 2). Regional approach to communicable disease control focuses on providing the necessary support to high-risk groups including refugees, internally displaced population and others on constant mobility due to cross-border trade, conflict, natural disaster, etc. The success of National programs depends on joint countries’ efforts to control the spread of communicable diseases among cross-border mobile population, who cannot be easily targeted under national programs.

3.3.6 Integration of disease control in the agriculture and rural development, infrastructure, and water and sanitation operations often complement efforts being supported by the health sector. About 11 non-health projects approved between 2000-2001 incorporated communicable disease control activities mainly
focusing on HIV/AIDS and Malaria. These operations made it possible to integrate communicable disease interventions in activities that promote community participation, sensitization and awareness creation on prevention and control of communicable diseases as well as capacity building and impact mitigation activities.

3.3.7 Experiences accumulated over the past years also highlight the importance of partnership in the control of communicable diseases, with each partner drawing on its area of competency. For example, the success of the Onchocerciasis Program stems from effective partnership. In this program, the Bank provided project implementation support and infrastructure development while WHO provided technical expertise in epidemiology, clinical care, and health education. Host governments supplied logistic support and coordinated stakeholders’ participation. Bilateral partners supported the resumption of economic activities in hard-hit areas through rehabilitation of blind persons, and resettlement of families. The partnership was so successful that very few new cases of Onchocerciasis were detected in program areas after more than 15 years of program operations.

3.3.8 Under current policy guidelines, ADB countries do not qualify for concessional ADF loans and grants although some countries have major problems with communicable diseases (Annex 3 and 4). South Africa has the largest concentration of individuals living with HIV/AIDS in Africa. Botswana has the highest rate of HIV/AIDS in the world. In the absence of appropriate instruments to help the ADB countries with high prevalence, the Bank should focus on policy dialogue on how best to implement remedial programs against communicable diseases. As these countries are unlikely to borrow non-concessional loans for communicable disease control, the Bank will play catalytic role to mobilize grant resources from bilateral and multilateral institutions, international NGOs, foundations and other private sector entities to support communicable disease control activities, including the development of necessary infrastructure. For countries interested to borrow, the Bank will finance projects and programs on communicable diseases control through the ADB loans. In this regard MIC resources will be used where it is appropriate for the preparation of such projects and programs.

3.3.9 Bank Group non-health sector projects will be required to integrate health impact assessment in accordance with the procedures stipulated in the Bank Group Environment, Social and Health Impact Assessment, in particular, for the potential risk of spread of communicable diseases on the target population. The systematic application of these procedures to non-health sector projects (infrastructure, water and sanitation, irrigation scheme, dam construction waste management, agro-processing industries, hydro-electrical power, sewage and drainage system, etc.) and the subsequent classification of these projects in different categories (Categories I to IV) is an essential step towards averting risk of propagation of certain communicable diseases due to development projects.

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2 Botswana-Stock breeding project (2000); Ghana-Thema Aflao Road (2001); Lesotho-Improvement of National resources and Rural Income (2000); Mali-Support to community food security (2001); Mozambique-Improvement in Family Income (2000); Integrated water sanitation (2000); Road rehabilitation (2000); Mozam/Multinational- SATCC (2000); Nigeria-Poverty reduction (2000); Zambia-Small scale irrigation (2000); Central water supply (2000).

3 Category I- Projects requiring full environmental, social and health impact assessment (ESHIA), including the preparation of an Environmental and Social Management Plan (ESMP). These projects are likely to induce important adverse or significant environmental, social and Health impacts that are irreversible. Category II- Projects requiring the development of an Environmental and Social Management Plan (ESMP). These projects are likely to have detrimental and site-specific environmental and/or social/health impacts that are less adverse than those of Category I projects and that can be minimized by the application of mitigation measures or the incorporation of internationally recognized design criteria and standards. Category III – projects that do not require ESHIA. Category IV projects that involve Financial Intermediaries engaged in designing and implementing sub-projects warranting the application of Bank’s ESHIA procedures.
3.3.10 Lessons learned from the experiences of specialized agencies and development partners in Africa indicate the need for national governments to strengthen their capacity for action against communicable diseases, and poverty. A review of the experience of UNAIDS, WHO and the World Bank indeed suggests that factors militating against effective national control of communicable diseases include enduring levels of poverty, the inability of national programs to provide timely technical advice on epidemiology and disease outbreak control measures to local authorities, poor funding bases for national and local program activities, limited participation by stakeholders, lack of valid needs assessment, and low potential for the sustainability of programs beyond external funding cycles.

3.3.11 In most RMCs where communicable diseases such as malaria and HIV/AIDS are endemic, the public sector does not have the financial or logistic capacity to extend Insecticide Treated Nets (ITN) or ARV use to the scale required. In accordance with the Abuja targets for expanding ITN and the Bank’s health policy strategic directions on regional procurement system for pharmaceuticals, the Bank through CSPs and Country Dialogue Papers will, where appropriate advocate for government regulations and incentives (tax and tariff reduction, market priming, etc.) to stimulate private sector financing in this respect. As there are economies of scale to be gained in the production and procurement of pharmaceuticals, particularly essential drugs, and also in the purchase of equipment, the Bank will foster cooperation among countries to promote regional procurement and/or production of ITN, ARV drugs, vaccines and other pharmaceuticals.

3.3.12 Communicable diseases control services are global public goods for which user fee charges should be eliminated in order to ensure that these essential services including the provision of treatment are accessible to a sizeable proportion of poor population in RMCs. In this regard, the ADF resources can be used to finance local and recurrent costs on a decreasing scale so that it is phased out before project completion. The Bank will encourage RMCs to find other financing options including the participation of the private sector in cost sharing arrangement in order to ensure sustainability of project activities.

4. FRAMEWORK FOR BANK’S SUPPORT

4.1 POLICY FRAMEWORK

Scope and Purpose

4.1.1 The Bank Group Health Policy (1996) provides a general framework for the Bank’s role in financing activities to foster health development in RMCs by supporting both communicable and non-communicable diseases control. The Strategies on HIV/AIDS (2001) and on Malaria (2002) provide specific guidance for promoting Bank support to RMCs in the control of HIV/AIDS and Malaria respectively. Both strategies adopted single diseases approach and support vertical disease control programs. The Guidelines on Communicable Diseases builds on the Health Policy and these two strategies, and brings together the major communicable diseases in focus based on WHO’s broad classification. In addition, it allows for a multi-diseases approach in the control of communicable diseases to promote synergistic activities that permit spill over effect of the control of one disease to boost the control of others. The Bank’s thrust in communicable diseases is (i) to promote greater selectivity in program operations with a view to maximizing the outcome of its interventions; and (ii) to strengthen partnership with specialized agencies, other development partners and the private sector on the basis of comparative advantage. The Guidelines recognizes the need for (i) prevention of communicable diseases; (ii) the timely clinical management of diseases, and (iii) the rehabilitation of individuals disabled by
communicable diseases. It takes due account of the increasing role of global defense networks against diseases in setting its priorities and intervention modalities as highlighted below.

4.2 GUIDING PRINCIPLES

4.2.1 In carrying out its activities in the control of communicable diseases, the Bank will be guided by the following principles:

- **Long-Term Focus:** The Bank will have a long-term focus on communicable disease control and prevention in RMCs. In this regard, it will ensure that its support is directed towards enabling RMCs adhere to targets and indicators that support the MDGs for communicable diseases. In addition, the Bank will strengthen its support for interventions that build long-term capacities, develop or strengthen existing infrastructure, and provide continuous opportunities for training.

- **Needs Assessment:** The Bank will support countries efforts to undertake needs assessment through compilation and analysis of baseline and trend data on specific diseases. Such analysis will help identify RMCs unmet needs for prevention and control of communicable diseases based on which effective projects and programs can be designed and implemented.

- **Selectivity of Programme Operations:** The Bank will strive for greater selectivity and focus in its investments in communicable diseases. Selectivity of Programs/projects will be guided by more national priorities as reflected in PRSPs and identified in CSPs. It will also be guided by the following considerations: (i) cost-effectiveness of projects and programs; (ii) the Bank’s comparative advantage in the program; and (iii) expected tangible results from the particular intervention. Selectivity of programs on communicable diseases control should also give particular attention to gender concerns and multinational/regional initiatives.

- **Multi-Sectoral, Multi-Disease Focus:** The Bank will attach great importance to proposals that cut across sectors and include the participation of stakeholders from sectors other than health. In addition a multi-disease focus will be preferred, where appropriate to address the main as well as the opportunistic diseases.

- **RMC Ownership of Strategies of Proposed Interventions:** The Bank will ensure that its interventions in communicable diseases are anchored on stakeholders’ ownership. In this regard, the Bank will recognize (i) the indispensable roles of; individuals, target communities, the private sector, academic institutions, the civil society, and the government in control and prevention efforts and (ii) the need for PRSPs as development framework to outline RMC priorities in disease control; (iii) the responsibility of RMCs in the design, implementation and coordination of responses to communicable diseases. The role of the Bank and external partners will be to support and strengthen the national policies and actions of RMCs.

- **Stress on Vulnerability:** The Bank will give priority to projects that addresses the needs of vulnerable populations such as women, youth, migrant populations, and individuals living with communicable diseases, and those that demonstrate impact on poor families and communities.
- **Ending Stigma and Protecting Human Rights:** The Bank will strongly support legislation on enabling social, political and legal policies in RMCs to end stigma or sanctions against individuals living with communicable diseases, and to guarantee individual human rights.

- **Coordination of Donor Support, Partnerships and Alliances:** The needs of RMCs for the control of communicable disease are huge and beyond the capacity of any single institution. This calls for a coordinated approach by both local and international actors. The Bank’s interventions will, therefore, be based on open and transparent interactions with the other actors so as to maximize synergies with a view to increasing the development effectiveness of its interventions in the control of communicable diseases.

- **Harmonization of Policies and Procedures:** The Bank will continue to work with other donors to harmonize policies, procedures, including monitoring, evaluation and reporting frameworks. As much as possible, policies and procedures will be harmonized to the standards agreed between RMCs and donors. Flexibility in the application of procedures will be critical for successful implementation of SWAp for communicable disease control.

- **Cost Recovery:** The Bank will not encourage the recourse to user fees for cost recovery of communicable diseases control services; However, in line with ADF-IX directives, the Bank resources will be used to finance local and recurrent costs on a decreasing scale to be phased out before project completion. RMCs will be encouraged to find other sources of financing including the private sector to ensure sustainability of project and program activities.

- **Quest for Results:** All Bank operations in communicable disease control should include monitorable indicators to measure outcome. Baseline and trend data analysis as well as related performance indicators will facilitate the monitoring of progress and the assessment of the extent to which outputs and outcomes are the results of improved policies, guidelines and management of projects and programs.

### 4.3 PRIORITIES FOR BANK’S SUPPORT

**4.3.1** The Bank will support activities that prevent the transmission of communicable diseases, provide lifesaving treatment and support to infected persons where proven therapies are available. It will also rehabilitate individuals disabled by their encounters with communicable diseases. The Bank’s comparative advantage in these areas lies on its long years of operational experience through financing projects and programs that responded to the critical need of RMCs in health infrastructure, human resource development, access to improved technology for disease diagnosis, care and treatment, etc. In addition it has deeper knowledge of the socio-cultural factors that are determinant for the control of communicable diseases in RMCs. Owing to the scale of the diseases, the Bank priorities in communicable diseases will mainly focus on High Mortality Diseases (HIV, TB and Malaria). Bank support to “Neglected but Economically Costly Diseases” will be through mainstreaming in other sector operations. The Emerging and Epidemic-Prone diseases will be supported within the framework of emergency humanitarian assistance.

**4.3.2 High Mortality Diseases** (HIV/AIDS, TB, and Malaria). Recognizing the heavy burden in terms of morbidity and mortality associated with these diseases and their negative impact on the socio-economic development of Africa, the Bank identifies High Mortality Diseases as the priority area for its investments.
in the control of communicable diseases. It endorses the priorities and modalities specified in the Bank Strategies on HIV/AIDS, Malaria and the Health Policy. Interventions in this category of diseases will include information, education and communication campaigns (IEC); capacity building; infrastructure development; health systems reforms; support for proven clinical interventions; and rehabilitation services for disabled persons directly affected by communicable diseases. Emphasis will be placed on reproductive health and family planning infrastructural development, capacity-building and improvement in service delivery as critical areas for prevention and control of high mortality diseases among specific target groups, including the youth and women. Mainstreaming of control activities in other sector programs and projects will also be supported. The Bank will promote regional approach to the control of high mortality diseases by providing support to cross-border initiatives. Sector Wide Approach will be used where appropriate to provide support to RMCs in the control of communicable diseases. The Bank Group operations in high mortality diseases will also encourage partnership by allowing other partners in providing technical and/or financial assistance and promote partnership. Bank Group high mortality disease control activities will contribute towards the achievement of MDGs.

4.3.3 Neglected but Economically Costly Diseases: As mentioned earlier these diseases are neglected diseases despite their serious debilitating effect. In most cases prevention and control activities are economically costly and, therefore, do not attract urgent mobilization of support. Most of these diseases are, however, the subject of tightly focused global alliances and partnerships. The Bank’s intervention in this category of diseases will be subject to the availability of resources. The Bank will focus on mainstreaming prevention, control, and impact mitigation activities in relevant sector projects and programs (agriculture and rural development, water and sanitation, transport, etc.). Partnership with other development partners will be strengthened through Bank’s participation in SWAp operations designed to control neglected diseases. It will also provide necessary support under a partnership framework of global alliance and funding of these interventions will be done through co-financing arrangement.

4.3.4 Emerging and Epidemic-Prone Communicable Diseases: The threat of emerging and epidemic-prone diseases has vastly increased; causing frequent epidemic outbreaks of newly recognized infectious diseases as well as those that were once thought to be relatively stable. Due to the uncertainties in the type and frequency of occurrence of diseases under this category, global responses against this category of diseases will be implemented within the Bank’s emergency humanitarian assistance framework. Accordingly, the Bank will provide timely financial support through agencies specialized in emergency assistance and disease outbreak controls such as the WHO, UNHCR, Red Cross and Red Crescent Societies, etc. The Bank will respond to epidemics recognized as such by the WHO and will only support proven or promising intervention strategies that specialized agencies deem feasible.

4.4 AREAS OF INTERVENTIONS

In the priority diseases discussed under 4.3, the Bank will focus on the following areas of interventions in order of priority:

**Prevention**

4.4.1 The Bank recognizes the key role of prevention to avoid new infections. Prevention activities will be formulated through participatory approach of stakeholders to ensure that they reflect the needs of target populations. The Bank will also ensure that proposed prevention activities are sustained beyond the funding cycle. In this regard, it will request a sustainability plan from the government. Prevention activities include (i) setting up information, education and communication (IEC) programs for different target groups including school and youth programs; (ii) supporting immunization programs, (iii)
providing voluntary counselling and testing, as well as blood screening and transfusion services; (iv) production and social marketing of condoms, (v) Malaria prevention and control for children, adults and pregnant women through intermittent preventive treatment; insecticide-treated nets; case management of malaria, and maintenance of quality controls over anti-malaria drugs and other products; (vi) promotion of the internationally accepted DOTS strategy for prevention and control of Tuberculosis (vii) establishment of surveillance and epidemic intelligence activities for early warning of communicable disease outbreaks.

**Care and Treatment**

4.4.2 Key activities will include (i) provision of improved access to antiretroviral therapy (ART) for adults, particularly pregnant women and children to prevent PTCT (Parent to child transmission) of HIV; (ii) provision of prophylaxis for opportunistic diseases; (iii) provision of support for home-based care and community settings; (iv) delivery of improved access to quality and effective anti-malarial drugs, and provision of laboratory support for Malaria diagnosis; (v) provision of highly effective drug therapies for TB treatment, laboratory support for diagnosis and monitoring of treatment effectiveness; (vi) training of community health workers on malaria control; provision of drugs and highly effective clinical treatment regimes with direct observation of treatment program for TB; (vii) support to community directed treatment approach for control of malaria and TB, training of staff on directly observed treatment of TB and laboratory support for monitoring of treatment efficacy.

**Capacity Building**

4.4.3 The Bank will enhance RMCs’ capacities to respond to communicable diseases through, among other things (i) human capital development by training staff, especially for improving the quality of service delivery; (ii) establishment of integrated health information management system (IHIMS) and diseases surveillance. In this regard the Bank’s support will also include the strengthening of the capacity of RMCs for the generation of baseline and trend data in communicable diseases to carry out accurate needs assessment, monitoring and evaluation activities, and (iii) policy and planning; (iv) short focused studies on critical issues of communicable diseases and on intervention strategies.

**Infrastructure Support**

4.4.4 The effective delivery of services for communicable diseases in many RMCs requires the construction of new facilities or rehabilitation of existing ones. The Bank support in communicable disease prevention and control will also address critical needs for infrastructure support for effective service delivery. Activities in this area will include among other things, the provision of facilities for voluntary counselling and testing, blood transfusion, treatment of STI, etc.

**Impact Mitigation**

4.4.5 Activities in this area include support to orphans, families and people affected or disabled by communicable diseases and the reintegration of those able to ease into productive economic activities. They also include (i) the creation of educational and employment opportunities for empowering populations; (ii) the strengthening of their capacity for protection against social and legal discrimination based on disease status; (iii) promoting the development of sentinel sites to estimate the burden of diseases; (iv) supporting human resettlements, food security and other development interventions, etc.
4.5 OPERATIONAL GUIDELINES ON COMMUNICABLE DISEASES

A. Programming and Funding Instruments

4.5.1 The Country Strategy Papers (CSPs), which build on the Poverty Strategy Papers (PRSPs) or on development plans will be the principal instruments of policy dialogue with RMCs. This dialogue will, *inter alia*, underscore the importance of achieving progress towards the attainment of the MDGs. The CSPs will include a discussion of communicable diseases in line with the orientation of the present Guidelines. The discussion will be based on sector studies, research papers from the Bank and other sources.

Funding Communicable Diseases

4.5.2 ADB Countries: The Bank intervention in these countries will be limited to policy dialogue focusing on advocacy and sensitisation programs to raise political commitment, leadership and ownership in the fight against communicable diseases. As these countries are unlikely to borrow non-concessional loans for communicable disease control, the Bank will play a catalytic role in mobilizing grant resources from bilateral and multilateral institutions, international NGOs, foundations and other private entities. Achieving the national and global objectives on communicable diseases and related health matters requires new resources and unprecedented levels of cooperation among multilateral agencies, national authorities, communities, the private sector and other stakeholders. However, where countries are interested to borrow, the Bank will finance projects and programs on communicable diseases control through the ADB loans. In this regard the technical assistance fund for middle-income countries (MIC) and policy based lending (PBL) will be used where it is appropriate for project preparation, policy formulation, and reform.

4.5.3 ADF Countries: The Bank’s lending activities in communicable diseases will be organized around the following priority areas of interventions:

(i) Projects and programs under the high mortality diseases including HIV/AIDS, TB and Malaria will be of high priority for scaling up Bank Group responses in RMCs. Activities in this category designed as stand-alone interventions, or as components mainstreamed in non-health projects or as part of SWAp will be financed through loans or grant resources or a combination of both, in line with the directives of ADF-IX and subsequent directives.

(ii) Bank Group interventions in neglected but economically costly diseases will be through mainstreaming of prevention control and impact mitigation activities in Bank Group operations. The Bank will also lend its support to the control of diseases under this category through SWAp. Activities will be funded through loans and ADF grant resources. The Bank will seek co-financing arrangement with development partners to support RMCs in the control of diseases under this category as well as for support of programs that strengthen regional and sub-regional responses.

(iii) With respect to emerging and epidemic-prone diseases, the Bank will provide financial support to RMCs through more specialized agencies such as the UNHCR, WHO, WHO-AFRO, Red Cross and Red Crescent Societies to manage emergency response to emerging and epidemic-prone diseases and other natural disasters in RMCs. Support will be provided
within the Bank’s emergency humanitarian assistance framework through the Bank’s Special Relief Fund (SRF) grants. In rare circumstances and in line with relevant SRF guidelines, the Bank may provide short-term assistance to counter loss of economic activities in areas that suffered the brunt of a disease outbreak or emergency situation.

Mainstreaming

4.5.4 The Bank will promote the mainstreaming of communicable diseases in its non-health sector operations. The Bank will also explore options to mainstream communicable diseases in its cooperation with bilateral and multilateral partners. The responsibility for mainstreaming communicable diseases in Bank supported projects lies with Sector and Country Departments. The starting point will be the need to ensure that the CSPs, which are informed by PRSPs include communicable diseases as one of the priority areas for Bank interventions. Mainstreaming of communicable diseases in Bank operations, in particular Neglected Diseases will be promoted through mandatory analysis of communicable diseases dimensions in CSPs. In this regard, the Bank will rely on the checklists in Annex 5, which reflect conclusions drawn from major reviews on the subject by UNAIDS and UNDP. Annex 5 is designed to assist task managers in the mainstreaming process.

4.5.5 The activities that can be mainstreamed into non-health operations include: IEC programs on communicable diseases; immunization programs; provision of essential drugs including ARVs and prophylaxis as workplace initiatives; insecticides; research/studies that will lead to increased knowledge on the control of communicable diseases; capacity building for raising quality of service delivery; improved access to blood safety and transfusion programs; improvement in potable water supply, and control of water borne diseases. The Bank will also give due consideration to sector-wide approaches for mainstreaming communicable diseases prevention, control and impact mitigation activities that will address among other things the critical concerns of the disproportionate disease burdens of women.

B. Project Cycle Activities For Communicable Diseases

4.5.6 The Bank’s project cycle comprises the following sequential steps: Project identification; Project preparation and sustainability determination; Project appraisal; Project implementation; Monitoring/Evaluation. The Bank’s Operations Manual is the primary reference document for managing the project cycle operations in communicable disease control. A brief overview of the project cycle as it relates to communicable diseases follows.

4.5.7 Project Identification: In recommending Bank support for a proposed intervention, especially for emerging and epidemic-prone diseases, there is a need to verify if: (i) the request is line with broad communicable diseases priorities stated in CSP for a. given RMC; (ii) the proposed intervention reflects standards set by relevant specialized agency, especially the WHO (Annex 6); and (iii) none of the ongoing donor supported initiatives in the RMC is directly addressing objectives stated in the project proposal.

4.5.8 It is critical, at this stage, to assess Bank projects in the health and non-health sectors, for potential impacts, mitigation or enhancement measures in accordance with the Bank’s Environmental, Social and Health impact assessment, and to set clear objectives, as well as targets with verifiable indicators. It is equally important to allocate appropriate resources to carry out specific mandates with regards to the health impact assessment and mitigation. Costs of such assessment should be included in the project costs.
Although financing will come from the project, potential source of funding shall be discussed. Prospective sources of funding for such activity include: Rollback Malaria, bilateral sources, etc.

4.5.9 The Task Manager should also point out the merits and demerits of financing the proposed communicable diseases programme/project as well as the risks and opportunities related to the proposed intervention. It is also important to identify sectoral linkages that will guide the mainstreaming process, and ensure ownership of the proposed programme/project by stakeholders in RMCs.

4.5.10 **Project Design (Preparation and Appraisal):** In the design of projects and programs under the project preparation and appraisal cycle, emphasis will be on technical design. The task manager will, amongst other, rely on the present Guidelines, Bank Group Strategies on HIV/AIDS and Malaria as well as on WHO standard guidelines for specific diseases (available at WHO website). They will also clearly indicate process and impact indicators for monitoring and evaluating effectiveness of proposed actions. In this regard, the Bank’s paper on how to achieve MDGs in Africa and UN data can be used (see Annex 7 on the MDG targets and indicators for communicable diseases). It is also crucial to assess the capacity of existing national structures to implement proposed interventions in communicable diseases.

4.5.11 There are three standard coordinating levels for implementation of communicable disease interventions at the country level: (i) the peripheral level which includes mostly primary care centre and community-based programs; (ii) the intermediate level, mostly district, local government or province-based programs; and, (iii) the central level, national level programs that include interface with external partners. The task manager will assess the appropriateness of these levels for the proposed intervention.

4.5.12 At Appraisal, the focus should be on specific measures to improve efficiency, effectiveness and viability, and, the relevance of proposed interventions to national poverty reductions strategies. Task Managers should ensure that each item under particular intervention is costed and appropriate resources allocated. At this stage of the project cycle there should be clear program/project implementation, monitoring and evaluation criteria for the proposed intervention. As timely implementation of the intervention is crucial, factors such as loan/grant conditions should be carefully formulated in order to avoid risk of delay in the implementation of diseases control activities due to government failure to fulfil such conditions.

4.5.13 However, there are unique risk factors Task Managers should particularly keep in mind during project preparation and appraisal: (i) baseline data may change quickly due to a disease outbreak; (ii) national program priorities may drastically change due to an unforeseen emergency, as showed by the Ebola epidemic; and, (iii) a resurgence of hitherto stable disease may arise due to high incidence of another disease, for example, the high co-infection rates between TB and HIV.

4.5.14 **Project Launching and Implementation Phase:** Task Managers should give top priority to follow up activities and continuously monitor indicators for progress in the implementation of the project to avoid delays. They should ensure that potential beneficiaries are active participants in program implementation. Task Managers should pay special attention to country’s fulfilment of loan conditions to expedite start up. They should ensure that the launching mission includes well prepared briefing material and presentation to inform all stakeholders (beneficiaries, partners, project implementation staff and government representatives) about the salient features of the project and planned implementation strategies, including monitoring and evaluation strategies, disbursement and procurement issues. Submission of regular progress reports and mid-term review is a top priority.
4.5.15 **Monitoring and Evaluation:** Valid baseline and trend data are critical for assessing progress made in achieving project objectives. They would also facilitate carrying out regional, continental and international comparisons of progress made. In addition to output indicators, it is important to use process indicators to monitor the implementation of communicable disease activities. The standard set by WHO and other specialized agencies could serve as a guide. Monitoring and evaluation of progress in project implementation should be pursued through regular supervision of projects and a well-planned mid-term review.

4.5.16 **Partnership and Coordination:** Task managers should ensure that the role of all partners is clearly outlined for every stage of the project cycle. For greater coordination, the project cycle activities including monitoring evaluation and reporting, as well as staff training and capacity building issues need to be agreed upon a priori among partners and a clear roadmap established on the role of each collaborator. For joint missions, the role and responsibilities of each partner should also be spelt out before the commencement of the mission.

**Institutional Arrangements**

4.5.17 **Organization and Management:** Implementation arrangements for Communicable Disease Control Programmes should be sound, sustainable and be integrated with on-going activities in the country. The Ministry of Health in the countries will be the executing agency for Communicable Disease Control Programmes. It is also important to involve the private sector, NGOs and CBOs in the implementation of communicable disease interventions by strengthening the public-private partnership. A National Communicable Disease Control Committee (NCDCC) where it exists or an equivalent institution will oversee the programmes. Its role will be to provide policy guidance, review project, approve annual budgets and ensure synergy in donor interventions in the communicable disease control. The NCDCC will be chaired by a higher official from Ministry of Health and members of the committee will be nominated from relevant Government Ministries, Donor representative, a UN Agency, NGO representative and Programme/Project Managers of disease control programmes under implementation. Each programme/project will be executed by existing local structures, as their involvement in the management of communicable disease control projects is essential for sustainability of project activities.

4.5.18 Existing administrative structures will be used to supervise the activities under the communicable disease control programmes. It is only in exceptional circumstances that new project implementation units (PIU) may be created outside the existing structure. The creation of new PIUs will have to be adequately justified. However, where institutional capacity of existing local structures and PIUs is weak, suitable capacity-building programmes should be initiated. PIUs will be responsible for the day-to-day management of the programme/project. Their core functions should include planning, preparation of annual work plans and budget, financial management, procurement of goods and services, co-ordination, supervision, monitoring, continuous evaluation of programme/project activities and reporting.
4.6 IMPLEMENTATION MODALITIES

4.6.1 To ensure durable implementation arrangements and enhance capacity building for communicable disease projects, the Bank will take the following actions:

- Sector and Country Departments will have primary responsibility for mainstreaming communicable diseases into Bank Group operations in RMCs. The Bank’s health and related sector experts will take the lead in the implantation of the Guidelines.

- The Operations Policies and Review Department (POPR) will coordinate policy compliance issues on communicable diseases through the review process. It will also coordinate partnership activities on communicable diseases with specialized agencies and global alliances. POPR will also provide periodic updates to Operations staff on the latest developments in the area of communicable diseases and state of art in prevention, care and treatment techniques. It will organize seminars and workshops to disseminate information and share knowledge.

- The Sustainable Development Unit (PSDU) will assess and categorize health and non-health sector projects for potential impacts on the basis of the Bank’s Environmental, Social and Health impact assessment.

- There is a need to strengthen the Bank’s capacity in order to allow it to respond effectively to the challenges of communicable diseases in Africa. The development effectiveness of Bank prevention, care and treatment, and impact mitigation activities depend, among other things, on the expertise and experience of staff, the soundness of policy frameworks and the availability of resources. Thus the Bank will step up staff training and sensitization programs on mainstreaming communicable diseases in Bank projects, and will ensure the availability of critical skills mix for analysing multi-sectoral issues of communicable diseases by recruiting relevant staff and consultants for project design and implementation; and supporting research, and knowledge-sharing activities that include internal exchange of information as well as with external partners.

- The Bank will organize seminars and conferences on how to mainstream communicable diseases in policy dialogues within RMCs through inclusion of disease impacts in CSPs and PRSPs.

- Communicable diseases prevention, care and treatment will be enhanced through more stand-alone grant financed projects to combat high mortality diseases in counties with significant grant allocations in the context of scaling up of the Bank’s responses in RMCs. Communicable diseases control activities will also be integrated in relevant sectoral Bank operations and crosscutting themes. Specifically, Management will ensure that communicable diseases issues are taken into consideration during review of project proposal for entry into the project pipeline and in the lending program.
• As part of its effort to raise RMCs capacities in the control and monitoring of communicable diseases, the Bank will support needs assessment exercises through baseline surveys and trend analysis. The development effectiveness of Bank operations increases when projects and programs are designed to respond to critical needs identified by credible needs assessment exercise.

• PRSPs and CSPs will include discussions on communicable diseases prevention and control efforts with a view to providing macro-level information on the status, unmet needs and resource requirements for appropriate responses.

• Selectivity of Bank Group projects and programs should be guided by critical review of Bank’s comparative advantage, cost-effectiveness of interventions and tangibility of expected results. In this regard, Country Strategy Papers will indicate actions to be taken at country level and the resources required to implement them.

• The impact of communicable diseases in all phases of the project cycle will be carefully reviewed with a view to ensuring that project activities are designed and implemented to give the desired output.

• The Bank will monitor and evaluate its achievement in mainstreaming and direct support of communicable disease control on a regular basis through Bank supervision missions, mid-term reviews and joint reviews with development partners.

• In major infrastructure projects that will have significant impact on communicable diseases, there is a need for the Bank to provide resources for implementing impact mitigation operations as recommended by Environment, Social and Health Impact Assessment.

• Partnership provides an appropriate framework for successful implementation of Bank interventions on communicable diseases. In accordance with ADF-IX directives, the Bank promotes communicable diseases control activities through partnership that include:

(i) The strengthening of its existing partnership on HIV/AIDS with the World Bank and UN specialized agencies to include other communicable diseases and promote joint activities. It will continue to seek economies of scale in project and program financing through enhanced relationships with specialized agencies and development partners. The implementation of existing MoUs and joint plan of actions with these institutions will be enhanced and monitored.

(ii) The nurturing and development of activities within existing partnership framework, including International Partnership against AIDS in Africa, Roll Back Malaria, Stop TB, Global AIDS Vaccine Initiative (GAVI), Commission on HIV/AIDS and Governance in Africa (CHGA).

(iii) The coordination of Bank communicable disease control activities within the framework of NEPAD with the AU, the ECA and Regional Economic Communities, etc with a view to assisting RMCs better in meeting the MDGs, in particular, those bearing on communicable diseases.
(iv) The promotion of public-private partnership with a view to mobilizing resources to support communicable disease control activities in ADB countries. In addition, the Bank’s catalytic role in this regard will foster cooperation among countries to promote regional procurement and/or production of ITN, ARV drugs, vaccines and other pharmaceuticals. It will continue to monitor the evolving global public/private/civil society partnerships and alliances against communicable diseases, especially as it relates to regional and multinational initiatives. He development of strategic partnership in the control of communicable diseases allows the Bank to make an optimal use of its limited resources while it creates the opportunity for sharing knowledge and experience as well as for harmonization of procedures.

5. CONCLUSION AND RECOMMENDATIONS

5.1 The Bank has a long-standing experience in financing health sector projects including programs that deal directly or indirectly with communicable diseases. The Bank’s lending in this sector is driven by its Health Sector Policy approved in 1996, the HIV/AIDS Strategy Paper approved in 2001, and the Malaria Control Strategy approved in 2002. The Bank has identified 9 communicable diseases for priority investment in its Health Sector Policy. Moreover, the Deputies for ADF-IX reaffirmed the significant impact of HIV/AIDS, Malaria and vaccine preventable diseases on the socio-economic development of RMCs and directed Management to develop a guideline on communicable diseases. The Bank’s Strategic Plan 2003-2007 also recognized communicable diseases control and prevention as an institutional priority.

5.2 The Guidelines present the Bank’s new thrust in communicable diseases, which builds upon the Health Policy and the strategies on HIV/AIDS and on Malaria control. The priority diseases identified by the separate existing policies are brought in focus under the present Guidelines using the current WHO Broad classification with a view to setting Bank priority areas of interventions and defining the modalities of implementation. It also applies the ADF-IX directives for greater selectivity in program operations, to maximize the Bank’s comparative advantage, and strengthen partnerships with specialized agencies and development partners.

5.3 The operational focus at the core of the Bank’s new thrust in communicable diseases consists of the following:

(i) **High Mortality Diseases of HIV/AIDS, Malaria and Tuberculosis.** The Bank’s primary investment priority will be on high mortality diseases of HIV/AIDS, Malaria and Tuberculosis. These diseases represent significant morbidity and mortality disease burdens in RMCs. The Bank will provide loan and grant assistance for prevention, control and impact mitigation of these diseases, in line with ADF-IX. Directives.

(ii) **Neglected but Economically Costly Diseases.** The Bank will intervene in neglected but economically costly diseases through mainstreaming of prevention, control and impact mitigation of these diseases in Bank Group operations. The Bank’s support for control of diseases under this category (Onchocerciasis, Schistosomiasis, soil Helminthiasis, Guinea worm, Filariasis, Leishmaniasis, and Buruli ulcers), which in most cases are the subject of
tightly focused global alliances and partnerships, will be through loans and grants under co-financing arrangement with other development partners.

(iii) **Emerging and Epidemic-Prone Diseases.** For emerging and epidemic-prone diseases, the Bank will provide support to more specialized agencies with experience in disease control and disaster management. These diseases include Yellow Fever, Cholera, Vaccine preventable diseases, Food borne diseases, Epidemic Meningitis and Ebola.

5.4 The Bank will provide support to communicable diseases as a stand-alone interventions or as components of projects and programs comprising: (i) prevention; (ii) care and treatment; and (iii) impact mitigation.

5.5 For project cycle processing of communicable disease activities, the Bank’s Operations Manual remains valid. Bank Group intervention will target the Millennium Development Goals, in particular, those that are set for communicable diseases (Annex 6). The MDG targets and indicators (Annex 7) will serve as a benchmark for reviewing, monitoring and evaluating progress made towards the achievement of the MDG.

5.6 In addition, communicable diseases will be mainstreamed into relevant sector Bank operations in accordance with the step-by-step operational guidelines and implementation modalities outlined in Chapters 4 and 5 of this paper.

5.7 The Boards of Directors are invited to approve the proposed Guidelines on Communicable Diseases.
United Nations Millennium Development Goals (MDGs)

The MDGs consist of the following eight goals:

1. **Eradicate extreme poverty**
   - Halve the proportion of people whose income is less than one dollar a day by year 2015;
   - Have the proportion of people who suffer from hunger by year 2015

2. **Attain universal primary education in all countries by 2015**
   - Ensure children of both sexes everywhere will be able to complete a full course of primary schooling

3. **Promote gender equality and empower women**
   - Eliminate gender disparity in primary and secondary education, preferably by year 2005, and at all levels of education no later than 2015

4. **Reduce child mortality**
   - Reduce by two-thirds under five mortality rate by 2015.

5. **Improve maternal health**
   - Reduce by three-quarters the maternal mortality ratio by year 2015.

6. **Combat HIV/AIDS, malaria and other diseases**
   - Halt by 2015, and begin to reverse the spread of HIV/AIDS;
   - Halt by 2015, and begin to reverse the incidence of malaria and other major diseases.

7. **Ensure environmental sustainability**
   - Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources;
   - Halve by 2015 the proportion of people without access to safe drinking water;
   - Achieve a significant improvement in the lives of at least 1000 million slum dwellers by 2020.

8. **Develop a global partnership for development**
   - Develop further an open, rule-based, predictable, non discriminatory trading and financing system;
   - Address the special needs of the least developed countries;
   - Address the special needs of land-locked countries and small island developing states;
   - Deal comprehensively with the debt problem of developing countries through national and international measures in order to make debt sustainable in the long term;
   - In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries;
   - In cooperation with the private sector, make available the benefits of new technologies, especially information and communications.
ANNEX 2

CONGO-OUBANGUI-CHARI RIVERS BASIN MULTINATIONAL HIV/AIDS INITIATIVE

Box 1
Project in support of the Congo-Oubangui-Shari Rivers STI/HIV/AIDS

This multinational cross-border HIV/AIDS control intervention, committing UA 6 million of Fund resources on grant terms, was approved by the Board of Directors on 11 September 2003. Four countries are sponsoring this project – the Democratic Republic of Congo, Republic of Congo, Republic of Chad and Central African Republic. The total cost of the project is UA 6.55 million; thus, the beneficiary countries will finance some 8.4% of this intervention. Of the total cost of the project, 71.8% involve foreign exchange expenses (medicines, pharmaceutical consumables and laboratory reagents, basic equipment of the health facilities, and equipment of the Executive Secretariat, etc) against 28.2% in local costs of goods and services to be procured within the four countries (for the rehabilitation of the premises of the referral hospitals and those of the health centres, and services provided by local NGOs - awareness campaigns, training of peer educators, community services development, etc).

The overall goal of the project is to help reduce the spread and socio-economic impacts of HIV/AIDS and sexually transmitted infections. This goal is congruent with the Millennium Development Goals (MDGs which specify, with regard to AIDS: “to halt by 2015, and begin to reverse the spread of HIV/AIDS”. The specific objective is to reduce the vulnerability of the migrant populations and those living along rivers Congo, Ubangi and Shari to the risks related to these diseases. Particular attention will be paid to persons that migrate within the river valleys and to the populations with whom they interact in the ports, villages, markets, and in the private and public commercial boats that provide transport on the waterways. To achieve the objectives stated above, the project will be implemented in three components: The first will aim to strengthen the preventive measures and treatment of, and assistance to infected and affected persons. The second will promote multi-sectoral and sub-regional co-ordination. The third will strengthen project management.

With a view to maximising the development impacts of this Fund intervention, Management has set a number of objective verifiable indicators. At the global level, the target impacts are a reduction in the sero-prevalence of HIV among pregnant women aged 15 to 24 years, stabilisation of the number of children made orphans by HIV/AIDS, and an increase in the contraception prevalence rate. At the level of specific project objectives, the attainable impacts are to achieve, between 2003 and 2006, a 50% reduction in the rate of incidence of sexually transmitted infections; an increase by 75% in the rate of utilization of male and female condoms; the provision of voluntary counselling and testing (VCT) by all Health Centres (HC) in the project area; and the acquisition of better knowledge of the risks and responsible sexual behaviour among sex workers.

All of the health structures in the area covered by this multinational initiative will be equipped with testing facilities and medicines for the treatment of STI/HIV/AIDS. Sentinel sites will be equipped with testing facilities and means of communication. The project will finance increased availability and accessibility of condoms at all the project sites; and 100% of the health workers on the project sites will be trained in information, education and communication (IEC) and the treatment of STIs and HIV/AIDS. Some 16 Doctors will be trained as facilitators, and laboratory technicians will be trained in STI and HIV testing. Also, about 100 members of NGOs will be trained and involved in STI and HIV/AIDS control, and 2,800 peer educators trained and supervised. Sensitisation seminars will be organized for local and national authorities, as well as quarterly awareness campaigns at all the sites. IEC facilities, posters, leaflets will be disseminated. Socio-behavioural surveys will be conducted in 2003 and 2005.

A functional regional communication network will be established by 2006, and radio-telegraphic equipment will be installed in all the sites and riverboats used for public transport. By project completion, a viable data collection and processing system will be operational within the Executive Secretariat of the multinational Initiative, which will have the capacity to publish and disseminate quarterly bulletins on the control of STIs and HIV/AIDS in the project area. External evaluation of this Fund intervention will be conducted at the project completion.

Even before the commencement of project implementation, the Fund intervention in support of the joint initiative of the four countries sharing the Rivers Congo, Ubangi and Shari have already achieved two fundamental objectives that hold the key to accelerating support to these countries in the fight against STI/HIV/AIDS: Firstly, it has cemented the culture of regional cooperation in tackling endemic structural problems that hinder countries from getting out of the poverty trap and they cannot be overcome by countries acting in isolation. Secondly, it has reinforced the countries’ resolve to act boldly in facing up to the threat posed by STIs and HIV/AIDS.
## ANNEX 3

### BURDEN OF DISEASE INDICATORS FOR HIV, TB, MALARIA, MENINGITIS AND Trypanosomiasis (Sleeping Sickness) IN ADF COUNTRIES

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### ANNEX 4

**BURDEN OF DISEASE INDICATORS FOR HIV, TB, MALARIA, MENINGITIS AND TRYPANOSOMIASIS (SLEEPING SICKNESS) IN ADB AND ADF (BLEND) COUNTRIES**

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**Key explanatory points**

1. High-burden TB countries reflect WHO designation of high prevalence and incidence rates and high socio-economic costs. Worldwide, 22 countries, including 8 African countries, are designated “high burden” TB countries and they represent over 80% of all cases in the world.
2. Designation of countries prone to malaria epidemics over a five-year period is a WHO classification and refers to sudden malaria attacks in populations with limited immunity.
3. WHO also establishes endemic levels of Sleeping Sickness and epidemic levels of Meningitis. Epidemic meningitis represents 15 or more cases per 100,000 population.
4. Statistics on HIV/AIDS refers to adults ages 15-49. Countries without data on HIV do not necessarily imply lack of infection. UNAIDS reports lack of any data.
5. WHO designates HIV/AIDS, TB and Malaria as high mortality diseases; Trypanosomiasis (sleeping sickness) as a neglected but economically costly diseases; and, Meningitis as an example of the emerging and epidemic-prone disease.
6. ADF countries – countries eligible to borrow from concessional resources only (Category A); ADB/ADF – Blended countries eligible to borrow from both ADF and ADB resources (Category B); ADB countries – countries eligible to borrow from non-concessional resources only (category C).
<p>| | |</p>
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<tr>
<td>1.</td>
<td><em>Did the Country Strategy Paper (CSP) and the Poverty Reduction Strategy Paper (PRSP) include baseline and trend epidemiological data on communicable diseases (high mortality diseases of HIV/AIDS, TB and Malaria; Neglected but Economically Costly Disease; Emerging and Epidemic Prone Disease)</em>?</td>
</tr>
<tr>
<td>2.</td>
<td><em>Did the CSP and PRSP include a review of the socio-economic impact of communicable diseases, and the implications for poverty reduction strategies?</em></td>
</tr>
<tr>
<td>3.</td>
<td><em>Did the CSP and PRSP discuss the relationship between national plan of action against communicable diseases and poverty reduction strategies? Are national plans of action against communicable diseases and poverty reduction strategies properly linked, complement each other, and share common program targets and priorities?</em></td>
</tr>
<tr>
<td>4.</td>
<td><em>Did poverty reduction strategies stated in CSP and PRSP include specific strategies for addressing communicable diseases?</em></td>
</tr>
<tr>
<td>5.</td>
<td><em>Does the section of the poverty reduction strategy on combating communicable diseases include specific commitments, targets, medium-term goals and short-term targets against specific communicable diseases?</em></td>
</tr>
<tr>
<td>6.</td>
<td><em>Has the national plan of action against communicable diseases been fully costed and is it included within Medium Term Expenditure Frameworks of the RMC?</em></td>
</tr>
<tr>
<td>7.</td>
<td><em>Are concerns about communicable disease prominently discussed in debt relief frameworks, negotiations and HIPC documents (where applicable), and are there verifiable strategies for earmarking savings for specific interventions in communicable diseases?</em></td>
</tr>
<tr>
<td>8.</td>
<td><em>How is the RMC taking steps to meet the 2001 Abuja OAU declaration on setting aside 15% of national budgets to health? What proportion of health budgets go to interventions in communicable diseases?</em></td>
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Overview of World Health Organization Recommended Guidelines on Communicable Diseases

1. National Strategies and Capacities Crucial to International Defence Against Communicable Diseases

2. Adopt “Multi-disease, Multi-sectoral” Approach to Disease Control and Prevention

3. Understand and Participate in WHO Global Defence Security Network

4. Recognize the Broad Classification of Communicable Diseases
   - High Mortality Diseases (HIV/AIDS, TB, Malaria);
   - Neglected Diseases with Severe Disability and Cost (Onchocerciasis, Leprosy, Guinea worm, schistosomiasis and soil helminthiasis, buruli ulcer, etc.);
   - Emerging and Epidemic-Prone Diseases (Cholera, Yellow Fever, Epidemic Meningitis, Childhood Respiratory Diseases, Food Borne Diseases, Ebola, etc).

Focus on Three Levels of Intervention
   - The peripheral level, mostly primary care centres and community based programs;
   - The intermediate level, mostly district, local government or province based programs;
   - The central level, national level programs that include interface with external partners.

Set Priorities on Communicable Disease
   - Focus on developing and strengthening surveillance and control systems;
   - Select diseases for prevention and control;
   - Set standards for case definitions;
   - Set up laboratory support;
   - Set up information, communication and education (IEC) strategies;
   - Detect and report cases;
   - Investigate outbreaks and confirm outbreaks;
   - Take appropriate programme action (control; response; policy review; feed back);
   - Assess results of programme action.

Rely on tight Coordination of Program Activities
   - Performance-based monitoring and evaluation;
   - Cost-efficient management of resources (especially, avoid duplication of efforts);
   - Results-based supervision and training.
Goal: Combat HIV/AIDS, Malaria and Other Diseases

**Target**

Have halted by 2015 and begun to reverse spread of HIV/AIDS

**Indicators**

- HIV prevalence among 15-24 year-old pregnant women
- Percentage of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS
- Ratio of school attendance of orphans to school attendance of non-orphans 10-14 years of age
- Condom use at last high-risk sex

**Target**

Have halted by 2015 and begun to reverse incidence of malaria and other major diseases

**Indicators**

- Prevalence and death rates associated with Malaria
- Proportion of population in malaria risk areas using effective Malaria preventive and treatment measures
- Prevalence and death rates associated with Tuberculosis
- Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)

The choice of indicators is under continuous refinement. The Office of the Secretary General of the UN is managing the process of refining MDG indicators. The WHO provides technically feasible indicators for other communicable diseases. Global alliances that address specific diseases also work with WHO to continuously evaluate indicators for various diseases.

*Sources:* UN Statistics Office; UN Office for Achieving Millennium Development Goals; WHO, UNICEF, UNDP
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