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Development Committee 2003 Spring Meetings

Fighting HIV/AIDS: Progress, Prospects and Issues

Addendum 2

Abbreviations and Acronyms

ART	Antiretroviral Treatment
ARV	Antiretroviral
CBO	Community-Based Organization
CCM	Country Coordination Mechanism
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
FBO	Faith-Based Organization
IBRD	International Bank for Reconstruction and Development
HIPC	Heavily Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IDA	International Development Association
IDF	Institutional Development Fund
IDU	Injecting Drug User
M&E	Monitoring and Evaluation
MAP	Multi-Country HIV/AIDS Program
MDG	Millennium Development Goal
NAC	National AIDS Council/Commission
NGO	Non-Governmental Organizations
PRSP	Poverty Reduction Strategy Paper
SWAp	Sector-Wide Approach
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS

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Fighting HIV/AIDS: Progress, Prospects and Issues

I. THE HIV/AIDS CHALLENGE

A. INTRODUCTION. This addendum reviews the status of the global fight against HIV/AIDS, charting progress to date and prospects for achieving the Millennium Development Goal (MDG), which includes to "have halted by 2015 and begun to reverse the spread of HIV/AIDS". Following an overview of the state of the epidemic, the paper reviews the current financial commitments that international donors have made and actual spending for the fight against HIV/AIDS. These are then compared against the best available estimates of the resources required to scale up HIV/AIDS activities if enough funding were available to use existing infrastructure to its maximum potential. The addendum also discusses how best to remove impediments to progress, and accelerate implementation of HIV/AIDS programs. The overall conclusion is that without significant changes in the way the epidemic is addressed, there is little chance of halting and beginning to reverse the spread of HIV/AIDS by 2015**.**

B. STATUS OF THE HIV/AIDS EPIDEMIC

1. The epidemic continues to increase in all regions, and its impact in terms of human suffering has intensified over the last 10 years. The number of people living with HIV/AIDS continues to accelerate, despite high levels of mortality among those infected early in the decade. While 12.9 million people were living with HIV/AIDS in 1992, more than 42 million people are today, reflecting a global development crisis of huge proportions. This statistic masks the fact that millions have already died. The epidemic is now shifting, and can no longer be thought of as primarily or even mainly a crisis of Sub-Saharan Africa.

2. **Sub-Saharan Africa.** The disease is especially hard hitting in Sub-Saharan Africa, which now has 29.4 million people living with HIV/AIDS, of which 10 million are aged 15-24 and almost 3 million are under 15. Sub-Saharan Africa suffered approximately 3.5 million new infections and lost 2.4 million people to AIDS in 2002. Four southern African countries have prevalence rates beyond what was thought imaginable, with over one-third of the population infected; 38.8 percent in Botswana, 31 percent in Lesotho, 33.4 percent in Swaziland and 33.7 percent in Zimbabwe. Today, more than 58 percent of those living with HIV/AIDS in Africa are women. The long term consequences of this pattern are significant given the central role that women play in building and maintaining human capital.

3. **Eastern Europe and Central Asia.** At present, the Eastern European nations and Central Asian republics face the fastest growing epidemic. Available data show that there were 250,000 new infections in 2002, and the region now has a total of 1.2 million people living with HIV/AIDS. The acceleration of the epidemic in the Russian Federation is especially worrying: the total number of reported HIV infections climbed to over 200,000 by mid-2002, a huge increase from about 11,000 reported cases in 1998, but still likely an underestimate of people living with HIV. These increases are closely

associated with a rise in injecting drug use. Young people are particularly hard hit by the disease as an estimated one percent of the populations inject drugs, placing these young people and their sexual partners at risk. The region faces a major challenge in preventing the further spread of the epidemic from highly vulnerable, high risk groups (injecting drug users, commercial sex workers) through their sex partners to the general population.[1]

4. **Latin America and The Caribbean.** The epidemic is widespread in the Latin America and Caribbean region, where an estimated 1.9 million people are living with HIV/AIDS, and about 210,000 people were newly infected in 2002. This is the second most affected region after Sub-Saharan Africa, with adult prevalence over 6 percent in Haiti, 3.5 percent in the Bahamas and an estimated 2 percent HIV prevalence in the adult population of the Caribbean as a whole. According to the most recent estimates, about one in 20 adults aged 15 to 49 in Latin America are infected with HIV and approximately 567 people are infected every day. It is estimated that 600,000 people in the region have died from AIDS over the past 20 years and HIV/AIDS has become the major cause of death among men under the age of 45. The infection rate is estimated to have reached 12 percent in some urban areas, spreading in many countries from high-risk groups to the general population.[2]

5. **Middle East and North Africa.** Systems for tracking the epidemic in the Middle East and North Africa are especially weak, but available data show that this region is also at risk of a growing epidemic. HIV infection rates in this region are relatively low. Available data suggest that about 83,000 people were infected in 2002, and a total of 550,000 people are living with HIV/AIDS – about 37,000 people died of AIDS in 2002. A recent review by the World Bank projects possible acceleration in overall prevalence levels to as high as 3.6 percent by 2015. Unfortunately, social and cultural norms reinforce an atmosphere of denial and stigma against those affected in the region, and are inhibiting the evolution of more assertive policies to address the epidemic before it gets out of hand. [3]

6. **South Asia.** South Asia accounts for over four million people living with HIV/AIDS. Several countries in the region are characterized by a low prevalence among the general population but significantly higher rates among subpopulations that are engaging in high-risk behaviors, such as injecting drug use and selling and buying sex in conjunction with low condom use. For example, whereas the HIV prevalence rate among adults in Nepal is estimated at 0.5 percent, about 50 percent of the injecting drug using population in Kathmandu are HIV positive.[4]

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[1] Spread of HIV/AIDS is evident in Azerbaijan, Georgia, Kyrgyzstan, Tajikistan, Kazakhstan and Uzbekistan.

[2]The above description is drawn from Marquez, Patricio, et. al. *HIV/AIDS in Latin America and the Caribbean Region: A Briefing Note*, November 2002. World Bank Internal Memorandum.

[3]Jenkins C., Robalino D. *Overview of the HIV/AIDS Situation in the Middle East & North Africa Region/Eastern Mediterranean Region*, June 10, 2002.

[4] UNAIDS. *Report on the Global HIV/AIDS Epidemic*, July 2002.

7. India has an estimated four million people living with HIV/AIDS, the second highest figure in the world, after South Africa. India's national adult HIV prevalence rate of less than one percent offers little indication of the serious situation facing the country and several analyses indicate that weakness in current surveillance systems may seriously underestimate the scope of the disease.

8. **East Asia and the Pacific.** It is estimated that over two million people are living with HIV/AIDS in East Asia and the Pacific. With the exception of Cambodia, Myanmar and Thailand, national HIV prevalence levels remain comparatively low in most countries. That, though, offers no cause for comfort. In vast, populous countries such as China and Indonesia, low national prevalence rates blur the picture of the epidemic. The situation in China is especially worrisome, given the huge numbers of people, and the tendency, until recently, to downplay concerns about the spread of HIV. Official estimates are that over one million people were living with HIV/AIDS at end of 2002, but projections at current rates suggest this could grow to 10 million by the end of the decade. Several factors are driving the epidemic in China–the large migrant population, intravenous drug use, and poor hygiene in plasma sales–increasing the odds that the disease will continue to spread.[5]

9. Increased use of drugs in Indonesia, partly a function of growing urban poverty, is now resulting in large increases in HIV/AIDS prevalence among injecting drug users (IDUs). About 50 percent of an estimated 43,000 IDUs are already infected, and risk spreading HIV to the general population**.** Estimates are that if current high-risk injecting behaviour continues, the number of IDUs in Indonesia living with HIV could almost double in 2003, accounting for more than 80 percent of new HIV infections in the nation.

Impact of HIV/AIDS

10. **Demographic impact.** More than 60 million people have been infected with HIV since the beginning of the epidemic. HIV/AIDS is the leading cause of death in Sub-Saharan Africa, and the fourth biggest killer globally. The death toll from this disease is enormous, and is reflected in tragic reversals of hard won gains in life expectancy in a number of countries. For example, the average life expectancy in Sub-Saharan Africa is currently 47 years but would have been 62 years in the absence of HIV/AIDS. In the 45 most affected countries, it is projected that, between 2000-2020, 68 million people will die earlier than they would have in the absence of AIDS.[6] There are 14 million AIDS orphans in the world (of which 11 million are in Africa) and it is projected that by 2010 there will be 25 million orphans worldwide.[7]

11. **Impact on the education sector.** HIV/AIDS has affected the education sector disproportionately. It is draining the supply of teachers and administrators, eroding the

[5] National Intelligence Council. *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China*, September 2002. available at http://www.fas.org/irp/nic/hiv-aids.html
[6] UNAIDS. *Report on the Global HIV/AIDS Epidemic*, July 2002.
[7] UNAIDS, UNICEF, USAID. *Children on the Brink 2002, A Joint Report on Orphan Estimates and Program Strategies*, July 2002.

quality of education, weakening demand and access, drying up countries' pools of skilled workers, and increasing the sector's costs.[8]

12. **Impact on food security and nutrition.** HIV poses a potentially major threat to food security and nutrition[9] as is currently seen in southern Africa. It reduces households' capacities to produce and purchase food, depletes their assets, and exhausts social safety nets.[10] For example, in Malawi, where the HIV prevalence is 15 percent, the epidemic has caused drastic demographic changes in farming communities, with families now increasingly headed by women, children or grandparents, many of whom lack the skills and labor power to farm successfully.

13. **HIV and tuberculosis.** Countries with the highest HIV rates also have the highest TB rates per 100,000 inhabitants.[11] Increasing tuberculosis cases in people living with HIV/AIDS pose an increased risk of tuberculosis transmission to the general community, whether or not HIV infected.[12]

14. The HIV/AIDS epidemic starts slow and invisible (often in smaller subgroups or communities), but then spreads through various transmission routes and speeds up dramatically once infection rates hit a "takeoff point," which varies by country depending on a host of factors. A country with relatively low prevalence today could potentially experience an explosive epidemic. For example, Botswana has a current prevalence rate of over 38 percent in the general population yet it had a 0.1 percent prevalence rate in 1986. The Botswana experience underscores the need for China, India, Russia and other countries, that currently have relatively low adult HIV prevalence rates in the general population, to galvanize action in curbing the HIV/AIDS epidemic sooner rather than later.

II. THE RESPONSE TO THE GLOBAL HIV/AIDS CRISIS

15. **Global commitments**. Commitments made by developing countries, UN agencies, the donor community, multilateral development banks, and other partners in development have increased to begin to match the challenge posed by the pandemic. Most notably, resources have been mobilized to respond to the crisis through commitments from the G8 and other donors, both in the public and private sector, agreements made at Monterrey and coordinated actions by partners in UNAIDS.[13] In June 2001, the UN General Assembly Special Session (UNGASS) on HIV/AIDS

[8] World Bank. *Education and HIV/AIDS: A Window of Hope*, 2002.
[9] UNAIDS. *Report on the Global HIV/AIDS Epidemic*, July 2002.
[10] UNAIDS/WHO. *AIDS Epidemic Update*, December 2002.
[11] WHO. *TB/HIV Fact Sheet*, 2003, Available at: http://www.stoptb.org/Working_Groups/TBHIV/Factsheettb-hivWTBD01.htm
[12] WHO. *Strategic Framework to Decrease the Burden of TB/HIV*, 2002. WHO/CDS/TB/2002.296 WHO/HIV_AIDS/2002.2
[13] UNAIDS cosponsors are: UNICEF, UNDP, UNFPA, UNDCP, ILO, UNESCO, WHO and the World Bank Group.

concluded with a Declaration of Commitment for an intensified effort to mobilize national and international resources for combating HIV/AIDS.[14]

16. The UNGASS Declaration of Commitment pledged UN agencies, partners and governments to a series of broad-ranging goals related to HIV (some of which are summarized below) which, if met, will certainly contribute towards reaching the MDGs. **However, without significant changes in the way the epidemic is addressed, there is little chance of meeting the MDG goal which encompasses halting and beginning to reverse the spread of HIV/AIDS by 2015**. Further, even interim MDG goals, such as those for education, will not be realized, given the huge toll that HIV/AIDS exacts on teachers and educational systems in some countries (particularly in Sub-Saharan Africa). Simply put, progress toward a number of the other MDGs will be hindered or even reversed in the seriously HIV-affected countries unless business as usual changes. Substantial changes are needed to redress existing blockages to implementation.

17. **Resources.** With regard to financial requirements, UNGASS calls for resources for the global response to HIV/AIDS that are "substantial, sustained, and achieve results."[15] By 2005, UNGASS cites an overall annual target of between USD 7 billion and USD 10 billion to be spent on HIV/AIDS for low- and middle-income countries and countries with, or at risk of, high rates of HIV infection. It also calls for national governments to do their part in allocating domestic resources. As part of the call for additional resources, an explicit call was made for the international community to provide assistance for HIV/AIDS to developing countries on a grant basis.[16]

18. While the international donor community has begun to respond to this call for a massive effort, global commitments to date have not kept pace with the rising demands. A review of global HIV/AIDS related spending, (from all sources, including out of pocket expenditures and based on current and projected disbursement levels from multi- and bilateral sources) estimated that at least USD 3.2 billion was needed in 2002 for the fight against HIV/AIDS in developing countries. Yet far less was available, with an estimated gap of nearly 1.5 to 2 billion US dollars in 2002. UNAIDS projections are that the total funding required for all key interventions will increase to USD 10.5 billion in 2005, and USD 15 billion in 2007.[17] Available funding and pledged funding will not match the need, as discussed in section III, under the heading "Resource Gap."

[14] The full declaration is available at http://www.unaids.org/UNGASS/docs/AIDSDeclaration_en.pdf
[15] Ibid, para. 79.
[16] Ibid, para.81
[17] UNAIDS. *Financial Resources for HIV/AIDS Programmes in Low and Middle Income Countries over the next Five Years*, *Paper for the thirteenth meeting of the Programme Coordinating Board*, Lisbon, 11-12 December 2002. (UNAIDS/PCB/(13)/02.5) 28 November 2002.

The World Bank Group Response

19. World Bank lending commitments currently constitute the largest source of financing from the UN system for the fight against HIV/AIDS. Current Bank commitments for HIV/AIDS amount to over USD 1.3 billion, with USD 612 million committed to Sub-Saharan Africa, and the remainder dedicated to the Caribbean and other regions. In addition, the International Finance Corporation (IFC) is pursuing an intensive program of supporting HIV/AIDS activities, which includes helping firms to get started in addressing HIV/AIDS, raising awareness at management level, advising on corporate AIDS strategies and workplace HIV/AIDS programs, and disseminating good practice.

20. **About the MAP (the Multi-Country HIV/AIDS Program).** Recognizing the need for more substantial finance, greater attention to implementation, and direct funding for communities, the World Bank launched the Multi-Country HIV/AIDS Program (MAP) in 2000. The MAP has thus far made USD one billion available to African countries for individual country projects and, beginning this year, sub-regional projects reaching multiple countries. MAP projects support the implementation of national HIV/AIDS strategies. All activities encompassed in national plans are eligible for MAP support, the goal of which is to scale up programs as quickly as possible in each country context. The MAP allows funds to flow to all sectors and stakeholders in the national response, with a significant share (typically 50 percent) channeled directly to civil society. At the same time, the MAP has supported the development of institutions, tools and fiduciary processes which are strengthening the capacity of each country to implement its program. This implementation architecture will also enhance countries' ability to use support from other donors.

21. Demand for MAP support has been very strong. Currently, the Africa MAP includes 18 approved projects (with total commitments of USD 611.8 million, and disbursements of USD 77 million as of March 10, 2003).[18] An additional 15 country programs are being prepared through this program, and the Bank anticipates having committed the full USD one billion through this mechanism by end FY04.

22. **Caribbean MAP.** A similar MAP 'umbrella program', committing USD 155 million for a Multi-Country HIV/AIDS Prevention and Control (using a flexible instrument known as Adaptable Lending Program or APL) for the Caribbean Region was approved on June 28, 2001. So far, five country specific projects have been approved: for the Dominican Republic, Barbados, Jamaica, Grenada, and more recently, St. Kitts and Nevis, for total commitments of USD 66 million.

23. **Other countries implementing HIV/AIDS programs.** Prior to the MAPs, there were limited programs financed by the Bank devoted to HIV/AIDS, with the notable exceptions of India and Brazil. Hence, of the nearly USD two billion committed since 1986 for Bank-financed projects on HIV/AIDS, most is accounted for in just the last two

[18] The Sub-Saharan MAP includes: Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Eritrea, Ethiopia, The Gambia, Ghana, Guinea, Kenya, Madagascar, Nigeria, Senegal, Sierra Leone, Uganda, Zambia.

years. For example, in FY2002, over USD 545 million was devoted to HIV/AIDS in various health and population projects (i.e.; projects with an AIDS component of >USD 1 million and at least 10 percent of total project costs), and additional funds were devoted to HIV activities in other (non-health) projects. With programs now running in most of Africa, emphasis is being placed on South Asia and on East and Southeast Asia (principally India, China, and Indonesia, due to their large population and the burden of the disease), as the epidemic shifts. Intensified action is in the works for Eastern Europe and Central Asia. Increasingly, other sectoral projects are adopting HIV-specific interventions as, for example; in education or the urban sector.

24. **IDA grants.** An encouraging development has been the recent (2002) decision by the International Development Association (IDA) deputies to allow for grant funding of HIV projects. IDA 13 allows for a grant element in HIV/AIDS programs such that: IDA grants may finance up to 100 percent of national HIV/AIDS projects/programs in IDA only countries; up to 25 percent in blend (IDA/IBRD) countries; and Regional (i.e.; multi- or cross-country) HIV/AIDS projects for IDA countries will be fully financed by grants.

25. With the above-mentioned World Bank Group commitments to date, along with a projected pipeline of new HIV/AIDS lending and grants, expectations are that the Bank's active portfolio will grow to more than USD 2.1 billion by the end of FY03. In addition to being an active partner in UNAIDS, and in order to enhance public-private partnership potential and synergies, the Bank is having an ongoing dialogue with pharmaceutical companies about ways to improve in-country collaboration and make drug treatment programs more accessible to those in need. The Bank is also a steering committee member of the International HIV Treatment Access Coalition (ITAC). ITAC is a broad global partnership which aims to expand access to HIV treatment for all people living with HIV/AIDS.

26. Disbursements of MAP projects in Africa as of March 2003 were $77 million or 15 percent for the fourteen countries already disbursing funds. While disbursements are more than one third for the two oldest MAP projects, Ethiopia and Kenya, which became effective in early 2001, implementation in general has been slower than expected given the flexibility of the MAP approach and much slower than needed given the severity of the AIDS epidemic. A continual process of progress reviews both by the Bank and with partner institutions has highlighted areas where improvements in implementation are necessary and possible, including actions to stimulate multi-sectoral programs, channel funds more quickly to communities, and bring more proactive support to the establishment of program monitoring and evaluation. The Bank is supporting these efforts through an ambitious program of direct technical support, knowledge dissemination, specialized workshops and support for inter-country learning networks. In addition, the Bank is taking actions to improve its own performance, especially in providing enhanced implementation support and donor coordination. Country Directors have been asked to take a direct role in overseeing Bank MAP task teams and in stimulating donor coordination. An Implementation Acceleration Team has been created within the Bank to suggest ways of making Bank policies, procedures and practices more appropriate to the MAP approach. A series of Institutional Development Fund (IDF)

grants are being prepared to create additional implementation and coordination capacity at both the country and regional levels. Generic operational guidelines with lessons learned are being produced and shared with networks of program practitioners, and ACT*africa* is accelerating the work of its Technical Support Team to supplement traditional Bank supervision with additional implementation support.

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

27. The GFATM emerged in early 2002 as an important vehicle to contribute towards the desired rapid scaling up of activities focused on AIDS. An independent entity, the Global Fund has so far committed almost $1.5 billion to the fight against these communicable diseases, of which over half would be targeted at HIV/AIDS. Disbursements from the Global Fund have lagged behind early forecasts, mainly because of operational delays related to the establishment of a working Secretariat to manage the grants, and the difficulties of developing and implementing an innovative and effective country-level fiduciary framework.

28. While significant additional resources are required in the fight against HIV/AIDS and other epidemics, it is important that these resources are employed as effectively as possible. In that context it is important that proposals submitted to the Global Fund are well coordinated with national health or AIDS strategy frameworks, which has hitherto not been the case. Especially in countries where strong government and donor partnerships already exist, e.g. in the form of health sector-wide programs, it is critical that grants from the Global Fund be seamlessly integrated in these ongoing efforts, if duplication of effort and unnecessary administrative burdens on recipients are to be avoided. UNAIDS partners, including the World Bank, have committed themselves to assisting with the process of ensuring better coordination between existing programs and grants from the Global Fund. Lastly, one should note that as the Global Fund's grants begin to be implemented they are likely to experience the problems that have been historically associated with other health sector and service delivery interventions: namely, insufficient absorptive capacity and inability by recipient governments to guarantee accountability down the line.

III. MAIN GAPS/OBSTACLES TO MAKING HIV/AIDS PROGRAMS WORK

29. **Need to change course.** It is widely acknowledged that existing obstacles to implementation need to be lifted. Fortunately, strategies and approaches are identifiable and available to prevent and mitigate the devastating impact of HIV/AIDS, and change the course of its stranglehold over prospects for national development and poverty eradication.

30. Overall spending by both donors and countries has significantly increased over the last three years, but much more needs to be done. The mismatch between need and funding is one of the biggest obstacles to controlling the epidemic. The other is implementation. For example, as evidenced most starkly by the slow pace of disbursements within Bank MAP projects and by the GFATM, donors and countries alike now must overcome obstacles to the implementation of these commitments.

Resource Gap

31. UNAIDS recently completed a major effort to assess gaps in the availability of resources for HIV/AIDS. The report[19] reflects estimates of the cost of HIV/AIDS prevention, care and support for 135 low- and middle-income countries from 2001 to 2007. The total funding required for all key interventions increases from USD 3.2 billion in 2001 to USD 10.5 billion in 2005, and USD 15 billion in 2007.

32. Global HIV/AIDS related spending reached approximately USD 2.8 billion in 2002. While this is encouraging, UNAIDS notes the estimate does not reflect the costs above the service delivery level (e.g. of setting up and operating a national HIV/AIDS organization, or the costs of mobilizing and managing the flow of resources incurred by donor agencies). Overall, UNAIDS estimates a gap between available and needed resources on the order of USD 1 billion, and expects this gap to grow to USD 3.5 billion by the end of calendar year 2003, and to USD 5 billion for 2004. If current budgetary trends continue, donor support in 2003 will still be much less than the bare minimum required for basic prevention and care programs. (In this vein, the Bush Administration proposal to add USD 10 billion to global funding would represent a tremendous step forward if ultimately approved by Congress).

33. **Consensus on multi-sectoral approach.** Lessons have been learned on strategic approaches for ensuring national leadership and coordination such that an appropriate mix of these activities can be developed and scaled up as fast as possible. The international community recognizes that past efforts to wage war against the virus have failed because of insufficient commitment and leadership to fight the epidemic (both in developed and developing countries); and too few human and financial resources were devoted to the cause. Programs that were effective, often undertaken at the local level, were seldom scaled up or replicated, and rarely expanded to national levels. Other programs were often too narrowly focused on the health sector. Finally, resources have not been reaching the community level.

34. **What works and what can be scaled up.** There is broad agreement, especially at the highest levels of the eight agencies and organizations participating in UNAIDS and among developing countries, that a multi-sector approach is required to ensure sustained success against HIV/AIDS. Other important lessons are that ownership and empowerment are key, through mechanisms such as:

- Defining national HIV/AIDS programs through a participatory and more comprehensive process, empowering and mobilizing stakeholders from the village to the national level with money and decision-making authority within a multi-sectoral framework;
- Establishing National AIDS Councils (or equivalents) as legal entities with broad stakeholder representation from the public and private sector

[19] UNAIDS. *Financial Resources for HIV/AIDS Programmes in Low and Middle Income Countries over the next Five Years, Paper for the thirteenth meeting of the Programme Coordinating Board*, Lisbon, 11-12 December 2002. (UNAIDS/PCB/(13)/02.5) 28 November 2002.

and civil society, and with access to the highest levels of decision-making, including in government;

- Using exceptional implementation arrangements such as channeling money directly to communities and civil society organizations, and contracting services for many administrative functions such as financial management and procurement, monitoring and evaluation, elements of program approval, as well as capacity development and techniques of Behavior Change Communication (BCC).

35. The emphasis on a multi-sectoral approach is a positive transition that is now being embraced by nearly all development partners. Given how little is still understood about the dynamics of the epidemic in individual countries, and how quickly it evolves, the way forward must rely on speed, scaling up of existing programs, building capacity, "learning by doing" and continuous project rework, rather than on exhaustive up-front technical analysis of individual interventions. The new approach relies on continuous monitoring and evaluation (M&E) of programs to determine which activities are efficient and effective and should be expanded further and which are not and should be stopped or benefit from more capacity building. Funding "good" programs quickly is more important than delaying action to try to identify an optimum cluster of "best practices", which is likely to prove futile in the majority of cases and runs the risk of excluding important activities which are not yet fully understood. The Multi-Country HIV/AIDS Program (MAP) supported by the Bank and operating through strong donor and country level partnerships is among several initiatives that is making considerable progress through application of these lessons (see Box 1).

Box 1: MAP Achievements

While much remains to be done, the MAP has produced major improvements in the Bank's contribution to the war against HIV/AIDS in Africa:

- Countries are embracing the multi-sectoral approach of the MAP and its focus on all aspects of society as evidenced by the creation of National AIDS Councils with broad membership and national HIV/AIDS strategies created in a participatory manner.
- Annual IDA commitments for HIV/AIDS in Africa since FY01 have increased by a factor of more than 10.
- Countries are using more than half of MAP funding for civil society organizations and for channeling funds directly to communities.
- Within the public sector and in civil society and the private sector, the MAP is beginning to reach the much broader spectrum of prevention, care and treatment and mitigation programs that is required to reach the Millennium Development Goal for HIV/AIDS.

Accelerating Implementation of HIV/AIDS Programs: Challenges Ahead

36. **It takes more than money.** Resources alone will not solve the HIV/AIDS problem. It is also vital to strengthen country capacity to carry out programs. Few developing countries today have in place the systems, incentives, and mechanisms to support an adequate response. This is an unfortunate legacy of most prior donor support for HIV/AIDS, which was designed mainly to produce pre-determined outputs and paid little attention to building or sustaining national capacity. This is one reason that the substantial investments to date have produced few lasting results against the epidemic. As the Development Committee noted in its September 2002 meetings, it is clear that ensuring that available resources are put to use now requires a concentrated effort to strengthen this capacity and accelerate the pace of implementation.

37. The situation is well illustrated by a review of the World Bank's own commitments to HIV/AIDS. The Bank is currently projecting total lending (including IDA 13 grants) commitments of close to USD 2.1 billion in the next two years. At the same time, the actual disbursement of Bank loans are slow. For instance, the disbursement pace in MAP projects, while comparing favorably with non-AIDS projects approved in the same countries in the same year, are far from what is required to match the need. Constraints on implementation and disbursement are considerable, as reflected in projections of total disbursements in the MAP program by end-FY03 of about USD 95 million.

38. Similarly, the GFATM is finding that establishing the fiduciary framework for managing the flow of resources at the country level is time consuming, placing large demands on already weak administrative capacities at the country level, and calling for close attention to coordinating with existing systems to avoid overtaxing these capacities. Identifying the obstacles to implementation, and using these findings to improve the mechanics of providing development assistance for HIV/AIDS, is a challenge equal to that of further resource mobilization. Indeed, further resource mobilization will largely depend on how well countries use existing resources. The implementation challenges cover a wide spectrum of issues, as discussed below.

39. **Establishing unified leadership structures.** Effective response to the epidemic requires a comprehensive program encompassing prevention, treatment, provision of care and support as well as efforts to mitigate impact. This in turn requires establishment of high level coordinating capacity to coordinate strategic planning, resource mobilization and allocation to a wide range of 'implementing partners' in the public and private sector, as well as among NGOs and Community-Based Organizations (CBOs). Most countries in Africa have moved to establish National HIV/AIDS Commissions or Councils. These bodies are typically new, and still working out operational procedures. Moreover, creation of a high level coordinating body can create conflicts with long established programs in Ministries of Health, whose efforts are critical, but which lack the stature and authority to stimulate action across sectors and are often weak at transferring resources to support local and community action. Doing away with bureaucratic and political infighting over funding will help avoid delay in identifying and addressing critical implementation issues. Establishing clear roles and accountabilities is particularly

difficult in settings where civil service is poorly rewarded, where there is inevitable competition for access to limited foreign exchange/donor financing, and where action is required across a range of sectoral ministries and nongovernmental organizations.

40. Moreover, the very fact that all major donors are working hard to ramp up their response can lead to multiple and sometimes conflicting efforts to help countries establish a workable and effective leadership/coordination function. The GFATM, for instance, requires countries to form Country Coordination Mechanisms (CCM) to validate the submission of proposals to the Fund. These CCMs have in some cases worked at cross-purposes with the existing National AIDS Councils or Commissions. Respecting national structures and recognizing the opportunities to share operating procedures calls for renewed commitment for donor cooperation in the 'nuts and bolts' of program design at the country level.

41. **Social and political obstacles to reaching key target groups.** Effective prevention and treatment of HIV/AIDS requires *educating and promoting behavior change* among population groups that are normally far beyond the reach of government and mainstream NGO programs (e.g. commercial sex workers, injecting drug users, prisoners, demobilized military personnel, men who have sex with men, etc.) Such groups are not readily targeted through normal mechanisms (e.g. geographic targeting, focused subsidies, etc.) and instead require provision of support through key intermediary groups such as NGOs and CBOs rooted in the populations themselves–which are typically under-resourced in terms of both human resources and financing. At the same time, many governments lack experience, administrative mechanisms, or political will to transfer resources to these organizations.

42. **Behavior change and mobilizing community action.** As is well recognized, perhaps the most difficult challenge to be faced in both preventing and treating HIV/AIDS is that success requires changing deeply personal behaviors. Fear, stigma, and social norms inhibiting discussions of sexual mores and behaviors all contribute to the challenge. Effectively halting the HIV/AIDS epidemic requires altering individual, group and social behaviors. Changes in attitudes, values and practices emerge from social processes, which themselves vary enormously across settings and cultures. Finding ways to enable families and communities to cope with the devastating local impact of the disease requires time, patience and intensive efforts to engage individuals and communities in the response. **Mobilizing the entire community to assist individuals and households in their response against the epidemic is key.**

43. Governments alone cannot achieve the basic well being of the entire population. This calls for the active support of civil society including NGOs, CBOs, and the private sector. It is now well recognized that the fight against HIV/AIDS requires a national response involving all sectors and all stakeholders, and should be well coordinated and decentralized to move quickly toward comprehensive national coverage.

44. Community-based programs have been especially effective in enhancing prevention, care, support and treatment for those infected and affected by HIV/AIDS. Successful HIV/AIDS programs in Sub-Saharan Africa have involved local communities

in the identification, design, preparation and implementation of activities. In prevention, communities can set norms, influence behavior, and tailor interventions in ways appropriate to local culture. In care and support, communities bear the lion's share of the responsibility, especially for home-based care for those living with HIV/AIDS and support for orphans. But most communities lack resources to mount programs of adequate scope, and central governments typically lack the means to deliver resources quickly and sustainably to the community level.

45. **Access to treatment**. Antiretroviral treatment (ART) for those infected with HIV can prolong life. It can also reduce transmission of HIV from mothers to infants when ARV drugs are used during pregnancy and delivery. ARVs can cut by half the rate of mother to child transmission (MTCT) of HIV during pregnancy, labor and delivery. However; access to ARVs is extremely limited, especially in resource-constrained environments.

46. Affordability and access to antiretrovirals remain key issues. An estimated 5-6 million adults in developing countries are currently in need of ART, yet only about 300,000 of them are currently using ARV drugs, or roughly five percent of those who might benefit. Brazil accounts for over one-third of those taking ART in resource-limited settings and has devoted considerable resources from its national budget allocation and strategic planning towards warding off the epidemic. The challenges of making ART available to those in resource-limited settings are gradually being overcome. Technical hurdles are being surpassed, as WHO has now issued guidelines on simplified regimes for taking the drugs. Price reductions have occurred over the last two years (prices have fallen on average by 85 percent). Thus, despite some headway, making drug treatment available to those who are infected remains a daunting challenge.

47. **Financial management/contracting services.** HIV/AIDS prevalence tends to be highest in countries with weak institutional capacity, particularly in Africa, and where public expenditure management and fiscal transfer are weakest. Few of these countries have efficient civil administrative capacity, and many are especially weak at transferring resources, particularly for non-salary recurrent expenditures, among and between various levels of government, let alone to NGOs or CBOs. The Bank's MAP program is explicitly addressing this, but finds that few governments (here referring to Sub-Saharan Africa) have experience in using contractual procedures to transfer resources, which, in combination with major questions of government/NGO/CBO trust, can seriously impede action at local levels. Addressing the problem requires changing attitudes at governmental levels, as well as development of new 'mechanics' of transfer e.g. formats and procedures for requesting proposals, proposal review mechanisms and financial monitoring procedures. While progress is evident–e.g. Kenya's National AIDS Control Council has hired a financial management agency which in turn has helped channel resources to more than 750 local CBOs and NGOs in only a few months–the time required to establish faster ways of doing business in each country ought not be underestimated.

48. In addition, many countries have developed or inherited formal controls and financial management procedures which conflict with the desire for rapid and widespread

disbursement of funds. Problems are attitudinal as well as procedural – lower and middle level management in countries with high rates of corruption may be excessively risk averse and reluctant to seek ways to overcome longstanding procedures to encourage local action. In some countries, government rules dictate disbursement on a periodic (rather than performance-based) basis and only commit resources to sub-projects for one year, constraining the ability of smaller NGOs or CBOs to design and implement programs that are may require longer implementation periods.

49. **Procurement of goods and services**. Efficient and economic procurement of the commodities necessary for HIV/AIDS prevention and treatment (condoms, testing kits, drugs for opportunistic infections and ARV treatment etc.) is a challenge in most developing countries. Governments have until very recently been reluctant to 'contract out' such services. Expertise in design and implementation of more effective approaches to procurement are limited, and most donor staff lack the detailed knowledge of either country procurement rules and regulations or the characteristics of the goods/services (e.g. ARVs) necessary to provide effective advice.

50. **Disbursements.** Country HIV/AIDS programs are increasingly designed to be implemented through a number of actors, with multiple transactions at national, regional and local levels, as between NAC (Commissions), multiple line agencies, private sector players and NGOs/CBOs. NGOs often work in areas with limited access to banks for receiving funds. Design of reporting formats for claiming reimbursement can be made difficult by highly constrained resources for communication/contact to facilitate transfers (e.g., many sub-national levels of government, NGOs and CBOs have no telephones or ready access to electronic mail).

51. **Accountability and learning.** Skills and mechanisms for routine monitoring of the provision of services and evaluation of effectiveness are weak in most countries, and among most donors. Donors tend to concentrate on implementation of narrow systems which enable them to monitor results/performance on a project by project rather than national or programmatic level. Planning and budgeting systems are not oriented toward performance management, thereby weakening incentives for using results measures in decision making. Conflict between donor desire for comprehensive monitoring and service delivery data and 'top down' planning and budgeting systems can result in burdensome monitoring/data collection efforts among field staff (NGO as well as governmental) with little payoff in terms of local decisions.

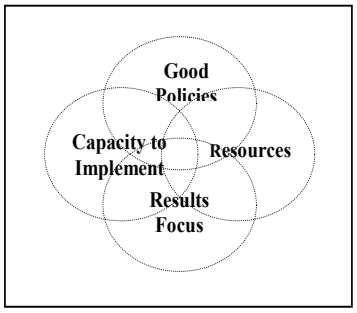
52. **Limited health system capacity.** Public health delivery systems are especially weak in Africa and South Asia, in terms of both physical and human resources. Economic pressures have led to large scale transfer of public providers (doctors, midwives) to the private sector (limiting access among the poorest and most vulnerable) or overseas, incapacitating ability to provide or support provision of treatment at local levels. Even NGOs face human resource constraints in their efforts to demonstrate and extend the reach of key activities. Stronger health systems are necessary for the provision of all major elements of an effective national response. WHO and UNAIDS promote a unified health sector strategy to control HIV-related tuberculosis as an integral part of the strategy for HIV/AIDS. Because HIV is the most potent force driving the

tuberculosis epidemic, fighting HIV should also include tackling tuberculosis as a leading killer of people living with HIV/AIDS.

IV. PAVING THE WAY FORWARD TOGETHER: ISSUES AND PRIORITIES FOR ACCELERATING IMPLEMENTATION OF HIV/AIDS ACTIVITIES

53. **What it takes to put strategy into place.** As reported in case studies presented to the Development Committee in September 2002, there is increasing consensus on the basic requirements that are required to put a multi-sectoral strategy in place.[20] The case studies, which appear in the companion volume, underscore a broad consensus on the key factors that together create a favorable environment for growth and social progress (see Figure 1):

Figure 1: A framework for results and scaling up



- Sound **policies** and committed leadership at the country level, supported by appropriate expenditure frameworks, effective budget execution, and good governance;
- Adequate operational **capacity** to implement at all levels, including the capacity of communities to participate effectively, and the right incentives, so that countries can translate sound policies and strong leadership into effective action;
- Financial **resources** to scale up programs that work, and that reach the service delivery level; and
- A strong focus on **results**—accountability for learning and outcomes—so that policies and programs are built on empirical evidence of problems and solutions that work.

Where these factors are in place, and donors have been supportive, impacts have been significant.

54. Global, national and local leaders face two major challenges. They must continue to work to mobilize massive increases in the resources available and must find ways to go beyond 'business as usual' in assuring that available resources are being put to effective use. Several steps toward these twin objectives are recommended.

55. **Country level**. At the country level there is a need to design and quickly deploy new or revised 'standard operating procedures' that enable and make transparent the transfer of resources to local levels, and to use new contracting mechanisms to assure the flow of funds to NGOs, civil society and communities. Meeting these demands will

[20] World Bank paper presented to Development Committee. *Development Effectiveness and Scaling Up: Lessons and Challenges from Case Studies*, September 2002.

require revisions of planning and budgeting procedures to promote new instruments for the transfer of central resources, such as 'block grant' agreements and performance contracting – methods of work that are new and challenging to most current public administrators.

56. Effectively unleashing the capacity of NGOs, community groups, and civil society presents a major challenge to governments. It will often demand significant changes in financial management and accountability systems, and willingness to be more flexible in the use of public expenditures. It means developing willingness to work through facilitating agencies (NGOs, faith-based organizations) who have the comparative advantage in helping small community groups plan and learn from their efforts. Most fundamentally, it requires the evolution of greater trust between governments and these groups.

57. **Donors**. Donor agencies, and the Bank itself, must also find new ways of doing business to promote successful local response. The donor community needs to improve its knowledge about how best to implement, particularly in resource-poor settings, while recognizing that promoting behavior change and community action is a difficult, time consuming process, where progress occurs with small amounts of money and over long periods. They must find ways to balance the inevitable tension that develops between their tendency to assess results in terms of dollars spent and the time required to establish and operate activities at the local level.

58. Second, donors must honor their longstanding commitments to collaborate under the leadership of national authorities. Kenya now leads regular joint reviews of its full HIV/AIDS program, including all partners. Only through such collaborative effort can an effective response be maintained, without gaps, overlaps, or vast duplication of effort purely for the benefit of donors.

59. Finally, donors need to strengthen their efforts to close the health infrastructure gap by ensuring continued close coordination between those working on HIV/AIDS and those working to strengthen health systems. Preparation of joint analyses, at the regional level, of major gaps in health infrastructure (physical, workforce, and policy) should be an important priority for future analytic work.

60. **The World Bank.** An obvious challenge for the World Bank will be to continue its current efforts to streamline its operating procedures and work with governments to help them develop ways to channel funds and technical support to local levels with a minimum of bureaucratic red tape. The Bank now devotes substantial resources to implementation support at country level. It is also improving its own response. Efforts to examine and modify Bank processing procedures to facilitate more rapid transfer of resources received a major boost in January 2003 through the establishment of a high level Implementation Acceleration Team whose goal is to resolve internal and country level obstacles to more rapid disbursement of funds. Ensuring that there are staff and financial resources necessary to deliver on the current pipeline of HIV/AIDS projects is a priority.

61. **New frontiers for partnership.** Countries cannot expect success in the fight against HIV/AIDS without strengthening partnerships between government, NGOs and civil society. Donors, too, must continue to strengthen their partnerships. The establishment and successes of UNAIDS are a powerful testament to the strength of collaborative approaches–building on this success is a continuing priority, and recent efforts to strengthen collaboration are promising. Ensuring that the GFATM is fully integrated into existing collaborative mechanisms is a high priority to prevent a re-fragmentation of HIV/AIDS efforts.

62. **Harmonization of monitoring and evaluation.** Recognizing the high costs and confusion at the country level generated by multiple donor-driven efforts to employ 'results based' approaches to HIV/AIDS programming, UNAIDS and its cosponsors have assigned the World Bank the lead responsibility to house a multi-agency Global Monitoring and Evaluation Support Team (GAMET) within the Global HIV/AIDS Program. The GAMET facilitates cosponsor efforts to build country level M&E capacities and coordinate technical support in this field. The GAMET was established in June 2002 to fill gaps and facilitate coordination among existing sources of M&E expertise, including the M&E units in each of the cosponsoring agencies, and key elements of the UNAIDS Secretariat, including the Country Response Information System (CRIS). It is helping to build networks and relationships with the M&E units of other UN agencies, bilateral donors and GFATM. The Team has initiated work in several African settings, and is working in close cooperation with others to promote the preparation of responsive monitoring and evaluation strategies which will further strengthen efforts to track HIV/AIDS responses.

63. **Tackling HIV/AIDS in IBRD countries at risk.** Four of the seven hardest-hit countries on earth are ineligible for IDA grant support by virtue of their middle income status: Botswana, Namibia, Swaziland and South Africa. They have all developed major national programs, with many of the core elements of the strategy and interventions recommended in the global consensus reached at UNGASS (and embodied in the MAP), but the scale of these programs is small relative to the extent of the disease and its impact. Innovative financing and scaling up of activities will be necessary to turn prevalence rates around in such countries.

64. **Strengthen cooperation in analyzing and removing implementation obstacles.** In large part through the efforts of UNAIDS, donors have collectively made enormous strides toward building consensus on the broad strategic elements of effective national level response, as reflected in the massive effort to prepare guiding National Strategic Frameworks in well over 100 countries. An obvious next step to push the frontier on partnerships is to consolidate the review and establishment of arrangements for implementing national HIV/AIDS programs. For example, each of the countries participating in the MAP program are making progress toward establishing an appropriate institutional and fiduciary architecture for managing their HIV/AIDS programs. As major new sources of funds become available, particularly those from the GFATM, it will be important that donors work collectively to avoid the creation of parallel 'architectures'. Prospects for such cooperation, particularly in Africa, are very positive but deserve high level endorsement and intensification.

65. Several countries are at high risk of not meeting the MDG goals if the Bank and development partners do not act swiftly. The current level of commitment and approach both by the Bank and its partners will not be sufficient to meet the MDG goals. The recent increases in financial resources have been encouraging, but even with the planned Bank support through the MAP and other programs, and the planned contributions of the Global Fund, there is unlikely to be enough money to address the urgent needs of the epidemic. Without a great increase in overall resources, the response will be insufficient. Moreover, for existing HIV/AIDS programs it is acknowledged that implementation capacity is lacking. A key part of building this capacity is building the knowledge base of what works, sharing that knowledge with implementing partners, and creating networks of practitioners that can share experiences and help each other. In the short term, advocacy and better implementation will go a long way, but in the medium term increased funding will be needed in aggregate.

66. **Issues for the Development Committee.** Overcoming the HIV/AIDS pandemic is a daunting task. In light of the myriad demands that countries and donors are facing to scale up their response, it is important to ascertain how far the Ministers of Finance are willing to go with their own resources, and what their expectations are with respect to fighting HIV/AIDS.