

# Southern Africa HIV/AIDS and Tuberculosis Plan of Action, 2010–2011

for Botswana, Lesotho, Namibia,  
South Africa, and Swaziland



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## Abbreviations

AAA	Analytic and advisory activities
AAP	Africa Action Plan
AFA	Agenda for Action
AFTHE	Africa Health, Nutrition, and Population Unit
AFTHV	AIDS Campaign Team for Africa (ACTafrica)
BAIS	Botswana AIDS Impact Survey
CPS	Country Partnership Strategy
DEC	Development Economics Vice Presidency
DfID	Department for International Development, United Kingdom
DHS	Demographic and Health Surveys
DOH	Department of Health, South Africa
DOTS	Directly observed treatment, short course
EC	European Commission
GAMET	Global HIV/AIDS Monitoring and Evaluation Team
GFATM	Global Fund Against AIDS, Tuberculosis, and Malaria
GHAP	Global HIV/AIDS Program
HCTA	HIV/AIDS Capacity and Technical Assistance Project
HIV/AIDS	Human immunodeficiency virus/acquired immunodeficiency syndrome
HSRC	Human Science Research Council, South Africa
IBRD	International Bank for Reconstruction and Development
IDA	International Development Association
IDF	Institutional Development Fund
IFC	International Finance Corporation
IMF	International Monetary Fund
IPT	Isoniazid preventive therapy
JSDF	Japanese Social Development Fund
JURTA	Joint UN Regional Team for AIDS
M&E	Monitoring and evaluation
MAP	Multi-Country AIDS Program
MCP	Multiple concurrent partners

MDG	Millennium Development Goal
MDR	Multi-drug-resistant
MICs	Middle-income countries
MOH	Ministry of Health
MOHSS	Ministry of Health and Social Services, Namibia
MSM	Men who have sex with men
MTR	Mid-term Review
NABCOA	Namibia Business Coalition against HIV/AIDS
NAC	National AIDS Council/ commission
NASA	National AIDS Spending Assessments
NERCHA	National Emergency Response Council on HIV/AIDS, Swaziland
NGO	Nongovernmental organization
NPA	National plan of action
ODA	Official development assistance
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief (United States)
PER	Public expenditure review
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PPP	Purchasing power parity
QIMS	Quality, Relevance, and Comprehensiveness of Impact Mitigation Services Survey
RATESA	UNAIDS Regional Support Team for Eastern and Southern Africa
RBF	Results-based financing
RST	Regional support team
SACU	Southern African Customs Union
SADC	Southern African Development Community
SANAC	South African National AIDS Council
STIs	Sexually transmitted infections
TB	Tuberculosis
UNGASS	United Nations General Assembly Special Session
WDR	World Development Report
WFP	World Food Programme
XDR-TB	Extensively drug-resistant tuberculosis

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## Executive Summary

This paper for senior World Bank (Bank) management and staff describes the current status and impact of the HIV (human immunodeficiency virus) and tuberculosis (TB) epidemic in southern Africa, the strategic role the Bank has played to date, and puts forward an action plan for deeper Bank engagement with the middle-income countries (MICs) in this subregion, especially in light of the new political commitment by the government of South Africa. The approach presented is consistent with the Bank's Executive Board-approved Africa Region HIV/AIDS Agenda for Action 2007–2011 (World Bank 2008b) effort to “increase Bank engagement in the epicenter of the epidemic—Southern Africa” and the Global HIV/AIDS Program of Action (World Bank 2005), and is designed to support national efforts through evidence-based, prioritized strategies; scaling up targeted multisectoral and civil society responses that have demonstrated effectiveness; improving monitoring and evaluation (M&E) capacity; and harmonizing donor collaboration. This Southern Africa HIV/AIDS and Tuberculosis Action Plan 2010–2011, for Botswana, Lesotho, Namibia, South Africa, and Swaziland (referred to henceforth as the “SACU Action Plan”) delineates an expanded operational response to the unique constraints posed by this subregion, with a focus on assisting countries to better utilize available resources, and making the money work better. This approach is aligned with the Africa Action Plan (AAP; 2005),<sup>1</sup> emphasizing new ways of doing business, including enhanced leveraging of available financial and technical resources. This strategy responds to the World Bank President's strategic themes of “building a competitive menu of development solutions for middle-income countries, with customized services

as well as finance” and “playing a more active role in regional and global issues that cross national borders, including...infectious diseases.”<sup>2</sup> The Bank has made specific attempts in recent years to adapt its approach to MICs, particularly the southern African MICs, in view of their economic impact on the continent, especially the impact of the South African economy on the rest of Africa (World Bank 2008a).

The MICs in southern Africa (Botswana, Lesotho, Namibia, South Africa, and Swaziland), which have closely linked economies under the Southern African Customs Union (SACU), have the highest HIV prevalence in the world, as well as the highest HIV incidence rates. The epidemic in these countries is described as hyperendemic—sustained high numbers of people living with HIV (PLHIV) and high levels of new infections: an epidemic at very high equilibrium. At the end of 2007, HIV prevalence ranged from 15 to 26 percent of the population aged 15–49 years, and 19 percent for the subregion overall. By 2007, these countries, with only 1 percent of the world's population, carried a staggering 20 percent of the total number of PLHIV in the world (up from 3 percent in 1990), and 32 percent of all new infections. Women account for almost 60 percent of HIV infections. South Africa has the highest number of PLHIV (estimated at 5.7 million in 2007 by the Joint United Nations Programme on HIV/AIDS [UNAIDS]). With only 0.7 percent of the world's population, South Africa has 17 percent of the world's HIV cases and the greatest HIV/AIDS burden closely linked to a TB epidemic that has more than doubled since 2001 (an estimated 73 percent of the PLHIV in South Africa also have TB). Globally, Swaziland's 26 percent HIV prevalence among adults is the highest ever documented in a national population-based survey (UNAIDS 2008). The five SACU states are among the 15 countries with the highest TB incidence in the world, ranging from 637

<sup>1</sup> <http://go.worldbank.org/E2QNH2SY91>.

<sup>2</sup> <http://go.worldbank.org/Z9C8QDP860>.

new cases per 100,000 people annually in Lesotho, to 1,198 cases per 100,000 in Swaziland; this compares with a continental average of 363 per 100,000 (WHO 2009).

The impact of HIV/AIDS is evident in all sectors of the economy and in households in every community. In 2007, southern Africa bore almost one-third (32 percent) of the world's AIDS-related deaths (UNAIDS 2007). In the five SACU countries, life expectancy declined from an average of 60 years in 1990 to 51 years in 2007 (World Bank 2009d). AIDS-related illnesses kill predominantly adults in their most socially and economically productive years, leaving behind orphaned children and the elderly, and thereby increasing dependency ratios. The number of orphans as a result of AIDS in South Africa alone was estimated at 1.4 million in 2007 (UNAIDS 2008). The epidemic has had significant developmental impact, representing a risk to living standards, especially for poor households, and for which additional expenditures and income losses caused by illness and death result in more severe deprivation, in a subregion that already has high income inequality. HIV has an immediate macroeconomic impact through productivity losses and erosion of human capital (Haacker 2004). The cost of responding to the epidemic has put a strain on the economy and diverted resources from other development needs. The high need for HIV-related health care has strained health systems and affected the provision of other services, and AIDS has increased the shortages of skilled medical providers and other health support staff.

After 25 years of responding to the HIV epidemic through an unprecedented mobilization of resources and advances in knowledge and technology, the response is at a critical crossroads, both globally and in southern Africa. Population-based surveys and better surveillance have improved the reliability of HIV data. HIV prevalence in the five SACU countries appears to have stabilized, but at extraordinarily high levels (UNAIDS 2008), and every year, 100,000

more PLHIV are added to the pool of those who need care and support. Increased access to antiretroviral therapy for over 700,000 PLHIV in the five national programs by end-2007 has saved their lives and restored the health of most; Botswana and Namibia have reached over 80 percent of those who need treatment, and Swaziland has increased coverage to 67 percent. All countries have made progress in preventing infants from contracting HIV from their mothers; Botswana has made the prevention of mother-to-child transmission (PMTCT) a major priority and has reduced the rate to only 4 percent (UNAIDS 2008).

Despite the progress, challenges remain. HIV prevention progress lags, as is evident from the still high incidence rates of 2.8 percent on average (almost 3 out of every 100 people become infected each year). More effective approaches and interventions as well as behavior changes are needed. The sustainability of existing antiretroviral therapy programs is contingent on available funding and efficient systems to deliver the programs as well as to monitor and measure their impact. This will require skilled staff, good coordination to facilitate collaboration between communities and the private sector, and the efficient allocation and use of available resources. Countries are aware of the need to strengthen the institutions involved in providing services in a multisectoral approach to mitigate social and economic impacts, and are especially eager for assistance in identifying which programs are most effective, and how to make them more efficient.

Even with constrained resources and financing options, the Bank continues to play an important strategic role in the subregion, especially in Swaziland and Lesotho.<sup>3</sup> Bank support<sup>4</sup> to all SACU countries has been met with appreciation by country officials and key development partners and has been de-

<sup>3</sup> Lesotho is the only International Development Association (IDA) country in SACU eligible for concessional funding under the Multi-Country AIDS Program (MAP).

<sup>4</sup> Activities completed and ongoing are listed in annex 3.

scribed as catalytic. The high-quality analytical work and technical assistance were provided in record time and served as an essential background for the preparation of HIV projects in Botswana, Lesotho and Swaziland, and responded to urgent demands from Namibia and Swaziland. The Bank has used Institutional Development Fund (IDF) financing in Swaziland to help build the M&E system and in Namibia to enhance capacity for a coordinated public-private response. The current Bank portfolio (active and pipeline projects) in the SACU countries provides good opportunities for mainstreaming HIV and TB (see annex 4). While some projects have specific HIV components, all operations seek appropriate ways to integrate HIV and TB support—which will also require a scale up of resources. The World Bank's Global HIV/AIDS Program (GHAP) has provided resources to help build the HIV M&E systems in Namibia, Swaziland, and Lesotho at the specific request of governments. GHAP has also conducted an analysis on the transmission modes and the epidemic in Lesotho and Swaziland.

This SACU Action Plan is intended to deepen the dialogue with the respective governments and jointly identify areas where the World Bank can use its comparative strengths to help curb the spread of HIV and TB in the subregion. The Bank's presence in the subregion is seen as critical, especially due to the current global financial uncertainty. At this crucial time, the Bank has an important role to play in integrating HIV and TB into the development agenda by filling financing gaps, and more importantly, by providing analytical and technical support based on global knowledge and experience. The proposed action plan builds on experience in the SACU countries and the HIV/AIDS operational approach developed in 2006,<sup>5</sup> and is the first attempt to address the HIV-TB

co-epidemic in a coordinated fashion, to the extent possible. The team successfully provided an array of analytical series and technical assistance under the 2006 operational plan (annex 3) on a purely demand-driven basis. The rationale for the new action plan rests on three main factors: the extraordinarily high burden of HIV and HIV-related diseases, especially TB; recognition by SACU countries that the Bank's analytical, policy, and operational experience have been catalytic in securing support; and, triggered by the financial crisis, the growing need for complementary funding in addition to funding provided by governments and others. At governments' request, future Bank support will focus primarily on analytical work and technical support, but will also explore innovative financing to fill financial gaps. The Bank will also focus its support on systems strengthening, mainstreaming, regional integration, knowledge sharing, capacity building, and partnerships. New lending for HIV support will depend on the gaps unfilled by other donors or governments, the receptivity of the International Bank for Reconstruction and Development (IBRD) countries to available Bank financing, and/or partner willingness to provide parallel financing. Mainstreaming HIV and TB support into lending operations will depend on available opportunities and collaboration with various sectors. Analytical work will focus on the efficiency, effectiveness, and fiscal sustainability of government programs; the impact of HIV and TB on development; cross-border transmission of HIV and TB; and helping countries use new evidence on the epidemic to make prevention more effective. Technical support will be provided on M&E, governance, and neglected vulnerable populations.

Depending on country context and regional opportunities, various Bank instruments will be used: project-type lending or grant assistance, mainstreaming in sectoral projects, technical analysis and knowledge management, capacity building, partnership collaboration, or other means of support. Several

<sup>5</sup> The 2006 strategy, "Sub-Regional HIV/AIDS (and OVC) Operational Strategy, FY06–FY08, Southern African Customs Union, (Botswana, Lesotho, Namibia, South Africa & Swaziland)," was prepared as an internal Bank document.

resource options will be explored to implement the action plan, including: exceptional rapid-response funding and/or accessing IBRD surpluses; innovative financing mechanisms, such as buy-downs for IBRD SACU countries; using results-based financing (RBF); creating priority categories for HIV-TB SACU funding in special facilities such as the IDF, the Japanese Social Development Fund (JSDF), or other trust funds; and establishing a multidonor trust fund for SACU HIV-TB support.

## Subregional Diagnosis

The Southern African Customs Union—comprising Botswana, Lesotho, Namibia, South Africa, and Swaziland—is an economically and culturally integrated subregion. This is both the most economically developed subregion in sub-Saharan Africa and the epicenter of the global HIV epidemic. The situation is exacerbated by the extremely high TB burdens found in all five countries, including multi-drug-resistant (MDR) and extensively drug-resistant (XDR)-TB.<sup>6</sup> The SACU countries and the international development community have recognized the extraordinary burden placed on the economies by the HIV-TB epidemic and are providing considerable domestic and development assistance to national HIV/AIDS and TB programs. However, the relative amount of official development assistance (ODA) supporting national HIV/AIDS programs in the middle-income SACU countries is much less than in the low-income countries in sub-Saharan Africa, including many countries with significantly lower HIV prevalence. The classification of the SACU MICs as IBRD countries makes them (except Lesotho) ineligible for World Bank–International Development Association (IDA) zero-interest credits.

### Status of the HIV/AIDS and TB Epidemic

The SACU subregion has the highest HIV prevalence in the world, as highlighted in table 1, ranging from 15 to 26 percent of the population aged 15–49 years at end-2007, and an average of 19 percent, compared to 5 percent for sub-Saharan Africa and a worldwide average of 0.8 percent.<sup>7</sup> With only 1 per-

<sup>6</sup> Multi-drug-resistant TB is a form of TB that is difficult and expensive to treat and fails to respond to standard, first-line drugs. Extensively drug-resistant TB occurs when resistance to second-line drugs develops on top of multi-drug-resistant TB.

<sup>7</sup> UNAIDS (2008).

<b>Table 1</b>				
<b>Country-Specific HIV Estimates (2007)</b>				
<b>Country</b>	<b>Adult<sup>a</sup> HIV prevalence rate (%)</b>	<b>Adult<sup>a</sup> HIV prevalence range (%)</b>	<b>Number of adults and children living with HIV (estimate range)</b>	<b>Proportion of women over age 15 living with HIV among PLHIV (%)</b>
<b>Botswana</b>	24	22–25	300,000 (280,000–310,000)	61
<b>Lesotho</b>	23	22–25	270,000 (260,000–290,000)	58
<b>Namibia</b>	15	12–18	200,000 (160,000–230,000)	61
<b>South Africa</b>	18	15–21	5,700,000 (4,900,000–6,600,000)	59
<b>Swaziland</b>	26	25–27	190,000 (180,000–200,000)	59

Source: UNAIDS (2008).

a. Adult = ages 15–49 years.

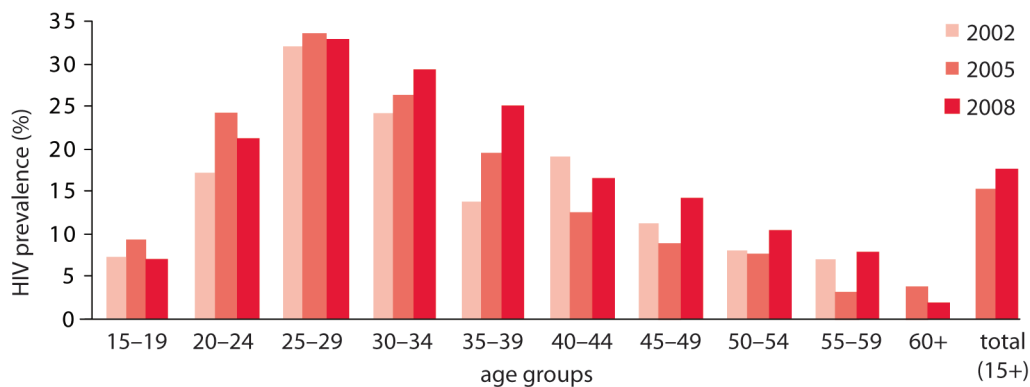
cent of the world's population, the five SACU countries have seen a staggering increase in total numbers of PLHIV from, 3 percent (1990) to 20 percent (2007) of the world's HIV-positive population (UNAIDS 2008; World Bank 2009b).

There are nearly 7 million HIV-positive people in the five SACU countries, similar to the combined total population of the four small SACU countries.<sup>8</sup> For example, in Lesotho, with a population of 2 million, there are nearly 60 new infections daily and prevalence is more than 23 percent, with both men and women having sexual debut at an early age (UNAIDS 2009). A disproportionate share of HIV-positive people in the subregion are women (59 percent compared to their 52 percent population share; figure 1). In South Africa, for instance, HIV incidence among women aged 20–29 years in 2005 was more than six times higher than for men of the same ages (Rehle et al. 2007). The latest results from Botswana's AIDS impact survey (Botswana CSO, NHL, and NACA 2009) show a national HIV prevalence of 17.4 per-

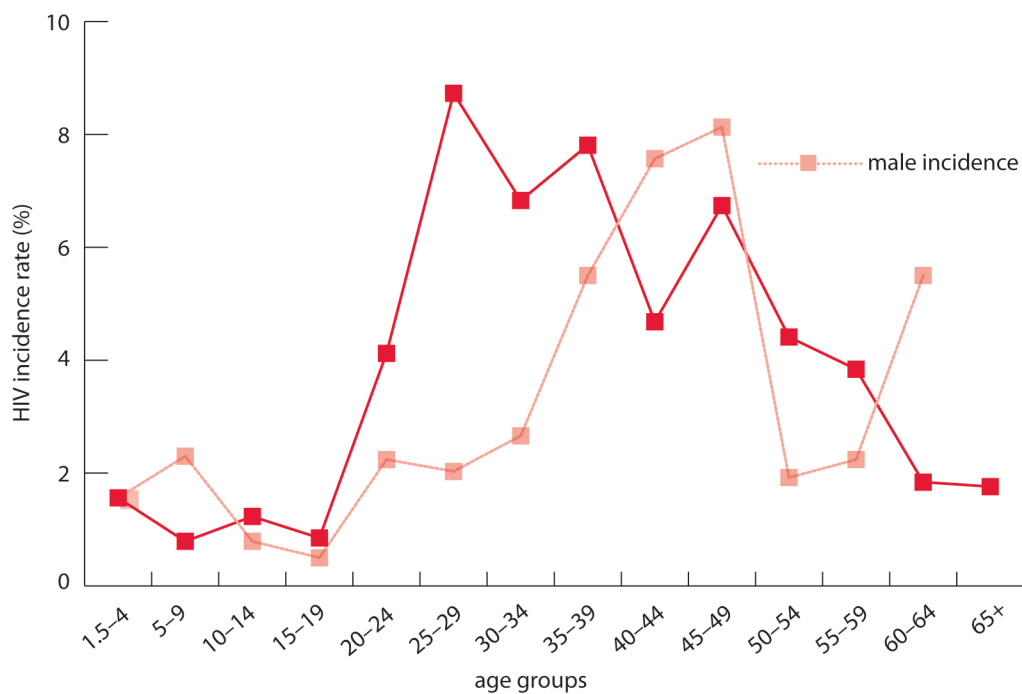
<sup>8</sup> The combined population of Botswana, Lesotho, Namibia, and Swaziland is about 7 million.

cent, with women at 20.4 percent prevalence, compared to 14.2 percent in men. Average national incidence is 2.9 percent, but 8.7 percent among women aged 25–30 years (figure 2); nearly 9 percent of the women from this population group become infected each year. Gender differences are most pronounced for those in the 15–24 years population group, and in Swaziland, the estimated prevalence among young women (aged 15–24 years) is 22.6 percent, compared to 5.8 percent for men in the same age group (Ofosu-Amaah, Egamberdi, and Dhar 2009). More details on the country-specific situation can be found in the country briefs (annex 1).

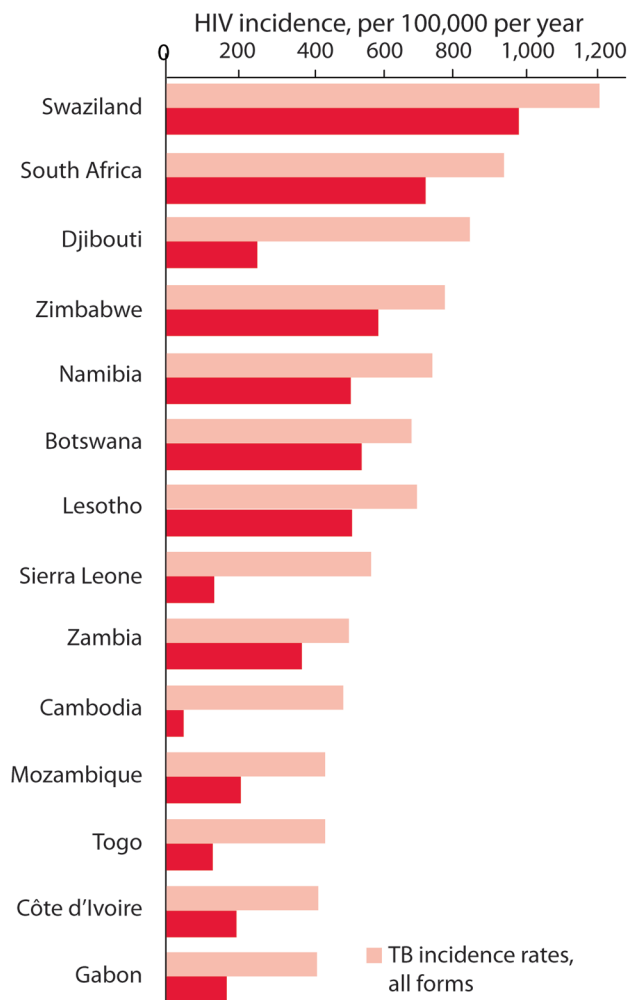
Worldwide, TB is the leading cause of death among HIV-positive people, and HIV is the strongest predictor of progression from latent TB infection to active disease. Eighty percent of HIV-related TB is in sub-Saharan Africa, with South Africa carrying 24 percent of the burden. All five SACU countries are in the top seven countries in the world for highest TB incidence, highest rates of TB-HIV co-infection (figure 3), and all have confirmed cases of XDR-TB. The unchecked spread of drug-resistant TB is a re-

**Figure 1** HIV Prevalence among Young Women

Sources: Shisana et al. (2009).

**Figure 2** Estimated HIV Incidence in Botswana, 2008Source: Botswana CSO, and NHL, and NACA (2008), [www.cso.gov.bw](http://www.cso.gov.bw).

**Figure 3** TB Incidence and Corresponding Incidence Rates of HIV-Positive TB Cases



Source: WHO (2009), and [www.who.int/tb/country/global\\_tb\\_database/en/index.html](http://www.who.int/tb/country/global_tb_database/en/index.html).

gional public health issue that threatens HIV investments, the lives of co-infected people, and the most vulnerable group of all—those with HIV who do not yet have TB, especially infants (Hesseling et al. 2009).

The HIV/AIDS and TB co-infection is a deadly mix and the need to address both requires global attention. Although the SACU countries have been significantly affected by the HIV-TB co-epidemic, the response to integrate HIV and TB programs has been delayed. This co-epidemic has placed extraordinary demand on the health care systems in all five countries (table 2), which are struggling to cope in the face of insufficient human resources and already overstretched public health services, particularly in rural areas. Thus, there is a clear need to utilize HIV/AIDS entry points to encourage HIV-TB collaboration, and vice versa. This approach is, in theory, supported by all leading multilateral agencies, donors and implementers at all levels, and yet the scale up of integrated responses has not happened to the extent needed.<sup>9</sup>

### Drivers of the Epidemic

High HIV prevalence in the SACU countries has been the subject of numerous studies. The causes appear to be a combination of behavioral and sociocultural factors (Shisana et al. 2009; Namibia MoHSS 2008a; and UNAIDS 2008). The Expert Think-Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa (SADC 2006) identified the drivers of the epidemic in the SADC region as high population mobility; inequalities of wealth; cultural factors and gender inequality; male attitudes and behaviors; intergenerational sex; gender and sexual violence; stigma; lack of

<sup>9</sup> For example, data from WHO (2008) notes that presently only 2 percent of the PLHIV are screened for TB.

<b>Table 2</b>								
<b>TB in SACU Countries, 2009</b>								
	<b>Incidence</b>		<b>Mortality</b>			<b>Co-infection</b>	<b>Detection</b>	<b>Treatment</b>
<b>Country</b>	New cases per year (all forms)	TB deaths per year (all cases, including PLHIV)	TB deaths per year (all forms) per 100,000 of population	TB deaths per year (all forms) per 100,000 of population	TB deaths per year among PLHIV	Of TB patients tested for HIV, percent that are HIV positive <sup>a</sup>	DOTS, new smear-positive case detection rate (%)	DOTS new smear-positive treatment success (MDG indicator 24 <sup>d</sup> ) (%)
<b>Botswana<sup>b</sup></b>	13,761	731	3,649	194	2,945	67	57	72
<b>Lesotho<sup>b</sup></b>	12,782	637	5,282	263	4,542	76	16	66
<b>Namibia<sup>b</sup></b>	15,905	767	2,124	102	1,518	59	84	76
<b>South Africa<sup>b,c</sup></b>	460,600	948	111,924	230	93,703	64	78	74
<b>Swaziland<sup>d</sup></b>	13,674	1,198	3,619	317	3,160	74	55	43
<b>Total Africa</b>	2,879,434	363	734,891	93	377,535	51	47	76

Source: Data compiled for SACU countries from the WHO global TB report (2008).

Note: DOTS= directly observed treatment, short course.

a. Only 37 percent of all TB patients were tested for HIV.

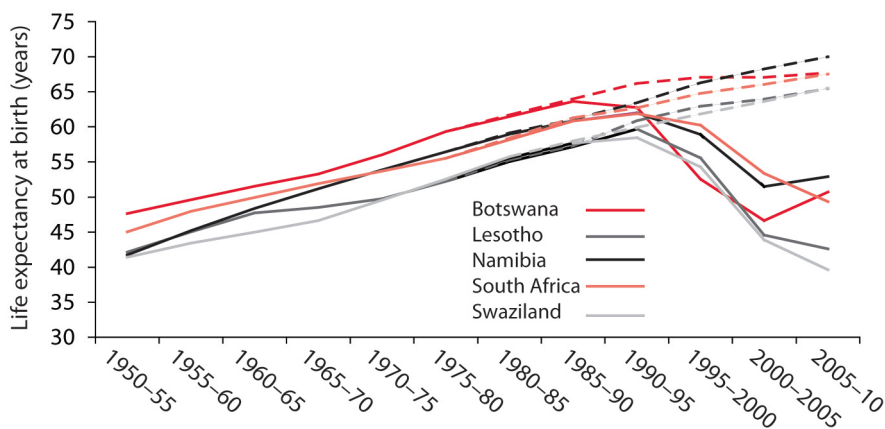
b. Confirmed XDR-TB.

c. High TB burden country.

d. Proportion of tuberculosis cases detected and cured under DOTS (internationally recommended TB control strategy).

openness; untreated STIs; and multiple concurrent partnerships (MCPs) by men and women with low consistent condom use and in the context of low levels of male circumcision. Widespread mobility, the migration of workers between workplaces and rural homes, and protracted periods working in mines, plantations, and border-trading zones put men with money next to women with limited access to the formal economy. Sexual coercion, gender-based violence, gender inequality, and particularly women's lack of economic empowerment and inequality in sexual relationships result in unprotected sex and multiple concurrent sexual partners, which fuels

HIV, which is in turn exacerbated by gender-related sociocultural, legal, and physiological factors. While data among men having sex with men (MSM) is poorly documented, preliminary results from South Africa's largest cities show HIV prevalence ranging from 12.6 percent to 47.2 percent (Shishana et al. 2009), albeit the studies involved only self-declaring MSM and the sample sizes were small (200 respondents or less).

**Figure 4** Life Expectancy at Birth in Southern African Countries

Source: United Nations Population Division (2009).

Note: Broken lines represent counterfactual “no-AIDS” scenario.

## Impact of the Epidemic

### Demographic Impact

The HIV epidemic has led to high mortality rates and declining life expectancy. AIDS-related illnesses account for up to half of all deaths and are the major cause of death among young adults in this subregion.<sup>10</sup> As a consequence, life expectancy has dropped dramatically (figure 4). Three of the five SACU countries (Botswana, Lesotho, and Swaziland) have lost almost 20 years in life expectancy, reversing all gains in life expectancy achieved since the 1950s. In

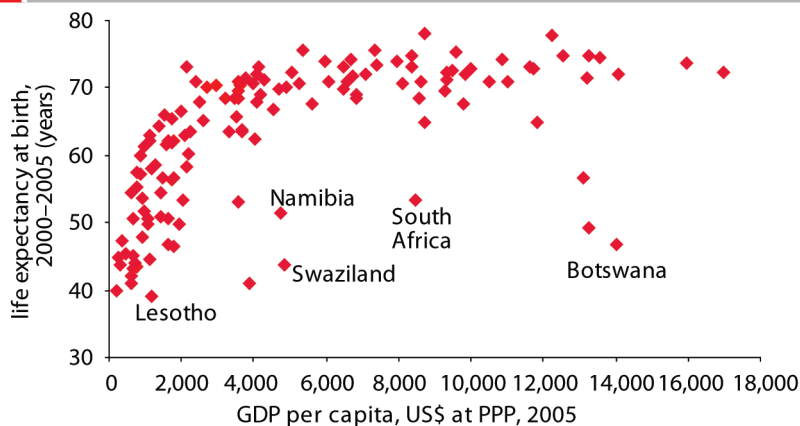
<sup>10</sup> For example, the United Nations Population Division (2007) estimates that crude mortality in Swaziland in 2000–2005 was 1.7 percent, compared to 0.7 percent for a “no-AIDS” scenario. For the population between ages 15 and 49, estimated mortality is 1.8 percent, a six-fold increase compared to a “no-AIDS” scenario.

Swaziland, life expectancy fell from 60 years in 1990 to 46 years (UNDP 2009). It is estimated that in 2005, more infants died from AIDS-related illnesses than any other cause in Botswana and Namibia, with infant mortality in Botswana estimated at 55 infant deaths per 1,000 live births in 2005 (Epstein 2004). Based on preliminary data, figure 5 shows estimates of the impact of increasing the availability of antiretroviral therapy. While antiretroviral therapy increases life expectancy of PLHIV, AIDS continues to have a large impact on life expectancy even where treatment coverage rates are now high.

Figure 5 relates life expectancy and GDP per capita in low- and middle-income countries, showing that SACU countries had life expectancy levels about 20 years lower than countries with similar income levels that were not as affected by HIV/AIDS. Life expectancy levels in middle-income SACU countries are as low as normally seen in low-income countries.<sup>11</sup>

<sup>11</sup> Few countries in figure 5 with life expectancy levels and income similar to SACU countries have recently experienced large gains in GDP associated with oil revenues (Angola, Gabon, and Equa-

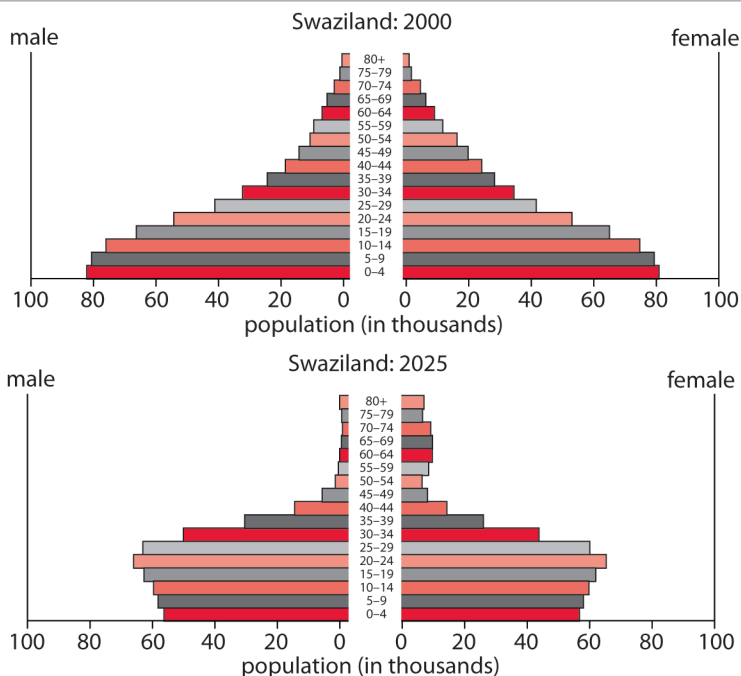
**Figure 5** GDP per Capita and Life Expectancy, 134 Low- and Middle-Income Countries



Source: IMF, World Economic Outlook Database (2008) for GDP per capita, and United Nations Population Division (2007) for life expectancy.

Note: PPP = Purchasing power parity.

**Figure 6** Swaziland Population Pyramid, 2000–2025



Source: U.S. Census Bureau Web site, <http://www.census.gov/ipc/www/idb/country.php>.

The main costs of the pandemic arise from increased mortality and lower life expectancy. The impact of AIDS in the SACU countries can be compared to other catastrophic events, such as war. The only country where the increase in the death rate and reduction in life expectancy were more devastating than the effect of AIDS on Swaziland is the case of Rwanda in the 1990–95 period, and the conflict-related drop in life expectancy there was far less persistent than the impact of AIDS.

Increased mortality due to AIDS-related illnesses is distorting the population structure of SACU countries, deforming their population pyramids. Figure 6 illustrates the situation in Swaziland. By removing adults during their most socially and economically productive years and leaving behind orphaned children and the elderly, the epidemic has greatly increased dependency ratios.

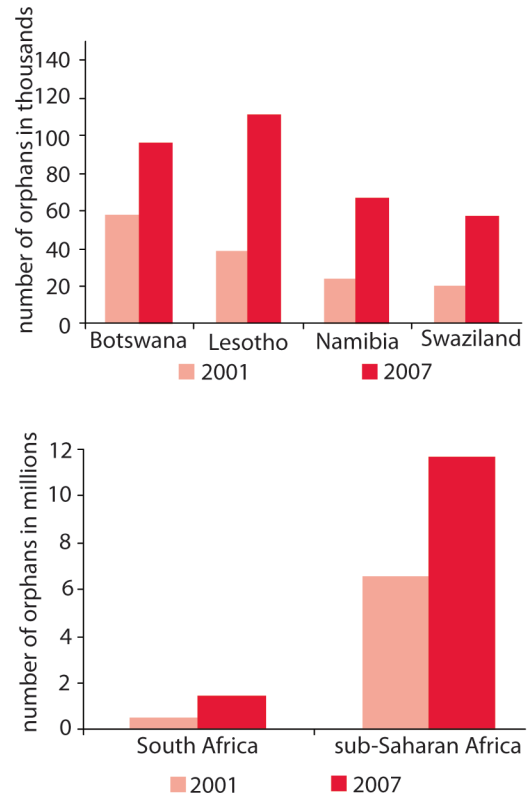
### Children Affected by AIDS: The Lost Generation

One of the most dramatic consequences of the epidemic is the number of orphans in SACU countries; more than 1.7 million children have been orphaned by AIDS (figure 7).<sup>12</sup> AIDS has orphaned a percentage of children in the SACU countries that is higher than even countries that have endured many years of civil war. Households headed by young children, who are trying to care for their siblings, are not uncommon. Many orphans end up living as “street-kids” deprived of an education and often turn to child labor or criminal activities to survive. Many children are also affected by HIV through their own infection or their parents’ HIV-related illness. These children are particularly vulnerable to poverty, discrimination, child labor and social exclusion.

torial Guinea), whereas other development indicators have not improved in line with the fast gains in GDP per capita.

<sup>12</sup> The UNAIDS definition of orphan, a child who has lost either one or both parents, is used here.

**Figure 7** Number of Orphans in Sub-Saharan Africa, 2001 and 2007



Source: Compiled from UNICEF (2008).

### Development and Economic Impact

Numerous studies have shown the significant impacts HIV has had on development gains; such as life expectancy, maternal and infant mortality and the immediate consequences, including orphans and

higher dependency ratios.<sup>13</sup> The AIDS epidemic—on the scale seen in the SACU subregion—also has macroeconomic implications for growth, poverty, human capital investments and public services (especially the delivery of health services), and microeconomic level effects, both generally (increased risks to living standards to the population overall) and for households affected by HIV, which are a significant share of the population in SACU countries.

The premature mortality of adults increases poverty and inequality and perpetuates a poverty trap for the next generations, who have little prospect of upward mobility (Bell, Devarajan, and Gersbach 2004). According to Bell, Devarajan and Gersbach, early adult mortality reduces incentives and the ability to invest in education and training, and deprives orphaned children of the parental guidance and formal education that combine to produce a wellspring of long-term economic growth. Arbache (2009) further suggests that limited learning opportunities mean that orphans will likely earn less, and in turn invest less in their own children's education, transmitting the deleterious impact of AIDS over generations and affecting national long-term economic growth and capital formation.

While there is consensus that HIV/AIDS, mainly due to reduced population growth, results in lower GDP growth rates, currently the evidence is much less clear regarding the impact on the growth of GDP per capita. While GDP growth in the region has declined since 1990, much of the slowdown took place before mortality rates related to AIDS escalated, and other factors such as developments in the mining sector and the end of apartheid appear to have played a key role as well. Changes in GDP per capita patterns are less evident, because differences in the demographic transition across SACU countries mask the impacts of AIDS.<sup>14</sup>

<sup>13</sup> The sector-specific development impacts of AIDS are detailed in numerous program documents, including the Multi-Country HIV/AIDS Program for Africa and the Africa Region HIV/AIDS Agenda for Action, 2007-2011.

<sup>14</sup> SACU countries are more advanced in the demographic transi-

tion than other subregions of sub-Saharan Africa. In other subregions, population growth is declining because of reasons other than AIDS. The decline in population growth in the SACU countries, relative to sub-Saharan Africa overall, is therefore much smaller than the impact of AIDS on population growth.

HIV has implications for public policy in the SACU subregion, such as eroding revenues and other resources, as well as the long-term costs of providing antiretrovirals to all PLHIV. A slowdown in growth also translates into a slowdown in fiscal revenues. More directly and immediately, high AIDS-related mortality erodes the human resource base of the public and private sectors. Scarce evidence suggests that this creates disruptions to public services, especially in rural areas, where replacements for public servants falling ill cannot be found as easily as in urban areas. HIV also poses substantial challenges to the cost, allocation, and efficiency of government services, particularly because of the increased demand for care and treatment and the need to address the social and economic consequences of HIV/AIDS on households, including the massive increase in the number of orphans. Swaziland (where 31 percent of children are classified as vulnerable), for example, reports that 30 percent of all HIV-related spending in 2006 was for the basic needs for orphans and vulnerable children (OVC; UNAIDS 2008). Responding to the double challenge of eroding resources and increased demand for services is particularly problematic in the health sector, where the additional demand for services is concentrated and the limited availability of skilled personnel creates bottlenecks.

<b>Table 3</b>			
<b>Access to Antiretroviral Therapy, End-2007</b>			
<b>Country</b>	<b>Number on antiretroviral therapy</b>	<b>PLHIV requiring treatment (%)</b>	<b>Percentage of total population</b>
<b>Botswana</b>	93,000	79	4.9
<b>Lesotho</b>	22,000	26	1.1
<b>Namibia</b>	52,000	88	2.5
<b>South Africa</b>	460,000	28	0.9
<b>Swaziland</b>	25,000	42	2.2
<b>Sub-Saharan Africa</b>	2,250,000	30	0.3
<b>Sub-Saharan Africa, excluding SACU</b>	1,600,000	29	0.2

Source: Authors' estimates, based on data from WHO, UNAIDS, and UNICEF (2008) and the United Nations Population Division (2007).

## Strategic Challenges

### Balancing Treatment and Prevention

SACU countries have made progress in addressing HIV impact, particularly in expanding access to treatment. Antiretroviral therapy coverage rates ranging from over 80 percent (Botswana and Namibia) to 26 percent (Lesotho) as of end-2007 are major achievements, and compare well to an average for sub-Saharan Africa of about 30 percent (table 3; WHO, UNAIDS, and UNICEF 2008). This is particularly important given that SACU countries are facing great demand for treatment and stand out in terms of the absolute number of people receiving treatment as a proportion of the population, ranging from 4.9 percent in Botswana to 0.9 percent in South Africa. Compared to the rest of Africa, only Zam-

bia has a higher percentage of people on treatment (with a coverage rate of 46 percent). While this is impressive progress, insufficient M&E of antiretroviral therapy programs have failed to provide a complete and reliable snapshot of the coverage or compliance with treatment, complications, or development of drug resistance. According to Serrao 2009, nearly 15 percent of HIV-positive patients in the Gauteng province (South Africa) have stopped using antiretrovirals, and that nationally between 15 and 20 percent of these patients are dropping treatment.

Looking ahead, SACU countries face considerable challenges in sustaining their responses to the HIV/TB co-epidemic. Compared to treatment, prevention progress has not kept pace, with high numbers of new infections throughout the subregion.<sup>15</sup> Lesotho and

<sup>15</sup> The "HIV Prevention Response and Modes of Transmission Analyses" (March 2009) for Lesotho (Lesotho National AIDS Commission, UNAIDS, and World Bank 2009) and Swaziland (NERCHA, UNAIDS, and World Bank 2009) show that incidence in Lesotho has stabilized at 1.7 percent, which still translates to 21,000 new infections in adults in 2007, while in Swazi-

Country	Year of reporting	Treatment and care (%)	Prevention (%)	OVC (%)	Management (%)
Botswana	2007	61	7	22	9
Lesotho	2006	20	13	16	21
Namibia	2007	69	17	n/r	13
Swaziland	2006	19	16	30	14

Source: Compiled from UNAIDS country data sheets (<http://www.unaids.org/en/CountryResponses/Countries/default.asp>).

Botswana report more spending on management than on prevention, while Swaziland allocates one-third of its resources to the basic needs of OVC (table 4). At the same time, the effectiveness and efficiency of HIV expenditures have not been carefully assessed. The prospects are daunting: rising numbers of orphans, increasing numbers of people needing treatment, and possibly escalating costs of treatment as more people need expensive second-line drugs. The need for major treatment, prevention, and mitigation support in SACU countries will continue for years to come, and one of the most critical analytical interventions should be a careful assessment of the effectiveness of programs and the expenditures associated with them.

Prevention programs and efforts have yielded some results. According to the UNAIDS 2010 Outlook Report (UNAIDS 2009), the virtual elimination of mother-to-child transmission is achievable by 2015, and in Botswana, Namibia, and Swaziland it is reported that more than 90 percent of all HIV-positive pregnant women receive antiretroviral prophylaxis to prevent transmission to newborn babies. In addition, UNAIDS (2009) reports that the integration of TB and HIV services in South Africa has helped to save lives and reduced the TB burden. If these positive

land the annual adult HIV incidence is estimated at 3 percent. Botswana reports 2.9 percent incidence in the latest impact survey (Botswana CSO, NHL, and NACA 2009).

trends are to be sustained, all partners need to carefully review and focus their resources on programs that have demonstrated positive impact and can turn the situation around.

## Global Financial Crisis

The global financial crisis and economic downturn have not spared the SACU countries (table 5). The IMF expects the tighter global funding conditions to have noticeable effects on the MICs, particularly South Africa (IMF 2009). The latest IMF estimates for 2009 show a 0.8 percent decline in global GDP, as many countries were in recession (South Africa 2010). South Africa's economy saw its sharpest decline in 17 years, shrinking by 1.8 percent in 2009 compared to 3.7 percent growth in 2008. Given the close economic ties between South Africa and its neighbors, the downturn had negative effects on the smaller SACU countries. Output was significantly compromised by lack of demand for commodities and other exports, which in turn, worsened an already serious unemployment situation. South Africa's unemployment rate increased to 24.3 percent during 2009Q4 compared to 21.9 percent in 2008Q4. The mining and manufacturing sectors, which constitute a significant proportion of the countries' GDP, were particularly hard hit. Many companies in these sec-

Country	2006	2007	2008	2009 estimated	2010 projected
<b>Botswana</b>	5.1	4.4	2.9	0.0	5.0
<b>Lesotho</b>	8.1	5.1	4.4	1.4	3.0
<b>Namibia</b>	7.1	5.5	2.9	-0.7	1.8
<b>South Africa</b>	5.6	5.5	3.7	-1.8	2.3
<b>Swaziland</b>	2.9	3.5	2.4	0.4	2.7

Source: IMF (2009).

tors retrenched workers and some increased their shut-down periods to contain their losses. Declines in taxes on international trade, which generate more than 50 percent of the SACU revenue pool, resulted in 46 percent decline in SACU transfers. Falling revenues undermine the fiscal space available to cushion the adverse effects of the slowdown. Thus, countries face difficult decisions regarding public spending.

## Migration

Oscillatory worker migration, as well as the geographically disparate family structures caused by such frequent migrations, has been a factor in the spread of HIV. “High morbidity rates of preventable diseases, including STDs, have been the toll exacted as a pre-capitalist, rural and agricultural society was transformed into a capitalist, industrial economy dependent largely on male, migrant labor” (Jochelson 1999). These oscillatory migrations created a different social structure and “led to the development of an urban life which has profoundly disturbed the family stability and sexual mores of several million people” (Clark 2001). The consequences were devastating, and created geographically disparate families that rely heavily on remittances from migrant workers. Nowhere else but in southern Africa are these distorted

family structures and their consequences more visible; table 6 shows the dramatically low percentage of children who grow up with both a mother and a father.

South Africa in particular, but also Namibia and Botswana, attracts people from across southern Africa and beyond. In South Africa, for example, the annual number of visitors from other Southern African Development Community (SADC) countries increased from around 1 million in the early 1990s to over 5 million in 2004 (Crush, Williams, and Peberdy 2005). The SACU countries are home (permanent or temporary) for migrant workers and refugees from neighboring countries, with unknown HIV-TB status, and who fall out of national health or social systems. The South African mining industry, despite its good HIV and TB treatment programs, inadvertently contributes to the spread of HIV, TB, and drug-resistant TB through its employment of migrant workers (especially in Swaziland and Lesotho).

## Donor Coordination and National Planning

National AIDS coordinating bodies in all five SACU countries are relatively well staffed and receive support from development partners, including the Bank. However, particularly with ministries of health, co-

<b>Table 6</b>		<b>Family Structure: Percentage of Children Growing Up without Parents</b>				
<b>Country</b>	<b>Year</b>	<b>Living with both parents</b>	<b>Living with mother only</b>	<b>Living with father only</b>	<b>Living with neither mother nor father</b>	<b>Status of parents unknown</b>
<b>Botswana</b>	2005	26.5	35.8	2.6	28.1	7.1
<b>Lesotho</b>	2004	46.8	22.3	3.5	23.5	3.8
<b>Namibia</b>	2006–7	27.0	33.8	4.7	32.7	1.7
<b>South Africa</b>	2003	33.7	35.2	2.3	21.1	7.7
<b>Swaziland</b>	2006–7	22.5	39.5	5.4	30.8	1.8

Source: Data from Demographic Health Surveys from all countries, BAIS for Botswana, and HSRC surveys for South Africa.

ordination and implementation capacity to scale up services remain major challenges. Countries are improving their understanding of the drivers of transmission, which must be targeted to prevent HIV, and have a better appreciation of the additional human and financial resources required. All national plans are costed, estimate the resources needed, and identify shortfalls that cannot be addressed by the countries themselves, particularly in the current economic environment. However, it is clear that financing gaps remain, yet they are not always articulated. Given the multisectoral aspect of the programs, there is insufficient clarity on which institution is responsible for the absorption and monitoring of financial flows. In terms of coordination, particularly with ministries of health, with which relationships are often complex, further improvements are needed.

Major health systems issues negatively impacting the effectiveness of national AIDS programs include:

- ◆ Limited and insufficiently trained human resources
- ◆ Unpredictable or conditional funding

- ◆ Poorly costed action plans
- ◆ Slow disbursement and procurement procedures
- ◆ Weak supply chain management for HIV-related commodities
- ◆ Limited implementation partnerships with civil society and private sector agencies
- ◆ Weak M&E systems
- ◆ Insufficient funder coordination to complement each others' financing

These issues pose a major challenge in reaching the Millennium Development Goal (MDG-6) of halting and beginning to reverse the spread of HIV by 2015.

### **Efficiency and Institutional Capacity**

Greater efficiency in use of resources, accountability, and other systemic aspects remain a challenge. An analysis of HIV program implementation in South Africa reported that the “increase in funding has not translated into positive results and this is due to

lack of or inadequate accountability mechanisms... that may be impinging on delivery” (Reddy 2007). These inadequacies include the ineffective tracking of donor funding, which results in the duplication of resources and efforts. The consequences of these inadequacies were confirmed in a draft paper on coordination of ODA prepared by the South African Department of Health (South Africa DOH 2009), which notes an overcrowded HIV field while the rest of the health sector is left unattended. Despite efforts to build effective M&E systems, there is little information on the impact of interventions and far too little monitoring of compliance and drug resistance.

Limited focus on building institutional capacity, particularly on leadership, and coordination of the national HIV response are additional national challenges. SACU countries have pursued different institutional arrangements in their HIV/AIDS efforts. South Africa and Namibia’s responses are coordinated and led primarily through their health department/ministry, while Botswana, Lesotho, and Swaziland have created separate national AIDS commissions. The different models have strengths and weaknesses, with some more attuned to a multisectoral, prevention-oriented approach. No matter the model chosen, capacity and human resource constraints exist and need to be overcome, generally, and in the health sector in particular.

## Financing HIV and TB Programs

While it is difficult to obtain precise estimates, funding gaps remain despite significant country and international resource commitments (table 7). Major financiers in the region include the United States President’s Emergency Plan for AIDS Relief (PEPFAR); the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM); the United Kingdom’s Department for International Development (DfID); the European Union; several European

bilateral donors; and major foundations, including the Gates Foundation, the Clinton Foundation, and the Merck and Kaiser Foundations. Despite efforts for better coordination among partners, at national and international level, and an agreed division of labor among UN agencies, the global HIV “architecture” has become increasingly complex with overcrowding in some areas. Further, international assistance is unevenly distributed in the SACU subregion and largely concentrated in the highest income countries. For example, financial arrangements and fiscal years do not always coincide with the country’s own medium- and long-term commitments, and reporting on financial flows from donors are often ad hoc and incomplete, making forecasts and long-term projections difficult. Countries, and some development partners, do not always report a detailed breakdown on funding and spending, and some lack the capacity to capture and analyze such information for use in planning.

The financial crisis is threatening the sustainability of HIV/AIDS and TB programs, especially those for treatment. ODA and private assistance funding commitments have remained in place for the moment, but the global economic downturn is likely to affect future external resource flows. Projections of declining SACU revenues as a result of reduced exports, particularly in commodities, and lower remittance flows put SACU governments under pressure regarding spending priorities. Unemployment, already high in all five countries, particularly among youth,<sup>16</sup> will remain a pressure point (at least in the short term). Higher unemployment may trigger more risky behavior. Further, the influx of “economic” refugees, mostly from neighboring Zimbabwe to South Africa, but also to Botswana and Namibia, increases the number of people in need of HIV and TB services.

<sup>16</sup> Youth unemployment in 2000–2006 was 39.6 percent in Botswana, 44.8 percent in Namibia, and 60.1 percent in South Africa (World Bank 2009a).

<b>Table 7</b>		<b>Country Reports on Domestic and International Spending and Funding Sources</b>					
<b>Country</b>	<b>Year</b>	<b>Total reported expenditures (US\$ millions)</b>	<b>Share by financing source (%)</b>				
			<b>Domestic (%)</b>	<b>International</b>			
				<b>Bilateral (%)</b>	<b>GFATM (%)</b>	<b>UN and other multilateral sources (%)</b>	<b>All other international sources (%)</b>
<b>Botswana</b>	2007	229	88.8	10.5	0.2	n/a	0.4
<b>Lesotho</b>	2006	24	18.7	28.5	14.5	30.3	7.9
<b>Namibia</b>	2007	130	50.8	n/a	n/a	n/a	49.2
<b>South Africa</b>	2007	621	77.3	4.0	13.0	3.2	2.6
<b>Swaziland</b>	2006	49	39.8	5.8	31.0	9.7	13.6

Source: UNAIDS (2008).

Note: n/a = data unavailable.

## Regional Cooperation and Coordination

Coordination among the five countries is limited and is a concern in this interdependent subregion. Some progress has been made in moving the dialogue forward; for instance, the SACU national AIDS authorities meeting,<sup>17</sup> held in 2005, was critical in confirming the Bank's commitment to the subregion. Participants expressed the need for a subregional forum for institutional, professional and technical capacity building and endorsed a possible mechanism for such a network, which would also permit SACU countries facing similar challenges to learn from each other and to commission relevant analytical work to inform policy and program decisions.

<sup>17</sup> A successful and promising first meeting of national AIDS councils' heads or representatives and donors was held in October 2005, for which the Bank secured funding and high-level Bank participation. South Africa was not represented. The first SACU operational strategy (2006) was one result of that meeting. A follow-up on the macroeconomics of AIDS to be hosted by Botswana (at their request) was planned, but has not taken place.

The SADC Secretariat is the key policy coordinating body in the region, and there has been progress since the SADC HIV/AIDS summit in 2003.<sup>18</sup> SADC extends well beyond the SACU region and has broad policy and programmatic functions. The SACU countries are a subset of SADC and subscribe to all SADC protocols, including the SADC HIV and AIDS Strategic Framework (2009–2015) and the accompanying documentation, the five-year business plan 2010–15, M&E plan, and others. Hence, a separate SACU-specific subregional strategy is not envisaged by the five countries at this point. Donor support to strengthen the SADC Secretariat has resulted in improved performance, including a stronger SADC HIV/AIDS unit, but which has not integrated TB. However, given its broad mandate and diverse membership, SADC has not yet been able to provide sustained regional facilitation and integration, attract

<sup>18</sup> The Bank supported the summit, held in Maseru, Lesotho, which was attended by all 14 member states.

financing, or implement significant regional projects. More recently, a SADC-wide HIV prevention strategy, HIV M&E framework, and HIV capacity-building strategy were developed, which all member states have agreed to implement. At the Seventh Annual Forum of SADC National AIDS Authorities held in Kinshasa, Democratic Republic of Congo, October 12–14, 2009, the Bank was specifically requested to present the impact of the global financial crisis on HIV program financing, and the Bank's engagement. One of the meeting recommendations was to urgently call a high-level meeting of financial and HIV representatives of the SADC countries to discuss financing options that would ensure the sustainability of the programs underway.

## World Bank Group Engagement to Date

The Bank's dialogue with SACU countries and jointly elaborated partnership strategies have highlighted the development challenges posed by HIV for each country, and for the subregion. For example, the current Lesotho Country Assistance Strategy<sup>19</sup> (2006) and the new one under preparation emphasize support to HIV and TB through new health and HIV projects. The Swaziland Interim Strategy (2008) is built around the "chronic disaster" of HIV, which makes Swaziland a special MIC/IBRD case. The Botswana Country Partnership Strategy (2009) stresses that "if not for the devastating HIV/AIDS situation, Botswana would be well on its way to achieve remarkable development success of meeting the MDGs." Namibia's Interim Strategy (2007) also has HIV as one of the three key Bank areas of support, greatly appreciated by government and nongovernment actors that have benefited from the targeted assistance. The South Africa Country Partnership Strategy (2007) specifically notes the impact of HIV on the biggest economy on the African continent. Dialogue with the South African government, which has significantly expanded on HIV-TB and health-related issues recently, offers good opportunities for more Bank involvement. The Bank is exploring how it can play a constructive role in responding to HIV/AIDS, TB and health sector needs, whether directly or through mainstreaming in Bank-supported products, analytical work, and subregional efforts. In addition to HIV- and TB-specific lending, all health and other relevant Bank-funded projects in the SACU countries will seek to integrate HIV and TB (see annex 4).

<sup>19</sup> This strategies mentioned in this paragraph can be found at <http://go.worldbank.org/CIUL1PYIB0>.

Despite the Bank's constraints in supporting the IBRD SACU countries, much has been achieved through innovative approaches. Stand-alone lending has been provided to Lesotho through a \$5 million<sup>20</sup> IDA grant for HIV/AIDS capacity building and technical assistance. A \$50 million IBRD HIV/AIDS–TB operation in Botswana, with buy-down parallel financing from the European Commission (EC), is the first such operation in an IBRD country. A similar approach has been adopted for Swaziland, where a project on health, HIV, and TB is under preparation. Projects in key sectors—transport, energy, water, and education—have included HIV/AIDS in the workplace, and surrounding community subcomponents have mainstreamed HIV into their operations, either as specific components or interwoven in activities.

A stand-alone rapid response facility (fiscal years 2004–2006) was extended to support Swaziland. This was the first such experimental approach within the Bank and proved to be an effective way to urgently respond to country demand and engage with development partners, who have greatly appreciated the timely assistance. This flexible approach allowed the Bank to demonstrate its commitment to the most affected region in the world and provide technical support, mostly for analytical work, not only to Swaziland, but also to other SACU countries.

Analytical support, usually in response to specific requests from governments and the nongovernment sector, has been provided to all SACU countries in a range of areas including, but not limited to:

- ◆ Macroeconomic and fiscal sustainability
- ◆ Socioeconomic impacts
- ◆ Health information management systems
- ◆ The private sector response to the HIV epidemic
- ◆ Financing modes, such as conditional cash transfers for OVC

- ◆ Assistance in developing and costing national AIDS strategies and action plans
- ◆ Communication strategies
- ◆ Review of antenatal clinic surveillance methodology
- ◆ Impact of HIV on people with disabilities
- ◆ Understanding how and through whom HIV is being transmitted (the main groups and behaviors driving the epidemic).

An analysis of the HIV impact on the banking and nonbanking sectors in Namibia (for example, insurance schemes, health insurance and pensions) supported by the Bank is the first such study in southern Africa and was conducted at the request of the Bank of Namibia. While these important pieces of analytical work contributed to the overall research agenda, were of the highest quality, and were appreciated by both governments and partners, the fact that they were completed without a concrete, focused, jointly developed framework makes the whole of Bank analytical work in the field appear a lot less than the sum of its parts.

In addition, grant funding was mobilized through the Institutional Development Fund (IDF) to provide assistance to Swaziland and Namibia. In Swaziland, the project helped develop the HIV M&E system, a critical factor in Swaziland obtaining GFATM financing. The IDF project was the beginning of a valuable partnership not only with the national AIDS coordinating agency (NERCHA), but across the human development and social sectors, with M&E as one of the Bank's main areas of support to Swaziland. A JSDF grant has also been approved for Swaziland to build capacity for delivering maternal-child health care to vulnerable populations. Namibia's IDF grant piloted an HIV/AIDS public-private partnership approach, which was a cornerstone in bringing together various stakeholders involved in providing services and advocacy. The project was hailed by government as the “pioneering”

<sup>20</sup> All dollars are U.S. dollars unless otherwise noted.

of the concept that has demonstrated the benefits of public-private partnership well beyond the HIV-specific agenda and programs.

A Development Marketplace competition<sup>21</sup> for small HIV grants in the SACU countries provided seed money to implement innovative ideas and also fostered regional exchange and support through follow-up meetings. The competition developed a network of nongovernmental organizations (NGOs) that has been maintained through Bank follow-up facilitation and events. In addition, the Bank has initiated an HIV development-dialogue series sponsored by learning institutions at the Bank's Development Information Centers, which are now open in all SACU countries. The first event in the series, jointly organized in Lesotho by the Bank and the University of Lesotho, attracted a large and diverse audience, including the First Lady of Lesotho. A list of completed and ongoing activities is found in annex 3.

Capacity building has included hands-on training to design impact evaluations and a workshop in which marginalized high-risk groups and program managers worked together to identify ways to improve programs and grant assistance to civil society organizations for service delivery improvements.

Collaboration with key partners through joint planning and implementation has included working with partners and governments to harmonize fiduciary and M&E systems, and advocacy for critical priorities, such as prevention for key populations at higher risk. HIV M&E systems building, with hands-on support to Lesotho, Namibia, South Africa, and Swaziland, has been provided by GHAP, with funding from UNAIDS.

The International Finance Corporation (IFC) has played a strong role in catalyzing private sector HIV/AIDS efforts. The strategic purpose of the IFC

Against AIDS Initiative has been to advise IFC clients and their implementation partners on effectively developing and implementing HIV/AIDS, TB, malaria and community health programs and on mobilizing resources to improve people's health and protect profitability. One objective is to accelerate private sector involvement in national efforts and mitigate the effects of communicable diseases on the sustainability of communities and companies. IFC has been involved in the mining and agricultural sectors in South Africa, helping with workplace programs for employees and disadvantaged communities directly linked to the IFC clients. Herculite Ferrochrome (Pty) Limited, the world's fourth largest producer of ferrochrome, is based in South Africa and worked with the IFC Against AIDS Initiative to develop an HIV/AIDS policy and action plan in 2005 after collaboration was initiated in 2004. IFC joint work with IDA in Lesotho on public-private partnerships in health has been positive and has triggered interest in other countries.<sup>22</sup>

Overall, with the limited resources available for IBRD countries, the World Bank Group has provided substantial assistance through innovative methods, working closely with development partners in the subregion, using every opportunity to build relationships and extend services to the SACU countries to the extent possible based on demand from governments and the nongovernment sectors.

<sup>21</sup> The competition awarded 24 grants in the five SACU countries; the funding of over \$400,000 was from IBRD, IFC, and the United States Agency for International Development.

<sup>22</sup> Lesotho New National Referral Hospital PPP project.

## Southern Africa HIV/AIDS and Tuberculosis Plan of Action, 2010–2011

While Bank engagement has been relatively limited, SACU countries have recently expressed a clear demand for the Bank’s global knowledge, experience, and policy advice on the overall development agenda, which integrates HIV and TB. The Bank has adopted a multisectoral approach to dealing with HIV and HIV-related diseases, which includes mainstreaming HIV support into Bank operations. The analytical work carried out in the SACU countries has been greatly appreciated by country counterparts and development partners and has provided solid foundations for preparing HIV projects in Lesotho, Botswana, and Swaziland. Analytical support and technical assistance are seen as the most important Bank contributions to the national and regional HIV and TB programs.

The strategic objective of this action plan is to support the southern African MICs in reaching MDG-6 (reversing HIV and TB by 2015). In line with the Bank’s Africa Region HIV/AIDS Agenda for Action (AFA), this SACU action plan will seek to strengthen the long-term, prioritized, sustainable response; build stronger national systems to manage the response effectively and efficiently; and strengthen coordination. This will be achieved through the strategic AFA pillars:

- ◆ Focusing the response through evidence-informed and prioritized HIV and TB strategies
- ◆ Scaling up effective multisectoral and civil responses

- ◆ Delivering effective results through better M&E
- ◆ Improving donor harmonization.

While there is a large menu of options, the Bank’s future support will be focused primarily on demand-driven analytical work, technical support, and knowledge-sharing, including capacity building, consistent with its role as a “knowledge bank,” and capitalizing on its experience across the region and globally. The Bank’s provision of high quality analytical work, including economic analysis, impact evaluation, and systems strengthening, is highly regarded by its partners and client countries. While the Bank’s financial contribution is minimal, it is seen as an important and valued partner, leveraging resources and providing analytical and technical support that have contributed to the development agenda, supported national programs, and brought the HIV and TB epidemics to the attention of high-level government officials. With respect to stand-alone lending, much will depend on the gaps not filled by other donors or governments, the receptivity of the IBRD countries to available Bank financing, and/or partner willingness to provide parallel or buy-down financing. Mainstreaming HIV and TB into other lending operations will depend on the sector units preparing such products and incorporating suitable activities. The Bank will seek to focus on providing strategic advice to assist countries make their programs more efficient and effective by applying a combination of products and further seeking innovative financing (figure 8). More details on the specific proposed activities are contained in annex 5.

### Analytical Support

In line with the Bank’s knowledge agenda and capabilities, analytical work requested from SACU countries will be the mainstay of the Bank’s efforts. Two to three major analytical pieces will be delivered per year, designed to contribute to policy mak-

ing, including political economy aspects.<sup>23</sup> Countries have expressed specific interest in analyses of the fiscal implications of scaling up HIV and TB efforts. Substantial resources have been allocated to provide treatment, and in Botswana and Namibia, national targets have been met. Discussions reveal significant concerns about the financial sustainability of treatment, reduced donor contributions to fund treatment costs, and the impact on health sector budgets into the future. The need to analyze the sustainability of antiretroviral therapy programs in light of the potential for greater demand is a priority for all countries in this subregion. Analysis has already started for Botswana and South Africa, and Swaziland, which will provide governments with a clearer picture of how HIV/AIDS is impinging on the governments' fiscal space and capacity to achieve broader development and program objectives and inform decision makers on the implications of policy choices. In South Africa, the fiscal space work will link with the AIDS 2031 costing component already underway.<sup>24</sup> Data from the national AIDS spending assessments (NASA) being conducted in all SACU countries and information from the epidemiology and response synthesis reports will provide the basis for looking at allocation efficiencies and effectiveness of HIV and TB programs.

A clear understanding of the HIV epidemic and response is even more critical in the context of uncertain long-term funding. A proposed study on the cross-border spread of HIV and TB via the mining and transport sectors and associated costs will review and distill evidence on the impact of the co-epidemic and stimulate a dialogue on coordinated approaches

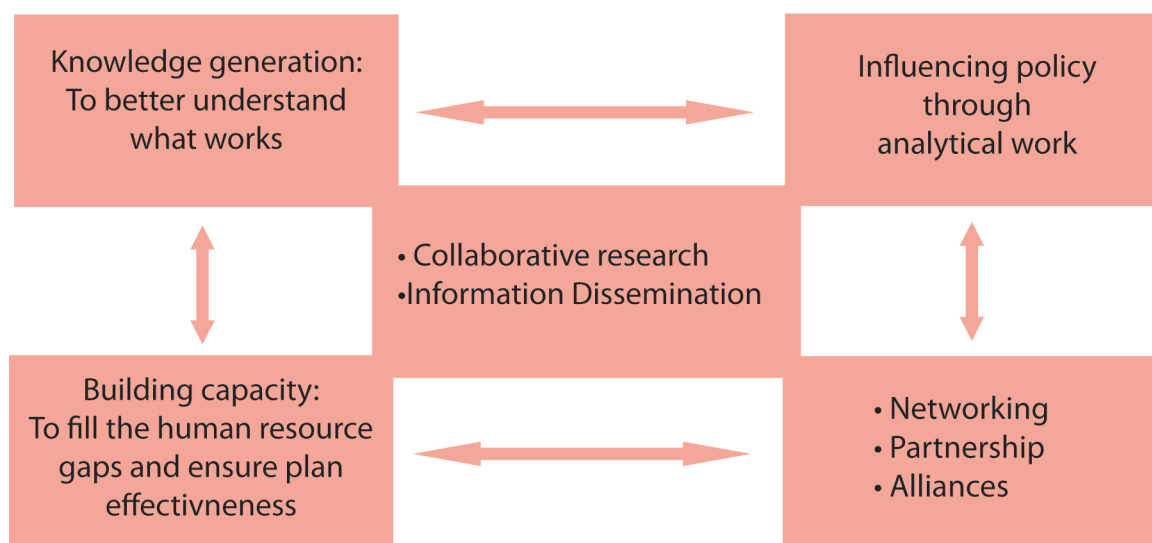
<sup>23</sup> The Independent Evaluation Group report, *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population* (World Bank 2009c), provides useful lessons for assessing the political economy, particularly in IBRD countries.

<sup>24</sup> This work on future HIV/AIDS financing and program costs covers many countries and is being conducted by expert teams coordinated by the Results for Development Institute (<http://www.resultsfordevelopment.org/projects/aids2031-costs-and-financing-working-group>).

for risk reduction. As part of this study, a technical group will consider good practices in HIV/TB interventions in worker-based populations, with special reference to the mining sector. The Bank has established a positive relationship with the South African National Institute for Occupational Health and will explore opportunities to jointly work on issues related to services, challenges, and opportunities for ex-miners (HIV positive or affected by HIV) and their families after they leave the sector and return to inadequate health systems.

The Bank, along with other partners and client countries, has conducted studies on the prevention response and transmission modes in Lesotho and Swaziland and is analyzing how prevention could be better targeted and more effective in changing or mitigating the risk behaviors that cause most new infections. A similar study is being carried out in South Africa as part of the mid-term review of the national strategic plan for HIV and STIs. The goal is to improve prevention, which is critically important in all SACU countries, particularly in South Africa, because of its large antiretroviral therapy program. The Bank will continue working with UNAIDS and strive to deliver the synthesis work in South Africa during 2010, as well as a regional synthesis report to distill key messages across the subregion.

A study on HIV and disabilities was conducted for South Africa as part of a three-country comparison, and will be disseminated in 2010. Swaziland has requested a similar study to provide increased understanding of the challenges facing people with disabilities and to assist in the national policy dialogue. In addition, the Bank is also looking into the impact of HIV/TB on the social safety nets in the SACU countries and will undertake a rapid assessment, specifically in Botswana and Swaziland, as part of the ongoing project supervision and project preparation work respectively, but also in Namibia and South Africa, should there be interest. Working with partners, the Bank can contribute to the analysis of a range

**Figure 8** Bank Strategic Approach to Providing Support

Source: Authors.

of issues to help countries consider the immediate and longer-term implications of their national HIV responses and options. Possible areas of analysis include: labor mobility and policy, social mapping, gender assessments, sustainability of drug financing, fiduciary management, medical supply chains, assessing the potential and implications of pooled procurement, and addressing vulnerable groups, including people with disabilities.

### Lending Operations and Mainstreaming

Currently, the Bank has HIV- and TB-specific projects under implementation and preparation in three SACU countries: Botswana, Swaziland and Lesotho. In Botswana, the Bank approved its first IBRD HIV/AIDS operation in Africa in 2008. The project aims to assist the government of Botswana to increase the coverage, efficiency, and sustainability of targeted and evidence-informed HIV/AIDS

interventions through strengthening institutional management and coordination capacity, financing strategic and innovative prevention and mitigation activities, and integrating HIV/TB services to contain proliferation of the dual epidemic. The Swaziland operation is following the same approach of parallel donor financing to strengthen the capacity of the health and social sector to mitigate the impact of the HIV epidemic. In addition, the Bank has developed a grant-financed (JSDF) project for providing integrated sexual and reproductive health and HIV services to young women through a mobile clinic, along with health education, life skills, and leadership training. In Lesotho, the Bank has prepared a new HIV/AIDS technical assistance project to build the capacity of government agencies and civil society organizations at the national and local level to support the implementation of the national HIV and AIDS strategic plan and expand coverage of effective interventions in an effort to contain and reverse the

epidemic. The projects in all three countries address the critical issues of health system strengthening and the integration of the HIV and TB responses. In addition, all Bank projects in the transport, energy, water, and education sectors have incorporated HIV components or activities.

Additional funding will be provided through IDF funds. A regional project has already been approved to strengthen health systems and will focus on building capacity in TB epidemiology in Botswana, Lesotho, Namibia, and Swaziland by working with the South African Medical Research Council, which has the only supranational TB reference laboratory in Africa. IDF proposals on further M&E strengthening will be considered depending on demand from the countries.

## Technical Assistance

The primary focus of technical assistance is on improving HIV prevention. Following the multicountry workshop on vulnerable and most-at-risk populations, which all SACU countries (except Namibia) participated in, the Bank will support countries in developing national action plans for evidence-based responses targeting neglected populations, and will continue to support HIV stigma reduction activities. Building on the impact assessment training that provided countries with a set of tools and practical exercises on how to better assess the results of various interventions, evaluation of results will continue to be emphasized in Bank support.

A critically important factor for improving prevention is the reduction of multiple concurrent partners (MCP). Work is underway to develop more accurate ways of measuring MCP behaviors, and technical support for the evaluations of MCP programs will be carried out in three SACU countries. All countries have indicated the need for improved M&E and impact assessments, which will be addressed through

the work already underway in several countries by the World Bank Global HIV/AIDS Monitoring and Evaluation Team (GAMET), Development Economics Vice Presidency (DEC), and the Impact Evaluation Initiative. Working closely with partners, regional training on building decentralized M&E systems will be carried out in the next two years. An institutional assessment of the HIV structures will be completed in Lesotho at the request of the government, which will complement the recently finalized mid-term review of the national strategic plan and provide a clearer picture of coordination and management mechanisms currently in place, and how they could be streamlined and improved.

## Regional Activities

Regional activities will promote cross-country learning and capacity building within the SACU countries, and beyond, with a major focus on the transfer of experience and knowledge among the smaller SACU countries, which face many similar challenges and have opportunities for productive cross-fertilization. The Bank is also supporting the newly formed Champions for an HIV-Free Generation Initiative, a proposal of the former president of Botswana, which is an emerging instrument for mobilizing regional leadership to address common issues and for providing support to strengthen political commitment across the region. The initiative is supported by the Gates Foundation, UNAIDS, PEPFAR, the United Nations Children's Fund (UNICEF), GFATM, and the Bank. The Champions visited Namibia in June 2009, and South Africa in early 2010. This interaction at the highest political level could help the new players in South Africa who are responsible for the response to HIV and TB to gain momentum and support.

The Bank is also seeking to expand its collaboration with the SADC Secretariat with respect to financial sustainability in light of the global economic crisis.

SACU countries will continue to benefit from all regional knowledge-sharing activities, including the development-dialogue series and training activities provided for IDA countries in the SADC, the Africa region, and globally.

## Working with Partners in the Subregion

While other development partners provide greater funding, the Bank is recognized as being well positioned to assist in making the money work. The Bank has made considerable efforts throughout the years to engage with partners, and has strengthened its dialogue with governments and major players and funders in this subregion. Stronger linkages with key partners,<sup>25</sup> within and between SACU countries, should focus on pooling technical and financial resources and working within each agency's comparative advantage(s). Working closely with other development partners is essential, especially in countries where the Bank has yet to have a physical presence. The World Bank Group, including the IFC, has positive relationships with major partners working on HIV, namely the UN family, the European Commission, the United Kingdom (DFID), the United States (PEPFAR, USAID, and the Centers for Disease Control and Prevention), and the Gates and Clinton Foundations, and will continue to develop concrete partnerships to avoid duplication, coordinate efforts, and leverage resources. Through the preparation of this action plan, the Bank has informally consulted the countries and development partners; is regularly informing them of the proposed and ongoing Bank work and providing inputs to strategic documents as requested; participating in various partnership fora<sup>26</sup>

<sup>25</sup> The Bank is a member of the UN Thematic Group on HIV/AIDS in South Africa and Lesotho.

<sup>26</sup> The Bank is a member of several country-specific and regional consultative groups, such as the EU+ Health and HIV/TB Development Partners Consultative Group; the Department of Health Partners Forum in South Africa; the joint UN teams on HIV; the Eastern and Southern Africa Regional UNAIDS Team (based

and activities; and contributing to efforts supporting national and regional strategies. In addition, the Bank will continue to work with national and international organizations involved in research such as the South African Human Science Research Council (HSRC), the Desmond Tutu HIV Foundation, and universities.

This SACU action plan is aligned with the new UNAIDS “Joint Action for Results 2009–2011”<sup>27</sup> approach and the Paris Declaration on Aid Effectiveness.<sup>28</sup> Following the historic commitment of the United Nations in 2006 to achieving universal access for HIV prevention, treatment, and support for those in need, the new UNAIDS Outcomes Framework (UNAIDS 2009) outlines nine priority areas, including the need for an integrated approach to HIV and TB. The Outcomes Framework also calls for mainstreaming HIV and working jointly under the UNAIDS Unified Budget and Workplan. Specific joint activities will be coordinated and carried out with the UNAIDS Regional Team for Eastern and Southern Africa and all country teams. The SACU action plan 2010–2011 is consistent with the Paris Declaration on Aid Effectiveness, and in implementing the action plan, the Bank has specifically focused on areas that will complement and build on work already underway.

The Bank will continue to explore options for working with the nongovernment sector (both for-profit and not-for-profit groups), including public-private partnerships. The highly successful regional Devel-

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in Johannesburg); the 2031 financing pilot in South Africa; and more.

<sup>27</sup> [http://data.unaids.org/pub/Report/2009/jc1713\\_joint\\_action\\_en.pdf](http://data.unaids.org/pub/Report/2009/jc1713_joint_action_en.pdf).

<sup>28</sup> The Paris Declaration is an international agreement to which over 100 ministers, heads of agencies and other senior officials adhere to and committed their countries and organizations to continue to increase efforts in harmonization, alignment and managing aid for results with a set of monitorable actions and indicators ([http://www.adb.org/media/articles/2005/7033\\_international\\_community\\_aid/paris\\_declaration.pdf](http://www.adb.org/media/articles/2005/7033_international_community_aid/paris_declaration.pdf)).

opment Marketplace<sup>29</sup> could be repeated and the impact further reinforced by expanding the network group that emerged from the first competition. Civil society practitioners in the SACU countries are a major driving force in providing services and promoting behavior change at the grassroots level, and work can be channeled through NGOs, particularly for addressing the problems of marginalized populations and scaling up prevention efforts.<sup>30</sup> Positive relationships already established with corporations (for example, Anglo American) and business coalitions (including the Pan-Africa HIV/AIDS Business Coalition) should be sustained and expanded.

## Conclusion

Bank intervention in the SACU countries is contingent on the commitment of the respective governments to interact and work collaboratively with the Bank. The Independent Evaluation Group (IEG; World Bank 2009c) reviewed the objectives of the Africa Multi-Country AIDS Program (MAP), the assumptions underlying the rationale, the validity of the assumptions, followed by an assessment of the program's design and risks. One of the main conclusions was that lack of political commitment was the most important constraint to action—not only in Africa, but in all developing regions.

While the SACU countries (except for Lesotho) have not benefited from MAP, the lessons identified by the IEG report are important in terms of the risks associated with Bank engagement in the subregion with the highest co-epidemic. Given the changing conditions, including the landmark speech<sup>31</sup> of South Africa's President Jacob Zuma calling for an end to denialism, there is a clear, growing demand from the SACU countries for Bank engagement to help address HIV/AIDS, TB and health systems issues. Also, there is an opportunity for the Bank to have significant subregional impact in the part of the world most affected by the HIV-TB co-epidemic.

Beyond the buy-down operation in Botswana, the Bank runs the risk of not having the appropriate financing instruments to assist MICs in southern Africa, and funding the proposed programs will depend on sufficient allocation of internal resources for analytical and technical support and on grant donors' willingness to make financing packages attractive to the IBRD countries, especially for HIV and TB support. The Bank is exploring options for mobilizing

<sup>29</sup> A network of SACU countries' NGOs was informally established during the Development Marketplace competition event in 2004 and has been maintained through Bank facilitation (follow up in Namibia in 2005; Africa-wide youth consultations on the Africa action plan, Johannesburg, 2006; and youth HIV prevention event, Johannesburg 2008).

<sup>30</sup> Examples where working with NGOs is especially valuable include the consultation on vulnerable and neglected groups; work involving people with disabilities; protection of orphans; and M&E and impact assessments.

<sup>31</sup> South African President Zuma's speech, October 2009, <http://www.thepresidency.gov.za>.

trust funds and parallel financing. Implementation of the proposed programs hinges on making funding available, ensuring the capacity to deliver, and focused, intensive dialogue and good project supervision on the Bank side. On the government side, ownership and a clear indication of where they want the Bank's inputs will be critical in focusing the limited resources. Working with other development partners will be essential to making the money work. To ensure a clear understanding of its role and engagement in the subregion, the Bank will develop a communications and dissemination strategy to inform Bank internal audiences and partners in the government and nongovernment sectors as well as the development partners of the proposed approach and activities.

## **Annexes**

## Annex 1. Country Briefs

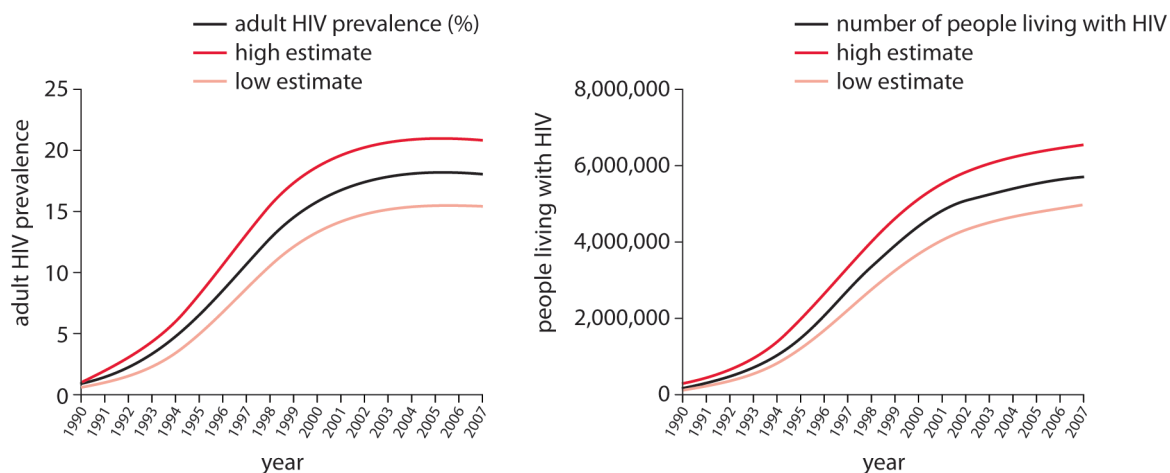
### South Africa

South Africa faces a huge health sector challenge due to explosive HIV and TB epidemics, a high burden of chronic diseases, and a “silent epidemic” of maternal, neonatal, and child mortality. According to a recently published study (*Lancet* 2009), South Africa’s per capita health burden is the highest of any MIC in the world, with the brunt borne by the poorest families. With only 0.7 percent of world’s population, South Africa has 17 percent of the world’s HIV cases and a closely linked TB epidemic that has more than doubled since 2001. An estimated 5.7 million South Africans currently live with HIV (figure A1.1)—more than any other country in the world. South Africa is currently implementing the largest antiretroviral therapy treatment program in the world (Shisana et al. 2009; South Africa DOH 2008; USAID 2008). HIV incidence data from 2008 among the 15–20 years age group shows a promising decline of nearly 50 percent compared to 2002 and 2005, however, age at first sex has not changed for those aged 15–24 years (Shisana et al. 2009). HIV prevalence among young women is four times higher than in men aged 15–24 years, estimated at 16.9 percent and 4.4 percent respectively (WHO, UNAIDS, and UNICEF 2008). HIV prevalence in older age groups has significantly increased. Since the antiretroviral treatment program launch in 2004, more than 700,000 adults and children have been enrolled in public sector programs alone. The success of the massive roll-out is contingent on uninterrupted drug supplies and careful monitoring of patients, which are currently major challenges.

Unlike HIV, TB is a notifiable disease. TB incidence has increased rapidly from 110,000 new cases per year in 1990 to 460,000 new cases per year in 2007, and South Africa ranks fourth in the world in terms of number of cases. It also has the greatest share of HIV-positive TB cases, accounting for 24 percent of the global total. TB has become the most common notified natural cause of death in South Africa, and the yearly TB mortality rate increased almost three-fold from 1990 to 2006 (*Lancet* 2009).

Outbreaks of drug-resistant (MDR and XDR) TB complete the scenario of a perfect storm. For every 100 infectious TB patients in South Africa, only 58 are currently being found and cured by the health system. Collaborative activities to address the co-epidemic have far to go; for example, in 2006, only one-third of TB patients were tested for HIV (WHO 2008). Up-to-date incidence and prevalence estimates of drug-resistant TB are lacking, although surrounding countries have confirmed MDR- and XDR-TB in their citizens, infections that were acquired while working in the mining industry in South Africa. TB drug resistance is a deadly commodity imported and exported through migrant labor in the subregion.

The poor are particularly vulnerable to the co-epidemic, which has considerably strained the health system and caused a range of health indicators to decline: South Africa is 1 of only 12 countries in which mortality rates for children have increased since the baseline for the MDGs in 1990 (*Lancet* 2009). South Africa has made significant strides in focusing on the epidemic and addressing the crisis, including numerous policies and legislative changes and increases in social grants and primary health care services, but much remains to be done in addressing the co-epidemic. The HIV/AIDS and STI National Strategic Plan (2007–2011) spells out the multisectoral response to HIV that is managed at different levels in government and nongovernment

**Figure A1.1** South Africa: HIV Prevalence and Number of PLHIV, 1990–2007

Source: South Africa Epidemiological Fact Sheet, WHO, UNAIDS, and UNICEF (2008), [http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008\\_ZA.pdf](http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_ZA.pdf).

sectors. The Tuberculosis Strategic Plan for South Africa (2007–2011) similarly identifies deficiencies and the approach to dealing with the disease. However, implementation lags, investments have not shown strong enough results, and the pressure on the health system is enormous, especially at district level.

The biggest challenges are human resources, allocation and efficiency of services, and the need for an aggressive campaign for HIV prevention and TB detection and treatment. HIV poses a great threat to the economy; analysis (BER 2006) suggests that GDP growth could be 0.5 percentage points lower on average per year over the period 2000–2020 compared to a no-AIDS scenario, and that anti-retroviral therapy coverage of 50 percent could reduce this impact by 17 percent to 0.4 percentage points. The same study projects the number of orphans to increase to 2.3 million in 2010, which will put further pressure on the public system to provide foster care grants and on community systems

to ensure the care, socialization, and protection of these OVC. Thus the sustainability of the antiretroviral therapy program is of critical importance to the country for protecting human capital and economic growth and mitigating the HIV impact on development. The 2010 budget recently presented to Parliament allocated more than ZAR 8 billion (over US\$1 billion) for HIV programs. The budget provides for the number of people on antiretroviral therapy to rise to 2.1 million in 2012/2013.<sup>32</sup>

With the revived South African National AIDS Council (SANAC), the country is well positioned to reverse the national and regional trend and continue its role as a leader and center for research and capacity building for the continent. In his speech to Parliament,<sup>33</sup> South Africa's President Zuma emphasized the significance of urgently addressing the HIV and TB epidemics:

<sup>32</sup> As quoted in the Financial Mail, February 19, 2010.

<sup>33</sup> President Zuma's speech to South African Parliament, October 29, 2009.

*We must not lose sight of the key targets that we set ourselves in our national strategic plan. These include the reduction of the rate of new infections by 50 percent, and the extension of the antiretroviral program to 80 percent of those who need it, both by 2011. Prevention remains a critical part of our strategy. We need a massive change in behavior and attitude especially amongst the youth. We must all work together to achieve this goal.*

## Botswana

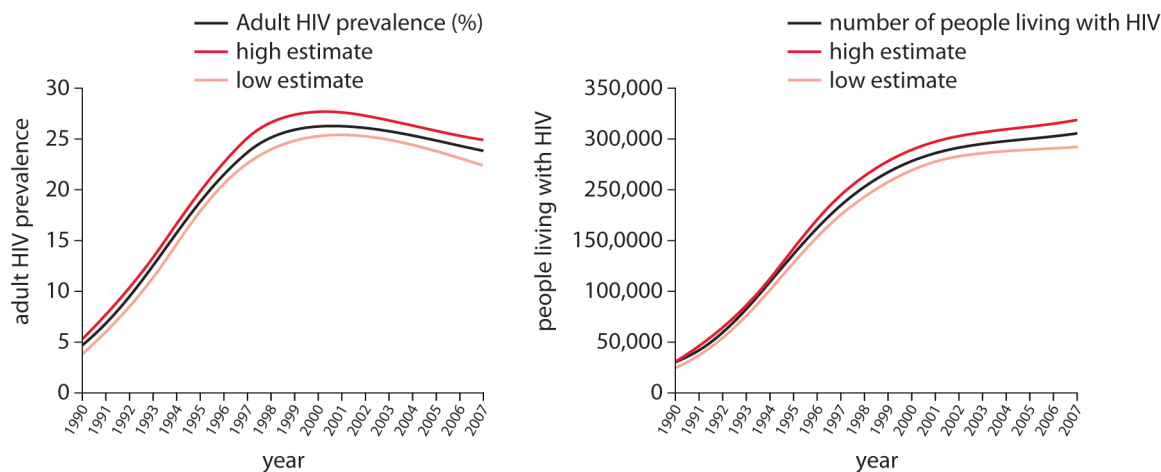
The latest results from Botswana's AIDS Impact Survey (Botswana CSO, NHL, NACA 2009) show a national HIV prevalence of 17.4 percent, with women carrying the brunt with 20.4 percent prevalence compared to 14.2 percent in men. Average incidence is 2.9 percent for the country as a whole, but 8.73 percent among women aged 25–30 years (nearly 9 percent of these women become infected each year, figure A1.2). HIV prevalence among young people

(15–24 years old) in 2004 was 5.8 percent for men and 18.2 percent for women (WHO, UNAIDS, and UNICEF 2008). Government finances approximately 90 percent of the national response to HIV/AIDS in Botswana, including treatment with over 80 percent coverage, achieving a five-year survival rate of 88.6 percent for people receiving antiretroviral therapy (Botswana MOH 2007).

In terms of TB, for every 100 infectious TB cases in Botswana, only 41 are being found and cured by the health system. Case detection is 57 percent (WHO 2009), which lags behind the global target of 70 percent. An estimated 67 percent of new TB patients are HIV positive and 38 percent of AIDS-related deaths are due to TB. TB incidence has more than doubled since 1990, from 307 to 731 per 100,000 people. MDR and XDR-TB continue to spread.

Botswana's HIV/AIDS program has been supported by GFATM, PEPFAR, other bilaterals, the Gates Foundation, and Merck, an international pharmaceutical company. However, even the combined levels of donor and government spending have not kept

**Figure A1.2** Botswana: HIV Prevalence and Number of PLHIV, 1990–2007



Source: Botswana, Epidemiological Fact Sheet, WHO, UNAIDS, and UNICEF (2008), [http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008\\_BW.pdf](http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_BW.pdf).

pace with the rising cost of the response to the epidemic. Given the magnitude and long-term impact of the epidemic, the government is moving from an “emergency” response to a broader, more strategic, and more sustainable approach. A critical element for success will be a massive prevention effort to bring down the number of new infections.

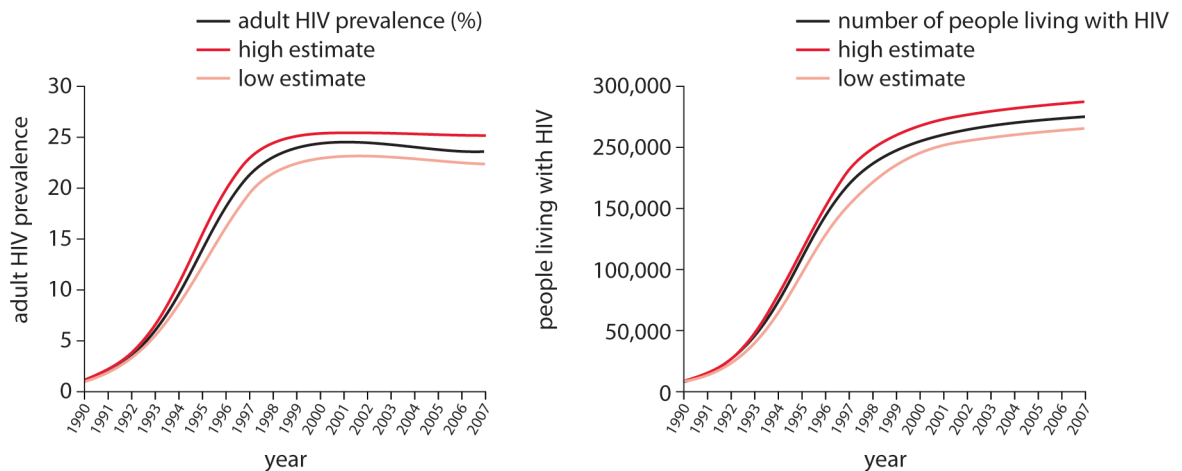
## Lesotho

Adult prevalence in Lesotho in 2007 was estimated at 23 percent, with nearly 300,000 HIV-positive people, and a prevalence of 6 percent for young men and 15.4 percent for young women in 2004 (WHO, UNAIDS, and UNICEF 2008). HIV prevalence in women aged 15–24 years appears to be falling, but was still increasing between 2005 and 2007 in antenatal clinic clients aged 30–40 years. In September 2008, coverage of antiretroviral therapy among those in need was at 45 percent (38,600 treated, 85,000 in need). The estimated number of AIDS-related deaths has dropped sharply since its peak in 2005. Services to prevent

mother-to-child transmission coverage increased rapidly to 31 percent in 2007 (Lesotho National AIDS Commission, UNAIDS, and World Bank 2009). TB incidence has increased fourfold since 1990, when there were 2,945 new cases per year, to 12,782 cases in 2007. Of TB patients tested for HIV, 76 percent tested positive—the highest rate in the world (WHO 2009). The case detection rate (16 percent; WHO 2009) is appallingly low and lags significantly below other countries in SACU, and indeed the world. For every 100 infectious TB cases in Lesotho, only 11 are being found and cured by the health system.

The country has placed a lot of emphasis on addressing the HIV/AIDS epidemic through strong community involvement. HIV and TB programs are financed primarily by grants from GFATM. The Bank provided \$5 million to support implementation of GFATM activities through the HIV/AIDS Capacity and Technical Assistance Project (HCTA), supporting capacity building for key functions of the national AIDS council (NAC) and the Ministry of Health and Social Welfare, as well as civil society organizations.

**Figure A1.3** Lesotho: HIV Prevalence and Number of PLHIV, 1990–2007



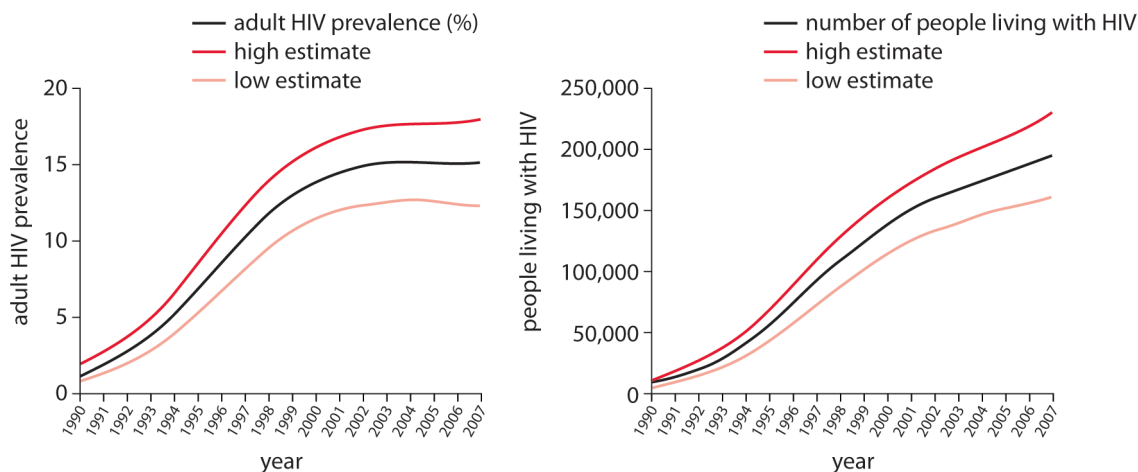
Source: Lesotho Epidemiological Fact Sheet, WHO, UNAIDS, and UNICEF (2008), [http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008\\_LS.pdf](http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_LS.pdf).

## Namibia

The most recent sentinel survey conducted in 2008 shows an overall prevalence of 17.8 percent among pregnant women, with some regions as high as 31.7 percent (Namibia MOHSS 2008c). Namibia is recognized for doing exceptionally well in rapidly expanding its antiretroviral therapy program to 64,000 people—about 90 percent of those who needed treatment in 2009, and more than double the national plan target. Namibia recently conducted a study on the impact of AIDS, which projects that the number of people needing antiretroviral therapy will increase from 69,500 in 2008 to 114,500 in 2013 (Namibia MOHSS 2008b). Namibia has the fourth highest TB incidence in the world after Swaziland, South Africa, and Djibouti. Since 1990, the incidence of TB has more than tripled, from 4,566 to 15,905 new cases per year in 2007. A high proportion of TB pa-

tients are HIV positive (national average 59 percent, but as high as 72 percent in some districts), with most accessing appropriate HIV care and treatment, but not HIV prevention services.<sup>34</sup> All government departments have developed strategies and allocated resources for workplace programs, as is clearly specified in the medium-term expenditure framework.<sup>35</sup> The private sector is also playing a vital role in the AIDS response, and the Namibian Business Coalition against HIV/AIDS (NABCOA) is among the most active in Africa. While fully committed to addressing the HIV epidemic, the country is still very dependent on external funding, which accounts for half of the total according to the latest United Nations General Assembly Special Session (UNGASS) report. PEPFAR is the largest donor and has increased funding tenfold in the past five years, to \$109 million per year.

**Figure A1.4** Namibia: HIV Prevalence and Number of PLHIV, 1990–2007



Source: Namibia Epidemiological Fact Sheet, WHO, UNAIDS, and UNICEF (2008), [http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008\\_NA.pdf](http://apps.who.int/globalatlas/predefinedReports/EFS2008/full/EFS2008_NA.pdf).

<sup>34</sup> Namibia External National TB Control Program Review, Executive Summary, February 28, 2009.

<sup>35</sup> Namibia Medium-Term Expenditure Framework for 2008/9–2010/11, <http://www.mof.gov.na>.

## Swaziland

This small country of one million has among the highest rates of HIV and TB in the world and is struggling to address one of the worst co-epidemics in Africa. HIV prevalence is 26 percent among the population aged 15–49 years, with infection rates higher among women (31 percent) than men (19 percent; Swaziland CSO 2007). HIV prevalence peaks at 49 percent for women aged 25–29 years, almost five times the rate among women aged 15–19 years and more than double the rate among women aged 45–49 years. About 33,000 of the estimated 58,250 people who needed treatment were on antiretroviral therapy by the end of 2008.

The HIV epidemic has also given rise to a TB epidemic in the country, with recorded new cases rising sixfold from 2,310 in 1990 to 13,674 in 2007. TB has become a major public health problem. It is estimated that over 80 percent of all people with TB also have HIV (WHO 2008). The case detection rate (55 percent) and cure rate (43 percent) are below the international targets of 70 percent (detection) and 85 percent (treatment success rate); only 24 out of every 100 infectious TB cases in Swaziland are being detected and treated.<sup>36</sup> Increasing rates of drug resistance combined with inadequate laboratory infrastructure remain major obstacles to tackling the co-epidemic. This results in higher mortality and, combined with labor migration, will produce negative population growth in the foreseeable future. With staggering orphan numbers, the situation in Swaziland is seen as a major demographic crisis by the National Emergency Response Council on HIV/AIDS (NERCHA). Since inception in 2001, NERCHA has played a key role in the fight against HIV, against all odds, and with very limited capacities in other government agencies and in the face of the most severe epidemic worldwide. Swaziland's

response is financed mainly through grants from GFATM, which has approved expenditures of nearly \$150 million for HIV, TB, and malaria programs.

As a result of the socioeconomic situation and the HIV/AIDS epidemic, all children in Swaziland are potentially vulnerable, hence the National Plan of Action (NPA) 2011–2015 for All Children (Swaziland 2009). While there are many ways of defining and evaluating vulnerability, the NPA acknowledges that communities themselves best define vulnerability. They know which children are vulnerable and prioritize accordingly. In addition, the National Children's Policy (2008), recognizes that children orphaned and made vulnerable because of HIV/AIDS are the most vulnerable population in Swaziland. The policy notes that these children are subjected to a wide range of social and economic difficulties: psychosocial distress, grief, stigma, discrimination, isolation, economic deprivation, loss of educational opportunity, burdensome domestic responsibilities, and fear for their own future. The NPA 2011–2015 places these issues at the heart of its strategic agenda.

Currently, the trend shows that poverty and hunger are on the increase in Swaziland, in both rural and urban areas, with the number of people living on food aid increasing from 210,000 in 2005–6 to more than 400,000 in 2006–7. The World Food Programme (WFP) Crop and Food Supply Assessment Mission to Swaziland in 2007 observed that 21 percent of the nation's households are food insecure, while 69 percent are living below the poverty line. According to the Swazi Vulnerability Assessment Committee (2006), approximately 40 percent of the poor were not accessing sufficient food, with a further 40 percent receiving food aid.

"Child Poverty and Disparities in Swaziland" (UNICEF 2009b) examines the demographic and socioeconomic characteristic of Swazi children based on the Demographic and Health Survey, and for the first time looks at the extent and distribution of se-

<sup>36</sup> Based on the calculation:  $100 \text{ cases} \times 57 \text{ percent (case detection)} \times 42 \text{ percent (of those detected that are cured)} = 24$ .

vere deprivations among this population group. The results show that 28 percent of children have two or more deprivations (education, health, nutrition, water and sanitation, shelter, and information), with education strongly influencing severe deprivation, including household income and wealth. There are wide disparities within and among the four regions, and rural children are more likely to suffer two or more severe deprivations than urban children. The “Situation and Needs Assessment of Child-Headed Households in Drought Prone Areas of Swaziland” (UNICEF 2009a) provides for the first time systematic findings on the needs and the plight of child-headed households, and confirms that these households are particularly vulnerable. Results show that most child-headed households do not fulfill the basic needs such as food, shelter, water and sanitation, and lack basic necessities, such as blankets, clothes, and shoes. In addition, children from such households show emotional and behavioral problems.

## **Annex 2. Recommended Collaborative HIV-TB Activities and Targets (WHO Interim Policy)**

### **A. Establish the mechanisms for collaboration**

1. Set up a coordinating body for HIV-TB activities effective at all levels
2. Conduct surveillance of HIV prevalence among TB patients
3. Carry out joint HIV-TB planning
4. Conduct M&E

### **B. Decrease the burden of TB in PLHIV**

1. Establish intensified TB case finding
2. Introduce isoniazid preventive therapy
3. Ensure TB infection control in health care and congregate settings

### **C. Decrease the burden of HIV in TB patients**

1. Provide HIV testing and counseling
2. Introduce HIV prevention methods
3. Introduce co-trimoxazole preventive therapy
4. Ensure HIV/AIDS care and support
5. Introduce antiretroviral therapy

<b>Table A2.1</b>	<b>TB/HIV Targets</b>	
<b>Activity</b>	<b>Global plan target</b>	<b>Country reports for 2007</b>
<b>Number of PLHIV actively screened for TB</b>	14,000,000	630,000 (4.5% of target)
<b>Number of eligible PLHIV offered IPT</b>	1,500,000	29,000 (1.9% of target)
<b>Number of TB patients tested for HIV</b>	2,000,000	1,000,000 (50% of target)
<b>Number of HIV-positive TB patients started on antiretroviral therapy</b>	300,000	90,000 (30% of target)

Source: World Health Organization, Stop TB Department.

## Annex 3. Activities Completed and Ongoing

Completed fiscal year (FY) 2005–10	Ongoing
<b>SACU subregion</b>	
Development Marketplace (FY2005)	
SACU NACs consultation meeting (FY2005)	
Dissemination and presentation of key Bank HIV/AIDS–related documents (for example, MAP interim review, school health report, IEG report, and board response)	Dissemination and presentation of key Bank HIV/AIDS–related documents
HIV and disabilities study of three countries (South Africa, Uganda, and Zambia), findings presentation workshop (FY2008)	HIV and disability study of three countries (South Africa, Uganda, and Zambia), publication, and dissemination
WDR youth report (HIV-focused sections) consultations (FY07)	
Youth HIV prevention event organized by LoveLife (SACU countries + Kenya, FY2009)	
Africa region impact evaluation workshop (Botswana, Lesotho, South Africa, and Swaziland participation, FY2009)	
Vulnerable groups consultation (sexual minorities, such as MSM, commercial sex workers, and prisoners); Botswana, Lesotho, South Africa, and Swaziland participation (FY2009)	
	Champions for an HIV-Free Generation Initiative, advocacy
	IDF project on TB laboratories: Botswana, Lesotho, Namibia, and South Africa
<b>Botswana</b>	
Consultancy and technical assistance support for medium-term review of the national HIV strategy (FY2006–7)	Fiscal implications of scaling up the HIV response (AAA)
Multicountry voluntary counseling and testing study (DEC; FY2006–7)	Multiple Concurrent Partnerships program evaluation—technical assistance
Economic analysis of HIV/AIDS funding and resource flows (FY2008)	
HIV/AIDS IBRD buy-down, project preparation (FY2008)	HIV/AIDS IBRD buy-down, supervision

Completed fiscal year (FY) 2005–10	Ongoing
<b>Lesotho</b>	
Assessment of dual HIV and TB infection linkages within the national program (FY2006)	
Assessment of impact/coverage of young people (FY2007–8)	Supervision of AIDS Implementation Support Grant
HIV/AIDS Capacity and Technical Assistance Project (HCTA), closed December 2008	HCTA-2 Project, preparation
Development dialogue on HIV/AIDS (FY2009), in cooperation with the University of Lesotho	
“HIV Prevention Response and Modes of Transmission Analysis,” joint World Bank, UNAIDS, government study, March 2009	Evaluating the impact of community-based support interventions in improving the sustainability of antiretrovirals
<b>Namibia</b>	
Public-private partnership against AIDS, IDF project (FY2005–8)	
Study on the impact of HIV on banking sector (FY2007)	
Study on the impact of HIV on the nonbanking sector (FY2009–10)	Assessment of the health sector in Namibia (FY2010–11)
Technical assistance on the national review of the health sector in Namibia (FY2009)	
<b>South Africa</b>	
Conditional cash transfers for OVC pilot (FY2006–7)	ARV Assessment in Free State University (DEC) FY2006–10
	Fiscal implications of scaling up the HIV response (Analytic and Advisory Activities, AAA)
	Know-your-epidemic analysis—support for the Mid-Term Review of the National Strategic Plan for HIV and STIs
<b>Swaziland</b>	
Conditional cash transfers, bringing back into the school system the children orphaned by HIV/AIDS, technical assistance (FY2004–5)	Health and HIV project, preparation
Private sector response to HIV, Royal Swazi Sugar Corporation and pulp factory case studies, economic sector work (FY2004–5)	JSDF—Delivering Maternal Child Health Care to Vulnerable Populations, proposal preparation
Communications strategy review, technical assistance (FY2005)	Fiscal implications of scaling up the HIV response (AAA)
Costing the HIV/AIDS national strategy—technical assistance (FY2006)	Quality, Relevance, and Comprehensiveness of Impact Mitigation Services Survey (QIMS; AAA)

Completed fiscal year (FY) 2005–10	Ongoing
Health management information systems review (FY2006)	
AIDS and education assessment and dissemination (FY2007)	
Socioeconomic impact of HIV assessment (FY2007)	
Hospital assessment (FY2006–7)	
IDF, building M&E system and capacity supervision (FY2004–7)	
Assessment of medical referral schemes (Phalala and Civil Service; FY2008)	
Small grants HIV competition (FY2008)	
“HIV Prevention Response and Modes of Transmission Analysis,” joint World Bank, UNAIDS, and government study, March 2009	

Source: Compiled by author.

## Annex 4. World Bank Active and Pipeline Portfolios in the SACU Countries

### Active Portfolio as of March 2010

Country	Project ID	Project title	Fiscal year of approval	Commitment amount (US\$ millions)
Botswana	P095617	Northern Botswana Human Wildlife Coexistence Project	2010	5.5
Botswana	P102299	Botswana National HIV/AIDS Prevention Support Project	2009	50.0
Botswana	P102368	Integrated Transport Project	2009	186.0
Botswana	P112516	Botswana - Morupule B Generation and Transmission Project	2010	136.4
Lesotho	P056418	Lesotho Water Sector Improvement Project	2005	14.1
Lesotho	P075566	Lesotho Integrated Transport Project	2007	23.5
Lesotho	P088544	Private Sector Competitiveness and Economic Diversification	2007	8.1
Lesotho	P104403	Lesotho New Hospital PPP	2008	6.3
Lesotho	P107375	Lesotho HIV and AIDS Technical Assistance Project	2010	5.0
Lesotho	P108143	Water Sector Improvement APL Phase II: Metolong Dam and Water Supply	2009	25.0
Namibia	P070885	Namibian Coast Conservation and Management Project	2006	4.9
Namibia	P073135	Integrated Community-Based Ecosystem Management	2004	7.1
South Africa	P064438	Greater Addo Elephant National Park Project	2004	5.5
South Africa	P073322	Renewable Energy Market Transformation	2007	6.0
South Africa	P075997	C.A.P.E.: Biodiversity Conservation and Sustainable Development Project	2004	9.0
South Africa	P086528	Development, Empowerment and Conservation in the Isimangaliso Wetland Park and Surrounding Region Project	2010	9.0

Source: World Bank Business Warehouse. Data also available on World Bank website: [www.worldbank.org](http://www.worldbank.org).

## Pipeline Portfolio in the SACU Countries as of March 2010

Fiscal year	Country	Project ID	Project title	Bank approval date	Total commitment amount (US\$ millions)
2010	Lesotho	P112817	2nd Poverty Reduction Support Credit	3/30/2010	25.0
2010	Lesotho	P119443	Lesotho Integrated Transport Project— Additional Financing	5/20/2010	15.0
2010	Swaziland	P095232	Local Government Project (SLGP)	5/28/2010	16.1
2010	Swaziland	P110156	Swaziland Health, HIV/AIDS, and TB Project	5/27/2010	20.0
2010	South Africa	P116410	Eskom Investment Support Project	4/8/2010	3,750.0
2011	Lesotho	P114859	Lesotho Health Sector PPP Technical Support Project	7/13/2010	5.0
2011	Lesotho	P119432	Lesotho Smallholder Agriculture Development Program	6/15/2011	10.0

Source: World Bank Business Warehouse; data also available on World Bank Web site: [www.worldbank.org](http://www.worldbank.org).

## Annex 5. Matrix for the Southern Africa HIV/AIDS and Tuberculosis Plan of Action, 2010–2011

Objectives	Specific actions	Indicators	Anticipated results	Critical risks	Strategic partners
<b>AFA Pillar I</b>					
<b>Support for evidence-informed and prioritized HIV and TB strategies</b>					
Analytical work and knowledge management	Studies on drivers of the epidemic and transmission modes	Two studies conducted in response to requests (Lesotho and Swaziland completed), South Africa underway	Improved evidence base for response interventions	Availability of Bank technical and budget support	HNP GHAP PREM DEC WHO Stop TB UNAIDS
	Fiscal implications of scaling up antiretroviral therapy	South Africa, Swaziland, and Botswana underway; and Namibia proposed		Partners' commitment	
	Regional analysis of epi synthesis data, NASA, and fiscal data analysis	SACU countries	Improved efficiency and effectiveness of programs		
	Effectiveness and efficiency of HIV programs	SACU countries			
	Study on cross-border spread of HIV and TB (via mining and transport sector) and associated health system costs	One study on cross-border spread of HIV and TB		SACU countries consider coordinated approach to HIV-TB response	

*Continued on next page.*

Objectives	Specific actions	Indicators	Anticipated results	Critical risks	Strategic partners
Vulnerable group studies (most-at-risk-populations)	<p>Support development of national actions plans as a follow-up to the March 2009 Cape Town workshop</p> <p>Increase understanding, constraints, and possible national policy dialogue</p>	<p>At least one country develops national plan for integrating vulnerable groups</p> <p>Assessment of HIV and disability conducted in one country—Swaziland expressed interest</p> <p>Study already completed for South Africa</p>	<p>Evidence-informed responses developed for most-at-risk groups</p> <p>Better understanding of HIV and disabilities</p>	Weak country commitment to work with vulnerable groups and deal with stigma	<p>UNAIDS</p> <p>Norwegian Agency for Development Co-operation (NORAD)</p> <p>UN Population Fund</p> <p>SWEAT (South African NGO)</p> <p>UN Development Programme (UNDP)</p> <p>Bonela (Botswana NGO)</p> <p>D. Tutu Foundation</p>

#### AFA Pillar II

#### Scale up targeted, multisectoral response (mainstreaming and lending operations)

HIV/AIDS integration into priority sectors (mainstreaming)	Technical assistance to support sectoral institutional capacity for HIV/AIDS in critical sectors, particularly education, transport, energy, and urban development	<p>At least one key sector effort supported with good practice or technical support in four countries</p> <p>Botswana—Morupule B energy project; integrated transport project</p> <p>Lesotho—water project; transportation project</p> <p>Namibia—education sector project</p> <p>Swaziland—local government project</p>	Increased commitment in key sectors to include HIV/AIDS and TB	Insufficient sectoral commitment, lack of clarity and guidance from government, and insufficient budget	<p>UNAIDS</p> <p>DfID</p> <p>EC</p>
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Objectives	Specific actions	Indicators	Anticipated results	Critical risks	Strategic partners
Lending operations	Botswana—HIV project Lesotho—second capacity building and technical assistance project Swaziland—health and HIV project	Project performance indicators Project performance indicators Project performance indicators	Improved prevention Improved financial and procurement management Improved health management systems, including HIV	Slow disbursement rates Institutional arrangements and coordination Capacity constraints and institutional arrangements	EC UNAIDS UNAIDS GFATM EC GFATM
<b>AFA Pillar III</b>					
<b>Systems strengthening: financial, supply chain, health, and M&amp;E</b>					
M&E capacity building	Training and capacity building for decentralized M&E systems  IDF grant proposals	Lesotho, Namibia,  South Africa and Swaziland	Improved management and decision-making capacity		GHAP SADC UNAIDS RST GFATM
Impact assessment	Integrate impact assessments in Bank projects  Follow-up of Cape Town workshop	Botswana—HIV project Lesotho—HIV project, impact assessment Swaziland—impact evaluation and cost effectiveness South Africa—impact assessment of antiretroviral therapy program in Free State University Design program/studies for Lesotho and South Africa	Better evidence-informed approach to HIV	Impact evaluation, staff working with teams on developing appropriate system	AFTRL AFR Impact Evaluation initiative DEC  Free State University
Prevention policy strengthening	MCP program evaluation	Botswana, Namibia, and Swaziland	Improved knowledge on reducing risky behavior	Delicate nature of dialogue	

Continued on next page.

Objectives	Specific actions	Indicators	Anticipated results	Critical risks	Strategic partners
Governance (including, HIV) and public sector management support	<p>Assist in improving existing governance structures, public sector management, and transparency mechanisms through PER and institutional assessment as part of project preparation</p> <p>Examine options for pooled procurement</p>	<p>Botswana—HIV project</p> <p>Botswana—Public Expenditure Review (PER)</p> <p>Lesotho—health PER</p> <p>Swaziland—fiduciary assessment</p> <p>Swaziland—finance management, IDF</p> <p>Swaziland—local government project</p> <p>Concept for pooled procurement of HIV-TB medication developed</p>	<p>Improved governance structures, demand for accountability, and performance</p> <p>Economies of scale</p>	<p>Delicate nature of governance dialogue</p> <p>Lack of coordination among national AIDS authorities</p>	<p>PREM</p> <p>HD</p> <p>AFTHV</p> <p>UNAIDS</p> <p>Regional Support Team (RST)</p> <p>UNDP</p> <p>DfID</p> <p>PEPFAR</p> <p>GFATM</p> <p>Gates Foundation</p>

#### AFA Pillar IV

#### Strengthen donor coordination and support to subregional and cross-border initiatives

Collaboration and harmonization with key partners	<p>Collaboration with key partners to harmonize financing, fiduciary, M&amp;E systems (including impact evaluation), and supply chains</p> <p>Cooperation with SADC</p>	<p>At least one regional meeting annually with key partners</p> <p>Meeting with SADC NAC heads</p>	<p>Better implementation and division of labor</p> <p>Review of the collaboration and funding from World Bank to SADC states</p>	<p>Willingness of partners to take common action</p>	<p>GHAP</p> <p>UNAIDS and all other UN agencies</p> <p>GFATM</p> <p>PEPFAR</p> <p>Gates Foundation</p> <p>DfID</p> <p>EC</p> <p>SADC Secretariat and member states NACs</p>
Joint planning and reviews with partners	<p>Conduct joint planning and operational and capacity building</p>	<p>At least two joint UN-AIDS/GFATM/World Bank missions and partnership fora</p> <p>Bank inputs in UN joint team work plans in all countries</p>	<p>More effective and efficient allocation and utilization of resources</p>	<p>Difficulty in coordinating with other partners in countries where the Bank has no country offices or a dedicated HIV-TB coordinator</p>	<p>UNAIDS Regional AIDS Team for Eastern and Southern Africa</p> <p>Joint UN Regional Team on AIDS</p> <p>GFATM</p> <p>PEPFAR</p>

Objectives	Specific actions	Indicators	Anticipated results	Critical risks	Strategic partners
Support for cross-border projects	Support in the design and financing of cross-border efforts	One cross-border project that addresses critical gaps in national efforts  At least one regional TB consultation cofinanced by World Bank  Shared TB good practice documentation	Improved recognition and dealing with HIV/AIDS and TB as a multicountry public health issue	Lack of concessional funding mechanisms for IBRD countries	Human Development network Transport sector UNAIDS DfID International Organization for Migration SACU
Policy dialogue on cross-border labor mobility	Analysis of cross-border labor mobility	Assessment of effectiveness of cross-border health/HIV points	Harmonized protocols and procedures on treatment, care, and support for HIV and TB mobile populations	No harmonized approach to cross-border issues	UNAIDS DfID
Advocacy	Support to the Champions for an HIV-Free Generation Initiative  Development dialogues via the Development Information Centers	Visits to all SACU countries, planned visits: Namibia—June 2009 Lesotho and Swaziland—2010  HIV development dialogue: Lesotho—March 2009 Namibia—planned for 2009	Commitment of highest level of government to scaling up the response to HIV	Complicated coordination	GHAP HD Vice President's Office  UNAIDS GFATM Gates Foundation PEPFAR

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