

# HIV/AIDS: Supporting Effective Prevention, Treatment, and Care

**A**IDS is a major threat to global health, and a roadblock to lasting development and progress on other Millennium Development Goals (MDGs). Fighting HIV/AIDS and other major diseases is one of the eight MDGs which aim to halve poverty and improve welfare by the year 2015. Yet the number of people living with HIV has continued to increase, reaching 39.5 million people in 2006, including almost 25 million people in Sub-Saharan Africa. UNAIDS estimates that in 2006 4.3 million people became newly infected with HIV and 2.9 million people died of HIV-related illnesses, including approximately 350,000 children.

The International Development Association (IDA), the World Bank's fund for the world's poorest countries, was the first source of substantial funding for HIV/AIDS in Sub-Saharan Africa, the Caribbean, and India, and remains the most predictable, flexible, long-term financing source. Beginning in the late 1980s, IDA has committed over two billion dollars to support HIV and AIDS responses in 67 countries, and has helped scale up HIV prevention, treatment, and care, benefiting millions of people, especially in Sub-Saharan Africa and South Asia.

### At a glance

- According to UNAIDS, in 2006 HIV was most prevalent in Sub-Saharan Africa (5.9 percent of adult population), followed by the Caribbean (1.2 percent), Eastern Europe and Central Asia (0.9 percent) and South Asia (0.6 percent).
- IDA has committed over two billion dollars to support HIV/AIDS responses in 67 countries since 1988.
- Total resources for HIV in developing countries increased from around US\$300 million in 1996 to US\$8 billion in 2005 (including about US\$2 billion in domestic public and private spending).
- Comprehensive effective prevention, care, and treatment to fully meet global needs would cost at least US\$20 billion per year, compared to the US\$8 billion available in 2006.

IDA's Multi-Country AIDS Program (MAP)—especially the grant resources set aside under IDA13—paved the way for other global health initiatives focused on AIDS. IDA's MAP helped to increase total resources for HIV in developing countries from US\$300 million in 1996 to US\$8 billion in 2005 (including US\$2 billion in domestic public and private spending). IDA-supported projects helped raise political awareness and mobilize societies early in the epidemic, build systems and institutions to channel resources to affected communities, and bring the public, private and non-profit sectors together to deliver effective, evidence-based strategies and policies.

Today, with the large grant resources of the Global Fund to Fight AIDS, TB and Malaria (Global Fund) and the US President's Emergency Plan for AIDS Relief (PEPFAR), IDA is no longer the major financier for AIDS, but it remains a key source of support—continuing to strengthen national and subnational capacity for planning, managing, and monitoring HIV responses and thus enabling countries to use other sources of global funding effectively. IDA is also a valued source of funding because it can be used flexibly to complement other sources, deliver sustained support to strengthen health systems, and support investments and outreach outside the health sector that are key for preventing HIV transmission—for example, in education, transport, income generation, for grassroots initiatives that reach poor and remote communities, and marginalized groups that often drive HIV epidemics.

IDA also plays a global leadership role. It is a founding co-sponsor of UNAIDS. It helped create the Global Fund and serves on its Board and as Trustee. IDA analytical work, to support better HIV/AIDS data collection and use, rigorous evaluation of program impact, and studies of the macroeconomic and productivity impact of AIDS, have contributed importantly to the development of evidence-based national strategies and global awareness. Finally, IDA plays a strong role in promoting donor harmonization, coordination and alignment.



## IDA'S CONTRIBUTIONS

IDA has committed US\$2.08 billion for HIV/AIDS in 67 countries since 1988. From FY2001-05, annual new commitments averaged nearly US\$300 million, and in FY06 they totaled US\$98 million.

Out of 20 completed, IDA-financed HIV projects (from 1998 through 2006), two-thirds were rated marginally satisfactory or better by the World Bank's Independent Evaluation Group.

These ratings are not high, and reflect the difficulty of designing effective projects in new areas of intervention as well as some

features unique to the AIDS epidemic, such as persistent stigma and denial; the difficulties of changing social norms and sexual behavior; and the challenges of working with many diverse stakeholders and groups, including sex workers, men who have sex with men and injecting drug users.

However, the IDA portfolio for HIV/AIDS shows clear evidence of "learning by doing." Fortright action to correct earlier issues in disbursement and procurement, coordination capacity, health sector engagement, and monitoring and evaluation is paying off. IDA-financed HIV projects are achieving relevant and important results.

## M&E

Results-based monitoring and evaluation is critical to monitor the epidemic and implement and manage an appropriate response. It takes time and resources to build robust, well-functioning national M&E systems.

UNAIDS established the Global HIV/AIDS Monitoring and Evaluation Support Team (GAMET), which is located at the World Bank. GAMET's dedicated experts in the field provide intensive, hands-on practical help, working with countries and diverse donors to strengthen monitoring and evaluation capacity, systems and practice at the country level.

Because of the MAP program's emphasis on monitoring and evaluation, key outputs to which IDA-supported AIDS projects have contributed have been carefully tracked. In Sub-Saharan Africa, these include:

- Services to prevent mother-to-child HIV transmission for over 1.5 million women.
- 1,500 new voluntary counseling and testing sites (about 20 percent of all sites in those countries), and enabled nearly 7 million more people to be tested for HIV.
- Anti-retroviral treatment (ARV) for 27,000 people and treatment for HIV-related infections for nearly 300,000 more funded by the MAP.
- Training to provide HIV services for over half a million people.
- More than 173 million people reached with information about HIV/AIDS (about 60 percent of the total population aged 15+ in MAP-supported countries).
- Workplace HIV information, testing, counseling and treatment programs to serve 2.3 million employees.
- About 40,100 organizations supported with technical advice and financing in 36 countries.

- The impact of AIDS mitigated for more than half a million adults and 1.8 million children, through education, nutrition, and income-generating activities delivered by 38,000 grassroots initiatives.
- 1.3 billion male condoms and 4 million female condoms delivered.

Individual project outcomes are also noteworthy.

**India** illustrates the benefits of sustained and predictable long-term support. Through continuous support since 1992, IDA helped spur early action on HIV. IDA helped create the institutional framework of India's entire HIV response at the national level and in 28 states and territories. It helped finance over 1,000 targeted interventions, reaching 35-45 percent of female sex workers and 46 percent of injecting drug users. This has helped contain HIV prevalence (antenatal surveillance) at 0.9 percent.

Declining prevalence in the most affected southern and western states in India offers hope that the world's second largest country can avert a catastrophic epidemic.

In **Moldova**, an ongoing IDA-financed project has helped develop a national HIV/AIDS strategy that includes public campaigns and targeted NGO-run programs for injecting drug users, screening of pregnant women, prophylactic treatment for HIV-positive mothers, and free milk formula for replacement feeding. Together, these actions have helped decrease mother-to-child transmission by 76 percent, stabilize HIV incidence (diagnosed new cases) among 15-24 year olds, and reduce overall AIDS mortality by 70 percent between 2002 and 2005.

**The Africa MAP Treatment Acceleration Project.** In its first 18 months, this demonstration project gave treatment and care to over 20,000 people in Burkina Faso, Ghana and Mozambique, while maintaining adherence rates of over 95 percent. It is learning and sharing crucial lessons about how to expand treatment successfully and responsibly, promote treatment adherence and prevention, monitor and minimize drug resistance, and enhance program effectiveness.

### When Speed is Crucial

In 2000 IDA made an initial amount of US\$500 million in flexible and rapid MAP funding available to African countries to assist in scaling up national HIV/AIDS efforts. IDA approved an additional US\$500 million in 2002 to meet unexpectedly rapid uptake. The MAP has now committed US\$1.28 billion to 29 countries and four regional, cross-border projects in Africa and US\$118 million in the Caribbean MAP in 9 countries and the regional Pan-Caribbean Partnership Against HIV/AIDS.

The emphasis is on speed, scaling up existing programs, building capacity, “learning by doing,” and reworking projects as new data become available. This approach relies on monitoring and evaluation (M&E) of programs to determine which activities are efficient and effective and should be expanded further and which are not and should be stopped or benefit from more capacity building. Funding “good” programs quickly is more important than funding “best practices” with delay.

**Rwanda’s** MAP project highlights include: (i) expanding rural access to AIDS care, with over 5,000 poor patients (mainly women) benefiting from ARV (60 percent of those in need); (ii) HIV testing for about 500,000 people, 12 million condoms, and 400 events to educate and promote behavior change; (iii) supporting income-generating activities reaching

100,000 people, school fees for 27,000 orphans and vulnerable children, subsidizing community health insurance for 52,000 households (covering about 250,000 people); and (iv) strengthening capacity to deliver HIV and other health services in district hospitals and other institutions, with positive health systems impact.

**Ethiopia’s** MAP project has provided the country with the only systematic support for civil society organizations working on AIDS and community action. These activities have changed attitudes towards people living with HIV, encouraged testing and led to a remarkable growth in associations of people living with HIV. It has mobilized groups of women, youth, religious leaders, and *iddirs* (neighborhood leaders) to discuss the risks and responsibilities of their communities, and to take direct action such as caring for orphans and bedridden people with AIDS. The project financed life-saving drugs for HIV-related infections, and income-generating activities for people living with HIV and those at risk of infection due to poverty.

In **Guyana**, a MAP project has enhanced civil society and multi-sectoral ministerial responses. Before the MAP project, fewer than 10 small, inexperienced civil society organizations (CSOs) were active in HIV/AIDS. The project set up a transparent system for CSOs to access funds, and within the first 18 months, approved US\$600,000 for 28 CSOs. IDA, PEPFAR and the government have done much to build CSO capacity. Seven ministries have HIV focal points and are implementing their second annual HIV/AIDS plans, with IDA providing the only source of HIV funding for non-health ministries.

### **Building the evidence base for policy on HIV/AIDS.**

Successful national and local responses—especially for prevention—are grounded in understanding and careful analysis of the epidemic and the behaviors and groups driving most new infections. Better evidence on HIV epidemiology and risky behaviors requires investments in surveillance, data collection and analysis. IDA is co-financing nationally representative household surveys (DHS) in many countries, providing a better basis for HIV program decisions.

IDA is also working with countries to rigorously evaluate the impact of different AIDS prevention and treatment programs. In Rwanda, Burkina Faso, the Dominican Republic and elsewhere, IDA technical support for carefully designed evaluations is expanding the knowledge base on “what works” to combat HIV.

Finally, IDA has produced pioneering work to assess the economic impact of AIDS and the productivity and family welfare impacts of access to treatment and prevention programs.

### **Providing predictable, long-term, and flexible funding.**

IDA remains the most predictable long term source of funding for AIDS. Ministries of Finance and AIDS Program Managers emphasize the importance of being able to rely on IDA funding when they need it. This is most obviously necessary for the sustainability of life-saving treatment programs, but equally important for sustained prevention and care efforts.

### **Economic Impact of AIDS**

- Analysis of the economic impact includes work that shows the intergenerational effects of AIDS in undermining educational attainment and future productivity and economic growth, by reducing incentives and resources for investing in education and leaving children without parental guidance and support (Bell, Devarajan & Gersbach, 2003).
- An analysis of the impact of HIV-related illness and deaths on three large African cities demonstrates the strong financial imperative for workplace prevention and treatment programs. A conservative estimate of the cost to the city of each HIV infection is approximately twice the annual salary of an employee, and total annual costs at 1–2 percent of the municipal wage bill. AIDS undermines municipal services efficiency and quality, and reduces the returns to investments in municipal capacity building (Sarzin 2006).
- IDA analysis of the epidemiology of HIV also offers vital evidence to inform sound policies, for example demonstrating that epidemics driven by injecting drug users and sex workers demand effective interventions with high coverage of these high risk populations (Wilson; Kang et al 2006).

Countries also value the flexibility of IDA funding and processes, enabling them to respond to rapidly changing circumstances, fill unanticipated gaps and fund important interventions that others do not fund.

### **Working across sectors.**

IDA is able to work across all the sectors that need to be engaged for effective HIV/AIDS responses, and embed funding and technical support in IDA-financed operations and work in other sectors. For example, the Standard Bidding Documents include a clause that

requires all IDA-funded construction contracts to include prevention and treatment for the workforce. The Multi-Country AIDS Program (MAP), IDA's major HIV funding mechanism, has a strong multi-sectoral focus.

### Filling important funding gaps.

IDA funds some interventions that others do not fund and some countries that others cannot—especially those affected by conflict. PEPFAR funding, for example, is heavily concentrated in 15 countries and subject to various constraints, while IDA has funded efforts in 67 countries and across borders.

In the Caribbean, IDA resources have softened the borrowing terms for HIV, providing additional external resources to countries whose borrowing capacity is constrained by high levels of external debt and the need to cope with effects of devastating hurricanes (Grenada, St. Lucia, St. Vincent and the Grenadines). In a region only second to Sub-Saharan Africa in HIV prevalence, IDA resources have provided direct funding to the Pan-Caribbean HIV/AIDS Partnership through the Caribbean Community (CARICOM).

Whereas a large proportion of other global funding for HIV/AIDS focuses on treatment, one third of IDA funds have been allocated to prevention.

IDA is able to support controversial but crucial, evidence-based, effective interventions with marginalized groups where the epidemic often ignites, such as interventions for sex workers, men who have sex with men, and injecting drug users (who account for 60-80 percent of new infections in some countries).

IDA has also been the only significant source of support for many thousands of grassroots initiatives that reach poor and remote communities. This funding has empowered communities and people with HIV to take the initiative, define their needs and work together to fill them, caring for orphans, offering home-based care for poor people ill with AIDS, counseling and psycho-social support, information, encouraging HIV testing, and supporting income-generating activities. These actions are crucial to reducing stigma and changing behaviors to prevent infections, and caring for people infected and affected by HIV.

### CHALLENGES AHEAD

The AIDS virus mutates faster than any known virus and radiates along myriad, complex transmission lines in societies and across borders. Over the past 25 years, AIDS has presented a formidable development challenge. Although global action to fight AIDS today is larger-scale and more concerted than ever before, it is clear that unrelenting effort will be needed to reverse and end the epidemic.

Uganda, long a beacon of hope against HIV, now offers a warning against complacency. Uganda was the first country in Africa to make significant gains against the epidemic, reducing prevalence among antenatal clients in Kampala from 30 percent in 1992 to 7 percent by 2001. Now there are worrying signs of HIV prevalence rising again in some rural areas (prevalence doubled in Masaka from 4-5 percent in 2001 to 8-10 percent in 2005).

For IDA specifically, the challenge is to maintain strong engagement and achieve results in the priority areas where IDA has been asked by partners and countries to focus, to support effective countries' HIV responses.

Global partners have asked IDA to play a leadership role in key areas crucial for “making the money work” to deliver effective responses: (i) helping countries develop stronger results-focused and evidence-based national HIV and AIDS *strategies*; (ii) building *national M&E* systems to measure and manage programs to achieve results; and (iii) helping *integrate HIV into the broader development agenda*, including into Poverty Reduction Strategies. The Bank is also a key partner in improving implementation and helping countries resolve bottlenecks. These are consistent with the priority action areas in *The World Bank’s Global HIV/AIDS Program of Action* (December 2005). To play these roles effectively, IDA needs to remain fully engaged in supporting national HIV responses.

New IDA commitments are faltering perhaps because of a perception that AIDS is “over-funded” relative to other needs, even though

funding is concentrated in a relatively small number of countries and is less than half of the amount estimated needed for effective comprehensive national responses. The end of the special IDA13 grant allocation for AIDS (covering FY 2001-04) has also had an impact.

Within the shifting global aid architecture, IDA’s role is as the “funder of first resort” for some low-income countries and key activities which other major donors avoid, and as the “funder of last resort” to enable countries to sustain prevention and treatment programs. IDA is also a valued partner for the technical, logistical, analytical, fiduciary, and policy support to national programs, and for working to better harmonize and align donor support with country needs.

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<http://www.worldbank.org/ida>