IDA AT WORK

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

Addressing AIDS and other major diseases is one of the eight Millennium Development Goals that aim to halve poverty and improve welfare by 2015. Progress has been made in preventing new infections, increasing treatment access, and mitigating the effects of AIDS. But much more remains to be done, with more than 33 million people living with HIV in 2007—including more than 22 million people in Sub-Saharan Africa. UNAIDS estimates that in 2007, 2.5 million people became newly infected with HIV and 2.1 million people died of HIV-related illnesses, including 290,000 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 more than $3 billion to support HIV/AIDS responses in 67 countries, and has helped developing countries broaden and intensify their efforts in HIV prevention, treatment, and care, benefiting millions of people, especially in Sub-Saharan Africa and South Asia.

At a glance

- According to UNAIDS, in 2007 HIV was most prevalent in Sub-Saharan Africa (5.0 percent of adult population), followed by the Caribbean (1.0 percent), and Eastern Europe and Central Asia (0.9 percent).
- IDA has committed more than $3 billion 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$15 billion in 2008 (including domestic public and private spending).
- The creation of 1,500 counseling and testing sites has enabled nearly seven million more people to be tested for HIV, and IDA funds have helped get information about HIV/AIDS to more than 173 million people.
- IDA support also has helped mitigate the impact of AIDS for more than 1.8 million children and half a million adults through education, nutrition, and income-generating activities delivered by 38,000 grassroots initiatives.

IDA's Multi-Country AIDS Program paved the way for other major AIDS support initiatives. This helped increase total resources for HIV in developing countries from $300 million in 1996 to $15 billion in 2008 (including 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 (the Global Fund) and the US President's Emergency Plan for AIDS Relief, IDA is no longer the major financier for AIDS, but remains a key source of support—continuing to strengthen national and sub-national capacity for planning, managing, and monitoring HIV responses and thus enabling countries to use other sources of global funding more 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; support investments and outreach among marginalized groups which is key to preventing transmission in concentrated HIV epidemics; and sustain grassroots initiatives that reach poor, remote, and marginalized communities, empowering infected and affected people to cope better.

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 has contributed importantly to the development of evidence-based national strategies and global awareness. This analytical work supports better HIV/AIDS data collection and use, rigorous evaluation of epidemic patterns and potential and program impact, and studies of the macroeconomic and productivity impact of AIDS. Finally, IDA plays a strong role in promoting donor harmonization, coordination, and alignment.

RESULTS

IDA has committed US$3.27 billion for HIV/AIDS in 67 countries since 1988. Since FY2001, annual new commitments have averaged more than US$400 million.

Of 25 IDA-financed HIV/AIDS projects completed between 1998 and 2007, just over half were rated marginally satisfactory or better by the World Bank's Independent Evaluation Group.

These ratings 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." Forthright action to correct earlier issues in disbursement and procurement, coordination capacity, health sector engagement, and monitoring and evaluation is paying off. IDA-financed HIV/AIDS projects are achieving relevant and important results.

Monitoring & Evaluation

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 monitoring and evaluation systems.

In 2003, UNAIDS established the Global HIV/AIDS Monitoring and Evaluation Support Team, which is located at the World Bank. Working with partners, the team's dedicated experts in the field provide intensive, hands-on practical help to countries to strengthen monitoring and evaluation capacity, systems, and practice at the country level. The broader aim is to build a new model of accountability, and a culture of achieving results and using data to improve programs.

Because of the Multi-Country AIDS Program's emphasis on monitoring and evaluation, key outputs have been carefully tracked. In Sub-Saharan Africa, in the first 5 years of the Program ending 2006, these include:

- Services to prevent mother-to-child HIV transmission for more than 1.5 million women.
- The establishment of 1,500 new voluntary counseling and testing sites (about 20 percent of all sites in participating countries), which has 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 Multi-Country AIDS Program.
- 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.

The Africa Multi-Country AIDS Program Treatment Acceleration Project. This demonstration project helped scale up treatment, care, and services to prevent HIV transmission from mother-to-child, reaching over 300,000 people in Burkina Faso, Ghana, and Mozambique, while maintaining good adherence rates by those on anti-retroviral treatment. It learned and shared crucial lessons about how to expand treatment successfully and responsibly, promote treatment adherence and prevention, monitor and minimize drug resistance, and enhance program effectiveness.

As of 2009, Rwanda's Multi-Country AIDS Program highlights include: (i) funding voluntary counseling and testing for close to one million people; (ii) distributing 18 million condoms; (iii) providing lifesaving antiretroviral therapy to more than 9,000 patients (well above the project target of 2,350); (iv) providing financial assistance for school fees for about 28,000 children; (v) subsidizing community health insurance for over 52,000 households; and (vi) reaching 100,000 individuals with

When Speed is Crucial

In 2000, IDA made available an initial amount of US$500 million in flexible and rapid Multi-Country AIDS Program funding to African countries to assist in expanding national HIV/AIDS efforts. IDA approved an additional US$500 million in 2002 to meet unexpectedly rapid uptake. The Program has now committed US$1.5 billion to 33 countries and five regional, cross-border projects in Africa and US$118 million in the Caribbean Multi-Country AIDS Program in nine countries and the regional Pan-Caribbean Partnership Against HIV/AIDS.

The emphasis is on speed, on expanding existing programs, building capacity, "learning by doing," and reworking projects as new data become available. This approach relies on monitoring and evaluation 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.

income-generating activities that are helping alleviate poverty. The project has also supported government efforts to introduce performance-based financing for HIV services with hopeful initial results.

Ethiopia's component of Multi-Country AIDS Program 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. They have 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 lifesaving 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 project under the Multi-Country AIDS Project has enhanced civil society and responses by government ministries across a range of sectors. Before the Program, 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 quickly approved US$1.6 million for 65 CSOs through competitive proposals. IDA, the US President's Emergency Plan for AIDS Relief, and the government have done much to build CSO capacity. Eleven ministries and five national agencies are implementing HIV/AIDS plans, with IDA providing the only source of HIV funding for non-health ministries.

In **Moldova**, an IDA-financed project helped develop a national HIV/AIDS strategy that includes public campaigns and targeted CSO-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 helped decrease mother-to-child transmission by 76 percent, stabilize HIV incidence (new cases) among 15-24 year olds, and reduce overall AIDS mortality by 70 percent between 2002 and 2005.

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 activities targeting those most at risk, reach-

ing 35-45 percent of female sex workers and 46 percent of injecting drug users. This has helped contain HIV prevalence in the general population below 0.3 percent, with notable declines among highly affected groups in the most affected southern and western states in India.

Building the evidence base for policy on HIV/AIDS.

Successful national and local responses—especially for prevention—are grounded in understanding 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 in many countries, providing a better basis for HIV program decisions. To ensure that data are actually used, IDA is also systematically compiling and analyzing all available data and information on the epidemic in each country, and drawing out the implications for where effective programs must focus.

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, Haiti, 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.

Economic Impacts 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).

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 lifesaving treatment programs, but equally important for sustained prevention and care efforts.

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, as part of its procurement system, 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 focus of actions across relevant economic and social sectors.

Filling important funding gaps.

IDA has funded some important interventions that others did not fund and some countries where others cannot work—especially those affected by conflict. Funding from the US President's Emergency Plan for AIDS Relief, for example, is heavily concentrated in 15 countries, 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 that is second only to Sub-Saharan Africa in HIV prevalence, IDA resources have provided direct funding to the Pan-Caribbean HIV/AIDS Partnership through the Caribbean Community.

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. The funding has been used to care for orphans, offer home-based care for poor people ill with AIDS, counseling and psychosocial support, information, to encourage HIV testing, and support 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. Since it emerged in the early 1980s, 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, and to invest in health systems that can also meet all the other urgent needs for care.

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 risky behaviors and 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, and to help countries use scarce resources more effectively and efficiently for stronger results.

Global partners have requested that IDA play a leadership role in key areas: (i) providing analysis to "know your epidemic" so that national responses can be tailored and well-focused; (ii) helping countries develop stronger results-focused and evidence-based national HIV and AIDS strategies; (iii) building national M&E systems to provide data that is used to measure and manage programs to achieve results; and (iv) 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 reflected in the priority action areas in *The World Bank's Global HIV/AIDS Program of Action* (December 2005), and the new strategy for Africa, *"HIV/AIDS Agenda for Action 2007–2011,"* that positions the Bank for the next phase of the African response. To play these roles effectively, IDA needs to remain fully engaged in supporting national HIV responses.

After reaching a peak in the 2007 fiscal year, new IDA commitments were only $65 million the next fiscal year and most of the $232 million committed in fiscal year 2009 comprised a large credit for Nigeria. New commitments may remain modest in future years, perhaps because of a perception that AIDS is "overfunded" relative to other needs. This is despite the fact that funding is concentrated in a relatively small number of countries and remains well below the amount needed to deliver services to all who need them. The end of the special IDA13 grant allocation for AIDS (covering FY 2001–04) and the availability of large amounts of grant funding through other sources are also factors.

Within the shifting global aid architecture, IDA's role is as the "funder of first resort" for some low-income countries and key activities, 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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