

The HIV/AIDS Epidemic in Africa: Implications for Development

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Dear colleagues, let me begin by saying how honored I am to be asked to give the keynote address on the number one threat to population and development of this century.

First I would like to go over the current state of the epidemic and then take a look at the devastation the epidemic has caused. I will also discuss the global community's response to the epidemic to date, point out what challenges we are currently facing and offer some insight on how we can move forward.

Overview

- State of the epidemic
- The cost of inaction
- Response to the HIV/AIDS epidemic
- The changing landscape of HIV/AIDS
- Challenges and moving forward

2

When we look closely at the state of the epidemic the numbers are shocking. To date more than 60 million people have been infected, 20 million have died and 40 million are living with HIV/AIDS. Despite our collective effort in the past two decades, the epidemic continues to grow as evidenced by the fact that more people were infected in 2004 than in any previous year. The impact of AIDS is also felt by more than 15 million children who have been orphaned of these; 12.3 million are in Sub-Saharan Africa.

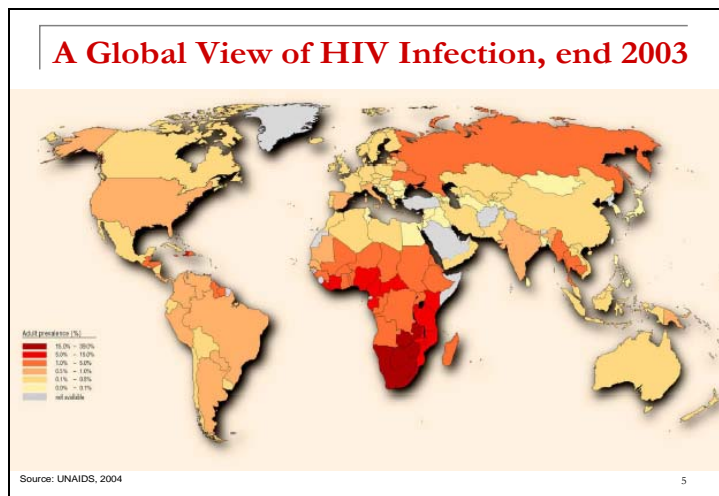
HIV Infection Shows No Sign of Abating

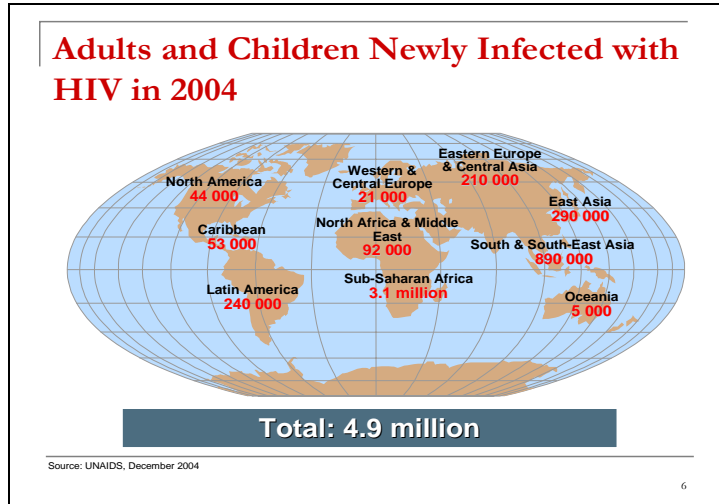
- More than 60 million people infected to date
- More than 20 million people have died
- 40 million people are living with the virus
- More than 15 million children orphaned by AIDS
- 5 million people were newly infected with HIV in 2004 alone

4

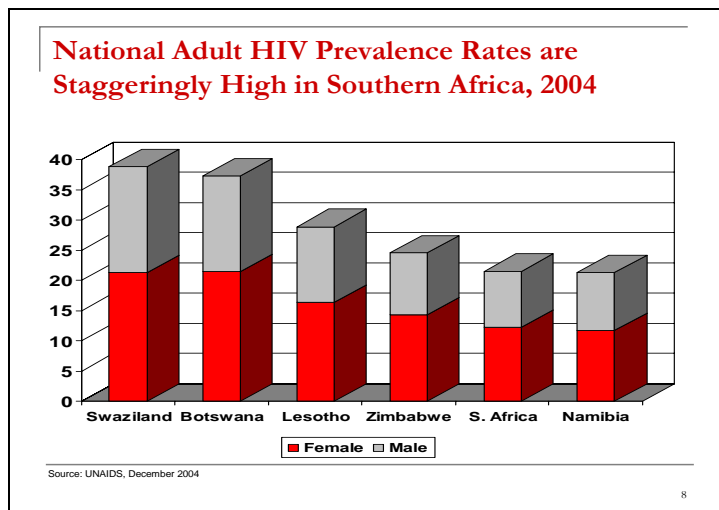
While Sub-Saharan Africa is home to just over 10 percent of the world's population, it has more than 60 percent or more than 25 million people living with HIV/AIDS. Two important issues to note with regard to the epidemic in Sub-Saharan Africa are, first we are dealing with multiple epidemics requiring multiple strategies and, two the face of the epidemic is becoming more feminine which has dire consequences.

These next two slides show that while Sub-Saharan Africa bears the brunt of the epidemic in terms of the number of people affected, HIV/AIDS spares no one. As it has already hit hard in other regions such as the Caribbean and is fast-growing in others, HIV/AIDS is truly a global emergency.

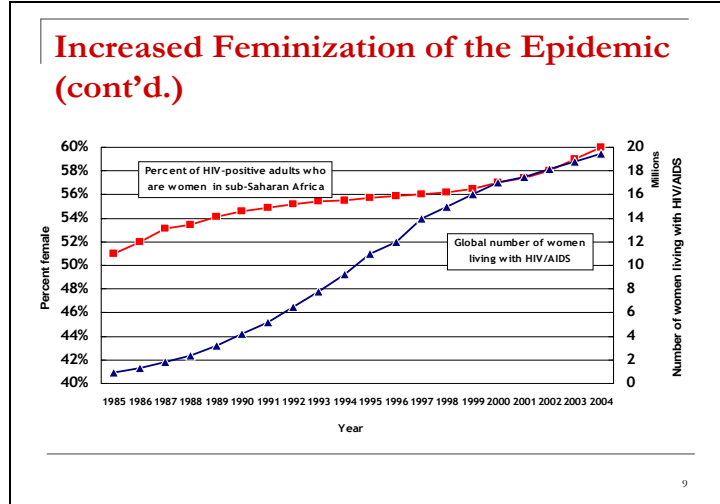




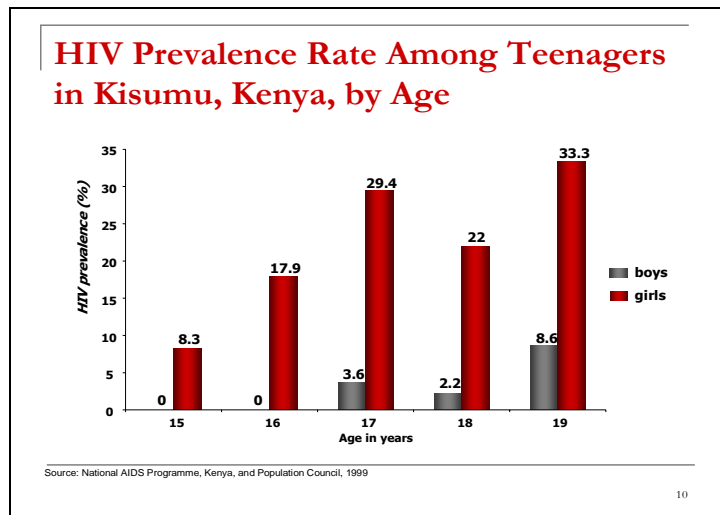
As you can see prevalence rates in some of the worst affected countries are not only staggeringly high, but they are also higher among women which should be of serious concern.



This is due to women's increased biological but also social susceptibility to infection.

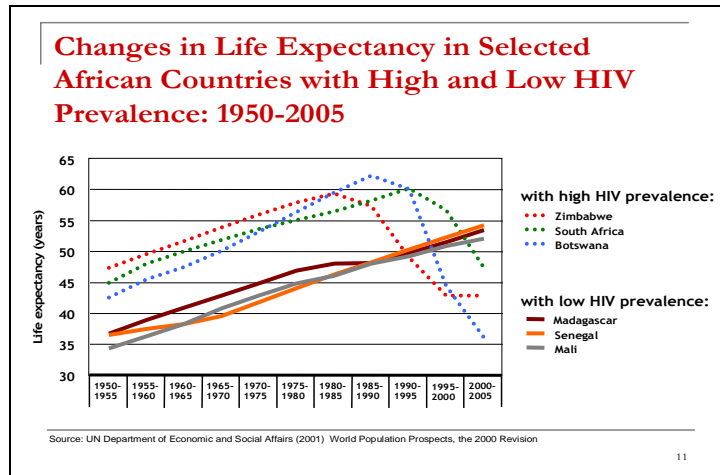


Young girls are up to three times more likely to get infected with HIV as evidenced by the prevalence rates among teenagers in Kenya shown here.

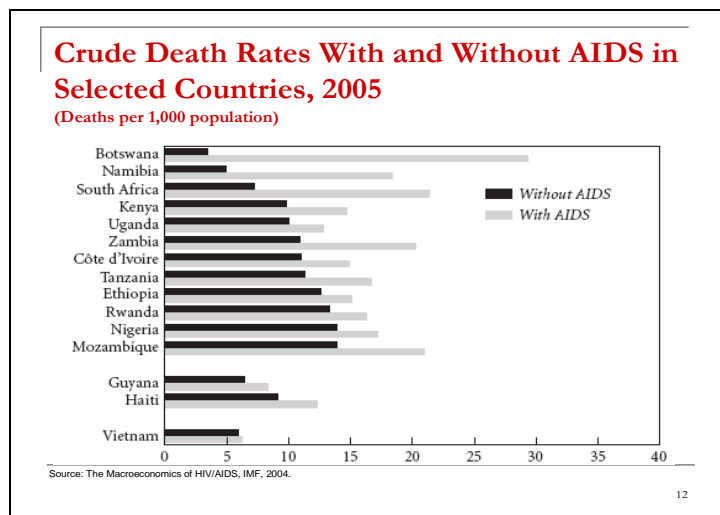


For a longtime now the global community has come to a consensus that HIV/AIDS is no longer only a health problem but a major development concern. While this is very significant we still have a lot of work to do to make sure that HIV/AIDS is actually factored in development planning. Some examples of the impact of HIV on development include: reducing life expectancy, orphaning children, striking people during their most productive years and therefore worsening poverty.

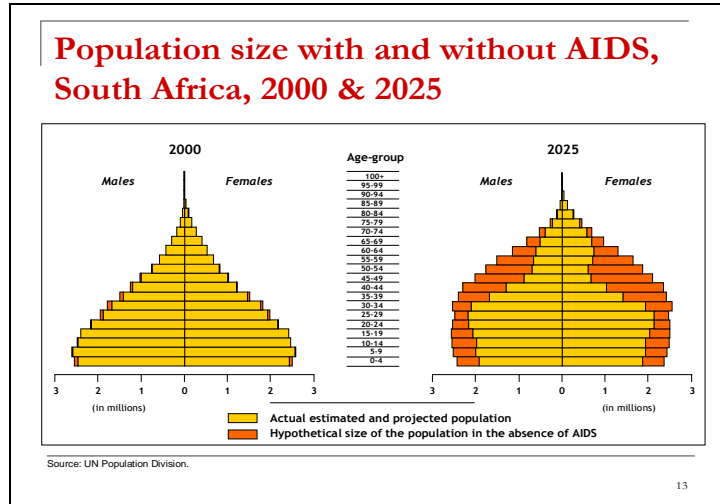
Here is a startling example of how life expectancy has dropped in three countries with high prevalence; in fact it has wiped out forty years of progress.



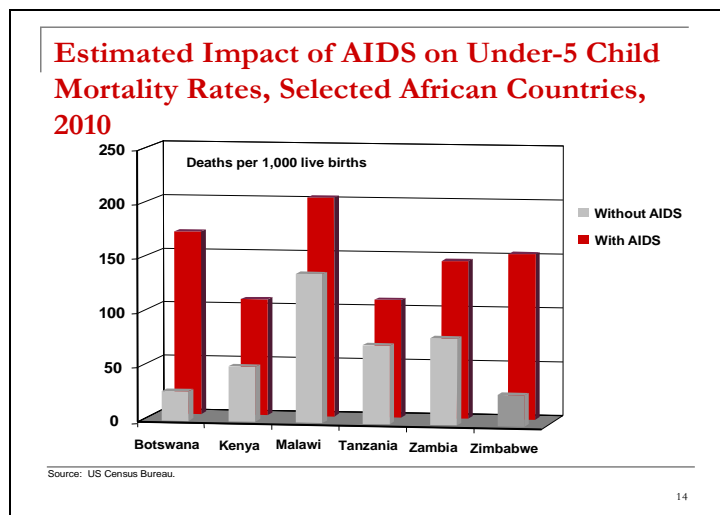
The impact of AIDS on both adult and child mortality is clear as we look at these scenarios and see where we could have been without HIV/AIDS.



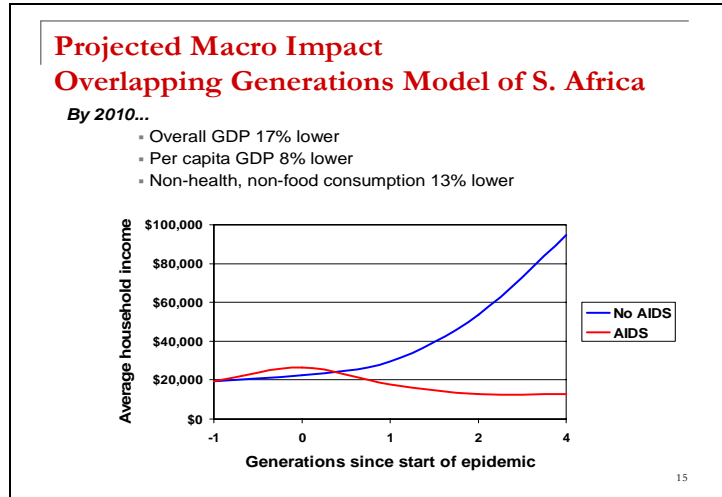
The impact of HIV/AIDS on the demography of Botswana is staggering.



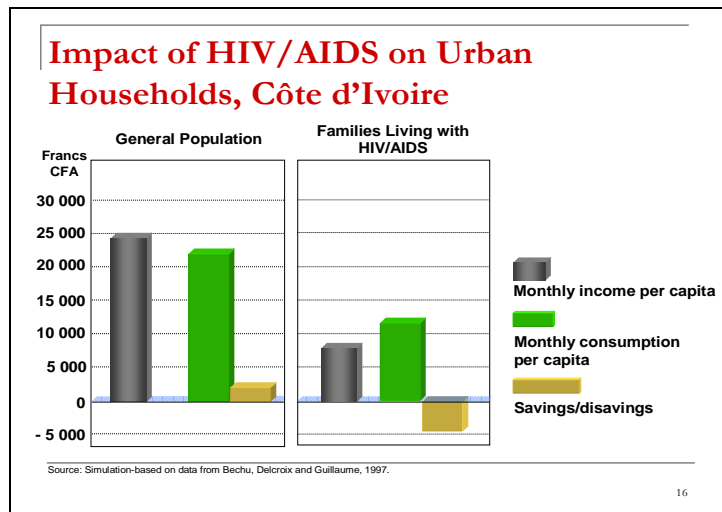
As a result of increased mortality, the number of children orphaned by AIDS has increased steadily over the past fifteen years and will reach 18.4 million by 2010.



Research from South Africa shows that the loss of human capital will have far reaching economic and social impact.

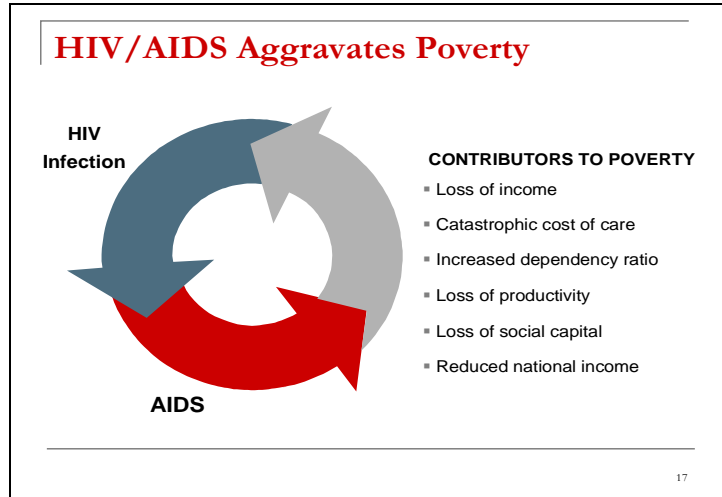


In fact, HIV/AIDS threatens entire economies as it will significantly shrink the workforce and lead to declines in economic growth and household income.



As I mentioned earlier, HIV/AIDS affects all sectors. While its impact on the health sector may be most evident, HIV can also jeopardize food security, decrease the quality and availability of education, affect the infrastructure, transport and mining sectors as workers in these sectors are away from home for long periods of time, and increase costs and absenteeism in the private sector.

HIV/AIDS and poverty are inextricably linked. AIDS exacerbates poverty and poverty can lead to risky behaviors which further increase HIV infection.



Here we see that HIV and AIDS are seriously jeopardizing the attainment of most of the MDGs in African countries due to its multisectoral impact. This is one of the reasons why HIV/AIDS is exceptional requiring an exceptional response.

AIDS and the Millennium Development Goals

Millennium Development Goal	Africa Progress	AIDS effect
Reduce poverty/hunger	<i>Stagnant at best</i>	Large
Universal primary education	<i>Lagging</i>	<i>Moderate</i>
Gender equality	<i>Lagging</i>	Large
Child & infant mortality	<i>Worsening</i>	Large
Maternal health	<i>Worsening</i>	Large
Combat AIDS & diseases	<i>Worsening</i>	Large
Environmental sustainability	<i>On track</i>	<i>Minimal</i>
Improve global partnerships	<i>On track</i>	<i>Favorable</i>

18

What has been the response to the AIDS epidemic?

Lack of Fast Action

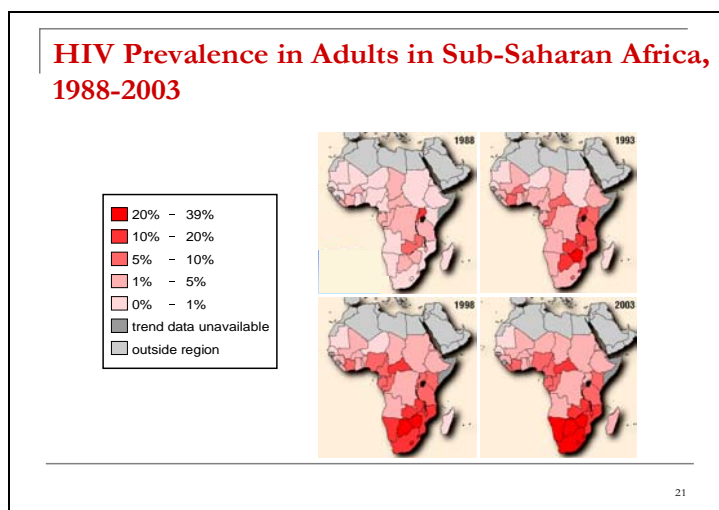
- The world started focusing on the epidemic in a sporadic half-hearted manner
- HIV/AIDS never been dealt with on a war-like footing
- Even in countries with above 20% prevalence it is still business as usual
- The fact that HIV/AIDS is an exceptional epidemic requiring an exceptional response was never realized

20

Both the countries directly affected by this epidemic and the international donor community are partially to blame for the current situation. When we take a critical look we can see that the traditional response to the epidemic leaves much room for improvement. We took a long time to respond, and when we did, the response was an emergency response without a strategy that took into account the dynamics of the epidemic; it was a one size fits all approach. This is one of the reasons why we do not see scaled-up programs after many years of saying “we know what to do”. Further we were working with governments that were not fully committed; there was a lack of coordination between donors; funding was insufficient and unfocused and to top it all off we did not have the monitoring and evaluation systems in place to see what was working and what was not.

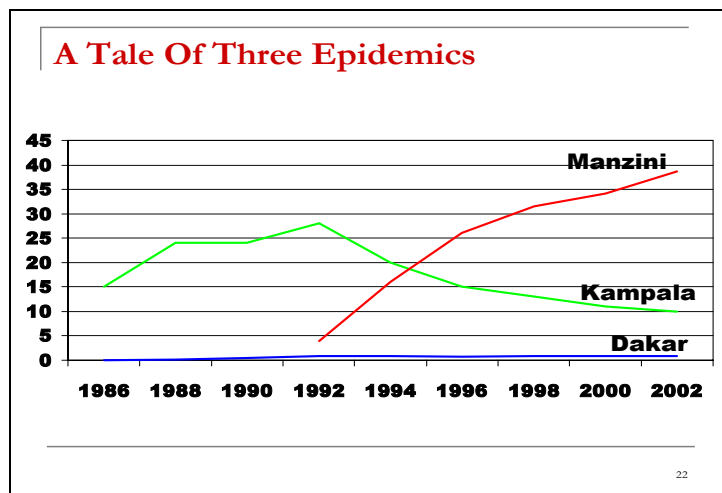
Let me go into a little more detail on each of these points.

For example, as a result of our slow start the epidemic gained an even stronger foothold as you can see in these maps showing the growth in prevalence over the years.



Early responses were too few, too small, lacked focus and were not evidence-based. To this day few programs are evaluated and results used to plan, program and implement. A one size fits all approach masked strategic focus to arrest the epidemic before it got out of hand.

Here, we can see that the epidemics in Manzini, Kampala and Dakar have progressed differently over the years and would require different mitigation approaches. While the epidemic in Senegal remained at a low level, a good proxy of the epidemic in Western and Central Africa, the epidemic in Uganda increased substantially between 1985-1992 and started declining around 1994 which is a good example of the result of concerted action. On the other hand we saw an exponential increase in the epidemic in Swaziland, a proxy of what we see in Eastern and Southern Africa today. It is worthwhile mentioning here that in addition to all the factors that are responsible for spreading the epidemic, the strain of virus circulating in this region is particularly virulent. These three countries present a good example to show that we are dealing with at least three different epidemics in Africa.



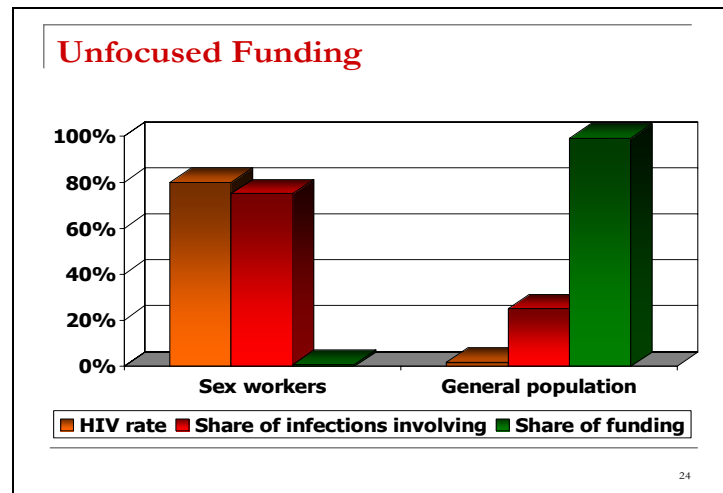
In developing our responses we need to take into account the nature of the epidemic including local transmission patterns and sources of vulnerability and ensure that our responses address them.

Distinct Approaches for Distinct Epidemics

- Distinct epidemics call for distinct approaches, which address proven local transmission patterns
- Concentrated and generalized epidemics require distinct approaches, depending on transmission patterns and sources of vulnerability
 - West Africa's epidemic concentrated
 - East Africa's mixed
 - Southern Africa's highly generalized

23

For example, in one country where prevalence among sex workers was nearly 80%, prevalence in the general population was less than 2% and where 75% of new infections were occurring among sex workers and their clients, less than 1% of the funding for HIV/AIDS was used to target sex workers. In such cases we should not be surprised if we do not see quick results as we are not putting the resources where the problems are.



Going into further detail, we need to explore and understand transmission patterns, factors that affect transmission such as variability of HIV infectiousness across disease stages, concurrent sexual partnerships and contentious issues such as male circumcision. Although there are still disagreements regarding circumcision, meta-analyses show that circumcised men are 50-70% less likely to become infected with HIV. This might be one of the reasons for the differences within the region.

**Lack of Understanding of the Epidemic
Hinders Appropriate Response and Scaling Up**

- Overestimating HIV - and underestimating its diversity
- Understanding transmission patterns
- Understanding the role of male circumcision
- Underestimating the variability of HIV infectiousness across disease stages and how concurrent sexual partnerships drive transmission
- Applying distinct approaches for distinct epidemics

25

In summary, multi and bilateral donors and the international community in general responded to this epidemic with insufficient, unfocused and short-term funding which did not focus on building sustainable capacity. The affected recipient countries response lacked commitment. While funding was required to implement programs, creating an enabling environment, putting appropriate policies in place such as sex education in schools, inheritance laws, fighting stigma and discrimination and attacking the epidemic on a war-like footing was not a priority of many of the affected countries. This deadly combination led to what we see in Africa today.

But let us look at where we are right now and what we can do to move forward. With the increased political commitment both on part of the donors and the recipient countries and an unparalleled amount of funding we have more than ever an opportunity to tackle the epidemic. Realizing that there are no quick solutions, we need to make a long-term commitment to HIV/AIDS prevention, care and treatment, we need to focus on mainstreaming and scaling up programs that have proven to be effective where they are most needed. The fact that we saw 4.9 million new infections in 2004 is a wake-up call to show that what we have been doing so far remains far short of what is needed. We have very few success stories to date. Success can only be declared when we manage to stop new infections.

Changing Landscape of HIV/AIDS

- Increased resources
- Increased political commitment
- Improved coordination
- No quick solutions - long-term commitment to HIV/AIDS prevention, care, and treatment
- Scaling up existing interventions and build capacity
- Mainstreaming programs that have proved effective
- Focusing prevention efforts in areas where spread of the epidemic continues; provide care, support, and treatment for people who have developed AIDS
- **However**, with 4.9 million new HIV infections in 2004, a lot more remains to be done

27

In the last few years we have seen major changes in the global response to HIV/AIDS.

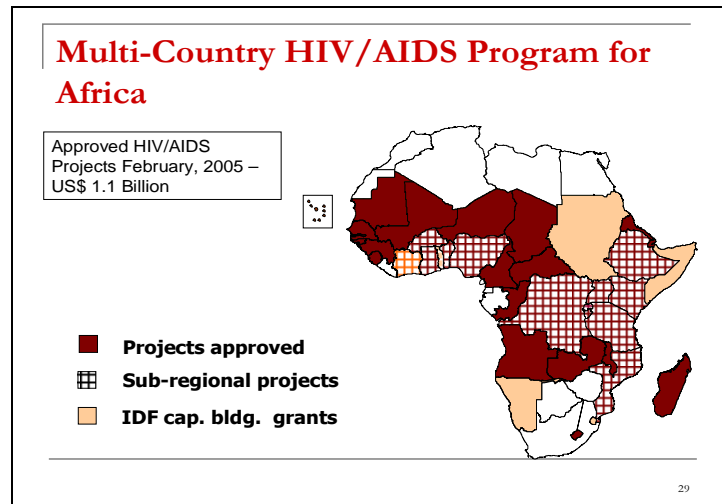
We have shifted from a narrow, health-sector approach to a multisectoral focus. Declining ARV prices have made treatment on a large scale possible. We now have more players and resources available than ever before to fight the epidemic.

Changing Landscape of HIV/AIDS

- Shift from health sector to multisectoral focus
- Declining prices for ARV drugs and increased focus on treatment
- New players and increased financial commitment
 - World Bank Multi-Country HIV/AIDS Programs, GFATM, PEPFAR, UK

28

The World Bank led the way by putting over \$1 billion to fight the epidemic in Africa. Our commitment is 15-20 years until countries build sustainable capacity to fight the epidemic. Since 2000, the World Bank has committed more than US\$ 1.1 billion in 29 countries and four sub-regional projects under the MAP in Africa. The Bank also has traditional investment projects focusing on HIV/AIDS as well as technical assistance projects, Institutional Development Funds, and new regional initiatives such as the Treatment Acceleration Project and the African Regional Capacity Building Network for HIV/AIDS Prevention, Care, and Treatment. In addition, the creation of the Global Fund and the commitment of the U.S. Governments' President's Emergency Plan for AIDS Relief have contributed to the additional resources available.



So far, the Global Fund has committed US\$ 1.74 billion to fight the HIV/AIDS epidemic globally and in its first five years it expects to have 1.6 million people on treatment, to reach 52 million people with VCT, and to support one million orphans.

- Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)**
- US\$ 1.74 billion committed over two years for HIV/AIDS
 - By 2007:
 - 1.6 million people are projected to receive antiretroviral treatment
 - 52 million persons will be reached with voluntary counseling and testing services for HIV prevention
 - More than one million orphans will be supported through medical services, education and community care
- 30

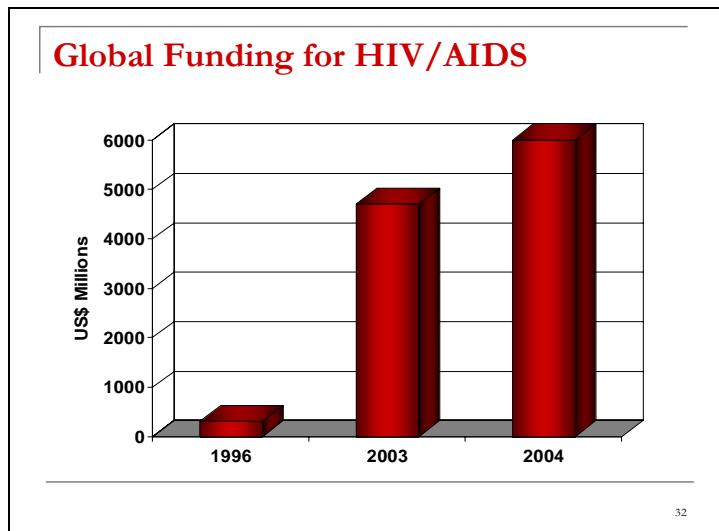
The U.S. President's Emergency Plan for AIDS Relief has pledged US\$10 billion in new resources for 15 focus countries. The goal of the program is to prevent seven million new infections, treat two million people and care for 10 million people living with HIV/AIDS and orphans.

President's Emergency Plan for AIDS Relief (PEPFAR)

- Five year plan, US\$ 10 billion new resources
- 15 focus countries in Africa, Caribbean and South-East Asia
- Prevent 7 million new infections (60% of the projected new infections in the target countries)
- Treat 2 million HIV-infected people
- Care for 10 million HIV-infected individuals and AIDS orphans

31

These are emerging developments whereas in 1996 we had only US\$300 million of global funding, in 2004 we have about US\$ six billion. While this is only half of what is needed, effective implementation of the available resources is paramount.



Despite these welcome developments, there are a number of persistent challenges that we must address.

AIDS is still considered a short-term crisis and donors are reluctant to make long-term funding commitments. Donor funding remains sporadic. For example, some donors will only fund the cost of purchasing ARVs and not the associated administrative and other costs of delivering ARV treatment. Even though increased resources are welcome, for recipient countries they can also mean complying with additional reporting requirements from multiple donors. Furthermore, the capacity and systems to utilize the funding needs to be strengthened. There is a lot of work to do in terms of coordination at country-level, evidence based programming and a huge implementation gap.

Persistent Challenges

- HIV/AIDS still perceived as a short-term crisis, lack of long term funding
- Sporadic and segmented funding
 - E.g. ARV drugs only
- Multiple claims of donors reducing efficiency and impact of programs
- Growing “implementation gap” and not managing by results (M & E)
- Lack of evidence based program planning
- Lack of coordination at country level
- Weak health systems
- Absorption capacity

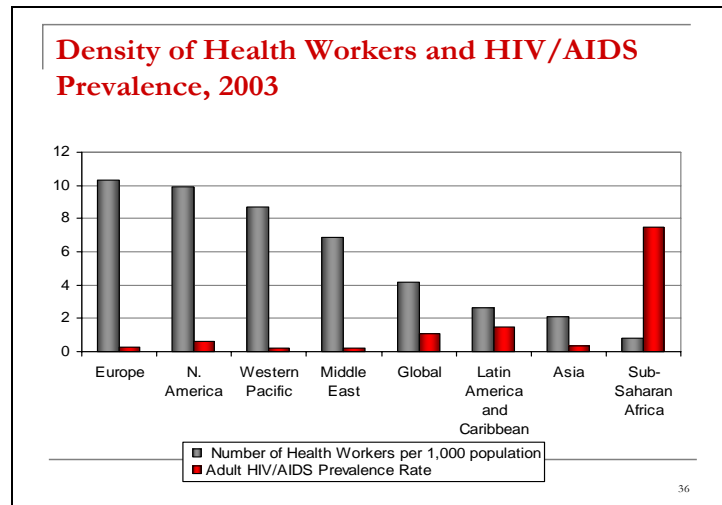
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As much as HIV/AIDS is a multisectoral issue, the health sector plays a critical role in providing care and treatment for people living with HIV/AIDS. In many of the affected countries, the health systems are weak. The problem ranges from lack of basic drugs to debilitated facilities to erosion of the health work force. Donor support in building health systems has been sporadic and insufficient

Weaknesses in Health Services

- Lack of basic drugs, supplies, equipment and personnel
- Facilities need major repair
- Health professionals are dying due to AIDS
- Migration of health workers to higher income countries
- Very limited coverage of health services
- Health services failing the poor in access, quality and affordability (WDR, 2004)
- Inadequate donor support

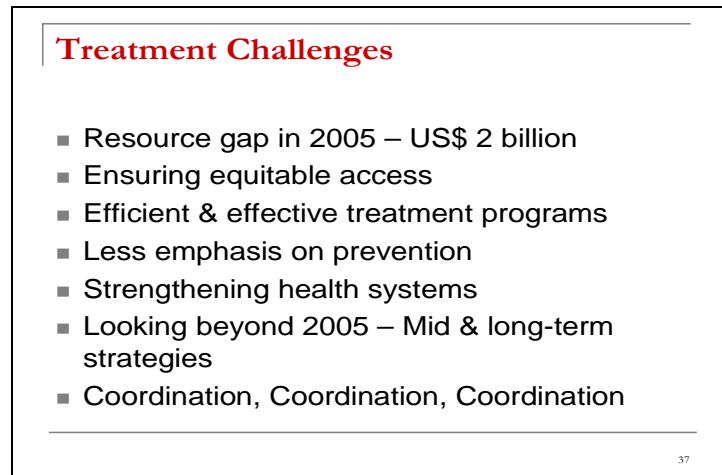
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Unfortunately, health systems especially where HIV/AIDS has hit hardest – are in need of major reform and improvement. In many countries facilities are decaying and there is a lack of drugs, supplies, equipment and personnel.

Countries and donors should work together to address historic challenges to linking HIV/AIDS, TB and sexual and reproductive health programs to benefit from the synergies between the two fields.

The availability of ARVs has changed the way we deal with this epidemic.



While the global donor community has made a commitment to put three million people on treatment by the end of 2005, there are many challenges to making this goal a reality. These include: insufficient resources, equity issues, ensuring program effectiveness, maintaining the emphasis on prevention and most importantly, coordination and long-term commitment. How we deal with treatment and the challenge of balancing it with effective prevention programs will determine how we respond to this epidemic in the next decade.

One agreed AIDS action framework that provides the basis for coordinating the work of all partners; NOT mere strategic plans; One national AIDS authority, with a broad-based multisectoral mandate; led by government but NOT about only government control; and One agreed country-level monitoring and evaluation system; NOT merely reporting, but accountability.

What are the “Three Ones?”

- One agreed AIDS action framework that provides the basis for coordinating the work of all partners; NOT mere strategic plans
- One national AIDS authority, with a broad-based multisectoral mandate; NOT about only government control
- One agreed country-level monitoring and evaluation system; NOT merely reporting, but accountability

40

The “Three Ones” Coordination and Harmonization Continuum

Partial Coordination and Harmonization

Comprehensive Coordination and Harmonization

Exchanging Information

Joint Programming and Annual Reviews

Common Implementation Units

Pooling of Funds/SWAs

41

You may ask yourselves how we implement the Three Ones. There is no valid reason why we cannot start with one M&E system today. Another step forward would be joint programming and annual reviews as in the case of Kenya; common implementation units as in Rwanda and truly coordinating our efforts would involve the pooling of funds as is the case in Malawi.

I’ve spent a lot of time discussing weaknesses and challenges and now I’d like to focus on what we can do to address them as we move forward. We need to capitalize on the unprecedented global solidarity brought about by the epidemic. Every time we let go a little, the virus gains more ground. Coordination, translating the “Three Ones” into action which will ensure effective implementation of programs, and evidence based programming should be a priority for donors and recipient countries. We need to act faster than ever. While other regions might not have Africa’s fate, arresting the epidemic or driving it

downwards in low prevalence countries both in Africa and elsewhere needs a clear strategy now before it is too late.

What we need to do now is to sustain the good things the changing landscape has brought. While the rich countries need to provide sustained support, the recipient countries need to put their house in order. Fighting stigma and discrimination does not require external funding; fighting its consequences requires millions. Coordination, implementing the Three Ones, evidence based programming should be a priority.

We need to translate the three ones into action. Start harmonization now by having one M&E system and move to pooling funds. Let us provide long-term political commitment and sustainable funding. Let us use the opportunity HIV provides to build long forgotten health systems. Let our programs be evidence based, tailor-made and not one size fits all. Most of all let us internalize the fact that HIV/AIDS is a long term problem requiring the World's long term commitment.

To conclude, I cannot stress enough the importance of implementing the Three Ones, addressing HIV/AIDS as a long-term development problem, and using evidence-based approaches to drive effective programs. In the last two decades, the world has learned the bitter lesson of not responding adequately to an unprecedented epidemic. The simple truth is inaction is expensive. We all need to believe that the world cannot be a good place to live when whole generations are being wiped out right in front of our eyes. We need to act now – not only for them, but also for us.

Conclusion

- Implementing the “Three Ones”
- Internalizing that HIV/AIDS is a long term development problem and the world :
 - Needs to come up with ensured and sustained funding
 - Recipient countries need to treat this epidemic seriously, put their own resources into it and create the policy environment to fight the epidemic
 - Factor the impact of HIV/AIDS when planning development programs
- Understanding the different epidemics and using evidence to drive programs

42

Africa's future is not pre-ordained...it depends on how we respond to the HIV/AIDS epidemic today



43

Let us make sure to do everything we can to treat and care for the millions infected and affected. Most of all let us provide our children with a world free of AIDS.