AIDS Prevention and Mitigation in Sub-Saharan Africa
An Updated World Bank Strategy

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Human Resources and Poverty Division
Technical Department
Africa Region
AIDS Prevention and Mitigation in Africa: An Updated World Bank Strategy was written by Wendy Roseberry. Portions of this report draw from World Bank materials prepared by Martha Ainsworth, Jill Armstrong, Ed Bos, Rodolfo Bulatao, Siddarth Dube, A. Edward Elmendorf, Andran Gupta, Mubina Kirmani, Jean Louis Lamboray, Jeannette Murphy, and Mead Over. Insights to understanding the epidemic’s determinants and consequences are summarized from the works of many, most notably: Maxine Ankrah, Stefano Bertozzi, John and Pat Caldwell, Michel Caraël, J. Cleland, Steve Moses, Karen Oppenheim Mason, Peter Piot, Frank Plummer, Elizabeth Reid, John Stover. Much of the epidemiological data was obtained from the Global Program on AIDS, World Health Organization and the Center for International Research, U.S. Bureau of Census. The paper was processed by Donna McGreevy, Chris Blanchard and Heather Imboden, edited by Paul Holtz, and written under the direction of Ishrat Z. Husain, Chief, and A. Edward Elmendorf, Principal Management Specialist of the Human Resources and Poverty Division of the Africa Technical Department.
**ACRONYMS**

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<th>Acronym</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>CARE</td>
<td>Cooperative for Assistance and Relief Everywhere, U.S.</td>
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<td>FAO</td>
<td>Food and Agriculture Organization</td>
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<td>GPA</td>
<td>Global Programme on AIDS</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>ICAPP</td>
<td>Intensified County Action Planning Process</td>
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<td>NGOs</td>
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<td>NIARSH</td>
<td>Network for Improved Adolescent Reproductive and Sexual Health</td>
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<td>OAU</td>
<td>Organization of African Unity</td>
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<td>PHN</td>
<td>Population, Health &amp; Nutrition</td>
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<td>STDs</td>
<td>Sexually Transmitted Diseases</td>
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<td>TASO</td>
<td>The AIDS Support Organization, Uganda NGO</td>
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<td>Joint United Nations Program on HIV/AIDS</td>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organization</td>
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<td>UNFPA</td>
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<td>WAMATA</td>
<td>Tanzania NGO to Assist People with AIDS</td>
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Executive Summary: Confronting AIDS in Africa

AIDS is taking a calamitous toll in human suffering, in reduced life expectancy and productivity, in disruption of social systems, and in increased poverty in Africa. AIDS is now believed to be the leading cause of adult death between the ages of fifteen and thirty-nine in Malawi, Tanzania, Uganda, Zambia, and Zimbabwe. Just as striking have been the escalating deaths from AIDS of children under the age of five in these same countries. Thus many Africans are witnessing the reversal of gains made over the past two decades in adult and child survival.

Yet the full consequences of the epidemic are still to be felt.

- Three-quarters of the estimated 8.5 million adults in Africa infected with HIV have not yet developed AIDS (World Health Organization 1995). Between 1995 and 2005 these 6.3 million HIV-infected people will succumb to illness, tripling the region's caseload of AIDS patients. This figure is the minimum, since more Africans are sure to become infected. With few exceptions, HIV infection continues to spread at alarming speed, particularly in Southern Africa.

- Fraying health and welfare services in many countries will be overwhelmed—costs of caring for AIDS patients could consume Kenya's entire recurrent health budget by 2000 (Family Health International 1993). The burden of caring for the nine million Sub-Saharan children orphaned by the disease by 2000 will strain Africa’s extended family network.

- AIDS is thought to have lowered life expectancy in Uganda by eight years, and worst-case scenarios suggest a fall of eighteen years by 2005 (Armstrong 1995).

- AIDS is projected to slow per capita income growth, through its effects on savings and productivity, by an average of 0.3 percentage point a year between now and 2025 in the ten Sub-Saharan countries with the most advanced epidemics (Over 1992). This is a potentially significant setback in countries that have experienced slow or even negative growth in per capita income over the past decade.

Despite the adverse effects caused by the epidemic, the response from governments, nongovernmental organizations (NGOs), and others is commendable, and examples of human valor and strength among African HIV-infected communities are numerous.

PREVENTING INFECTION AND MITIGATING THE CONSEQUENCES

Because sexual transmission is the predominant mode of HIV transmission, preventing the epidemic's further spread requires fundamental changes in individual and communities' sexual attitudes and practices.

The means by which to affect change are: education on safe behaviors, promotion of condoms and improved treatment of the other sexually transmitted diseases (STDs). Of lesser
importance in slowing the transmission but still a necessity, is ensuring blood used in
transfusions is safe from HIV contamination.

Across the continent, many, but not enough health care providers, educators, and
community leaders promote safer sexual behavior through person-to-person education and mass
communication channels. Messages range from sexual abstinence to use of condoms. They are
delivered to the general population as well as targeted to special groups: adolescents and youth
(who make up the greatest number of new HIV infections), sex workers, military personnel, and
truck drivers. All national programs provide condoms free of charge and condom social
marketing programs in more than twenty countries sell condoms at affordable prices. These
prevention activities also lower the rates of other STDs, since STDs are a consequence of the
same sexual behaviors as HIV infection. Training of public and private health care providers in
improved diagnosis and treatment of the other STDs is beginning to be included in primary
health care services in urban areas throughout Africa.

Among the many lessons learned in implementing these interventions, one is paramount:
the messages and activities must be gender sensitive. Most African women infected with HIV
have been infected by their husbands. The choices and actions they need to take to protect
themselves from infection are different than those for most men. Understanding better the
factors that influence sexual behavior in men and women is an ongoing challenge for both AIDS
prevention and family planning programs.

Nevertheless, research and pilot efforts promoting these cost-effective interventions—education, condom promotion, and STD care—against HIV across the continent show risky behavior has changed and rates of HIV infection and STDs have been significantly lowered in several groups and communities. The prevention interventions do work. For example, AIDS awareness among the African population is now high, many communities and families are talking about sexual roles and responsibilities, sex education in schools is leading to delayed and safer sexual behavior among adolescents, treatment of STDs has improved, condom sales have skyrocketed, and persons living with AIDS are involved in prevention and care activities. Pilot projects in Nigeria, Rwanda, Tanzania, Uganda, Zaire, and Zimbabwe have lowered HIV infection and STD incidence among special population groups. Recently published data from two intervention projects in Uganda and Tanzania involving larger communities have shown encouraging results in increasing preventive behaviors (Uganda) and decreasing levels of HIV infection (Tanzania). Such efforts must now be expanded and the capacity to do so strengthened, for recent data suggest that the spread of the epidemic has yet to be significantly slowed.

Attempts to mitigate the adverse affects of AIDS are challenging the health sector to
provide quality care for the rapidly growing number of persons with AIDS. With health facilities
already overburdened, particularly hospitals, the aim is to give as much quality care to the extent
possible to AIDS patients in the home. Twenty-seven African countries have at least one
community-based AIDS home care program, many of them managed by NGOs. In fact, NGOs
have become instrumental in serving communities in AIDS-related activities. A formidable task
for many community-based programs is to meet the many physical and psychosocial needs of AIDS patients for drugs, supplies, and counseling.

Both prevention and mitigation strategies can be found in several sectors beyond the health sector. Ministries of education, defense, youth and women’s affairs, and information are working closely with national AIDS control programs to integrate AIDS prevention and care activities with their program plans. Many—but not enough—innovative workplace programs among private industries reflect a strong commitment to educating employees on prevention and ensuring adequate care for those infected. Sectors and industries severely hit by the epidemic are attempting to secure adequate levels of financial resources to accord prevention efforts first priority while still meeting the costly needs of those already infected.

About $100 million was spent in 1992 in Africa on prevention programs for AIDS and other STDs; 10 percent of this total came from African governments. A World Health Organization (WHO) study suggests that comprehensive prevention services would cost from $225 million to $435 million a year. Such spending would be two-and-a-half times 1992 spending, but it would yield enormous benefits, averting as many as 4.2 million new infections by 2000.

About $183 million was spent on care for AIDS patients in 1992 by African countries. Although this is a small share of the $4.7 billion spent by industrial countries to care for their AIDS patients, it still exceeds what is spent on prevention in Africa. The cost-benefit relationship between prevention and ‘cure’ rings true for AIDS—it costs more to not prevent AIDS. By 2000 spending for care in Africa will nearly double, rising to $347 million a year.

THE BANK’S ROLE

In response to the ever-changing nature of the epidemic, this update is the second review of the World Bank’s 1988 AIDS Strategy for Africa. The first review, in 1992, found that the six strategy actions from 1988 concerning economic and sector work, lending, and capacity-building had been initiated with progress. But the 1992 review identified four new areas requiring attention:

- Concentrating on countries vulnerable to HIV because of their high prevalence rates of other STDs;
- Promoting a core AIDS control strategy that recognizes AIDS as an STD and accentuates the prevention of the other STDs;
- Reinforcing the key elements of the health infrastructure;
- Developing multisectoral policies for coping with the economic and social impacts of AIDS.
The first three of the four new areas have been addressed as the 1992 review intended. For example, ten of the twelve countries with high rates of STDs identified by the 1992 review have executed Bank-assisted projects with AIDS-related components. A core AIDS control strategy consisting of the main interventions for prevention (including STD care) and mitigation now exists in most African countries—and in all thirty-six Bank-assisted AIDS control projects. Twenty-five of the thirty-six Bank-assisted projects with AIDS-related components are strengthening key elements (such as pharmaceutical delivery and laboratory support) of the health infrastructure. Three projects have combined AIDS and population activities.

Attention to the fourth area—developing multisectoral policies—while noteworthy, has not progressed beyond description and projection of the socioeconomic impacts of AIDS to actual development of multisectoral policies and interventions. For example, two innovative and comprehensive studies to assess the impact of AIDS on development have been sponsored by the Bank in Tanzania and Uganda. It is not evident, however, whether policies and interventions to mitigate the adverse socioeconomic effects of AIDS have been developed as a result of these studies’ findings. A third study, a nearly complete Bank-sponsored survey of adult mortality in Tanzania will provide a closer look at the effects of AIDS at the household and community levels—and more specific recommendations on policy. Although eight more studies similar to those performed in Tanzania and Uganda are planned (in Botswana, Burundi, Central African Republic, Chad, Congo, Côte d’Ivoire, Madagascar, and Zambia), for a variety of reasons initiation has been slow.

Overall, the implementation of the Bank’s AIDS strategy since the 1992 review can be categorized into three domains: economic and sector analysis (including the socioeconomic impact studies discussed above), policy dialogue and regional programs, and lending operations. Each of the Country Departments and the Technical Department has developed an AIDS workplan that sets forth AIDS prevention and mitigation activities under these domains.

*Economic and Sector work* specific to AIDS has focused on learning more about the prevalence of STDs and, as mentioned above, about the impact of AIDS on development. In all, ten studies have been performed and twelve more are ongoing or planned.

A review of recent poverty assessments, policy framework papers, public expenditure reviews, country economic memoranda and country assistance strategies found that, although AIDS was frequently mentioned in these Bank documents, more consideration must be given to the epidemic’s socioeconomic implications, how these implications will affect development goals, and what actions are required in the Bank’s assistance strategy.

Working closely with national and international organizations, the World Bank has increased the *policy dialogue on AIDS* by putting the subject on development agendas in a variety of African forums, from the annual meetings of the African Development Bank to a seminar on AIDS and the military. A high-level Organization of African Unity (OAU) delegation with Bank participation visited leaders of four African countries in August 1995 to discuss ways of expediting the response to AIDS.
The Bank has also designed regional programs on AIDS and population to increase awareness, build commitment, and facilitate action. All three initiatives focus on demand-driven community services and on promoting healthy sexual behavior—goals shared by population programs.

By 1995 Bank lending operations included thirty-six human resource development projects with cost-effective AIDS prevention and mitigation components in twenty-four African countries. And Burkina Faso, Chad, Kenya, Uganda, and Zimbabwe had initiated freestanding AIDS projects. Three additional projects focusing mainly on AIDS in Congo, Niger, and Tanzania are expected to be effective by the end of 1996. Total financing for AIDS-related lending exceeds $250 million.

The freestanding AIDS projects in Burkina Faso, Chad, Kenya, Uganda, and Zimbabwe have several strengths. They support all the basic interventions, including AIDS and STD education, STD care, condom promotion, blood supply protection, and mitigation of AIDS consequences. In addition, they provide the resources necessary to expand successful pilot projects to scale, and create grant mechanisms to support community-based implementation of interventions that are more gender sensitive in their approach. They design and incorporate national evaluation strategies to measure the impact of interventions. Finally, they strengthen the skills of public and private personnel in program management. In brief, the governments of these countries ensure their AIDS control programs are comprehensive—all interventions are implemented simultaneously (depth) and all target groups are reached (breadth)—by including these elements in one large project.

Few other national AIDS control programs in Africa contain these comprehensive elements. Because of high HIV and STD prevalence rates a number of countries—including Burundi, Cameroon, Central African Republic, Côte d'Ivoire, Ethiopia, Malawi, Namibia, Nigeria, Rwanda and Togo—are in great need of such comprehensive programs, whether Bank-assisted or not, and whether supported by AIDS-specific or integrated health projects.

Implementation of the Bank-assisted projects has shown some progress, although frequent delays common to most projects have been experienced. Clinical management for the curable STDs has greatly improved in Lesotho and in Zimbabwe, where the availability of STD drugs among facilities has increased by 21 percent. National data on impact among the more recently designed AIDS projects will not be available for five to seven years. Eighteen additional projects are planned for fiscal 1996 and 1997, a reflection of government commitment to cost-effective interventions against AIDS and other STDs.

**ADDITIONAL BANK STRATEGY ACTIONS 1996-2000**

Africa’s AIDS epidemic demands a collective, urgent response. A number of interventions have been identified as being highly effective, and many national and international partners have adopted these interventions—making up the Global AIDS Strategy—to save lives. The challenge now is to intensify the implementation of these interventions to significantly slow
the epidemic’s rapid spread. The new Joint United Nations Programme on AIDS (UNAIDS) is envisioned to help meet the challenge, through improved coordination of UN assistance.

Much of the Bank’s work in assisting African countries to prevent HIV infection and mitigate the adverse effects of AIDS should continue. In addition, the Bank by updating its Country and Technical Department workplans on AIDS for the period 1996-2000 should undertake five new actions.

The Bank should continue to support the cost-effective interventions—education, condom promotion, STD care, and safe blood—for prevention. Prevention efforts will have more impact on slowing the epidemic if they are backed with strong leadership, if knowledge on the determinants of behavioral change in Africa is increased and interventions are intensified. Thus the Bank will assist Africans to:

- generate greater political commitment to the OAU declarations on AIDS
- work more vigorously to change health behaviors
- intensify national programs according to a typology of countries based on severity of prevalence levels

Although AIDS is often referenced in Bank economic and sector documents, the adverse consequences of AIDS on development objectives such as decreased life expectancy and productivity is rarely factored in the analyses used to develop a severely affected country’s assistance strategy. In addition, the 1992 review found that few policies and cost-effective interventions exist in mitigating the socio-economic effects of AIDS. Thus, the Bank should address these gaps by helping governments and NGO’s:

- increase the analysis of AIDS and its impact on development goals in economic and sector work,
- improve the design and implementation of cost-effective approaches to mitigate the consequences of AIDS

**Generate greater commitment to the OAU declarations**

Attaining the required intensity of interventions to slow the epidemic’s spread is a formidable goal for Africa—but one that must be achieved. African leaders have pledged to meet this goal, having made commitments to secure the resources needed to fight the epidemic in the 1992 and 1994 OAU declarations on AIDS. First, the Bank should help the OAU monitor country progress in implementing the activities contained in the two declarations through the development of a reporting system (see Annex). Second, the success of the OAU delegation tour of four countries in August 1995 suggests that the Bank should assist the OAU in undertaking
undertaking tours of additional African countries to meet with Heads of State and accentuate their support in carrying out the OAU activities.

**Work vigorously to change behavior**

The Bank should also support Africans in the strengthening of programs leading to the adoption of safe sexual behaviors and practices. Three separate tasks would strengthen capacity in this field. First, a group called *African Advisers on Behavioral Change* would bring together spokespersons from various backgrounds to advise other Africans, international partners and the Bank on the many facets of adopting healthy behaviors. Second, a comprehensive review would be made of the progress to date and challenges ahead in adopting safe behaviors in Africa, with particular focus on lessons learned and shared sub-regionally. This study would be overseen by the African Advisers on Behavioral Change. Finally, African public and private institutions and community-based organizations currently involved in behavioral interventions would be strengthened. These organizations would serve as centers of expertise for building the capacity of professionals and community leaders in improving health practices.

**Intensify national programs in additional AIDS-affected countries selected from a typology of countries based on severity of prevalence levels.**

Of the forty-seven African countries, thirteen have HIV prevalence rates among adults greater than 5 percent, and another sixteen have adult prevalence rates greater than 1 percent. Intensified national AIDS control programs exist or are planned in twelve of these twenty-nine countries. Of the seventeen countries remaining, the Bank should first help about half—most likely—Burundi, Cameroon, the Central African Republic, Ethiopia, Malawi, Nigeria, Rwanda, and Togo—and the other half at a later date to secure the resources needed to have a substantial impact on the epidemic’s spread. Within its new role as a cosponsor of the UNAIDS, and in collaboration with the Global Coalition for Africa, the Bank should initiate discussions in these countries to ascertain what is required to intensify program interventions and how resources can be mobilized and coordinated. If required, the Bank would provide additional resources to help these governments mount intensified national AIDS control programs, as donor of last resort.

**Increase the analysis of AIDS and its impact on development goals in economic and sector work**

The Country Departments serving the most severely affected countries should ensure that AIDS is addressed in relevant country analytical work both in and outside the PHN sector. Specifically, AIDS impact on adult and child morbidity, mortality and life expectancy, labor, productivity and savings should be assessed for several sectors, particularly PHN, education, agriculture, industry and transport. The findings of these assessments should be incorporated into the country assistance strategies. Thus, the country assistance strategy, country economic memorandum, policy framework paper, poverty assessment and public expenditure review
should not only mention AIDS, as they often do now, but also factor the consequences of AIDS in their analyses and recommendations for improved development strategies.

**Improve the design and implementation of cost-effective approaches to mitigate the consequences of AIDS**

Because it is not yet clear which approaches best deliver community-based care or which policies best ease the adverse socioeconomic consequences of AIDS, the Bank should support African decisionmakers in designing and implementing mitigation policies. Increasing the cost-effectiveness of health care for AIDS patients is an obvious priority. Other priorities include the need to decrease the economic hardships confronting AIDS-affected households and communities, improve care and schooling of orphans and replace the skilled workers in industry and government lost to AIDS.

The Bank should identify best practices and summarize lessons learned, define directions for future Bank and country policy, and design and implement interventions to help families, communities and sectors mitigate the adverse consequences of the epidemic. These policies and interventions will need to answer such questions as: How can quality care of AIDS patients be provided in facilities and homes at minimal cost to both the health system, other health system beneficiaries and home care givers? What components of AIDS patient care are the most likely to be sustained? What assistance is most needed by impoverished families and communities affected by AIDS and what criteria should be used to assess the most needy? What measures can families, industry and other sectors severely-affected by AIDS take to replace lost labor and productivity?

**The Bank’s Comparative Advantage and Risks Involved**

What are the Bank’s comparative advantages to carrying out these new actions? The Bank’s access to decision makers in government ministries such as finance and plan in addition to the ministry of health, gives the Bank the advantage in generating increased political commitment. Although traditionally, the Bank has not been seen as a lead player in supporting programs that strive to influence behavior change, this role is undoubtedly changing and becoming more visible as the Bank increases its involvement in human resource development, particularly in population, health and nutrition. The Bank’s mobilization of funds for several regional programs (NIARSH and the West Africa Regional Program), the increase in demand for Bank support for AIDS activities and the Bank’s new partnership with the UNAIDS program illustrate that the Bank has been and continues to be in a position to assist African governments secure the resources necessary to launch intensified AIDS-related activities.

Few other agencies involved in AIDS work have the clear economic mandate in development as does the Bank. Of the six UNAIDS cosponsors, it is the Bank that is looked to, to provide the leadership in economic analyses of AIDS interventions and impact. As the UNAIDS Strategic Plan becomes operational, the request for Bank contribution to ‘the economic side’ of AIDS will increase.
The overwhelming risk to 'taking on AIDS' has been that of having only to rely on behavior change for success as opposed to a cure or vaccine. This risk remains. If the success of the collective response to AIDS is still most dependent on widespread adoption of safe behaviors, the risk in failing will have to be reduced by 'taking on' the subject of behavior. Few, but enough examples of successful behavior change exist in Africa and worldwide, as a knowledge base from which to expand. Thus, for the Bank to assist Africans in this endeavor, the Bank should strengthen its own understanding of what factors influence the adoption of safe behaviors and what improvements in project design, implementation and evaluation are required to attain healthy practices in Africa.

Figure 1 summarizes these new actions of the AIDS Strategy for Africa and those of previous reviews.

![Figure 1: Actions under the Bank's AIDS strategy for Africa](image)

As indicated above, the evolving nature of the epidemic requires frequent assessment of the epidemiological situation and concurrent revision of the AIDS Strategy. This the Bank should continue to do, particularly as the response to the epidemic is fine-tuned. The effectiveness of the interventions to prevent HIV evidenced in small population groups thus far and the impressive response mobilized across the continent, suggest to the Bank that taking on AIDS in Africa is an achievable goal.
1. AIDS In Africa—The Rapid Spread Continues

During the past decade more than 11 million adults and 1 million children—roughly two-thirds of the estimated global total—have been infected with the human immunodeficiency virus in Africa. Every day 1,800 more Africans are infected. Projections suggest that within five years the cumulative number of infected people in Africa will increase by a third, reaching 15 million (WHO 1995). Rapid increases in infection are occurring among adolescents and young adults, particularly females.

The majority of HIV infections are in East and Central Africa, with the epidemic spreading to contiguous areas in Southern Africa, principally Botswana, South Africa, Swaziland, Zambia, and Zimbabwe (map 1.1, next page). The government of South Africa estimates that more than 500 black South Africans are infected with HIV each day. In Swaziland national AIDS control program managers expected the 1993 HIV infection prevalence rate among pregnant women to be twice the 1992 level of 3.9 percent, but instead the rate quintupled, to 21.9 percent (AIDS Analysis Africa 1994b).

Rates of infection are also rising in limited areas of West Africa—Burkina Faso, Côte d'Ivoire, Guinea-Bissau, Niger, and Nigeria. The slow but steady increase in infection rates in Nigeria (from about 1.4 percent among pregnant women attending antenatal facilities in 1991 to 3.8 percent in 1994) is a cause of concern because of that country's large population and considerable internal and external migration (Federal Ministry of Health and Social Services 1995).

HIV PREVALENCE AND DISTRIBUTION

Throughout the continent, HIV has spread along the major migration routes. Several studies have shown that a change of residence is strongly associated with an increased risk of HIV infection. Thus, the extensive labor migration in Central and Southern Africa, the long-distance commercial transportation lines operating in both East and West Africa, and the mobilization and entrenchment of military forces are clearly tied to the spread and acceleration of the epidemic.

Political and social instability gives rise to migration and thus to increased HIV transmission among both soldier and civilian populations. Some observers believe that HIV and AIDS were an important cause of the widespread despair and unrest in Rwanda before the recent upheavals. HIV prevalence among Rwandan soldiers was estimated to be as high as 65 percent in 1994 (AIDS Analysis Africa 1994b). Interviews with the military found fear, anxiety, and uncertainty in the ranks because AIDS was seen as "more dangerous than bombs," since it was invisible. The subsequent months of displacement and living in enclosed camps for the millions of Rwandan refugees will undoubtedly fuel the epidemic. Cooperative for Assistance and Relief Everywhere (CARE) estimates that 33 percent of sexually active adults in refugee camps in Tanzania are HIV positive.

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1 The terms Africa and Sub-Saharan Africa will be used synonymously in this paper.
Map 1.1 High HIV infection rates are concentrated in East and Central Africa and along major migration Routes.

Population density and disease go together. Recent studies in urban areas in Côte d'Ivoire, Malawi, Zambia and Zimbabwe show a consistent and swift increase in HIV infection levels (figure 1.2). In Harare, Zimbabwe, for example, more than 38 percent of pregnant women attending antenatal clinics (a group considered most representative of the general adult population) are estimated to be infected.

Figure 1.2 HIV infection rates have increased considerably among pregnant women in urban areas

(HIV infection, percent)

![Graph showing HIV infection rates in urban areas of different cities across Africa.]


On average, HIV prevalence in urban areas is five times that in rural areas. The proportion of women to men in urban areas appears to influence HIV transmission. An analysis of 1987 HIV seroprevalence rates and female-male ratios found that higher HIV prevalence is associated with urban areas in which there are fewer young adult women than men (Over and Piot 1993).

The overwhelming proportion of HIV infections in Africa occur through sexual activity. Hence, HIV is classified as an STD, along with gonorrhea, chlamydia, syphilis, chancroid, trichomonas, and herpes. While it is not clear how extensive the spread of HIV infection may be throughout the population, herpes prevalence rates as high as 50 percent of adult populations in urban areas have been reported in Africa (Nahmias and others 1990). Thus HIV infection rates could potentially reach such levels.

The HIV epidemic is also worsening the region’s tuberculosis problem, with large numbers of people infected by dormant tuberculosis likely to develop active tuberculosis once HIV weakens their immune response. The annual number of deaths from tuberculosis in Africa is projected to double from 1995 to 2000.
RISK FACTORS

Rates of HIV and other STDs are highest among individuals who have unprotected sex (intercourse without a condom) with many partners: sex workers, clients of sex workers, truck drivers, migrants, and the military and police. HIV prevalence rates are approaching 100 percent among sex workers in Nairobi and Abidjan (U.S. Bureau of Census 1994). A 1992 study among truck drivers from eight countries who drive the Mombasa-Nairobi highway found an HIV prevalence rate of 27 percent (Bwayo and others 1992). Among truck drivers in Ouagadougou, Burkina Faso, the HIV prevalence rate in 1993 was 13 percent. The rates among military personnel are believed to be higher than 50 percent in some countries.

Two principal factors facilitate the sexual transmission of HIV in Africa: the viral subtype and having other STDs. Two other important biological factors may influence HIV transmission as well. First, the immature genital tracts of adolescent women make them very susceptible to infection. This susceptibility would help explain the high rates of HIV infection among young women. Second, men who are not circumcised appear to have greater risk of HIV (figure 1.3 - next page).

The risks of acquiring HIV can be reduced significantly by the use of condoms during sexual intercourse. But condom use remains low in Africa because of inadequate supply, high cost, poor demand, and psycho-social barriers to use.

Data from several studies suggest that age, sex, education, and marital status are influential demographic predictors of sexual behavior—and of the risks of contracting HIV and other STDs. Individuals younger than twenty-four years old account for more than half of new HIV infections, according to a recent WHO review of countries with high seroprevalence levels. Most of these infections are among young women. In Africa men consistently report higher numbers of sexual partners than women (figure 1.4). Most women report having only one sexual partner, which suggests that infected married women have been infected as a consequence of their husband's high-risk behavior.

Figure 1.4 Men are much more likely than women to have casual or commercial sex

Note: Data compiled from surveys conducted during the late 1980s.
Source: Canfell and others 1993.
Figure 1.3 Uncircumcised men may be more susceptible to infection

The boundaries, colors, denominations and any other information shown on this map do not imply, on the part of The World Bank Group, any judgment on the legal status of any territory, or any endorsement or acceptance of such boundaries.
Like other STDs, HIV infection is gender sensitive in acquisition and consequences. HIV-infected females outnumber infected males six to five, and, as mentioned previously, the ratio increases significantly among younger age groups, where young women are much more likely to be infected than young men (WHO 1995). This difference is thought to be not only a result of greater female biological susceptibility, but also of asymptomatic infections with other STDs, lack of female-controlled preventive methods (for example, a female condom), and unequal power relations that limit women’s ability to influence the conditions under which sexual intercourse occurs.

Several pathways have been proposed to show how gender inequality in Sub-Saharan countries translates into increased female vulnerability to acquiring HIV. One hypothesis focuses on sexual inequality, positing that the inferior status of women induces young women to form relationships with older men and to accept money and favors in exchange for sex, placing them at risk of HIV infection. In addition, the subordinate sexual status of women makes it difficult for them to question a male partner’s sexual activities or non-use of safe sex methods. Economic and political inequality between the sexes is thought to encourage commercial sex. In environments where women’s ability to be financially independent is constrained by laws or customs that restrict their ownership of or access to land and other productive assets, or to education and employment, women may be forced to turn to commercial sex. The paucity of health facilities that promote comprehensive reproductive health care for women, the poor health-seeking behavior of women, low self-esteem, and limited freedom of movement in some societies are also thought to inhibit diagnosis and treatment of STDs among women.

Several traditional practices increase the risk of HIV transmission for both genders and can fuel the epidemic in a community. These include:

- Ritual cleansing and inheritance of a widow by the late husband’s brother;

- Heirship for chieftaincy, where each household in the community supports the sexual union of a female member with the chief, to ensure that each family has the opportunity to produce an heir to the chief; and

- Use of unsterile equipment during male circumcision and female genital mutilation.

Widespread cultural reluctance to discuss sexual issues—particularly information on healthy practices—with children and adolescents also increases the risks of acquiring HIV. Early family planning program studies in Africa found that, as in many parts of the world, sexual behavior and experience, and opinions on sexually related matters are rarely, if ever, discussed. This reluctance exists among peer groups, between spouses, and especially between generations. The breakdown of traditional norms and values resulting from urbanization and modernization

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2 The spouse of a deceased person has sexual intercourse with a family member of the deceased to be “cleansed” and to free the dead person’s spirit.

3 Female genital mutilation also may increase susceptibility to infection during sexual relations because of tearing and bleeding; in contrast, some data suggest that male circumcision serves several hygienic functions.
(isolation from extended family, commercialization, improved modes of transportation) are also thought to contribute to increased rates of HIV and other STDs. Such changes have lessened the role of community elders in instilling moral and cultural values, especially where extended families are separated.

Socioeconomically, HIV/AIDS is a disease of both poverty and affluence. Studies among population groups in Ethiopia, Kenya, Nigeria, Tanzania, and Zimbabwe find an association between high rates of HIV infection and low income, unemployment, or low levels of education. But other studies in Malawi, Rwanda, Tanzania, Zaire, and Zambia find that high educational attainment and socioeconomic status are associated with higher rates of infection.

In the end, it is sexual behavior—the numbers of partners with whom an individual has unprotected sex and, correspondingly, the number of partners with whom his or her partner(s) has unprotected sex—that determines the risk of individual becoming infected.

The biological and socioeconomic determinants described above help explain why Africa has experienced such high levels of heterosexual transmission of HIV. These determinants include unprotected sex with several partners, a viral subtype that many scientists believe is extremely efficient in sexual transmission, noncircumcision of males, widespread prevalence of STDs, gender inequalities, disproportionately high ratios of men to women in urban areas, and extensive migration (figure 1.5). The HIV epidemic in Africa would have been less severe if not for the pervasiveness of these determinants.

Figure 1.5 A number of factors influence susceptibility to HIV infection

- Time
  - time since virus was introduced
  - duration of infection

- HIV subtype
  - type of virus present

- Socioeconomic and political environment
  - mobility and sexual networking
  - lack of education
  - lack of health care services
  - lack of economic opportunities
  - gender inequality
2. AIDS Undermines Development—and Exacerbates Poverty

Because AIDS takes a heavy toll on the most productive age groups, is fatal, and often kills more than one adult in a family, it will have a greater impact on African development than other, more common diseases. HIV infection is second only to neonatal tetanus in terms of the long-term health benefit of averting a single case (figure 2.1). If the benefits of averting a case of disease are measured in terms of the productivity of years lost, HIV ranks highest among all diseases (Over 1992).

More than 650,000 new HIV infections could occur in 1995 and by 2000 the rate of new infections could reach 1 million a year. The WHO estimates that by 2000, 15 million Africans will be infected with HIV, 6.5 million people will have AIDS (figure 2.2), and nearly 6 million people will have died. Even if the spread of the disease were stopped immediately, the impact of the deaths of HIV-infected people would be felt for more than a decade.

Thus, by 2000 AIDS will have reversed hard-won gains in improved adult and child mortality in many countries. Tanzania, Uganda, Zaire, Zambia, and Zimbabwe have all reported increases in adult mortality because of AIDS, which in Tanzania, Uganda, and Zimbabwe is likely to have already tripled (Gregson and others 1994). Because of the quick progression from infection to death in young children, the fastest and most visible impact will be on infant and child (under five) mortality (figure 2.3). During the next three years AIDS is projected to cause more deaths in African children than

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**Figure 2.1 Preventing a single case of HIV infection yields significant benefits**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Discounted healthy life-years saved by interventions for selected illnesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal tetanus</td>
<td>25</td>
</tr>
<tr>
<td>HIV infection</td>
<td>20</td>
</tr>
<tr>
<td>Pneumonia (children)</td>
<td>15</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>10</td>
</tr>
<tr>
<td>Measles</td>
<td>5</td>
</tr>
<tr>
<td>Syphilis</td>
<td>3</td>
</tr>
<tr>
<td>Malaria</td>
<td>2</td>
</tr>
<tr>
<td>Pneumonia (adults)</td>
<td>1</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>0</td>
</tr>
</tbody>
</table>


**Figure 2.2 Cumulative cases of HIV and AIDS will continue to rise in Sub-Saharan Africa**

(Millions)

either malaria or measles (United Nations Children’s Fund 1994). Furthermore, life expectancy at birth has fallen and will continue to fall because of AIDS in several African countries. Observers believe that life expectancy has already fallen by at least eight years in Uganda, and six years in Zambia.

Although HIV is projected to slow annual population growth in Sub-Saharan countries by about one percentage point, there will still be a substantial increase in population in most countries.

AIDS is also likely to slow the growth of per capita income (figure 2.4). Why? Because AIDS reduces the productivity of the labor force, diverts household savings to medical and burial expenses, and decreases public spending on health and welfare services. One recent study suggests that for every 10 percentage point increase in the prevalence of HIV infection, the share of the adult labor force sick at any one time will rise by 0.9-1.4 percentage points (Stover 1993a). If more than half of AIDS treatment costs are financed from savings (data suggest that this is plausible) and the ratio of the cost of treating an AIDS case to per capita income is more than twice the capital-output ratio (also plausible), the epidemic could reduce the growth of per capita income from 0.1-0.8 percentage point a year (Over 1992). For many African countries, this drop means a worsening in already slow or negative per capita growth rates.

What effect will AIDS have on the sector and household levels? Survey and anecdotal evidence suggest a significant impact.

**THE IMPACT ON THE HEALTH SECTOR**

The increasing numbers of AIDS patients put tremendous pressure on the health sector. In several urban hospitals in Africa, AIDS patients occupy half the

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**Figure 2.3 AIDS is projected to raise child mortality rates in Africa by 2005**

(Deaths ages 0-4 per thousand live births)


**Figure 2.4 Per capita incomes could fall because of HIV and AIDS**

beds. In Tanzania the costs of treating even half of all AIDS patients were estimated by a World Bank study to represent 25 percent of the government's fiscal 1991 recurrent health budget. In Malawi 20 percent of the government's 1994 recurrent curative budget is needed for AIDS treatment—rising to as much as 40 percent by 2000 for the worst-case scenario (Family Health International 1994).

Studies in Kenya, Malawi, Tanzania, Zaire, and Zimbabwe suggest that the lifetime cost of treating a person with AIDS is between $200 and $900, or 1.2 to 3.3 times the per capita income of each AIDS patient (Ainsworth and Over 1995). These costs need to be considered in the context of average public spending on health care in African countries, which ranges from $1-30 a person a year.

As a result of such pressures on the health sector, some countries (Botswana, South Africa, Uganda, Zaire, and Zimbabwe) are exploring alternative models of care, such as community home-based care, which would reduce the burden on costly inpatient facilities. Such programs usually provide basic medical care, counseling, and homemaking services for households with AIDS patients. The lifetime cost per patient for home-based care (five visits) came to $54 in the home-based program in Monze, Zambia. Although the cost to the public health system is less, home-based care shifts the cost of treatment and other related costs (especially time costs) back to the household. More research is needed to determine which services are feasible in these alternative models of care, their costs and to whom the costs and benefits fall.

AIDS is also decreasing the pool of qualified health care providers through sickness and early death. Studies in Uganda and Zambia report HIV prevalence rates ranging from 5-44 percent among health care personnel (table 2.1).

**THE IMPACT ON THE EDUCATION SECTOR**

The education sector will also experience demand and supply shocks as a result of AIDS. Demand for schooling may be lower than it would have been in the absence of AIDS for two reasons. First, the cohort entering school may be smaller than it would otherwise have been. The worst-case scenario in a World Bank study of AIDS in Tanzania projected that by 2020 the epidemic will have reduced the cohort of primary school-aged children by 22 percent and that of secondary school-aged children by 14 percent over their projected size in the absence of AIDS (World Bank 1992).

Second, adult deaths from AIDS may lower investment in children's schooling, reducing future productivity and household stocks of human capital. When an adult falls ill or dies, children may be removed from school because they are needed at home or because the family has fewer resources to pay for schooling. Preliminary results from an ongoing World Bank study of

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>HIV-positive (percent)</th>
<th>Number</th>
<th>HIV-positive (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td>379</td>
<td>39</td>
<td>373</td>
<td>21</td>
</tr>
<tr>
<td>Nurses</td>
<td>370</td>
<td>44</td>
<td>381</td>
<td>11</td>
</tr>
<tr>
<td>Office workers or teachers</td>
<td>370</td>
<td>42</td>
<td>371</td>
<td>18</td>
</tr>
<tr>
<td>Traditional birth attendants</td>
<td>369</td>
<td>12</td>
<td>375</td>
<td>5</td>
</tr>
</tbody>
</table>

Tanzania households (Kagera region) affected by adult mortality suggest that children who have lost a father or both parents are less likely to enroll in school than are other children. All children in households that have experienced the recent death of a female adult have markedly lower enrollment rates and, when enrolled, spend fewer hours in school. AIDS is thus likely to lower school enrollments as children substitute for the loss of female labor. Additionally, in countries like Uganda—where households finance about 70 percent of the costs of primary schooling—the death of adults will probably substantially reduce households’ ability to pay school fees.

On the supply side, AIDS will affect the number of teachers needed in the work force, their turnover and training costs, and the efficiency of the schooling system. A projection for Uganda suggests that 2,200 teachers (of 6,262) will develop or die from AIDS between 1993 and 1996, with the direct cost of replacement reaching $1 million. The World Bank study of AIDS in Tanzania projects that 14,460 teachers will die from AIDS by 2010, costing $21 million in training for replacements. Several observers have been particularly concerned about the impact of the epidemic at the university level. Data on other professional groups suggest faculty (and students) are most likely experiencing higher rates of HIV infection than the general population. The reported HIV prevalence among university faculty in Kenya is 14 percent (Mburuou 1993). Coupled with already high attrition rates, rates of 25 percent and more could have disastrous consequences for urban universities and national investments in higher learning.

**THE IMPACT ON LABOR PRODUCTIVITY**

A recent Food and Agriculture Organization (FAO) study in Tanzania, Uganda, and Zambia concluded that rural occupations and farming systems are being affected by AIDS, although the impact between and within communities can vary substantially. Agriculture was most severely affected in Uganda's Guanda community (Rakai District), which suffered a marked shift toward a less varied and nutritious diet (to cassava, yams, and sweet potatoes from an earlier diet that also included bananas and groundnuts) because the cultivation of several labor-intensive crops had been abandoned. This shift was particularly pronounced among poor households made up of women and children.

The burden of caring for AIDS patients usually falls on women, who otherwise would be engaged in farming or other productive work. The FAO study emphasizes how small differences in gender roles and resources—among households and communities—often influence how effectively they respond to the epidemic. For example, whether women are allowed to ride bicycles and whether bicycles are available can be an important determinant of the marketing capacity of household or community. Gender roles also influence the continuation or adoption of labor-economizing responses, such as use of oxen.

AIDS also affects labor productivity in nonagricultural activities. The FAO study found that industry workers in Zambia who fall ill due to AIDS are less productive on the job and are absent more often. Absenteeism is also likely to increase among healthy workers as they take time off to attend funerals and care for the sick. Observers in South Africa, Zambia, and Zimbabwe have suggested that absenteeism and fatigue on the job due to AIDS may be more costly than AIDS deaths. Job turnover, training, and recruitment costs will rise as well, particularly among occupational groups with high rates of infection.
AIDS-related deaths also reduce a firm's pool of skilled labor. Certain types of scarce, highly skilled local labor may have to be replaced with expatriates, raising the costs of production. For example, the AIDS death of a senior Zambian manager delayed plans to "nationalize" the top management of the Zambian Sugar Company. In Kenya about 10 percent of the mining labor force can be classified as highly skilled, and infection rates among them are estimated to be 12 percent. HIV infection rates in Zambia were 17 percent in 1991 among miners of the copperbelt area. A 1993 survey of twenty-one firms in Zambia reported that AIDS had affected their productivity, and four reported that it had affected their recruitment (Sida Alerte #36). The impact of the deaths of skilled workers and managers will depend on how difficult and costly it is for firms to replace workers at various grades, a subject about which little is known. A detailed analysis of five Kenyan companies found a disproportionate impact from AIDS among higher-level employees, who required high training costs and earned substantial salaries. Supervisors, technical professionals, and senior management represented only 13 percent of employees, but 47 percent of training and salary costs.

Larger financial outlays for health, unemployment, funeral, and death benefits will raise the costs of production and reduce the productivity of labor. The Kenyan study suggests that the average company incurred mean annual costs attributable to HIV and AIDS of $140,000 in 1992; by 2005 the total will be $403,000. The average Kenyan company is spending an average of $45 per employee per year for HIV and AIDS-related costs, about 3 percent of company profits. These costs are projected to rise to $120 per employee or 8 percent of company profits, by 2005. Among these costs are absenteeism, training, burial, health care, and recruitment. Uganda's Railway Corporation saw the average costs per hospitalized patient (from all causes) quadruple from 1988 to 1992. For countries in Southern Africa, AIDS now accounts for two-thirds of the death claims made to insurance companies during the first five years of life insurance policies (AIDS Analysis Africa 1992).

Firms will cope with lower productivity and loss of skilled staff through their production and investment decisions. They may choose less labor-intensive technology, substituting capital for labor. They may recruit and train more workers than needed for a specific job, in anticipation of losing some to AIDS. Although these activities initially may be seen as costs to the firms, workers may ultimately bear the brunt of them through lower wages, discriminatory hiring practices, and less liberal leave policies.

THE IMPACT ON HOUSEHOLDS

At the household level, AIDS causes personal pain and loss and cuts into income, human capital, and time available to families (Box 2.1). People with AIDS need physical care, counseling for coping, and help in making arrangements for the future care of their dependents. Illness and death are costly. The average HIV-infected Malawian adult will lose 15.6 years of productive lifetime due to the disability and fatality of AIDS (Family Health International 1992). In Tanzania (Kagera region) households with an adult death spent 8.2 percent of their annual household consumption budget on medical care and funeral expenditures for the deceased. Three-quarters of these expenditures were for funeral costs. In contrast, spending on medical
care in households without an adult death amounted to only 0.8 percent of household consumption.

AIDS also creates large numbers of survivors—spouses, elderly parents, and orphaned children. Spouses and parents often must sell assets. The FAO study found that the average

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**Box 2.1: AIDS, Social and Economic Disruption in Uganda: A New Challenge to Development**

What happens when AIDS infiltrates the society and economy of a Sub-Saharan country? Many families and communities in Uganda are personally familiar with the answer to this question. A capsulated look at Uganda provides a preview of future challenges to other Sub-Saharan countries with similarly high rates of HIV infection.

An estimated 15 percent of adults in Uganda are infected with HIV. In 1995 alone about 110,000 people will die from AIDS. The number of AIDS deaths will not peak until 2003. Child and adult mortality increases in Uganda are believed to have already caused life expectancy to fall by eight years, from forty-nine years to forty-one years of age (box figure below).

Most Ugandans know someone who has died of AIDS. Although the social consequences of AIDS are difficult to measure, they are easy to describe: grieving, stigmatization, and large-scale disruption of family and community structures. Ugandans who know they are infected confront imminent mortality and, too often, public condemnation. Those who survive wonder about their own HIV status and look for hope. All Ugandans affected by AIDS look for peace of mind.

AIDS affects male and female survivors very differently. Widows face particularly difficult times because of widespread socio-cultural and economic disadvantages. They can be inherited by their brothers-in-law(s), and lose their homes, possessions, and even their children to their late husband’s relatives. Observers believe that desperate women are becoming sex workers, although little data exist on this subject. AIDS-affected communities do, however, report increased alcohol production, since this is one of few livelihoods open to women and is less labor-intensive than farming. Alcohol is a poor substitute for nutritious food. And increased alcohol abuse only compounds the disintegration of family and community welfare. Widowers and other survivors often substitute the loss of a wife’s labor by keeping children (girls) home from school. Orphans, now estimated at 0.75 million, are very visible in Uganda. Without stable homes, love, food, clothing, and school, what kind of contribution to Ugandan society will these orphans make as adults?

The economic consequences of AIDS in Uganda will occur largely through the epidemic’s impact on the size and quality of the labor force. By killing a significant number of male and female workers between the ages of fifteen and sixty, AIDS will reduce both the size and growth rate of the labor force. By 2010 the Ugandan labor force will be about 12 percent (2 million people) smaller than it would have been without AIDS. Most economic activity and production in Uganda is related to agriculture and takes place in rural areas on smallholder farms. Despite rapid population growth, labor is a relatively scarce factor of agricultural production in Uganda, with less than one percent of the work force unemployed. The spread of HIV in rural areas, combined with the intensity and scarcity of agricultural labor, suggests that AIDS will have an impact on both production and per capita incomes. *HIV infection will lower projected life expectancy at birth for Ugandans*

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*Source:* adapted from Armstrong 1995.

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[Graph showing life expectancy projections for Uganda with and without AIDS]
working day for widows and their oldest children increased by two to four hours to make up for the labor and income shortages that resulted from their husbands' death. Children spend less time in school to compensate for labor shortages at home. Many orphans are being cared for by extended families, who must bear the additional responsibilities and costs for their care. More than 9 million HIV-negative children under age 10 in Africa will have lost their mothers to AIDS by 2000, according to the WHO. Observers do not believe that the extended family network will be able to bear this burden. The reported increase in the number of street children in Kampala (Uganda), Dar es Salaam (Tanzania), and Nairobi (Kenya) by local NGO's suggests that the extended family network's absorptive capacity has already been surpassed.
3. **Responses to the Epidemic—Impressive but Limited**

The Global AIDS Strategy\(^4\), revised by the World Health Assembly in 1992, is a sound blueprint for global AIDS work. In addition to mobilizing and unifying national and international initiatives against AIDS, the main objectives of the strategy are to prevent HIV infection and to mitigate the personal and social impacts of AIDS.

Thus, the HIV/AIDS epidemic requires two mutually reinforcing strategies: prevention and mitigation. *Safe sexual behavior* is the main preventive measure and will continue to be for some time, given the slow pace on developing a potential vaccine or cure. Mitigation—including caring, coping with immediate effects, and planning for the future impacts of the epidemic—must take place in households, communities, and industries, and at various levels of government. Both strategies must be carried out in gender-differentiated ways.

About $100 million was spent in 1992 in Africa on prevention programs for AIDS and other STDs; 10 percent of this total came from African governments. A World Health Organization (WHO) study suggests that *comprehensive* prevention services would cost from $225 million to $435 million a year. Such spending would be two-and-a-half times 1992 spending, but it would yield enormous benefits, averting as many as 4.2 million new infections by 2000.

About $183 million was spent on care for AIDS patients in 1992 by African countries. Although this is a small share of the $4.7 billion spent by industrial countries to care for their AIDS patients, it still exceeds what is spent on prevention in Africa. The cost-benefit relationship between prevention and ‘cure’ rings true for AIDS—it costs more to *not* prevent AIDS. By 2000 spending for care in Africa will nearly double, rising to $347 million a year.

A survey among 17 low-income African countries estimates per capita *spending* for prevention circa 1993 ranged $0.07 - $0.44 and for care, $0.05 - $0.70. The intervals grow as level of national economies increase. For upper middle African countries, per capita spending for prevention circa 1993 ranged $0.58 - $2.20 and for care $2.88 - $71.93 (Tarantola 1996).

**PREVENTION AND CARE**

Finding an appropriate balance between preventing new infections and caring for those already infected has been one of the main challenges to national AIDS control programs in Africa. The other challenges involve problems of management and resources: a high turnover of decisionmakers and AIDS program managers within ministries of health, the lack of clarity on how programs within the health ministries can coordinate multisectoral activities with other ministries and with groups outside the government, and the lack of financial resources for essential commodities, such as drugs and condoms.

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\(^4\) The Global AIDS Strategy will be replaced with the new UNAIDS Strategic Plan in 1996.
Supported by these essential commodities, a combination of prevention interventions is crucial to stemming the spread of HIV and other STDs. Cost-effective interventions include:

- providing information on how to avoid infection;
- promoting condom use;
- treating the curable STDs; and
- reducing blood-borne transmission.

Promoting safer sexual behavior through affective mass communication strategies would cost $0.06 - 0.32 per capita per year. Encouraging condom use in addition to promoting safer sexual behavior through person-to-person education is more expensive ($0.47 - 3.73), but intensity of contact is likely to be greater. Costs per visit for STD prevention and treatment services are relatively high ($9.46 - $10.16), although these costs are based on only a few existing programs. The cost of ensuring a safe blood supply vary between $34.50 to $51.60 per blood unit (WHO 1993).

Prevention activities must reach diverse populations. Programs for the general population are less cost-effective than targeted programs at the onset of an epidemic, but are critical to increasing awareness and understanding of AIDS and other STDs, and to stemming discrimination. Given that half of Africa's population is under sixteen and largely free from HIV infection—young people, both in and out of school—need comprehensive education on reproductive and sexual health to avoid infection. Studies worldwide indicate that sex education and condom promotion do not increase promiscuity or lower the age of sexual debut (box 3.1).

Many African educators are working closely with United Nations Children’s Fund, the United Nations Population Fund, and other agencies in designing family life education courses. These programs are still in the preliminary stages in most countries, however, and have not been incorporated into the standard curriculum.

Box 3.1 Sex Education Leads to Safer Sexual Behavior

Teaching young people about sexuality and contraception is often thought to encourage early sexual experimentation. This belief has been disproved by a World Health Organization/Global Programme on AIDS review of nineteen studies among industrial and developing countries on the effects of sex education in schools. In fact, sex and AIDS education often encourages young people to delay sexual activity and to practice safer sex when they are sexually active. No study revealed evidence of sex education leading to earlier or increased sexual activity in young people, and in six studies sex education either delayed the onset of sexual activity or caused a fall in its overall extent. Two studies showed that access to counseling and contraceptive services did not encourage earlier or increased sexual activity, and ten studies showed that sex education increased the adoption of safer practices among sexually active youth.

School programs that promoted the postponement of sexual intercourse and the use of condoms when sex occurs were more effective in attaining one goal or the other than those that promoted only abstinence. They were also more effective when given before young people become sexually active, and when they emphasized skills and social norms rather than knowledge. Two public information programs on HIV and AIDS brought about a large rise in the use of condoms and other contraceptives, while causing no drop in age at first intercourse and no rise in the amount of sexual activity among young people.

Source: WHO 1993c.
It is essential to tailor communication strategies to the specific needs of different audiences. Interventions work best when they:

- are based on input from communities and groups about their perceived needs;
- are developed, implemented, and evaluated with the active participation of these same groups or communities;
- use multiple channels and are multilevel in their design;
- seek both to persuade and to enable individuals to adopt and maintain safe behaviors; and;
- are accompanied by the provision of appropriate services (Communicate! 1995).

Experience and simulation models suggest that prevention interventions work best when they are implemented simultaneously (figure 3.1). An experimental study in twelve villages in rural Tanzania (Mwanza region) has shown sharper decreases in HIV infection in communities that promote three activities—education, condom promotion and treatment of STDs—than in communities that promote only two: with education and condom promotion; (Grosskeuth and others 1995). In addition, early targeting of HIV interventions is critical because the interventions become less cost-effective as the infection moves out of the high-risk, high-transmission core groups (sex workers, the military, truck drivers). Simulations also suggest that the impacts of a prevention program continue for years even if the program is terminated. Thus, worries about sustainability should not stand in the way of establishing a program, since delays are costly in terms of the spread of HIV.

Finally, the delivery of HIV prevention interventions and many aspects of care for AIDS patients must be integrated with primary health care services. The primary health care setting allows the greatest efficiency in use of limited resources and a more holistic approach to care. Recent World Bank publications—Women's Health and Nutrition—Making a Difference, World Development Report 1993: Investing in Health, and Better Health in Africa—recommend AIDS prevention as one of the interventions making up a minimum package of cost-effective services (box 3.2).
Box 3.2 Package of Cost-Effective Services

Governments in developing countries should reduce spending by about 50 percent on less-cost-effective interventions and instead double or triple spending on such basic public health programs as immunizations, AIDS prevention, and essential clinical services. A minimum package of essential clinical services should include sick-child care, family planning, prenatal and delivery care, and treatment for tuberculosis and STDs. This package also should include services that improve communication between health care providers and patients seeking information. Low-income countries would have to redirect their public health spending from tertiary care toward this minimum package of essential clinical services. Tertiary care and less-cost-effective services could continue, but public subsidies to them should be phased out if they mainly benefit the wealthy.

The *Better Health in Africa* report suggests that about $1.6 billion a year would be needed to ensure a basic package of services in the rural and periurban areas of low-income Africa. Beyond an increase of nearly $1 billion from governments, the $600 million would represent a 50 percent increase in levels of external assistance for health in Africa. The report estimates that these services could be provided for about $13 a person in the low-income countries. The activities supporting the prevention and mitigation of AIDS would cost $1.9 per capita annually—or about 15 percent of the $13 per capita for the package of services. Based on a survey, circa 1993 per capita spending by low-income African countries for AIDS prevention and care was estimated at $0.09.


**PROGRAMS AND PROGRESS**

Every African country now has a multisectoral plan for AIDS prevention and mitigation, and some have begun to succeed on many fronts, from management to behavior change. The WHO's AIDS program management courses are providing managers with essential skills in planning, epidemiology, advocacy, and leadership. AIDS awareness is high among most people in Africa. Services to treat the other STDs are being improved. For example, Abidjan, Dakar, Harare, Johannesburg, Kampala, Lusaka, and Nairobi now have at least one clinic where personnel have been trained to provide effective care. Condom use has increased despite fears that Africans would be reluctant to use them. A village-based AIDS prevention program in Uganda increased the consistent use of condoms during casual sex from 6 percent to 33 percent among women and from 27 percent to 48 percent among men over an eighteen month period (Schopper and others 1995). Condom sales in Africa grew from 2 million in 1986 to 120 million in 1994 (figure 3.2).

Several communities are demonstrating that people with AIDS can receive appropriate care, live productively with the disease, and play a visible role in a country's national response to the epidemic. For example, twenty-seven of forty-seven African countries have at least one
community-based AIDS home care program, and training and counseling modules on community-based home care are now available in Botswana, Burundi, Malawi, Senegal, Zaire, and Zimbabwe. Traditional healers, religious leaders, social workers, and youth are learning to become counselors and AIDS resource persons in Angola, Benin, Botswana, Burundi, Cameroon, Congo, Ethiopia, Malawi, Namibia, Nigeria, and Zimbabwe. Much of this success stems from the efforts of national programs, the support of international agencies, and collaboration with NGO’s and community-based groups.

Much progress in these AIDS prevention efforts has led to limited impact. Pilot projects on prevention in Côte d’Ivoire, Ghana, Kenya, Madagascar, Nigeria, Rwanda, Tanzania, Uganda, Zaire, and Zimbabwe have used peer education, community leadership, and media programs to significantly reduce unprotected sexual contacts among groups engaging in high-risk sexual practices (figure 3.3). The Mwanza region, Tanzania study reduced HIV incidence by 42 percent in six villages where improved diagnosis and treatment of STDs was introduced. A five-year study covering fifteen neighboring villages and roughly 5,200 adults in Uganda (Masaka district) recorded a drop in HIV prevalence rates of 80 percent from 11.8 percent in 1989 to 2.6 percent in 1994, among men aged 20 to 24, and from 21.3 percent to 19.4 percent among women of the same age group (AIDS Analysis Africa 1995). The intensity of these interventions was modest. Although it is too early to tell what caused the decline in the Masaka district, these data offer evidence that HIV infection rates has fallen in these villages. Declining HIV prevalence rates over a one-year period (1993-94) among pregnant women attending antenatal facilities in five areas in Uganda—although again too early to tell—may be indication of significant behavior change.

Countries, however, are only beginning to expand such pilot and research activities to national scale. Few African countries—if any—have in place adequate prevention and mitigation interventions operating simultaneously (that is, depth) reaching all appropriate target groups (that is, breadth) to claim a comprehensive AIDS prevention and mitigation program, within or across national borders. Thus the impact of successful small projects has so far been felt only among a small number of targeted groups and their partners, with perhaps some inhibition in transmission within a limited sexual network. For the most part, too few sexually active people have changed their behavior for there to have been significant nationwide impact. And few African universities and research networks have the capacity to design and undertake the kind of socio-behavioral research needed to better understand what factors influence sexual behavior change and how best to expand successful efforts.
Only the most basic health-related AIDS prevention messages and interventions (such as AIDS education and condom promotion) have become *multisectoral*, that is, introduced outside the health sector to the education, agriculture, defense, and private sectors. School-based family life education and AIDS in the workplace activities (box 3.3) were among the first activities to be encouraged by ministries of health, with activities in the military and police services following soon after.

**Box 3.3 AIDS and the Workplace in Zimbabwe**

Some companies in Zimbabwe have implemented impressive AIDS education programs:

At nickel mines operated by Rio Tinto Zimbabwe (RTZ), volunteer AIDS educators go hundreds of meters below ground to distribute information to fellow employees. The company also distributes condoms at company clinics, beer halls, and social clubs. In two years the program has lowered by between one-fifth and half the number of STDs treated at clinics in RTZ's refinery and three mines.

David Whitehead Textiles has trained its sixty-five health and safety representatives as "AIDS information officers." In Mutare the HIV Prevention Project has trained seventy-eight peer educators, including thirty-eight former prostitutes and forty men from private companies, security firms, the local prison, and the Zimbabwe National Army.

The Zimbabwe Congress of Trade Unions has one of the most promising programs, having trained 700 health and safety representatives in AIDS-related human rights issues in the workplace and AIDS awareness and prevention. "We want people to get to the point where they can take control over their sexual lives," said Rene Loewensen, head of the Congress's health department. "They need to understand the pressures acting on them, and they should have all the information they need to make choices."

*Source: WHO 1994.*

Efforts are only just beginning to move beyond the basic AIDS prevention interventions to interventions that address the socio-cultural and economic factors in Africa that increase vulnerability to HIV. For example, the WHO is undertaking exploratory missions to examine the interaction of migration and HIV transmission in the commercial plantation sector in Côte d'Ivoire and the mining sector in South Africa. In Zambia a project is seeking to reduce HIV infection among women fish-traders who have sex with fishermen in exchange for lower prices on their purchases of fish. In addition to promoting condom use and STD care-seeking, this project aims to reduce the economic pressures on women that force them to engage in commercial sex. Shortening the time long-distance transport drivers are away from home, outlawing wife inheritance and ritual cleansing practices, and improving a range of opportunities for women are other possible examples of multisectoral interventions that go beyond the basic health perspective. In short, research to better understand the socio-cultural and economic factors that increase vulnerability to HIV is limited, and the interventions to lessen this vulnerability—save efforts to enhance girls' education and increase women's economic opportunities and legal rights—are still exploratory. These broader development efforts that are also part of the response to the epidemic are discussed further in the next two chapters.
4. Bank’s Contribution to the Response—Making Progress

The World Bank’s AIDS strategy—enunciated in 1988 and reviewed in 1992—has evolved as understanding of the epidemic has improved and appropriate responses have become more apparent. The 1988 Strategy Paper on AIDS called for specific action in resolving policy issues, improving the efficiency of resource allocation, mobilizing financial resources, preparing detailed action plans, strengthening country implementation capacity, and improving the information base. The 1992 review concluded that progress had been made in all these areas, although progress had varied by country and issue. According to the 1992 review, new areas meriting attention included:

- focusing activities in countries where the high prevalence of other STDs indicated a potential for rapid spread of HIV;
- establishing a core strategy for AIDS control that reflected the importance of sexual transmission and the role of other STDs in the epidemic;
- strengthening the key elements of the health infrastructure (such as basic facility and outreach services) critical to the prevention and control of AIDS; and
- developing multisectoral policies for coping with the economic and social impact of the epidemic.

This update finds the Bank’s recent work strong on the first three areas—focusing on countries with high STD prevalence, establishing a core AIDS strategy, and strengthening the health infrastructure—but weak on the last area, developing multisectoral policies. For example, ten of the twelve countries with high rates of STDs identified by the 1992 review have executed Bank-assisted projects with AIDS-related components. A core AIDS control strategy consisting of the main interventions for prevention (including STD care) and mitigation now exists in most African countries—and in all thirty-six Bank-assisted AIDS control projects. Twenty-five of the thirty-six Bank-assisted projects with AIDS-related components are strengthening key elements (such as pharmaceutical delivery and laboratory support) of the health infrastructure. Three projects have combined AIDS and population activities. Efforts to develop multisectoral policies, however, have failed to progress beyond description and prediction of the socioeconomic impact to actual development of policies and interventions.

Since the 1992 review the AIDS strategy has been actively pursued in three general areas of Bank operations: economic and sector work, policy dialogue and regional programs, and lending operations.

ECONOMIC AND SECTOR WORK

The Bank’s sector work has focused on learning more about the prevalence of STDs and about the impact of HIV and AIDS on development. For example, rapid assessment studies sponsored by the Bank (and in two countries with WHO) have assessed the prevalence of STDs
in conjunction with the risky behaviors responsible for their high transmission. Rates for an STD have reached as high as 43 percent among pregnant women, 9 percent among military men and 13 percent among truck drivers. It is very common for female prostitutes to have several infections simultaneously (figure 3.4). The studies are the first reliable assessment of STDs in these countries, providing data that AIDS program managers need to monitor disease prevalence trends, to adjust patient treatment guidelines, and to learn more about sexual behaviors.

**Figure 4.1** Sexually transmitted diseases are extremely common in many African countries

<table>
<thead>
<tr>
<th>Disease</th>
<th>Pregnancy Women</th>
<th>Military Men</th>
<th>Female Sex Workers</th>
<th>Truck Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea</td>
<td>10%</td>
<td>6%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>7%</td>
<td>7%</td>
<td>7%</td>
<td>3%</td>
</tr>
<tr>
<td>Trichomonas</td>
<td>10%</td>
<td>6%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>10%</td>
<td>6%</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Source: World Bank and country data.

These STD rapid assessment studies have been completed in Burkina Faso, Chad, Lesotho, Madagascar, Mali, Niger, Senegal, and Uganda, are under way in Zimbabwe, and are planned in The Gambia and Nigeria.

Sector work has also included studies with governments and other agencies to assess current and projected HIV infection levels, and to ascertain the consequences of AIDS on development. Tanzania and Uganda have each hosted a Bank-assisted study to assess the magnitude and impact of AIDS. These studies have been the first comprehensive analysis of their kind on the continent. It is not evident, however, that these two countries have developed policies and interventions to mitigate the socioeconomic impacts of AIDS as a result of the studies' findings. Although eight more studies similar to those performed in Tanzania and
Uganda are planned (in Botswana, Burundi, Central African Republic, Chad, Congo, Côte d'Ivoire, Madagascar, and Zambia), for a variety of reasons initiation has been slow. In short, subsequent action in the area of policy and interventions by governments supported by Bank lending has not been forthcoming, and replication of these studies has been slow-moving.

In 1991 the University of Dar es Salaam and the World Bank initiated a research project in Tanzania's Kagera district, among the worst-hit regions in Africa, to study the economic impact of sharply increased male and female adult mortality caused by AIDS. Preliminary findings of the study suggest that AIDS patients are more likely to seek medical care than those who die of other causes—only 13.3 percent of AIDS patients did not seek medical treatment compared with 27.4 percent of those who died from other causes—underscoring the large effects on household savings. Through its interviews with Tanzanian traditional healers, the study has found that even though a fairly large share of healers offered treatment of gynecological problems and STDs, few were actively involved in educating the public about AIDS prevention. This study concluded that:

- Households are coping with the impact of AIDS through private transfers and by adjusting household composition of members before and after an adult death. Thus, household composition is dynamic.

- AIDS deaths reduce the economic welfare of survivors, at least temporarily, and some households are more vulnerable than others. This will likely increase the already large numbers of poor people in the affected countries. It is not yet clear how vulnerable AIDS-affected households are relative to all households in poverty. The emphasis should be on helping the most vulnerable households, whether the vulnerability is AIDS-related or not.

- Programs to mitigate the impact of AIDS must be carefully designed so as not to impede the post-death adjustment process, but rather to help households adjust more easily. For example, programs that target based on household composition (such as the number of children or orphans) are likely to create incentives that will inhibit the redistribution of children and adults across households. The study also suggests that assistance to mitigate the impact of AIDS can be temporary.

It is hoped this study, when completed, will provide a better understanding of the impact of AIDS at the household and community levels—and more specific recommendations on policy for mitigating the impact.

As background to this paper a review of Bank economic and sector work, country assistance strategies, and operations documents was performed to ascertain whether AIDS was being considered in such contexts. The review was restricted to documents that had been completed since 1991 for twelve most severely affected countries (Burkina Faso, Burundi, Central African Republic, Congo, Côte d'Ivoire, Kenya, Malawi, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe). This restriction is based on the assumption that HIV prevalence data were available by 1991, and that the multisectoral implications of the epidemic were also obvious by that time.
The review found that of all economic work performed since 1991, consideration to AIDS was greatest in poverty assessment, policy framework papers and country assistance strategies, and least in public expenditure reviews and country economic memorandum.

All five poverty assessments and nine policy framework papers completed since 1991 for the twelve countries all mention AIDS (table 4.1). For example, the 1994 Zambia Poverty Assessment recommends that Zambia “bring AIDS to the center of the development debate and ensure strong political commitment to prevention as the first step.” The paper also incorporates the health and dependency effects of AIDS in its model of household responses to agricultural policies. The paper concludes that policymakers should be more concerned about the impact of the epidemic on poverty, because already vulnerable households are more adversely affected by AIDS. The 1994 Rwanda Poverty Reduction and Sustainable Growth paper draws attention to the severe health and economic impacts of AIDS and makes recommendations on AIDS care activities, such as developing low-cost, family-oriented approaches and home-based care.

Eight of ten country assistance strategies and four of six public expenditure reviews make reference to AIDS. The exceptions for the assistance strategies are the documents for Uganda and Zambia and, for the expenditure reviews, Burkina Faso and Burundi. These are serious exceptions given the heavy burden AIDS is placing on health and welfare spending in Burundi, Uganda, and Zambia. The 1994 public expenditure review for Tanzania, on the other hand, assesses the burden AIDS will have on the health sector in both human and financial terms.

Only one (Zimbabwe) of three country economic memorandums completed since 1991 mentions AIDS, despite the severe epidemics in the countries studied (the other two countries were Burundi and Côte d’Ivoire). The Zimbabwe memorandum emphasized the impact of AIDS on poverty and on the overall welfare of Zimbabweans.

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Congo</td>
<td></td>
<td></td>
<td>√ (1995)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>√ (1994)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: √ (date) = document makes reference to AIDS and document date.

Of sixty-one economic and sector work and adjustment lending documents reviewed, eleven include AIDS in their discussions of sectors and poverty. For example, the “Primary Education and Teacher Development Project” for Uganda makes extensive reference to AIDS and its impact on households and Ugandan demographics. Seven of these eleven documents deal with agriculture, education, the social sectors, and poverty alleviation in two countries, Tanzania and Uganda.
Given the epidemic's socioeconomic implications, the potential impact of these implications on development goals, and the actions required of the World Bank's assistance strategy, the analysis in most of these documents is incomplete. Because economic and sector work, including poverty assessments, is an important input to country assistance strategies, and because country assistance strategies provide the basis for Bank lending, more documents and analytical work should factor in the AIDS-related changes in morbidity, mortality, life expectancy, productivity, and household use of savings. The examples cited above—the works on poverty in Zambia and Rwanda, the public expenditure review in Tanzania and education sector report in Uganda represent the first good attempts to factor the consequences of AIDS in Bank analyses.

A review of recent population, health, and nutrition (PHN) operations documents for Sub-Saharan countries indicates that—regardless of a country's HIV prevalence—most World Bank staff and country officials are taking AIDS into consideration when preparing PHN operations. Of forty-two PHN project documents (dating from 1990-94), thirty-four (81 percent) mention AIDS. Twenty-four discuss AIDS extensively, factoring in its consequences for the sector, and fifteen specify the resources needed to respond to the epidemic. Of the eight documents that do not mention AIDS, three are for Botswana, Kenya, and Rwanda, where the prevalence of HIV infection exceeds 10 percent in the general population. The numerous prevention and service delivery factors commonly shared by AIDS and STD prevention programs, safe motherhood programs, and family planning programs, as well as the serious burden AIDS places on the health infrastructure, suggests that such issues need to be raised when designing PHN projects in these severely affected countries.

**POLICY DIALOGUE AND REGIONAL PROGRAMS**

Policy-related Bank activities have attempted to increase awareness, focus policy dialogue on AIDS, and to link AIDS and population activities. Working closely with other international organizations, the Bank has helped put the subject of AIDS and Development on many agendas in a variety of African forums—including the annual meetings of the African Development Bank, the International Conferences on AIDS, and seminars on AIDS and policy (sponsored by the Economic Development Institute)—to increase awareness, build commitment, and facilitate action. In addition, a high-level OAU delegation with Bank participation visited four African countries in August 1995 to review country progress in carrying out the OAU's “1992 Declaration On AIDS in Africa” and “1994 Declaration on AIDS and the Child” (Annex). The delegation members will report their findings at the OAU Assembly in June 1996.

Linking AIDS and population activities makes sense because integrated reproductive health services and sexual behavior education are objectives shared by AIDS control and family planning programs. The World Bank and African governments have started to build on these common aims by designing population and AIDS prevention projects in Burkina Faso, Chad, and Lesotho, and by developing two regional initiatives, the Intensified Country Action Planning Process (ICAPP) for population activities (including STD care) and the Network for Improved Adolescent Reproductive and Sexual Health (NIARSH).

The two regional initiatives, ICAPP and NIARSH, are working with African countries to intensify national plans, learn more about the determinants of sexual behavior, assess service demands among their beneficiaries, and share these lessons regionally to strengthen capacity.
Another regional program, the West Africa Regional Advocacy and Capacity Building Program for AIDS Prevention, has recently started working with the WHO and the United Nations Development Programme and several NGO's to deliver AIDS information and communication activities across borders and along migration routes among West African countries.

LENDING OPERATIONS

Between 1986 and 1990 ten Bank-assisted health projects included HIV prevention interventions, and an AIDS-specific project was set up in Zaire. By 1995 thirty-six projects with AIDS prevention or mitigation components were under way in twenty-four African countries, and Burkina Faso, Chad, Kenya, Uganda, and Zimbabwe had initiated freestanding (or combined with population) AIDS projects. Three additional projects focusing on AIDS in Congo, Niger, and Tanzania are expected to be effective by the end of 1996. Sixteen additional AIDS-related projects are planned for fiscal 1996 and 1997, a reflection of government commitment to cost-effective interventions against AIDS. Total Bank financing for HIV prevention and AIDS mitigation in Africa, now $250 million, will most likely increase by 50 percent over the next two fiscal years (figure 4.2).

Because adoption of safe sexual behavior is the most important intervention, nearly two-thirds of Bank-assisted projects with AIDS components promote this intervention through a variety of information, education, and communication methods. Other important interventions supported by the projects include supply and promotion of condoms, provision of community care and support for individuals directly or indirectly affected by AIDS, strengthening of STD care, and promotion of safe blood. Many of the newer AIDS projects include significant implementation by NGO's. Bank-assisted projects with HIV prevention and AIDS mitigation components totaling $1 million or more are listed in table 4.2.

These lending activities have achieved mixed progress. For example, the Lesotho Second Health, Population, and Nutrition Project (not included in table 4.2), started in 1989, has supported the renovation of an STD clinic in the Queen Elizabeth II Hospital and a study of the prevalence of STDs and effective treatments. The new clinic, recent training, and updated treatment guidelines strengthen Lesotho's capability to control STDs. But the Tanzania Health and Nutrition projects, started in 1990, only began procuring drugs to treat STDs and tuberculosis in 1994. In addition, political and civil unrest have impeded project activities in some countries, such as Burundi, Rwanda, and Zaire.
Table 4.2  Bank projects in Africa with 1 million U.S. dollars or more in funds for AIDS

<table>
<thead>
<tr>
<th>Country</th>
<th>Project focus</th>
<th>Project focus</th>
<th>Loan/credit amount</th>
<th>Effectiveness date and duration (fiscal year)</th>
<th>Total funds for HIV/AIDS activities (millions of U.S. dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>Population and health</td>
<td>1, 2, 3, 4, 6, 7</td>
<td>30.0</td>
<td>1994, 5 years</td>
<td>1.2</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Population and AIDS</td>
<td>1, 4, 6, 7</td>
<td>26.3</td>
<td>1994, 5 years</td>
<td>1.0</td>
</tr>
<tr>
<td>Chad</td>
<td>Health and safe motherhood</td>
<td>1, 3, 4, 7</td>
<td>20.0</td>
<td>1995, 5 years</td>
<td>1.0</td>
</tr>
<tr>
<td>Guinea</td>
<td>Health services development</td>
<td>2, 3, 7</td>
<td>19.7</td>
<td>1988, 7 years</td>
<td>1.0</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>Health and nutrition sector</td>
<td>1, 3, 7</td>
<td>24.6</td>
<td>1994, 5 years</td>
<td>1.0</td>
</tr>
<tr>
<td>Kenyana</td>
<td>Health and nutrition sector</td>
<td>1, 2, 3, 4, 5, 6, 7, 8</td>
<td>40.0</td>
<td>1995, 7 years</td>
<td>1.0</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Health sector improvement</td>
<td>1, 6</td>
<td>31.0</td>
<td>1992, 6 years</td>
<td>2.0</td>
</tr>
<tr>
<td>Mali</td>
<td>Second health, population, and rural water supply</td>
<td>1</td>
<td>26.6</td>
<td>1992, 7 years</td>
<td>1.4</td>
</tr>
<tr>
<td>Nigeria</td>
<td>Health and population</td>
<td>1, 2, 3</td>
<td>27.6</td>
<td>1990, 7 years</td>
<td>1.0</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Health and nutrition</td>
<td>1, 3, 6</td>
<td>78.5</td>
<td>1992, 8 years</td>
<td>50.0</td>
</tr>
<tr>
<td>Uganda</td>
<td>Sexually transmitted infections</td>
<td>1, 2, 3, 4, 6, 7, 8</td>
<td>37.0</td>
<td>1989, 7 years</td>
<td>1.0</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Sexually transmitted infections</td>
<td>1, 2, 3, 4, 5, 6, 7, 8</td>
<td>64.5</td>
<td>1994, 5 years</td>
<td>64.5</td>
</tr>
</tbody>
</table>

Note: Key to project focus:
1. Promoting safer sexual behavior
2. Promoting safe blood
3. Providing condoms
4. Providing care and support
5. Providing voluntary counseling and testing
6. Providing STD care
7. Program management
8. Social and economic impact

Since the five AIDS projects in Burkina Faso, Chad, Kenya, Uganda and Zimbabwe are relatively new—three were approved in 1994—baseline data to measure their impact are only now being collected. The Zimbabwe project has been in place for more than two years, however, and is beginning to improve service delivery. The project has achieved one of its primary objectives—ensuring adequate national supplies of drugs for STDs and AIDS-related infections—marking a big improvement over the frequent shortages experienced earlier. Drug availability for STDs and AIDS-related infections among countrywide facilities has increased from 68 percent, to 89 percent. In addition, automated condom testing (quality assurance) machines in the Zimbabwe Regional Drug Control Center have increased testing capacity sixfold; the center provides these services to sixteen African countries. A Japanese grant has enabled the project to learn more about how information centers can provide HIV testing and counseling services at reasonable costs. The grant funds also have made possible work on a national AIDS evaluation strategy, likely to be the first in Africa. Finally, the project has increased domestic capacity because close to all activities are carried out by local consultants.

The freestanding AIDS projects in Burkina Faso, Chad, Kenya, and Uganda have several strengths:

- They support all the basic interventions—AIDS and STD education, STD care, condom promotion, blood supply protection, care of opportunistic infections, and mitigation of AIDS consequences—and they provide the necessary resources to expand these interventions to scale.
They meet national needs for commodities: condoms, diagnostics, and drugs to treat STDs, tuberculosis, and other opportunistic infections.

They provide grants to NGO's that support community-based implementation of interventions.

They design and incorporate national evaluation strategies to measure the impact of interventions.

They strengthen the skills of public and private personnel in program management.

In brief, the projects ensure that the national AIDS control program is comprehensive in depth—all interventions function simultaneously and—nationwide in breadth—reaching all target groups by including these elements in one large project.

With the exception of these programs, few national AIDS control programs in Africa contain the five characteristics listed above that make up a comprehensive program. A number of countries—because of their HIV prevalence levels or limited response effort such as Burundi, Central African Republic, Ethiopia, Malawi, Nigeria, Rwanda and Togo—are in great need of such comprehensive programs, whether Bank-assisted or not, and whether supported by AIDS-specific or integrated health projects (table 4.3).

<table>
<thead>
<tr>
<th>Table 4.3 Status of comprehensive AIDS control programs in Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently include characteristics of comprehensive program</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>HIV prevalence</td>
</tr>
<tr>
<td>&gt;5%</td>
</tr>
<tr>
<td>Burkina Faso</td>
</tr>
<tr>
<td>Kenya</td>
</tr>
<tr>
<td>Zimbabwe</td>
</tr>
<tr>
<td>Burundi</td>
</tr>
<tr>
<td>Guinea</td>
</tr>
<tr>
<td>Benin</td>
</tr>
<tr>
<td>Nepal</td>
</tr>
<tr>
<td>Botswana</td>
</tr>
</tbody>
</table>

Source: World Bank data.

The Bank has promoted both types of projects, those specifically geared toward AIDS (freestanding) and PHN projects with HIV prevention and AIDS mitigation components. Country circumstances should dictate which design will best support overall health goals and delivery systems. Ultimately, Bank staff, country decisionmakers, and other donors should work toward AIDS control programs that are comprehensive in their interventions and implemented in all geographical (including across borders) locations and all relevant sectors.

Two limitations common in Bank lending practices inhibit a multisectoral response to the epidemic. First, PHN projects rarely deal with the issues from other sectors that influence health. For example, among thirty PHN projects with AIDS components, only four address exogenous variables, such as women's status, that influence the PHN sector. Second, most of Bank-assisted
projects with AIDS components still originate in the PHN sector—even in the most severely affected countries, where the impact of AIDS on other sectors is apparent. Only six projects with AIDS activities out of the total thirty-six originate outside the PHN sector. Five of these are in social sector development projects, and one is in the transport sector. (See Box 4 below for one example). Thus, the Bank and African governments have yet to fully integrate (a) the interventions that target the exogenous determinants into PHN projects and (b) AIDS prevention, mitigation, and planning into the other sector projects: education, transport, agriculture, and industry.

### Box 4 Widening the Health Sector Response to a Multisectoral Response: Supplementing the Health Interventions with Socio-economic Interventions

The adverse impact of the disease on development calls for widening the response outside the health sector and supplementing the health interventions with interventions that address the socio-economic determinants and consequences of AIDS.

Providing AIDS information in schools, workplaces, military bases and agricultural outreach programs is an example of widening the response outside the health sector. Programs that organize income-generating activities for women as alternatives to commercial sex work or provide care for orphans are examples of supplementing health interventions with interventions that address the socio-economic issues around AIDS.

One Bank-assisted project in Uganda that consists of both these enhanced approaches to AIDS prevention and mitigation is the Program of Assistance to Orphans of AIDS (Gakuweekbwa, Munno) implemented by World Vision. The project focuses on empowering people within the Rakai and Masaka Districts to take the critical actions needed to respond to the AIDS crises. Visible outputs include 1) installation of 5 grinding mills providing daily income for the communities; clothing, food, and school tuition to 1,000 orphans, and provision of 234 loans to 237 clients (of which 60 were women) through the Small Scale Production Enterprise activity. Overall, 43,113 of the projected 58,241 orphans and 17,500 foster parents (6,500 more than the projected 11,000) are receiving assistance. 150 health workers have graduated and each given a drug kit and bicycle.
5. The Collective Response—Broadening the Paradigm

The AIDS epidemic demands a collective, urgent response. This update of the World Bank’s AIDS Strategy for Africa has reviewed the World Health Assembly’s universally endorsed Global AIDS Strategy and the impressive progress made to date in mobilizing the resources to carry out the Global Strategy. A number of the strategy’s interventions are highly effective, and many national and international partners have adopted these interventions to save lives. The challenge now is to intensify the implementation of these interventions to significantly slow the epidemic’s rapid spread.

This chapter summarizes the achievements and shortfalls of the global response, including that of the Bank. Based on this analysis, Chapter 6 suggests new actions to enhance the work currently supported under the Bank’s AIDS Strategy for Africa.

Figure 5.1 below introduces an AIDS response paradigm to assess the adequacy of prevention and mitigation. This paradigm broadens the response to include multisectorial and socio-economic concerns summarized previously in Box 4. Two types of prevention efforts, direct (square 1 in figure 5.1) and indirect (square 2), inhibit HIV transmission. Two types of mitigation efforts, those directed toward AIDS patients (square 3) and those directed toward AIDS-affected groups (square 4), help ease the adverse health and socioeconomic effects of AIDS.

**Figure 5.1 Efforts that prevent HIV infection and mitigate the impacts of AIDS**

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct</strong></td>
<td><strong>Indirect</strong></td>
</tr>
<tr>
<td>AIDS interventions</td>
<td>Human resource and economic development</td>
</tr>
<tr>
<td>Education on safe behaviors</td>
<td>Strengthening health systems</td>
</tr>
<tr>
<td>Condom promotion</td>
<td>Increasing girls education</td>
</tr>
<tr>
<td>STD treatment</td>
<td>Increasing economic opportunities for women</td>
</tr>
<tr>
<td>Safe blood supply</td>
<td></td>
</tr>
<tr>
<td>Infected individuals</td>
<td>Care of AIDS patients</td>
</tr>
<tr>
<td>Treatment of infections</td>
<td></td>
</tr>
<tr>
<td>Care of AIDS patients</td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td></td>
</tr>
<tr>
<td>Affiliation of care</td>
<td></td>
</tr>
<tr>
<td>Financial and in kind aid</td>
<td></td>
</tr>
<tr>
<td>Affected groups</td>
<td></td>
</tr>
<tr>
<td>Care of AIDS-affected families, communities, and sectors</td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td></td>
</tr>
<tr>
<td>Targeted interventions for the poor</td>
<td></td>
</tr>
<tr>
<td>Replacement of lost labor</td>
<td></td>
</tr>
</tbody>
</table>

**Prevention that works**

Direct prevention of HIV transmission is the first priority in the response to the epidemic.

**Direct efforts**

The four most effective HIV prevention interventions (education on safe behavior, condom promotion, STD treatment, and a safe blood supply) can be found in every African country (square 1). Studies in Rwanda, Tanzania, Zaire, Zambia and Zimbabwe have shown these interventions to be cost-effective in reducing the incidence of HIV and other STDs in certain target groups (the military and commercial sex workers) and in larger communities of the
general population. Still, these interventions have rarely attained the depth (all interventions in place at the same time) and breadth (reaching all target groups) required to substantially slow the epidemic’s spread. For example, HIV prevalence rates among pregnant women continue to exceed more than 30 percent in several urban areas in southern Africa.

The Bank’s role. The Bank’s new freestanding AIDS projects in Burkina Faso, Chad, Kenya, and Uganda were designed to intensify the depth and breadth of the four interventions. Bank-assisted projects containing AIDS-related activities with intensified interventions are being planned in Congo, Côte d’Ivoire, Guinea-Bissau, and Tanzania. But these nine countries are the exception. Many affected countries—among them Burundi, Cameroon, the Central African Republic, Ethiopia, Malawi, Nigeria, Rwanda, and Togo—lack the essential elements that intensify the depth and breadth of the interventions making up their national AIDS control programs. The progress of these interventions in preventing HIV infection is summarized below.

a.) Education on safe behaviors

Education on AIDS and safe sexual behaviors has substantially increased AIDS awareness throughout Africa. About 65 percent of rural populations and 100 percent of urban populations are aware of AIDS. How this knowledge influences the adoption of safe behaviors is less clear. Some African men are taking fewer sexual partners, and some men (about 25 percent of those surveyed in Burundi and Zambia) engaging in casual sex are regularly using condoms (Caraël and Cleland 1993). Because the largest share of new HIV infections is among young adults and adolescents, this is one of the most important groups to target. Yet not all youth are being reached—sexual education courses in schools are often optional, and community activities targeting out-of-school youth are limited in number. And every year a larger cohort requires consistent and sustained messages on prevention.

It is not yet widely known how Africa’s high awareness of AIDS can be internalized by Africans into the adoption of safe sexual practices continent wide. The experience and best practices on how to bring about fundamental changes in social norms is thin in Africa and elsewhere. Several European donors, U.S. and Australian institutions, and United Nations agencies have recently acknowledged the role behavior plays in AIDS (and family planning), and have substantially increased grant funding in this area. And some African universities have increased the number of social research programs. Still, few NGO’s and institutions in Africa have the capacity to expand the knowledge of which factors influence behavior. Technical and financial assistance is needed to increase the number of African organizations and institutions adept in the behavioral fields.

The Bank’s role: Through its regional programs, the Bank is expanding the efforts of three nongovernmental organizations and one institute in carrying out behavior research and interventions across country borders in East, Southern and West Africa. In addition, nearly two-thirds of thirty-six Bank-assisted projects with AIDS components promote safe sexual behaviors.
b.) Condom promotion

The explosive increase in sales of socially marketed condoms (from 2 million in 1988 to 120 million in 1994) suggests that consistent demand for condoms can be created if the condoms are affordable, accessible, and of good quality. With safer sexual behaviors becoming more common, condoms requirements in Africa are expected to reach 932 million condoms a year by 2000 (WHO 1993). Thus the twenty-five African countries without social marketing programs for condoms must immediately establish them to fill this projected need. In addition to socially marketed condoms, the demand for condoms will have to be met by free condoms procured internationally by the United Nations Fund for Population Activities, the U.S. Agency for International Development, the WHO, and governments with Bank financing, and possibly by condoms manufactured in Ghana and Nigeria and sold for profit regionally. On a parallel course, testing of the new female condom and research for a female controlled virucide must continue.

The Bank's role. The freestanding Bank-assisted AIDS projects in Burkina Faso, Chad, Kenya, and Uganda and health projects in Benin and Guinea include procurement and distribution of free condoms for HIV/STD prevention. The projects in Burkina Faso and Chad also support social marketing programs. The proposed STD prevention project in Nigeria includes the plan to explore the profitability of manufacturing condoms locally.

c.) STD treatment

Many capital cities can boast one clinic providing quality STD care—but few countries have the drugs, training, and personnel to integrate STD care with their primary health care services. The importance of STD treatment was highlighted by the recent findings of a Mwanza, Tanzania study, which found that effective treatment of curable STDs lowered HIV incidence by 42 percent.

The Bank's role. Studies assessing STD prevalence and related risk factors have been sponsored by the Bank in eight countries and are planned in three more, in Central and Western Africa. Working with the WHO, the Canadian International Development Agency, and the U.S. Agency for International Development (USAID), the Bank is increasing the University of Nairobi’s ability to meet countries’ needs for STD training. The Bank is also one of the few international organizations financing the procurement of drugs for STD care.

d.) Safe blood supply

Although HIV transmission through blood products contributes only minimally to the African epidemic, safe blood is a necessary objective of any AIDS control program. Only ten countries in Africa screen all blood and blood products for HIV. Testing equipment is expensive and in short supply in most countries, especially in rural areas. The testing equipment that is available is usually supplied by the European Union, the WHO, and the Danish International Development Agency, in addition to the Bank.
The Bank's role. Fourteen Bank-assisted health projects support the screening of blood for HIV. This intervention includes procuring tests and testing equipment and setting up management and logistical systems for screening, referral, and reporting. Of critical importance is ensuring that confidential mechanisms exist to exclude blood donors of high risk to HIV and all persons are counseled before (and after if HIV-positive,) while donating blood.

Indirect efforts

Human resource and economic development efforts (square 2 in figure 5.1) are addressing many of the socioeconomic conditions that make people—especially women—more vulnerable to HIV. These prevention activities often require a longer time frame than the direct interventions just discussed. The United Nations Development Programme (UNDP), bilateral donors, and the African Development Bank are the main international actors, in addition to the Bank, assisting African governments with these development efforts.

a.) Strengthening health systems

A number of national and international organizations—public and private—have made tremendous strides toward improving the delivery of health services throughout Africa. The decreases in child and adult mortality witnessed in Africa over the past decades attest to this progress. But much more can be done. An additional $1.6 billion a year is needed to ensure a basic package of health services in the rural and periurban areas of low-income Africa. Strengthening the health system will involve improving the physical and managerial operations of health systems, with an emphasis on facility renovations, pharmaceutical procurement, and better management and training of personnel.

The Bank's role. Bank-assisted health projects implemented in Angola, Burkina Faso, Guinea, Madagascar, Malawi, Mali, Mauritania, Niger, Nigeria, Uganda, and Zimbabwe. Bank assisted-health reform projects have recently begun in Ethiopia, Kenya, Mozambique, Tanzania, and Zambia. New lending in health to Sub-Saharan countries averaged more than $200 million a year during 1993–95. This total will rise to more than $400 million during 1996–98.

b.) Increasing girls' education

Educating girls is widely recognized as one of the most important steps in development. Education for girls has a catalytic effect on every dimension of development: lower child and maternal mortality rates, reduced fertility rates, increased educational attainment by daughters and sons, higher productivity, and better environmental management. Yet less than 70 percent of eligible African girls enroll in primary school, and only 68 percent of those girls enrolled in first grade complete primary school (Carr-Hill and King 1992). The United Nations Children's Fund, the United Nations Educational, Scientific, and Cultural Organization, and the African Development Bank follow the Bank as the leading multinational and bilateral supporters of education.
The Bank's role. Bank lending for education has increased significantly the past decade. Annual lending to Africa for education averaged $122.8 million during FY 1985–89, and reached $325.5 million in FY 1994. Since 1990, about 40 percent of Bank-assisted education projects in Africa have included female education components, from providing scholarships to training female teachers.

c.) Increasing economic opportunities for women

Improving women's productive capacity can contribute to growth, efficiency, and poverty alleviation—key development goals everywhere. Yet numerous barriers continue to shut out women and limit their opportunities. Effective strategies for reducing the barriers to women's economic participation have emerged over the past two decades through work performed by nongovernmental organizations, women's groups, and the Bank.

The Bank's role. Since 1992, 57 percent of Bank lending to Africa has promoted macroeconomic adjustments that foster growth, and 17 percent is directed to narrowly targeted services whose main beneficiaries are the poor. Between 1987 and 1990 the Bank introduced eighty-one projects with enterprise development and financial services for women components—the majority of them in Africa—to raise incomes and generate new employment. These activities are found in agriculture, industry, and urban development projects. The Bank also supports through a regional program legal reforms (in land ownership and credit access) for women in Africa.

Although these human resource and development efforts occur outside the health sector, they can be used to target populations specifically at risk of HIV infection. For example, programs to educate girls and increase women's access to credit could include female sex workers, orphans, and street children. More communication and collaboration between the sectors and among community leaders would strengthen the program linkages between development and HIV vulnerability.

Mitigation that is responsive and sustainable

Although efforts to mitigate the consequences of AIDS (squares 3 and 4 in figure 5.1) are less urgently needed than those to prevent HIV, mitigation is still important. People living with AIDS can lead productive lives if they receive support from their families and communities. They can also contribute to prevention efforts in their communities, as agents of change and peer educators. In addition, families that are affected by AIDS suffer from personal loss, increased medical costs and burial fees, and reduced income. These larger socioeconomic impacts are significant—and should be addressed.

Improving care for AIDS patients

None of the thirteen countries most severely affected by HIV has experienced its peak of AIDS cases. Thus the number of AIDS patients requiring care in these countries is going to increase. Several NGO's (Tanzania NGO to assist People with AIDS—WAMATA and The
AIDS Support Organization—TASO) have shown that AIDS patients and their survivors can receive appropriate care and counseling away from the overburdened hospital systems. In fact, twenty-seven countries have some form of community-based care for AIDS patients. Questions regarding the cost-effectiveness and sustainability of these programs have yet to be answered, however. Thus, more information is needed on the costs of various approaches to service provision, and on who bears these costs.

The Bank's role. Bank-assisted research into alternative, cost-effective modes of caring for the increasing number of AIDS patients has been performed in Tanzania and Uganda, and is planned in Botswana and Côte d’Ivoire. This research complements the work performed by others in Kenya and Zambia. A Bank-assisted project in Zimbabwe has increased the availability of drugs for tuberculosis and other opportunistic infections by 21 percent. Similar results are expected in Burkina Faso, Chad, Kenya, and Uganda.

Caring for AIDS-affected families, communities, and sectors

USAID, UNDP, the FAO, and several other international organizations have studied the consequences of AIDS, most recently in Kenya, Malawi, South Africa and Zambia. For example, the average Malawian family loses, in addition to a personal loss, a contribution of more than fifteen years of productive life when a male family member dies of AIDS (Family Health International 1994).

The Bank's role. Three comprehensive Bank studies in Tanzania and Uganda and other analytical work sponsored by the Bank assess the socioeconomic impact AIDS is having or will have on African households and communities, as well as on the public and private sectors. This information helps convince policymakers of the need for a multisectoral response to AIDS and of the epidemic's dramatic impact on development. Still, few policies addressing these impacts have been developed as a result of such efforts. An abbreviated form of these studies, with better use of the data for policy and program decisionmaking, is planned for many of the other severely affected African countries, including Botswana, Burundi, Congo, Côte d'Ivoire, and Rwanda.

Outside the health sector, integration of the findings of AIDS-related sector work with Bank operations has been limited. Among twelve most severely affected countries, the five poverty assessments and nine policy framework papers completed since 1991 make reference to AIDS. In addition, eight of ten Country Assistance Strategies and four of six public expenditure reviews mention the disease. But few of these documents factor the consequences of AIDS (for example, loss of skilled labor, increased economic hardship, and the impact on adult mortality) into their analyses of sector development or recommendations for poverty alleviation.
6. **Enhancing the Bank’s Strategy—1996-2000**

This last chapter sets the scene for the Bank’s AIDS strategy for the near future. Simply stated, the Bank will continue to support what works, plus undertake several additional actions to enhance its Strategy.

**Build on Current Strengths**

Through its sector work and lending operations with African countries and in collaboration with UNAIDS, the Bank should continue to support cost-effective HIV prevention measures, both directly (through education on sexual behavior, condom promotion, STD treatment, and a safe blood supply) and indirectly (through better health services, education for girls, and economic opportunities for women). The Bank should also continue to support facility and community-based mitigation efforts, that alleviate the adverse health effects of AIDS on patients, and the adverse socioeconomic effects on their families, and their communities.

Five new actions are required from the Bank. The Bank should help Africa to • generate greater political commitment to the activities contained in the two recent OAU declarations, • intensify national AIDS control programs in additional countries, • work more vigorously on the adoption of safe sexual behaviors, • increase the analysis of AIDS and its impact on development goals in economic and sector work, and • improve the design and implementation of cost-effective approaches to mitigate the consequences of AIDS.

**Additional Areas for Bank Action**

The Bank should continue to support the cost-effective interventions—education, condom promotion, STD care, and safe blood—for prevention. Prevention efforts would, however, have more impact on slowing the epidemic if the interventions were backed with strong leadership, if knowledge on the determinants of behavioral change in Africa is increased, and the interventions are intensified. Thus the Bank will assist Africans to:

• generate greater political commitment to the OAU declarations on AIDS

• work more vigorously to change health behaviors

• intensify national programs according to a typology of countries based on severity of prevalence levels

Although AIDS is often referenced in Bank economic and sector documents, the adverse consequences of AIDS on development objectives in severely affected countries such as decreased life expectancy and productivity is rarely factored in the analyses used to develop a country’s assistance strategy. In addition, the review found that few policies and cost-effective interventions exist in mitigating the socio-economic effects of AIDS. Thus, the Bank should address these gaps by helping governments and NGO’s:
• increase the analysis of AIDS and its impact on development goals in economic and sector work, and

• improve the design and implementation of cost-effective approaches to mitigate the consequences of AIDS

**Generate greater political commitment to the OAU declarations**

Attaining the required intensity of interventions is a formidable goal for Africa—but one that must be achieved. African leaders have pledged to meet this goal, having made personal and political commitments to carry out the activities in the 1992 and 1994 OAU declarations on AIDS.

Through the Bank’s close working relationship with the OAU, the Bank should help the OAU monitor country progress in implementing the activities contained in the two declarations. A reporting instrument and system should be devised to track progress and report back periodically to the OAU Assembly. Furthermore, the success of the OAU delegation tour of four countries in August 1995 suggests that additional tours should be undertaken with Bank assistance. Based on criteria that includes geographical representation and needs, suggested countries for the next tour include the Central African Republic, Gabon, Mozambique, and Namibia. The findings of these country visits and of the reporting instrument circulated to all African country should be the subject of a report to be presented at the OAU Assembly in June 1996.

**Work more vigorously to change behaviors**

The Bank should support Africans in strengthening of programs leading to the adoption of healthy sexual behaviors and practices. Three separate tasks built on the Bank’s cooperative advantage in policy dialogue and sector work are proposed to strengthen capacity in this field:

• Establish a group called *African Advisers on Behavioral Change* to organize analytical work and behavioral change programs in Africa for better health. The group will bring together prominent spokespersons from various backgrounds to explore, promote, and give direction to other Africans, the Bank and international partners on the many facets of changing behavior. Sub-regional lessons learned will be emphasized.

• Design and undertake a comprehensive review of the progress to date and challenges ahead in changing risky practices and adopting safe behaviors in Africa. The terms of reference and work for this study will be commissioned by the African Advisers on Behavioral Change, and its findings will shape the Bank’s regional lending activities.

• Augment Bank initiatives to strengthen African public and private institutions, and community-based organizations currently involved in behavioral interventions. These
organizations will serve as national and regional centers of expertise for building the capacity of professionals and community leaders in improving health practices.

**Intensify national programs according to a typology of countries based on severity of prevalence levels**

Of the forty-seven African countries, thirteen have HIV prevalence rates among adults greater than 5 percent, and another sixteen have adult prevalence rates greater than 1 percent. Among these twenty-nine countries, intensified AIDS control programs exist or are planned in twelve. Of the seventeen countries remaining, the Bank should first help eight—Burundi, Cameroon, the Central African Republic, Ethiopia, Malawi, Nigeria, Rwanda, and Togo—secure the human and financial resources needed to attain the intensity in depth and breadth required to have a substantial impact on the epidemic’s spread. The last nine countries should be assisted in a later phase.

The financial resources required to prevent HIV and mitigate the consequences of AIDS are estimated at $1.9 per capita annually—about 15 percent of the $13 per capita needed to supply a basic package of health care services in low-income African countries. Less is known about the human resources required to support a comprehensive AIDS response, although the health personnel and community mobilization needs are extensive.

As grant money becomes more scarce—and the direct and indirect costs of HIV and AIDS increase—the need for borrowing is becoming more apparent for the severely affected countries. Within its new role as a cosponsor of UNAIDS, and in collaboration with the Global Coalition for Africa and the Organization of African Unity, the Bank should initiate discussions with government leaders in these countries to ascertain what is needed to intensify AIDS control program interventions and how resources can be mobilized and coordinated. If required the Bank should provide additional resources to help these governments mount intensified national AIDS control programs.

**Increase the analysis of AIDS and its impact on development goals in economic and sector work**

The country departments serving the most severely affected countries should ensure that AIDS is addressed in relevant country analytical work both in and outside the PHN sector. Specifically, AIDS impact on adult and child morbidity, mortality and life expectancy, and on labor, productivity and savings should be assessed for several sectors, particularly PHN, education, agriculture, industry and transport in the severely-affected countries. The findings of these assessments should be incorporated into the country assistance strategies. Thus, the country assistance strategy, country economic memorandum, policy framework papers, poverty assessment and public expenditure reviews should not only mention AIDS as they often do now, but also factor the consequences of AIDS in their analyses and recommendations for improved development strategies.
Improve the design and implementation of cost-effective approaches to mitigate the consequences of AIDS

Because it is not yet clear which approaches best deliver community-based care or which policies best ease the adverse socioeconomic consequences of AIDS, the Bank should support African decisionmakers in designing and implementing mitigation policies. Many of the donors supporting AIDS work look to the Bank to provide specific support to these socio-economic aspects of the epidemic. Increasing the cost-effectiveness of health care for AIDS patients is an obvious priority. Other priorities include the need to decrease the economic hardships confronting AIDS-affected households and communities, improve care and schooling of orphans and replace the skilled workers in industry and government lost to AIDS.

The Bank should identify best practices and summarize lessons learned, define directions for future Bank and country policy and design and implement policies and interventions to help families, communities and sectors mitigate the adverse consequences of the epidemic. These policies and interventions will need to answer such questions as: How can quality care of AIDS patients be provided in facilities and homes at minimal cost to both the health system, other health system beneficiaries and home care givers? What components of AIDS patient care are the most likely to be sustained? What assistance is most needed by impoverished families and communities affected by AIDS and what criteria should be used to assess the most needy? What measures can families, industry and other sectors severely-affected by AIDS take to replace lost labor and productivity?

Bank Comparative Advantages and Risks in Undertaking the New Actions

What are the Bank’s comparative advantages to carrying out the first three new actions for prevention? The Bank’s access to decision makers in government ministries such as finance and plan in addition to the ministry of health, gives the Bank the advantage in the first action regarding increased political commitment. Although traditionally the Bank has not been seen as a lead player in supporting programs that strive to influence behavior change—the second action—this role is undoubtedly changing and becoming more visible, as the Bank increases its involvement in human resource development. Three reasons justify the third action. The Bank’s mobilizing of funds for several regional programs (NIARSH and West Africa Regional Program), the increase in demand for Bank support for AIDS activities and the Bank’s new partnership with the UNAIDS program, illustrate that the Bank has been and continues to be in a position to assist African governments secure the resources necessary to launch intensified AIDS-related activities, the third action.

The Bank’s comparative advantage in the last two actions for mitigation is that few other agencies involved in AIDS work have the clear economic mandate in development as does the Bank. Of the six UNAIDS cosponsors, it is the Bank that is looked to, to provide the leadership in economic analyses of AIDS interventions and impact. As the UNAIDS Strategic Plan becomes operational, the request for Bank contribution to ‘the economic side’ of AIDS will increase.
The overwhelming risk to ‘taking on AIDS’ has been that of having only to rely on behavior change for success as opposed to a cure or vaccine. This risk remains. If the success of the collective response to AIDS is still most dependent on widespread adoption of safe behaviors, the risk in failing will have to be reduced by ‘taking on the subject of behavior’. Few, but enough examples of successful behavior change exist in Africa and worldwide, as a knowledge base from which to expand. Thus, for the Bank to assist Africans in this endeavor, the Bank should strengthen its own knowledge of what factors influence the adoption of safe behaviors and what improvements in project design, implementation and evaluation are required to attain healthy practices in Africa.

Figure 6 below summarizes the updated AIDS Strategy for Africa.

| Purpose: Preventing HIV Infection and Mitigating the Impact of AIDS in Sub-Saharan Africa |
| Activity: Economic and Sector Work |
| Outcome: Learning more about STDs/HIV and the impact on development |
| | Performed | On-going | Planned |
| STD Rapid Assessment Studies | 8 | 1 | 2 |
| AIDS Impact Studies | 2 | 1 | 8 |

New actions: Assist Africans to
- Increase the analysis of AIDS and its impact on development goals in collaborative economic and sector work
- Improve the design and implementation of cost-effective approaches (care and coping) to mitigate the consequences of AIDS

| Activity: Policy Dialogue and Regional Programs |
| Outcome: Increasing awareness, linking AIDS and population activities and building capacity |
| Putting the subject of AIDS and development on Agendas |
| Combining Population and AIDS projects in countries, where appropriate |
| Developing regional programs to intensify national AIDS and population plans, identify the determinants of sexual behavior, and assess service demands among beneficiaries. |

New Actions: Assist Africans to
- Generate greater commitment to the two OAU declarations on AIDS
- Establish African Advisers on Behavior Change Group
- Broaden influence of African Centers of Expertise

| Activity: Lending Operations |
| Outcome: Assisting African countries strengthen AIDS prevention and mitigation programs |
| By 1995 - 36 projects in 24 countries |
| By 1997 - 16 additional projects in 15 countries |

New Actions: Assist Africans to
- Mount intensified AIDS Control Programs according to a typology of countries based on severity of prevalence levels.
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Containing Indications for Use by OAU Member States in Their Implementation of the OAU Declarations Adopted In Dakar (1992) and Tunis (1994)
## Agenda for Action: Point One

**Point One of the Dakar Declaration:** Agreement of giving our fullest political commitment to mobilizing society as a whole for the fight against HIV/AIDS

No corresponding point in Tunis Declaration

### Timeframe: Within 3-12 months of 1994

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<tr>
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<th>Activities and Target</th>
<th>Output</th>
<th>National Responsibility</th>
<th>Action Performed?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heads of State and Government to confirm publicly personal commitment to mobilize society to fight against HIV/AIDS and reduce isolation of people living with AIDS.</td>
<td>1. Make a public declaration by Heads of State and Government to mobilize the nation against AIDS in general, and its impact on specific groups at risk, especially children.</td>
<td>Written public declaration submitted to OAU Secretariat</td>
<td>* Ministry of Health with Office of President and Ministries of Information, Foreign Affairs and National Planning/Finance</td>
<td>Yes</td>
<td></td>
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<tr>
<td>2. Heads of State and Government will establish multisectoral AIDS Advisory Committee and encourage preparation and processing of necessary legislation.</td>
<td>2a. Prepare the necessary legislation for establishment of a National AIDS Advisory Committee within 3-5 months.</td>
<td>Committee established and a list of members provided to OAU Secretariat</td>
<td>* Head of State and Government</td>
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<td></td>
<td>2b. Form a multisectoral, multi-disciplinary National AIDS Advisory Committee within 6 months - 1 year.</td>
<td></td>
<td>* Office of the President</td>
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</table>

* Example: yes; committee formed within 1 year, June 1994.
### Agenda for Action: Point Two

Point One of Tunis Declaration: Commitment to elaborate a national policy framework for the needs of HIV/AIDS-affected children

No corresponding point in Dakar Declaration:

**Timeframe:** Within 8 to 24 months of 1994

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Activities and Target</th>
<th>Output</th>
<th>National Responsibility</th>
<th>Action Performed?</th>
<th>Comments</th>
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</thead>
</table>
| 1. Elaborate a 'national policy framework' to guide and support appropriate responses to the needs of affected children covering social, legal, ethical, medical and human rights issues. | 1a. Form a multi-sectoral multi-disciplinary team (as a sub-group) of the National AIDS Committee to develop a 'national policy framework' to guide and support responses to the needs of children affected by HIV/AIDS within 8 months - 1 year.  
1b. Develop a 'National policy framework' on children with active NGO participation which takes into account issues related to food and nutrition, education problems of orphans, medical care and social services for HIV-infected persons and their families within 24 months. | Committee established  
National policy framework developed | * Head of State and Government  
* Office of the President  
* National AIDS Advisory Committee  
* Ministry of Justice  
* Ministry of Health  
* Ministry of Social Affairs  
* Ministry of Education  
* Ministry of Local Government  
* National AIDS Advisory Committee | | |
<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Activities and Target</th>
<th>Output</th>
<th>National Responsibility</th>
<th>Action Performed?</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A multisectoral team (including Ministries of Health, Finance, Information, private sector and NGOs) will initiate on-going nationwide professionally designed and sustained media campaigns using television, radio, films, video and audio-music cassettes, concerts and sporting events, with inputs from professional or advertising sectors.</td>
<td>1a. Form a multisectoral, multi-disciplinary team (as a sub-group of the National AIDS Advisory Committee) responsible for designing media campaigns and other information, education and communication campaigns (IEC) within 6 months.</td>
<td>Sub-committee established and campaigns designed and messages developed</td>
<td>* National AIDS Advisory Committee</td>
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<td>1b. Develop a schedule for repeated nationwide media coverage and public events to mobilize the nation against AIDS within 6 months.</td>
<td>Schedule developed</td>
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<td>1c. Expose urban and rural residents aged 15-49 to media messages, at least once weekly, on safer sex, condom use and compassion for people with HIV/AIDS within 18 months.</td>
<td>Media messages broadcast to residents at least once weekly</td>
<td></td>
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<td></td>
<td>1d. Develop media messages to reach out-of-school youth on prevention of HIV/AIDS and to inform them of health care services available within 18 months.</td>
<td>Youth exposed to media messages regularly and aware of services available</td>
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<td>2a. A multisectoral team (including Ministries of Health, Education, Finance, NGOs and Parent-Teacher Associations) to intensify nationwide training for Sex and HIV/AIDS-specific education for primary and secondary schools.</td>
<td>2a. Form a multisectoral team (as a sub-group of National AIDS Advisory Committee) responsible for intensifying nationwide training for the development and conduct of sex HIV/AIDS educational programmes within 1 year, including development of training materials and training of trainers.</td>
<td>Sub-group on training formed and list including terms of reference provided to OAU Secretariat. Materials developed. Trainers trained.</td>
<td>* National AIDS Advisory Committee * Ministry of Education * Ministry of Local Government * Ministry of Culture</td>
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<tr>
<td>Action Steps</td>
<td>Activities and Target</td>
<td>Output</td>
<td>National Responsibility</td>
<td>Action Performed? Comments</td>
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| 2b. A multi-disciplinary team (including Ministries of Health, Social Welfare, Youth, Labour, Agriculture, Transport, Defense and Finance, private sector and NGOs) will initiate nationwide HIV/AIDS education programmes for target communities, youth and groups at high risk to HIV infection (e.g. prostitutes/clients, truckers, traders, military, migrant labourers, STD patients). | 2b. Provide intensified education training for primary and secondary school teachers, including skills training, within 2 years | Training programmes developed and teacher training on-going | • Ministry of Health  
• Ministry of Education | |
|                       | 2c. Develop culturally appropriate sex education programmes for youth in schools to help increase their knowledge and skills to avoid sexual exploitation and for prevention of HIV infection and other STDs within 24 months. | Sexual education programmes developed for youth and youth training on-going | • Ministry of Education  
• Ministry of Social Affairs  
• Ministry of Health  
• National AIDS Advisory Committee | |
|                       | 2d. Develop and introduce community and person-to-person AIDS education for target communities (e.g. prostitutes/clients, truckers, traders, military, migrant labourers, STD patients) in at least 70% of urban and 50% of rural areas within 2 years. | Person-to-person and community programmes for AIDS education designed and target communities being educated | • Ministry of Health  
• Ministry of Education | |
| 3. Legal protection of young people from HIV infection. | 3a. Review laws and policies that affect the welfare and economic status of young people and their families; e.g. laws that criminalize destitute children; laws of inheritance, laws that regulate age of consent, and policies on employment, education and child care and policies of HIV testing of children within 24 months. | Laws and policies reviewed and revised and copies provided to OAU Secretariat | • Head of State and Government  
• Government  
• Ministry of Social Affairs  
• Ministry of Justice | |
|                       | 3b. Develop national policies and guidelines to prevent parental transmission of HIV through infected blood on the use of contaminated needles/syringes or traditional surgical manipulation, also introduce legislation to discourage potentially harmful traditional practices within 24 months. | Policy and guidelines developed and copies provided to OAU Secretariat | • Ministry of Health  
• National AIDS Advisory Committee  
• Head of State and Government | |
### Agenda for Action: Point Three (cont’d)

**Timeframe:** Within 6 months to 24 months of 1994

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Activities and Target</th>
<th>Output</th>
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<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. A favourable policy climate will be created to promote gender issues geared towards strengthening women's needs and rights as groups sexually vulnerable to HIV/AIDS.</td>
<td>4a. Develop and issue a policy statement on needs and rights of women as groups sexually vulnerable to HIV/AIDS, within 6 months.</td>
<td>Policy statement developed and issued to public and copied provided to OAU Secretariat</td>
<td>• National AIDS Advisory Committee with Government Ministries</td>
<td></td>
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<td></td>
<td>4b. Establish a multisectoral subgroup on women and AIDS, responsible for promoting gender issues and creating a policy climate geared towards strengthening the rights of women within 6 months.</td>
<td>Sub-committee on women established and list and terms of reference submitted to OAU Secretariat</td>
<td></td>
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<td></td>
<td>4c. Develop a policy to decrease the cases of discrimination against the rights of women so that a reduction in the number of cases is evident within 2 years.</td>
<td>Policy developed and issued publicly and in international fora, copy provided to OAU Secretariat</td>
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<td></td>
<td>4d. Increase media attention (e.g. press reports) to support the policy statement on women within 6-12 months, with the support and involvement of the sub-group on media.</td>
<td>Press reports released</td>
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</tbody>
</table>

* • Multisectoral team under the direction of the National AIDS Advisory Committee
  • Ministry of Information with National AIDS Advisory Committee
  • Media sub-group
### Agenda for Action: Point Four

**Point Three of Dakar Declaration:** Commitment to planning for the care of people with HIV infection and AIDS and the support of their families and survivors  
No corresponding point in the Tunis Declaration

**Timeframe:** Within 12 to 24 months of 1994

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Activities and Target</th>
<th>Output</th>
<th>National Responsibility</th>
<th>Action Performed? Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Ministry of Health will formulate policies and national guidelines on</td>
<td>1a. Formulate National Policy guidelines for HIV testing.</td>
<td>National policies and guidelines formulated and copy submitted to OAU</td>
<td>* Ministry of Social Affairs and Ministry of Local Government</td>
<td></td>
</tr>
<tr>
<td>HIV testing, and care of AIDS orphans.</td>
<td>1b. Formulate National Policy guidelines for care of AIDS orphans within 1 year.</td>
<td>Secretariat</td>
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<td></td>
<td>2a. Develop national guidelines for comprehensive AIDS care including guidelines</td>
<td>as above</td>
<td>* Ministry of Health, Ministry of Social Affairs, Ministry of Local Government</td>
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<td>for ensuring the access of all young people and women to reproductive health care,</td>
<td>as above</td>
<td>* Health Training Institutions</td>
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<td>counselling and medical care services within 18 months.</td>
<td></td>
<td>* Ministry of Health</td>
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<tr>
<td></td>
<td>3. National policies formulated and guidelines initiated for integration of HIV/AIDS</td>
<td></td>
<td>* Ministry of Health</td>
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<td></td>
<td>and specified health programmes within 1 year.</td>
<td></td>
<td>* Health Training Institutions</td>
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<td></td>
<td>4a. Hold workshops of national experts to identify types of prevalent HIV/AIDS-</td>
<td>Workshops held; types of infections identified; treatment schedules</td>
<td>* Ministry of Health and Ministry of Planning</td>
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<td>related infections, TB and STDs, define treatment and identify basic drugs to be</td>
<td>defined and basic drugs included in EDL</td>
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<td>included in National Essential Drugs List (EDL) within 1 year.</td>
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<td></td>
<td>4b. Increase the availability of essential drugs for TB, STDs and HIV-related</td>
<td>Mechanisms established to increase availability of drugs and drugs</td>
<td>* Ministry of Health</td>
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<td></td>
<td>infections at 50% of urban and 50% rural health service facilities within 24 months.</td>
<td>made available on a sustainable basis.</td>
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</tr>
</tbody>
</table>
**Agenda for Action: Point Five**

**Point Four of Dakar Declaration: Commitment to supporting of appropriate and relevant AIDS research**

**Point Three of Tunis Declaration: Commitment to promote and support applied research**

**Timeframe: Within 12 to 36 months of 1994**

<table>
<thead>
<tr>
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</thead>
</table>
| 1a. Research needs will be assessed and research achievements or gaps identified through consultancies or national workshops. Local or collaborative research studies needed will be identified. | 1a. Assess AIDS research needs and develop research capability inventory within 1 year. | Research needs assessed and inventory developed                           | *Ministry of Health*  
*National AIDS Coalition Programme*  
*Medical Research Committee* | No                                |                                                                                          |
| 1b. Promote research efforts based on African experience and tradition and support institutes of research in Africa working mainly in the field of determining the magnitude and extent of HIV infection in children and women and the underlying factors to HIV infection in order to prevent the spread of infection and alleviate its consequences on children and women. | 1b. Give support to or conduct studies to establish the scale and nature of the problem of AIDS-affected children. The numbers, where they are, the circumstances of their lives, and the nature of their needs within 12 months. | Research issues identified and high priority given to studies in this area | *Ministry of Health*  
*National AIDS Coalition Programme*  
*Medical Research Committee* | No                                |                                                                                          |
| 1c. Give support to or conduct studies to determine the factors underlying the spread of HIV infection in children within 24-26 months. | 1c. Give support to or conduct studies to determine the factors underlying the spread of HIV infection in children within 24-26 months. | Research issues identified and high priority given to studies in this area | *Ministry of Health*  
*National AIDS Coalition Programme*  
*Medical Research Committee* | No                                |                                                                                          |
| 1d. Establish a research committee and develop a national consensus on priority research areas including human and financial resources required within 1 year. | 1d. Establish a research committee and develop a national consensus on priority research areas including human and financial resources required within 1 year. | Committee established; meeting held to develop a national consensus and human financial resource needs identified | *Ministry of Health*  
*National AIDS Coalition Programme*  
*Medical Research Committee* | Yes                               |                                                                                          |

2. National research guidelines to be drawn up, and AIDS Research Plan and Programme to be established and promoted among potential donors and partners.

- 2a. Develop and endorse National AIDS policy guidelines within 1 year.
- 2b. Research policy developed, endorsed and disseminated widely for researchers and research institutions nationally and internationally.
### Agenda for Action: Point Five (cont'd)

**Timeframe:** Within 12 to 36 months of 1994

<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| 2b. Design and endorse National AIDS Research Plan and Programme within 1 year. | National Research Plan and Programme designated and endorsed, plan disseminated and funding sources identified or being sought, plan provided to OAU Secretariat | * National AIDS Control Programme  
* Medical Research Council | | |
| 2c. National AIDS Research policy guidelines, and research plan and programme promoted among national research institutions and potential donors and partners within 18 months. | Mechanism to promote research plan and policy designated and implemented | * medical research committee  
* National AIDS Control Programme  
* Ministry of Health | | |
| 3. Research capacity will be promoted and strengthened and a mechanism established to ensure coordination of AIDS research between African countries. | Ways of promoting and strengthening regional research networks identified including registration of national and regional branches of African research networks | * Ministry of Health  
* Medical Research Council with National AIDS Control Programme | | |
| 3. Promote and strengthen national and regional research networks, e.g. by registration of national and regional branches of African research networks within 18 months. | | | | |
### Agenda for Action: Point Six

**Point Five of Dakar Declaration:** Commitment to using our leadership position to ensure that all sectors of society work together to tackle the AIDS pandemic

No corresponding point in Tunis Declaration

**Timeframe:** Within 6 to 12 months of 1994

<table>
<thead>
<tr>
<th>Action Steps</th>
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<th>Output</th>
<th>National Responsibility</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. The Head of State and Government will present the Dakar Declaration for debate in Cabinet and strive to achieve consensus on the need for a multisectoral strategy.</td>
<td>1a. Make a presentation and debate of Dakar Declaration in Cabinet within 6 months.</td>
<td>Presentation made and debate held in Cabinet</td>
<td>* Cabinet</td>
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<tr>
<td></td>
<td>1b. Achieve consensus on need for multisectoral strategy within 6 months.</td>
<td></td>
<td>* Head of State and Government</td>
<td></td>
</tr>
<tr>
<td>2. Cabinet, will establish a Master Plan defining the process for building a multisectoral strategy for the national plan for HIV/AIDS.</td>
<td>2. Establish a Master Plan defining process for building multisectoral strategy for the national plan for HIV/AIDS.</td>
<td>Master Plan established and submitted to OAU Secretariat, and partners for endorsement</td>
<td>* National AIDS Advisory Committee</td>
<td></td>
</tr>
<tr>
<td>3. Individual Ministries will prepare according to the master plan sector-specific budgeted plans of action.</td>
<td>3. Prepare sector-specific budgeted plans of action within individual Ministries within 6 months.</td>
<td>Sector-specific plan prepared and submitted to OAU Secretariat</td>
<td>* Cabinet</td>
<td></td>
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<tr>
<td>4. Each sector-specific plan of action prepared by individual Ministries will identify partners, e.g., in other Ministries, NGOs and agencies, for collaboration to achieve planned objectives.</td>
<td>4. Identify and initiate collaboration between individual Ministries with partners in relevant Ministries, NGOs and agencies in order to achieve planned objectives within 6 months.</td>
<td>Areas of collaboration identified and initiated with partners</td>
<td>* Head of State and Government</td>
<td></td>
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<tr>
<td>5. The Head of State and Government will set up a multidisciplinary mechanism to monitor the Master Plan of sector-specific action plans, and to mobilize necessary resources.</td>
<td>5a. National AIDS Advisory Committee monitors progress of Master Plan of sector-specific action plans and mobilizes necessary resources, within 18 months.</td>
<td>Monitoring of action plans ongoing and resources being identified</td>
<td>* National AIDS Control Programme</td>
<td></td>
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<td></td>
<td>5b. Produce progress report within 1 year (and progress reports produced annually thereafter).</td>
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</table>
## Agenda for Action: Point Seven

### Point Five of Tunis Declaration: Commitment to monitoring the epidemiological situation and impact of the action programme and evaluate its implementation

No corresponding point in Dakar Declaration

**Timeframe:** Ongoing activity

<table>
<thead>
<tr>
<th>Action Steps</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1. Continuously monitor the epidemiological situation and the impact of the action programme (NAP) and regularly evaluate its implementation in order to effect any necessary modifications or reorientation.</td>
<td>1a. Monitor (with the support of collaborating agencies) the epidemiological situation of children infected with HIV and develop reports annually for circulation to all collaborators (ongoing).</td>
<td>Reports developed and circulated annually to collaborating agencies</td>
<td>* Ministry of Health</td>
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<td></td>
<td>1b. Develop and agree on selected programme indicators to measure progress to enable reporting and at regular intervals within 1 year.</td>
<td>Progress indicators detected and disseminated; information provided to OAU Secretariat</td>
<td>* Ministry of Health</td>
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<td></td>
<td>1c. Develop a report to consolidate the findings of the annual NAP reviews to be shared with all collaborators (ongoing).</td>
<td>Annual reports developed and disseminated to collaborators and OAU Secretariat</td>
<td>* Ministry of Health</td>
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<tr>
<td></td>
<td>1d. On the basis of the reviews, refine/revise the overall national AIDS plan annually (ongoing).</td>
<td>Plan refined/revised annually and update submitted to OAU Secretariat</td>
<td>* Ministry of Health</td>
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<td></td>
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</tbody>
</table>
## Agenda for Action: Point Eight

**Point Six of Dakar Declaration:** Commitment to make AIDS a top priority for external resource allocation so that our continent benefits from maximum international cooperation and solidarity in overcoming the pandemic and its impact.

**Point Four of Tunis Declaration:** Commitment to make definite and substantial budgetary provisions to meet identified requirements for preventive programmes among children.

### Timeframe: Within 6 to 18 months of 1994

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Activities and Target</th>
<th>Output</th>
<th>National Responsibility</th>
<th>Action Performed?</th>
<th>Comments</th>
</tr>
</thead>
</table>
| 1. | Reviews will be carried out of existing national HIV/AIDS programmes, of the effectiveness of specific preventive programmes including those for children, and of the capability for health service infrastructure and communities to cope with the epidemic. | 1. Conduct review of existing national HIV/AIDS programmes of effectiveness of specific preventive programmes and capability of health service infrastructure and communities to cope with the epidemic within 18 months. | Reviews conducted and information disseminated to all partners and donors, programmes revised accordingly. | • National AIDS Advisory Committee  
• National AIDS Prog.  
• Ministries of Health and National Planning  
• National AIDS Advisory Committee  
• National AIDS Prog.  
• Ministries of Health and National Planning | | |
| 2. | A review will be carried out of national manpower capabilities and needs in relation to national HIV/AIDS programmes and manpower training prepared and conducted where necessary. | 2a. Conduct a national manpower review within 1 year. | National manpower review conducted and mechanisms identified to strengthen resources; information shared with partners to support training. | | |
| 3. | A review will be carried out of national and international resource allocations to the health and social sector for HIV/AIDS, including the budgetary provisions for preventive programmes among children and for the care and support of those affected by HIV/AIDS. | 2b. Identify training needs and preparation and implementation of relevant training begun within 18 months. | Review conducted and gaps identified, mechanisms proposed to improve funding situation and share with partners. | • Ministry of Finance (MOF) with National AIDS Advisory Committee  
• Ministry of Finance with National AIDS Advisory Committee | | |
<p>| | 3a. Conduct a review of national and international resource allocations to health and social sectors and identify gaps within 6 months. | | | | |
| | 3b. Policies defined for increasing national and international contributions within 6 months. | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>4. On the basis of the reviews (1-3) the National Plans of Action will be formulated/refined. Based on those plans, the overall Plan for Africa will be prepared.</td>
<td>4a. Formulate and refine National Plans for Action based on a rational use of resources with the help of a coordinating group to avoid duplication of efforts and to consider the development of umbrella projects within 12 months. 4b. Make definite substantial and budgetary provisions to meet identified requirements for preventive programmes among children and for the care and support of those affected by HIV/AIDS. 4c. Develop an overall Plan for Africa prepared within 1 year.</td>
<td>National Plans of Action formulated and shared with partners and OAU Secretariat Budget developed and provisions made to support activities in collaboration with partners Plan of Action for Africa developed with involvement of all partners Plan promoted at relevant international and donor fora</td>
<td>• National AIDS Advisory Committee  • National AIDS Control Programme  • Ministry of Health  • National AIDS Advisory Committee  • Ministry of Health  • Ministry of Finance  • National Governments</td>
<td></td>
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<tr>
<td>5. The overall Plan for Africa will be promoted at international and donor fora.</td>
<td>5. Promote the overall Plan for Africa at international and donor fora.</td>
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