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April 28, 2000

U.S. GOVERNMENT USE ONLY

INTERAGENCY WORKING GROUP CONSENSUS PAPER

SUBJECT: Expanded United States Role in the Global HIV/AIDS Crisis

Background

Extent of the Problem: The human toll of AIDS is staggering. Fifty million people worldwide have been infected with the HIV virus; 33.6 million are now living with HIV/AIDS, and annual AIDS-related fatalities hit a record 2.6 million last year. Ninety-five percent of all cases are in the developing world. AIDS is now the leading cause of death in Africa and fourth in the world. In at least five African countries, over 20 percent of adults are HIV-positive. And the highest rates of new infections are often among young women who will soon be mothers.

Other parts of the world are going down the same road as Africa. Infection rates in Asia are climbing rapidly, with several countries, especially India, on the brink of a large-scale expansion of the epidemic and needing to take action immediately to forestall the disaster that Africa has suffered. Parts of Latin America and the Caribbean also show high and rising rates of infection. And the former Soviet Union countries and Eastern Europe are vulnerable as well, with Russia experiencing the highest increase in infection rates in the world last year.

AIDS as an economic and security issue: On January 10, under the leadership of Vice President Gore, the United Nations Security Council held a daylong session on the global threat posed by HIV/AIDS. This event was the first time the Security Council considered a health issue. The session reinforced what we have stated repeatedly, that AIDS is much more than a health or humanitarian issue -- it is a development issue, a trade issue, and a key stability and security issue.

At the Security Council meeting, Secretary General Kofi Annan said that the "high rate of infection among police and armed

forces has left many African countries ill-equipped to face security threats." World Bank President James Wolfensohn added: "We're losing teachers faster than we can replace them. We're losing judges, lawyers, government officials, and persons in the military. Unless we act, there will surely be continued instability on the continent."

USG International HIV/AIDS programs: The U.S. Government remains the world leader in responding to the global pandemic of AIDS. Current USG activities emphasize enhanced financial and political commitment, primary prevention, improving community and home based care and treatment, caring for children affected by HIV/AIDS, health infrastructure development, biomedical and behavioral research and training, and multisectoral efforts from the grass roots to the international level that reduce the impact of AIDS. Since 1986, USAID has dedicated over \$1.2 billion to mitigate the epidemic. In FY 2000, we contributed four times as much as the next largest donor. But we will need to spend more -- much more.

During the Security Council meeting, the Vice President outlined Phase II of our LIFE Initiative (Leadership and Investment in Fighting an Epidemic), the enhanced global AIDS effort which was launched last year with a budget amendment for a \$100 million increase in our global AIDS program. Congress appropriated the funding; bringing our FY 2000 global AIDS prevention and care program to \$225 million -- nearly two thirds of which will go to Africa. The FY 2001 budget includes an additional \$100 million increase in our global AIDS effort (for a total of \$325 million, excluding research) which will be targeted to: prevention; basic care and treatment; support for orphans; and health infrastructure development, and implemented by USAID, HHS (CDC), DOL and DOD.

Many other agencies are contributing to the USG efforts. For example, in mobilizing human resources, the Peace Corps is training all new volunteers in HIV/AIDS prevention and education strategies. There are currently over 6000 Peace Corps volunteers globally, and more than 2,400 in Africa alone, many having primary assignments in HIV/AIDS work. In addition, a cadre of experienced "Crisis Corps Volunteers" is now being selected to work directly with HIV/AIDS in countries with high HIV/AIDS prevalence.

And NIH is spending over \$1.8 billion annually on AIDS research, with over \$200 million each year in the search for a vaccine.

Extent of financial needs -- the example of Africa: UNAIDS estimates that it will take at least a \$1 billion HIV prevention program in Africa to stem the rising tide of infection, including mother-to-child transmission. In 1999, all host governments and donors spent less than one third that amount on prevention, and very little in the military context. In addition, UNAIDS believes that it would cost an additional \$1 billion to begin to bring basic medical care and treatment to the 24 million people in Africa already living with AIDS. At present, spending is less than one tenth that amount, with only 1-5 percent of those who are sick receiving even the most basic antibiotics and treatment for opportunistic infections. The total expenditure from all sources for HIV/AIDS prevention and care in the average sub-Saharan African country is only \$5-20 million per year.

The Interagency Process

With the growing concern that the U.S. Government needed to further increase its efforts to deal with the AIDS crisis, an interagency working group (IWG) was convened under the co-chair of Sandra Thurman, Director, Office of National AIDS Policy (ONAP), and Kenneth Bernard, Special Advisor, National Security Council. The first meeting was held on February 8, 2000, and included representation from State (including USUN), USAID, Defense, Joint Staff, Treasury, Commerce, CIA, DOL, DIA, HHS (including NIH and CDC), Office of the Vice President, OMB, USTR, NEC, NSC and OSTP. Issue oriented IWG subgroups were formed to develop recommendations for enhanced USG action. They included 1) budget and legislation, 2) diplomacy and public awareness, 3) security, 4) economics, trade and finance, and 5) prevention and care.

An ongoing process: This consensus document, drafted with input from all listed agencies and IWG subgroups (with the addition of Peace Corps), is not intended to be static, but rather an ongoing attempt to ramp up the USG response to the HIV/AIDS crisis. A number of the following issues and actions raised by the IWG will require further discussion at the departmental level as well as in the Deputies and Principals Committee process.

The IWG, co-chaired by NSC and ONAP, will meet again in June, prior to the International AIDS Conference in Durban, to document progress on each of the action items outlined in the consensus document. It will then reconvene periodically

thereafter. Decisions on outstanding issues will be referred to Deputies or Principals as needed.

Strategic framework for action

To ensure that the United States continues its leadership role in combating HIV/AIDS, the IWG recommended that new USG activities be considered in the context of four overall objectives:

- Mobilizing an enhanced and coordinated United States Government response, and maximizing its leadership and effectiveness in the international battle to reduce HIV transmission and care for those who are sick.
- Enhancing political commitment by national governments to combat HIV/AIDS as a national and international priority, including mobilizing and leveraging increased internal national budget resources.
- Leveraging an enhanced response from other bilateral donors and multilateral institutions through a U.S.-lead international cooperative effort.
- Leveraging an enhanced response from the private sector in the United States, including corporations, foundations, religious institutions and non-governmental organizations.

Issues and Actions

(Note: Agencies in parentheses below are not the only agencies to be involved in listed issues or initiatives. They are, however, tasked with responsibility for convening discussion or planning groups as necessary and acting as rapporteurs for the specified issues at IWG meetings.)

1. Budget and legislation

During this session of Congress, more than ten global AIDS initiatives have been introduced. Committees of jurisdiction in both chambers have favorably reported global AIDS legislation ranging from \$510 million for FY 2001 in the Senate to \$1 billion over 5 years in the House. Ideas vary from enhancing existing bilateral efforts through USAID to creating a new multilateral AIDS Trust Fund at the World Bank. Currently, there seems to be considerable momentum on the Hill for moving a

global AIDS initiative either freestanding or as part of the Foreign Assistance or African Trade bills.

- Pending authorizing legislation should support or enhance the Administration's goal of securing an additional \$100 million for the expansion of our current global AIDS initiative. Outcomes and strategic USG goals should define which legislative mechanisms and pending bills we should support.
- The Administration would proactively work with Congress to craft HIV/AIDS legislation that bolsters and helps launch international leadership initiatives and do not undermine other vital antipoverty/AIDS priorities such as HIPC.
- ONAP and WH legislative affairs will coordinate Administration response to the authorization bills, and take a proactive approach to the appropriations debate so as to maximize FY2001 funding of global AIDS activities. (ONAP)

2. Diplomacy and awareness

The Department of State has aggressively increased its diplomatic outreach and education efforts, including the Secretary's 1999 International Response to HIV/AIDS and recent cables (State 34645, State 58033) to diplomatic posts calling for a dramatic increase in Embassy engagement with host countries.

- Strengthen U.S. diplomatic efforts
 - ✓ Advance the concept, suggested by USUN, of having countries name Presidential Envoys for AIDS Control (PEACs). Each concerned country would name a senior envoy that would meet, debate, and help coordinate international efforts to deal with the thornier problems of the epidemic. Meetings of PEACs would provide a forum for discussion of issues needing international action, such as drug availability in poor countries, and making recommendations for innovative actions. (ONAP, State)
 - ✓ Target USG efforts at the countries most at risk and target leadership in countries already heavily infected. (State, USAID)

- ✓ Broaden diplomatic efforts to include regions other than Africa, including Asia and the Newly Independent States. (State)
- ✓ Highlight and actively implement in other at-risk countries the successful national AIDS programs in Uganda, Thailand and Senegal. (USAID, State)
- ✓ Develop a high-profile communications strategy for public diplomacy on HIV/AIDS control. (State)
- ✓ Develop at each Embassy a comprehensive HIV/AIDS action plan and integrate it into work and reporting requirements and resource allocation. (State)
- ✓ Establish required HIV/AIDS briefings for appropriate DOS Bureau personnel, including new Chiefs of Mission, Ambassadors, DCMs and others in Washington or in regional meetings. (State)
- ✓ Provide diplomatic posts with sufficient epidemiological and best-practices information through a dedicated DOS AIDS information officer, or through USAID missions. (State, USAID)
- Persuade foreign leaders of the profound effect of AIDS on their national security in terms of impact on political stability, economic growth, and civil society. (NSC, State)
 - ✓ Provide leaders with briefs and analyses on AIDS in their regions. (State, USAID, DOC)
 - ✓ Issue new demarches on the security and health aspects of AIDS to be carried by the Ambassador to the head of state. (State)
- Develop innovative sustainable policies in partnership with other U.S. agencies, international organizations and entities. (State)
 - ✓ Increase involvement with the U.S. and foreign business communities on HIV/AIDS, including information dissemination and worker education. (DOC, USTR, USAID)
 - ✓ Work with the G-8, multilateral development banks and others to move basic health care, including AIDS prevention

and control, to the top of the finance and debt reduction agendas. (Treasury)

- ✓ Collaborate with WHO, UNAIDS and other UN agencies to develop more effective prevention, awareness and treatment programs. (HHS, USAID, State)
- Make international health and scientific collaboration on HIV/AIDS a priority in science and technology programs facilitated by the State Department. (State, HHS)

3. Security

This year, the NIC, CIA and DIA have all produced excellent intelligence products on the impact of AIDS on the security, stability and economies of the hardest hit nations. DoD has prepared U.S. military education and training materials for HIV/AIDS prevention, some of which have been adapted for UN peacekeeping forces and given to USAID for review in FY 2000. These materials could be adapted for African militaries in FY 2001. Funding for expanding military-to-military training for HIV/AIDS prevention is in the President's FY 2001 budget request.

- In order to advance our operational goals regarding the public health and security aspects of the epidemic, each component of the intelligence community should work to increase collection of relevant data and provide periodic updates on the extent and impact of AIDS in their specific areas of responsibility. (CIA, NSC)
- DoD has shared U.S. military specific educational modules with USAID. These education modules will be adapted for specific cultural needs. DoD has begun limited, active involvement with HIV/AIDS prevention education and training with certain African militaries and should expand these efforts as soon as possible. (DoD)
- Secretary Cohen ensures appropriate and adequate HIV/AIDS prevention, education and training for the U.S. military. It is recommended that he should, as a priority, also reinforce the need for comparable HIV/AIDS prevention, education and training in international defense forces, and for UN peacekeeping forces. (DoD, State, USUN, NSC)

- In addition to supporting the Administration's \$10 million funding directly to DoD for this program in FY 2001, DoD will work closely with DOS to identify FY 2002-2007 International Military Education and Training (IMET) resource additions to fund (in the U.S.) HIV/AIDS professional education and prevention efforts. (DoD, State)
- All UN peacekeeping operations should effectively deal with AIDS education as an active and required responsibility. The U.S. should pursue negotiation of a UN Security Council Resolution on HIV/AIDS as a security issue, mandating HIV/AIDS prevention efforts for UN Peacekeepers. (State)

4. Economics, Trade and Finance

- Multilateral
 - ✓ Support UNAIDS International Partnership Against AIDS in Africa and its efforts to dramatically increase political will and action by African governments. (USAID, State)
 - ✓ Actively seek support for the President's proposal that the multilateral development banks dedicate an additional \$400-\$900 million in concessionary loans for basic health care and systems needed to expand immunization and prevent and treat infectious diseases, including AIDS. Actively encourage the EU and the G-7 to join in this request, and request all OECD donors to increase AIDS funding at each meeting and opportunity. (Treasury, NSC, OSTP)
 - ✓ Actively encourage Highly Indebted Poor Countries (HIPC) to use, as a priority, their debt service savings for poverty reduction, including HIV/AIDS prevention and care activities. USAID and Treasury should help countries prepare Poverty Reduction Strategies to include AIDS control. High priority countries, either approved or being considered, include Uganda, Mauritania, Mozambique, Benin, Tanzania, and Senegal. (Treasury)
 - ✓ Follow-up the DOL/AFL-CIO Trade Unionist Summit to advance HIV prevention issues at the April meeting of the ICFTU in Durban, the SADC meeting and the 13th International AIDS Conference in Durban in July. (DOL)

- ✓ Collaborate with the International Labor Organization to establish and enhance multisectoral framework for HIV/AIDS workplace education. (DOL)
- Bilateral
 - ✓ Expand DOL involvement with AIDS prevention activities with other country labor unions, using \$10 million FY 2001 funds. (DOL)
 - ✓ Develop web sites containing workplace training manuals for HIV/AIDS to promote HIV/AIDS workplace education and prevention. (DOL, DOC)
 - ✓ Establish a workplace HIV/AIDS education/training pilot project in Malawi during current fiscal year. (DOL)
- Private Sector
 - ✓ Convene representatives from different industry sectors with government officials to discuss concrete suggestions to increase public/private cooperation in the battle against AIDS. Add NGOs as discussions progress. Do not limit to Africa. (OVP, DOC, HHS, Treasury)
 - ✓ Expand the current USTR/HHS working group on trade and access to essential medicines. In discussions among health and trade agencies, generate a rational and forward-leaning approach to improving infrastructure and access to needed medications, while ensuring protection of intellectual property rights. Solicit input from NGOs and affected industries. Aim for mid-May delivery date for "next steps" in advance of the State visit of President Mbeki from South Africa. (ONAP, HHS, USTR, DOC, Treasury)
 - ✓ Work with Congress to approve the Presidential initiative to provide a \$1 billion tax credit for the sales of vaccines developed for HIV/AIDS (and other diseases such as TB and malaria that kill over 1 million annually). (Treasury, NSC, OMB)
 - ✓ Increase outreach activities to foundations to raise funding of international AIDS activities. (USAID, ONAP, HHS)

- ✓ Work with industry to develop multimedia commercials showcasing a unified public, private, NGO, international AIDS effort. Will motivate industry participation and raise public awareness. (DOC)
- ✓ Implement an outreach to industry for donations of multimedia equipment for communities and grass roots organizations to promote HIV/AIDS prevention and awareness. (DOC)
- ✓ Select a group of high-profile U.S. and foreign personalities for public service announcements related to global AIDS issues. (ONAP)
- ✓ Construct a Global AIDS Internet site, "Millennium Networking Against the Global HIV/AIDS Epidemic." (USAID, HHS)
- ✓ Sponsor video productions, in cooperation with U.S. national filmmakers, and with the partnership of African and other national governments. Emphasize real people in real situations. (State, USAID)
- ✓ Initiate an "adopt-a-school" program with NGOs, religious groups and the private sector, providing funds to keep AIDS orphans in school. (ONAP)

5. Prevention and Care and Research

The U.S. Government is spending, in FY 2000, over \$225 million overseas for HIV/AIDS prevention and care programs alone (excluding research funding). Current USG activities emphasize primary prevention, biomedical and behavior research and training, and improving community and home based care. The following recommendations are for additional emphasis and action.

- Develop a working list of what governments and donors are spending in each country on HIV/AIDS prevention, treatment and care activities to focus new efforts on needs and gaps. (USAID)
- Restate the Administration commitment to develop a preventive HIV vaccine within the next 10 years. This should emphasize developing country (Africa, India, others) participation in the critical research. (HHS, USAID)

- Initiate regular meetings co-chaired by USAID and HHS to coordinate specific strategies focusing on the delivery of prevention, medical treatment and care services to impacted communities. Expand activities and funding for treatment of opportunistic infections (such as TB and pneumonia), including increased availability of appropriate antibiotics and other medications. (USAID, HHS)
- USAID should be the lead agency for coordinating USG input into country-level HIV/AIDS activities, and will collaborate with HHS and the Department of State to develop a clear protocol to facilitate the entry of new USG partners into collaboration with individual country programs. Country-level coordination, especially where USAID or HHS do not have permanent staffs, should be part of the developed protocol. In situations where HHS/NIH are doing collaborative biomedical research, arrangements for adequate coordination with other USG agencies working in country must also be assured. (USAID, HHS)
- Quickly establish a Working Group, under the joint chair of HHS and USAID, to focus on the challenges of delivering services to reduce mother-to-infant HIV transmission. Issues include: increased access to accurate HIV testing and confidential counseling; the risk of breast feeding and safety of infant formula in low resource situations; efficacy and safety of short course anti-retroviral drugs such as Nevirapine and AZT, and concern that drug treatment may divert resources from other services. (HHS, USAID)
- Fully implement an initiative to train all 2,400 Peace Corps Volunteers in Africa in HIV/AIDS prevention and awareness techniques, and field teams of experienced former Peace Corps Volunteers to assist on critical AIDS projects. (Peace Corps).
- Highlight and actively implement in other countries the successful Peace Corps AIDS projects in Malawi, Thailand and Senegal. (Peace Corps).
- NIH, CDC and others should establish centers of excellence in international settings that will support basic research and long-term cohort studies; serve as locations for studies of efficacy of biomedical and behavioral prevention interventions, including Phase I, II, and III vaccine trials as well as trials of topical microbicides; function as training centers for investigators from throughout the region;

and provide bridges to services. The centers should provide an environment for the development of true and equal partnerships between the U.S. and foreign investigators. (HHS)

- Call for consistent Administration messages on the need to empower women to reduce their vulnerability. Consider a major initiative to accelerate microbicide development. (HHS, USAID, State)
- Call for the Administration to make a statement to more fully involve the faith communities, both here and abroad, with prevention efforts and patient care. (ONAP)
- Because global TB, now exacerbated by HIV/AIDS, is the leading cause of death in the developing world, pledge increasing support to the international "Stop TB" initiative. (HHS, USAID)
- Endorse community-based approaches to support children and their families affected by AID (especially avoiding dependence on orphanages). (ONAP, USAID, Peace Corps).
- Consult with Congress on extending the "notwithstanding" provisions of the Foreign Assistance Act, Section 522, (Child Survival, AIDS and other activities) to include an exemption from the "Buy America Act" (Section 604) to allow procurement of critical HIV/AIDS pharmaceuticals and other selected commodities. (OMB, USAID)

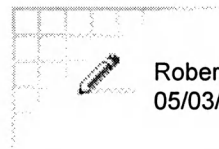
USG Coordination of International AIDS Activities

Commending the work of the Office of National AIDS Policy (ONAP) in our global efforts, the Interagency Working Group recommended that ONAP retain the USG focus for international HIV/AIDS coordination. However, that office currently has insufficient personnel resources to fully staff its international as well as domestic responsibilities.

Therefore it is recommended that ONAP be expanded to include a Deputy for International Affairs to cover the broad coordination of USG activities related to the global epidemic.

The Deputy Director for International Affairs, to complement ONAP's interagency responsibilities, would be designated to coordinate USG international activities for that office, and, in

doing so, maintain a close working relationship with National Security Council senior staff, especially the senior health advisor to the Assistant to the President for National Security Affairs.



Robert F. Wescott
05/03/2000 06:24:45 PM

Record Type: Record

To: Lael Brainard/OPD/EOP, Sharon H. Yuan/OPD/EOP

cc:

Subject: DC Meeting on Thursday at 2 pm on HIV/AIDS

Lael,

I gave Sharon the NSC memo for the HIV/AIDS meeting tomorrow at 2:00 pm. It was prepared by Ken Bernard and gives a good description of the issues for discussion.

MAIN NEC ISSUES ON AIDS

Now that you will be there for the whole meeting, I think you should be prepared to talk about what we are doing to get the G-8 and the EU to help with AIDS. I believe you are quite up to speed on the G-8 side and although I have not been involved in the EU-US summit prep, I imagine you also are up on what is going on there as well. On the AIDS mil-mil issues, question of whether to appoint an AIDS "ambassador," etc., I think you have good instincts for what makes sense or what questions to ask.

The main issues for us are the debt relief proposals. Treasury is (surprise, surprise) dead set against an extension of the HIPC program for AIDS countries or a more expanded debt relief program for AIDS countries and Tim will argue against them. The reasons are the standard ones: we are having trouble even getting our HIPC money from Congress and it is not realistic to think Congress will give us lots more; worried that debt relief will hurt these countries' ability to get private sector money in coming years, etc. Also, I personally agree with Rick S. that debt relief is probably a very circuitous route to really help--better to put money directly into the problem.

The other main issue is the IPR issue, which I also believe you are quite familiar with. The trick here is the classic one: anything that chops rents from patents and pharma inventions may be good in the short run (lowers costs for getting vaccines or drugs to sick people), but over time works to destroy innovation and incentives to invest. A tough call, but I would argue that we need to keep the long-run incentives in place--best prospects for ultimate solutions.

BACKGROUND

I am giving Sharon a packet of articles about HIV/AIDS that Helen Walsh has prepared for Tim Geithner to read. World Bank and UN Health reports. Lots of very very dismal reading about how bad the problem is.

I do have a fairly strong opinion that the industrial countries are "waking up" to the AIDS crisis in Africa and that there may well be more popular support for spending more money in Africa, etc., to help.

Rob

AIDS epidemic update:

December 1999



**World Health
Organization**

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Joint United Nations Programme on HIV/AIDS (UNAIDS)
World Health Organization (WHO)

UNAIDS/99.53E – WHO/CDS/CSR/EDC/99.9 – WHO/FCH/HSI/99.6
(English original, December 1999)

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Global summary of the HIV/AIDS epidemic, December 1999

People newly infected with HIV in 1999	Total	5.6 million
	Adults	5 million
	Women	2.3 million
	Children <15 years	570 000
Number of people living with HIV/AIDS	Total	33.6 million
	Adults	32.4 million
	Women	14.8 million
	Children <15 years	1.2 million
AIDS deaths in 1999	Total	2.6 million
	Adults	2.1 million
	Women	1.1 million
	Children <15 years	470 000
Total number of AIDS deaths since the beginning of the epidemic	Total	16.3 million
	Adults	12.7 million
	Women	6.2 million
	Children <15 years	3.6 million

The AIDS epidemic in the 21st century - a widening gap

As the 20th century draws to a close, some 33.6 million men, women and children face a future dominated by a fatal disease unknown just a few decades ago. According to new estimates from the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO), 32.4 million adults and 1.2 million children will be living with HIV by the end of 1999.*

- Over the course of the year, some 5.6 million people became infected with the human immunodeficiency virus (HIV), which causes AIDS.
- The year also saw 2.6 million deaths from HIV/AIDS – a higher global total than in any year since the beginning of the epidemic, despite antiretroviral therapy which staved off AIDS and AIDS deaths in the richer countries. Deaths among those already infected would continue mounting for some years even if prevention programmes managed to cut the number of new infections to zero. However, with the HIV-positive population still expanding – there were 5.6 million new infections this year alone – the annual number of AIDS deaths can be expected to increase for many years before peaking.
- Around half of all people who acquire HIV become infected before they turn 25 and typically die of the life-threatening illnesses called "AIDS" before their 35th birthday. This age factor makes AIDS uniquely threatening to children. By the end of 1999, the epidemic had left behind a cumulative total of 11.2 million AIDS orphans, defined as those having lost their mother before reaching the age of 15.

Many of these maternal orphans have also lost their father.

- The overwhelming majority of people with HIV – some 95% of the global total – live in the developing world. That proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health systems and limited resources for prevention and care fuel the spread of the virus.
- HIV is still a challenge in industrialized countries. There is evidence that safe sexual behaviour is being eroded among gay men in some Western countries, perhaps because of complacency now that life-prolonging therapy is available. If this is the case, the complacency is misplaced. The disease remains fatal, and information from North America and Europe suggests that the decline in number of deaths due to antiretroviral therapy is tapering off.
- HIV infections in the former Soviet Union have doubled in just two years. Injecting drug use gave the Eastern European and Central Asian region the world's steepest HIV curve in 1999. Drug-injecting is also a major concern in the industrialized countries, as it is in the Middle East, where total AIDS cases are still relatively low but drug-injecting accounted for two-thirds of cases in Bahrain, half in the Islamic Republic of Iran and over a third in Tunisia.
- Some Latin American countries are managing to expand efforts to provide treatment to those infected. However, there is evidence that infections are on the rise in Central America and in the Caribbean

* This appears to be a relatively small rise over the global HIV totals at the end of 1998. The real rise is larger, however. Improved surveillance now suggests that national infections in a few populous countries of Latin America and Asia were overestimated in 1998.

basin – which has some of the worst HIV epidemics outside Africa.

- Strong prevention programmes seem to have reduced HIV risk and lowered or stabilized HIV rates in some countries of Asia, such as Thailand and the Philippines. Other Asian countries have raised warning flags after collecting new information showing that injecting drug use is spreading and that condom use is uncommon, including among clients of prostitutes and men who have sex with men. In many places prevention efforts are hampered by the shame and stigma attached to AIDS.
- Sub-Saharan Africa continues to bear the brunt of HIV and AIDS, with close to 70% of the global total of HIV-positive people. Most will die in the next 10 years, joining the 13.7 million Africans already claimed by the epidemic and leaving behind shattered families and crippled prospects for development.
- Because of AIDS, companies doing business in Africa are hurting and are bracing themselves for far worse as their workers sicken and die. According to a survey of commercial farms in Kenya, illness and death have already replaced old-age retirement as the leading reason why employees leave service. Retirement accounted for just 2% of employee drop-out by 1997.
- Life expectancy at birth in southern Africa, which rose from 44 years in the early 1950s to 59 in the early 1990s, is set to drop to just 45 between 2005 and 2010 because of AIDS. In contrast, South Asians, who could barely reach their 40th birthday in 1950, can expect by 2005 to be living 22 years longer than their counterparts in AIDS-ravaged southern Africa.
- New information suggests that between 12 and 13 African women are currently

infected for every 10 African men. There are a number of reasons why female prevalence is higher than male in this region, including the greater efficiency of male-to-female HIV transmission through sex and the younger age at initial infection for women.

- In 1999, an estimated 570 000 children aged 14 or younger became infected with HIV. Over 90% were babies born to HIV-positive women, who acquired the virus at birth or through their mother's breastmilk. Of these, almost nine-tenths were in sub-Saharan Africa. Africa's lead in mother-to-child transmission of HIV was firmer than ever despite new evidence that HIV ultimately impairs women's fertility: once infected, a woman can be expected to bear 20% fewer children than she otherwise would.

In short, the huge gap in HIV infection rates and AIDS deaths between rich and poor countries, and more particularly between Africa and the rest of the world, is likely to grow even larger in the next century. Likely, but not certain. Massive national and international efforts may yet help to end the stifling silence that continues to surround HIV in many countries, to explode myths and misconceptions that translate into dangerous sexual practices, to expand prevention initiatives such as condom promotion that can reduce sexual transmission, to create conditions in which young children have the knowledge and the emotional and financial support to grow up free of HIV, and to devote real money to providing care for those infected with HIV and support to their families. A trail of successful responses has already been blazed by a small number of dedicated communities and governments. The challenge for the leaders of Africa and their partners in development is to adapt and massively expand successful approaches that make it harder for the virus to spread, and that make it easier for those affected to live full and rewarding lives.

Regional HIV/AIDS statistics and features, December 1999

Region	Epidemic started	Adults & children living with HIV/AIDS	Adults & children newly infected with HIV	Adult prevalence rate (*)	Percent of HIV-positive adults who are women	Main mode(s) of transmission (#) for adults living with HIV/AIDS
Sub-Saharan Africa	late '70s-early '80s	23.3 million	3.8 million	8.0%	55%	Hetero
North Africa & Middle East	late '80s	220 000	19 000	0.13%	20%	IDU, Hetero
South & South-East Asia	late '80s	6 million	1.3 million	0.69%	30%	Hetero
East Asia & Pacific	late '80s	530 000	120 000	0.068%	15%	IDU, Hetero, MSM
Latin America	late '70s - early '80s	1.3 million	150 000	0.57%	20%	MSM, IDU, Hetero
Caribbean	late '70s - early '80s	360 000	57 000	1.96%	35%	Hetero, MSM
Eastern Europe & Central Asia	early '90s	360 000	95 000	0.14%	20%	IDU, MSM
Western Europe	late '70s - early '80s	520 000	30 000	0.25%	20%	MSM, IDU
North America	late '70s - early '80s	920 000	44 000	0.56%	20%	MSM, IDU, Hetero
Australia & New Zealand	late '70s - early '80s	12 000	500	0.1%	10%	MSM, IDU
TOTAL		33.6 million	5.6 million	1.1%	46%	

* The proportion of adults (15 to 49 years of age) living with HIV/AIDS in 1999, using 1998 population numbers.

MSM (sexual transmission among men who have sex with men), IDU (transmission through injecting drug use), Hetero (heterosexual transmission).

The world's splintered epidemics

Contrary to expectations when AIDS was first identified, the epidemic has taken different forms in different parts of the world. In some areas HIV rapidly became common among men and women throughout the population. In others it became entrenched in certain sub-populations whose sexual or drug-injecting behaviour carries an especially high risk of contracting or passing on the virus – particularly sex workers and their customers, men who have sex with men, and drug injectors.

The extent to which HIV spreads between groups with high-risk behaviour and any larger

population depends on whether members of those groups have sex with people who do not share their high-risk behaviour, and whether condoms are used in those sexual encounters. For an HIV epidemic to take off in a country's general population, there also has to be a substantial amount of sexual mixing among adults. To sustain a heterosexual epidemic, on average each infected person must have unprotected sex with a minimum of two partners, becoming infected by one and passing on the infection to at least one other. Indeed, since not every encounter between an HIV-positive and an HIV-negative partner will result in a new infection, a sustained heterosexual epidemic suggests that a substantial proportion of the population, both male and female, have a number of sex partners over their lifetimes.

The high HIV risk run by drug injectors

Sharing drug-injecting equipment without sterilizing it between users is an extraordinarily efficient way of spreading HIV. Where equipment sharing is common, HIV infection can race through drug-injecting populations with unparalleled speed. Because of the way drug solutions are prepared in Eastern Europe and Central Asia, there is also a danger that the solutions themselves are contaminated with HIV. This means that even if clean needles are used, there is still a danger of transmitting the virus.

Drug-injecting doubles HIV rates in the former Soviet Union

The world's steepest HIV curve in 1999 was recorded in the newly independent states of the former Soviet Union, where the proportion of the population living with HIV doubled between end-1997 and end-1999. In the larger region comprising the former USSR as well as the remainder of Central and Eastern Europe, UNAIDS/WHO estimate that the number of infected people rose by a third over the course of 1999, reaching a total of 360 000.

The bulk of new HIV infections were caused by unsafe injection of drugs and occurred in two countries, the Russian Federation and Ukraine.

In the Russian Federation, nearly half of all cases of HIV infection reported since the start of the epidemic were reported in the first nine months of 1999 alone. While reported infections admittedly represent only a fraction of real HIV infections, little has changed in the reporting system and public health officials therefore believe this massive rise in reported cases accurately reflects trends in the overall epidemic.

The virus has been recently introduced into networks of drug injectors in Russian cities where HIV was previously virtually unknown. This is true of smaller provincial cities as well as of large metropolitan areas.

- This year, for example, HIV prevalence rose rapidly among drug injectors in Moscow. Over 2700 cases of HIV were reported in the Russian capital in the first nine months of 1999 alone – three times as many as in all previous years combined.
- An even more stratospheric rise was recorded in the towns and cities around Moscow, with over five times as many infections reported in the first nine months of 1999 as in all other years combined.
- The virus has spread far and wide. In the Siberian city of Irkutsk, nearly 1300 infections have been reported, most of them in 1999.

The HIV epidemic among drug injectors in Ukraine started earlier than in the Russian Federation, and the consequences are now being seen in the numbers of people progressing to AIDS. Some 90% of all AIDS cases reported in 1998 and 1999 in the entire Eastern European region were in Ukraine, according to the European Centre for the Epidemiological Monitoring of AIDS.

Bridges into the wider Eastern European population

Since drug injecting is illegal, it is very difficult to estimate the size of the drug-injecting population, let alone the extent to which they are linked in sexual networks with non-injectors.

One good indicator of unprotected sex with multiple partners is infection with sexually transmitted infections (STIs) such as syphilis and gonorrhoea. Using this indicator, evidence indicates that many drug injectors also have unprotected sex. An outreach service providing support and safe injecting services for drug users in the Russian city of St Petersburg reported that 10% of over 1800 clients tested positive for syphilis. Among 100 female drug injectors who make a living as sex workers and who attended the outreach service, 32% had syphilis. Clearly, these people are at extraordinarily high risk of HIV infection because of their drug-injecting behaviour. The fact that they have unprotected sex would indicate that their sex partners are also at risk, whether or not they use drugs.

The prevalence of sexually transmitted infections has skyrocketed in the former Soviet bloc region in recent years, indicating that many people are having unprotected sex with non-monogamous partners. If HIV were to spread from drug-injecting populations into this larger population, it would find fertile ground for a much wider expansion.

For the time being, however, the extent of the HIV epidemic in Eastern Europe and Central Asia is determined primarily by the number of people injecting drugs. Preliminary studies suggest that drug injecting is becoming extremely common among unemployed young people in many of the industrial cities of the Russian Federation and Ukraine, and is well-established even among schoolchildren. An outreach programme for drug injectors in St Petersburg reported clients as young as 12, with the percentage of clients aged 14 or less rising from 0.1% in 1997 to 2% in the first quarter of 1999.

Several areas in the Eastern European and Central Asian region, in partnership with United Nations Children's Fund (UNICEF), WHO and the UNAIDS Secretariat, are currently preparing studies that should give a better idea of the

scale of drug injecting and associated risk behaviours. Their findings should point to interventions that might help to reduce risk.

Warning signs in the Middle East

Injecting drug use may also touch off a wave of HIV in the Eastern Mediterranean region. Although overall AIDS cases remain relatively few in number, drug injecting is already the most common cause of AIDS in some countries, accounting for two-thirds of reported cases in Bahrain in 1998 and half in Islamic Republic of Iran. In Tunisia, injecting drug use is responsible for more than one-third of AIDS cases. In Egypt, one AIDS case in 10 is among drug injectors. In Pakistan, 5.4% of 703 drug injectors tested HIV positive in 1995. Recent studies by the United Nations International Drug Control Programme (UNDCP) in a few countries of the Middle East – Egypt, Iran and Lebanon – indicate that the magnitude of the drug abuse problem should not be underestimated. By most conservative estimates, the numbers of addicts are counted in the millions in this part of the world. A relatively high proportion of these addicts inject drugs, and needle-sharing is very common.

Sexually transmitted infections are not uncommon in the Eastern Mediterranean region. It is estimated that around 10 million cases occur in the region every year, although reporting rates are low – fewer than 6% of that number were reported in 1998. STI rates are particularly high among young adults and in urban areas. Sexually transmitted infections are an important indicator that high-risk sexual practices do exist in the region, as national behavioural surveys confirm.

Risky behaviour in high-income countries may be rising

HIV/AIDS surveillance in the richer countries has been complicated by the advent of antiretroviral drugs that stave off the development of AIDS and prolong survival (see box). Where antiretroviral therapy is widely available, it has increased the

Estimates of HIV-related deaths

For both technical and historical reasons, estimates of the current number of people living with HIV (HIV prevalence) are more reliable than estimates of the number of deaths among people with HIV/AIDS. Prevalence estimates are based directly on data collected through HIV sentinel surveillance, while estimates of HIV-related deaths are derived indirectly from mathematical models, based in turn on HIV prevalence data. Some countries began to establish HIV surveillance systems with WHO assistance as far back as the mid-to-late 1980s. By that time, however, epidemics had often been running for as long as a decade, and without direct HIV data it was difficult to know how many people had already become infected and estimate how many of them had died. Even recent deaths are difficult to model in countries which delayed the establishment of reliable sentinel surveillance. Moreover, knowledge about length of survival with HIV infection is imperfect, adding to the uncertainty about the timing of HIV-related death.

WHO and UNAIDS continue to work with national AIDS programmes and research institutions to refine knowledge and improve sentinel surveillance systems, especially in the developing world, where 95% of the epidemic is concentrated. These efforts should narrow current uncertainties and increase the future reliability of estimates of both HIV infection and death.

incentive for people at high risk of HIV to get tested, since the earlier they start taking the drugs the better. This means that a substantial proportion of HIV infections are detected relatively early on in most industrialized countries.

However, it is hard to tell whether the rise in reported infections simply reflects a change in the proportion of existing infections that are detected and reported, or whether it reflects a real increase in the number of people acquiring HIV.

The surveillance challenge in the antiretroviral era

It is becoming increasingly difficult to understand the epidemic in industrialized countries. Until the mid-1990s, HIV infections were estimated by calculating backwards from reported AIDS cases according to well-established patterns of disease progression. This method gave a delayed picture of new infections but was useful in ascertaining changes in the overall scale of the epidemic. While AIDS remains fatal, life-prolonging therapy can postpone death for an unknown period of time for some HIV-positive people. This means that the timing of the progression from HIV infection to AIDS and from AIDS to death has become very difficult to predict, so calculating past trends in HIV infection from current AIDS cases or deaths has become more or less impossible.

Many industrialized countries are thus beginning to strengthen their systems for tracking HIV infection, mostly by improving the system for reporting identified HIV cases. HIV case reporting suffers from many biases, and may tend in particular to neglect marginalized groups at risk of heterosexual infection.



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LONDON, 23 November 1999

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AIDS NOT LOSING MOMENTUM HIV HAS INFECTED 50 MILLION, KILLED 16 MILLION, SINCE EPIDEMIC BEGAN

- In Africa HIV-positive women now outnumber infected men by 2 million -
- Countries of former Soviet Union see infection rates double in just two years -
- Strong prevention efforts, care programmes, find success in certain regions -

Since the beginning of the AIDS epidemic, 50 million individuals worldwide have been infected with HIV, of whom more than 33 million are still alive and over 16 million have died, according to a report issued today by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Health Organization (WHO). The report, entitled AIDS Epidemic Update - December 1999, was released in advance of World AIDS Day, commemorated each year on 1 December. It shows that AIDS deaths reached a record 2.6 million this year and that new HIV infections continued unabated, with an estimated 5.6 million adults and children worldwide becoming infected in 1999.

"With an epidemic of this scale, every new infection adds to the ripple effect, impacting families, communities, households and increasingly, businesses and economies. AIDS has emerged as the single greatest threat to development in many countries of the world", said Peter Piot, Executive Director of UNAIDS.

"We have to ensure that health systems are capable of handling the increasing numbers of HIV-positive people who develop AIDS. De-stigmatization, access to health care and low-cost measures such as the treatment of opportunistic infections become important. WHO is working with Ministries of Health across the world to ensure that adequate facilities and resources are made available to the millions of people likely to develop AIDS in the coming years", said Gro Harlem Brundtland, Director-General of WHO.

AIDS develops in an HIV-positive person after years of infection, as HIV steadily weakens the body's immune system and increases its vulnerability to pneumonia, tuberculosis, diarrhoea, tumours and other illnesses. With the number of people infected with HIV continuing to rise, the number of people falling sick and dying of AIDS will multiply.

HIV-positive women now outnumber HIV-positive men in Africa

In sub-Saharan Africa - still the global epicentre of the epidemic - new evidence shows clearly for the first time that women infected with HIV outnumber men. "Ten years ago, it was hard to make people listen when we were saying AIDS wasn't just a man's disease", said Dr Piot. "Today, we see the evidence of the terrible burden women now carry in Africa's epidemic."

- Fifty-five percent of infected adults in sub-Saharan Africa are women, which means more than six HIV-positive women for every five HIV-positive men. UNAIDS and WHO estimate that 12.2 million African women and 10.1 million African men aged 15-49 are living with HIV at the end of 1999.
- Studies in several countries have found that African girls aged 15-19 are five to six times more likely to be HIV-positive than boys the same age. Ease of male-to-female sexual transmission, and sex with older, infected men appear to be contributing factors to girls' greater vulnerability to HIV.

According to the United Nations Development Programme (UNDP), a number of African nations suffered downward changes this year in the Human Development Index, a ranking based on levels of health, wealth and education. Almost all of the major changes in rank could be attributed to declining life expectancy as a result of AIDS.

- Life expectancy at birth in southern Africa, which climbed from 44 in the early 1950s to 59 in the early 1990s, is expected to drop back to 45 sometime between 2005 and 2010.
- UNDP estimates that fewer than 50% of South Africans currently alive can expect to reach the age of 60, compared with an average of 70% for all developing countries and 90% for industrialized countries.
- According to a survey of commercial farms in Kenya, illness and death have already replaced old-age retirement as the leading reason why employees leave service.

Yet there are reasons for optimism even in this most devastated region: a number of African countries have demonstrated a much stronger commitment to fighting AIDS than ever before. "I believe we are now at a turning point in the 20-year history of the AIDS epidemic in Africa. Everywhere I go, I hear the top African leaders speaking out about AIDS as the major threat to

the continent's development", said Dr Piot. "This gives me grounds for hope that in the coming years, we will see stronger, more effective responses to AIDS in many more sub-Saharan African nations - responses to complement the strong programmes that already exist."

Injecting drug use in former USSR fuels world's steepest HIV increases

The report further reveals that the world's steepest HIV curve in 1999 was recorded in the newly independent states of the former Soviet Union, where the proportion of the population living with HIV doubled between 1997 and 1999. In the larger region comprising these nations and the remainder of Central and Eastern Europe, the number of HIV-infected rose by more than a third in 1999 alone, to reach an estimated 360 000.

- In the Russian Federation, nearly half of all reported cases of HIV infection since the start of the epidemic were recorded in the first nine months of 1999 alone.
- In Moscow, three times as many cases were reported in the first nine months of 1999 as in all previous years combined. Towns around Moscow had even sharper rises in HIV, with over five times as many infections reported in the first nine months of 1999 as in all previous years combined.
- Preliminary studies suggest that injecting drug use is becoming increasingly common among unemployed young people in many of the industrial cities of the Russian Federation and Ukraine. HIV is not limited to Russia's major metropolitan regions; in the Siberian city of Irkutsk, nearly 1300 infections have been reported, most of them in 1999.
- Injecting drug use appears to be well established even among Russian schoolchildren. An outreach programme for drug injectors in St Petersburg reported that the caseload for clients under age 14 increased 20-fold between 1997 and the first quarter of 1999.

Strong prevention efforts, care programmes, find success in certain regions

In the report, UNAIDS and WHO also point to some countries and regions which are managing to keep down the number of new infections or improve the well-being of those already infected. For example, evidence continues to mount that the strong prevention programmes of Thailand and the Philippines have had sustained success in reducing HIV risk and lowering or stabilizing HIV rates.

- In India, major efforts to improve the tracking of the epidemic more than tripled the number of HIV surveillance sites in 1998. Estimates now place total HIV infections in the country at around 4 million-more than in any other country, but fewer than projected on the basis of earlier surveillance estimates. Consequently, the regional

estimate of HIV infections in Asia has been revised downward by 800 000.

- The AIDS Society in the Indian state of Tamil Nadu has enlisted the support of an advertising agency to encourage safer sexual behaviour, airing television advertisements during major sporting events. Casual sex among factory workers in the state reportedly fell by half between 1996 and 1998, while condom use with casual partners rose from 17% to 50%.
- Some Latin American countries have joined the ranks of those providing antiretroviral drugs to people infected with HIV. Brazil, for example, spent an estimated US \$300 million to treat some 75 000 people in 1999. Brazilian health officials said the considerable expense was offset in part by savings in hospitalization and medical care; the country averted an estimated US \$136 million in such costs between 1997 and 1998.

"Providing care to growing numbers of HIV-positive people when health systems are already overburdened is no straightforward task. But these examples show how countries around the world can make a difference in fighting the epidemic through both prevention and care. WHO has shown how relatively inexpensive modifications and additions to health-care systems can bring major benefits to people with HIV. Everyone, and every country, can learn and benefit from these examples", said Dr Brundtland.

No room for complacency

Releasing the report, UNAIDS Executive Director Peter Piot also urged industrialized nations to put more emphasis on HIV prevention efforts. "There is no room for complacency in any discussion of this epidemic. The threat of HIV has not diminished in any country. We have even seen evidence from North America and Western Europe suggesting that availability of life-prolonging therapies may be contributing to an erosion of safer sexual behaviour. This is tragic", Dr Piot said.

"While antiretrovirals have brought hope to many people with HIV who are fortunate enough to have access to them, they are not a panacea, and they are not available in most of the world", Dr Piot said. "The key to fighting AIDS is preventing new infections. For this more resources are needed - to implement the prevention strategies we have today, and to develop new and better tools, such as microbicides and a vaccine."

Dr Brundtland added, "While prevention is the most promising strategy for managing the AIDS epidemic in the long term, we cannot lose sight of the fact that millions of people are infected today. For them, we must do a much better job of increasing access to health care and support, including inexpensive antibiotics that can add many months to the lives of people already sick with AIDS, to palliative therapies that can help increase comfort and reduce suffering, and to psychological and social support for patients and their families. WHO and UNAIDS will continue to engage the pharmaceutical industry to

make new HIV-related drugs available at affordable prices for those in need. "

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DEVELOPMENT COMMITTEE
(Joint Ministerial Committee
of the
Boards of Governors of the Bank and the Fund
On the
Transfer of Real Resources to Developing Countries)



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March 24, 2000

**INTENSIFYING ACTION AGAINST HIV/AIDS:
RESPONDING TO A DEVELOPMENT CRISIS**

Attached for the April 17, 2000 meeting of the Development Committee is an issues note on Intensifying Action against HIV/AIDS: Responding to a Development Crisis prepared by World Bank Staff as background to item 1.A of the Provisional Agenda.

* * *

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**INTENSIFYING ACTION AGAINST HIV/AIDS:
RESPONDING TO A DEVELOPMENT CRISIS**

DEVELOPMENT COMMITTEE

APRIL 17, 2000

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INTENSIFYING ACTION AGAINST HIV/AIDS: RESPONDING TO A DEVELOPMENT CRISIS

HIV/AIDS represents a serious crisis for development in large parts of the developing world, where it is rapidly reversing the social and economic achievements of the past half century. The epidemic now poses the foremost threat to development in Sub-Saharan Africa, a growing threat in Asia and the Caribbean, and a probable threat in some Eastern European countries. This paper summarizes the impact of HIV/AIDS, explains the importance of acting fast, and seeks the engagement of Development Committee members in a strategy by which the international community could help stop the further spread of the epidemic while alleviating its effects.

The Explosive Epidemic of HIV/AIDS

1. The HIV/AIDS epidemic has spread with ferocious speed. Virtually unknown 20 years ago, HIV has now infected 50 million people worldwide. More than 16 million have died—2.6 million in 1999 alone. Today, 34 million people are living with HIV/AIDS, over 95 percent of them in developing countries. AIDS is already the fourth-leading cause of death in the world, and the leading cause in Sub-Saharan Africa. Yet despite heightened awareness and a mounting death toll, the growth of the epidemic continues unabated. Each day, over 15,000 people—approximately half between the ages of 15 and 24—are newly infected.
2. The effect on social outcomes has already been extensive. In the most-affected countries, HIV/AIDS is swiftly dismantling the development achievements of the past 50 years. *Life expectancy* is now declining in a host of countries after decades of progress. In several nations it is already 10 years shorter because of HIV/AIDS. In the hardest-hit countries such as Botswana and Zimbabwe, it will soon be 17 years shorter than it would otherwise have been. *Adult mortality rates* have risen by 50 percent in many countries and 100 percent in those most affected by AIDS. *Child mortality rates* in many countries have doubled, and could double again if HIV/AIDS continues unchecked. And the rapid rise in adult deaths is leaving an unprecedented number of *orphans*—11.2 million worldwide, 10.7 million of them in Africa alone. Before AIDS, one in 50 children in the developing world was an orphan. Today as a result of AIDS, in some countries the rate is one in ten.
3. ***AIDS is a global epidemic.*** In 1982, there was only one country (Uganda) with an HIV prevalence rate¹ as high as two percent in the general population, along with a much higher rate in certain “at-risk” population groups (*e.g.* commercial sex workers, truckers). Today there are 21 countries with prevalence rates of more than seven percent, and many other developing and transition economies are now where Uganda was in the 1980s—at the dangerous early stage of the epidemic. The behavior of HIV is such that once the prevalence rate reaches around five percent in the general population, the virus spreads very fast. What has happened in these 21 countries now threatens to happen in many other developing and transition economies if action is not taken while the epidemic is young.

¹ The HIV prevalence rate refers to the percentage of all adults age 15-49 who are HIV-positive, which is the standard definition for the scope of the epidemic in a country. In this paper, the terms “HIV prevalence,” “HIV rate” and “adult HIV rate” are used interchangeably.

Intensifying Action Against HIV/AIDS**Page 2**

4. *Sub-Saharan Africa* has experienced the most severe impact so far. The 13.7 million Africans who have died account for 85 percent of the global toll from AIDS, and another 23.3 million are living with HIV/AIDS. In at least five countries, more than 20 percent of adults have HIV. Africa's burden has resulted from conditions that allow the virus to spread—notably poverty, dilapidated health systems, and a high level of untreated sexually transmitted infections. But *inaction* has also played a crucial role. Although prevention strategies were known years ago and many measures were taken on a small scale, very few countries or their international partners have taken sufficient action to slow the spread of HIV. The lessons from Africa, both positive and negative, now urgently need to be applied to the other regions where HIV/AIDS is rapidly advancing.

5. *South and Southeast Asia* is the second most-affected region. HIV/AIDS came relatively late to the area, but has already killed more than one million people. India has the largest number of persons living with HIV/AIDS—nearly four million—and the virus has appeared in new Indian states in the past two years. HIV rates in Cambodia now exceed two percent among adults and 40 percent among commercial sex workers (a key leading indicator of rates in the general population). In Myanmar, the adult HIV rate is approaching two percent and has already surpassed 20 percent among commercial sex workers. Leading indicators are also troubling in Bangladesh and Vietnam.

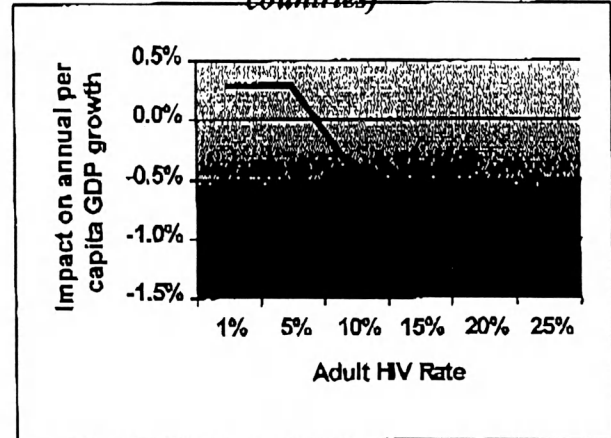
6. *Eastern Europe and Central Asia* show the most worrisome trend. Half the people now living with HIV/AIDS in this region have been infected in the past two years alone. In 1999, the fastest growth of HIV anywhere took place in Russia. Unlike in Africa and Asia, intravenous drug use (IDU) is the primary mode of transmission in this region for now. Typically, however, IDU fuels the early growth of the virus, which then becomes sexually transmitted and spreads among the general population. The fact that HIV has grown so rapidly in a region where awareness is high underscores that awareness alone is insufficient; support for behavior change must follow.

The Economic and Social Impact of HIV/AIDS

7. The epidemic poses a great threat not only to public health, but to development itself. The World Bank has identified the following factors (among others) to be essential in promoting development and poverty reduction: macroeconomic growth; good governance; human capital development; a favorable climate for private investment; and growth in labor productivity. By undermining each of these, HIV/AIDS is increasingly impeding development. In the worst-hit countries, otherwise sound public and private investments are already proving uneconomic and unsustainable as a result of the epidemic. While many other diseases also kill millions, HIV/AIDS is virtually unique in its impact on the economic and demographic underpinnings of development. Because it weakens and kills adults in the prime of their lives as workers and parents, it erodes productivity, decimates the workforce, depletes the skills base, consumes savings, orphans millions and changes the very structure of households. Many of the following examples come from Africa, because that is where the epidemic and its impact are most advanced. But they are indications of what could happen across the developing world if HIV/AIDS continues to spread.

8. **AIDS and the economy.** Recent World Bank estimates suggest that HIV/AIDS has a substantial negative impact on economic growth. This relationship was difficult to discern when rates were lower, but it now appears that the economic impact grows as the epidemic advances.² Figure 1 shows the most conservative estimate of the epidemic's impact on economic growth in 75 countries; the actual impact may well be greater. As long as prevalence remains below about five percent, annual per capita economic growth is minimally affected. As prevalence rises, per capita growth can be expected to decline. When HIV prevalence reaches eight percent—about where it is in 21 African countries today—the cost in per capita growth is estimated to be about 0.4 percentage points per year. Compared to historical performance in Africa, such losses are significant. Annual per capita growth in Africa as a whole for the past three years has been about 1.2 percent, for instance. In countries such as Zimbabwe where the HIV rate exceeds 25 percent, annual per capita growth is at least a full percentage point lower than it otherwise would be, because of HIV/AIDS.

Figure 1. Estimated impact of AIDS on annual per capita growth, 1990-97 (75 countries)



9. The fiscal cost of HIV/AIDS is also significant. One year of basic treatment for a person with AIDS costs an estimated two to three times per capita GDP in medical costs alone. Most of these costs are typically borne by the public sector, which faces difficult choices. As the number of AIDS cases increases, so does the cost. In a country with HIV prevalence of 15 percent, the estimated budgetary cost of prevention and basic care could rise from 2.5 percent of GDP today to 6.0 percent by 2010. For most countries, this would imply a substantial worsening of the fiscal deficit.

10. **AIDS and the production sectors.** In general, it is the 15-49 age group that is disproportionately affected by the HIV/AIDS epidemic. Through its impact on the labor force, HIV/AIDS diminishes productivity just as developing countries need to become more competitive to cope with rapid globalization. All sectors are affected. For example:

- **Agriculture.** HIV/AIDS reduces investments in irrigation, soil enhancements, and other capital improvements, thereby inhibiting agricultural production. Households are shifting from more nutritious foods to less nourishing but less labor-intensive crops. The epidemic is forcing families to make irreversible decisions to sell livestock, equipment, and land to cover AIDS-related costs. HIV/AIDS illness and care also siphon time away from vital farm work.
- **Private sector development.** HIV/AIDS is undermining private sector development by removing skilled labor, increasing expenditures, and reducing revenues. Nearly 19 percent of all skilled laborers in South Africa will have HIV by 2015, according to a new report by ING Barings. On one sugar estate in Kenya where 25 percent of the workforce was HIV-positive, company spending on funerals increased 500 percent and direct health expenditures rose 1,000 percent in eight years. At

² This result is derived from cross-country regressions of GDP growth rates as a function of country-specific policy ratings and other parameters, including life expectancy, to control for the different starting conditions of each country. Combining these results with demographic projections of the impact of AIDS on life expectancy and population growth yields the estimated impact on per capita growth.

the same time, productivity fell by half in four years. In Madras, India, a study of large industries projected that absenteeism would likely double over the next two years because of sexually transmitted infections and HIV/AIDS. At the firm level, higher labor costs are diminishing scope and incentive to invest in training.

11. **AIDS and the social sectors.** AIDS overtakes social systems and aborts the health and educational development that the poor (especially children) need to escape poverty:

- **Education.** Across Africa, HIV/AIDS has drained skilled manpower in every sector, which was scarce to begin with. Teachers and students are dying or leaving school because they can no longer afford it, have fallen ill, or because they are needed at home to work or care for the sick. Illness and deaths of students and teachers will reduce both the quality and efficiency of educational systems. In some countries more than 30 percent of teachers are living with HIV/AIDS, and more now die each year than graduate from teacher training programs. Moreover, faltering education also diminishes human capital for the future in every other sector. Girls' education—a critical factor in development—is particularly vulnerable to HIV/AIDS.
- **Health.** Health care systems in many countries are stretched beyond their limits as they deal with a growing number of AIDS patients and the loss of health personnel to illness and death. Once HIV prevalence reaches five percent, demand for medical care is estimated to rise by at least 25 percent and to increase faster than government is able to supply it. In Cote d'Ivoire, Kenya, Zambia, and Zimbabwe, HIV-infected patients occupy 50-80 percent of all beds in urban hospitals, crowding out other patients and consuming scarce health care resources. AIDS also has large negative externalities for people who are HIV-negative. The epidemic has already sparked a resurgence in tuberculosis (TB) in Africa after years of decline. In some countries, TB cases have risen 500 percent from where they stood before HIV/AIDS.

12. **AIDS and governance.** Many developing countries depend crucially on a small number of policy makers and managers for the overall operation of government. Tax and customs administration, legal systems, central banks, finance ministries, schools, hospitals, public utilities and sectoral planning departments all rely on such officials, whose skills are typically scarce. Such personnel are now being rapidly depleted by HIV/AIDS. In South Africa, for instance, 15 percent of civil servants are living with HIV/AIDS. The loss of these key officials is further reducing capacity, which is weakening the prospects for good governance while raising the costs of recruitment, training, benefits, and replacements.

13. **AIDS and gender.** Women in general, and girls in particular, are biologically and socially more vulnerable to HIV/AIDS and are disproportionately infected and affected by the epidemic. In some countries, for every 15-19 year-old boy who is infected, there are six girls infected in the same age group. Women and girls also bear the greatest burden of care; families often take girls out of school to care for sick relatives or assume family responsibilities, jeopardizing recent gains in health, nutrition and girls' education. This has an especially detrimental impact on girls' development, which in turn makes them more vulnerable to HIV infection. Girls out of school are less likely to obtain the earning power to increase their economic independence, and more likely to have to resort to commercial sex work. They are also less likely to develop the confidence and knowledge to make sound decisions about their sexual health.

14. **AIDS and poverty.** HIV/AIDS particularly targets the poor. The epidemic has overwhelmingly hit the world's poorest countries and those with the greatest disparities of income. Although people at all income levels are vulnerable to HIV, the poor have suffered the most economically, as the costs of care, foregone income and funerals are substantial. The poor also have less access to basic health care and are

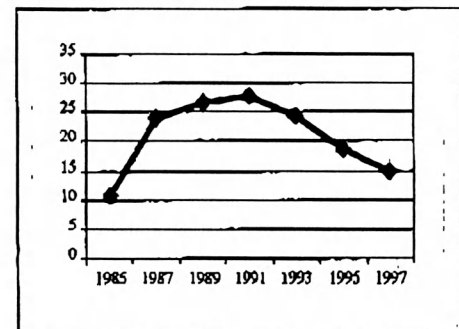
more likely to have to resort to commercial sex and other survival strategies that put them at risk for HIV. The epidemic has been found to exacerbate both income inequality and absolute poverty.

The Importance of Acting Fast

15. The tragedy of this epidemic is compounded by the fact that it is preventable. Despite the lack of a vaccine, behavior change has been proven a highly effective means of reducing HIV transmission. Young people (particularly under age 15) are especially receptive to learning safe behavior messages and skills. Since very few persons at this age are infected, they represent a window of opportunity to prevent HIV/AIDS from afflicting future generations. There is broad consensus and abundant evidence on the impact of behavior change. Early and aggressive action against the epidemic has paid dividends in several settings:

- In Uganda, where the government has led a strong campaign, HIV fell significantly among pregnant women and young people ages 15-24 in urban and peri-urban areas.
- In Senegal, enlisting all key actors in a timely prevention campaign has helped maintain one of the lowest HIV infection rates in Sub-Saharan Africa.
- Asian countries have mounted some of the most effective prevention programs. Rates among pregnant women and military conscripts in northern Thailand fell sharply in four years following concerted prevention efforts. The Indian state of Tamil Nadu launched a safe behavior campaign and saw steep reductions in risky behavior in two years.

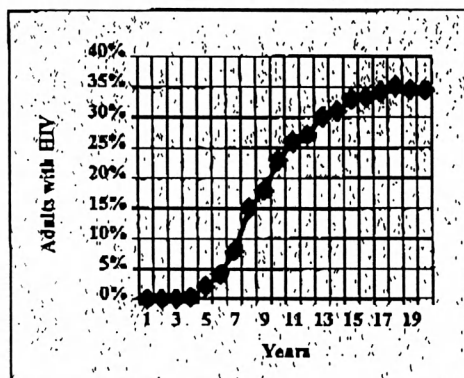
Figure 2. HIV rates in urban Uganda fell sharply after preventive programs were put



16. Prevention not only averts suffering and death, but pays vast dividends in future savings to the health system and the public sector at large. Cost-effective interventions such as greater use of condoms, public information programs, and treatment of sexually transmitted infections cost as little as \$8 per infection

averted, compared to the hundreds of dollars that each case of AIDS costs to treat.

Figure 3. Typical spread of HIV in a southern African



17. Early action is vital. Once it passes a certain threshold, HIV spreads extremely fast. As Figure 3 illustrates, it can increase tenfold in five years, as it has in several southern African countries. The more widely HIV/AIDS spreads, the more difficult and costly prevention and treatment become. In Sub-Saharan Africa, it is estimated that a national program would cost less than \$3 per capita while prevalence remained below five percent. Once rates reach 15 percent, however, program costs could be \$12 per capita or more. The longer the introduction of programs is delayed, the greater the likelihood that the epidemic will grow exponentially.

18. Countries therefore face two policy options: (1) delay while prevalence remains low and face far higher expenses once it is widespread; or (2) take comprehensive action early on. Since a strong

HIV/AIDS program would be multisectoral, the costs could be spread among several ministries, agencies, civil society, and private actors.

Building an Effective National Response

19. Every nation threatened by HIV/AIDS must lead its own response. There is no substitute for strong national commitment and ownership. Building an effective national response requires an enabling environment and the necessary resources to bring proven interventions quickly up to nationwide scale. In many countries, it is government that creates such an environment so that all sectors of society can contribute. Many governments have initiated a limited response to HIV/AIDS. Few, however, have brought it to the nationwide necessary. Governments of all vulnerable countries (with their partners) need to expand and intensify their responses rapidly, and to address HIV/AIDS as a multisectoral development issue—not only a health concern.

20. In too many countries, however, there is still official denial or silence surrounding the epidemic. Some governments are unwilling to acknowledge that certain practices such as commercial sex work and intravenous drug use exist in their country. Some are reluctant to tamper with practices that are part of “cultural norms,” such as female genital mutilation, even when these place people at higher risk of HIV infection. Some will not address sensitive issues such as sexual behavior by adolescents because of traditions and fears. Since these concerns arise from particular cultural contexts, they can only be overcome by customizing strategies to be culturally appropriate. Governments need to lead a major change in attitudes, to break the conspiracy of silence, and to scale up national responses. Seven actions are fundamental:

21. ***Increase Government Commitment, Attention, and Funding.*** Strong government commitment has proved essential in every country that has made headway against the epidemic. This calls for bold political action and leadership, not merely tacit approval of public HIV/AIDS interventions. Leaders need to speak openly about HIV/AIDS, overcome taboos, and place the epidemic at the center of their development agendas. Each country at risk needs a multisectoral national program with adequate funding. To ensure such funding, governments need to re-examine spending priorities in light of the rapidly growing costs of AIDS, and reallocate accordingly. But government can also leverage existing programs (e.g. education, agricultural extension) by integrating HIV/AIDS into them at modest cost. Management of national programs belongs in the highest office of government to ensure the power, resources, flexibility, and effective coordination to act multisectorally.

22. ***Scale Up Prevention Activities.*** Governments and their partners need to expand proven interventions to a scale large enough to reach all vulnerable individuals. Because of scarce resources, this calls for setting priorities and focusing on a core set of activities that have proven effective and feasible, including: *behavior-change communications* that move audiences from awareness to risk-reducing behavior; making *condoms, treatment of sexually transmitted infections, and voluntary counseling and testing* more accessible; ensuring a *safe blood supply*; and reducing *HIV transmission from mother to child*. Gender-sensitive programs need to be developed to build women’s awareness and empowerment. To ensure effectiveness, governments need to work in partnership with persons living with HIV/AIDS, community groups, religious organizations, NGOs, health professionals, and the private sector.

23. ***Scale Up Care Activities.*** Governments also need to develop strategies to care for and support the vast numbers of people who are infected and/or affected by HIV/AIDS. Given that the costs of life-prolonging triple-drug therapy are currently out of reach for virtually all developing countries, governments will need to focus on effective treatment for the opportunistic infections that afflict persons

Intensifying Action Against HIV/AIDS**Page 7**

living with AIDS. In addition, governments and their partners need to mount programs to care for the millions of orphans and other vulnerable children where extended families can no longer bear the load.

24. Support Community-Level Prevention, Care and Support. In many countries, the scale of the epidemic exceeds government's capacity to address it. In all countries, communities play a decisive role against HIV/AIDS because of their capacity for social mobilization, their awareness of the local cultural and social context, and their daily influence on the lives of their members. Communities, NGOs and community-based organizations (CBOs) therefore need to receive direct financial support to act at the local level, where the public sector is often less effective. Communities also have a vital role to play in HIV/AIDS care, since long-term hospital care is not affordable or even possible in most developing countries. Strategies to provide high-quality community and home-based care need to be developed. Since it is usually in the best interests of orphans to remain in their extended family or community, innovative support to communities will be important in this respect as well.

25. Integrate HIV/AIDS into Poverty Reduction Strategies. Poverty and HIV/AIDS form a vicious circle. Poverty can drive people to leave their families to find work or into commercial sex for economic survival, placing them at high risk for HIV infection. HIV/AIDS, in turn, can drive a household deeper into poverty. It is therefore important to address the socioeconomic factors that make people vulnerable to HIV and to mitigate the impact of AIDS on poor households. Poverty reduction policies and programs can prevent people from adopting risky survival strategies and mitigate the financial impact of HIV/AIDS. Poverty Reduction Strategy Papers (PRSPs) need to address the structural factors that have been found to increase people's vulnerability to HIV/AIDS.

26. Support More Research. Continued research is needed into the cost of HIV/AIDS treatment and care alternatives, the sectoral impact and costs of the epidemic, and the effectiveness of existing prevention tools in different cultural and infrastructure settings. Leaders in each sector will continue to view HIV/AIDS as a health issue unless they see the potential impact on their sector and the comparatively low cost of intervention.

27. Make Policy Changes to Mitigate Public and Private Impact. AIDS is shrinking capacity in the public sector and imposing new social welfare burdens as families collapse. Countries need to explore innovative ways of rebuilding capacity in government, as well as changes in labor and social legislation and new means of delivering social services to aid the growing number of households headed by orphans.

Building an Effective International Response

28. Developing country governments cannot overcome the HIV/AIDS challenge alone. Given the scope of the epidemic, its costs, widespread denial, and sensitivities, sustained support from all development partners will be required. Two overarching goals should guide this support. For the present, the goal is to replicate what has been proven to work—that is, *to help every country at risk to establish an appropriate national HIV/AIDS program comprising basic prevention, basic treatment, basic care, and mitigation tools*. This is the minimum needed to prevent the epidemic from spreading further and to begin reversing it where it is already widespread. For the future, the goal is an effective HIV vaccine. Because such a vaccine will not likely be available for at least 10-15 years, however, no country can afford to delay strengthening its prevention and care programs. To help achieve these goals, no single step will suffice. What is needed is a balanced combination of advocacy, incentives, disincentives, funding, and policy support. This will call on the international community for strong partnerships and coordinated action.

29. The international effort is led by the Joint United Nations Programme on HIV/AIDS (UNAIDS), which comprises seven UN cosponsors.³ With the guidance of the UNAIDS Secretariat, the cosponsors coordinate their assistance to countries addressing the epidemic. This division of labor allows each cosponsor to focus on its comparative advantages and thereby hastens and strengthens international support. The UNAIDS cosponsors have also launched the broader International Partnership Against HIV/AIDS in Africa. This Partnership joins the UNAIDS cosponsors with African governments, donor countries, the private sector, NGOs, and people living with HIV/AIDS. Its goal is to help all African countries put comprehensive national programs in place within a few years under the leadership of the government.

30. **The Role of the World Bank.** The World Bank brings four primary comparative advantages to UNAIDS and the Partnership: (1) Strong influence on the global development agenda; (2) Involvement in virtually all sectors; (3) Ability to support large scaling-up of effective programs; (4) Economic expertise. The Bank has recently adopted a comprehensive new approach to bring each of these strengths to bear on HIV/AIDS. In full collaboration with the UNAIDS Secretariat, the Bank is treating HIV/AIDS as a multisectoral development issue and according it top priority in development policy, dialogue with all sectors of government, planning, analysis, and lending. The Bank's president has corresponded with heads of state on HIV/AIDS. The Bank's senior managers have begun highlighting the issue in some high-level appearances and meetings. Administrative resources have been reallocated, and HIV/AIDS projects have been put on a fast track. From a corporate perspective, the Bank will review the situation every six months to maintain momentum and focus corporate interest continually on the issue.

31. The Bank is acting at both regional and corporate levels to strengthen its support to prevention, care and research. At the regional level, it is taking several steps to integrate HIV/AIDS into both lending and non-lending services. The Africa region is retrofitting its current portfolio to include prevention and mitigation components in as many sectors and projects as possible. A multisectoral AIDS Campaign Team for Africa (ACTAfrica) has been established under the office of the Africa Regional Vice Presidents. ACTAfrica is designing a flagship regional IDA operation to expedite support to HIV/AIDS programs throughout Africa, including innovative forms of funding which will put resources directly in the hands of communities. This operation should reach the Board in the first half of fiscal year 2001. ACTAfrica is also spearheading the incorporation of an AIDS impact assessment module into the Bank's environmental assessment process, and HIV prevention requirements into the Bank's standard procurement requirements for civil works. Economic work is underway to better assess the macro and micro impacts of the epidemic at various stages. Africa country teams are incorporating HIV/AIDS into development planning, HIPC, PRSPs, Country Assistance Strategies, and into projects such as social funds and community action projects. And they are rapidly identifying opportunities to support more comprehensive AIDS programs wherever possible.

32. While the Bank will continue to regard Africa as a funding priority, it is also boosting its support to other regions. Last fiscal year, the Bank approved major HIV/AIDS projects in India and Brazil as a follow-up to earlier projects, and is now developing projects in Russia and Ukraine.

33. At the corporate level, the Bank is using its knowledge and influence to help provide more tools against the epidemic. For instance, the Bank is part of a UNAIDS task force mandated to work with pharmaceutical companies to find ways of making anti-retroviral drugs more available in the developing world. The development of an HIV/AIDS vaccine would produce immense benefits, particularly for the

³ The UN International Drug Control Programme (UNDCP), the UN Development Programme (UNDP), the UN Educational, Scientific, and Cultural Organization (UNESCO), the UN Population Fund (UNFPA), the UN Children's Fund (UNICEF), the World Health Organization (WHO), and the World Bank. See Annex 1 for more details.

Saharan Africa would be approximately \$1.0-2.3 billion. Both financial and technical resources need to increase substantially. Concessional and grant funds will be especially important to avoid adding to the debt burden of affected countries. Technical resources will also be needed to help countries build expertise in research, planning, implementation, and evaluation. A larger share of HIV/AIDS funding needs to be allocated directly to communities and local NGOs, which are doing some of the best work in HIV/AIDS and will play an indispensable role, especially in caring for the infected and for orphans. Global agencies can also help by harmonizing administrative arrangements and simplifying procurement, disbursement, and accounting. At the same time, even the resources currently available have not been used to the extent possible. There is no shortage of IDA funds, for instance, but demand for HIV/AIDS support from IDA has been modest at best. Developing countries need to reallocate more of their own resources, increase the effectiveness of current HIV/AIDS assistance, and make greater use of current resources.

- (5) **Stimulate the development of vaccines and microbicides.** Current market incentives may not be enough to induce industry to develop vaccines that will be affordable and effective in developing countries. To address this, the International AIDS Vaccine Initiative, GAVI and others have been exploring ways of accelerating development of an AIDS vaccine for developing countries. To succeed, this effort may ultimately require innovative financial instruments as well as legal and institutional policy changes. Although an effective vaccine is probably years away, research is far more advanced on microbicides (substances to kill sexually transmitted infections on contact). Since far more women are infected than men in Sub-Saharan Africa, woman-controlled methods of HIV prevention could reduce both overall infections and the disproportionate burden of infection on women. The international community needs to give priority to enhance the development, clinical testing and accessibility of microbicides and female condoms to help women protect themselves from HIV.
- (6) **Strengthen partnerships.** Because HIV/AIDS affects so many aspects of development, external actors must work in unprecedented partnerships with civil society and the private sector under the leadership of governments to exploit the comparative advantage of each. Support must be well-planned and coordinated to enhance synergy and avoid duplication of effort. Bureaucracy should be minimized and processing of aid dramatically accelerated. Most of all, a concerted effort to break the silence surrounding HIV/AIDS needs to be made and consolidated action taken very early in the epidemic.

Issues for Committee Consideration

- *Ministers may wish to comment on the development impact of HIV/AIDS in their own countries' experiences.*
- *What advice do ministers have on how governments can help to change attitudes and increase awareness? Do ministers also have advice on how best to help bring about the coordinated action within governments needed to overcome this epidemic? Are there important issues and differing viewpoints not addressed in this short paper which ministers must confront?*
- *What priority would ministers assign to the different actions set out in the paper, and what activities do they think governments should scale back to make room for more action on HIV/AIDS?*

FOR IMMEDIATE
RELEASE

DEVELOPMENT COMMITTEE

JOINT MINISTERIAL COMMITTEE
OF THE
BOARDS OF GOVERNORS OF THE BANK AND THE FUND
ON THE
TRANSFER OF REAL RESOURCES TO DEVELOPING COUNTRIES



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April 17, 2000

COMMUNIQUÉ

1. The 61st meeting of the Development Committee was held in Washington, D.C., on April 17, 2000 under the chairmanship of Mr. Tarrin Nimmanahaeminda, Minister of Finance of Thailand. The Committee's deliberations took place against the background of growing public debate about the appropriate roles of international institutions at a time when governments and people throughout the world confront the opportunities and rapid changes brought about by globalization. In their discussions of how to strengthen efforts to reduce poverty, to intensify the attack on HIV/AIDS, and to expand the benefits of trade to all countries, Ministers emphasized the importance they attach to preserving and further strengthening the family of multilateral institutions as a powerful force for global progress, equity and stability.
2. **Intensifying Action Against HIV/AIDS.** Ministers emphasized that the HIV/AIDS epidemic, which has already infected about 50 million people, is not only a very serious public health concern and the cause of great human suffering, but a severe danger to development progress itself. Ministers recognized that HIV/AIDS weakens economic growth, governance, human capital, labor productivity, and the investment climate, thereby undermining the foundations of development and poverty reduction. Ministers noted that the epidemic now poses not only an acute danger to development in Sub-Saharan Africa, but is a rapidly growing threat in Asia and the Caribbean, and a probable threat in many Eastern European countries and elsewhere as well. As HIV spreads quickly, even countries with currently low infection rates cannot afford to delay strengthening anti-HIV/AIDS programs.
3. In view of this alarming situation, the Committee called for rapid intensification of international action on the global HIV/AIDS crisis. Given the urgency of prevention and the vast needs for care and treatment, the Committee stressed the importance of effective partnerships to encourage each actor in the international system to focus on its comparative strength. Ministers urged governments, international agencies, civil society, the media and the private sector, including the pharmaceutical industry, to step up their efforts, building on experience gained in on-going activities. They urged developing and transition countries to increase their political and economic commitment to combating HIV/AIDS, to address the epidemic on a multisectoral basis, to scale up programs to nationwide - and in some cases regional - scope, to strengthen the primary health care systems needed for effective delivery of services, and to provide more

resources directly to local communities. The Committee encouraged industrialized countries and international organizations to mainstream HIV/AIDS in their development programs and to devote increased financial and institutional resources on a scale commensurate with the scope of the crisis. Ministers recognized that support for capacity building is particularly important in addressing this long-lasting development problem.

4. Ministers welcomed the World Bank's expanded efforts against HIV/AIDS, in particular its active participation in the UNAIDS partnership, its new HIV/AIDS strategy for Africa, and its work with the Global Alliance for Vaccines and Immunizations (GAVI). They urged the Bank to intensify its HIV/AIDS work on a global basis, focusing on its areas of expertise, and called on the Bank and the Fund to take full account of HIV/AIDS in their support for poverty reduction strategies and the HIPC Initiative.

5. **Trade, Development and Poverty Reduction:** Ministers emphasized the critical importance of trade for development and poverty reduction. They noted that accelerated and sustainable growth is a necessary condition for reducing poverty, and that more open economies tend to grow faster than closed ones; evidence suggests that substantial benefits could be gained from further liberalization of trade regimes in both developed and developing (including transition) countries. Ministers recognized that developed countries have much to do to improve market access for developing countries' exports (e.g. agriculture, textiles). Developing countries need to implement appropriately sequenced outward-oriented reforms that will permit trade expansion to promote development and poverty reduction. Ministers noted that the majority of the poorest countries lag behind in their integration into the world trading system. Additional domestic and international reforms are needed, including special consideration of enhanced market access for these countries (e.g. by extending comprehensive and predictable duty- and quota-free market access). Ministers also noted the potential of regional integration to help developing countries increase their share in global markets. Ministers strongly endorsed a timely initiation of WTO multilateral trade negotiations that address, *inter alia*, issues of most concern to developing countries.

6. Ministers emphasized that countries should ensure that their efforts to expand trade are integrated into a comprehensive framework for development that includes the necessary complementary reforms and investment in institutions, infrastructure and social programs. Ministers endorsed the commitment of the World Bank and the IMF to use their programs to support these efforts, which are increasingly reflected in countries' poverty reduction strategies. Ministers reiterated their call on the Bank, the Fund and WTO to cooperate with other parties in developing effective programs of capacity building for trade, including through an improved Integrated Framework for Trade Related Assistance for the Least Developed Countries. The Committee urged the Bank to mainstream trade in its country assistance programs by providing greater financial and technical support to improve trade-related infrastructure and institutions, including building domestic capacity for trade policy and negotiations, and by undertaking a strengthened research program on, *inter alia*, trade barriers to developing country exports, the issues developing countries face in implementing the Uruguay Round Agreement and the complex links between trade and poverty.

MULTILATERAL DEVELOPMENT BANK LENDING FOR HEALTH AND HIV/AIDS

Loans Approved - 1995-99

(\$ Millions)

<u>MDB</u>	<u>TOTAL HEALTH</u>	<u>BASIC HEALTH</u>	<u>HIV/AIDS</u>
WORLD BANK/IDA	7,502*	5,233	520
AFRICAN DEVELOPMENT BANK/FUND	251	n/a	63**
ASIAN DEVELOPMENT BANK	1,226	1,061	0.1***
INTER-AMERICAN DEVELOPMENT BANK/ FSO	1,106	n/a	(45)****
TOTAL	10,085		583

SOURCE: MDB Reports

* Includes all World Bank/IDA funding in the Health, Population/Nutrition sector

** Includes small amount of grants

*** Funding for Fourth International Congress on AIDS in Asia and the Pacific in 1997/It does not include two other regional technical assistant interventions

**** Indirect support on screening of blood supply in Epidemiology/ health an to Bolivia

n/a Not available

Multilateral Development Bank (MDB) Activities on AIDS

Lending Activities

The World Bank has been the major MDB supporter of activities to combat HIV/AIDS. Regional MDB engagement has generally been more modest through technical assistance and support for epidemiology and disease control in general.

Following are summaries of health sector interventions on AIDS in each of the MDBs, which encompass direct lending for HIV/AIDS prevention/treatment. This does not include multi-sector and other activities which substantially support AIDS prevention, e.g., girls education, womens microenterprise endeavors, and womens rural extension training.

The World Bank/IDA

Cumulative HIV/AIDS lending by the World Bank and IDA has been around \$986 million between FY85 to FY99, or 7 percent of total health/nutrition/population lending during this period. Recently, the World Bank has intensified its efforts to combat HIV/AIDS in Sub-Saharan Africa by making its containment a central development objective of its lending and on-lending programs in the countries of the region. It will use its policy dialogue with finance and planning ministers to encourage greater openness concerning HIV/AIDS and develop preventive interventions to assist in containing the disease. The Bank has done analysis on the economic/development impact of the disease and has supported the International AIDS Vaccine Initiative (IAVI). It has developed expertise within the Bank to assess the impact and growth of the disease and suggest "push" and "pull" mechanisms to provide incentives for the pharmaceutical industry to undertake the necessary R & D to discover and develop an AIDS vaccine.

As part of an international vaccine/health initiative, the World Bank is contemplating a \$1 billion increase of its funding in basic health/vaccines and medicines to be considered by the IDA Deputies. Although not as yet finalized, part of this amount would support efforts to prevent and control AIDS, and would probably be in addition to the \$400 million for HIV/AIDS activities for FY2000-FY02, a rough estimate by operations staff of the prospective pipeline of projects.

The African Development Bank/Fund

Cumulative lending by the African Development Bank/Fund for components and stand alone projects to combat HIV/AIDS has totaled \$183 million to date in 15 borrowing member countries, or 14 percent of cumulative lending to the health sector. Since 1990, these projects have been to Cote d'Ivoire, Togo, Mali, Malawi, Burundi, Gabon, Morocco, Mauritania, Tanzania, Uganda, and Burkina Faso. In addition, a permanent task force on HIV/AIDS has been established to develop a multi- sectoral policy to guide future assistance. Current operations in the southern region of borrowing countries are mainstreaming HIV/AIDS control activities in all

From: Brian Crowe
To: EX.MAIL."Richard_Samans@OPD.eop.gov"
Subject: MDBs and HIV/AIDs

Sorry for delayed response. Our two gurus on the issue are both out & it took a while to get the facts together. Suggest language along the following lines:

The World Bank has been the major MDB supporter of activities to combat HIV/AIDs, lending a total of roughly \$520 million for this purpose over the last five years. (Cumulatively the Bank has committed almost \$1 billion.) Over the same period, lending from the African Development Bank totaled \$63 million. Lending from the Inter-American Development Bank totaled \$45 million.

At the April 17 meeting of the Development Committee, Ministers called for a rapid intensification of international action on the global HIV/AIDS crisis, including mainstreaming HIV/AIDS into development programs and an expanded World Bank role. Consistent with this effort, World Bank President Wolfensohn has committed to a significant expansion in the level of Bank financial support.

I am also faxing you two more detailed (off the shelf) papers. In addition, Helen Walsh sent over yesterday a World Bank paper prepared for the recent Development Committee meeting.

Hope this is helpful.

CC: CONLEYR, WALSHH, HERZB, HERRLINGS, BEASLEYM

OPTIONAL FORM 99 (7-90)

FAX TRANSMITTAL

of pages **9**

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sector work and projects.

Asian Development Bank

The Asian Development Bank has not financed any stand alone HIV/AIDS projects to date. However, the ADB has financed several regional technical assistance for HIV/AIDS programs: (i) to support the Fourth International Congress on AIDS in Asia and the Pacific in 1997 (\$100,000); (ii) to develop cooperation in the prevention and control of HIV/AIDS in the Greater Mekong Subregion; and (iii) to help prevent HIV/AIDS among mobile populations in the Greater Mekong Subregion. A seminar on the current situation of HIV/AIDS in the region is being developed as an adjunct to the ADB Annual General Meeting in 2000 in Chiang Mai, Thailand. In the project pipeline 2000-2002, in 2000 the Bank is preparing a technical assistance to assist capacity building for the HIV/AIDS program in Cambodia (\$600,000).

Inter-American Development Bank

The Inter-American Development Bank has, also, not as yet, funded any stand-alone activities to constrain HIV/AIDS in the region, although, a regional technical cooperation for HIV/AIDS and sexually transmitted diseases is pending for approval in 2000 (\$126,000). In 1999, the Bank funded a epidemiological/health project in Bolivia (\$45 million) which will control the supply of blood and blood products which will help block the transmission of AIDS. Three other regional technical cooperations, one in 1999, and two pending for 2000 will support epidemiology and disease control, as well.

HIPC Initiative

Support for HIV/AIDS activities may result from the use of savings of debt service by each country which is eligible for debt relief under the Highly Indebted Poor Countries (HIPC) debt initiative. Priorities for allocation of savings to reduce poverty will be made by each country in the drafting of its "Poverty Reduction Strategy", which will then be reviewed by the World Bank and IMF. Bilateral donors, including USAID, will be consulted by the HIPC countries as they develop this strategy. This would be an opportunity to urge these countries to include expanded programs for immunization, prevention and treatment of infectious diseases, and support for effective basic health service delivery, including AIDS, in each country's "Poverty Reduction Strategy". (Bolivia, Uganda and Mauritania have been found eligible for HIPC debt relief; Mozambique, Benin, Burkina Faso, Tanzania and Mali are expected to be considered before the World Bank/IMF Development Committee Meeting, April 17, 2000.)

OASIA/IDB 2/8/00

Bilateral Agency Resources Directly and Indirectly Committed to International HIV/AIDS (Millions of USD in FY2000 excluding FTE)

	USAID	CDC	NIH	TOTAL
Primary Prevention	154	13		167
Community and Home Based Care and Treatment	14	9		23
Capacity Building and Infrastructure Development	24	13		37
Research				
Vaccine			25	25
Non-Vaccine Prevention			35	35
Research Capacity Bldg			10	10
Other			20	20
Other Programs	8	11		19
TOTAL	200	46	90	336

**Multilateral Development Bank Lending for Health and HIV/AIDS 1995-1999
(Billions USD)**

	Total Health	Basic Health	HIV/AIDS	TOTAL
World Bank/IDA	7.502	5.233	0.52	13.255
African Development Bank	0.251		0.063	0.314
Asian Development Bank	1.226	1.061	0.0001	2.2871
Inter-American Development Bank/FSO	1.106		0.045	1.151
TOTAL	10.085	6.294	0.6281	17.0071

US Contribution to UNAIDS FY2000 (Millions USD)

	USAID	TOTAL
UNAIDS	15	15