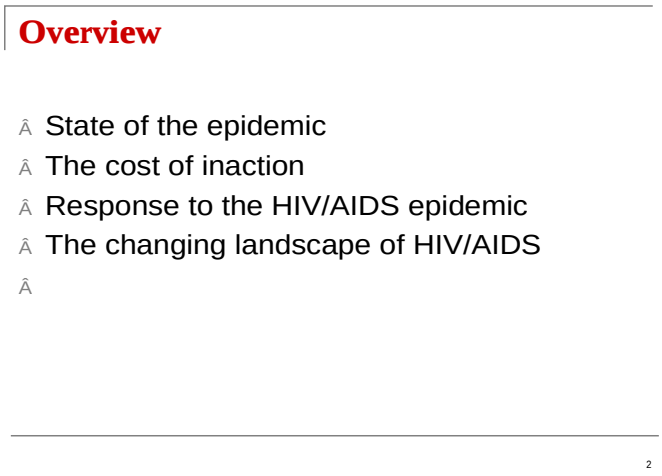
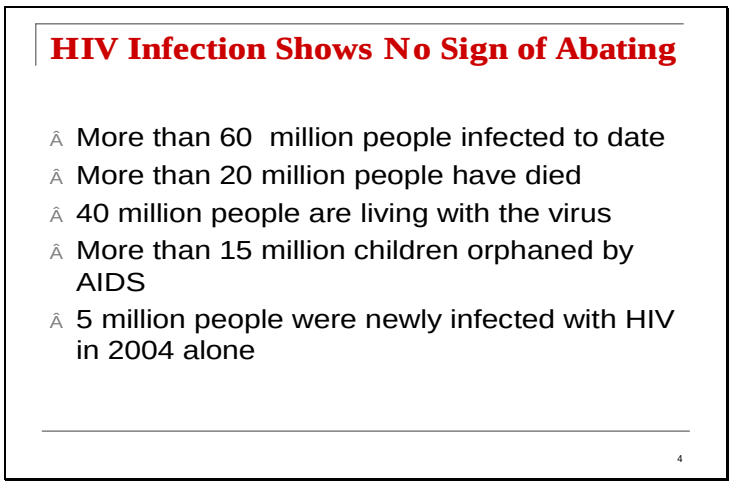
Dear colleagues, let me begin by saying how honored I am to be asked to give the keynote address on the number one threat to population and development of this century.

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



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



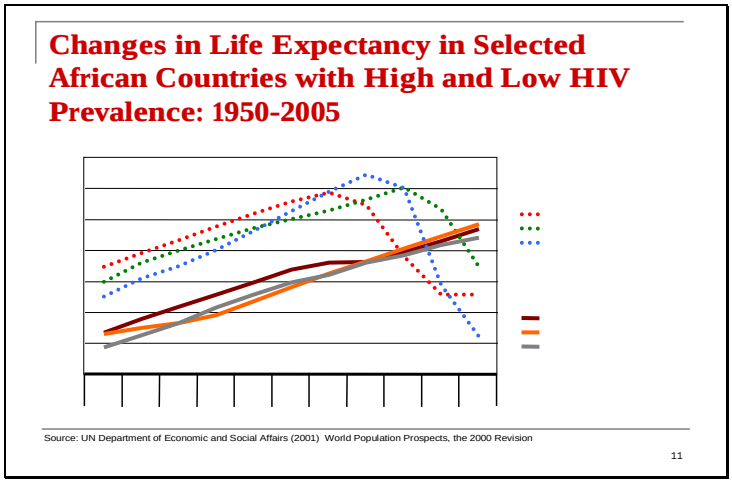
While Sub-Saharan Africa is home to just over 10 percent of the world's population, it has more than 60 percent or more than 25 million people living with HIV/AIDS. Two important issues to note with regard

Adults and Children Newly Infected with HIV in 2004

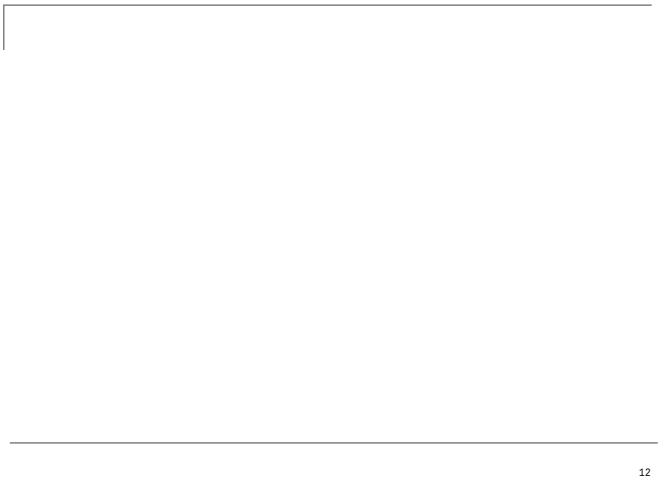
Total: 4.9 million

6

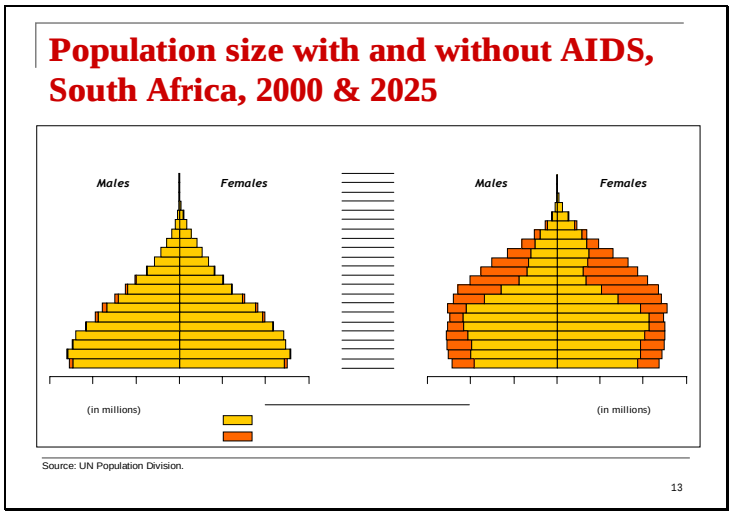
Here is a startling example of how life expectancy has dropped in three countries with high prevalence; in fact it has wiped out forty years of progress.



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

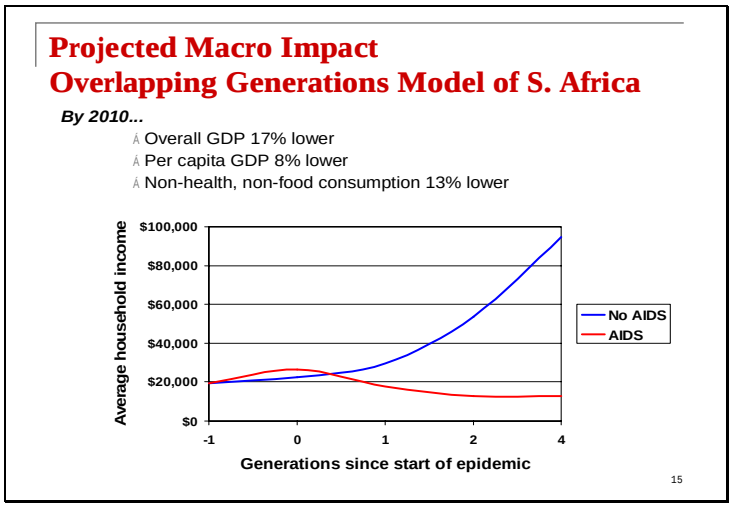


The impact of HIV/AIDS on the demography of Botswana is staggering.

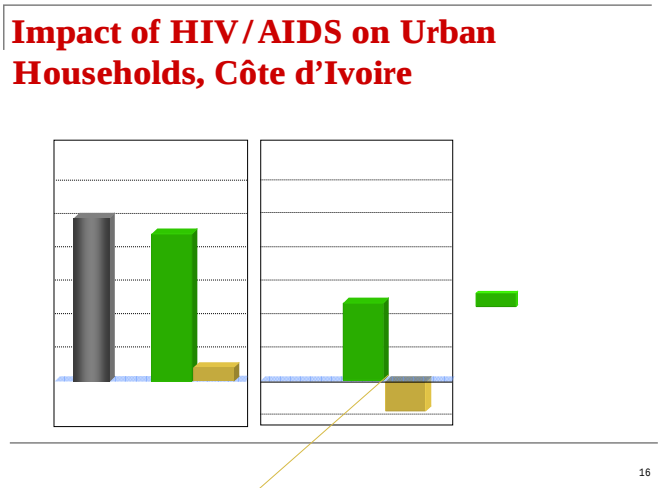


As a result of increased mortalh7 TD 4m98.4(d A296.48 -To)1s270.124(s)-15.3(h21 T44-2 0 TD [064 TD 0.0 of).2(tc24
150
200250WDSWi thAI DSSour ce: US Census Bur eau.

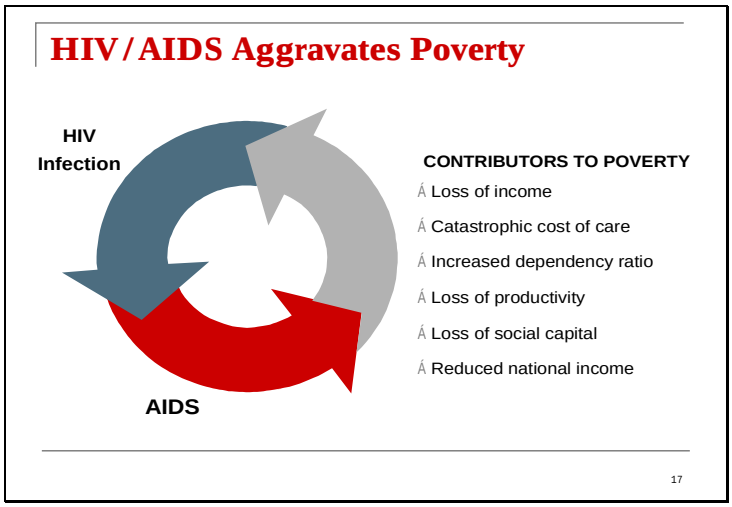
Research from South Africa shows that the loss of human capital will have far reaching economic and social impact.



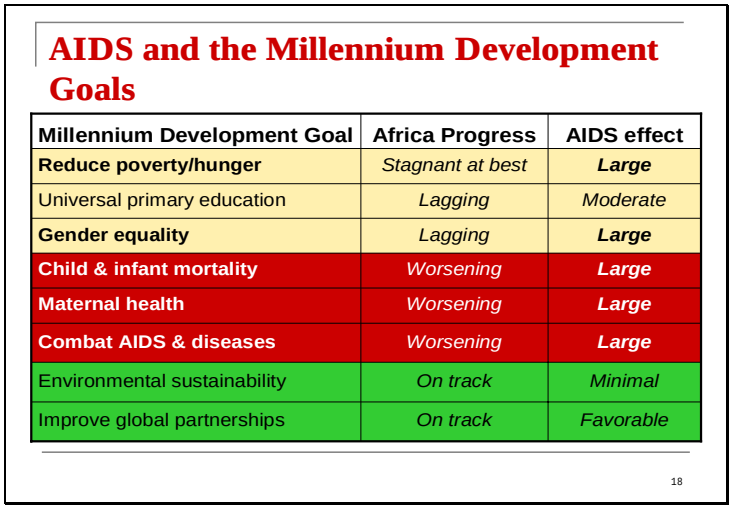
In fact, HIV/AIDS threatens entire economies as it will significantly shrink the workforce and lead to declines in economic growth and household income.



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

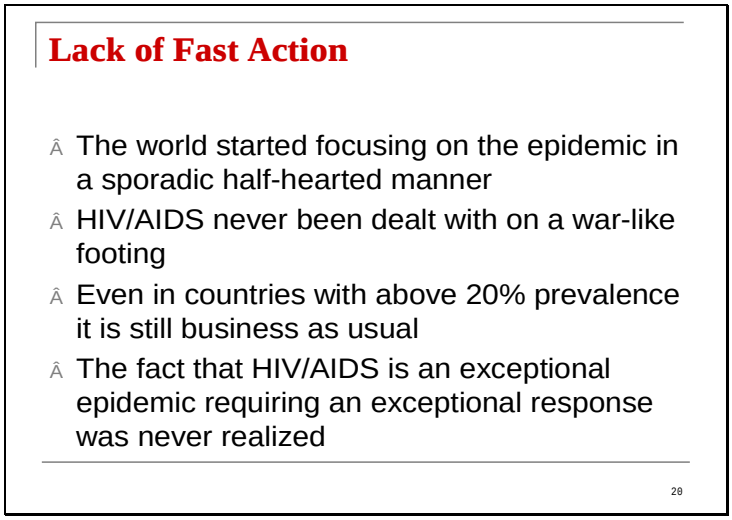


Here we see that HIV and AIDS are seriously jeopardizing the attainment of most of the MDGs in African countries due to its multisectoral impact. This is one of the reasons why HIV/AIDS is exceptional requiring an exceptional response.



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

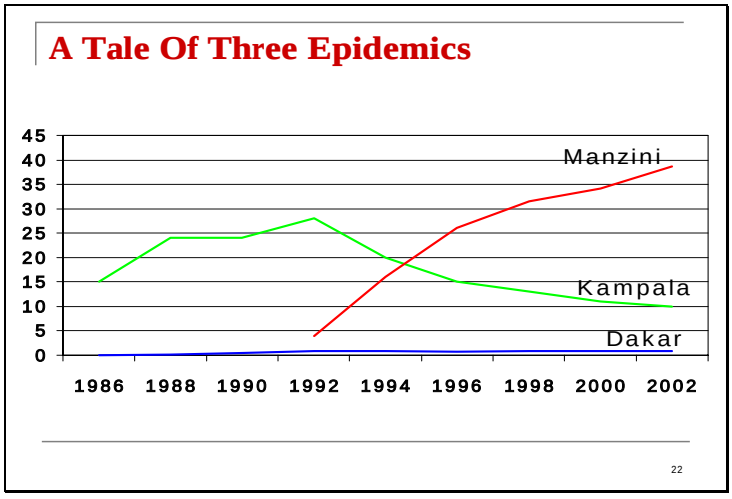
What has been the response to the AIDS epidemic?



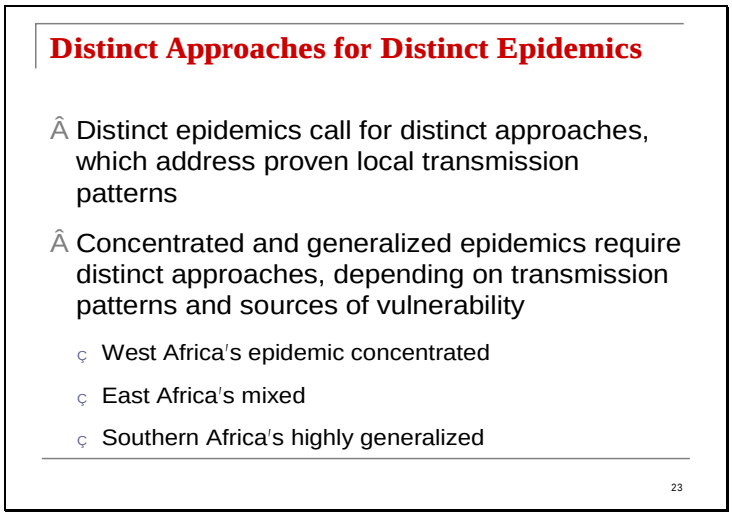
Both the countries directly affected by this epidemic and the international donor community are partially to blame for the current situation. When we take a critical look we can see that the traditional response to

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

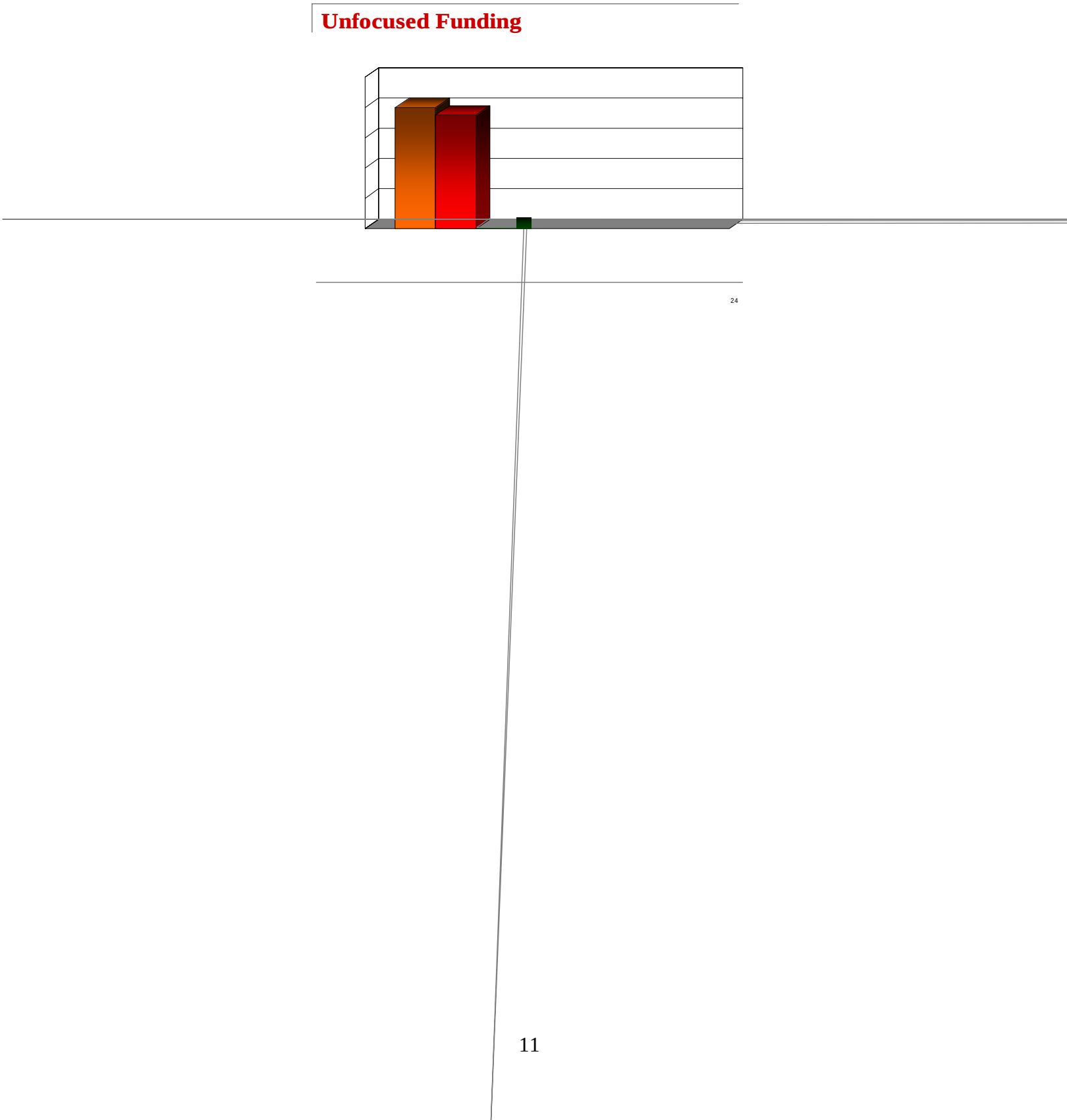
Here, we can see that the epidemics in Manzini, Kampala and Dakar have progressed differently over the years and would require different mitigation approaches. While the epidemic in Senegal remained at a low level, a good proxy of the epidemic in Western and Central Africa, the epidemic in Uganda increased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



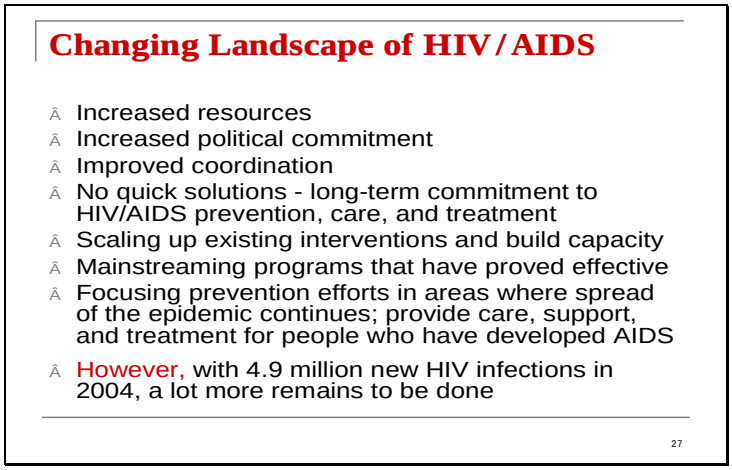
In developing our responses we need to take into account the nature of the epidemic including local transmission patterns and sources of vulnerability and ensure that our responses address them.



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

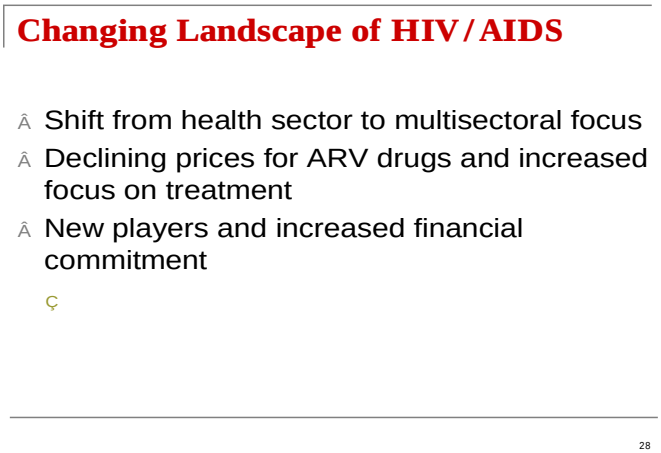


But let us look at where we are right now and what we can do to move forward. With the increased political commitment both on part of the donors and the recipient countries and an unparalleled amount of funding we have more than ever an opportunity to tackle the epidemic. Realizing that there are no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



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

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



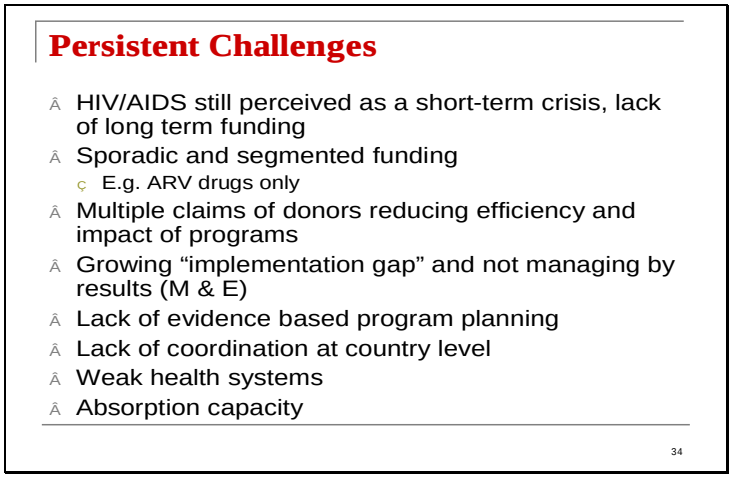
The World Bank led the way by putting over $1 billion to fight the epidemic in Africa. Our commitment is 15-20 years until countries build sustainable capacity to fight the epidemic. Since 2000, the World Bank has committed more than US$ 1.1 billion in 29 countries and four sub-regional projects under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

Multi-Country HIV/AIDS Program for Africa

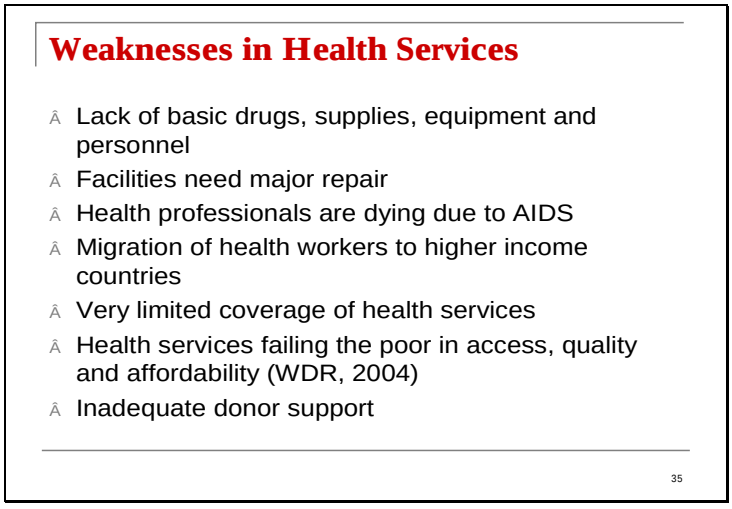
29

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

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

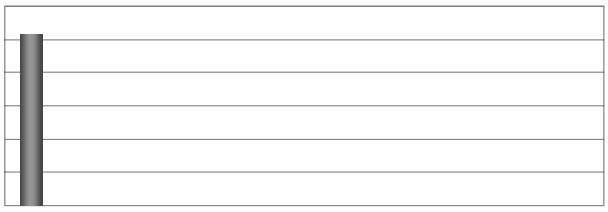


As much as HIV/AIDS is a multisectoral issue, the health sector plays a critical role in providing care and treatment for people living with HIV/AIDS. In many of the affected countries, the health systems are weak. The problem ranges from lack of basic drugs to debilitated facilities to erosion of the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



.

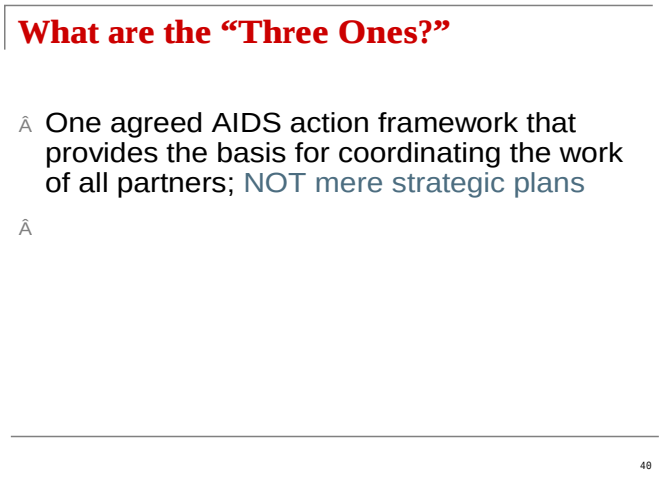
Density of Health Workers and HIV/AIDS Prevalence, 2003



As you can see, the unmet need for treatment is enormous.

38

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

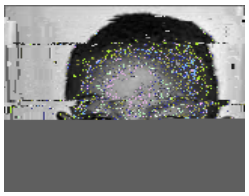


downwards in low prevalence countries both in Africa and elsewhere needs a clear strategy now before it is too late.

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

We need to translate the three ones into action. Start harmonization now by having one M&E system and

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



43