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Mr. Chairman, Distinguished Delegates, I am deeply honored to be addressing this conference today.

The topic of the conference today is the threat that HIV/AIDS poses to development. The fact that this topic appears as the main heading for the opening session is an indication of how far we have come is recognizing that AIDS is putting the development of Africa at stake.

During the last fifteen years it has been a privilege for me to participate in numerous economic missions of the World Bank and the IMF and to witness the tremendous effort spent by government officials in promoting development. More recently, I also the privilege of witnessing the destruction of these same hard-fought gains in Southern Africa.

From these perspectives, there is only one conclusion: the HIV/AIDS epidemic is indeed unique and unprecedented. If left unchecked, it will put at stake the development of all African nations.

Yet, there are strong lessons to be learnt from the past decade. We can all see clearly the differences that leadership, empowerment and community-based actions can make. Those countries that have acted early on are deriving long-term benefits from a reduction in the number of new infections and savings in medical expenditures. Globally, this is resulting in a decrease in the total number of new infections in Africa. From 4 millions last year to 3.8 millions this year. While modest, this decline is a hopeful indication of what can be done. The challenge --our challenge-- is to build upon these gains by scaling interventions to a nation-wide level.

Mr. Chairman, the challenge is now more pressing than ever. We cannot afford any longer to delay action. We must act now. We now longer have the excuse of not knowing the cost of inaction. What is this cost?

Simply stated the HIV/AIDS epidemics has become a key factor of economic and social stagnation.

This is described in the background paper "HIV/AIDS and Economic Development in Sub-Saharan Africa" that was distributed to the participants. I will not therefore reiterate all the evidence presented in that paper. Instead I will summarize the main conclusion that the economic cost of HIV/AIDS is substantial.

Until recently, the evidence on the economic cost of HIV/AIDS was scarce and ambiguous. This is no longer the case. The available evidence strongly highlights the cost of infectious diseases for Africa. Take malaria and HIV/AIDS together and this accounts for most, if not all of the slowdown in growth that occurred in the 1990s.

The latest **growth** evidence is especially striking. A decade of data from 75 developing countries suggests that AIDS is costing Africa about 1 percentage point of economic growth per year every year. For the hardest-hit countries, the cost is even more staggering: about 3-4 percentage points of economic growth **every year**. It means that these countries are facing economic stagnation or decline if nothing is done. At the end of a ten-year period, the total output of these countries would be some 35% lower than otherwise.

What is underlying the reduction in growth are various **sectoral impacts**.

Health. The health sector is at the forefront of the HIV/AIDS epidemic. It is the most exposed as shown by the high prevalence rate among the medical staff in some countries. And it is the sector which is clearly overburdened by HIV/AIDS. In Zambia and Zimbabwe, some 50-70% of hospital beds in urban areas are occupied by AIDS patients.

Education. The education sector is also at the forefront of the epidemic. While it is being asked to play a key role in the prevention of HIV (through school-based education on HIV), it is losing teachers. In Zambia, for example, the loss of teachers amounted to 2/3 of the number of teachers newly trained.

Agriculture. For most African countries agriculture is a key sector. But HIV/AIDS is undermining its long-term survival. It is depleting the labor pool and reducing the available capital (remittances from urban areas), which are used for financing medical expenditures. The result is a decrease in cultivated areas and a shift in cropping patterns. Cash crops are being abandoned in favor of less labor-intensive subsistence crops. Livestock –which is often the accumulated saving of households – are also being sold to generate cash. The overall result is a decrease in the quality and quantity of food with a concomitant rise in malnutrition.

Private sector. It is being affected by the loss of skilled labor, which in many African countries, is already in short supply. In addition, the loss of skilled labor is adversely affecting the rate of technological advance, and it may affect investment.

Demographic impact. What we may now see is population declines in some African countries, an outcome that was judged improbable a few years ago. Underlying this trend is the dramatic increase in mortality due to AIDS. This is shown by the evolution of life expectancy. In all the countries with a HIV prevalence rate above 5%, life expectancy declined in 1990-97.

It should come as no surprise that AIDS destabilizes development. After all the disease takes its greatest toll among young adults at an age when they are the most productive and able to contribute to the building of their country.

What happens when, say a typical adult member dies because of AIDS. Most likely the other adult members are also infected and will die too leaving orphans behind. As one farmer in Malawi put it: “I am now spending more time digging the soil to bury people than cultivating it”.

Another consequence is that in some communities **children** are heading households. Many end up in the streets where they may be abused. Multiply that impact tens of thousand of times, and the social fabric begins to unravel. We may now see a whole generation of children that could be left to grow without the support and guidance of adults. Such topics used to be the subject of science fiction movies, but we never imagined that they could become reality.

It is because of these various sectoral effects that HIV/AIDS entails such dramatic impact on **welfare.** What we are likely to see is increased poverty. While high-income households can weather the consequences of a disease like AIDS, poor households cannot. They are most vulnerable to long-lasting diseases like HIV/AIDS.

The reason is that the main source of income of poor households is their labor. Once they fall sick, they do not have the financial means to maintain the household consumption by drawing their savings, and even less to finance the costs of care and treatment of AIDS. Quite often, they are forced to withdraw from school their children, which in turn compromises the chances of higher income these children might have.

The consequence is a transmission of poverty from one generation to the next and a poverty trap in which both disease and impoverishment are reproduced from one generation to the next. The end-result is a vicious circle of development in which the HIV/AIDS epidemics, poor health and poverty become mutually reinforcing

For this reason, we can no longer regard investing in HIV/AIDS programs as just one among many policy choices. In the worst-hit countries, otherwise sound investments are already proving uneconomic and unsustainable because of the epidemic. Investing adequately in AIDS is therefore a precondition to virtually **any other investment** a developing country has to make.

Mr. Chairman, the issue we now face – to borrow a medical term—is how to develop a social vaccine.

Broadly speaking we know that poverty, income inequality, labor migration, low levels of education and a range of other socio-cultural variables, and initial health conditions facilitate the speed of the HIV/AIDS epidemic.

Let us therefore be as opportunistic as the virus itself. Let us attack the key factors that make possible the spread of the virus. Medical co-factors such as the prevalence of sexually transmitted diseases have certainly played a key role. I will not address here the medical co-factors that are contributing to the spread of the virus.

Let us turn rather to some of the economic co-factors.

Human capital. There is now a vast body of literature which documents that the education of mothers has a positive impact on health. A similar result holds for HIV/AIDS. Investing in education, and especially for young girls, is associated with a reduction in the HIV prevalence rate.

More broadly, the issue is how to empower women. There is a positive association between greater gender equality and a lower HIV prevalence rate. What this implies is the need to remove constraints which are preventing women from entering the labor

force. Some of these constraints are often in the form of access to credit, or banking laws which prevent women from having their own banking and saving accounts.

Savings and physical capital. The main channel through which HIV/AIDS affects economic growth is the reduction in domestic savings. AIDS reduces the savings of households on account of medical expenditures. It also worsens budgetary deficits because AIDS leads to increased budgetary expenditures for medical expenditures, pensions, training of workers, etc.

Take the case of a typical African country with a per capita income of US$300. For such a country the cost of prevention, care and treatment of HIV/AIDS can reach 10% of GDP once the prevalence rate exceeds 25%. Few countries can afford such a cost.

What are the options?

(i) do nothing. What you save is the immediate cost of medical expenditures, but you lose the lives of millions of people. This is no longer a viable option.
(ii) cut consumption. This is what we see already. HIV-infected households experience large declines in consumption, but here again, it is not a solution that can be sustained for a long time.
(iii) mobilize external resources in the form of grants, credits, private sector contribution, etc.
(iv) reduce the cost of health delivery. This is happening in the case of drugs. But more generally, there is a need to build upon existing systems such as traditional medicine and community-based care, which offer the potential to reduce the cost of health services.
(v) Protect current investment. This means build HIV/AIDS interventions in every projects so that the investments are not lost to AIDS.

Social Capital. Recent evidence is that AIDS adversely affects macroeconomic outcomes. The reason is that it reduces the capacity of the government to provide sound macroeconomic policy and efficient regulation.

But there is also a growing body of evidence that some form social capital helps preventing HIV/AIDS. This is probably the case of information network, which provides information on HIV/AIDS. The solution is then to empower and trust local initiatives. For this to take place, funds will have to be transferred directly to local communities.

Mr. Chairman, let me now address briefly the following question. Well, if we do all that, what would be the result?

The indications are that even if we take the narrowest definition of benefits, namely the savings in direct treatment costs and the gain in output made possible by HIV/AIDS interventions, the return on investment is huge by any standards.

So what is preventing us from acting and implementing nation-wide HIV/AIDS programs?

For a start, we need strong commitment on the part of our leaders.
Second, we need to implement a broad strategy to address HIV/AIDS broadly in Africa. What does that mean?

First, we start with the tools at hand. This means that at the national level the epidemic is taken into account in all projects. Therefore, national policies will have to be multi-pronged and all ministries should be involved from health and education to the Army. And let's not forget the opportunities offered by debt relief and the Poverty Reduction Strategy Paper.

Second, the fundamental causes of HIV/AIDS need to be addressed if the epidemic is to be effectively challenged. Long-term structural policy reforms, aimed at combating gender inequality and the economic and social vulnerability of women will be of paramount importance in this endeavor. There is considerable scope for intervention at various levels: the individual, the child, the household and the community. Households have to participate in economic growth if they and their communities are to rise out of poverty. This means addressing the legal or social constraints which adversely affect the capacity of seropositive individuals from participating in economic activities.

Third, what is required is a comprehensive program for total national mobilization, backed by scientific and technological know-how, significantly enhanced levels of international donor support and improved access to drug therapies. Finally Aids research, especially, research by African scientists and institutions ought to be given the highest priority.

Fourth, resources invested in African countries, research institutions and industry ought to be drastically increased. As the Secretary General of the United Nations, Kofi Annan, noted, ‘donors - the OECD countries - must make more resources available to fight the epidemic.

Mr. Chairman, let me close by taking the longer view. We have run out of analogues for AIDS. The most common parallel one hears is to the bubonic plague of the 14th century or the influenza of the beginning of the 20th century. But HIV is more insidious, more invisible, and far more enduring. This plague is truly without precedent.

Similarly, we have run out excuses for not acting.

Let us therefore be as opportunistic as the virus.
Let us empower and entrust and exploit **every** opportunity to act.
Let us mount strong programs of prevention, care and treatment and fund them in full.
And let us **act fast**, as each year that passes is a missed opportunity to prevent more suffering and death.

Thank you.