



The Multi-Country AIDS Program

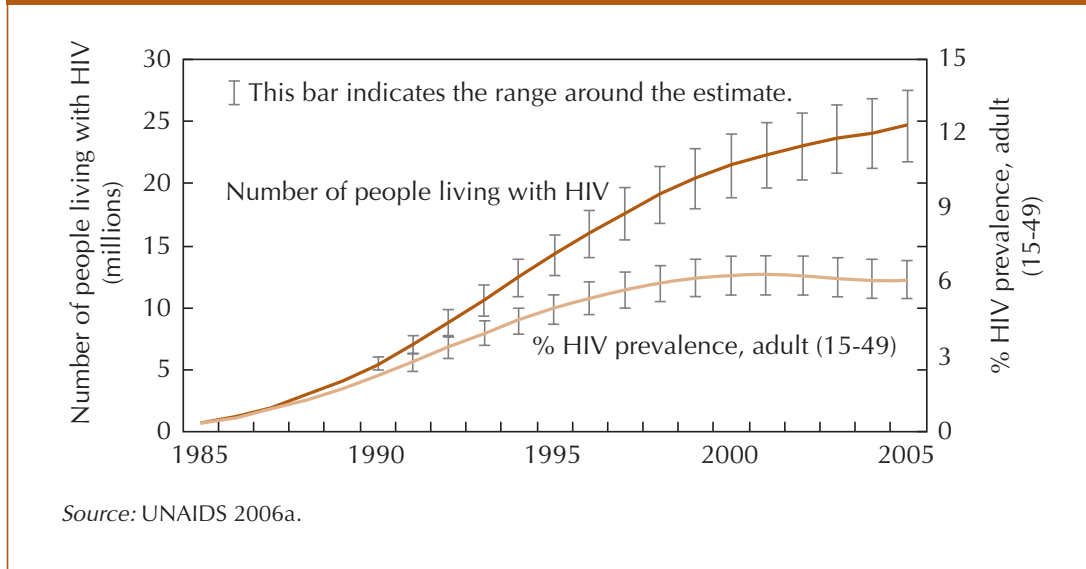
Context and Objectives

HIV/AIDS and the World Bank's Response

The World Bank began lending for HIV/AIDS projects in 1988. However, over the next decade, during which HIV was spreading rapidly across Africa (figure 1.1), few African governments mounted programs of adequate scale or took more than token support from the Bank. Country activities were sparse, coverage of programs was low, and few resources were reaching civil society or communities. For its part, the Bank had no overarching HIV/AIDS strategy and was doing relatively little analysis to understand the development implications of HIV or to motivate countries to do more. Bank lending for AIDS in Africa averaged only \$18 million per year from 1988 to 1999. Few other donors were active either. In short, both demand by governments for support and the supply of assistance from the donor community were unacceptably low. Both Africa and the Bank were failing to confront AIDS, a development problem that can threaten human welfare, socioeconomic advances, productivity, social cohesion, and even national security.

AIDS overtaxes social systems and impedes the health and educational development that enables poor people (especially children) to escape poverty. This will pose unprecedented social welfare demands for countries already burdened by vast development challenges. Whole families dissolve as the parents die and children and dependent elderly are dispersed to others that might care for them. (UNAIDS 2004a, 22)

Figure 1.1 Prevalence and Number of People Living with HIV in Sub-Saharan Africa, 1985–2005



By 1998, the World Bank recognized the need to reassess its approach to the epidemic and the mechanisms through which it was able to offer support to countries. Consequently, in 1999 the Africa Region of the Bank developed and began to implement a new strategy, *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis*, in partnership with African governments and UNAIDS. The strategy documented the ferocious spread of HIV; its broad economic, social, and demographic impacts; and the imperative of urgent, multisectoral, effective action to prevent new infections and to care for infected and affected people.

The strategy called on the Bank to take four key actions: (1) increase advocacy to boost demand for action against HIV/AIDS as a central development issue, (2) strengthen the Bank’s capacity to meet the anticipated increase in demand, (3) expand resources for AIDS programs, and (4) expand knowledge about the epidemic and how to respond effectively. The goal was to put HIV/AIDS at the center of the development agenda in Africa and to encourage client countries to expand their national responses.

The World Bank began to play a leadership and advocacy role at high levels, engaged international audiences about HIV, and put HIV/AIDS on the agenda of the annual spring meetings with finance ministers. Acting on the need recognized in the Africa AIDS strategy—to create a better instrument for supporting countries—in 2001 the Bank created an innovative new type of program: the Multi-Country HIV/AIDS Program (MAP) for Africa. Extensive consultations with client countries and others showed that the

Bank was perceived as slow, too narrow in focus, and unreliable over the long run as a partner in HIV programs. In response, the Bank designed the MAP to be a fast, comprehensive, multisectoral, and renewable instrument to fund the public and nonpublic sectors, to respond to the emergency of HIV using exceptional means, and to provide needed long-term support.

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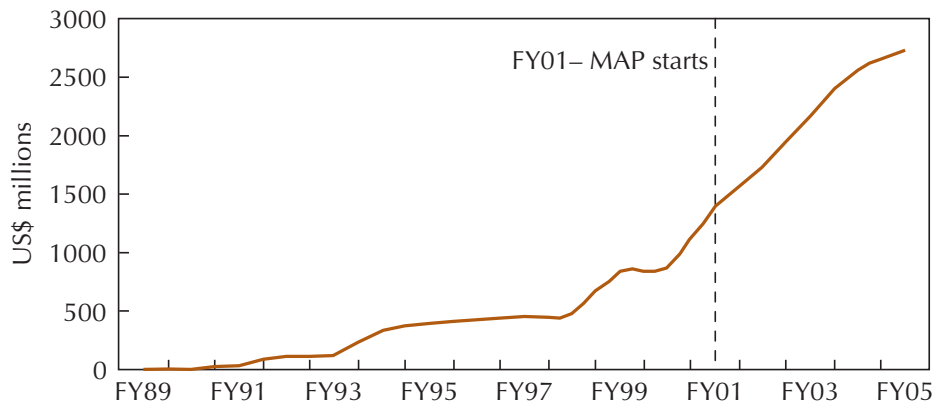
The World Bank's Board of Directors approved the MAP in the fiscal year ending June 2001 (FY 2001) as the first multi-country adaptable program lending (APL) instrument (as opposed to a single project approach). The Board gave the Africa Region the authority to approve individual country or subregional International Development Association (IDA) credits and grants on a fast, "no objection" basis, up to a total of \$500 million, to support national and regional HIV programs. To qualify, countries had to meet eligibility criteria by (1) having a strategic approach to HIV/AIDS, (2) having a high-level HIV/AIDS coordinating body, (3) agreeing to use accelerated implementation arrangements, and (4) agreeing to channel some of the project support to nongovernmental actors, including nongovernmental organizations (NGOs), community and faith-based groups, and the private sector.

The MAP was a central mechanism for implementing the Africa AIDS strategy, and it drove a rapid increase in Bank support for country HIV/AIDS responses beginning in 2000. The number of HIV projects increased substantially, and cumulative investments for HIV reached over \$2.75 billion by the end of FY 2005 (figure 1.2). Using the MAP funding mechanism, the Bank committed \$1.286 billion for HIV/AIDS in Africa in six years (FY 2001–06), or 47 percent of the Bank's global investment in HIV.

The exceptionality of AIDS and the MAP's innovative nature are reflected in the MAP design, approval, and implementation arrangements. "The MAP approach to HIV/AIDS represents a new approach by the World Bank to doing business in a situation where: (i) high quality performance will save lives; and (ii) the Bank's reputation is on the line" (World Bank 2001a). The philosophy was for the MAP design and implementation to focus on fast project approval by the Bank, flexibility, partnership, learning by doing and project modification on the basis of early monitoring and evaluation results, and use of multisectoral and multiagency implementation systems in the public sector and civil society.

The MAP broke ground in several ways. First, it offered comprehensive support for national programs, going beyond traditional project support for the first time. Second, it was the first major program to support strategic and

Figure 1.2 Cumulative HIV Commitments by the World Bank, FY 1989–2005



Source: ACTAfrica 2006a.

system investments at the national level, rather than just selected interventions. This helped build capacity and paved the way for other donors later on. Third, it channeled funds directly to communities and civil society organizations, recognizing the role of social mobilization in combating HIV. Fourth, it was fast. At the time, the average Bank project took more than 18 months to prepare. By taking a program approach, MAP projects could be prepared in roughly half that time. Fifth, by committing half a billion dollars, with more to come, it raised the funding benchmark for other donors. This level of commitment—and the strong demand that followed—help lay the groundwork for GFATM, PEPFAR, and other multi-million-dollar initiatives. Finally, it assured countries of long-term support by committing the Bank to continue funding for at least 12–15 years to any country with a sound HIV/AIDS strategy and action plan.

The MAP was designed to address four pressing country needs that were identified at the time: (1) the need for strong political and governmental commitment to the HIV response, (2) the need to create a conducive institutional and resource-appropriate environment in which successful HIV interventions could be scaled up to a national level, (3) the need to increase community participation and ownership in HIV interventions by providing financial resources and building capacity, and (4) the need to move to a multi-sectoral approach involving many governmental and nongovernmental actors, with improved coordination at the national level and decentralization to subnational government structures (World Bank 2000b).

Initial efforts to respond to HIV were too narrowly focused on the health sector. In the 1990s, the realization began to develop that the complex social and individual behaviors involved in HIV transmission, and the multifaceted impact of AIDS, meant that sectors in addition to health needed to be involved in mitigating the impact and preventing new infections. The Joint United Nations Programme on HIV/AIDS (UNAIDS) was created in 1996 as a secretariat and coordinator among United Nations organizations—not an implementing agency—in acknowledgment of the need for a multi-sectoral response (UNAIDS 2004a). Thus, another hallmark of the MAP approach is its emphasis on drawing in government agencies across many sectors, as well as the private and nonprofit sectors and civil society.

The overall objective of the MAP is to dramatically increase access to HIV prevention, care, and treatment programs, with an emphasis on the following: encouraging a local response, using a multisectoral approach, scaling up prevention of mother-to-child transmission (PMTCT), supporting children affected by AIDS, building capacity for treatment, establishing regional programs to address cross-border issues, and sharing knowledge (World Bank 2000b, c; World Bank 2001b, c).

“The ultimate impact of the MAP will be to avert millions of HIV infections, alleviate suffering for tens of millions, and help preserve the development prospects of entire nations.”

—MAP I Project Appraisal Document, August 14, 2000

Three phases of MAP support, each lasting four to five years, were envisaged (World Bank 2000c). The MAP Phase 1 objectives were to (1) scale up prevention, care, support, and treatment programs and (2) prepare countries to cope with the unprecedented burdens they will face as the millions living with HIV develop AIDS over the next decade. Phase 1 would lay the foundation for long-term, country-specific responses to HIV. Following a rigorous stocktaking, Phase 2 would be designed to mainstream the innovations that proved effective; to attain nationwide coverage where it was not achieved during Phase 1; to expand care, support, and treatment interventions; and to attempt to include all interested countries that did not take part in the first phase. By Phase 3, it was expected that new infections would have declined, allowing a sharper focus on areas or groups where spread of the disease continued (World Bank 2000c). While national capacity and frameworks and systems for monitoring and evaluation were being developed, MAP strategy was to use process monitoring and to foster learning. Later, when M&E systems and capacity were established, program impact evaluations would be done.

Evaluation of results to date

The first phase of the MAP is ending and countries are developing the follow-on projects envisaged during the second phase. Careful consideration of the results and lessons so far will help countries adjust and scale up national responses in light of accumulating evidence on the trends and drivers of the epidemic in each country, as well as evidence on the interventions that work best to prevent new infections and to increase access to care and treatment for the people affected and infected. This study contributes to that effort.

The main objective of this study is to report on results to date of the MAP Phase 1 using country survey and program data that are not usually captured in routine World Bank reporting systems. It also introduces the Results Scorecard and Generic Results Framework, two tools for better measuring and reporting the results of HIV support in future. The remainder of this first chapter describes how the MAP context has changed since the program began. Chapter 2 explains the purpose, principles, objectives, and methodology of the study. The results to which the MAP has contributed are presented in chapter 3. Chapter 4 goes beyond data to tell a few personal stories of how MAP support has changed the lives of some of the affected people in Ethiopia, Rwanda, and Uganda. Chapter 5 draws conclusions based on the results presented, and chapter 6 offers recommendations for how countries and the Bank can regularly measure and report on the results to which Bank financing for HIV/AIDS programs in Africa contributes in the future.

Changes in the HIV Landscape since the MAP Began

The environment for addressing the HIV epidemic in Africa has changed radically since the MAP was initiated in 2000. Political support at all levels has increased, boosted by the Declaration of Commitment on HIV/AIDS, which all 189 United Nations member countries signed in 2001. There has been unprecedented media attention and international advocacy for national, scaled-up, and relevant responses to HIV. Campaigns have been launched by international and national groups to promote the interests of specific groups or aspects of the response (for example, HIV and gender, and HIV and social protection) or to scale up the response. The World Health Organization (WHO) and UNAIDS, for example, launched the 3×5 campaign in 2002 (with the target of 3 million persons on antiretroviral treatment by the end of 2005), followed by a campaign for universal access to treatment, prevention, and care by the end of 2010.

Box 1.1 Non-MAP Funding from the Bank for HIV/AIDS in Africa

The MAP is not the only way in which the Bank has supported the HIV response in Sub-Saharan Africa. Four countries with among the highest HIV prevalence—Botswana, Namibia, South Africa, and Swaziland—were not eligible for MAP funding because their income levels exceed the threshold for concessional World Bank lending. Instead, Institutional Development Fund (IDF) grants were used to support the National AIDS Commission of Swaziland and Namibia’s Business Coalition and Association of People with HIV in building institutional capacity to effectively coordinate, monitor, and evaluate the national HIV response. The new *HIV/AIDS Strategy for Southern Africa* also proposes World Bank activities that would focus primarily on Botswana, Lesotho, Swaziland, and Namibia, some of the most heavily AIDS-impacted countries in Africa but also the countries where Bank activity remains most limited. Areas of technical support for these countries could include the following:

- Expansion of the existing subregional technical assistance models
- Regional networking
- Analytic economic and sectoral work—for example, to look at pooled drug procurement, how labor mobility is linked to HIV, and the financial implications of sustaining treatment programs
- Training
- Strengthened partnerships, including those with the private sector
- Innovative financing and regional lending

Source: World Bank 2006c.

Surveillance and monitoring and evaluation (M&E) have received more emphasis and greater financial and technical support. UNAIDS asked the World Bank to host a Global AIDS Monitoring and Evaluation Team (GAMET) in 2003 (appendix F). UNAIDS also has appointed country-level and regional-level M&E advisers in many countries.

Accumulating surveillance data and careful analysis have shown that the HIV epidemic is much more differentiated across and within countries than initially realized. There is growing understanding of different trends and patterns and of the complex factors that drive transmission.

Treatment has become simpler and more affordable. The cost of anti-retroviral drugs has dropped dramatically. The G-8 countries have committed to striving for “universal access” to treatment by 2011, which would require more than double the current expenditures for HIV. More than

800,000 Africans are now in treatment, or about 28 percent of the population in need. This represents an eightfold increase between 2003 and 2005. Treatment involves far fewer pills, taken at longer intervals and with fewer side effects, and it has been clearly demonstrated, in the face of widespread skepticism, that high levels of adherence and successful treatment can be achieved even in very low resource settings with poor patients with little education.

Global funding for HIV more than quadrupled between 2001 and 2005, from less than \$2 billion to over \$8 billion. The World Bank’s MAP was one of the catalysts for increased global and domestic funding for HIV. Many governments have increased their allocations for HIV expenditures by large amounts. The international Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was created in 2001, and the U.S. government announced the President’s Emergency Plan for AIDS Relief (PEPFAR) in 2003. Table 1.1 shows the amounts of funding committed by the World Bank, PEPFAR, and GFATM to MAP countries since 2001. Despite the significant increase in funding, it still falls well below the level needed for a comprehensive response (de Lay et al. 2007; Horton 2006).

The good news on increased funding for HIV is tempered by the growing complexity of the global aid architecture for health, bluntly described by many as “a mess.” Part of the solution lies in the concept of the “Three Ones,” a set of guiding principles for improving the coordination of international efforts and alignment with national HIV responses to better support governments in implementing national HIV responses (see box 1.2).

Table 1.1 Funding to MAP Countries in Africa from the World Bank, PEPFAR, and GFATM, 2001–06

Funding sources	Funding to MAP countries (US\$ billion)
World Bank (2001–06)	1.286
PEPFAR (2003–06)	1.820
GFATM (2002–06)	1.222
Total	4.328

Sources: World Bank Client Connection, PEPFAR Web site, GFATM Web site.

Note: PEPFAR and GFATM funding amounts are as reported on their Web sites. World Bank funding is the actual amount committed, in current year dollar equivalents. However, taking account of changes in the rate of exchange between the dollar and Special Drawing Rights, the September 2006 total value of MAP commitments was US\$1.32 billion.

Box 1.2 The “Three Ones”

1. **One** agreed-upon AIDS action framework that provides the basis for coordinating the work of all partners.
2. **One** national AIDS coordinating authority, with a broad-based, multi-sectoral mandate (typically referred to as the National AIDS Commission or NAC).
3. **One** agreed-upon country-level HIV/AIDS monitoring and evaluation system.

Numerous development partners signed an agreement to commit their organizations to the Three Ones in April 2004, during the World Bank’s Annual Meeting.

At a meeting in 2005 on “making the money work,” a Global Task Team (GTT) on Improving AIDS Coordination Among Multilateral Institutions and International Donors was formed to consider how to make faster progress toward the Three Ones and more effective use of the available resources. The GTT recommended specific actions to improve inclusive national leadership and ownership, ensure that donor support was better harmonized and aligned, achieve a more effective multilateral response, and promote accountability and oversight (including better monitoring and evaluation), all concepts central to the MAP design.