



MAP Results

MAP Funding Committed and Disbursed

Total MAP commitments

Table 3.1 shows that the Bank had committed a total of \$1,286 million in 39 MAP projects for Africa by the end of 2006, including four repeater projects (Burkina Faso, Eritrea, Ghana, and Madagascar) and four subregional, multi-country projects (see appendix E for a list of projects).

Uptake of MAP funding by African countries was large and rapid, exceeding Bank expectations. In FY 2002, the Board approved a second \$500 million for the Africa MAP from IDA 13 grant resources. By early FY 2004, all active IDA countries in Africa had MAP projects approved or in the pipeline, and by late FY 2004, the initial \$1 billion available for the MAP had been fully committed.

New commitments in 2005 and 2006 were small for several reasons. Most eligible countries already had active MAP projects. Countries were able to apply for GFATM grants, and whereas IDA 13 had provided all IDA funding for AIDS as grants, IDA 14 provides grants on the basis of debt burden. Countries that may want to use IDA credits for HIV usually have tight IDA envelopes and face difficult trade-offs with competing priorities. There is a perception in some countries that other needs are more underfunded than AIDS programs. Ministries of Finance often prefer general budgetary support to specific projects, because this gives them more flexibility in allocating funds. Some countries where MAP projects are ending, such as The Gambia, Rwanda, Senegal, Sierra Leone, Uganda, and Zambia are not yet planning

Table 3.1 MAP Funding Committed by the World Bank for MAPs in Africa, FY 2001–06

	FY01	FY02	FY03	FY04	FY05	FY06	Total FY01–06
Number of approved projects	7	10 ^a	5	9	5	3	39 ^b
New commitments (US\$ millions) ^c	287	221	239	356	80	103	1,286
Current value of active commitments (US\$ millions)							1,320

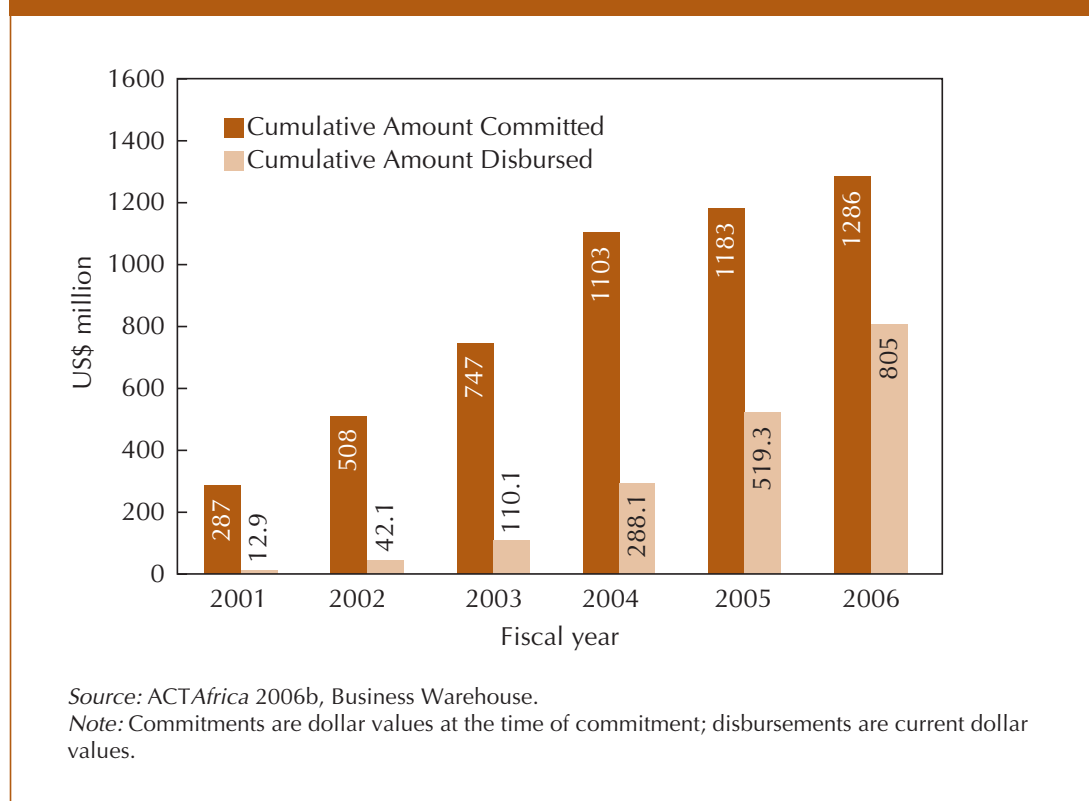
Source: ACTAfrica 2006b.

a One project, Central Africa Republic, approved in FY 2002 for \$17 million, has never become effective because the country has been in nonaccrual status. The data include this project.

b Four countries (Burkina Faso, Eritrea, Ghana, and Madagascar) have second-generation projects approved for \$122 million (included in the table). The Angola, Burkina Faso, and Eritrea projects have other components in addition to HIV/AIDS. Supplemental financing was approved for Burkina Faso in FY 2005 (and in Cape Verde and Rwanda in FY 2007; that funding is not included in the table).

c The dollar amounts are based on the dollar value at the time of signing the legal agreement (\$1.286 billion). The current value of the total commitments is \$1.320 billion due to a stronger Special Drawing Rights (SDR) exchange rate.

Figure 3.1 MAP Commitments and Disbursements in Africa, FY 2001–06



follow-on MAPs even though there are financing gaps in national HIV programs (ACTAfrica 2006b).

Total MAP disbursements

Figure 3.1 shows that as of July 2006, \$805 million had been disbursed under the Africa MAP (ACTAfrica 2006b). The percentage of total commitments disbursed rose from 44 percent at the end of FY 2005 to 63 percent at the end of FY 2006. Of the disbursed amount, \$709 million had been spent by the countries, and there was \$96 million in the project special accounts. These amounts include three closed projects.

Groups that have received MAP funding and amount received

An analysis of MAP Project Appraisal Documents (PADs) shows that MAP projects usually channel funds to three types of recipients: civil society organizations, the public sector, and National AIDS Commissions (NACs). MAPs typically include the following:

1. *A component to disburse funds to civil society* by either granting funds to civil society organizations directly, or by granting funds to intermediary organizations with financial and technical capacity to provide subgrants to smaller institutions.
2. *A component to disburse funds to the public sector, including the Ministry of Health (MoH) and other government ministries.* Some MAPs (Burundi, Ethiopia, and Ghana) did not have an MoH component because there was ongoing or pipeline financing to MoH from the Bank or other development partners.
3. *A component to provide funds to the NACs, subnational coordination structures, umbrella organizations, and others for institutional strengthening.* The MAP has provided significant financing for institution building, coordination, and capacity development. It has supported different sectors that are involved in the HIV response at the national and decentralized levels. Institutional strengthening includes Bank support to establish or strengthen institutions, monitoring and evaluation, operations research, drug procurement to fill gaps in PEPFAR/GFATM financing or delays, and capacity building at the central and decentralized levels. In addition, it helps fund policy or strategy reviews and development to create an environment for better implementation of national HIV programs that are supported by multiple development partners and government.

Table 3.2 Estimated Commitments and Disbursements to MAP Fund Recipients in Africa

Typical organizations that receive MAP funding	Estimated percentage of total financing	Estimated commitments (US\$ millions)	Estimated disbursements (US\$ millions)
Civil society organizations	38	502	306
Public sector organizations (excl. MoH)	13	172	104
Ministries of Health	17	223	137
Funding managed by NACs ^a	32	423	258
Total	100	1,320	805

Sources: World Bank MAP Project Appraisal Documents, World Bank Client Connection system, September 28, 2006.

Note: PAD data had to be used to estimate the average percentage of funding to each type of recipient (that is, planned amounts). Actual amounts are not readily available because countries are not obliged to maintain expenditure records by project components, and the Bank system maintains records only by expenditure categories (ACTAfrica 2006b). These percentages were applied to the total funding committed and total funding disbursed to estimate commitments and disbursements to each type of MAP fund recipient.

a. See component 3, on page 33, for a description of how NACs use these funds.

Table 3.2 summarizes the estimated percentage and amount of funding allocated to each type of MAP fund recipient (because MoHs receive a significant percentage, their allocation is shown separately). These percentages were estimated from Project Appraisal Documents or legal financial agreements and compared with data reported by countries in the annual ACTAfrica questionnaire. There are some differences in the various Bank systems that are primarily due to fluctuations in currency exchange rates (SDR, US\$, and local currency; countries report using current dollar values).

Output-Level Results to Which the MAP Has Contributed

Recipients use MAP funding to provide a range of HIV prevention, treatment, care, and support services; create an enabling environment for service delivery; or monitor and evaluate services. Determining the output-level results to which the MAP contributed involved three steps:

1. First, the study estimated the percentage and amount of MAP funding committed to each category of MAP funding recipient for each HIV service delivery area (table 3.3).

Table 3.3 Estimated Commitments to MAP Funding Recipients, by HIV Service Delivery Area

Type of recipient	HIV service delivery area (US\$ millions and percentage of total)					Total estimated commitment (US\$ millions)
	Prevention	Care and treatment	Impact mitigation	M&E	Systems strengthening	
Civil society organizations	282 ^a (56%)	73 ^b (15%)	56 ^c (11%)		91 ^d (18%)	502
Line ministries other than Health	108 ^e (62%)	32 ^f (19%)	8 ^g (5%)		24 ^h (14%)	172
Ministries of Health	62 ⁱ (28%)	105 ^j (47%)	8 ^k (4%)		48 ^l (22%)	223
Managed by NACs for institutional strengthening, M&E, capacity building, system building, and coordination				53 ^m (13%)	370 ⁿ (87%)	423
Total	451 (34%)	210 (16%)	72 (5%)	53 (4%)	534 (40%)	1,320

Sources: ACTAfrica questionnaires (percentages); PADs and table 3.2 (estimated allocations per recipient and service area).

Note: Percentages calculated across rows, so percentage (in parentheses) is of the total provided to the recipient type.

- a. Typically, peer education, information campaigns, and other efforts by civil society to communicate information about HIV, increase condom use, and increase use of voluntary counseling and testing (VCT) and sexually transmitted infection (STI) services.
- b. Home-based care and support by civil society organizations (CSOs), and NGOs providing ARVs or treatment for opportunistic infections (OIs).
- c. Income-generating activities, support for OVC, access to community-level health schemes.
- d. Support, training, and capacity building for NGOs. Umbrella organizations disburse funds to smaller NGOs to build their capacity and supervise and mentor them.
- e. Funds typically used by line ministries to run HIV prevention programs for their employees.
- f. ART programs of line ministries that run their own clinics, e.g., Ministry of Defense and police.
- g. Line ministry programs to mitigate the impact of HIV for affected/infected employees.
- h. Line ministries' HIV activities, including conducting impact assessments, planning, and capacity building.
- i. VCT, STI treatments, prevention of mother-to-child transmission (PMTCT), and other HIV prevention interventions managed by the health sector.
- j. Typically used for setting up ARV facilities, ARV treatments, etc.
- k. Typically, nutrition support and counseling services provided to ARV patients.
- l. Building capacity to provide HIV services, including infrastructure development.
- m. M&E of programs in all HIV service delivery areas, all sectors (4% of total allocation).
- n. NACs and their partners use this funding to build capacity, coordinate, set up decentralized coordination structures, review the NSP, improve supply chain management, design HIV policies, set up private sector coalition against HIV/AIDS, etc.

Table 3.4 Estimated Disbursements to MAP Funding Recipients in Africa, by Service Delivery Area

Type of recipient	HIV service delivery area (US\$ millions and percentage of total)					Total estimated disbursement (US\$ millions)
	Prevention	Care and treatment	Impact mitigation	M&E	Systems strengthening	
Civil society organizations	171 (56%)	46 (15%)	34 (11%)	34 (13%)	55 (18%)	306
Line ministries other than Health	29 (28%)	49 (47%)	4 (4%)		22 (22%)	104
Ministries of Health	87 (62%)	25 (19%)	7 (5%)	19 (14%)	137	
All other organizations, including NACs, decentralized structures, training institutions, consultants for institution building, M&E, coordination, capacity development					224 (87%)	258
Total	287 (35%)	120 (15%)	45 (6%)	34 (4%)	319 (40%)	805

Sources: ACT/Africa questionnaires (for percentages); PADs and table 3.3 of this report (for total estimated allocations per sector).

Note: Percentages are calculated across rows, so percentages are of the total provided to the recipient type. Notes to table 3.3 explain how the different institutions are likely to have used the money.

Table 3.5 MAP Input-Level and Output-Level Results in Countries in Africa with MAPs^a

Input	Result
Systems Strengthening for HIV/AIDS Service Delivery (estimated US\$319 million disbursed)	
Percentage increase in development partner funding	2,240%
MAP management integrated into NAC functions; no separate MAP project unit	59%
Non-Health Ministry and local government staff trained with MAP funds	74,793 (23 countries)
Health Ministry staff (including clinical staff) trained with MAP funds	13,181 (23 countries)
Civil society staff trained with MAP funds	474,391 (23 countries)
Total staff trained with MAP funds ^b	562,366 (23 countries)
Percentage of all staff and volunteer training funded by MAP	56% ^c
Number of decentralized government structures that have implemented HIV work plans	10,938 (25 countries)
Employees in workplace reached with HIV programs	2,258,844 (23 countries)
Number of organizations provided with technical support	41,107 (25 countries)
Percentage of NAC posts vacant	Median 7.5%, mode 0%
Percentage of NAC M&E posts vacant	Median 1.5%, mode 0%
GFATM grant and MAP coordinated by one unit	38%
HIV Prevention (estimated US\$287 million disbursed)	
Number of women enrolled in programs for prevention of mother-to-child transmission since start of MAP	1,546,388 (23 countries)
Number of voluntary counseling and testing (VCT) sites in all MAP countries	8,812 (23 countries)
Number of new VCT sites that MAP helped to establish	1,512 (17 countries)
Number of persons who have received HIV results	6,999,528 (25 countries)
Number of male condoms distributed	1,294,369,023 (25 countries)
Number of female condoms distributed	4,041,973 (15 countries)
Number of persons reached with IEC/BCC programs ^d	173,333,043 (21 countries)

(continued)

Table 3.5 MAP Input-Level and Output-Level Results in Countries in Africa with MAPs^a (continued)

Input	Result
Number of IEC/BCC events	726,876 (20 countries)
Number of transfused blood units screened for HIV	2,245,759 (23 countries)
Number of patients treated for STIs	4,811,751 (18 countries)
HIV/AIDS Treatment, Care, and Support (estimated US\$120 million disbursed)	
Number of sites providing antiretroviral therapy (ART)	3,012 (26 countries)
Cumulative number of patients on ART	554,648 in total (27 countries) (26,699 with MAP funding ^e)
Number of people living with HIV receiving OI treatment	287,805 (20 countries)
HIV Impact Mitigation (estimated US\$45 million disbursed)	
Number of affected/infected persons receiving external support ^f	502,958 (21 countries)
Number of vulnerable children receiving support ^g	1,779,872 (22 countries)
Number of income-generating activities supported	32,854 (18 countries)
M&E of HIV/AIDS Service Delivery Efforts (estimated US\$34 million disbursed)	
Average number of surveys/surveillance per country before MAP	2
Current average number of surveys/surveillance	4

Sources: Country Feedback Forms 2006; ACTAfrica questionnaire 2005; TAP Evaluation Report 2006.

Note: Data are from the Country Feedback Forms (completed by 93% of MAP countries in Africa), supplemented by data from the ACTAfrica questionnaire for 2005 and data from the Treatment Acceleration Project. Indicator values are missing for some countries because the component is not being implemented; data were not provided in the questionnaire; or the component is being implemented but data were not available. Unless specifically noted, the MAP contributed to these results; the results are not attributed solely to the MAP.

a. Unless specifically noted, these results are not attributed solely to MAP support. Countries were able to report separately on results achieved with MAP support only with respect to some outputs.

b. To put this in context, the 31 MAP countries listed in appendix G have just over half a million doctors and nurses in total (World Health Report 2006).

c. Denominator: number of persons trained according to Country Feedback Questionnaire (998,123 persons in 25 countries). Numerator: number of persons trained with MAP funds, from the ACTAfrica questionnaire for 2005 (562,366 persons for 23 countries).

d. The aggregate total population of the 31 MAP countries in appendix G is around 600 million, about half 15 years or older, implying coverage of about 60% of target audience.

e. ACTAfrica questionnaire reported 13,972 persons on ART by the end of 2005 (23 MAP countries, excluding the TAP); the TAP reported 12,727 persons on ART.

f. External support is defined as any form of psychosocial support: emotional support, nutrition, financial, or medical (excluding ARVs).

g. There are an estimated 9 million AIDS orphans in the 31 MAP countries in appendix G.

2. Next, using the table 3.2 percentages, the study estimated the amount of MAP funding disbursed by each category of MAP recipient for each HIV service delivery area (table 3.4).
3. Finally, the output-level results to which the MAP contributed were calculated through an analysis of Country Feedback Forms and combined with the total estimated disbursements from table 3.4 (table 3.5).

Outcome-Level Results to Which the MAP Has Contributed

Although the MAP focused on input-level and output-level results, good-quality output-level results and high coverage of interventions should lead to changes in outcomes. This section provides data on outcome-level results to which the MAP has contributed in Africa.

Outcome-level results are not available for all data sources. The results cited in this section have been drawn from column E of the Country Feedback Forms unless stated otherwise. It should be noted that the Bank is one of three major funders of HIV services at country level (see table 2.2), so changes in the enabling environment or changes in attitudes and behaviors as a result of the services delivered cannot be attributed to MAP funding only.

Outcome-level results in systems strengthening

Table 3.2 shows that approximately 32 percent of MAP funding was allocated to build institutions to contribute to a multisectoral response and to develop capacity to manage HIV responses at the national and decentralized levels. MAP funding directed at systems strengthening has contributed to increased political commitment; progress towards the Three Ones, including establishing NACs as a single national coordinating authority with a multisectoral mandate; helped catalyze additional funding from governments and partners; sparked a significant scaling up of national responses that are more multisectoral and decentralized; improved legislation and policies; and built capacity to better coordinate the national response. Overall results aggregated across all countries, and specific country examples, are presented in the following paragraphs. Appendix G presents outcome-level results for each country.

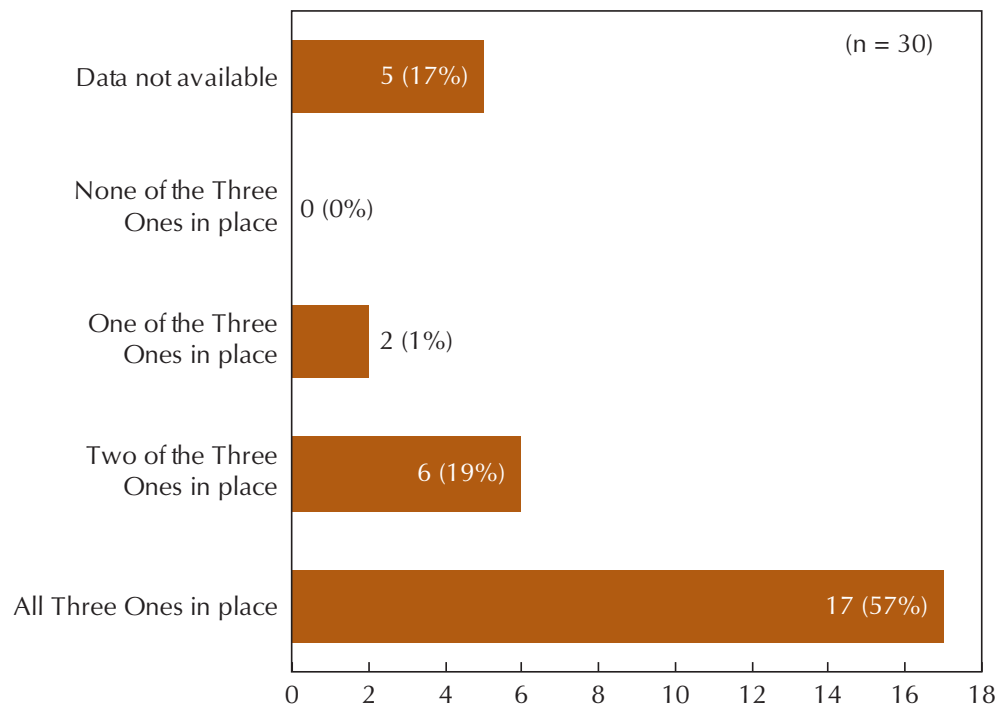
The MAP has contributed to increased political commitment at the highest government level. Evidence of political commitment is a MAP eligibility criterion. Of TTLs surveyed in 2005, 68 percent noted institutional changes—either the creation of an NAC or the chairing of the NAC by a cabinet minister—attributed to MAP eligibility criteria. In MAP countries, 33 percent of NACs are chaired by the prime minister or the president or his or her deputy, and all the other NACs are chaired by a cabinet minister

(UNAIDS 2006a). In the OED survey, 53 percent of TTLs indicated that increased political commitment to HIV is at least partially attributable to the MAP funding, and 47 percent of TTLs and 71 percent of country directors saw increased political commitment as a positive impact of the MAP (World Bank 2005a).

In Madagascar, political leaders demonstrated their commitment to HIV by publicly going for an HIV test to motivate the population to be tested as well.

The MAP helped countries get a head start toward the Three Ones. The MAP eligibility criteria of one coordinating structure, a national HIV strategic plan, and an M&E system preceded the agreement on the Three Ones. Figure 3.2 illustrates that 57 percent of MAP countries in Africa have

Figure 3.2 Extent to Which MAP Countries Have Achieved the Three Ones



Source: UNAIDS 2006.

achieved the Three Ones, and another 19 percent of countries have achieved two of the Three Ones (measured by whether a country has a National HIV Strategic Plan, a National AIDS Coordinating Authority recognized by law, and a national HIV M&E plan).

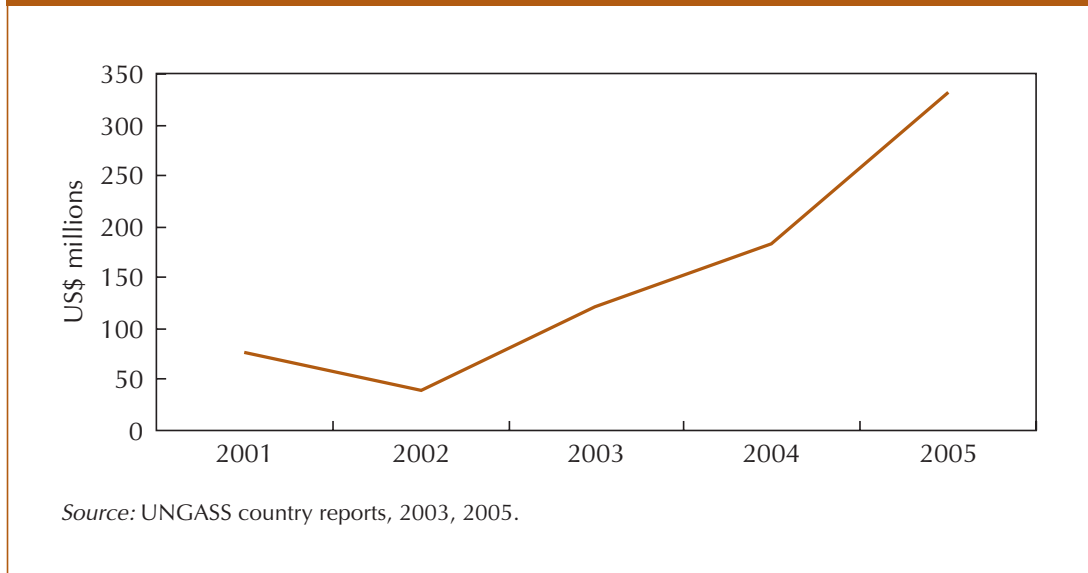
The MAP contributed toward institution building and strengthening of the NACs. The MAP was responsible for the creation of the NACs in many countries or helped strengthen those already in existence. Of TTLs, 89 percent said that the MAP has assisted in strengthening institutions involved in the HIV response (World Bank 2005a). The increased capacity of NACs is reflected in their ability to mobilize additional government resources and international funding, their ability to coordinate, their ability to partner and create a multisectoral response, their ability to manage large grants, and their ability to monitor and evaluate. The MAP funded over 900 consultants in 2005 to support NACs in different aspects of their responsibilities (ACTAfrica 2005 questionnaire). Two MAPs also assisted in creating or strengthening regional institutions to focus on mobile populations, who are often at higher risk of contracting and spreading HIV.

In Nigeria it “took two to three years to build the agencies to enviable status from scratch.” According to the Task Team Leader for Nigeria, “lack of clear roles and responsibilities created conflict which hindered the implementation of HIV programs in Nigeria; when the roles were clarified, there was better coordination of the national response.” He said that the NAC is “well structured with a functional organogram and detailed job descriptions for all staff” as against the chaotic situation at the onset of the MAP. GFATM and PEPFAR now work with well-established NACs (TTL interview 2006).

The Great Lakes Initiative on AIDS was created as a regional institution, endorsed by the parliaments of all six countries in the Great Lakes region in Africa, as a direct result of MAP, the Japan Policy and Human Resources Development Fund, and IDF funding and technical support.

MAP funding contributed toward NACs being able to mobilize additional government resources for HIV. The stronger NAC institutions were better able to negotiate additional funding and gave Ministries of Finance more confidence that they would be able to manage large amounts of funding. UNGASS data for 2003 and 2005 show a steady increase in government funding for HIV from 2002 to 2005. The 29 reporting country governments collec-

Figure 3.3 Increase in Government Allocations for HIV/AIDS (n = 29)



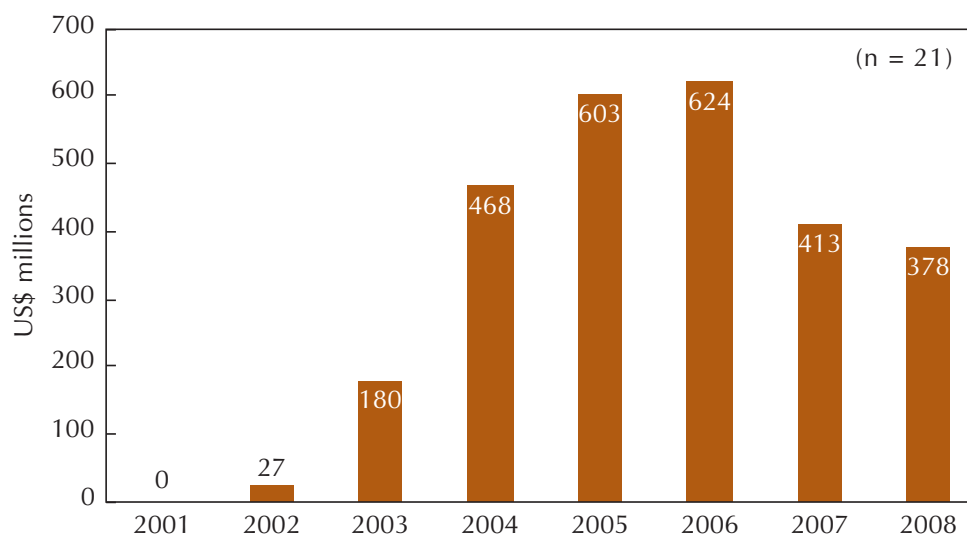
tively allocated about \$757 million for HIV/AIDS over the period, with a steady annual increase, as shown in figure 3.3.

The MAP served as a catalyst for increased international funding and therefore increased the total amount of funding provided to countries. The World Bank, through the MAP, was one of the first agencies to provide significant amounts of funding to countries to enable them to build institutions and channel funding to implementers to scale up the HIV response. This was a catalyst for GFATM and PEPFAR, a view held by 32 percent of TTLs (OED 2005). The MAP helped create environments at country level in which countries were able to apply successfully for funding, and other partners provided funding for scaling up national responses.

Key partners, such as DFID, channeled their support to MAP countries using MAP funding mechanisms that had already been created. The MAP and GAMET have helped countries develop national HIV M&E systems, which was a precondition for funding from GFATM. Figure 3.4 shows that total funding to 21 MAP countries in Africa from other sources increased 2,240 percent, from \$27 million in 2002 to \$624 million in 2006.

The MAP sparked a quantum shift in the scale of country action on HIV. The visibility, scale, and innovative nature of the MAP enabled countries to address HIV more openly and comprehensively. Programs that had previously reached only small enclaves were rapidly scaled up, and political commitment grew dramatically (as is evident from increasing government

Figure 3.4 Total Government and Development Partner Funding to MAP Countries (excluding MAP funding) since 2001



Source: UNAIDS Three Ones Data 2005.

Note: Data in Figure 3.4 are as reported by NACs. Lower funding reported in 2007 and 2008 probably reflects incomplete information about future flows of funds rather than decreased funding.

allocations, increased involvement of the public sector, and the creation of public sector HIV coordination structures). Through their broad support to civil society, MAP projects across the continent have supported widespread social mobilization against HIV (ACTAfrica 2006b).

In Congo (Brazzaville), the MAP facilitated the emergence of an NGO that specialized in the care of children affected by AIDS. This led to an improvement of services delivered to this population.

In Malawi, donor flexibility in how pooled funds can be allocated has contributed to rapid scaling-up of interventions. With other pooled funds, MAP funds have helped Malawi to (1) increase the number of people accessing counseling and testing services; (2) hold a very successful National HIV Testing Week during which about 100,000 people were tested; (3) increase the proportion of youth ages 15–19 years abstaining from sex; and (4) improve capacity of local authorities to coordinate the national response through personnel, transport, equipment, and operational support.

In Ethiopia, three national associations were capacitated in many aspects and encouraged to execute their advocacy role effectively. One of the three national associations, the Dawn of Hope Ethiopia Association (DHEA), which had been established in 1998 with 11 founding members, currently has more than 13,800 members and 13 branches in many parts of the country. The association, using mainly MAP funding, is actively involved in care and support (home-based care, income-generating activities, peer counseling, and financial support to orphans and vulnerable children); prevention (peer education and IEC/BCC); advocacy; and other partnership activities. Through its services and activities, DHEA aggressively campaigns against stigma and discrimination and helps its members to adopt responsible lifestyles and enhance positive behavioral change.

The MAP has contributed toward improved legislation. In many instances, national policies were developed, and laws were amended or enacted to facilitate the response to HIV. These address many sensitive issues, such as condom distribution, sex education in schools, traditional land inheritance laws, and the position of women.

In Ghana and Malawi, the MAP has supported the development of a national HIV policy and national workplace policy on HIV. In Rwanda, a national policy on condom use and condom promotion was developed with MAP support.

The MAP has succeeded in promoting and facilitating a multisectoral response. The MAP has promoted, created, strengthened, and enabled partnerships among NACs, civil society, the public sector, and the private sector. The MAP has mobilized over 66,000 civil society organizations (CSOs) and 234 line ministries across Africa to become involved in the HIV response (ACTAfrica 2004, 2005). CSOs have reported that this funding has given them unprecedented ability to implement HIV activities. So far, 30 to 40 percent of country MAP budgets have been allocated to local initiatives such as the HIV/AIDS Fund (Nigeria), the Community and Civil Society Initiative (The Gambia), the Community AIDS Response Fund (CARF) in Tanzania, and the HIV/AIDS Community Initiative (Kenya). Many CSOs have used innovative approaches to scale up implementation in their various countries, including, for example, the Rapid

Result Approach in Eritrea, the Cascade Approach in Cameroon, and Wide Collaboration in Ghana.

In Kenya, KHADREP mobilized and funded about 6,000 implementing agencies to carry out HIV activities, which enabled them to solicit resources from other sources as well. The MAP has ended, but it left an enduring capacity.

In Ghana, the MAP is reported to have improved partnerships between Muslims and Christians who support vulnerable, infected, and affected persons in the community.

The Uganda AIDS Commission (UAC) reported: “One of the best practices identified among community-led HIV/AIDS initiative (CHAI) groups is the building of alliances and linkages with other donors, local government structures, and NGOs/CBOs. These alliances are handling issues of financial support, skills enhancement and development, and service provision. Some CHAI groups have accessed funding from agencies other than UAC. If CHAI funding from the [MAP] project is discontinued, such groups will continue to benefit from the alliances. Examples of such groups include Nakatunya Parish HIV/AIDS Foundation in Soroti district, which secured five-year funding from the Soroti local government, and Abenda Emu in Masaka, [which] obtained cows from Send a Cow, an NGO.”

The Rwanda national police force has created eight anti-AIDS clubs with 30 members each, integrated HIV activities into the police’s national strategic plan, and provided access to treatment and care to HIV-positive police force members and spouses.

The MAP has supported improved coordination of the actors involved in the HIV response, both by the NAC and at decentralized levels. This increased coordination has enabled NACs to establish and maintain partnerships, to decentralize the HIV response, and to ensure better involvement of many sectors in the HIV response. In Ethiopia, the MAP funded the establishment of a National Partnership Forum and other coalitions such as the National Women’s Coalition Against AIDS.

MAP funding has supported the decentralization of the HIV response. Decentralization of government structures is an overall trend in Africa. MAP has supported the decentralization process by providing infrastructure, consultants, and capacity building for the decentralized structures in Ghana, Nigeria, The Gambia, Cameroon, Kenya, Malawi, Tanzania, and Rwanda.

The Ghana AIDS Commission reported that the “MAP has empowered the local structures and districts in the fight against HIV/AIDS by dispersing financial and decision making authority and providing support for district AIDS committees with their program monitoring and evaluation responsibilities.”

In Swaziland, the HIV-focused IDF funded the training of regional-level staff and purchased computers for all 80 Tinkundla (decentralized local government structure) in Swaziland.

In Senegal, the MAP funded multisectoral planning at the district level, involving all sectors, which produced a truly decentralized and costed plan for HIV activities at the district level.

In Nigeria, the MAP directly funded the State Action Committees on AIDS and has also built their capacity for project and financial management. In return, the local government has made funding available for district voluntary counseling and testing centers.

The MAP has supported international partnerships on HIV at country level that have resulted in many programs that support the HIV response. TTLs consult with other donors on harmonization and alignment, and the MAP is helping to implement a number of global partnerships and initiatives within countries—the Global Fund to Fight AIDS, Tuberculosis and Malaria; the Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors; the Universal Access Program; and the Three Ones principles, including support for building national monitoring and evaluation systems. Several MAP projects have implemented joint supervision missions, one of the recommendations of the Global Task Team.

The MAP built capacity to plan, coordinate, monitor, evaluate, and implement HIV services. The NACs trained many civil society organizations to apply for and manage MAP funds and to help implement HIV projects. Capacity building extended beyond training workshops. MAPs also funded consultants who transferred skills to local staff, and participation in regional conferences for knowledge exchange and learning by people coordinating and implementing MAPs.

In Uganda, small CSOs were strengthened. In the words of the NAC: “A good example is Anamany in Soroti district which started as a small CBO but is now a big CBO that has been engaged by UWESO to provide technical and supervisory services to other NGOs in the area.”

In Tanzania, all eligible CSOs were trained in proposal writing, project management, and reporting (over 600).

In Sierra Leone, the district councils were empowered and procedures were laid down for training and engagement of the community-based organizations.

In Angola, it was reported that “focal support teams have been created and trained in seven priority Government Ministries, i.e., Education, Interior, Youth, Family, Social Assistance, Labour and Health,” and 250 NGOs were trained in service provision.

In Zambia, His Royal Highness Chief Mumena of Solwezi District, North Western Province, stated that “CRAIDS [as the MAP is known] is the only institution that is building the capacity of the communities to implement HIV/AIDS activities. They sit down with them and teach them how to manage the finances and keep records. The others just dump the money and disappear. Therefore, projects under CRAIDS are very well managed as a result of building the capacity of communities to manage these projects.”

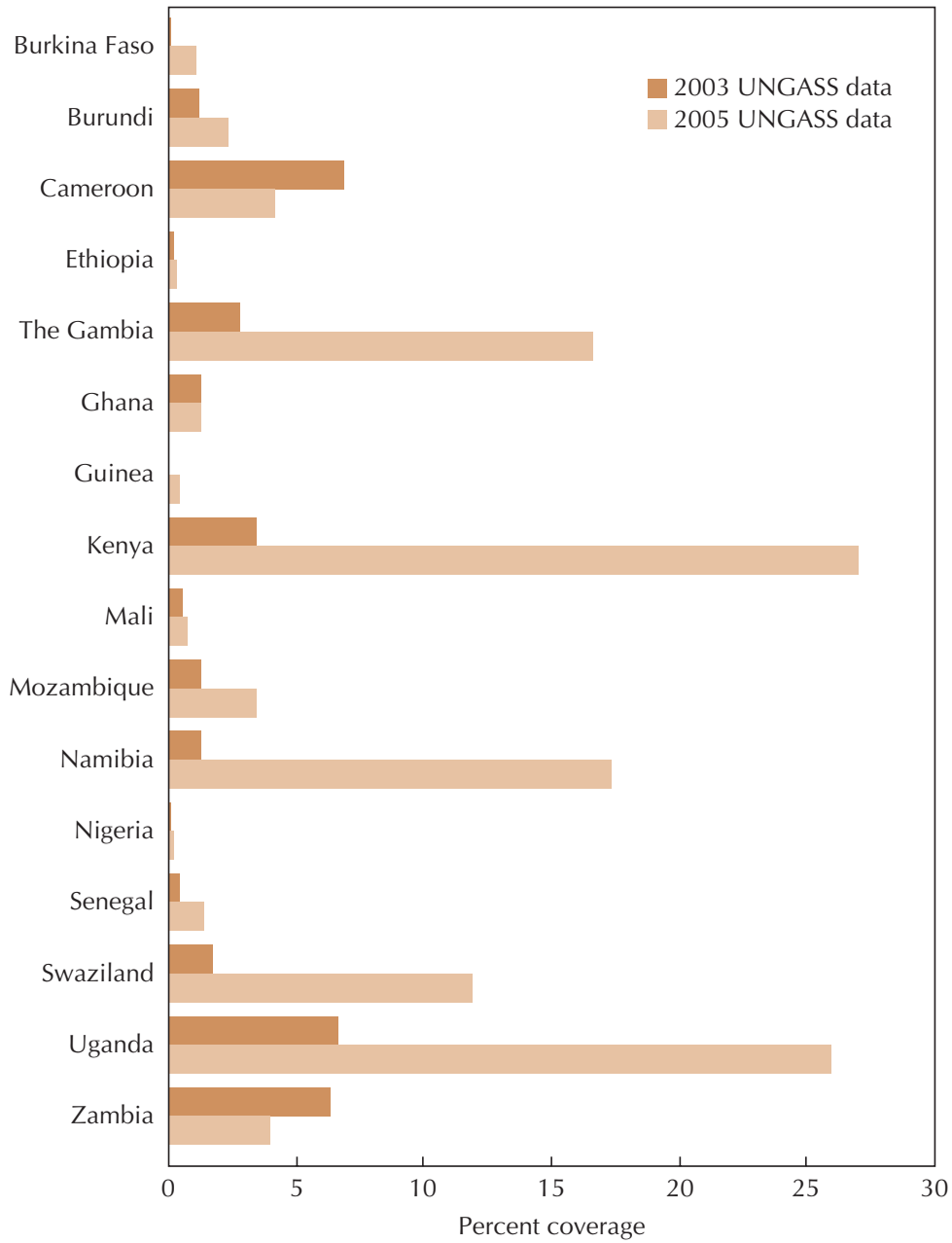
Outcome-level results in prevention

The MAP has helped increase the number and percentage of women who have accessed PMTCT services at antenatal clinics (figure 3.5).

In some cases, PMTCT provided wider benefits for the husband and family as well. In the Democratic Republic of Congo, the concept of *Prise en Charge Globale* was introduced, focusing not only on the HIV-positive mother, but taking into account other members of the family, and supporting whatever services they needed, whether income-generating activities or legal support.

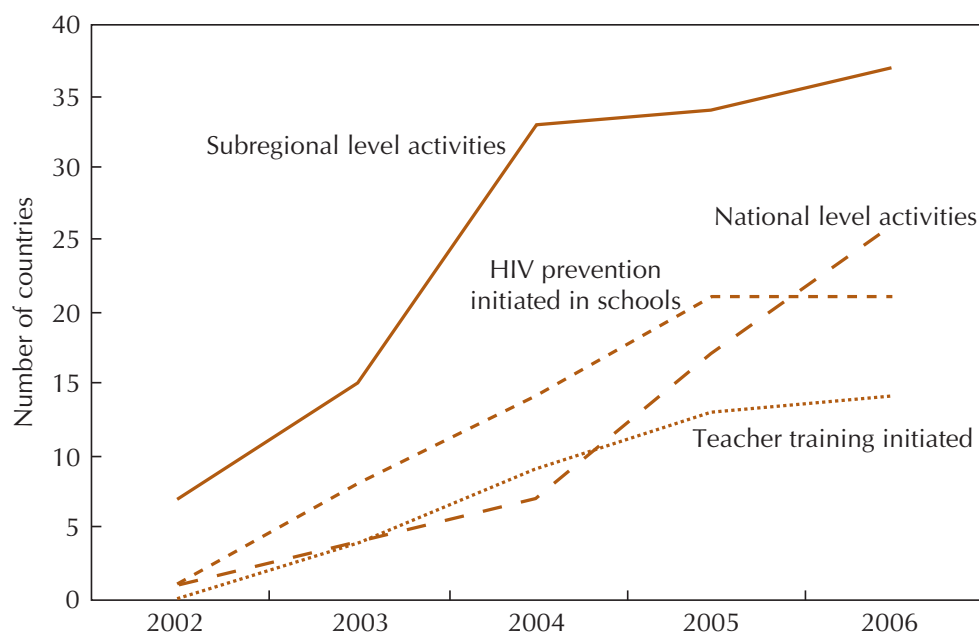
The MAP has supported HIV education in schools and helped protect teachers. There are two aspects to HIV in the education sector: (1) the impact on learners and the effect of education on attitudes, knowledge, and behaviors and (2) the impact on the education system and its ability to provide educational services. With MAP assistance, 36 countries in Sub-Saharan Africa have participated in a multiagency effort to “accelerate the Education Sector response to HIV in Africa” (figure 3.6). For example, Ghana,

Figure 3.5 Increase in the Percentage of Pregnant Women Receiving PMTCT



Source: UNGASS 2003 and UNGASS 2005 country reports from MAP and IDF countries.

Figure 3.6 Progress in Implementing Prevention Activities in the Education Sector, 2002–06



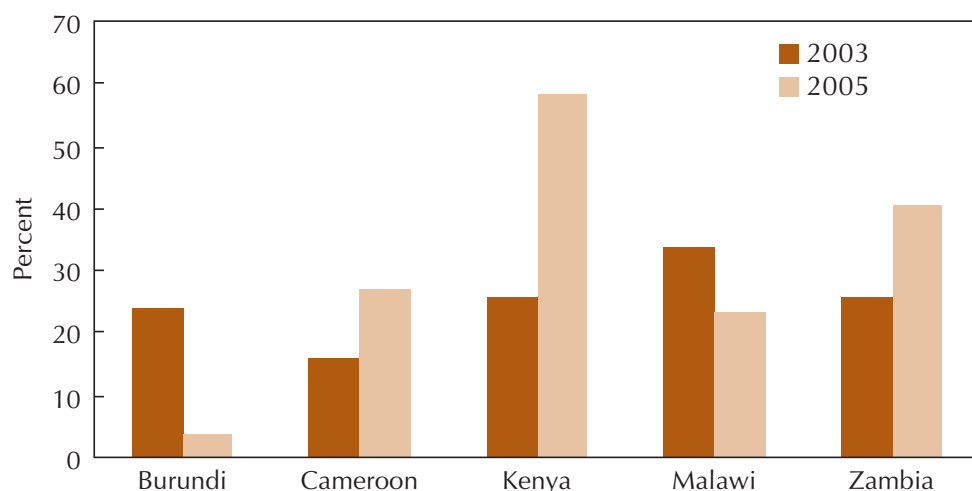
Guinea, Niger, Senegal, and Tanzania have used MAP resources to develop curricula that reduce stigma. In addition to teacher training and development of curricula and teacher training materials, the MAP has supported VCT services for teachers and education staff, who make up more than 60 percent of the public sector workforce in many countries.

In Ethiopia, the MAP has supported over 12,000 school AIDS clubs that provide information and support for preventing HIV infection and combating stigma and discrimination.

Nigeria, faced with the particular challenges of a very large population and a federal structure, used the MAP to establish a national training center, which over two years has helped 28 of the 36 state education departments to implement responses to HIV.

The MAP has contributed to increasing knowledge about how HIV is transmitted, or to maintaining high levels of knowledge, through interpersonal communication and mass media campaigns. A variety of media

Figure 3.7 Young Women with Comprehensive Knowledge about HIV, 2003 and 2005



Source: UNGASS country reports, 2003, 2005.

and innovative methods were used, including radio, television soap operas with HIV messages, mobile movie screens, free help centers, and short text messages sent to mobile phones. Interpersonal communication has focused on peer education, primarily for young people and in many different settings. It needs close follow-up because of the need for technical updates, and because peer educators are paid nominal sums (if at all) and initial enthusiasm can wane quickly. However, when done well it has proved effective, and the MAP supports peer education in almost every country. Figure 3.7 shows increases in knowledge among young women in three of the five MAP countries for which data were available. The decrease in knowledge in Burundi is a result of the large mobile population and instability in the country. In Malawi, the apparent decrease in the level of knowledge about HIV is due to the use of a new method to calculate the value of the indicator.

Madagascar reported increased knowledge about HIV among young people, and a rise in the percentage of women who had heard about HIV/AIDS from 69 percent to 79 percent. The percentage that identified condom use as a prevention method went up from 27 percent to 51 percent. The percentage of women who know that being faithful can help prevent HIV increased from 38 percent to 60 percent. (It is also encour-

aging that the NAC used DHS data as a source for describing the MAP results.)

The Sierra Leone National HIV/AIDS Secretariat (NAS) reported that “Another group of beneficiaries are members of the women’s traditional secret societies who also through sensitization and awareness raising activities of the CSOs now use sterilized or modern instruments in their operations in a bid to prevent HIV transmission. In a recent development, traditional/local leaders with funding from NAS have taken the lead in fighting HIV/AIDS in their various chiefdoms. The information about HIV/AIDS can now be transmitted to the people through the local dialects by peer educators. The Chiefs also made a declaration about the benefit in terms of awareness which their involvement in the HIV/AIDS campaign has brought to their constituents.”

MAP may have contributed to a reduction in high-risk sex in some countries. Demographic and Health Survey data indicate that the percentage of young people who have multiple partners has fallen in Benin, Burkina Faso, Kenya, and Uganda. The percentage of young men reporting premarital sex has fallen in Benin, and the percentage has fallen among both young women and men in Kenya and Tanzania. However, DHS data show no marked changes in the median age at first penetrative sex or in the percentage of young people who had sex before the age of 15 years.

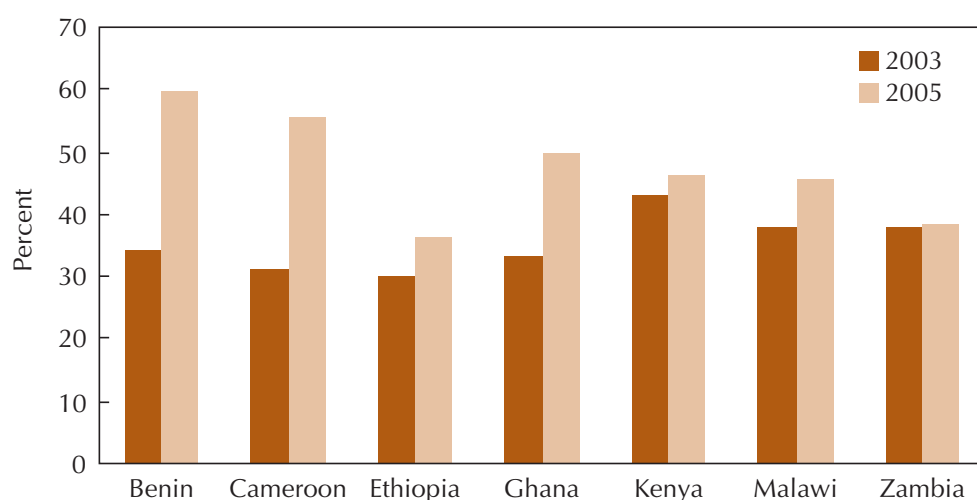
There is some evidence of the MAP focusing on the most vulnerable and at-risk populations. Although the OED evaluation in 2005 criticized the MAP for not focusing on the most vulnerable and at-risk populations, data from both the Rwanda Beneficiary Assessment and the Republic of Congo indicate that in those countries the MAP is targeting support, and enabling communities to focus on populations that are most affected or vulnerable. Congo’s NAC reported that the MAP resulted in “[b]etter organization of the NGO specialized in reducing HIV/AIDS in vulnerable groups.” In Rwanda, the MAP led to a dramatic increase in the number of organizations of people living with HIV. The scaling-up of the ART program in Rwanda was initially supported by the MAP and had a pro-poor focus: it extended access to care to people living outside the capital, and two-thirds of MAP-supported patients on ARVs are poor women. Two regional MAPs—the Abidjan-Lagos Transport Corridor and the Great Lakes Initiative on AIDS—both focus exclusively on most-at-risk populations, that is, mobile populations and sex workers. Sierra Leone and Rwanda also reported specific programs that focus on these populations.

The evaluation team of the Abidjan-Lagos Corridor project reported that “In a hotel (Le Rocher) at Aboisso in Côte d’Ivoire, we arrived in the hotel, where we gave no indication of what our mission was, and as we waited for food to be served, a receptionist came close to us. He engaged in discussions with us, which then led us to address HIV/AIDS issues. We pretended not to be interested by ‘this nonsense.’ But then we were surprised by the man’s ability to talk about HIV and by his level of personal conviction. At the end of the day, he provided us with a box of condoms. We went through a similar experience when we were briefed by two Ghanaian drivers, who benefited from an NGO’s sensitization campaign. We were simply seduced by these two drivers’ level of knowledge on these issues and by their ability to talk about them in simple and easily understandable language.”

The MAP has contributed to an increase in condom use. Condom use has been rising significantly (although distribution of female condoms remains scant). Country DHS data confirm that condom use during risky sex has increased in a number of countries. Figures 3.8 and 3.9 show large increases among men and women in Benin, Cameroon, Ghana, and Kenya and among men (but not women) in Ethiopia and Malawi.

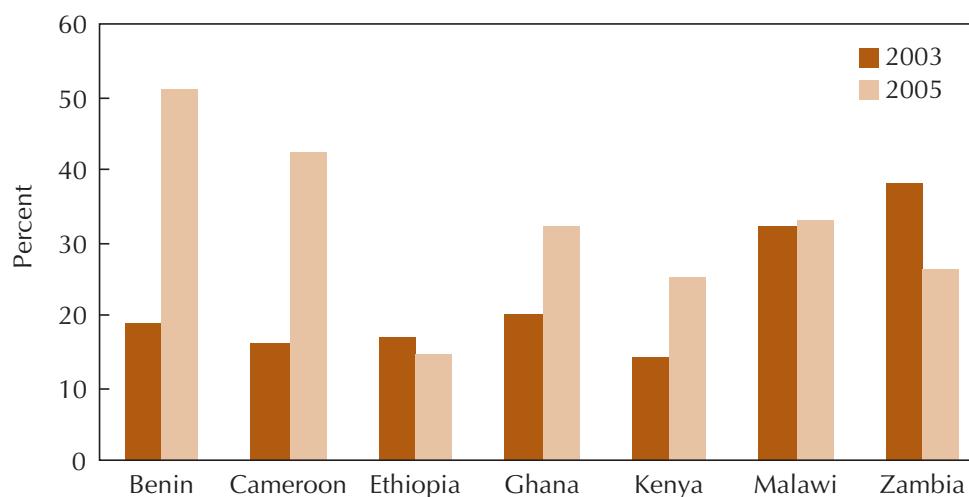
The MAP has ensured that more people know their HIV status. This is an essential component of HIV prevention and was facilitated by increased

Figure 3.8 Percentage of Young Men Who Reported Using a Condom in Last Sex with a Nonregular Partner



Source: UNGASS country reports, 2003 and 2005.

Figure 3.9 Percentage of Young Women Who Reported Using a Condom in Last Sex with a Nonregular Partner



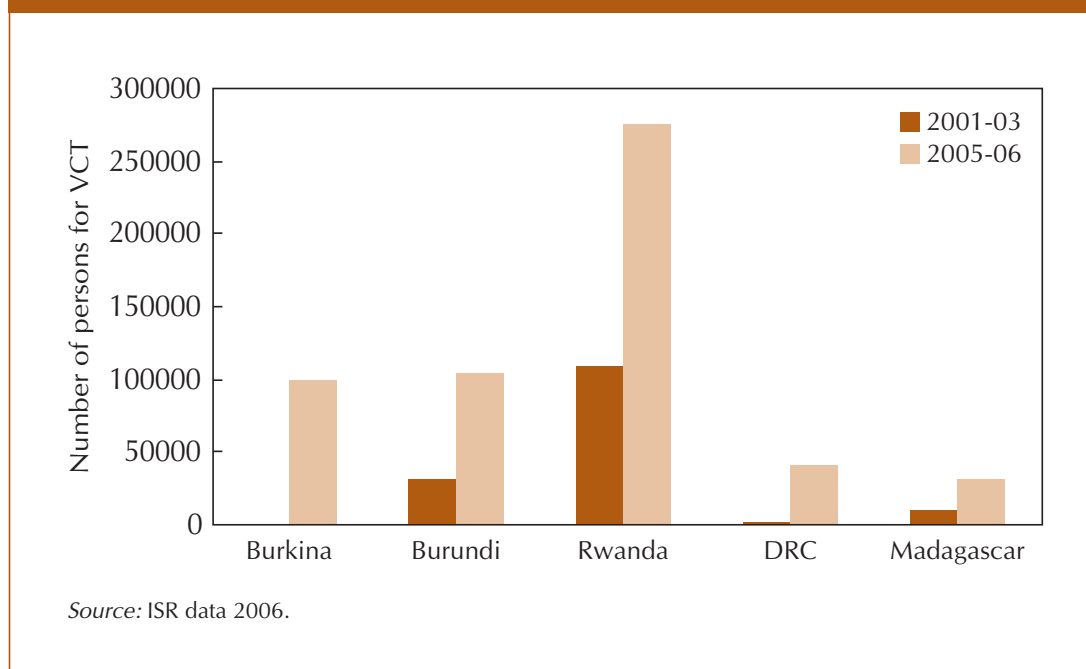
Source: UNGASS country reports, 2003 and 2005.

involvement of communities in HIV interventions. In Ethiopia, for example, there was a 300 percent increase in the number of VCT visits over a two-year period. More evidence of increases in the number of people who have used VCT services (and therefore the number who know their status) is illustrated in figure 3.10.

Nigeria reported this comment from one of the community pharmacists trained under the MAP: "Prior to this, I did not know when patients come with symptoms. Now I am able to identify such patients, counsel them to go for testing, make referrals when they are found positive and continuously assist them through counseling. This has given more life to my practice in the community and fulfillment to me."

The MAP has contributed toward preventing transmission of HIV in health facilities. The MAP has funded measures to guarantee safe blood transfusions and promoted universal precautions against HIV transmission among health care workers. A number of medical waste management plans were developed and incinerators constructed as part of the effectiveness conditions of MAP projects.

Figure 3.10 Increase in VCT Visits over Time, Various Years 2001–06

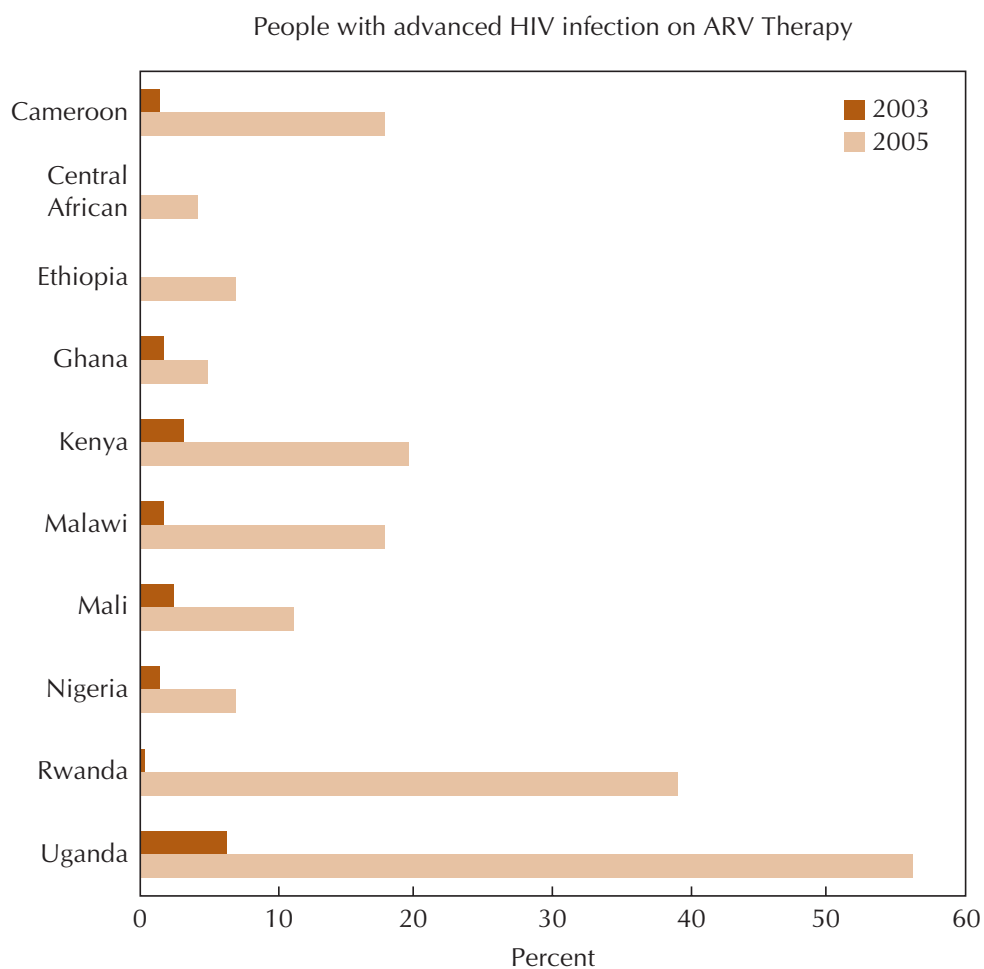


Sierra Leone used MAP funding to build 17 incinerators attached to health facilities and is implementing postexposure prophylaxis.

Outcome-level results for treatment, care, and support

The MAP has helped increase the number of facilities able to provide ARTs and increased the number of people on ART. Antiretroviral drug therapy was not initially a part of the MAP, but ARVs have been procured with MAP funds, and by the end of 2005 the MAP had funded ARVs for 27,000 people. Some MAP projects funded ARVs and drugs for opportunistic infections as an interim measure while countries were waiting for GFATM funding or when there were stock-outs. In a few cases, MAPs have been the main source of supply; for example, in the Abidjan-Lagos Corridor project, MAP is the main source of ARVs for border communities that would otherwise have no access to the drugs or would have been forced to travel long distances to get the drugs. The MAP also enabled health ministries to build, renovate, and equip clinics and train health care providers in ART management and treatment of opportunistic infections. Local community-based organizations (CBOs) provided home-based care and training in infection prevention (uni-

Figure 3.11 Increased Percentage of HIV-Positive Persons Receiving ART in MAP-Funded Countries



Source: UNGASS country reports, 2003 and 2005.

versal precautions) and adherence counseling. Service coverage statistics show increased access to ART (figure 3.11), to which the MAP has contributed.

The MAP supported improved health service delivery. The MAP funded staff training, improvements in infrastructure, and purchase of equipment, in addition to setting up ARV sites. For example, the Uganda Drug Authority used MAP funding to purchase a condom testing machine that has reduced the costs to government of postshipment testing and has increased public confidence in condoms imported into the country. In Rwanda, the MAP upgraded 12 district hospitals serving about 2 million Rwandans, strengthening their capacity to provide non-AIDS care as well as

ART, with better laboratories, logistical support, and additional human resources. The project also increased access to health care by subsidizing community health insurance for roughly 52,000 poor households.

In Eritrea, the MAP also supported treatment for malaria and tuberculosis, which is the principal opportunistic infection. This has contributed to a continued decline in malaria morbidity.

In Guinea-Bissau, approximately one and a half years into its implementation, it is reported that the MAP is beginning to change health services in the country, empowering and enhancing regional and national health care facilities as well as personnel in five priority regions in the country (Bissau, Bafata, Cacheu, Gabu, and Oio).

Impact mitigation outcomes

The MAP supported and promoted school attendance of orphans and vulnerable children. In a third of MAP countries in Africa, orphans' school attendance increased relative to that of non-orphans. In Rwanda alone, the MAP enabled more than 25,000 children to remain in school by paying their school fees. In Burundi, data collected in a survey on the effects of the war show that the quality of life of orphans and vulnerable children has improved as a result of MAP funding.

In Rwanda, an association that was established for groups of sex workers and vulnerable and at-risk women has provided a support network, helped them find alternative income sources, reduced high-risk behavior, and benefited their families. The association pays school fees for around 500 orphans and has funded vocational training for some of the older orphans who were engaged in sex work. One of the beneficiaries explained that joining the association gave her access to the "right channels." She now engages in a productive trade, has a stable source of income, and has regained her self-esteem.

In Zambia, a widow reported that "my children who were not going to school because of lack of money are now going to school because of this assistance we have received."

The MAP increased access to good-quality psychosocial care for affected households and vulnerable children. The direct involvement in

the MAP by faith-based organizations and organizations of people living with HIV has helped provide for the social and psychological needs of people infected and affected by HIV within their communities. Stigma and discrimination have been reduced, which has helped in impact mitigation.

In Ethiopia, the Mekdim National Association of AIDS Orphans and Persons with HIV/AIDS was established with MAP funds. The association began in 1997 with three committed people living with the virus and nine AIDS orphans, and it currently has more than 5,000 members and six branches. In addition to its advocacy and legal support activities, the association (mainly through MAP funding) provides home-based care, social support, and psychological services to people living with HIV. It also undertakes HIV/AIDS education for the public. The MAP has also financed the activities of Tesfa Birhan National Association of Orphans to bring meaningful change in the lives of orphans.

The MAP has supported community-level care, including projects that aim for self-sustainability. MAP projects at the community level have provided microcredit and food to indigent people living with HIV through local community-based organizations. Despite the challenges with income-generating activities (especially finding markets where the products from income-generating activities can be traded), there are success stories from many countries. The community approach of MAP seems to have contributed to better understanding of the disease and greater readiness of communities to respond together.

In Sierra Leone, an example of good practices is the Camp Women's Vocational Training Institute located in Freetown, which works with sex workers. This institute trains sex workers in various activities and empowers them to undertake activities in trading, catering, sewing, or soap making on a commission basis for 3–6 months. The savings they accrue from their commissions are used as seed money to start their own businesses. A good number of the graduates are now self-employed in various businesses.

In Ethiopia, members of Dawn of Hope Ethiopia Association are achieving socioeconomic integration, rediscovery and development of potential, and increased self-esteem. DHEA believes that most of its members could now engage in sustainable income-generating activities (IGAs) and other gainful employment if they were provided with seed money and relevant training. Currently, 1,037 members of the association (623 women and 414 men) are engaged in different IGAs such as metal and wood works, cattle

fattening, poultry and dairy farming, grain milling, horticulture, and petty trading activities. Most of these IGAs are group owned and managed.

In Uganda, some CHAI groups are engaged in crop and animal husbandry for income generation as well as domestic consumption, such as the Nakatunya Serere women's group and Kasana women's group. Proceeds are used for educating children, buying basic household necessities (including food) for people living with AIDS and orphans, and transporting group members to undertake community sensitization and to travel to seminars and district visits. Other innovative activities include drama and handicraft-making by Kanihiro in Bushenyi, Lira Veterans, Community Mobile Theatre Association, and Agora choir group in Soroti.

One Zambian district commissioner remarked that "Income-generating activities have made a very big difference. Before we were funded by CRAIDS [the MAP], other funders just used to give us food to give to our clients. When the food ran out we had nothing to give to our clients. Now we have this hammer mill from CRAIDS as an income-generating activity, [so] we always have some income and food for our clients."

Monitoring and evaluation outcomes

Operationalizing a national HIV M&E system implies that a country should have in place a system that consists of the following components:

- Component 1. HIV M&E resources at national, decentralized, and implementer levels
- Component 2. Strong partnerships to coordinate implementation of an M&E system
- Component 3. A national M&E operational plan with which to measure outcomes
- Component 4. An integrated, costed M&E work plan
- Component 5. A national database with key information
- Component 6. A strategic flow of information and data
- Component 7. Data auditing and supervision procedures
- Component 8. Harmonized M&E capacity building
- Component 9. A learning and evaluation agenda
- Component 10. Advocacy and communication for HIV M&E
- Component 11. Strategies for data dissemination and data use

In the Country Feedback Form, NACs were asked to rate each of these 11 components of their national HIV M&E system, noting the status before the start of the MAP, and currently. Table 3.6 documents the results of this

Table 3.6 Progress in Operationalizing National HIV M&E Systems

Component of a national HIV M&E system	Status before the Map	Status in September 2006
1. HIV M&E Unit	In most countries, there was no M&E unit and no personnel.	There is an M&E unit with an approved budget in most countries.
2. Monitoring and evaluation task team or working group	Most countries did not have an M&E Technical Working Group.	In most countries, an M&E Task Team or Technical Working Group exists and meets at least quarterly.
3. HIV M&E strategy or framework that describes all 11 M&E system components, including a set of indicators	Most countries did not have an M&E strategy or framework.	Most countries have developed and approved an M&E strategy that is linked to National Strategic Plan objectives and includes an indicator set (including all UNGASS indicators) that is agreed to by all partners.
4. Costed HIV M&E action plan	Most countries did not have a costed and integrated M&E action plan.	Many countries have an action plan, although few have costed their plans.
5. National HIV database	Most countries did not have an HIV database.	Most countries are in the process of developing an HIV database.
6. Strategic Information Flow		
6.1 Surveys	On average, one per country had taken place.	On average, two per country have taken place.
6.2 Routine data on nonmedical HIV services	Most countries did not have guidelines for nonmedical program monitoring.	Most countries have developed and approved guidelines but not yet trained stakeholders to follow them.
6.3 Routine data on medical HIV services	On average, two types of data were being collected by most countries.	On average, four types of data are being collected by most countries.
7. Supervision and data auditing	Countries had not developed guidelines.	Supervision responsibilities are now included in job descriptions, but supervision guidelines still have not been developed.

(continued)

Table 3.6 Progress in Operationalizing National HIV M&E Systems (continued)

Component of a national HIV M&E system	Status before the Map	Status in September 2006
8. Harmonized capacity building	Most countries did not have M&E training materials.	Most countries reported that there are M&E training materials but they are not harmonized.
9. Evaluation and learning agenda	Most countries reported that there was no research agenda or research strategy to coordinate HIV research (biomedical and social sciences research).	Most countries have a research strategy, but reported that it is not well coordinated.
10. HIV M&E advocacy and communications	Most countries did not have a plan for advocacy and communication about HIV M&E.	Countries have developed plans, but they are not being executed yet.
11. Data dissemination and data use	Data were not being used.	There is some evidence of data use.

Source: Country Feedback Form submissions by NACs, 2006 (appendix D in this report).

part of the survey, listing the median ranking of all the responses before the MAP started and the current ranking. The UNAIDS Three Ones analysis also documents progress in developing national HIV M&E systems. Table 3.6 suggests areas where increased attention is still needed: specific data sources, supervision and data auditing, harmonized capacity building, evaluation and learning agendas, routine program monitoring of nonhealth data, and HIV M&E advocacy and communications.

By December 2005, Zanzibar had conducted an M&E capacity assessment and developed draft M&E training materials and a draft HIV M&E strategy, but the M&E system was not operational. By July 2006, seven months later, the Zanzibar AIDS Commission (ZAC) had launched the national HIV M&E system, finalized training materials, mobilized a significant amount of funding and technical assistance for operationalizing the M&E system, and were in the process of training all 200 HIV implementers on the islands of Unguja and Pemba on

how to report on a regular basis to the ZAC. These achievements were made possible through the development and approval of a national HIV M&E Road Map. The Road Map was used to draw all development partners together; it provided direction to the M&E technical working group as to what they should be coordinating; built skills needed to manage and operationalize a national HIV M&E system; and enabled the ZAC and its partners to obtain funding and technical support for specific M&E activities in the Road Map from other partners. The Road Map is not a collection of existing work plans, but rather a complete work plan of what is required for the M&E system to be fully operational, so it was also used to uncover areas that were not yet funded, which were included in Zanzibar's application for GFATM Round 6 funding.

The Treatment Acceleration Project (TAP) Evaluation Report (June 2006) commented on knowledge sharing, an important part of the project. Participants assessed the first meeting as very relevant and focused on issues they had hoped would be addressed. It promoted exchange of lessons and experiences on patient-tracking systems and monitoring of drug resistance. In addition, the meeting led the participants to consider follow-up activities in their respective countries. Activities mentioned are (i) putting in place an M&E system that will enable them to track patients and follow up treatment; (ii) undertaking activities related to drug resistance; and (iii) looking at financial sustainability more seriously and initiating dialogue with the Ministry of Finance on ways to take over financing after the TAP.

Results of the MAP for the World Bank as an Institution

In addition to the benefits for the countries, the MAP also has had positive outcomes for the Bank. The innovative approach and benefits of the MAP for the Bank include the following:

- It was the first major HIV/AIDS program to support strategic and system investments at the national level, rather than just selected interventions.
- The MAP approach was used as a model in other programs. It showed that it was possible to respond swiftly to emergency situations, using an innovative, large-scale program. A MAP program was set up in the Caribbean, and a MAP-like approach has been followed in Central Asia. Because of its speed and flexibility, the MAP was used as the model for the Bank's avian flu program.

- Further, the MAP established the Bank's reputation as a leader in AIDS, which had suffered greatly from the sustained neglect of the 1990s. There was a drastic change in attitudes to the Bank among people living with HIV, as well as NGOs, CBOs, and religious organizations as a result of the MAP. For the first time in 2003, and again in 2005, the Bank was highly commended for its efforts by the Civil Society Representatives at the International HIV/AIDS and Sexually Transmitted Infections Meeting in Africa (ICASA).