



## Conclusions

### *What Has the MAP Achieved So Far?*

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#### **Achieving the MAP Phase 1 Primary Objectives**

**What did the MAP set out to achieve?** The overall development objective of the Multi-Country HIV/AIDS Program is to dramatically increase access to HIV/AIDS prevention, care, and treatment programs, with emphasis on vulnerable and at-risk populations (such as youth, women of childbearing age, and other groups at high risk). To support the development objective, the specific objectives of the MAP Phase 1 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 today develop AIDS over the next decade (World Bank 2000b, c). The first phase also supports cross-border initiatives and pilot tests of ways to increase access to antiretroviral therapy.

**Is the MAP achieving its objectives?** The results presented in chapter 3 speak for themselves: the MAP set out to achieve a series of input and output results, and it is in the process of achieving them. The MAP has supported the scaling up of HIV services in a catalytic manner. Initially, as the only major funder for HIV, the MAP helped prepare countries to scale up their national response as additional funding became available, enabling governments to build and strengthen institutions at all levels that would be involved in the HIV response (MAP funds have supported more than 41,000 institutions across Africa). The MAP has contributed to resources for health systems strengthening: 17 percent of MAP funding has been allocated to

Ministries of Health. Cross-border projects that address populations at higher risk of infection are under way, and the MAP supports provision of ARVs and is testing different private-public partnerships for scaling up treatment access.

## Addressing Country Needs

**What country needs did the MAP aim to address?** The MAP was designed to address four key country needs: (1) to build strong political and government commitment to responding to HIV; (2) to create a conducive institutional and resource-appropriate environment in which successful HIV/AIDS interventions could be scaled up to a national level; (3) to make the HIV/AIDS response local—increasing community participation and ownership in HIV/AIDS interventions by providing financial resources and capacity building; and (4) to move to a multisectoral approach involving all government sectors, with improved coordination at the national level and decentralization to sub-national government structures.

**Is the MAP addressing these country needs?** Yes. All data sources concur that the MAP has helped build political leadership, created an institutional environment at the national and subnational levels in which the national HIV response can thrive, set the foundation for significant resource mobilization, and financially supported many sectors to become involved in the response to HIV. It also has begun to address most-at-risk and vulnerable populations and is supporting monitoring and evaluation systems (although this study, the 2004 interim review, and the OED evaluation in 2005 concur that more effort is needed). The MAP attempted to harmonize its efforts from the start: 59 percent of MAP projects are managed without a separate Project Management Unit, and 38 percent of NACs report that GFATM grants and MAP funding are managed by the same coordinating unit.

The MAP's large-scale direct support to communities and grassroots organizations remains unique among major funders; the MAP has been the only significant source of support for many thousands of initiatives that reach poor and remote communities. This funding has empowered communities and people with HIV to take the initiative, define their needs, and work together to fill them, by caring for orphans, offering home-based care for poor people who are ill with AIDS, offering counseling and psychosocial support, providing information on prevention and treatment, encouraging HIV testing, and supporting income-generating activities.

Recipients of MAP funding are investing in a range of HIV service delivery areas: predictably, health sectors spend their allocation primarily on

treatment; other line ministries and civil society spend their funding allocation mostly on prevention and care; and NACs use funding for institutional strengthening, coordination, research, M&E, capacity building, operational costs, and consultants (as part of capacity building).

**What about impact-level results?** There are countries in Africa with declining HIV incidence and stable or declining prevalence trends in one or more population groups: Burkina Faso, Côte d'Ivoire, Ghana, Kenya, Malawi, Rwanda, Senegal, Tanzania, Uganda, and Zimbabwe.<sup>4</sup> The MAP has supported programs in all but the last of these countries, and until recently was the main funder in many. Although the declines are the result of the collective efforts of many national stakeholders and international agencies and cannot be attributed to any single donor, the MAP has contributed to these positive impact-level results.

## Study Limitations and a Recommendation

Given the available data, this study was unable to assess whether MAP funds are being spent in the most efficient way, or the impact of the spending on final outcomes. It has a more limited scope, that of reviewing whether the MAP is being implemented as designed, and the inputs and outputs it has funded. This process evaluation clearly documents that the MAP is being implemented with considerable success in very difficult environments. Since it is not an impact assessment, it cannot measure the effect of the MAP on outcomes and impact indicators, but given the strong results documented, it can assert that the MAP has made a contribution to improved outcomes. However, in the next phase of the MAP, ex ante impact evaluation should be built into projects explicitly, and funded, in order to better align the MAP with the Bank's commitment to a results agenda.

Efforts to support monitoring and evaluation systems also need to be sustained, including supporting surveys that provide the UNGASS data on which the Bank also relies (avoiding duplicative and donor-specific reporting). A proposed framework for routine measuring and reporting of MAP results to the Bank is proposed in chapter 6.

<sup>4</sup> Beyond Africa, this is also the case in the Bahamas, Barbados, Brazil, Cambodia, Dominican Republic, Haiti, southern India, and Thailand. Uganda, the first country in Africa to achieve a marked decline in HIV, shows worrying increases in some population groups.

