



Overview

This study answers the question: What are the results of the World Bank’s Multi-Country HIV/AIDS Program (MAP) for Africa, so far? It documents the contributions of the MAP over the past five years, drawing on countries’ survey and program data that are not usually captured in routine World Bank reporting systems. It also proposes a new Results Scorecard and Generic Results Framework to better measure and report future results of HIV/AIDS programs in Africa that the World Bank helps to support.

Several factors provided the impetus for this work. First is the desire to systematically document the activities funded and to quantify the results to which the MAP has contributed. Second, this work contributes to broader efforts to reflect on the experience and lessons learned during the first phase of the MAP and on the changed global AIDS environment, as input to an updated World Bank Africa AIDS strategy, *AIDS Agenda for Action*. Third, the World Bank is committed to sharing information widely and to using the information to improve the MAP and to “manage for development results.” However, the intention was not to evaluate the MAP or assess its impact; rather, it was to review whether the first phase of the MAP has been implemented as designed, and to report on results of MAP contributions at the input, output, and outcome levels across participating countries.

Context and Objectives of the MAP

The World Bank has been involved in responding to HIV since 1986, with an intensified focus and leadership role after 1998. By the late 1990s, it was

clear that the AIDS response was too narrowly focused on the health sector and not commensurate with the burden and impact of HIV, especially in Sub-Saharan Africa. Intensified, multisector actions were needed, particularly in this region. The innovative Multi-Country HIV/AIDS Program for Africa, created in 2001, was a central part of the Bank's revitalized AIDS strategy, which was presented in the report *Intensifying Action against HIV/AIDS in Africa: Responding to a Development Crisis* (World Bank 2000a). The overall development objective of the MAP was to dramatically increase access to HIV prevention, care, and treatment programs, with an emphasis on encouraging local responses and multisectoral actions, scaling up prevention of mother-to-child transmission, supporting children affected by AIDS, building capacity for treatment, initiating regional programs to address cross-border issues, and sharing knowledge.

The specific objectives of 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 would face as the millions living with HIV developed AIDS over the next decade. Following a rigorous stocktaking (which includes the work reported in this book), phase 2 would be designed to mainstream the innovations that proved effective; to attain nationwide coverage wherever 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 be declining, and efforts would focus sharply on areas or population groups where infections were still increasing (World Bank 2000c).

The MAP funding mechanism was different from previous Bank funding for HIV. The exceptionality of AIDS and the innovative nature of the MAP are reflected in the MAP's design, approval, and implementation arrangements: the MAP focused on speed, flexibility, learning by doing, reworking of projects as needed, and reliance on multiple implementation agencies. To mitigate the risks associated with this approach, the MAP used eligibility criteria against which countries could qualify for MAP funding.

The MAP addressed four pressing country needs that were identified at the time: (1) the need for strong political and government commitment to respond to HIV, (2) the need to create a conducive institutional environment with adequate resources to enable successful HIV/AIDS interventions to be scaled up to a national level, (3) the need to make the response local—increasing community participation in and ownership of HIV/AIDS interventions by providing financial resources and capacity building, and (4) the need to move to a multisectoral approach in which

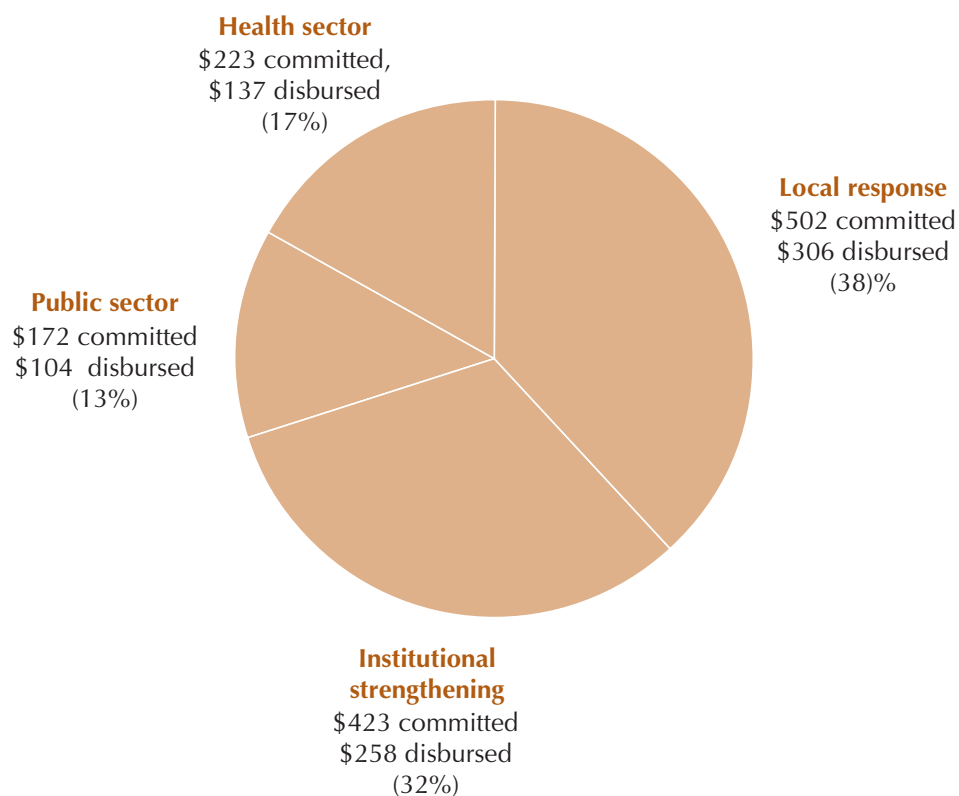
all government sectors are appropriately involved, with improved coordination at national level and decentralization through subnational government structures.

MAP Results: Input and Output Level

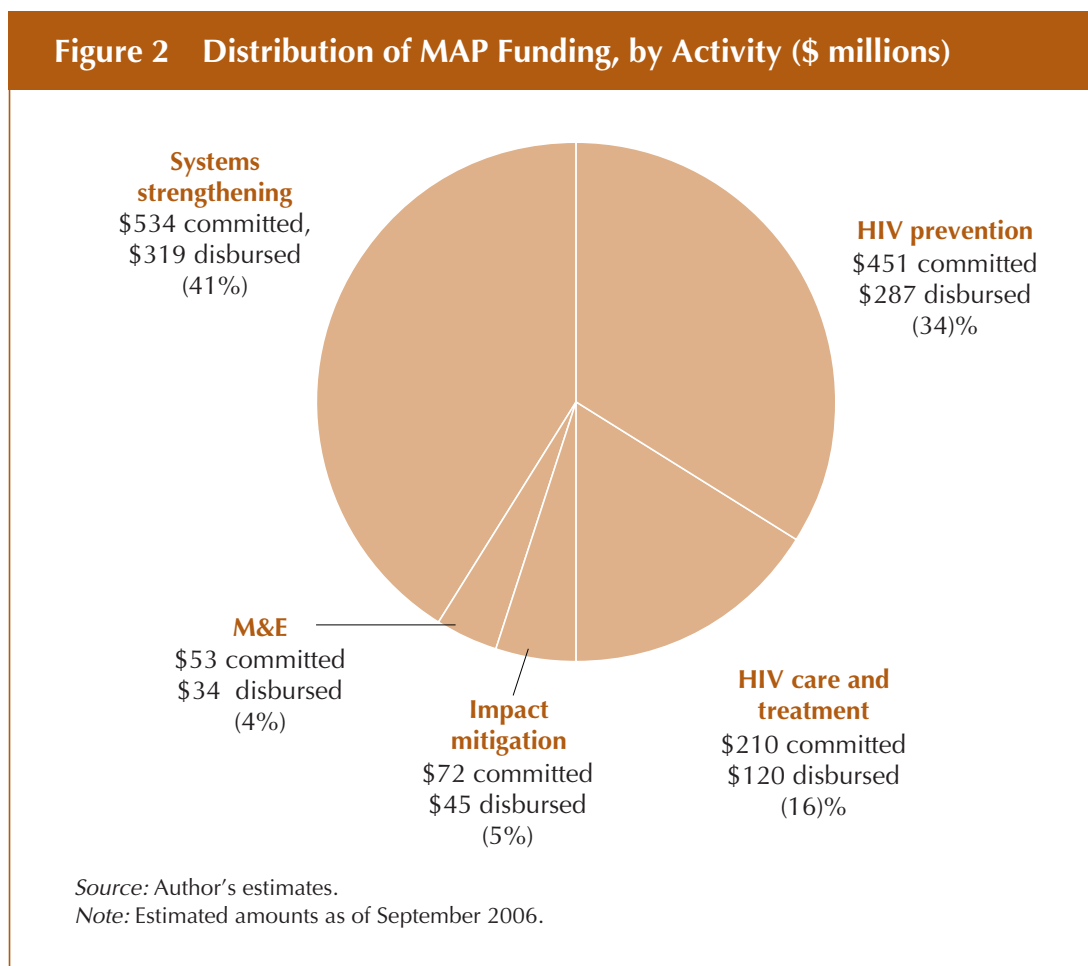
The MAP has committed and disbursed funding to a wide variety of sectors, as shown in figure 1.

The MAP's development objective focused on output-level results, rather than on outcome or impact objectives. Each sector that received funding used it to deliver HIV services, strengthen institutions, and monitor and evaluate program implementation. The distribution of funding by type of activity is shown in figure 2.

Figure 1 MAP Phase 1 Funding Commitments and Disbursements, by Sector (\$ millions), as of September 2006



Source: Author's estimates.



The MAP has contributed to the outputs shown in table 1. Unless specifically noted, the results cannot be attributed solely to MAP support. Countries were able to report separately on results achieved with MAP support only with respect to some outputs.

Conclusions

Is the MAP achieving its objectives? The results presented in this report show clearly that the MAP is in the process of achieving the input and output results it set out to achieve. The MAP has contributed to extensive scaling up of HIV services. Until 2003 it was the only major source of funds, and was a catalyst for additional funding from other sources. It enabled governments and civil society to build and strengthen institutions at all levels to contribute to the HIV response. For example, the MAP funding provided over 41,000 institutions with technical support. This capacity put countries in a better position to use additional funding as it became available. The MAP

Table 1 Outputs to Which the MAP Contributed as of September 2006

Areas	Output
Systems Strengthening	
Percentage increase in development partner funding	2,240%
MAP management integrated into National AIDS Commission (NAC) functions	59%
Number of persons trained with MAP funds	562,366 (23 countries)
Number of decentralized government structures that have implemented HIV work plans	10,938 (25 countries)
Employees reached with workplace HIV programs	2,258,844 (23 countries)
Number of organizations provided with technical support	41,107 (25 countries)
NACs that coordinate both the MAP and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) programs	38%
HIV Prevention	
Number of women enrolled in PMTCT (prevention of mother-to-child transmission) programs 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 test 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 (information, education, and communication/behavior change communication) programs	173,333,043 (21 countries)
Number of IEC/BCC events	726,876 (20 countries)

(continued)

Table 1 Outputs to Which the MAP Contributed as of September 2006
(continued)

Areas	Output
HIV Care and Treatment	
Number of sites providing antiretroviral therapy (ART)	3,012 (26 countries)
Total number of people on ART	554,648 in total (27 countries) (26,699 with MAP funding ^a)
Number of people living with HIV (PLWH) treated for opportunistic infections	287,805 (20 countries)
Impact Mitigation	
Number of infected/affected persons receiving support	502,958 (21 countries)
Number of vulnerable children receiving support	1,779,872 (22 countries)
Number of income-generating activities supported	32,854 (18 countries)
Monitoring and Evaluation (M&E)	
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.

a. Number includes 13,972 persons reported in the ACTAfrica questionnaire for 2005 (from 23 MAP countries, excluding the Treatment Acceleration Project, or TAP), and an additional 12,727 persons from TAP data about ARV therapy provision in the three participating countries.

has also started several cross-border projects that address most at-risk populations, and has helped increase access to ART. The MAP has supported the health sector and contributed to health system strengthening; 17 percent of MAP funding has been allocated to Ministries of Health. The MAP has attempted to harmonize its efforts from the start: 59 percent of MAP funding is managed without a separate Project Management Unit, and 38 percent of NACs indicated that GFATM grants and MAP funding are managed by the same coordinating unit.

Is the MAP addressing country needs? Yes. All data sources concur that the MAP has helped build strong political leadership. It has helped create an

Table 2 Outcome-Level Results to Which the MAP Contributed

Systems Strengthening
<p>The MAP has:</p> <ul style="list-style-type: none"> ■ Contributed to increased political commitment at the highest government level. ■ Given countries a head start in achieving the Three Ones (one action framework, one coordinating authority, one monitoring and evaluation system). ■ Contributed to institution building and strengthening of the NACs. ■ Helped mobilize additional government resources for HIV. ■ Been a catalyst for increased international funding. ■ Sparked a quantum increase in the scale of country action on HIV. ■ Contributed to improved legislation related to HIV. ■ Succeeded in promoting and facilitating a multisectoral response. ■ Supported the decentralization of the HIV response. ■ Supported improved coordination of the HIV response by NACs, and at decentralized levels. ■ Supported international partnerships on HIV at country level. ■ Built capacity to plan, coordinate, monitor, evaluate, and implement HIV services.
HIV Prevention
<p>The MAP has:</p> <ul style="list-style-type: none"> ■ Increased the number of women that have accessed PMTCT services. ■ Supported HIV education in schools and HIV testing among education sector staff. ■ Contributed to increased knowledge about how HIV can be transmitted. ■ Contributed to reductions in higher-risk sex in some countries. ■ Focused on the most vulnerable and at-risk populations to some extent. ■ Contributed to an increase in condom use. ■ Ensured that more people know their HIV status. ■ Helped prevent transmission of HIV in health care settings.
HIV Care and Treatment
<ul style="list-style-type: none"> ■ MAP funding has set up facilities that provide antiretroviral drugs and expanded access to ARV therapy. ■ The MAP has strengthened infrastructure for delivering health services.
Impact Mitigation
<p>The MAP has:</p> <ul style="list-style-type: none"> ■ Supported and promoted school attendance for orphans and vulnerable children. ■ Increased access to good-quality psychosocial care for affected households and children. ■ Contributed to sustainable community-level care.

(continued)

Table 2 Outcome-Level Results to Which the MAP Has Contributed
(continued)

Monitoring and Evaluation (M&E)

As a result of the MAP:

- Most countries have an M&E unit with an approved budget.
- Most countries also have an M&E Task Team that meets at least quarterly.
- Most countries have developed M&E training materials (although they are not always harmonized).
- Most countries have an approved M&E framework or strategy, with indicators that are agreed upon by all partners (including all the UNGASS indicators) and that are linked to the objectives of the National AIDS Strategy. However, often the M&E strategy is not well coordinated or well implemented.
- Many countries have a detailed M&E work plan, although only some are costed.
- Most countries have begun to build an HIV/AIDS database, but MoH data collection is still weak.
- Strategic information is flowing better than before; there are guidelines for data collection for nonmedical HIV services, and surveys and surveillance have increased.
- There is some evidence of data use.

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

institutional environment at national and subnational levels in which the national HIV response can thrive. It has been the foundation for significant domestic and external resource mobilization. It has financially supported many sectors to address HIV. It has begun to address vulnerable populations and those that are most at risk (although this study, the 2004 Interim Review, and the 2005 OED evaluation agree that more effort is needed). Finally, countries are building monitoring and evaluation systems with MAP, GAMET, and other support. The MAP has been the only significant source of support for community and grassroots initiatives, empowering over 50,000 communities, civil society and faith-based organizations, and organizations of people with HIV to define their needs and work together to fill them; caring for orphans; offering home-based care for poor people ill with AIDS; providing counseling and psychosocial support; providing information on prevention and treatment; encouraging HIV testing; and supporting income-generating activities. This book goes beyond the aggregate numbers to give a glimpse into the lives of a few of the millions of people who have benefited from or helped achieve the results documented in this book. These personal stories from Ethiopia, Uganda, and Rwanda are just a tiny sample of the results of the thousands of grants funded by the MAP across Africa.

How have the funds been allocated? Predictably, the health sector allocation has been spent primarily on treatment, whereas civil society and other ministries spent their fund allocations mostly on prevention and care activities. The National AIDS Commissions have used their funding for institutional strengthening, coordination, research, monitoring and evaluation (M&E), capacity building, operational costs, and consultants (as part of capacity building). Continued efforts are needed to strengthen M&E systems in the future. In particular, support for surveys that provide UNGASS data will enable the Bank to avoid duplicative, agency-specific data reporting, and ex-ante impact evaluations should be explicitly built into and funded in future phases of the MAP.

Results Scorecard and Generic Results Framework for the Future

To support future measurement and reporting of results, a Results Scorecard and Generic Results Framework have been developed for HIV/AIDS assistance in Africa. The Scorecard is a set of key indicators that all Bank-funded HIV/AIDS projects will be required to report on. The Generic Results Framework suggests an expanded set of indicators from which projects can choose (or to which they can add). The indicators in the Scorecard and Framework have been selected from globally agreed-upon UNGASS, Millennium Development Goal (MDG), and International Development Association (IDA) indicators. In addition, they are based on countries' reporting capacities and availability of baseline data, and to harmonize and align reporting requirements with major partners, especially UNAIDS, GFATM, and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The Results Scorecard and Framework will facilitate reporting for the World Bank's *Africa Action Plan* and new *AIDS Agenda for Action in Africa*, especially once they are captured in Implementation Status and Results reports (ISRs) and once the indicators in development credit agreements and project appraisal documents have been aligned.

The Way Forward

The unprecedented global response to HIV in Africa, which the MAP helped to stimulate, has also brought significant challenges. The growth of international funding, the rapid expansion of treatment, and the commitment to universal access hold great promise. However, they also place severe burdens on national health systems and have created tensions around health

funding, service delivery, community engagement, and global collaboration. The challenge, as the MAP moves into its second phase, is to work with countries and other partners to ensure that efficient use is made of the available funds to sustain support for effective national and regional HIV/AIDS responses.

The World Bank can contribute to “making the money work” by, in particular, (1) helping countries develop stronger results-focused and evidence-based national HIV/AIDS strategies; (2) helping to build national M&E systems to measure and manage programs to achieve results; (3) helping to integrate HIV into the broader development agenda; and (4) continuing to channel money to communities for grassroots actions that are crucial to reducing stigma, changing behaviors, and caring for people infected and affected by HIV.