
Results of the World Bank’s Response to a Development Crisis
The Africa Multi-Country AIDS Program
2000–2006

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David Blankhart
Oluwole Odutolu

The Global AIDS Monitoring and Evaluation Team of the Global HIV/AIDS Program

ACTafrica

THE WORLD BANK
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>ix</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>xi</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>xiii</td>
</tr>
<tr>
<td>Overview</td>
<td>1</td>
</tr>
<tr>
<td><strong>1 The Multi-Country AIDS Program Context and Objectives</strong></td>
<td>11</td>
</tr>
<tr>
<td>HIV/AIDS and the World Bank’s Response</td>
<td>11</td>
</tr>
<tr>
<td>Changes in the HIV Landscape since the MAP Began</td>
<td>16</td>
</tr>
<tr>
<td><strong>2 Study Purpose and Methodology</strong></td>
<td>21</td>
</tr>
<tr>
<td>Purpose</td>
<td>21</td>
</tr>
<tr>
<td>Study Design and Methodology</td>
<td>23</td>
</tr>
<tr>
<td><strong>3 MAP Results</strong></td>
<td>31</td>
</tr>
<tr>
<td>MAP Funding Committed and Disbursed</td>
<td>31</td>
</tr>
<tr>
<td>Output-Level Results to Which the Map Has Contributed</td>
<td>34</td>
</tr>
<tr>
<td>Outcome-Level Results to Which the Map Has Contributed</td>
<td>39</td>
</tr>
<tr>
<td><strong>4 Beyond Numbers: How the MAP Has Changed People’s Lives</strong></td>
<td>63</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>65</td>
</tr>
<tr>
<td>Uganda</td>
<td>75</td>
</tr>
<tr>
<td>Rwanda</td>
<td>92</td>
</tr>
</tbody>
</table>
## Contents

5 **Conclusions: What Has the MAP Achieved So Far?**
- Achieving the MAP Phase 1 Primary Objectives 115
- Addressing Country Needs 116
- Study Limitations and a Recommendation 117

6 **Measuring and Reporting on Future Bank-Financed HIV/AIDS Programs**
- Results Scorecard and Generic Results Framework to Measure HIV/AIDS Assistance by the Bank 120

**APPENDIXES**

A Summary of MAP Evaluations and Assessments 125
B Ghana MAP Project Summary of Results 127
C Task Team Leader Interview Guide 131
D Country Feedback Form 133
E All Approved MAP Projects in Africa 142
F Introduction to ACTAfrica, GHAP, and GAMET 145
G Results Achieved by MAP Countries in Africa 147
H Generic Results Framework for HIV/AIDS Projects 157

References 163
Index 167
Figures

1. MAP Phase 1 Funding Commitments and Disbursements, by Sector ($ millions), as of September 2006 3
2. Distribution of MAP Funding, by Activity ($ millions) 4
1.1 Prevalence and Number of People Living with HIV in Sub-Saharan Africa, 1985–2005 12
1.2 Cumulative HIV Commitments by the World Bank, FY 1989–2005 14
2.1 Percentage of 35 MAP and IDF Countries in Sub-Saharan Africa That Submitted an UNGASS Report with Values for the Common UNGASS Indicators 29
3.1 MAP Funding Committed by the World Bank for MAPs in Africa, FY 2001–06 32
3.2 Extent to Which MAP Countries Have Achieved the Three Ones 40
3.3 Increase in Government Allocations for HIV/AIDS (n = 29) 42
3.4 Total Government and Development Partner Funding to MAP Countries (excluding MAP funding) since 2001 43
3.5 Increase in the Percentage of Pregnant Women Receiving PMTCT 48
3.6 Progress in Implementing Prevention Activities in the Education Sector, 2002–06 49
3.7 Young Women with Comprehensive Knowledge about HIV, 2003 and 2005 50
3.8 Percentage of Young Men Who Reported Using a Condom in Last Sex with a Nonregular Partner 52
3.9 Percentage of Young Women Who Reported Using a Condom in Last Sex with a Nonregular Partner 53
3.10 Increase in VCT Visits over Time, Various Years 2001–06 54
3.11 Increased Percentage of HIV-Positive Persons Receiving ART in MAP-Funded Countries 55
4.1 Cumulative Number of People on ART at MAP Sites 108
4.2 Number of HIV Tests Performed 110

Tables

1. Outputs to Which the MAP Contributed as of September 2006 5
2. Outcome-Level Results to Which the MAP Contributed 7
1.1 Funding to MAP Countries in Africa from the World Bank, PEPFAR, and GFATM, 2001–06 18
2.1 Data Used to Document MAP Results 26
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2 Description and Limitations of Data Sources Used for the Study</td>
<td>26</td>
</tr>
<tr>
<td>3.1 MAP Funding Committed by the World Bank for the MAPs in Africa, FY 2001–06</td>
<td>32</td>
</tr>
<tr>
<td>3.2 Estimated Commitments and Disbursements to MAP Fund Recipients in Africa</td>
<td>34</td>
</tr>
<tr>
<td>3.3 Estimated Commitments to MAP Funding Recipients, by HIV Service Delivery Area</td>
<td>35</td>
</tr>
<tr>
<td>3.4 Estimated Disbursements to MAP Funding Recipients in Africa, by Service Delivery Area</td>
<td>36</td>
</tr>
<tr>
<td>3.5 MAP Input-Level and Output-Level Results in Countries in Africa with MAPs</td>
<td>37</td>
</tr>
<tr>
<td>3.6 Progress in Operationalizing National HIV M&amp;E Systems</td>
<td>59</td>
</tr>
<tr>
<td>6.1 Africa Region HIV/AIDS Scorecard</td>
<td>121</td>
</tr>
<tr>
<td>E.1 All Approved MAP Projects in Africa</td>
<td>142</td>
</tr>
<tr>
<td>G.1 Results Achieved by MAP Countries in Africa (from DHS, ISR, and UNGASS data)</td>
<td>148</td>
</tr>
</tbody>
</table>

**Boxes**

<table>
<thead>
<tr>
<th>Box</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Non-MAP Funding from the Bank for HIV/AIDS in Africa</td>
<td>17</td>
</tr>
<tr>
<td>1.2 The “Three Ones”</td>
<td>19</td>
</tr>
<tr>
<td>2.1 Joint Commitment to Manage for Development Results</td>
<td>22</td>
</tr>
<tr>
<td>2.2 Definition of HIV/AIDS Service Delivery</td>
<td>23</td>
</tr>
<tr>
<td>2.3 Challenges of Using HIV Prevalence as a Measure of Change</td>
<td>24</td>
</tr>
</tbody>
</table>
In 1999, the World Bank developed a new strategy for *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis*. Our aim was to provide urgent support to enable countries in Africa to scale up their programs against the devastating epidemic. The strategy called for a new, flexible way to provide resources quickly, both to governments and civil society, within sound strategic frameworks. So the Multi-Country HIV/AIDS Program—the MAP—became the first program to offer African countries substantial, long-term funding to support HIV programs of national scale and coverage. The response was overwhelming, and in short order the MAP was supporting nearly every low-income country in Africa.

Today, as the Bank prepares its updated Africa *AIDS Agenda for Action*, we are struck by how far we have come from the bleak situation of 2000. Before then, global funding for HIV/AIDS was paltry, political inaction was common, and denial ran deep. The MAP was designed to remedy these failings by focusing on high-level leadership, supporting strong engagement of civil society, and providing unprecedented amounts of money and technical backing. By offering united (but not uniform) support for African countries, the MAP underscored that HIV was a shared threat confronting the continent, and made it easier for leaders to break the silence. It enabled countries to begin implementing truly national programs while strengthening institutions and accountability. This had an immediate impact in program coverage and paved the way for rapid expansion as other funding became available in later years.
This book documents and celebrates the results that countries have been able to achieve on the foundation of MAP support. It is now clear that there is no single ideal AIDS program. Each country must work out its own solution, building on strong local evidence and learning from successes and mistakes alike. It has not always been smooth sailing, and still there are ups and downs, but through continuous learning and improvement the MAP is supporting national prevention, treatment, care, and mitigation services that reach millions of infected and affected people across Africa.

Combating HIV takes much more than delivering condoms and treatment effectively. It also takes changes in norms, beliefs, perceptions, and social and individual behaviors. These changes are happening, thanks to the engagement of thousands of courageous people and civil society groups. Empowered through MAP and other support, their efforts and energy in every country are boosting social immune systems, helping to reverse the advance of HIV and stop the damage done by AIDS.

To multiply the results described in this book, support for effective AIDS programs must be unrelenting. National responses—grounded in careful analysis of the local epidemic and the factors driving it, oriented toward results, efficiently implemented by an appropriate range of stakeholders, monitored and managed well and effectively coordinated—are the only sustainable way to prevail over HIV/AIDS. We hope the stories in this book will put a human face on the heroic efforts of Africans to turn the tide—efforts the World Bank is privileged to support.

Debrework Zewdie  
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Latin America and the Caribbean Region  
World Bank  
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Elizabeth Lule  
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ACTAfrica
Acknowledgments

The Global AIDS Monitoring and Evaluation Team (GAMET), ACTAfrica, and the Global HIV/AIDS Program sincerely thank the governments and project teams of the Abidjan-Lagos Corridor Project, Angola, Benin, Burkina Faso, Burundi, Cameroon, Cape Verde, Chad, Republic of Congo (Brazzaville), Democratic Republic of Congo, Eritrea, Ethiopia, The Gambia, Ghana, the Great Lakes Initiative on AIDS, Guinea, Guinea-Bissau, Kenya, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, the Treatment Acceleration Project, Uganda, and Zambia for providing detailed country-level data, and we congratulate them for the results summarized in this book. We are grateful to all the people who shared stories about how the MAP has changed their lives and who gave us permission to publish their stories and photographs.

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### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTAfrica</td>
<td>AIDS Campaign Team for Africa</td>
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<tr>
<td>AQ</td>
<td>ACTAfrica (annual) Questionnaire</td>
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<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral (drugs)</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior change communication</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioral Surveillance Survey</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based organization</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention (United States)</td>
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<tr>
<td>CFF</td>
<td>Country Feedback Form</td>
</tr>
<tr>
<td>CHAI</td>
<td>Community HIV/AIDS Initiative</td>
</tr>
<tr>
<td>CSO</td>
<td>Civil society organization</td>
</tr>
<tr>
<td>DAC</td>
<td>District AIDS Committee</td>
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<tr>
<td>DFID</td>
<td>U.K. Department for International Development</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
</tr>
<tr>
<td>ESW</td>
<td>Economic and sector work</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-based organization</td>
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<tr>
<td>GAMET</td>
<td>Global AIDS Monitoring and Evaluation Team</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>IDA</td>
<td>International Development Association</td>
</tr>
<tr>
<td>IDF</td>
<td>Institutional Development Fund</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, education, and communication</td>
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</tbody>
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Abbreviations

IEG Independent Evaluation Group  
(formerly the Operations Evaluation Department)
ISR Implementation Status and Results report
M&E Monitoring and evaluation
MAP Multi-Country HIV/AIDS Program
MARP Most-at-risk population
MoH Ministry of Health
NAC National AIDS Commission (or Council)
NGO Nongovernmental organization
NSP National Strategic Plan
OED Operations Evaluation Department  
(now the Independent Evaluation Group)
OI Opportunistic infection
OVC Orphans and vulnerable children
PAD Project appraisal document
PDO Program development objective
PEPFAR President’s Emergency Plan for AIDS Relief  
(United States)
PLWH People living with HIV
PMTCT Prevention of mother-to-child transmission
SDR Special drawing rights
STI Sexually transmitted infection
TAP Treatment Acceleration Project
TB Tuberculosis
TTL Task team leader
UN United Nations
UNAIDS Joint United Nations Programme on AIDS
UNDP United Nations Development Programme
UNGASS United Nations General Assembly Special Session on HIV/AIDS
VCT Voluntary counseling and testing
WHO World Health Organization
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 co-
ordination 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**

- **Health sector**: $223 committed, $137 disbursed (17%)
- **Public sector**: $172 committed, $104 disbursed (13%)
- **Institutional strengthening**: $423 committed, $258 disbursed (32%)
- **Local response**: $502 committed, $306 disbursed (38%)

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

<table>
<thead>
<tr>
<th>Areas</th>
<th>Output</th>
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<tbody>
<tr>
<td><strong>Systems Strengthening</strong></td>
<td></td>
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<tr>
<td>Percentage increase in development partner funding</td>
<td>2,240%</td>
</tr>
<tr>
<td>MAP management integrated into National AIDS Commission (NAC) functions</td>
<td>59%</td>
</tr>
<tr>
<td>Number of persons trained with MAP funds</td>
<td>562,366 (23 countries)</td>
</tr>
<tr>
<td>Number of decentralized government structures that have implemented HIV work plans</td>
<td>10,938 (25 countries)</td>
</tr>
<tr>
<td>Employees reached with workplace HIV programs</td>
<td>2,258,844 (23 countries)</td>
</tr>
<tr>
<td>Number of organizations provided with technical support</td>
<td>41,107 (25 countries)</td>
</tr>
<tr>
<td>NACs that coordinate both the MAP and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) programs</td>
<td>38%</td>
</tr>
<tr>
<td><strong>HIV Prevention</strong></td>
<td></td>
</tr>
<tr>
<td>Number of women enrolled in PMTCT (prevention of mother-to-child transmission) programs since start of MAP</td>
<td>1,546,388 (23 countries)</td>
</tr>
<tr>
<td>Number of voluntary counseling and testing (VCT) sites in all MAP countries</td>
<td>8,812 (23 countries)</td>
</tr>
<tr>
<td>Number of new VCT sites that MAP helped to establish</td>
<td>1,512 (17 countries)</td>
</tr>
<tr>
<td>Number of persons who have received HIV test results</td>
<td>6,999,528 (25 countries)</td>
</tr>
<tr>
<td>Number of male condoms distributed</td>
<td>1,294,369,023 (25 countries)</td>
</tr>
<tr>
<td>Number of female condoms distributed</td>
<td>4,041,973 (15 countries)</td>
</tr>
<tr>
<td>Number of persons reached with IEC/BCC (information, education, and communication/behavior change communication) programs</td>
<td>173,333,043 (21 countries)</td>
</tr>
<tr>
<td>Number of IEC/BCC events</td>
<td>726,876 (20 countries)</td>
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(continued)

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

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<tr>
<th>Areas</th>
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<tr>
<td>HIV Care and Treatment</td>
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<tr>
<td>Number of sites providing antiretroviral therapy (ART)</td>
<td>3,012 (26 countries)</td>
</tr>
<tr>
<td>Total number of people on ART</td>
<td>554,648 in total (27 countries) (26,699 with MAP funding*)</td>
</tr>
<tr>
<td>Number of people living with HIV (PLWH) treated for opportunistic infections</td>
<td>287,805 (20 countries)</td>
</tr>
<tr>
<td>Impact Mitigation</td>
<td></td>
</tr>
<tr>
<td>Number of infected/affected persons receiving support</td>
<td>502,958 (21 countries)</td>
</tr>
<tr>
<td>Number of vulnerable children receiving support</td>
<td>1,779,872 (22 countries)</td>
</tr>
<tr>
<td>Number of income-generating activities supported</td>
<td>32,854 (18 countries)</td>
</tr>
<tr>
<td>Monitoring and Evaluation (M&amp;E)</td>
<td></td>
</tr>
<tr>
<td>Average number of surveys/surveillance per country before MAP</td>
<td>2</td>
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<tr>
<td>Current average number of surveys/surveillance</td>
<td>4</td>
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</table>


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.
Table 2 Outcome-Level Results to Which the MAP Contributed

<table>
<thead>
<tr>
<th>Systems Strengthening</th>
</tr>
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<tbody>
<tr>
<td>The MAP has:</td>
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<tr>
<td>- Contributed to increased political commitment at the highest government level.</td>
</tr>
<tr>
<td>- Given countries a head start in achieving the Three Ones (one action framework, one coordinating authority, one monitoring and evaluation system).</td>
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<tr>
<td>- Contributed to institution building and strengthening of the NACs.</td>
</tr>
<tr>
<td>- Helped mobilize additional government resources for HIV.</td>
</tr>
<tr>
<td>- Been a catalyst for increased international funding.</td>
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<tr>
<td>- Sparked a quantum increase in the scale of country action on HIV.</td>
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<tr>
<td>- Contributed to improved legislation related to HIV.</td>
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<tr>
<td>- Succeeded in promoting and facilitating a multisectoral response.</td>
</tr>
<tr>
<td>- Supported the decentralization of the HIV response.</td>
</tr>
<tr>
<td>- Supported improved coordination of the HIV response by NACs, and at decentralized levels.</td>
</tr>
<tr>
<td>- Supported international partnerships on HIV at country level.</td>
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<td>- Built capacity to plan, coordinate, monitor, evaluate, and implement HIV services.</td>
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<tr>
<th>HIV Prevention</th>
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<tr>
<td>The MAP has:</td>
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<tr>
<td>- Increased the number of women that have accessed PMTCT services.</td>
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<tr>
<td>- Supported HIV education in schools and HIV testing among education sector staff.</td>
</tr>
<tr>
<td>- Contributed to increased knowledge about how HIV can be transmitted.</td>
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<tr>
<td>- Contributed to reductions in higher-risk sex in some countries.</td>
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<tr>
<td>- Focused on the most vulnerable and at-risk populations to some extent.</td>
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<tr>
<td>- Contributed to an increase in condom use.</td>
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<tr>
<td>- Ensured that more people know their HIV status.</td>
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<td>- Helped prevent transmission of HIV in health care settings.</td>
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<tr>
<th>HIV Care and Treatment</th>
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</thead>
<tbody>
<tr>
<td>MAP funding has set up facilities that provide antiretroviral drugs and expanded access to ARV therapy.</td>
</tr>
<tr>
<td>The MAP has strengthened infrastructure for delivering health services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The MAP has:</td>
</tr>
<tr>
<td>- Supported and promoted school attendance for orphans and vulnerable children.</td>
</tr>
<tr>
<td>- Increased access to good-quality psychosocial care for affected households and children.</td>
</tr>
<tr>
<td>- Contributed to sustainable community-level care.</td>
</tr>
</tbody>
</table>

(continued)
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.

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

<table>
<thead>
<tr>
<th>Monitoring and Evaluation (M&amp;E)</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a result of the MAP:</td>
</tr>
<tr>
<td>- Most countries have an M&amp;E unit with an approved budget.</td>
</tr>
<tr>
<td>- Most countries also have an M&amp;E Task Team that meets at least quarterly.</td>
</tr>
<tr>
<td>- Most countries have developed M&amp;E training materials (although they are not always harmonized).</td>
</tr>
<tr>
<td>- Most countries have an approved M&amp;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&amp;E strategy is not well coordinated or well implemented.</td>
</tr>
<tr>
<td>- Many countries have a detailed M&amp;E work plan, although only some are costed.</td>
</tr>
<tr>
<td>- Most countries have begun to build an HIV/AIDS database, but MoH data collection is still weak.</td>
</tr>
<tr>
<td>- Strategic information is flowing better than before; there are guidelines for data collection for nonmedical HIV services, and surveys and surveillance have increased.</td>
</tr>
<tr>
<td>- There is some evidence of data use.</td>
</tr>
</tbody>
</table>

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.
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)
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

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

![Graph showing prevalence and number of people living with HIV in Sub-Saharan Africa, 1985–2005.](Source: UNAIDS 2006a.)
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.

The Multi-Country AIDS program

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
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.
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 antiretroviral 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

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**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


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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

<table>
<thead>
<tr>
<th>Funding sources</th>
<th>Funding to MAP countries (US$ billion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank (2001–06)</td>
<td>1.286</td>
</tr>
<tr>
<td>PEPFAR (2003–06)</td>
<td>1.820</td>
</tr>
<tr>
<td>GFATM (2002–06)</td>
<td>1.222</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4.362</strong></td>
</tr>
</tbody>
</table>

*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.
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.

<table>
<thead>
<tr>
<th>Box 1.2 The “Three Ones”</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>One</strong> agreed-upon AIDS action framework that provides the basis for coordinating the work of all partners.</td>
</tr>
<tr>
<td>2. <strong>One</strong> national AIDS coordinating authority, with a broad-based, multi-sectoral mandate (typically referred to as the National AIDS Commission or NAC).</td>
</tr>
<tr>
<td>3. <strong>One</strong> agreed-upon country-level HIV/AIDS monitoring and evaluation system.</td>
</tr>
</tbody>
</table>
Study Purpose and Methodology

Purpose

This study documents the results to date to which the World Bank’s MAP financing in Africa has contributed. It also proposes a new Results Scorecard and Generic Results Framework for future measuring and reporting on results of Bank-financed HIV/AIDS programs in Africa. The study’s intended audiences are World Bank management and task teams, client countries, and others interested in World Bank support for HIV responses in Africa. Three points are important. First, the MAP results in this report are a snapshot of progress; many MAP projects are ongoing, and final results will be described in the projects’ Implementation Completion Reports.¹ Second, the results presented are for the Africa region only (even though the World Bank supports HIV responses in other regions). And third, this study does not evaluate the MAP or identify areas that need improvement (which other studies have done, and which requires careful fieldwork). Nor does it assess the MAP’s impact; rather, it reviews whether the MAP was implemented as designed and reports on inputs and outputs, and outcomes to which the MAP has contributed.

Six factors provided the impetus for this study:

1. ACTAfrica and the Global HIV/AIDS Program’s desire to document MAP results.

¹ An example summary of results of a completed MAP project (in Ghana) is presented in appendix B.
2. ACTAfrica and the Global HIV/AIDS Program’s desire to develop new strategies for HIV/AIDS funding in light of MAP experiences and lessons learned so far—consistent with the MAP’s “learning by doing” approach.

3. The Africa Region’s work to develop an Agenda for Action against HIV and AIDS in Africa for 2007–11.

4. The World Bank’s Global HIV/AIDS Program of Action, which calls for support to regions and knowledge sharing.

5. The Bank’s commitment to sharing information about its HIV/AIDS programs, which fulfills one of the recommendations of the Global Task Team, to implement information-sharing practices globally by December 2005.

6. The Bank’s commitment to managing for development results (see box 2.1).

With regard to the first impetus, three MAP-wide evaluations have been initiated by the Bank: the Implementation Assessment Review in April 2001, the MAP Interim Review in October 2004, and OED’s evaluation of the Bank’s HIV/AIDS assistance in May 2005 (see appendix A).2 All made useful recommendations on supervision, design, focus, and mitigation of risk and noted the early achievements of the MAP in general terms. However, none of them quantified the results to date of the MAP in a systematic, country-by-country manner. (The first MAP projects are only now reaching completion.)

This study builds on the “Where Is the Bank’s Money Going?” analysis that ACTAfrica undertook in 2006 (ACTAfrica 2006b) and aims to analyze further not only which institutions were funded, but also which activities were funded and how the MAP-funded activities have contributed to results to date in each country.

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2 These three evaluations or assessments were undertaken in addition to country-level MAP supervision processes that are part of the World Bank’s regular oversight functions.
Study Design and Methodology

Study principles and scope

The study follows the internationally recognized “results chain” for HIV monitoring and evaluation (Rugg, Peersman, and Carael 2004), which assumes that improved input-level results (for example, training and resources) are necessary to achieve output-level results (HIV/AIDS service delivery; see box 2.2). Output-level results, if well implemented, lead to outcome-level results—increased knowledge about HIV/AIDS, less stigma and discrimination, and reduced high-risk behavior. Outcome-level results ultimately lead to impact-level results—fewer new HIV infections, which may reduce HIV prevalence, and improved quality of life for those infected and affected by HIV.

Given this concept of a results chain, the study assesses input-level and output-level results, and outcome-level results to which the MAP contributed. Data are not available to quantify MAP contributions to outcomes. The study does NOT assess impact-level results for three reasons:

- The MAP objectives for the first phase were defined at the input and output levels and not as impact-level results (that is, to reduce HIV prevalence or incidence).

3 Although many individual MAP projects set prevalence targets that now seem inappropriate in the light of new data and better access to lifesaving treatment.
Changes in HIV prevalence or incidence cannot be attributed to a single development partner’s efforts; they reflect the totality of national and international HIV responses.

There are a number of valid concerns about using HIV prevalence as a measure (Box 2.3) and prohibitive difficulties and costs of estimating the numbers of new infections.

Also following internationally accepted principles, the study team used data generated by MAP projects to assess input-level results and output-level results (but did not independently verify the data), and presents independent data—from nationally representative surveys or independent evaluations at country level—on outcome-level results to which the MAP has contributed.

Given the MAP focus on learning by doing and the Global AIDS M&E Team’s intensive support to countries to operationalize their national HIV M&E systems, this study could use data about MAP results recorded at country level (that is, use existing or secondary data). The study team used data sets that provided two data points in as many MAP countries as possible.

Although some data on MAP results are recorded in World Bank Implementation Status and Results reports (ISRs), the study team knew from working with countries that additional data on MAP results were available. Therefore additional primary data were collected and analyzed from MAP countries.

The study considered country-specific and regional MAP projects and the HIV-focused Institutional Development Fund (IDF) countries (Lesotho, Namibia, and Swaziland).

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**Box 2.3 Challenges of Using HIV Prevalence as a Measure of Change**

HIV prevalence is a measure of the total number of infections in a given population at a given point in time (expressed as a percentage of the population). HIV prevalence is not a good measure of change for the following reasons: (1) The total number of infections includes people recently infected, and people infected in previous years who are still alive. Increasing use of ARVs, which increase longevity, may cause HIV prevalence to increase over time even if the number of new infections is falling. (2) There are different techniques for estimating prevalence, and the results from different types of studies may not be comparable. The results of population-based HIV testing cannot, for example, be compared with the results of antenatal clinic surveillance.
**Research questions**

- Research question 1 asked: What has the MAP done?
  
  a. How much MAP funding has been committed and disbursed? (input-level results)
  b. Which groups received MAP funding? (input-level results)
  c. To which output-level results has the MAP contributed?
  d. To which outcome-level results has the MAP contributed?
  e. Is the MAP achieving its objectives?

- Research question 2 asked: How should the MAP measure and report results in the future?

**Methodology**

Based on the principles for the study outlined above, the methodology was as follows:

First, a desk review was conducted of all key documents, including MAP Project Appraisal Documents; the OED (now IEG) evaluation of the MAP, management’s response, and the CODE recommendations; the interim review of the MAP; the “Where Is the Bank’s Money Going?” study and analysis files; the Development Committee paper on AIDS; the Implementation Assessment Review of the MAP in 2001; the Africa Region’s *AIDS Agenda for Action* concept note; MAP background and status from ACTAfrica; and indicator sets from PEPFAR and GFATM.

Second, secondary data were collected and analyzed to measure input-level results, output-level results, and changes in country outcomes, using the data sets shown in table 2.1.

Third, tools for collecting primary data on input-level and output-level results were designed and tested. Tools included an interview guide for TTL interviews and a Country Feedback Form for collecting raw service-coverage data from MAP countries (appendixes C and D).

Fourth, seven TTLs were (purposively) selected and interviewed, and data were analyzed from the Country Feedback Forms (data were captured in an MS Access screen capture form).

**Data source descriptions and limitations**

Table 2.2 describes the secondary and primary data sources that were used and their limitations.
Table 2.2 Description and Limitations of Data Sources Used for the Study

<table>
<thead>
<tr>
<th>Secondary data source description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implementation Status and Results reports (ISRs).</strong> The ISRs capture administrative data, observations and remarks, key issues and actions for management attention, indicator values, and rankings (n = 39).</td>
<td>Indicators differ across ISRs, making comparative analysis impossible. Only 16% of ISR indicators have at least two values (despite the fact that 30 of the 39 MAPs started in 2003 or earlier and should have had a midterm review, and thus baseline and midterm indicator values). Seven ISRs were awaiting imminent DHS results.</td>
</tr>
<tr>
<td><strong>Behavioral surveillance data.</strong> Demographic and Health Survey (DHS) data, Behavioral Surveillance data, and other behavioral data were downloaded from the ORC Macro Web site for all MAP- and HIV-focused IDF countries (<a href="http://www.measuredhs.com">http://www.measuredhs.com</a>) (n = 15). Data from the period 1998–2000 were used as a first data point, data from 2002–06 as a second data point.</td>
<td>15 of the 30 MAP countries in Africa (50%) had two data points.</td>
</tr>
</tbody>
</table>
Table 2.2 Description and Limitations of Data Sources Used for the Study *(continued)*

<table>
<thead>
<tr>
<th>Secondary data source description</th>
<th>Limitations</th>
</tr>
</thead>
</table>
| **Annual ACTAfrica questionnaire.** ACTAfrica sends out a MAP Questionnaire to all National AIDS Commissions and World Bank team leaders every year in January/February to collect input and output data for the previous year (n [2005] = 26). | - The questionnaire has small changes from year to year, so trend analysis is not always possible.  
- Not all countries submitted data every year (79% submitted data for 2005).                                    |
| **UNGASS reports for 2003 and 2005.** UNGASS reports are part of the Declaration of Commitment to HIV/AIDS, signed in 2001. The first round of UNGASS reports, focusing on 13 UNGASS indicators, was submitted in 2003; the 2nd round of UNGASS reports was submitted in 2005 (n = 35). | - 31 MAP/IDF countries (86%) submitted UNGASS reports in 2003 and 2005, but not all reports contained indicator values for all 13 original UNGASS indicators (see figure 2.1). |
| **UNAIDS Three Ones data.** UNAIDS conducted a one-off survey about the status of the Three Ones in 83 countries around the world in 2005 (n = 25). | - It was a one-off survey in 2005; no data are available for other years.  
- Comprehensive data are only available for 25 of the MAP/IDF countries.  
- It is a self-administered questionnaire, which can cause bias and inaccuracy. For example, 9 of the 25 countries reported a different value of MAP funding than Bank records. |
| **TTL Questionnaire analysis and Country Director Questionnaire analysis as part of the 2005 OED evaluation.** OED’s evaluation of the Bank’s HIV/AIDS assistance included questionnaires completed by MAP TTLs and country directors in June 2004. | - Only 19 MAPs were active when the questionnaires were administered |

*(continued)*
Table 2.2 Description and Limitations of Data Sources Used for the Study (continued)

<table>
<thead>
<tr>
<th>Primary data source description</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTL interviews. TTLs were purposefully selected and interviews took place with six TTLs: Giuseppe Zampaglione (Sierra Leone MAP); John Elder (Nigeria MAP); Nicolas Ahouissoussi (Benin MAP); Jean Delion (Cameroon and Central African Republic MAPs, interview incomplete); Maryanne Sharp (Chad MAP); Albertus Voetberg (Treatment Acceleration Program). The interview guide is in appendix C of this report.</td>
<td>■ Only 6 of the 7 TTLs selected for interviews were available.</td>
</tr>
<tr>
<td>Country Feedback Forms Country Feedback Forms were designed and used by the study team (see appendix D).</td>
<td>■ 93% (29 out of 31) of active regional and country MAPs submitted data. (The Central African Republic MAP was not effective, and the form was not relevant to the TAP). ■ It is a self-administered questionnaire; output-level results were not audited or verified; not all countries disaggregated data by category of MAP fund recipient. ■ Some countries did not complete all sections of the form. Angola did not complete sections A, B, and C; Nigeria did not complete section C; Chad did not complete section D; Cameroon and Cape Verde did not complete section E</td>
</tr>
</tbody>
</table>

Figure 2.1 shows that most of the UNGASS indicators (y-axis) had either one indicator value only, or no indicator value for 2003 or 2005. The figure also points to the areas where the most support is required to improve results monitoring.
Figure 2.1 Percentage of 35 MAP and IDF Countries in Sub-Saharan Africa That Submitted an UNGASS Report with Values for the Common UNGASS Indicators

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GE 14 (Ratio of orphan school attendance)</td>
<td>7%</td>
<td>23%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>GE 13 (Condom use during higher risk sex)</td>
<td>5%</td>
<td>22%</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>GE 12 (Higher risk sex)</td>
<td>19%</td>
<td>12%</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>GE 10 (Knowledge of HIV transmission)</td>
<td>14%</td>
<td>16%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>GE 9 (% of units screened for HIV)</td>
<td>3%</td>
<td>20%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>GE 7 (% of persons on ARVs)</td>
<td>8%</td>
<td>14%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>GE 6 (% pregnant women receiving ARVs for PMTCT)</td>
<td>8%</td>
<td>21%</td>
<td>6%</td>
<td></td>
</tr>
<tr>
<td>GE 5 (% patients appropriately diagnosed and treated)</td>
<td>26%</td>
<td>8%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>GE 4 (Workplaces with HIV programs)</td>
<td>16%</td>
<td>14%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>GE 3 (Life skills HIV education)</td>
<td>23%</td>
<td>7%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>GE 1 (Funds spent by govts)</td>
<td>7%</td>
<td>11%</td>
<td>17%</td>
<td></td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th></th>
<th>FY01</th>
<th>FY02</th>
<th>FY03</th>
<th>FY04</th>
<th>FY05</th>
<th>FY06</th>
<th>Total FY01–06</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of approved</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>projects</td>
<td>7</td>
<td>10</td>
<td>5</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>39</td>
</tr>
<tr>
<td><strong>New commitments</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(US$ millions)c</td>
<td>287</td>
<td>221</td>
<td>239</td>
<td>356</td>
<td>80</td>
<td>103</td>
<td>1,286</td>
</tr>
<tr>
<td><strong>Current value of active commitments (US$ millions)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1,320</td>
</tr>
</tbody>
</table>

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

Source: ACTAfrica 2006b, Business Warehouse.

Note: Commitments are dollar values at the time of commitment; disbursements are current dollar values.
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 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).

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

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


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

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

<table>
<thead>
<tr>
<th>Type of recipient</th>
<th>HIV service delivery area (US$ millions and percentage of total)</th>
<th>Total estimated disbursement (US$ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prevention</td>
<td>Care and treatment</td>
</tr>
<tr>
<td>Civil society organizations</td>
<td>171 (56%)</td>
<td>46 (15%)</td>
</tr>
<tr>
<td>Line ministries other than Health</td>
<td>29 (28%)</td>
<td>49 (47%)</td>
</tr>
<tr>
<td>Ministries of Health</td>
<td>87 (62%)</td>
<td>25 (19%)</td>
</tr>
<tr>
<td>All other organizations, including NACs, decentralized structures, training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>institutions, consultants for institution building, M&amp;E, coordination, capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>development</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>287 (35%)</td>
<td>120 (15%)</td>
</tr>
</tbody>
</table>

Sources: ACTAfrica 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

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

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

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

**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**

<table>
<thead>
<tr>
<th>Category</th>
<th>Count (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data not available</td>
<td>5 (17%)</td>
</tr>
<tr>
<td>None of the Three Ones in place</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>One of the Three Ones in place</td>
<td>2 (1%)</td>
</tr>
<tr>
<td>Two of the Three Ones in place</td>
<td>6 (19%)</td>
</tr>
<tr>
<td>All Three Ones in place</td>
<td>17 (57%)</td>
</tr>
</tbody>
</table>

*(n = 30)*

*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-
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
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
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.
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
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-
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 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

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

![Bar chart showing percentage of young men using condoms in various countries between 2003 and 2005.](chart)

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.
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-
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

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

![Bar chart showing the increased percentage of HIV-positive persons receiving ART in MAP-funded countries.](chart.png)

*Source: UNGASS country reports, 2003 and 2005.*
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
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

<table>
<thead>
<tr>
<th>Component of a national HIV M&amp;E system</th>
<th>Status before the Map</th>
<th>Status in September 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV M&amp;E Unit</td>
<td>In most countries, there was no M&amp;E unit and no personnel.</td>
<td>There is an M&amp;E unit with an approved budget in most countries.</td>
</tr>
<tr>
<td>2. Monitoring and evaluation task team or working group</td>
<td>Most countries did not have an M&amp;E Technical Working Group.</td>
<td>In most countries, an M&amp;E Task Team or Technical Working Group exists and meets at least quarterly.</td>
</tr>
<tr>
<td>3. HIV M&amp;E strategy or framework that describes all 11 M&amp;E system components, including a set of indicators</td>
<td>Most countries did not have an M&amp;E strategy or framework.</td>
<td>Most countries have developed and approved an M&amp;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.</td>
</tr>
<tr>
<td>4. Costed HIV M&amp;E action plan</td>
<td>Most countries did not have a costed and integrated M&amp;E action plan.</td>
<td>Many countries have an action plan, although few have costed their plans.</td>
</tr>
<tr>
<td>5. National HIV database</td>
<td>Most countries did not have an HIV database.</td>
<td>Most countries are in the process of developing an HIV database.</td>
</tr>
</tbody>
</table>

#### 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)
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

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

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

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

How the MAP Has Changed People’s Lives

The previous chapter noted that 38 percent of MAP funds are being channeled to communities and civil society organizations, faith-based groups, and other nongovernmental organizations. Over 50,000 small grants have supported a wide range of interventions and activities to empower and mobilize communities to prevent HIV infections and cope with the impact of AIDS, help people infected and affected by HIV, and fight stigma and discrimination. This chapter goes beyond the numbers to meet a few of the many people whose lives were changed by HIV, and then by the support the MAP provided. These personal stories from Ethiopia, Uganda, and Rwanda are just a tiny sample of the results of thousands of grants funded by the MAP across Africa, giving a glimpse of the faces of a few of the people who have benefited or helped achieve the results documented in this report.

Encouraging community engagement and initiatives is a central part of the MAP design. Communities and their institutions must somehow cope with the illness, deaths, and dependency that AIDS causes and are critical to creating enabling environments that can foster the behavior changes needed to confront AIDS. Most determinants of sexual behavior are deeply rooted in cultural norms, social environments (including the constraints that poverty brings), beliefs, roles, and practices that are established, maintained, enforced, and changed at the local level; they cannot be influenced by government alone. The most influential theories of behavior change recognize the centrality of community influence. For example, social diffusion theory notes that individuals are more likely to be positively
influenced by the testimonies and examples of close, trusted neighbors and friends than by external experts. Leading social scientists working on HIV emphasize that it is vital to work with and through communities in order to change behaviors.

*The likelihood that people will engage in health-promoting behaviors is influenced by . . . the extent to which they live in a supportive social environment.*

—Campbell 2000, 481

*Individuals cannot change their behavior in a vacuum, but are heavily influenced by their social networks and group norms. Their very perceptions of risk are ordered and nurtured by the peer group and social context within which they operate. [B]ehaviors have to be supported and reinforced by the value system of the society within which [people] function.*

—Ray et al. 1998, 1439

Many of the mechanisms by which social norms evolve are unforeseeable, organic, and even ineffable. This is why the MAP adopted a demand-driven model for civil society and community support. Stigma and silence, in particular, can be overcome only where civil society contributes to a deeply participatory process of social empowerment and social diffusion. In this realm of social change, knowing “what’s best” is not a matter of technical expertise but of local knowledge and local involvement. By definition, this can be supported—but not directed—from the outside.

There has been much work to prepare and guide community mobilization and to evaluate and document its impact. The report *Rural Workers’ Contribution to the Fight against AIDS: A Framework for District and Community Action* (Schapink et al. 2001) laid the foundation for the community mobilization process, presenting objectives, costs, and lessons from 10 years of experience in Tanzania and elsewhere. It was reviewed by 400 workshop participants from 30 African countries, facilitated by a global authority on participation. Participants visited communities that had taken actions against AIDS, revised the paper, and used it as a basis for a strategy for community mobilization against AIDS. They then assessed the cost-effectiveness of community action compared to action by NGOs, government, and the private sector.

Various other reports have also assessed the processes, procedures, and impact of community mobilization, as did the MAP Interim Review, many supervision missions, and technical support missions (e.g., Delion, Peters, and Klofkorn Bloome 2004). Simple instruments and indicators are being
used to measure results, and M&E tools have been developed to assess results and systematically insert lessons into operations. For example, report cards are being used in Benin and Cameroon. As a result of these assessments, many communities have made significant changes in their community action plans. This chapter does not present the findings of the various systematic assessments, nor is it a scientifically representative sample. The stories describe some impressive and successful grant results in strengthening community capacity, expanding service delivery, and reducing stigma and discrimination, but hundreds more similar stories could be told.

**Ethiopia**

**The Ethiopia MAP and community grants for HIV interventions**

The Ethiopia Multi-Sector AIDS Project (Ethiopia MAP) was one of the first of 39 projects approved under the MAP. The IDA credit of $59.7 million to the Government of Ethiopia was approved on September 12, 2000, and closed on December 30, 2006. Ethiopia used the project to develop a participatory, decentralized, and community-driven response to HIV/AIDS. This included establishing AIDS Councils and HIV/AIDS Prevention and Control Offices (HAPCOs) at federal, regional, and woreda (district) levels.

Nearly half of the project funds were channeled to approximately 6,000 community and NGO initiatives, through the Emergency AIDS Fund for community-level interventions, focused mainly on awareness, prevention, care, and support. This unique systematic support to civil society organizations working on AIDS and community action in Ethiopia has helped to establish the decentralized local response system that is in place today. The Emergency AIDS Fund financed NGOs and private sector organizations, and community groups and organizations operating at the woreda and kebele levels. The regional and woreda-level HAPCOs and their related multisectoral review boards provide technical support to the kebeles and communities, to help them in their own efforts to respond to the epidemic.

The Ethiopia MAP has funded local activities that have changed attitudes toward people living with HIV, encouraged testing, led to a remarkable growth in associations of people living with HIV; and mobilized groups of women, youth, religious leaders, and iddirs (neighborhood leaders) to discuss the risks and responsibilities of their communities and to take direct action such as caring for orphans and bedridden people with AIDS. The project also financed income-generating activities for people living with HIV and those at risk of infection due to poverty, and treatment for minor
opportunistic infections and food for needy people with HIV, helping many HIV-positive Ethiopians to stay alive to benefit from the ARV treatment that became available in 2004. “Community conversations” about HIV have flourished under the project, empowering people to demand accountability and services from their elected leaders and to see the value of their own initiatives. People living with HIV also report a reduction in the stigma and discrimination they face in society.

A follow-on Ethiopia MAP II project will be used to consolidate the achievements, spread the program into rural areas, strengthen and simplify subproject operating procedures, address nutritional needs of the many very poor people with HIV, and give additional support to the regional bodies that play a key role in the local response.

Providing life-enhancing and life-saving support to people living with HIV—Dawn of Hope, Nazareth Regional Branch

The metalwork and carpentry workshops in the middle of Nazareth, in Ethiopia, looks like any other in the town, though it produces far more than furniture. More importantly, it provides an occupation, an income, and a sense of self-worth to 15 people living with, affected by, or at risk of HIV. These workers—among them a few professional carpenters and metal-workers—are organized by the Nazareth branch of Dawn of Hope, a local NGO that supports people who are infected or affected by HIV. With funds from the Ethiopia MAP, the NGO provides space, equipment, and materials to enable these members to earn a living. The group includes 12 people living with the virus and two affected by it. There is also a young woman of 20 who is learning skills that provide an economic alternative to commercial sex work, enabling her to avoid the risk of HIV.

The products made in the workshop are sold at a showroom up the street, which is one in a long row of commercial spaces that were constructed by Dawn of Hope with funding from the MAP. The organization uses two of the other spaces for income-generating activities. One is a bulk grain shop, and
the other sells a variety of local spices. All three businesses are run by groups of about 10 to 12 Dawn of Hope members, who share the work and the profits. The smiles on their faces reflect their pride in being better able to care for themselves and their families as a result of their work (though many remain very poor).

In addition to the 34 members in these three IGA groups, another 116 people have been helped to start up independent business initiatives. Beyond these individual economic benefits, the organization earns income by renting out the rest of the commercial spaces.

The Nazareth branch of Dawn of Hope has 2,500 members, including 380 orphans, all of whom are HIV-positive. The organization offers free drugs for minor opportunistic infections and coverage of hospital charges. For the orphans, most of whom live with relatives or neighbors, it provides 50 birr (about $6) a month.

The NGO also operates the Recovery Center, where lifesaving care is provided to people on whom the local hospital has given up. The patients are extremely poor, previously having worked mainly as bar servers, petty traders, or casual laborers. While many of them are on ARV treatment, they are not able to regain their health due to serious undernourishment. Since it opened a year ago, the center has cared for 190 patients, many arriving with CD4 counts as low as 5—literally on the verge of death.

And yet, despite statements from referring doctors such as “this patient has only a few hours left to live,” all but 10 of the center’s 190 patients have recovered. This has been due to the care, counseling, and nutritious diet that patients receive at the center. The Recovery Center is staffed by a trained nurse/counselor, a manager, and 15 HIV-positive volunteers, many of whom are recovered patients. One staff member is a young woman who arrived at the Recovery Center several months ago in a precomatose state. Today she is the center’s bread baker.

Dawn of Hope/Nazareth has received some financial and in-kind support from the local Orthodox Church, and in-kind support from the Nazareth Association of Taxi Drivers, but its main financial backing has come from the MAP.
through the project’s regional-level grant window. But the gap in funding between the end of Ethiopia’s MAP in December 2006 and a planned follow-on project some time in 2007 is problematic, as it will leave this NGO (like so many others) unable to pay staff or rent, or continue its support for orphans.

The organization’s work has been enhanced by the contributions of seven professional staff, but it has been constrained by the lack of transport to travel around its catchment area. And so far the income-generating activities initiated by members have not always produced the profits necessary to ensure the group members have access to sufficient nutrition.

Nonetheless, the group’s project coordinator, Meslin Feyisa, notes with deserved pride the positive change in the members’ attitudes:

“While in the beginning they came to beg for five or ten birr (around $1), today they come asking for business start-up funds. All this is due to having been given an opportunity to improve their own lives.”

**Story of Silesi Betelei, Executive Director of Dawn of Hope, Addis Ababa**

In 2000, while finishing a university degree in plant sciences and then working as an agronomist, Silesi Betelei suffered two serious bouts of illness...
and was found to be HIV-positive. Counseling helped him find the courage to speak to his family about his HIV status, and he received their full support. He believes their positive reaction was due to their understanding that anyone can get HIV, even a hard-working, serious-minded professional like Sileshi.

Sileshi returned to work and continued to live normally, until 2001 when his CD4 count dropped to 52 and he became extremely weak. Though Sileshi wanted to start on ARV therapy (ART), he could not afford the drugs then available in the country. He refers to this period of his life as “the disaster time.”

However, in 2002 he saw on television the founders of Dawn of Hope—a local NGO of people living with HIV—and decided to join them and to work on the advocacy campaign for public provision of free ART. During this period he received drugs for opportunistic infections through Dawn of Hope—financed by the Ethiopia Multi-Sector AIDS Project (Ethiopia MAP)—which enabled him to manage his health well enough to keep going, and to marry. His wife is also HIV-positive.

As an activist, Sileshi attended the 15th International AIDS Conference in Bangkok, where he and other Ethiopians living with HIV met with Peter Piot (executive director of UNAIDS) and Richard Feacham (then executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, or GFATM). The group briefed Piot and Feacham on their struggle for survival without free ART and the urgent need to start a treatment program in their country. The two international AIDS leaders took the message to the Ethiopian Prime Minister, and in 2004 Ethiopia’s ART program was launched, with funding from GFATM.

After 18 months on ART, Sileshi’s CD4 count improved to 185 and he felt sufficiently strong and encouraged about his future to start a second university degree in management, and to start a family. Today, Sileshi’s CD4 count is 550, and he is a leader in the Ethiopian AIDS community, representing people living with HIV on the National AIDS Council and the National AIDS Committee Management Board. He is also the proud father of an 18-month-old son. (His son does not have HIV, thanks to treatment to prevent transmission from mother to child.)

While it is access to free antiretroviral drugs that is keeping him and his wife healthy today, Sileshi says clearly that it was the free OI drugs financed
by EMSAP that allowed him and “many, many other Ethiopians” to have lived long enough to finally benefit from ART.

“The MAP made a big difference in people’s lives—without it we couldn’t even talk about ART, since before ART people were dying of OIs. The MAP enabled us to arrive at the era of ART.”

Sileshi also notes that the counseling and home-based care provided through the MAP were essential—“without counseling there is no positive living, there is no hope.”

An AIDS orphan who wants to make a difference with his life—
the story of Zerihun Gashaw

The slow smile and quiet manner of Zerihun Gashaw give little hint of the traumas he has endured as an AIDS orphan, the weight of responsibility he shoulders in raising his younger siblings, and the success that he has achieved so far in his young life.

As members of Dawn of Hope, a local NGO in Ethiopia that supports people infected and affected by HIV, Zerihun’s parents received financial assistance to cover rent, grain, drugs for opportunistic infections, soap, and other basic essentials during the final period of their lives. They were also given funds to cover school fees for their children. Zerihun, the eldest of four, was thus able to continue his education and enter university even as he lost first his father, and then his mother, to AIDS. The assistance provided through Dawn of Hope was funded by the Ethiopia Multi-Sector AIDS Project (MAP).

After their parents’ deaths, the children became members of Dawn of Hope in their own right, as AIDS orphans. Zerihun’s siblings were 9, 7, and 5 at that time, and he, at age 17, became the head of their household. Dawn of Hope continued to provide support to the family, and this was supplemented by income Zerihun earned by tutoring schoolchildren and loading and unloading goods whenever possible. To work, however, he needed to drop out of university.

After a year, with support from Dawn of Hope, another organization, and the Ministry of Education, he was able to restart his studies at Addis Ababa University. His family manages to survive with the continued support of 150 birr ($18) a month from Dawn of Hope, the payment of rent by a friend who believes in Zerihun’s potential to make something of his life, and gifts of food provided by community members during religious ceremonies.

The support from those in the village where the family now lives reflects what Zerihun describes as “a national attitude change about HIV/AIDS”
due to the fact that “people have come to know that the problem is their problem.” Previously, however, the family lived in a village where the children were labeled and suffered social rejection because of their parents’ HIV status.

Once back at university, Zerihun became an AIDS activist. He has shared his experience with fellow students through anti-AIDS clubs and with communities through outreach efforts (both funded by the Ethiopia MAP), and at workshops and conferences. His thesis was titled “The Challenge and Prospects of the Millennium Development Goals, with Particular Emphasis on Combating HIV/AIDS in Ethiopia,” and prior to graduation he published an article in a university review called “The Politics of AIDS in Ethiopia.”

Having just completed his university degree with a double major in political science and international relations, Zerihun is a role model not only for AIDS orphans, but for all youth. Indeed, he says that most young people in his place “end up on the street.” He is invited to youth forums, contributes to local newspapers, and is now working to start an organization of and for AIDS orphans so that their voice can become “louder and louder.”

The combination of this young man’s sense of responsibility for himself and his siblings, his intelligence, and his personal drive—along with the financial backing provided to his family by the Ethiopia MAP and others—has led Zerihun Gashaw to where he is today. In his own words, he is preparing for the next chapter of his life, “standing for the rights of this segment of society.”

A faith-based HIV/AIDS initiative offers services and hope—
the Ethiopian Orthodox Tewahido Church Sunday School Project

Aba (Father) Serekebirhan Woldeasamuel and his dedicated team of young colleagues from the Ethiopian Orthodox Tewahido Church Sunday School HIV/AIDS Prevention and Control Project exemplify the important role played by the many faith-based organizations that have been funded by the Ethiopia Multi-Sectoral AIDS Project.
The church’s project began with the objective of educating their own young members (up to age 30), but soon expanded, and now reaches out to needy people in 12 communities through the church’s branch offices.

The project team believes that through the church’s wide geographical coverage, and the respect and trust accorded to them by their communities, they are well-placed to contribute to the national response to HIV in Ethiopia. Over the past three years, with financial support exclusively from the MAP, the project has provided the following services, all of which are offered irrespective of religion:

- **Training and initial start-up funds for youth (up to age 30) living with HIV.** Beneficiaries receive 1,000 birr ($120) to help them get off the ground, and most have used the money to start microbusiness activities such as petty trading and small-scale wooden furniture making. To date, the project has assisted 240 people with HIV in each of its 12 branches (720 in total), all now supporting themselves. However, due to the low levels of income they are able to earn, some still do not have enough
money to eat as well as they need to, especially if they are on ART.

- **Support for AIDS orphans**, whose growing numbers are overtaxing the ability of communities to respond on their own. The children face a range of problems, from lack of family love and care, to labeling and unkind treatment from the community, to lack of financial resources. The project has responded by providing psychosocial counseling, community sensitization, and school uniforms and instructional materials to make it possible for them to stay in school and off the streets. It has also provided 100 birr ($12) a month for each orphan, to assist the neighbors, friends, and extended family members who care for them. A total of 900 orphans (75 per branch) have been supported.

- **Home-based care for those bedridden with AIDS.** This critical community service is offered directly by volunteers from the church’s Sunday School HIV/AIDS Program, who receive funds for transport. In addition to the personal love and care they bring into the homes of people in need, these volunteers help with bathing, washing clothes, house cleaning, and cooking. During their daily visits they also ensure that drugs are taken correctly and on time.

- **Counseling and spiritual support** for those living with or affected by the virus.

With encouragement from the archbishop, who chairs the project’s board of directors, Aba Serekebirhan believes that the very difficult situation faced by Ethiopian communities is better today than before the MAP, in spite of the ongoing challenges of poverty and stigma and discrimination. Looking to the future, he says, “We have to work harder than before, as we haven’t achieved our goal yet.” But he notes with his characteristic enthusiasm that the Ethiopian Orthodox Tewahido Church’s Sunday School HIV/AIDS Project “plans to do better if we can get continued support.”
Caring for Ethiopia’s AIDS orphans and vulnerable children—
the Abebech Gobana Children’s Care and Development
Organization (AGCCDO)

It was 27 years ago that Abebech Gobana was traveling in the north of her coun-
try when her life was changed by a chance meeting with two little girls in a camp
for famine-affected Ethiopians. Seeing that they were destitute and alone, she
took them back with her to Addis Ababa, and shortly thereafter took in 19
impoverished street children. At that point she left her old life and ever since
has dedicated herself to providing care and support for vulnerable children.

In the beginning Abebech Gobana survived and supported herself and the
children by selling local foods, but she eventually found public and private
financial support that enabled her association to become one of the country’s
major providers of care for orphans and other needy children. Today the orga-
nization named for her—known by its acronym AGCCDO—has 226 staff,
works in two regions of the country, supports nearly 12,000 orphans, and offers
an impressive array of services. Over the past several years a focus on HIV has
been added to the long-standing support for orphans and vulnerable children.

With support from the Ethiopia Multi-Sector AIDS Project (Ethiopia
MAP), the organization has been able to provide the communities they serve
with funds and food to help extended families care for AIDS orphans, offer
voluntary counseling and testing, provide drugs for minor opportunistic infec-
tions, develop nutrition and hygiene materials, support income-generating
activities, provide psychosocial support, and undertake capacity building.

In order to increase awareness and
change behavior, Abebech Gobana,
through the MAP, has provided
HIV prevention information and
worked to reduce stigma at the com-
unity level by training peer educa-
tors, anti-AIDS club members, and
their teachers; training women com-
unity leaders to provoke discussion
of orphans and vulnerable children at
“coffee ceremonies” and get local
iddir (neighborhood organization
leaders) to do the same with their
members; and producing informa-
tion, education, and communication
(IEC) materials.
In an effort to provide care and support, the organization used MAP funds to ensure that AIDS orphans have a roof over their heads (mainly in extended families, though to a small extent in the organization’s own dormitories), nutritious food to eat, and an education. For orphans who are HIV-negative, this is an investment in a future free of HIV, by keeping them off the streets, where they could be put at risk of infection. The organization also offers skills training for people living with or affected by the virus, and provides home-based care to those who are bedridden because of AIDS.

The impact of these activities is reflected in the increased number of orphans able to stay in school, extension of the lives of parents so that children can remain under the care and protection of their families, less social harassment of people living with HIV, and a greater sense of self-worth among them as they learn new skills and manage to support themselves. The reduction in stigma and discrimination and the provision of anonymous voluntary counseling and testing have enabled many more people in these communities to know their HIV status, an important aspect of HIV prevention. In addition, with increased community awareness, demand for condoms has grown from 56,000 in 2005 to 241,000 in 2006. Finally, the iddirs have expanded their traditional role in the community from collection of funds and facilitation of funerals to fundraising and awareness-raising for orphans and vulnerable children.

From the perspective of this key player in the national response to AIDS in Ethiopia, these impacts—and the continued, healthy lives of many children affected by AIDS—could not have been realized without the financial support provided by the Ethiopia MAP.

Uganda

The Uganda AIDS Control Project and community grants for HIV initiatives

The Uganda AIDS Control Project was the fifth of 39 MAP projects approved; it provided an IDA credit of $47.5 million to the Government of Uganda. Approved on January 15, 2001, the project
was fully disbursed and closed on December 31, 2006. Of the total project financing of $55.2 million, 38 percent was channeled directly to support the local response: $8.5 million to 233 district-based departments, NGOs, and community-based organizations, and $12.5 million to 3,629 community-led HIV and AIDS initiatives (CHAIs). The communities with CHAIs contributed 5 percent of the total subproject costs themselves, in cash or in kind.

The community-led HIV/AIDS initiatives were an innovative approach, directly funding communities—defined as groups with common interests or needs—to develop and implement their own initiatives, rather than relying mainly on NGOs to do things for communities (which was not having the desired impact). A chain of support—from the District AIDS Committees (DACs) and district-based NGOs and community-based organizations (CBOs)—has trained community groups to plan, implement, monitor, and report and has built capacity to procure goods and manage funds. Procedures for community participation in the project were clear, simple, and well publicized, and they improved over time with experience on the government’s side and flexibility on the Bank’s side. Group accountability led to good use of the funds. Everyone involved knew how much was received and how much was spent, which helped to ensure that most projects were implemented as planned.

Communities have identified and been empowered to meet their priority needs. Results include increased use of condoms and of voluntary counseling and testing; wider access to treatment, through referrals for ARVs and drugs to treat opportunistic infections; and increased support for AIDS orphans and widows, home-based care services, and income-generating activities that benefit the community. Groups of people living with HIV have demonstrated their ability to manage funds and provide useful services, enhancing their own and the community’s perception of their potential to contribute to the national response, and helping reduce stigma and discrimination. This part of the MAP has helped strengthen and expand the local response to AIDS in a remarkable way. But the increased numbers of needy orphans, elderly guardians, child-headed households, and people living with HIV—along with poverty and the lack of long-term, reliable funding—pose a formidable challenge in responding to community needs.

Helping people to live positively with HIV and prevent new infections—Mukono AIDS Support Association (MASA)

In 1992, a group of six infected and affected people began trying to respond to HIV in their community. From this small and tentative begin-
ning, the Mukono AIDS Support Association (MASA) has grown to become a major provider of services in Mukono District. One of its founders, Ruth Kaweesa, is a trained nurse and medical clinical officer who was widowed by AIDS and is now the MASA director. MASA sees an average of 50 clients a day.

In the early years MASA relied on volunteers and small in-kind inputs such as benches and food from a few donors and the district government. Later, drugs for opportunistic infections came through the IDA-funded Uganda Sexually Transmitted Infections Project. In recent years an important share of the organization’s financial backing has come through the Uganda MAP. Working with the AIDS Information Center (a national NGO), MASA offers pre- and post-test counseling, undertakes HIV testing in their mini-lab, and provides drugs for the treatment of opportunistic infections. (Of those tested at MASA, 33 percent are HIV positive.) In addition, MASA has organized 120 partners (no longer considered clients or patients) into post-test clubs that offer group support to those who have tested positive.

With a combination of the services these clients receive directly from MASA and the ARV treatment provided through the Department of Health, 40 members of the MASA post-test club have organized themselves into a powerful instrument to communicate key AIDS messages. Through their strong, melodic, and upbeat songs, they transmit critical information to the community about how, where, and why to get services. They are extraordinary examples of how to live positively with the virus.

The technical information that infuses their messages comes directly from the community education charts produced and supplied by the Uganda MAP IEC office, which also provided training on how best to pass on the messages. With the support of the MAP, the MASA group of singers, dancers, and drummers—dressed in identical vibrant red outfits—sing of their confidence in themselves and hope for the future.

In one of their songs, with an irrepressible beat and the refrain “We are people of HIV,” group members tell their personal stories. A woman named Mary, whose enthusiasm is palpable, sings out that she is a widow with seven children and that she’s on ARVs; that’s why we see her strong, that’s why she sings and dances!

The next verse of the song is sung by Richard, the group’s leader and the father of a little boy, who was born HIV-negative thanks to medication to prevent mother-to-child transmission. The message of Richard’s verse is that HIV is not the end, and that people need to get tested and start taking drugs if they are HIV-positive. As for prevention, he urges young people to abstain, and others to either use condoms or to be faithful. He ends his
verse by singing out strongly that “We shall overcome AIDS, let HIV stop with me.”

Another of the group’s songs is all about ARVs—how they used to be too expensive but now are freely available in the community, how before, people were dying of malaria or diarrhea but now they have a future, and that the MASA group members hope to live until the day that a cure is found. The group members touch their wristwatches in time with the beat as the lyric goes on to give clear instructions about the importance of taking the drugs twice daily at regular times.

A third musical message is about the need to avoid rumors and misinformation. It explains that HIV is a virus, that it is transmitted by sex and not by witchcraft, and that it does not discriminate (nor does it come only from businessmen who have traveled to Tanzania!). The song urges those in the audience to come to MASA for screening: “If you’re positive, be strong, you are not the first to live with HIV.” It closes by singing the praises of MASA.
Indeed, the work of this MAP-supported district NGO is worthy of praise. Beyond the counseling, clinical, and communications services that MASA provides, it is also helping members to organize themselves into groups to generate additional income for themselves and their families. At present this includes a small piggery project. It has started with a few pigs, and the litters will be given to other members until eventually each member gets a female pig to continue breeding. The profits from selling pork are to be used for the upkeep of AIDS orphans. MASA has also begun a poultry project, using the profits from selling eggs to support sick patients, as contributions to funerals, and for other emergencies.

Through MAP funding, MASA has nurtured five remotely located groups of people living with HIV, providing them with skills in organizational development, community mobilization, counseling, and home-based care. In the areas where these groups live, MASA has also undertaken outreach HIV screening, an essential service for those unable to travel to Mukono town. Finally, through monitoring and evaluation training provided by the Uganda MAP, MASA’s director, Ruth Kaweesa, has become an M&E technical resource person in other districts, sharing her experience and knowledge widely.

From Ruth’s perspective:

“The MAP has helped the Ugandan response to HIV/AIDS to move to communities, which has made it possible for people to come out with their HIV status and live positively. This has allowed positive people to join together and has opened our eyes on how to support ourselves. While before they used to beg, now they are strong.”

All of this success notwithstanding, MASA notes that the growing number of people living with HIV is making it difficult to provide the required drugs for HIV-related infections, and orphans need food and health care as well as payment of school fees. In addition, funds are needed to continue to make home visits, conduct outreach screening, and support new groups of positive people, services that have had to be suspended due to lack of funds.

Community-led work for widows and orphans—Hadijah Hajati Nabukenya and the Agali Awamu (Coming Together to Overcome) HIV/AIDS Support Project

Hadijah Hajati Nabukenya was once the rich and beautiful young wife of a successful businessman, living in a large flat in the district capital of Mukono. Today Hadijah is an AIDS widow, living as an HIV-positive woman in rural Uganda. Along the way, she has lost all her worldly goods. At the same time,
this remarkable woman has gained the love and respect of other HIV-positive 
widows and many others as a result of the work she is doing in her commun-
ity and beyond. She coordinates HIV/AIDS work throughout her sub-
county of Nnama, and the organization she chairs—Agali Awamu 
(Coming Together to Overcome) HIV/AIDS Support Project—is one of the 
3,629 CHAIs supported by the Uganda MAP.

Hadijah’s story really started in 1988, the year in which her husband died, 
when she learned her own positive HIV status and came to the Mukono AIDS 
Support Association (MASA) for counseling. From that point on, she decided 
to care for her two young daughters on her own, and to live openly and posi-
tively with the virus. In the words of her MASA counselor, Ruth Kaweesa:

“Hadijah came from rich to the ground; she bent low and started asso-
ciating with the low. She is now in a new life, with the members of her 
community-based organization as her partners.”

Her work started unintentionally, after she came from the village (where she 
had to move after her property was taken by her husband’s family) to the dis-
trict capital to receive food for herself and her family from MASA. Soon she 
began collecting food not only for herself but for other women in her area 
who were bedridden—first three, then five, and soon the numbers of hungry 
widows and others she was helping grew. When MASA began to provide 
drugs for HIV opportunistic infections (OIs) the organization decided to 
open an outreach center at the subcounty level, so that the women coming 
to Hadijah for food could be tested for HIV and treated for OIs.

Over time, Hadijah began counseling the women of her area, and later 
she obtained a certificate from TASO (The AIDS Service Organization) as a 
community volunteer worker. With this, she began doing home visits, with 
the help of a bicycle provided by the subcounty chief in 2000.

When the Uganda MAP started the concept of community-led HIV/ 
AIDS initiatives, Hadijah’s group of widows, widowers, and orphans pro-
duced “a traditional proposal, what they had on their fingertips,” and sent 
it to the district for approval and submission for MAP funding. This secured 
a grant for orphan support (including school fees, books, blankets, matt-
tresses, and bed nets) and for widows (especially seedlings and gardening 
implements). One result of the gardening effort is that the members are able 
to produce beans to improve their own nutrition, some of which they have 
kept so they can plant them during the next rainy season when MAP sup-
port will have ended. They are also trying to grow passion fruit.

The work of this successful community-led organization has been strength-
ened by the technical support provided by Margaret Nakityo, a technical
resource person from MASA and herself an AIDS widow and woman living with HIV. Some of the critical skills Margaret was able to transfer to Hadijah included how to approach the community in the early days, how to get members to agree to HIV testing, and how to sensitize the subcounty chief. With funding from the Uganda MAP, Margaret visited the group to discuss nutrition, how to plant the garden, and how to share and store their beans. She also connected the members to the local agriculture extension officer for further advice. Understandably, Margaret feels very happy about the support she’s been able to offer Hadijah and her members.

Both women believe that MAP support empowered the group members to be open about their HIV status, to share information, and to support each other and live positively. As a result, the members say that HIV is no longer a cause for discrimination in their community. Further, by caring for orphans, the group acts as a good example to the community, helping them to understand that HIV is not the end and that positive people can be productive and strong.

The children of the group members are now all in school, including Hadijah’s two daughters, who are completing their secondary studies. Beyond
staying in school, these young people have been trained and deployed as a group to spread key messages about HIV prevention, care, and support in song. With her “voluntary heart,” Hadijah and her members have demonstrated strong results and the success of the MAP initiative to transfer resources to communities.

**The role of districts in supporting a multisector response in Uganda—views from Mukono, Rakai, and Soroti**

To encourage a multisector response at the district level and below, the Uganda MAP enabled the country’s District AIDS Committees (DACs) to put in place a chain of support that has given local civil society organizations and 3,651 CHAI’s funds and technical know-how to contribute to the national response to HIV.

**The role of the District AIDS Committees**

DACs are the first link in the chain. They coordinate planning, appraisal, financing, implementation, and management, including accounting and monitoring of all HIV activities for government departments, district-based NGOs, community-based organizations (CBOs), and CHAI’s. Each DAC is chaired by the district chief administrative officer. DAC members are heads of departments and representatives of all eight government directorates, district NGOs, and CBOs selected by local civil society organizations, and representatives of people living with HIV. A District HIV/AIDS Focal Point coordinates the DAC’s work, over and above his or her other responsibilities.

Because the DAC brings in partners from the whole district administrative structure, Mukono District HIV/AIDS Focal Point Dr. Khonde Anthony notes that colleagues from all departments have begun to understand that HIV/AIDS is not only a health problem and that they all have a role to play. His counterpart from Rakai District, Ereazer Mugisha, also underlines the importance of “integrating communities with other service providers to increase the impact of their activities.” With financial backing from the Uganda MAP, the districts have provided financing for the following tasks:

- Training DAC members to help local civil society organizations and communities mobilize and prepare proposals and manage their funds
- Field assessments of CHAI proposals by district-level NGOs and CBOs
- Ongoing support for procurement, implementation, record keeping, reporting, and financial management
Facilitation of networking with technical colleagues (e.g., from the Departments of Agriculture, Community Development, and Health) and with technical resource persons from district-based CBOs

Regular monitoring

The HIV/AIDS Focal Point for Soroti District, Godfrey Eretu, explains that “the technocrats’ job was to see if the work was done, and how well.” The focal points from these three districts note that the provision of funds and technical capacity building to district-based civil society organizations (the second link in the chain) to assist the CHAI (the third link) represented a change of strategy. Rather than supporting NGOs to come in and do things for communities (defined as a group with a common interest or need related to HIV), this time the money went directly to the communities themselves, and others only assisted. According to Godfrey Eretu, this allowed communities “to address their aspirations” and undertake the activities that best responded to their needs. Dr. Khonde Anthony also emphasizes the importance of communities’ identification of their own priorities, to ensure that funds received go for “the right activities and to the right individuals.”

Community-led HIV/AIDS initiatives

With the recognition that AIDS was overwhelming the ability of individual families, and especially of child-headed households, to cope, communities came together to see how best they could help mitigate the impact of AIDS on the most vulnerable groups. In most districts these included people with HIV, widows, orphans, and elderly guardians. It also included youth groups, people with disabilities, taxi drivers, women’s and men’s groups, farmers, and teachers, among others.

In Soroti District, migrant fishermen and their partners are an especially vulnerable group. Though it was difficult to work with them because of their frequent movement, the Soroti DAC provided special support by mapping their settlement patterns and helping them to come up with a CHAI proposal to address their basic needs for knowledge and medical services. And in light of their frequent movement in and out of the district, the Soroti focal point collaborated with neighboring districts by radio to ensure ongoing provision of HIV prevention information and services for fishermen.

The effect on people living with HIV

These three focal points believe that CHAI activities have had a strong and positive effect on people living with HIV in their districts. In Rakai, for example, Ereazer Mugisha says CHAI’s have encouraged health-seeking behavior, so that those living with HIV are now getting better medical care
and access to condoms. In Mukono District, Dr. Khonde Anthony explains that people living with HIV are helping each other to get information and go for services, and that healthy HIV-positive people are reaching out to support others in the community.

Similarly in Soroti, Godfrey Eretu notes that when an HIV-positive member of a CHAI does not show up for a meeting, the group will contact the local health worker to follow up with the missing member. HIV-positive CHAI members are also playing an important role in referring families of their members to get tested and, on the basis of their own experiences, undertake first-stage health care referral. This was done initially at community level, but later the DAC helped them to come together as a network at county level. In addition, the responsibility of managing a grant has also boosted people’s confidence. One AIDS widow, for example, gained the strength to stand up to her brothers-in-law to keep her land. This was done with the support of her CHAI group, which has helped to resolve other community disagreements too. It has also led local authorities to enforce land and property laws for people living with HIV and other widows.

**Strengthened capacity and accountable community leadership**

In addition to providing services, CHAIs have benefited from DAC support to build their capacity to write proposals, implement projects and report on progress, and develop financial management skills and accountable leadership. An example of accountability comes from Soroti District: CHAI members went together to the market to buy oxen with project money so that the transaction would be public and transparent. Each member of the group knows exactly how the project money is spent. Such accountability within the group (not only to those above) is now a way of operating that will continue and be used for other activities in the CHAI communities.

**Improved HIV knowledge and reduced stigma**

Moreover, the focal points (and many others) believe that by supporting post-test clubs to organize themselves into
musical and drama groups that give personal testimonies and communicate messages about services and the benefits of ART, CHAI has helped to spread critical prevention and care information and motivate people to access services. In addition, the growing involvement of communities has helped to reduce the stigma and discrimination experienced by people living with the virus. The work done by people living with HIV has made a special contribution in this effort, by demonstrating that they can carry out activities themselves, and do them well.

**Fighting poverty**

In Godfrey Eretu’s view, CHAI has also directly fought poverty by helping communities to “shock absorb problems beyond AIDS.” Through the purchase of ox plows, oxen, goats, and cows, or beekeeping and small-scale farming with disease-resistant seeds, CHAIs have earned the funds needed to pay for school fees, uniforms, and scholastic materials; to improve nutrition or rehabilitate shelter for orphans; and to provide basic household inputs for widows and people living with HIV. In areas where AIDS orphans have benefited from a one-year vocational training course, some are now able to pay their own school fees and support themselves by working as tailors, carpenters, and bricklayers. And today, even though Uganda MAP funds have stopped, Soroti community groups still come to the DAC to show what they are doing to contribute to the well-being of their members.

**Growth of CHAIs into CBOs**

Some groups have become sufficiently institutionalized that they have registered as community-based organizations. This is confirmed by the executive director of the Uganda Network of AIDS Service Organizations (UNASO), Syakula Hannigton, who says that whereas his organization had 600 members prior to the Uganda MAP, today it has 1,000. This is an important development as it expands the links between the grass roots and the national level, helping to transmit correct information both up and down the line and ensuring that communities know about the latest research findings and funding opportunities and that national-level advocates can base their messages on local needs and realities.

**DAC strategic planning**

Finally, the Uganda MAP has supported DACs to develop five-year strategic plans, produced with the involvement of all stakeholders. In Mukono District, for example, the strategic planning workshop included local businesses that want to put condoms in their washrooms. It also attracted the participation of a lodge proprietor, who came to learn how he could help protect
the people who use his premises for casual sex. According to the District HIV/AIDS Focal Point, before the MAP, these people would not even have spoken about workplace interventions.

**Challenges**

However, the DACs and the CHAI approach have had their challenges. The most stable CHAI groups are those that were funded more than once, and the sustainability of those that received only one payment is in question. Also, a small number of districts have had some accounting problems. Further, the turnover of District HIV/AIDS Focal Points has caused some delays, as new people need to be trained to coordinate and support the work. Finally, the fact that the Focal Points have had to undertake their DAC responsibilities in addition to their other full-time jobs has not been ideal.

**Positive assessment of the DAC chain of support for community-led initiatives**

Nonetheless, when asked what the HIV/AIDS response would be like in their districts without the interventions supported by the Uganda MAP, the District HIV/AIDS Focal Points were unanimous in their positive assessments. In Mukono, Dr. Khonde Anthony says he cannot even imagine where his district would be today without the MAP. Awareness would be lower, stigma would be higher, fewer people would know their status and decide to get drugs, there would be less use of PMTCT without the information communicated by the post-test clubs, and there would be lower demand for condoms. Through the work of the DAC and its decentralized partners supported by the MAP, there is now stronger multisectoral involvement and a strategic plan to guide interventions over the next five years.

In Rakai District, Ereazer Mugisha notes that without the MAP, orphans would not be in school or as well cared for, there would be less knowledge about the virus and more stigma in communities, and there would be less health-seeking behavior among people living with HIV. The capacity of com-
munities to write proposals; to liaise with other service providers to improve the quality of interventions; and to budget, report, and account would also not be where it is today. Finally, he points to the enhanced social cohesion that now exists, which is “the way to go to ensure wider participation.”

And in Soroti, Godfrey Eretu states strongly that without the MAP, nothing would be going on at the community level. No technical support would have been provided, and communities would not have an appreciation of their own ability to manage and contribute to the response. CHAI s allowed communities to discover that they had resources to address social and health needs and to move forward on their own. On the basis of their proven track record in financial management, some CHAI s in Soroti have gone on to get funding from the European Union, USAID/PEPFAR, and other sources. Others with CHAI experience in agriculture projects are now receiving grants through the Uganda National Agricultural Advisory Services.

He further notes that the relationship between the authorities and communities in his district has become one of mutual respect, which has helped operations to be carried out as planned and reporting to be done:

“The MAP was the first of its kind to give communities the chance to write their own reports, on their own. All the shillings reached the communities, and have stimulated them to believe ‘yes, you can do this.’ The benefit has been big, as once the money has reached the community it stays within—no one will take away an ox plow.”

**Strengthening and expanding of decentralized support by Uganda’s premier AIDS service organization—the story of TASO**

From a small initiative founded in 1987 by a group of volunteers, including people living with HIV, TASO (The AIDS Service Organization) has grown into one of the leading partners in the response to HIV/AIDS in Uganda and the region. It is known as a pioneer in the areas of HIV counseling, medical care, provision of home-based care, and medical outreach to communities. Recently TASO began a phased introduction of antiretroviral drug therapy (ART) and home-based testing and counseling. It also offers social support services to enhance positive living; skills building; educational music, dance, and drama; and fellowship among clients in the day care center. With its 840 staff and 142 volunteers, TASO operates service centers in 10 districts, each of them providing service to neighboring districts, and has created five mini-TASOs around the country.
On the basis of its track record and experience, TASO was selected by the Uganda MAP to work at the district level as a member of the District AIDS Committees (DACs) in the following areas:

- Sensitizing groups of people who are at high risk of infection (for example, commercial sex workers, fishermen, and motorcycle groups of out-of-school youth)
- Expanding home-based care, including providing drugs, counseling, and training for those caring for people living with HIV, in collaboration with community nurses
- Working with local legal experts to sensitize communities on the rights of people living with or affected by HIV (for example, the right of an AIDS widow to keep her property)

In addition, as members of DACs, TASO staff members supported local CBOs and community-led HIV/AIDS initiatives (CHAIs) to plan, implement, monitor, and report on the activities undertaken with support from the MAP. Sophie Nantume, the TASO DAC representative for Masaka District (and currently ART counseling coordinator at TASO headquarters), received training from the district to help communities apply for CHAI resources. She then sat with community groups to help them identify their problems and plan their responses. She points out that she did not plan for them, but rather facilitated their own process of discussion, analysis, and planning. Many of the CHAIs she worked with faced a huge orphan burden and needed to provide scholastic materials, uniforms, food, bedding, and, in some cases, shelter.

Sophie asked the communities with which she worked what else they might do to make their support sustainable. This led to the initiation of a range of income-generating activities, including keeping cows to provide milk, planting maize to provide flour for porridge to give to orphans who have no food, and providing sewing machines to girls so that they might learn and practice a useful skill. Other CHAI groups made herbal medicines for distribution to the bedridden during home visits and started fish pond harvesting, again for distribution to the needy. Groups of people living with HIV undertook the same types of activities as other groups and were empowered by being able to show they were still useful to the community.

With respect to the impact of the Uganda MAP support for community-led initiatives, Sophie Nantume says “the burden is so big, it can’t be left to one entity to handle”; everyone must be involved, in the effort, including communities. From Sophie’s perspective as a member of the Masaka
District AIDS Committee, CHAIIs contributed to the national response by spreading knowledge of how HIV is spread among the population and how people can protect themselves.

Moreover, she believes that CHAIIs made it possible to provide money to the grass roots, where it was used to improve the quality of life of orphans and the bedridden. As for the capacity of CHAIIs, on the basis of her twice monthly visits to the groups, Sophie concludes that capacity building has been “a big achievement—communities learned how to write in a cashbook, keep ledger books, and manage their money. They learned tendering and bidding, and were very appreciative of the funds they received. They did whatever they had planned, and did it the right way.” Although at the outset she and others feared that some of the funds might be stolen by communities, in the end she says “They did not steal, they used the money well.”

Sophie Nantume also believes that TASO’s own work has been supported by the CHAIIs. Before the MAP, TASO did not have the funds to respond to the needs of orphans and vulnerable children or to motivate people to work. Providing T-shirts and a bicycle was not sufficient. And although the TASO communities had work plans, they had no money to implement them. The MAP, through support to CHAIIs, helped fill these gaps. Further, by providing funds for the fuel and lunch allowances for TASO home visits, the MAP made it possible for TASO Masaka to double the number of clients it was able to cover through ongoing outreach activities. It also enhanced the communities’ appreciation of the role of civil society organizations.

Finally, Sophie points out that although supporting the communities was a challenge with just a single vehicle to cover over 150 CHAIIs in her district, the chain of support from the DACs, to district NGOs and other district-based partners, down to community-led initiatives made a difference.

“You can see that life had changed, the communities really benefited a lot.”
Flexible MAP funding spreads new knowledge about traditional herbal approaches in HIV treatment—THETA (Traditional and Modern Health Practitioners Together Against AIDS)

With 80 percent of Uganda’s population located in rural areas with limited access to modern health care it is not surprising that when people fall sick, the first place many go for treatment is to traditional healers. THETA (Traditional and Modern Health Practitioners Together Against AIDS and Other Diseases) was started in 1992 in response to the fact that communities needed to cope with HIV/AIDS, but at the time, the biomedical sector had little to offer. THETA aims to improve and make health care more accessible to the population by respecting the knowledge of traditional health practitioners and linking them to the modern health sector.

Seeing the success traditional health practitioners were having in treating opportunistic infections such as rashes (which are especially stigmatizing) and alleviating the loss of appetite and weight, THETA undertook research into herbal products that appeared to be effective and compared them to first-line medications used in the conventional sector. The herbal products were clearly helpful in alleviating common symptoms of HIV and related opportunistic infections.

With funding from the Rockefeller Foundation, THETA worked with traditional practitioners to document their findings. With support from the Uganda MAP, findings about the medicinal plants most commonly used to treat and manage HIV-related conditions were published in a practical booklet called “Herbs Commonly Used for the Treatment of HIV/AIDS, Related Infections and Other Common Illnesses.”

After working together with THETA on this research, the healers asked for education on HIV and AIDS, to improve their practices. From this, THETA services have expanded to include the following:

- Training and capacity building to build partnerships through joint training of traditional and modern practitioners, encourage collaboration at the community level, and help the two systems work together for better health care.
- Holistic care, to look into products and practices and to undertake observational research to improve hygiene, safety, dosage, and efficacy of herbal preparations, in collaboration with Makerere University Department of Pharmacology.
- Community initiative program. This work has grown out of THETA’s training and capacity-building efforts, leading healers to take actions on
their own or with their communities in the areas of orphan care, widow support, animal and agricultural projects, and use of dance and drama to educate the community.

- Information, documentation, and sensitization, to document the work of African traditional healers and disseminate lessons across the continent. The organization has established a regional initiative (with support from the Rockefeller Foundation, WHO-AFRO, and UNAIDS) to attract international attention and to fight the confusion around traditional practice and witchcraft. The organization also advocates official recognition of traditional health practitioners and supports policies to regulate their practices.

With support from the MAP, THETA has also supported groups across Uganda to produce culturally appropriate information, education, and communication messages for HIV prevention and traditional treatment and care, using instrumental music and drama. Although MAP funding was provided for just one year, the messages developed and the instruments used to deliver them are still very much in use today, two years after the end of the support.

THETA Executive Director Dorothy Balaba (MD, MPH) says that the MAP funds were also important to the organization, as they allowed THETA to do the work they believed needed to be done, in line with what communities wanted. Unlike donors that decline to finance research or development of traditional medicine, the Uganda MAP supported some of THETA’s key activities without restriction.

Dr. Balaba also notes that, by avoiding competition among CBOs and NGOs, the MAP allowed good community work to be undertaken by those who were less able to compete on the basis of good proposal-writing skills. Because of the support MAPs provide to CHAI s, Balaba believes that even with limited funding, “the effect the MAP has had, and the lives it has touched, have been tremendous.”
Rwanda

When Rwanda’s HIV/AIDS Multi-Sectoral Project was prepared in 2002, the country was classified among the 10 most severely affected by HIV. The recent war and genocide had left severe capacity constraints and human resources shortages. Antiretroviral therapy was available in a few urban facilities—to those who could afford to pay the high cost.

Since Rwanda’s MAP was approved on March 31, 2003, under the government’s leadership, performance has been consistently strong, with all project targets met or surpassed. The $30.5 million grant was disbursed in three years, two years ahead of schedule. Results include the following: (1) voluntary counseling and testing have been provided to nearly half a million persons; (2) 12 million condoms have been distributed; (3) over 5,000 patients have received lifesaving antiretroviral therapy; (4) financial assistance for school fees has been provided to 27,000 orphans and vulnerable children; (5) access to community health insurance schemes has been subsidized for over 52,000 households, reaching about a quarter of a million people; and (6) about 100,000 people have participated in income-generating activities. Personal testimonials confirm the positive impact of the MAP on the lives of average Rwandans who live on less than US$0.70 per day.

MAP community grants for HIV initiatives that provide new livelihoods

Rwanda’s MAP has an effective mechanism for channeling funds to civil society groups, which have received nearly half of the MAP project funds. A wide range of eligible organizations (NGOs and community development commissions) were screened, accredited, and recruited to help smaller associations prepare subprojects and access MAP funds. In total, over 100 civil society organizations received MAP funding nationwide to provide a full range of preventive, medical, and support services for people living with HIV. These activities were funded on a demand-driven basis and reflect the needs of the community and civil society groups.

Beneficiaries report great satisfaction with the MAP approach, which empowers them to find their own solutions, channels funds directly to them, and holds them accountable for results. This highly participatory approach has fostered innovation in service delivery and contributed to strengthening social capital through widespread use of solidarity mechanisms. The impact of these activities often has been dramatic. Numerous beneficiaries have reported that a small amount of money has gone a long way in helping infected people get back on their feet and providing alternative sources of livelihood for the vulnerable. HIV messages have been effectively combined with
poverty-reduction strategies, and measures to enhance sustainability have increasingly been built into the design. The accomplishments of CSOs and the consistently high rate of fund disbursements reflect not only the program’s success in providing services to targeted populations but also its successful capacity-building efforts. Capacity to plan, implement, and monitor projects has been enhanced at all levels, and local groups have demonstrated their ability to manage funds effectively and transparently.

New sources of livelihood for vulnerable women affected by HIV—Turwanye Ubukene Association: Let’s fight poverty

Epiphannie explains how her life has changed as a result of the new opportunities the Rwanda MAP offers to vulnerable women. She used to engage in sex work, like many of her coworkers who scramble to make a living in this crowded, poor, and highly transient neighborhood on the outskirts of Kigali. Sex work was not sustainable and not a dignified way of earning a living. The Turwanye Ubukene Association gave her “access to the right channels.” Authorities helped her and her coworkers to organize themselves into an association of former sex workers and to design their own income-generating activities. Now she engages in a productive trade, has a stable source of income, and most important, has regained her self-esteem and her desire to have children.
Women who are widows or orphans of the genocide or AIDS have come together to find common solutions and break the cycle of poverty and AIDS. Their stories are strikingly similar. They have shown determination and resilience, which Saumura Tioulong, a Cambodian member of parliament who participated in a parliamentary visit to Rwanda in 2006, characterized as a “phoenix emerging from its ashes.” She echoed the views of the other 15 parliamentarians, who were all impressed with the work of the group and their passion for living.

Emmaculette has five children and is landless. When her husband died, she tried to start a small business, but her success was limited. When district authorities put out a call to interested women, Emmaculette responded eagerly. She and many of her friends now claim to be “born again” as a result of what is perceived to be a successful project that is providing women with a stable source of income. The Turwanye Ubukene Association now pays her children’s school fees and materials and their local community health insurance scheme (mutuelle) premium. Another participant, 19-year-old Faida, explains that her family disowned her when she engaged in sex work. She now has regained their confidence as she participates in a vocational training scheme supported by the association. How did these women manage to break the cycle of poverty, and what can be learned from their experience? There are several important lessons.

**Social mobilization**

The first lesson is that local champions can make a difference in mobilizing people. In the district that used to be known as Kanombe, authorities worked proactively with vulnerable women to help them start income-generating projects and modify their sexual behavior. The deputy mayor in charge of social welfare on the district HIV/AIDS commission became personally engaged in the program design, demonstrating strong leadership and empathy. It was a win-win opportunity: the district authorities tackled a major social problem, and the women had the chance of an alternative livelihood. This example shows how the public sector can work effectively with civil society groups to mount a successful intervention that has a real impact on the day-to-day lives of poor women. In late 2004, 150 women from all corners of the district responded to the initial call for interest in participating. Within two years, membership had grown to 350, and more women join regularly, inspired by the success of their neighbors, friends, and coworkers.

**AIDS and poverty**

The second key lesson is that preventive measures are not sufficient unless they are accompanied by mitigating actions. In a relatively short time, the program
has provided an alternative way to earn a living, with beneficiaries now receiving monthly salaries of RF 10,000 (roughly US$20). Many of the more entrepreneurial women have also successfully applied for funds from local cooperative banks and set up additional small businesses. Several programs have built in elements of self-sufficiency. For example, association members have used the income generated through the hygiene and environmental protection project to buy a tract of land for their various activities and a truck for transporting solid waste collected from households. A goat-rearing project is another example that incorporates self-sufficiency and solidarity in the design. Each member of the association will take a turn caring for the goats and will be able to keep at least one kid for herself, which will encourage individual entrepreneurship and provide a stable source of income.

Empowerment of women

A third lesson worth highlighting is that empowering women has multiple benefits for the whole family. At the outset, many of the children of these destitute women did not attend school or have access to health care. Membership in the Turwanye Ubukene Association has enabled the women to enroll their children in school (with school materials provided) and to receive health care through membership in the mutuelles.

Ongoing challenges

The program’s initial success has motivated and inspired others to emulate this example, but it is still early, and a word of guarded caution is warranted. Behavioral change takes time and will hinge on the sustained success of these income-generating activities. Program managers know that these women remain highly vulnerable and could easily get disillusioned and resume their former line of work. Hence, the women need ongoing support from their local leaders and program managers as they face new hurdles and challenges. The original leaders of the initiative are in the process of replicating this successful experience nationwide. These Kanombe champions are not deterred by the enormous challenge of scaling up. They are highly motivated and inspired by
their initial success and determined to enable other Rwandan women to escape the trap of AIDS and poverty.

**Kibungo vocational training—assistance for orphans and vulnerable children**

The 1994 Rwanda genocide left a generation of orphans and vulnerable children who are exposed to child labor, sexual abuse, delinquency, and HIV. Many lost their parents and struggle to meet basic needs. In this context, the Kibungo vocational training school was established in a densely populated border area in the Eastern Province with high unemployment and deep-seated poverty. The Kibungo training school started with about 40 young beneficiaries from single-parent or child-headed households. The beneficiaries explain that before the school opened, “vulnerable children and orphans were living a miserable life and had no reliable means of maintaining a decent standard of living.” They experienced “discrimination, social isolation, and fear for their future.”

**Skills acquisition**

After a nine-month MAP-financed training program, the majority of these youths have acquired new tailoring skills. To foster self-reliance, at graduation, they were given sewing machines and assistance in forming an association. They successfully negotiated a contract to produce school uniforms for their district. These recent graduates say they now earn a stable income and can afford to buy food, soap, and clothes, and they are members of the community health insurance scheme. They also report a marked improvement in their self-esteem, as they gain the respect of their peers and community members. Their association has opened a local bank account to collectively save part of their income to reinvest in their business.

**HIV/AIDS messages**

The project has successfully combined income-generating activities with information about HIV and AIDS, reproductive health, and life skills. Many of the youths reach out to other orphans and marginalized children in their communities to raise awareness about the risk of HIV and how to protect themselves.
Impact on the lives of the vulnerable

The stories of three vulnerable women ring a common note. Jeanne d’Arc says:

“Prior to coming into the tailoring school project, my life was fixed in a dilemma because I did not have any hope to live a happy life as I was a complete orphan. But now the mental skills I acquired from the tailoring school have helped me to earn some daily income . . . my life has changed and improved.”

Ernestine says she was: “living a miserable life as a peasant farmer, and during the drought period cultivation came to a standstill . . . I remained redundant without any alternative.” As a result of the program she had the “chance to learn and acquire new skills.” Sonia adds that, in addition to the new skills she has learned, she is now able to “interact with people of different backgrounds and exchange ideas on development issues.”

Lessons and challenges

According to program managers and beneficiaries, the main lessons from this program relate to the importance of (1) establishing solidarity mechanisms by bringing vulnerable children together to find solutions to their
problems and design their own interventions, (2) enabling beneficiaries to be role models for behavioral change, and (3) tackling the underlying causes of AIDS, namely poverty and vulnerability. The success of the program has generated new challenges—mounting costs of materials, space constraints, and growing demand for the program—and some prospective students have traveled long distances to participate and require special assistance, such as food. Ultimately, the success of this initiative will hinge on achieving behavioral change and sustaining the new business endeavors.

Rwanda National Youth Council—an innovative voucher program for expanding HIV testing

Enabling people to learn their HIV status is a first critical step in changing behavior. The Rwanda National Youth Council has devised an innovative voucher system for expanding access to HIV testing for youths (10–24), who represent close to 40 percent of the population. Program designers used a two-prong approach. First, they mobilized all key stakeholders (i.e., youths, health staff, and local youth leaders) and raised awareness of the need to know one’s HIV status, the importance of using condoms, and the existence of local services. Social mobilization was done through various channels, including anti-AIDS clubs and sports and cultural activities, which were a very popular way to reach this target group. The council trained a total of 230 peer educators in behavioral change communication and carried out activities in over half the provinces.

Second, they designed a simple voucher system that enables youths to go to local health facilities on designated days, minimizing waiting times. Facilities are reimbursed for these services using MAP funds. This innovative approach has two main benefits. First, it is cost-effective: the cost to the health system of $2 per person is only a fraction of what it would cost ($10) to reach these youths through mobile units. Second, it enhances the returns on investments in facility-based voluntary counseling and testing (VCT) services, which were funded through a Global Fund grant. A snapshot of results at the end of the initial four months was impressive: 120,000 youths were reached through the massive
mobilization efforts, and nearly 70,000 were tested. About 6 percent tested HIV-positive.

**Modifying behavior**

During the National Youth Council campaign, 29-year-old Nicolas Niyonsaba, who was to be married soon, was encouraged to be tested, which revealed his negative status. “Before the campaign under MAP financing, I had neither an idea nor much knowledge about VCT. I have now dropped all previous prejudices,” he says. “I was able to prompt my partner to be tested before we married and now we live a happy life together, knowledgeable of our HIV status. I have learned the importance of being faithful.” Nicolas says that increased HIV awareness has also changed his views about condom use from “shame to pride.” Moreover, Nicolas now hopes to serve as a role model for others, saying: “I have successfully mobilized peers to help the infected people in my area, including using holidays to build houses for those who lack basic accommodation.”

**Tackling Stigma and discrimination**

Twenty-six year old Madine Kayitesi was an initiator of an anti-AIDS secondary school club. “I always feared HIV testing, for five years I remained at the level of slogans,” she says. When Madine adopted a child of a deceased neighbor, she assumed that the child was infected. “It was really a feeling of being discriminative when the child was tested and found to be negative,” she acknowledges.

Madine summoned up the courage to be tested when she was elected as a leader in the Youth Council’s campaign. Her knowledge about the disease has improved, and she now understands the importance of testing. Madine announces proudly:

> “I learned strong lessons after the VCT campaign, discovering that HIV status is not reflected by mere sight but rather by testing. I have now started an association which advocates for children who are affected and infected with the scourge.”

A Muslim whose own denomination accepts polygamy, Madine now strongly feels she will “be able to stand strong against polygamy . . . and this to me shall be a condition before marriage.” Underscoring the importance of greater individual responsibility, she concludes: “People can no longer be bound by cul-
tural or religious denominations [that are] possible causes/threats to getting infected with HIV.”

**Lessons and challenges**

The Youth Council’s large-scale mobilization campaign and voucher program proved highly successful in reaching young people like Nicolas and Madine. The validity of this approach was demonstrated by the quick results achieved—large numbers of youths were reached in a relatively short time. The voucher program is now being considered as a model for testing other groups.

The beneficiaries note three principal lessons:

- HIV testing is critical to modifying sexual behavior and expanding condom use.
- Enhanced knowledge leads to greater empathy and solidarity with people living with HIV.
- Awareness campaigns foster a culture of responsibility, trust, and faithfulness among young couples.

In spite of the initial success of this initiative, several important challenges persist. First, although program managers did an excellent job mobilizing health staff and involving them in this initiative, some VCT sites were unable to cope with the rapidly growing demand for these services. Second, in some cases youths had to travel long distances, and this proved to be an impediment to taking advantage of the voucher scheme. Finally, the postcounseling services were not always easily accessed; some youths became disillusioned and did not follow up, suggesting a need to strengthen psychosocial support for those found to be HIV-positive.

**HIV messages combined with income-generating activities—examples from the city of Gisenyi**

Local governments have played a supportive role in disseminating HIV prevention messages and helping local associations to access MAP funds. The
mayor of Gisenyi acknowledged his appreciation for the work of the eight associations of people living with HIV, which are making a huge difference in the lives of ordinary people. The unsung heroes of these associations are doing a remarkable job in organizing and supporting vulnerable people to design their own income-generating activities. Gisenyi is a local tourist destination in the north of the country, on Rwanda’s border with the Democratic Republic of Congo. There the lack of employment opportunities and high levels of mobility have left women and young girls with few alternatives to prostitution.

Associations and income-generating activities

Local leaders organized beneficiaries into associations and made a concerted effort to raise awareness through multiple channels, including anti-AIDS clubs, cultural events, and sport tournaments. The associations benefited from MAP funding and now enthusiastically report some of their initial successes. Their stories are broadly similar.

The Tuvugibyayo Association, which supports about 50 men and women, reports that at the outset members were in a “desperate state.” Today, they practice various small-scale commercial activities and are fruitfully employed. They bought conteneurs (small makeshift stores) and then rented them out to prospective vendors, which turned out to be highly remunera-tive. Part of the rental income generated by beneficiaries has been used to set up a small credit scheme through which they extend financial support to other association members. The modest loans need to be paid back within three months, freeing up resources to be lent to the next group.

Beyond the income-generating activities that have helped them feed their families, other important benefits include reducing stigma and discrimination. According to one member, “In the future we will no longer be called people living with HIV/AIDS because our situation continues to improve daily.” Finally, association members also have developed solidarity mechanisms through which each contributes to financing home visits for people who are ill and bedridden. Membership in the association offers the benefit of access to new sources of livelihood, as well as social and psychosocial support of peers.

Demand for HIV testing

Health providers in Gisenyi attribute the rapid growth in demand for HIV testing in large part to the social mobilization activities of the various associations. They note that individuals became particularly keen to be tested so that they could become members of the associations and benefit from the income-generating activities. The number of people tested rose from about 400 in 2004 to 1,000 in 2005 and close to 3,000 by the end of 2006.
National Faith-Based Organizations Network Against HIV/AIDS in Rwanda

Faith-based organizations (FBOs) historically have played an important role in the HIV/AIDS response in Rwanda. They have provided important financial, spiritual, and moral support to those affected or infected by this impoverishing illness. In recent years, FBOs have expanded the range and scope of their activities and better structured their support through a coordinating body, which is currently funded primarily through the Rwanda MAP. The FBOs reach virtually all Rwandans—Muslims, Protestants, Evangelicals, Episcopalians, and Catholics—through their nationwide networks of churches, mosques, dioceses, and parishes. The FBO network has played a pivotal role in mobilizing religious leaders and in guiding and coordinating investments.

Prevention

Religious leaders have been encouraged to play an increasingly important role in responding to AIDS, which deeply affects their parish members. They are role models for their constituencies in speaking regularly about HIV and AIDS, urging parish members to get tested, and encouraging fidelity. The FBO network has helped to strengthen capacities of members.

Stigma and discrimination

The culture of acceptance and the solidarity that FBOs encourage help fight stigma and discrimination. Religious leaders organize monthly collections to assist vulnerable parish members and provide spiritual support to those living with the illness. The FBO network estimates that these activities occur in about 70 percent of churches and mosques nationwide.

The AGAPE Association is a faith-based association created in 2001 under the auspices of the Evangelical Restoration Church to provide holistic support to those who teeter on the fringes of life and face numerous risks, including HIV. Program administrators note that the rapidly growing town of Rwamagana, where they are based, faces many challenges as a result of the genocide, which left scores of orphans, widows, and rape victims. The association, with a membership of 175 adults and 325 orphans and vulnerable children (OVCs), has used its MAP grant of about US$9,000 to support OVCs, start income-generating activities, offer home-based care, and provide access to community health insurance.

Orphans and vulnerable children

Although the total number of children reached nationwide remains modest in relation to those in need, FBOs have proved effective at identifying those
in need, channeling funds to them, and monitoring the use of funds and the results. FBOs aim to provide holistic care. Roughly 12,200 OVCs have received support to enroll in health insurance schemes, about 5,000 children have benefited from food aid, secondary school fees have been paid for about 8,600 children, roughly 90 young people have benefited from vocational training, and more than 2,200 have received various other forms of support.

At the Shakina Primary School, founded by the AGAPE Association, Macrine’s eyes fill with tears as she explains her situation.

**Income-generating activities**

Several religious groups serve as umbrella organizations for the MAP, helping smaller associations and community-based organizations gain access to funds and develop income-generating projects. Religious groups tend to have close ties to community members, and the trust, respect, and compassion they have are great assets for reaching out to vulnerable people. FBOs were among the first to assist those affected by AIDS and to organize them into associations. These associations have served as forums of solidarity as well as effective mechanisms for joint income-generating activities, including vocational training (e.g., plumbing, woodwork, mechanics, and sawing); small-scale commerce (e.g., food, drinks, animal husbandry, and fisheries); and service activities (e.g., taxis and bikes). FBOs aim to ensure that these income-gen-
erating activities benefit all association members to promote “unity, equity, transparency, and compassion.” The network estimates that 80,000 people have benefited from these activities through 600 subprojects, of which over 70 percent have been funded through the MAP operation.

**Restoring hope**

At the AGAPE Association in Rwamagana, 24-year-old Sylvie describes how she acquired new tailoring skills at the Freedom in the Sun International Center.

“After my father was killed in the 1994 genocide and my mother was handicapped, it was as if the bridge to cross for my future was cut down. I was the first born and still too young to care for my two younger siblings who counted on me. I was compelled to discontinue my primary school studies at form 4 level and take the responsibility to sustain the family. I sacrificed myself for my siblings’ feeding and . . . now the Almighty God has used MAP/Restoration Church through AGAPE Association to restore my lost hope.”
HIV/AIDS treatment

Health facilities run by religious missions (that administer roughly 40 percent of the health network in Rwanda) have played a key role in expanding access to a full range of HIV-related services, including HIV testing, prevention of mother-to-child transmission, and antiretroviral therapy. These services are provided in an atmosphere of confidence and trust and in a spirit of compassion and moral support. Many of these clinical services are linked to community-based support, giving patients access to an integrated package of services, which is essential for AIDS patients. Nearly half of the MAP-supported treatment sites (i.e., Gikonko, Gakoma, Kiziguro, Gahini, Mibilizi, Kibogora) are run by religious missions, as described below.

A mother’s story

Gloriose Murebwayire’s story is a source of inspiration to other women in similar predicaments. Gloriose has gone from denial to acceptance and has assumed responsibility for herself and her son.

“My son Oliver was born HIV-positive. My husband died in 1996 and I was not aware it was from AIDS. I always feared to get tested. That changed in 2004 when I was sensitized by the pastor from the MAP-sponsored AGAPE Association.”

The 34-year-old woman adds that “it was too hard accepting I was positive, even though I felt unhealthy and my child was ever sickly.” The counseling sessions of the association helped her come to grips with her status and seek care. Gloriose and Oliver are now on Bactrim (used to fight pneumonia in AIDS patients with weak immune systems) and receive nutritional support. She notes assertively, “Now who notices that we have AIDS?”

Gloriose and her son, Oliver.
Pride shines in her words and face as she tells visitors that 10-year-old Oliver “is always the first in his class, with 95 percent marks. He is no longer sickly.” In the absence of the government’s widely available treatment program, Oliver’s young life might not have been spared.

Gloriose, like other association members, benefits from income-generating activities that increasingly are building in measures to enhance sustainability. “I am a beneficiary of the rotating loan scheme. I have a small business to sustain my family,” she says. Gloriose reports that she was able to save money in the local bank, supplement the school materials paid for by the project, buy community health insurance, and provide a healthy diet to her family. “MAP is saving the life of thousands of people infected and affected by HIV/AIDS,” Gloriose says.

Main lessons

The program managers list five key lessons stemming from the wide range of MAP activities supported by faith-based groups:

- **The commitment and engagement of religious leaders in the fight against HIV/AIDS is critical.** The network of faith-based organizations has proved to be an effective mechanism for mobilizing religious leaders to be advocates and role models. AIDS, previously seen as a punishment from God and a taboo topic, is slowly being demystified.

- **Faith-based organizations have a comparative advantage in working with vulnerable people.** They are often close to the beneficiaries and have a good understanding of their situations, and they tend to treat them with respect and compassion. FBOs have nationwide structures and channels for reaching vulnerable people and can fairly easily add HIV interventions to their other activities.

- **Coordination of activities of FBOs through a network organization is an effective way to expand activities.** The Réseau des Confessions Religieuses has proved to be an effective structure for guiding investments, coordinating and monitoring activities, and minimizing duplication. Plans are under way to further strengthen coordination by having a single consolidated plan of activities covering all denominations, and one monitoring and evaluation system.

- **Links between HIV interventions and poverty reduction are gaining greater attention.** Many people infected or affected by HIV live in dire poverty. The impoverishing nature of the illness and the nonmedical aspects of this disease, such as food security, demand greater attention.

- **Flexibility in the use of MAP funds has allowed innovation.** The MAP approach of encouraging stakeholders to identify their own solutions
and design their own programs encourages innovative responses and ownership of the intervention.

**Scaling up and decentralizing access to lifesaving antiretroviral therapy—a pro-poor focus**

The World Bank was one of the first donors to support a major scaling up of antiretroviral therapy (ART) in Rwanda. The program has a strong pro-poor focus, targeting three underserved provinces. Two-thirds of the beneficiaries are women, who are disproportionately affected by HIV. A growing number of children have been enrolled as the government has increasingly focused on pediatric care. ART has prolonged lives and improved quality of life for people on the margin who might have otherwise succumbed to HIV-related illness. The MAP has also enhanced capacities at rural health facilities that serve 2 million people in some of the most remote and destitute provinces in the country.

**A harmonized approach**

The success of these activities is largely due to the harmonized approach promoted by the government. Rwanda’s early commitment to providing treatment helped rally partners and mobilize resources. Authorities developed a
treatment plan with the support of the Clinton Foundation and introduced a user fee policy with a sliding scale. Most Rwandans receive free care because they live below the poverty line. Under the government’s leadership, the Bank developed strong partnerships with the Clinton Foundation, the Global Fund, and PEPFAR to design, implement, and monitor the treatment program.

**Strong partnerships**

The World Bank recruited the U.S. Centers for Disease Control and Prevention (CDC) to do a baseline assessment and to propose alternative models of care for MAP-supported facilities. The analysis was done in close collaboration with the Treatment and Research Center on AIDS of the Rwanda Ministry of Health, which promoted ownership and ensured continuity in implementation and oversight. Instruments for site assessments and accreditation were developed and used to support the national scale-up. The district hospital model developed for the MAP inspired the scale-up of the Global Fund and PEPFAR-supported sites, and in turn, the experience of these partners benefited the MAP sites. Harmonization of strategies and instruments has been critical to the success of the scale-up. The strong partnership with CDC has resulted in an additional $4 million for MAP-related activities and technical backstopping on laboratory monitoring.

**Solid performance**

The performance of MAP sites has been solid. In less than three years more than 5,000 patients have been placed on ART in comparison to a MAP appraisal target of 2,350 (figure 4.1). Only 3 percent are lost to follow-up, and virtually all patients are on cost-effective first-drug regimens. The capacity to diagnose, treat, and follow up AIDS patients has been established at 12 district hospitals and one health center. These upgraded facilities have also strengthened their capacity to provide non-AIDS care, as most benefited from laboratory upgrading, renovations, logistical support, and additional human resources. The MAP program is now being decentralized to an additional 18 health centers, which will shorten travel time for patients and lower costs to the system. Overall, Rwanda has made excellent progress in expanding treatment, with roughly 32,000 patients on ART at 130 sites nationwide, which represents well over 50 percent of those who need care (i.e., those at an advanced stage of the disease) in contrast to 870 patients at seven sites at the end of 2002.

**Lifesaving care**

The impact of this massive scale-up on people’s lives has been remarkable. Edouard, a 36-year-old man, was bedridden and needed to be cared for by
his HIV-positive wife. When he arrived at the MAP-sponsored Butare Hospital he weighed just 35 kilos. He had previously been treated for meningitis, TB, pneumonia, and other infections.

Following the initiation of ART, his weight rose to 56 kilos and his CD4 count jumped to about 650. Edouard was able to take advantage of the government’s highly subsidized services (like most other Rwandans participating in the program, his low earnings of just US$.70 per day qualify him for free care). Edouard’s health improved and he was able to return to the fields and to start growing food for his family once again. His wife, who had recently given birth, was referred to the ART program to determine whether she needs treatment.

In the words of one of the nurses at the Butare Hospital,

“The availability of lifesaving ARV drugs is providing hope to people who are desperately ill, and also is leading to greater acceptance of people living with HIV/AIDS. You can see the reduction in stigma associated with expanded access to ARV therapy.”

Decreased stigma is reflected in lower numbers of patients reporting abusive behavior by community members, greater willingness to talk openly about their HIV status, and increased demand for HIV testing.
Managing poverty in Malawi

By Mphwiyo Chimba

I mproving livelihoods and reducing poverty is a critical strategy for Malawi to achieve the Millennium Development Goals (MDGs) and the National Poverty Eradication Plan (NPET) of 2012–2016. The Malawi Poverty Reduction Strategy Paper (PRSP) of 2008–2012, which was supported by the Poverty Reduction and Growth Strategy Program (PRSP), included the following goals:

1. Promote sustainable economic growth and poverty reduction.
2. Improve the standard of living of the poor and marginalized.
3. Strengthen governance and the rule of law.
4. Promote human development.

The Malawi government has been working to reduce poverty by implementing various programs and initiatives. However, progress has been slow in some areas. To achieve the MDGs and the NPET, it is essential to focus on key areas such as education, health, and agriculture.

Education

Access to education is critical for reducing poverty and improving livelihoods. The Malawi government has been working to increase enrollment rates in primary and secondary schools. The government has also been implementing initiatives to ensure that children from poor families have access to education.

Health

Improving access to health care is another critical area for reducing poverty. The Malawi government has been working to increase the number of health facilities and improve the quality of care. The government has also been implementing initiatives to reduce the costs of health care and ensure that all citizens have access to essential health services.

Agriculture

Agriculture is a major source of income for many Malawians. The government has been working to increase agricultural production and ensure that farmers have access to credit and markets. The government has also been implementing initiatives to improve the quality of agricultural inputs and ensure that farmers have access to the latest technologies.

Conclusion

Improving livelihoods and reducing poverty is a complex and challenging task. The Malawi government has been working to implement various programs and initiatives to achieve the MDGs and the NPET. While progress has been made, there is still much work to be done. The government needs to focus on key areas such as education, health, and agriculture to ensure that all citizens have access to the opportunities they need to improve their livelihoods and reduce poverty.
of bonus payments on the quantity and quality of services provided and on health outcomes.

Among interviewed providers and program managers, one said “Performance contracting has liberated the entrepreneurial spirit.” According to another, “When someone feels empowered and their views are taken into account, this is more important to motivation than the actual payments received.” Finally, “Money has no color . . . Irrespective of the source, it improves incomes of health workers.”

**Hospital grants**

When the contracting approach was introduced, all MAP-funded ART facilities received small grants (up to $60,000 annually), which were used to tackle staff shortages and improve the overall functioning of the facility. Focus group discussions with providers revealed a high degree of satisfaction with the empowering effects of these small grants, which allowed staff at MAP sites to decide on the number, profile, and payment levels of additional personnel. Providers report that the additional staff (doctors, nurses, and laboratory technicians) are not assigned exclusively to HIV care and support the district

![Figure 4.2 Number of HIV Tests Before and After MAP-funded Performance-based Contracting](source: CORAID (Cyangugu), Rwanda School of Public Health (Butare) program service data.)
hospitals more generally. Pay scales are comparable to those of existing personnel to avoid creating distortions. Financing of recurrent costs (e.g., maintenance of vehicles and equipment, office materials, communications) was modest but helped with the overall running of the hospitals. These grants were combined with minor refurbishing of facilities, including new incinerators for waste management, and an important upgrading of laboratories that served not only AIDS patients but also other patients. Travel time was reduced for those who no longer needed to go long distances for various laboratory tests. A provider at the recently renovated Kiziguro Hospital, run by a religious mission, says:

“MAP has assisted to improve the quality of care for both AIDS and non-AIDS patients. We are now able to provide ARVs and medications for opportunistic infections. We no longer need to refer our patients to Kigali but can perform a full range of lab services on site.”

**The challenge of financial sustainability**

The rapid scale-up of treatment has brought new challenges. The single most important challenge is the financial sustainability of these investments as the cost of ART remains beyond the means of most Rwandans, and the government faces numerous trade-offs and constrained budgets. In the medium-term, the government will need to absorb the additional personnel and recurrent costs supported by IDA at MAP facilities. The government has already assumed responsibility for financing performance contracting for basic health services at health centers and will be doing the same for the district hospitals. The Ministry of Health is also in the process of integrating HIV care into general health services, in an effort to give greater attention to cost effectiveness and sustainability. The decentralization of HIV care also is quite advanced. This will bring services closer to patients and help maintain high adherence levels.

**Monitoring and evaluation—a harmonized approach**

Harmonized monitoring and evaluation are a key focus of the Rwanda MAP. Indicators and a routine reporting system were developed from the start. The MAP reporting system was linked to the national HIV/AIDS monitoring and evaluation system. The
The project M&E system drew all its outcome-level data from national surveys, ensuring no duplication of effort. The MAP routine data collection system has now been adopted by the National AIDS Control Commission as the national standard to be used by all projects to plan and report data on a quarterly basis at the district level—the so-called *tronc commun* system of reporting (that is, the main trunk of a tree, from which all others originate). The “Most Significant Changes” technique—a participatory methodology to enable beneficiaries to analyze and record the changes that have resulted from a project—was initiated under the MAP and has now been adopted as a national model for preparing best practice case studies.

Solid, productive, and mutually beneficial partnerships were established for monitoring the national HIV/AIDS response in Rwanda, and the Bank has played a key role in this process. The MAP team plays an active role in the national monitoring and evaluation technical working group. The World Bank provides intensive technical support for the MAP and for the national response more broadly, working in close partnership with other key stakeholders (e.g., UNAIDS and PEPFAR partners).

**Conclusion**

Looking back at the MAP experience, Dr. Agnes Binagwaho, executive secretary of the National AIDS Control Commission, says:

> “The MAP has shown how holistic, high quality care can be provided effectively to those living in remote areas. Small amounts of money have played a catalytic role in generating new economic opportunities. Start-up funding has built institutional capacities that will be sustained by government.”

Even with strong support from all the partners, this young program will require sustained financial assistance to maintain the progress made to date in containing the epidemic. The government and partners will need to ensure that sustainable long-term financing is available to provide treatment to all who will eventually need it, and that a concerted effort is made to continue strengthening health system capacity to provide a broad range of high-quality care, helping the next and future generations to remain AIDS free.
Conclusions

What Has the MAP Achieved So Far?

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 subnational 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 alloca-
tion 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 declin-
ing 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. The MAP has sup-
ported 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 pro-
jects 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 sus-
tained, 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.

Beyond Africa, this is also the case in the Bahamas, Barbados, Brazil, Cambodia, Domini-
can 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.
To measure the achievements of the Bank’s HIV/AIDS investment portfolio, this study has shown the importance of recording, collecting, and analyzing data. The available rich and detailed data are an indication of the progress made in building and strengthening functioning national HIV monitoring and evaluation systems. The “learning by doing” approach of the MAP, and the changing and complex nature of the HIV epidemic and differences across and within countries, make good M&E even more important than usual. Right from the start, the MAP recognized this and noted the risk that nascent country M&E systems would not provide all the data needed. M&E is a persistent, difficult challenge in World Bank operations across all sectors, so unprecedented support was provided for M&E support to countries. The Bank offered to host a Global AIDS Monitoring and Evaluation Team (GAMET) on behalf of UNAIDS, to help countries build and operationalize national HIV M&E systems, by providing expert hands-on practical field support (as well as tools and guidance).

Even so, obtaining the MAP results presented in this report was not a straightforward process: secondary and primary data from various sources had to be collected and analyzed. Therefore, this section of the report recommends a new Results Scorecard and Generic Results Framework, and a reporting mechanism to make tracking results more routine.
Results Scorecard and Generic Results Framework to Measure HIV/AIDS Assistance by the Bank

Several factors point to the need for a new Results Scorecard and Generic Results Framework for Bank HIV/AIDS projects. First, many MAP projects have included HIV prevalence as a project development objective (PDO) indicator, but it has become increasingly clear that measurement and attribution difficulties make HIV prevalence an inappropriate project indicator (see box 2.3). The scorecard and framework provide guidance to task team leaders on the selection of indicators. Second, there is currently a global effort to harmonize indicators across all the HIV indicator manuals that have been produced. It makes sense for the Bank to develop a results framework that is consistent with the international results framework being prepared. The more that indicators are harmonized across major donors, the less the countries’ burden of reporting. Third, the Africa Region has developed a new AIDS Agenda for Action, and the new results scorecard and framework will be useful in monitoring implementation of the Africa Region AIDS Agenda for Action and Africa Action Plan. The consistent set of core indicators for all projects in the scorecard will simplify reporting on the aggregate achievements of Bank-funded projects.

The Results Scorecard (table 6.1) is a set of key indicators that all Bank-funded HIV/AIDS projects will be required to report on and that track overall country progress. The Generic Results Framework (see appendix H) is an expanded set of indicators from which projects can choose (or to which they can add). The indicators in the framework have been selected from globally agreed-to UNGASS, MDG, and IDA indicators. (The indicators in the scorecard are a subset of the indicators in the framework.) The selection of indicators was based on the reporting capacities of countries, availability of baseline data, and efforts to harmonize and align reporting requirements with major partners (especially UNAIDS, GFATM, and PEPFAR).

Many of the selected indicators are also UNGASS and MDG indicators, so countries should already be reporting on them and have included them in the country’s national HIV M&E framework. The indicators do not attempt to measure attribution (that is, specifically what World Bank funding has provided), but rather the contribution of World Bank funding to overall country progress. Thus much of the data for the scorecard indicators are available from international reports and verified data sources, while some data will need to be reported in the Implementation Status and Results report (ISRs) for all HIV/AIDS projects. The scorecard is therefore not a separate World Bank HIV M&E reporting system but instead will ensure that indicator data from national HIV M&E systems are reported to the World Bank regularly.
Table 6.1 Africa Region HIV/AIDS Results Scorecard

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</tr>
<tr>
<td>1. Total population (millions)</td>
<td>Number</td>
<td>World Bank</td>
<td>WDI database</td>
</tr>
<tr>
<td><strong>B. Challenge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Estimated number of adults and children living with HIV</td>
<td>Number</td>
<td>UNAIDS</td>
<td>UNAIDS Global Report</td>
</tr>
<tr>
<td>3a. Men and women aged 15–24 who are living with HIV (may need to be estimated from antenatal data)</td>
<td>Percentage</td>
<td>UNGASS, IDA 14</td>
<td>UNAIDS Global Report, WHO estimates</td>
</tr>
<tr>
<td>3b. Sex workers in the capital city who are living with HIV</td>
<td>Percentage</td>
<td>UNGASS alternate indicator</td>
<td>UNAIDS Global Report, WHO estimates</td>
</tr>
<tr>
<td><strong>C. Final outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4a. Condom use: Men and women aged 15–49 reporting the use of a condom during last sexual intercourse (of those reporting sexual intercourse in the last 12 months)</td>
<td>Percentage</td>
<td>UNGASS</td>
<td>ISR (from country UNGASS report)</td>
</tr>
<tr>
<td>4b. Condom use: Sex workers who report using a condom with their most recent client (of those surveyed who report having sex with any clients in the last 12 months)</td>
<td>Percentage</td>
<td>UNGASS</td>
<td>ISR (from country UNGASS report)</td>
</tr>
<tr>
<td>5. Women and men aged 15–24 who have had sex with more than one partner in the last 12 months</td>
<td>Percentage</td>
<td>UNGASS</td>
<td>ISR (from country UNGASS report)</td>
</tr>
</tbody>
</table>

(continued)
## Table 6.1 Africa Region HIV/AIDS Results Scorecard (continued)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Indicator origin</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>D. Intermediate outcomes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Men and women with advanced HIV infection receiving antiretroviral</td>
<td>Number</td>
<td>UNGASS</td>
<td>ISR (from country UNGASS report)</td>
</tr>
<tr>
<td>combination therapy</td>
<td>Percentage</td>
<td></td>
<td>ISR (from country UNGASS report)</td>
</tr>
<tr>
<td>7. Pregnant women living with HIV who receive a complete course of anti-</td>
<td>Number</td>
<td>UNGASS</td>
<td>ISR (from country UNGASS report)</td>
</tr>
<tr>
<td>retroviral prophylaxis to reduce the risk of mother-to-child transmission</td>
<td>Percentage</td>
<td></td>
<td>ISR (from country UNGASS report)</td>
</tr>
<tr>
<td>(MTCT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Orphans and vulnerable children whose households have received care/</td>
<td>Number</td>
<td>UNGASS</td>
<td>ISR (from country UNGASS report)</td>
</tr>
<tr>
<td>support in the past 12 months</td>
<td>Percentage</td>
<td></td>
<td>ISR (from country UNGASS report)</td>
</tr>
<tr>
<td>9. Persons age 15 and older who received counseling and testing for HIV</td>
<td>Number</td>
<td>World Bank</td>
<td>ISR (from country M&amp;E system)</td>
</tr>
<tr>
<td>and received their test results</td>
<td>Percentage</td>
<td></td>
<td>ISR (from country M&amp;E system)</td>
</tr>
<tr>
<td>10. Male and female condoms distributed</td>
<td>Number</td>
<td>World Bank</td>
<td>ISR (from country M&amp;E system)</td>
</tr>
<tr>
<td>11. Civil society organizations supported for sub-projects (includes</td>
<td>Number</td>
<td>World Bank</td>
<td>ISR (from country M&amp;E system)</td>
</tr>
<tr>
<td>NGO, CBO, FBO</td>
<td>Amount of funding</td>
<td></td>
<td>ISR (from country M&amp;E system)</td>
</tr>
<tr>
<td>12. Public sector organizations supported</td>
<td>Number</td>
<td>World Bank</td>
<td>ISR (from country M&amp;E system)</td>
</tr>
<tr>
<td></td>
<td>Amount of funding</td>
<td></td>
<td>ISR (from country M&amp;E system)</td>
</tr>
<tr>
<td>13. National AIDS coordinating authority that reports annually on at</td>
<td>Percentage</td>
<td>World Bank</td>
<td>ISR (from country M&amp;E system)</td>
</tr>
<tr>
<td>least 75 percent of the indicators in its national HIV M&amp;E framework</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and that disseminates the report to national-</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6.1 Africa Region HIV/AIDS Results Scorecard  (continued)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Unit</th>
<th>Indicator origin</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>level leaders in at least three public sector organizations, national civil society leaders, and business leaders in the private sector.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Financial commitments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Total commitments for HIV/AIDS, US$</td>
<td>Amount</td>
<td>World Bank</td>
<td>Calculation (15a + 15b + 15c)</td>
</tr>
<tr>
<td>15a. Country commitments</td>
<td>Amount</td>
<td>World Bank</td>
<td>ISR (from country UNGASS report)</td>
</tr>
<tr>
<td>15c. Other development partners’ commitments</td>
<td>Amount</td>
<td>World Bank</td>
<td>Development partner Web sites</td>
</tr>
<tr>
<td>F. Disbursements</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: All of the indicators in the scorecard are based on the latest international consensus on indicator wording. As there are currently efforts under way to harmonize indicators, the indicators in the scorecard may be slightly revised in 2008, when the harmonization process will be complete. Scorecard data are not disaggregated into age groups or sex. This will be reviewed in the future as better data sets become available.
The features of the Generic Results Framework (in appendix H) are as follows:

1. There are two variations of the Results Framework—one for generalized epidemics and one for concentrated epidemics.
2. The Generic Results Framework is intended for all HIV/AIDS funding in Africa.
3. It follows the format of the Africa Region’s latest results strategy and focuses on input-level results, output-level results, and outcome-level results.
4. The Generic Results Framework collects data on HIV service coverage, because these data are needed to determine progress toward universal access targets.
5. For output-level results, the Generic Results Framework has been harmonized with the PEPFAR and GFATM practice of counting the number of service delivery points, the number of persons trained to provide a service, and the number of persons who have accessed a service.
6. Although the results framework is generic, there is scope for countries to add indicators as appropriate to their programs. Further, countries may also drop indicators from the Generic Results Framework if the HIV/AIDS funding provided by the MAP does not address a specific HIV service delivery area.

For the Generic Results Framework to be fully operationalized, it needs to be included in a revised General Operations Manual for MAP projects. The indicators in the Project Appraisal Document (PAD), including the standard PAD annex 3, the Implementation Status and Results report (ISR), and the Development Credit Agreement (DCA), may need to be replaced by the indicators from this results framework. Then indicators will need to be routinely reported and updated in ISRs.
Summary of MAP Evaluations and Assessments

Since the start of the MAP, three MAP-wide assessments and evaluations have taken place, all initiated by the Bank. These three assessments are in addition to regular country-specific MAP supervision missions and MAP midterm reviews.

Implementation Assessment Review (IAR), April 2001

This review was jointly undertaken by the World Bank and UNAIDS and focused on supervision of MAP projects by task team leaders (TTLs). It made a series of recommendations relating to supervision mechanisms and processes under the MAP (World Bank 2001a).

MAP Interim Review, October 2004

A joint Bank, DFID, civil society, and UNAIDS team was assembled to evaluate the appropriateness of the MAP objectives, progress in realizing MAP objectives, the validity of the MAP approach, the suitability of the interventions funded, and the lessons of experience that might be incorporated into the next phase. The interim review concluded that the MAP objectives were generally appropriate and in the process of being realized, that there were implementation challenges, that most projects needed time to mature, that the context of HIV/AIDS funding had significantly changed since the MAP was launched in 2001, and that the MAP funding needed to become more strategic, collaborative, and evidence based (World Bank 2004).

OED Evaluation of the MAP, May 2005

The Bank’s Operations Evaluation Department (OED, now known as the Independent Evaluation Group, IEG) conducted an evaluation of the Bank’s efforts regarding HIV/AIDS. The OED study evaluated direct country-level assistance for HIV/AIDS—policy dialogue, analytic work, and lending. It also aimed to assess the effectiveness and lessons from past assistance and looked at the assumptions, design, and risks of the ongoing Africa MAP. It
made recommendations as to how the Bank’s HIV/AIDS assistance might be improved and how perceived risks in the Africa MAP might be addressed. From this evaluation, a series of recommendations agreed on by the Committee on Development Effectiveness (CODE) was accepted and is now being implemented by ACTAfrica and the Global HIV/AIDS Program (World Bank 2005a).
## Ghana MAP Project Summary of Results

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline appraisal estimate</th>
<th>End of project target</th>
<th>End of project actual (source, year)</th>
<th>Management comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the prevalence of HIV infections among commercial sex workers in Kumasi</td>
<td>15% for roamers 54% for seaters (WAPCAS, 2002)</td>
<td>Reduce by 75%</td>
<td>24% for roamers 39% for seaters (WAPCAS, 2006)</td>
<td>Moderately satisfactory</td>
</tr>
<tr>
<td>Increase the proportion of men and women who have reduced the number of sexual partners in response to perceived risk</td>
<td>60%</td>
<td>75%</td>
<td>N/A</td>
<td>Not rated. BSS conducted in 2006, results were not available when ICR was prepared.</td>
</tr>
<tr>
<td>Increase the median age at first intercourse</td>
<td>17 years</td>
<td>18 years</td>
<td>18.3 for females 20.2 for males (GDHS, 2003)</td>
<td>Satisfactory. Next GDHS to be conducted in 2008.</td>
</tr>
<tr>
<td>Increase the proportion of men in a union using condoms during their last intercourse</td>
<td>15%</td>
<td>30%</td>
<td>39% (GDHS, 2003)</td>
<td>Satisfactory. Next GDHS to be conducted in 2008.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline appraisal estimate</td>
<td>End of project target</td>
<td>End of project actual (source, year)</td>
<td>Management comments</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Increase the proportion of women in a union using condom during last intercourse</td>
<td>6%</td>
<td>20%</td>
<td>15% (GDHS, 2003)</td>
<td>Moderately satisfactory. Next GDHS to be conducted in 2008.</td>
</tr>
<tr>
<td>Increase the percentage of males/females who know they can avoid HIV by using condoms</td>
<td>40% of males 22% of females</td>
<td>75% of males, 50% of females</td>
<td>86% of males 77% of females (GDHS, 2003)</td>
<td>Highly satisfactory. Target exceeded.</td>
</tr>
<tr>
<td>Increase the percentage of males/females who know they can avoid HIV by restricting sex to one uninfected partner</td>
<td>60%</td>
<td>90%</td>
<td>95% of males 90% of females (GDHS, 2003)</td>
<td>Satisfactory. Targets attained/exceeded.</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>Satisfactory</strong></td>
</tr>
<tr>
<td>Increase the proportion of funds awarded to CBO-submitted sub-projects (through windows B and C)</td>
<td>0%</td>
<td>20%</td>
<td>96% (2,934 of 3,026) of institutions funded through windows B and C (NGOs and CBOs)</td>
<td>Highly satisfactory. Target exceeded.</td>
</tr>
<tr>
<td>Increase the proportion of districts that have prepared plans to address HIV/AIDS and are implementing part of their plans</td>
<td>0%</td>
<td>100%</td>
<td>100% in 2003 80% in 2004 80% in 2005</td>
<td>Satisfactory. Target initially attained but dropped by 20% at end of project, because the number of districts increased from 110 to 138.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline appraisal estimate</td>
<td>End of project target</td>
<td>End of project actual (source, year)</td>
<td>Management comments</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Increase the proportion of all sub-projects that develop IEC materials designed specifically for rural population (in local dialects)</td>
<td>0% in project sites; not available for the country</td>
<td>30%</td>
<td>45%</td>
<td>Satisfactory. Target exceeded for all calls.</td>
</tr>
<tr>
<td>Percentage of first- and second-cycle schools that are providing HIV/AIDS education</td>
<td>Not available</td>
<td>50%</td>
<td>100% of 7,281 junior secondary schools</td>
<td>Moderately satisfactory. Target achieved for second-cycle schools. Figures for first-cycle schools were unavailable.</td>
</tr>
<tr>
<td>Percentage of line ministries that have trained trainers at the district level on HIV/AIDS</td>
<td>0%</td>
<td>100%</td>
<td>100% for districts</td>
<td>Satisfactory. Target achieved; at least one trainer trained in every district.</td>
</tr>
<tr>
<td>Percentage of districts that have organized care of AIDS orphans and vulnerable children (OVCs)</td>
<td>0%</td>
<td>30%</td>
<td>35%</td>
<td>Highly satisfactory. Target exceeded and districts carrying out care for OVC activities.</td>
</tr>
<tr>
<td>Percentage of districts that have organized community-based care for people living with HIV (PLWHs)</td>
<td>0%</td>
<td>50%</td>
<td>50%</td>
<td>Satisfactory. Target attained and districts carrying out care for the PLWHs activities.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Baseline appraisal estimate</td>
<td>End of project target</td>
<td>End of project actual (source, year)</td>
<td>Management comments</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------------------</td>
<td>--------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Percentage of districts that have established an adequate and functional referral system between home-based and institution-based care</td>
<td>0%</td>
<td>40%</td>
<td>Not available</td>
<td>Not rated. No information on functional referral system between home-based care and institutional-based care.</td>
</tr>
<tr>
<td>Percentage of funds disbursed by component 1 for affiliations (umbrellas) that are able to manage smaller CSOs or affiliates to provide services</td>
<td>0%</td>
<td>30%</td>
<td>1%</td>
<td>Unsatisfactory. Target not achieved. There are no well-organized umbrella associations.</td>
</tr>
<tr>
<td>Increase by 10% every year the proportion of sub-projects that are implemented effectively, meeting their stated objectives.</td>
<td>0%</td>
<td>30%</td>
<td>91% for the 1st call for subproject proposals</td>
<td>Moderately satisfactory. No analyses were made for subsequent calls (2nd, 3rd, and 4th).</td>
</tr>
<tr>
<td>Percentage of districts that regularly receive information on “best practices” examples of HIV/AIDS interventions</td>
<td>0%</td>
<td>100%</td>
<td>100%</td>
<td>Satisfactory. Target achieved; best practices information in all districts.</td>
</tr>
</tbody>
</table>

Note: Project Indicators are at baseline and end of project, compared to targets.
Task Team Leader Interview Guide

1. Have you been completing ACTAfrica’s annual questionnaire?
2. Was it completed with inputs from the country office?
3. Did you find it useful?
4. What are the specific strengths of the WB MAP approach?
5. What, in your opinion, has the MAP done in your country?
6. How can this be measured?
7. Did the national M&E system help you in your work?
8. What kind of information are you currently receiving from the NAC on a regular basis, and in what form (descriptive overview, details, tables)?
9. What kind of information would you like to receive from the NAC on a regular basis? In what form (descriptive overview, details, tables)?
10. What kind of information would you need for reporting to the WB management?
11. Is the ISR sufficient for reporting to WB management?
12. What is your judgment/appraisal on the current ISR that you are using for reporting?
13. How would you rate cooperation with other donor organizations?
Country Feedback Form

What Has the MAP Done?

Questionnaire to determine the extent of HIV services funded by the MAPs in response to the Africa Region management’s question. Please use reasonable approximations where appropriate. Provide best estimated figures rather than no response.

General Notes About the Questionnaire

- This exercise is a follow-up to the Nairobi consultation where it was agreed that some of the MAP indicators and project development objectives needed to be reviewed.
- This questionnaire is part of a larger data collection process. At this stage, we will only collect service coverage data, and outcome data will be collected from other sources (e.g., www.measuredhs.com for all DHS data).
- This questionnaire is not the results framework for the MAP, but it will inform the eventual results framework of the MAP.

Notes for columns A through E of the Questionnaire:

- Only insert values for those indicators where the MAP has contributed financially towards the achievement of the output.
- If you know the contribution by each sector, complete columns A, B, and C. If you complete columns A, B, and C, you do NOT have to complete column D. If you do not know the individual values for each sector, complete column D (total) only.
- In column E, indicate YES if the indicator value that you inserted is a result of exclusively MAP funding only (select ‘YES’).
- In column E, indicate NO if the MAP has contributed together with other funders towards the achievement of the indicator value.
General Information

Country Name: __________________________
Name of Current TTL: __________________________
Year that the First MAP Started: __________
MAP Operational Setup:  
  Integrated into NAC □
  Separate PMU □

Year that the Second MAP Started: __________________________

Contact Details of Person Who Completed the Form:
Name: __________________________________________
Designation (position in organisation): __________________________________________
Number of years experience with HIV M&E in the country: __________________________
E-mail address: __________________________________________

Service Coverage Data

a  HIV Prevention

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Civil society</th>
<th>Private sector</th>
<th>Public sector</th>
<th>Total</th>
<th>Indicator value attributable to the MAP only?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>1. Number of women enrolled in PMTCT since the start of the MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>2. Total number of VCT sites in the country</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>3. Number of VCT sites established with MAP contributions since the start of the MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>4. Number of persons that have received their HIV test results after attending a VCT site since the start of the MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>5. Number of male condoms distributed since the start of the MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>6. Number of female condoms distributed since the start of the MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
</tbody>
</table>
### b Treatment, Care, and Support

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Civil society</th>
<th>Private sector</th>
<th>Public sector</th>
<th>Total</th>
<th>Indicator value attributable to the MAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>11a. Number of sites providing ART (including PMTCT) since the start of the MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>11b. Cumulative number of persons on ARVs since the start of the MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>12. Number of PLWHs receiving prophylaxis for opportunistic infections (TB, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
</tbody>
</table>

a. IEC / BCC events refer to all information, education, and communication (IEC) and behavior change communication (BCC) events where HIV prevention information, HIV treatment and care information, information to promote voluntary counseling and testing (VCT), information to promote disclosure and partner testing, and information to decrease stigma and discrimination have been communicated during the reporting period.
### Impact Mitigation

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Civil society</th>
<th>Private sector</th>
<th>Public sector</th>
<th>Total</th>
<th>Indicator value attributable to the MAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Number of persons infected or affected by HIV, age 18 or older, who have received basic external support(^a) at community level since the start of the MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>14. Number of vulnerable children [persons aged younger than 18] who have received basic external support at the community, school or household level since the start of the MAP [see note a for definition of basic external support, including school fee support]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>15. Number of income-generating activities since the start of the MAP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
</tr>
</tbody>
</table>

### Enabling Environment for Comprehensive National HIV Response

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total</th>
<th>Indicator value attributable to the MAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>16. Number of persons trained in basic skills(^b) to provide HIV prevention, treatment care and support, and impact mitigation services since the start of the MAP</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>17. Number of decentralised government structures responsible for HIV coordination that have budgets and work plans for the HIV response since the start of the MAP</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>18. Number of employees (in public sector, private sector, or civil society) reached with workplace programmes since the start of the MAP</td>
<td></td>
<td>Yes No</td>
</tr>
<tr>
<td>19. Number of organisations provided with technical assistance in the field of HIV planning, coordination, management, capacity building, implementation, monitoring, or evaluation</td>
<td></td>
<td>Yes No</td>
</tr>
</tbody>
</table>

---

\(^a\) **Basic external support** is defined as nutrition support, emotional support, domestic support, or financial support, and is not provided by members of the household.

\(^b\) **Basic skills** include skills in planning for, implementing, applying for funding, coordinating, or monitoring and evaluating HIV services.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total</th>
<th>Indicator value attributable to the MAP?</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Percentage of posts in organisational structure in NAC/NAS that are currently vacant</td>
<td>%</td>
<td>Yes</td>
</tr>
<tr>
<td>21. Percentage of posts in the NAC/NAS’s M&amp;E unit that are currently vacant</td>
<td>%</td>
<td>Yes</td>
</tr>
<tr>
<td>22. Are all the major sources of funding—GFATM, PEPFAR, MAP and others—coordinated from one unit?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

e Qualitative Data

Please provide examples of how the MAP funding has assisted your country’s HIV response. For instance, is there any qualitative evidence—stories of positive change or testimonies—that describes how the MAP has affected the lives of people (target groups) who were targeted through MAP funding or affected and improved the institutions that the MAP supported? These data that we request may be either formal data gathered through a qualitative survey (for example, a story of best practice collected during a field visit), or it may be anecdotal evidence (such as information about improvements relayed verbally during a meeting).
### f Monitoring & Evaluation (M&E)

<table>
<thead>
<tr>
<th>Aspect of a National HIV M&amp;E System</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV M&amp;E unit</td>
<td></td>
</tr>
</tbody>
</table>
| 1 = M&E unit has not been established and there are no personnel  
2 = M&E unit has been established, not yet or partially staffed  
3 = M&E unit is established and fully staffed  
4 = M&E unit has an approved budget  
5 = M&E unit executes M&E activities as per M&E unit’s work plan |         |
| Ranking before the start of the MAP: | □       |
| Ranking on 31 August 2006:            | □       |

| 2. HIV M&E plan                      |         |
| 1 = No M&E plan  
2 = M&E plan developed, not approved  
3 = M&E plan developed and approved  
4 = M&E plan developed, approved and costed |         |
| Ranking before the start of the MAP: | □       |
| Ranking on 31 August 2006:            | □       |

| 3. Indicators                        |         |
| 1 = No indicators  
2 = Indicator set agreed to by all stakeholders, does not include UNGASS indicators  
3 = Indicator set agreed to by all stakeholders, and include all UNGASS indicators  
4 = Indicator set agreed to by all partners, include all UNGASS indicators, and linked to objectives of National Strategic Plan |         |
| Ranking before the start of the MAP: | □       |
| Ranking on 31 August 2006:            | □       |

| 4. Information system                |         |
| 1 = Database not developed  
2 = Database specifications developed, database still being developed  
3 = Database developed and installed at NAC |         |
| Ranking before the start of the MAP: | □       |
| Ranking on 31 August 2006:            | □       |
### 5. Supervision and data auditing

- **4** = Database installed and functional at decentralised levels
- **5** = Database populated with report data on ongoing basis

#### Ranking before the start of the MAP:

- **Ranking on 31 August 2006:**

### 6. Harmonised capacity building

- **1** = Guidelines have been developed
- **2** = Supervision responsibilities included in job descriptions
- **3** = Supervision visits take place as per schedule
- **4** = Database installed and functional at decentralised levels
- **5** = Database populated with report data on ongoing basis

#### Ranking before the start of the MAP:

- **Ranking on 31 August 2006:**

### 7. Strategic Information Flow

#### 7.1 Surveys and surveillance

**List which of the following surveys and surveillance are being carried out as per national M&E plan:**

- **1** = Biological surveillance
- **2** = Behavioural surveillance
- **3** = Second generation surveillance
- **4** = Workplace survey
- **5** = Health facility survey (focusing on quantity of service delivery in health sector, e.g., Service Availability Mapping)
- **6** = Quality of HIV services survey (focusing on quality of HIV service delivery in health sector, e.g., Service Provision Assessment)
- **7** = Condom availability survey

**Surveys before the start of the MAP:** (you may choose all applicable options)

**Surveys completed before 31 August 2006:** (you may choose all applicable options)
<table>
<thead>
<tr>
<th>Aspect of a National HIV M&amp;E System</th>
<th>Ranking</th>
<th>Write an appropriate rank/number in the boxes below for the ranking of this aspect of the M&amp;E system before any MAP started, and as of 31 August 2006.</th>
</tr>
</thead>
</table>
| 7.2 Routine data on non-medical HIV services | 1 = No guidelines for non-medical programme monitoring exists  
2 = Guidelines have been developed and approved, but stakeholders not trained  
3 = Stakeholders have been trained in programme monitoring guidelines  
4 = Programme monitoring data flow back to the NAC | Ranking before the start of the MAP:  
Ranking on 31 August 2006: |
| 7.3 Routine data on medical HIV services | List which of the following medical HIV services have vertical monitoring systems where data flow to the Ministry of Health and NAC:  
1 = VCT  
2 = Condom distribution  
3 = CHBC  
4 = PMTCT  
5 = ART  
6 = STI | Systems before the start of the MAP: (you may choose all applicable options)  
Ranking on 31 August 2006: (you may choose all applicable options) |
| 8. Evaluation and learning agenda | 1 = There is no research agenda or research strategy with which to coordinate HIV research (biomedical and social sciences research)  
2 = There is a strategy, but it is not well coordinated  
3 = All aspects of the research strategy are being fully implemented | Ranking before the start of the MAP:  
Ranking on 31 August 2006: |
| 9. HIV M&E advocacy and communications | 1 = There is no plan for advocacy and communications about HIV M&E  
2 = An HIV M&E communications and advocacy plan has been developed (or included in the national HIV advocacy and communications strategy)  
3 = HIV M&E communications and advocacy activities (e.g., posters, briefing sessions with cabinet) | Ranking before the start of the MAP:  
Ranking on 31 August 2006: |
<table>
<thead>
<tr>
<th>Aspect of a National HIV M&amp;E System</th>
<th>Ranking</th>
<th>Write an appropriate rank/number in the boxes below for the ranking of this aspect of the M&amp;E system before any MAP started, and as of 31 August 2006.</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. HIV M&amp;E partnerships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.1 Costed HIV M&amp;E action plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 = There is no Action Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 = There is an Action Plan, but it is incomplete</td>
<td>Ranking before the start of the MAP:</td>
<td>■</td>
</tr>
<tr>
<td>3 = The Action Plan is completed, but not costed</td>
<td>Ranking on 31 August 2006:</td>
<td>■</td>
</tr>
<tr>
<td>4 = The Action Plan is approved and costed</td>
<td>Ranking before the start of the MAP:</td>
<td>■</td>
</tr>
<tr>
<td>5 = The Action Plan is approved, costed and resources have been mobilised for all Action Plan activities</td>
<td>Ranking on 31 August 2006:</td>
<td>■</td>
</tr>
<tr>
<td>6 = Activities in the Action Plan are being implemented</td>
<td>Ranking before the start of the MAP:</td>
<td>■</td>
</tr>
<tr>
<td>10.2 Monitoring and Evaluation Task Team (working group, technical committee, or reference group)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 = No M&amp;E Task Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 = M&amp;E Task Team exists, but does not meet frequently</td>
<td>Ranking before the start of the MAP:</td>
<td>■</td>
</tr>
<tr>
<td>3 = M&amp;E Task Team exists and meets at least on a quarterly basis</td>
<td>Ranking on 31 August 2006:</td>
<td>■</td>
</tr>
</tbody>
</table>
### Table E.1 All Approved MAP Projects in Africa (as of 3/30/2007)

<table>
<thead>
<tr>
<th>Proj. ID</th>
<th>Country</th>
<th>Project title</th>
<th>Date approved</th>
<th>FY approved</th>
<th>Status</th>
<th>Date Closed</th>
<th>Type</th>
<th>Total (Net) comm. AIDS millions</th>
<th>Estimated AIDS millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>P069886</td>
<td>Ethiopia</td>
<td>Multisectoral HIV/AIDS</td>
<td>09/12/2000</td>
<td>FY01</td>
<td>Closed</td>
<td>06/30/2006</td>
<td>IDA Credit</td>
<td>59.70</td>
<td>59.70</td>
</tr>
<tr>
<td>P070920</td>
<td>Kenya</td>
<td>HIV/AIDS Project</td>
<td>09/12/2000</td>
<td>FY01</td>
<td>Closed</td>
<td>12/31/2005</td>
<td>IDA Credit</td>
<td>50.00</td>
<td>50.00</td>
</tr>
<tr>
<td>P065713</td>
<td>Eritrea</td>
<td>HAMSET (HIV/Malaria/TB/STI)</td>
<td>12/18/2000</td>
<td>FY01</td>
<td>Closed</td>
<td>03/31/2006</td>
<td>IDA Credit</td>
<td>40.00</td>
<td>13.90</td>
</tr>
<tr>
<td>P071617</td>
<td>Ghana</td>
<td>AIDS Response Project</td>
<td>12/28/2000</td>
<td>FY01</td>
<td>Closed</td>
<td>12/31/2005</td>
<td>IDA Credit</td>
<td>25.00</td>
<td>25.00</td>
</tr>
<tr>
<td>P060329</td>
<td>Gambia</td>
<td>HIV/AIDS Rapid Response</td>
<td>01/16/2001</td>
<td>FY01</td>
<td>Closed</td>
<td>12/31/2006</td>
<td>IDA Credit</td>
<td>15.00</td>
<td>15.00</td>
</tr>
<tr>
<td>P072482</td>
<td>Uganda</td>
<td>HIV/AIDS Control</td>
<td>01/18/2001</td>
<td>FY01</td>
<td>Closed</td>
<td>12/31/2006</td>
<td>IDA Credit</td>
<td>47.50</td>
<td>47.50</td>
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<tr>
<td>P073065</td>
<td>Cameroon</td>
<td>Multisectoral HIV/AIDS</td>
<td>01/21/2001</td>
<td>FY01</td>
<td>Active</td>
<td></td>
<td>IDA Credit</td>
<td>50.00</td>
<td>50.00</td>
</tr>
<tr>
<td>P071433</td>
<td>Burkina Faso</td>
<td>HIV/AIDS Disaster Relief</td>
<td>07/06/2001</td>
<td>FY02</td>
<td>Active</td>
<td></td>
<td>IDA Credit</td>
<td>22.00</td>
<td>22.00</td>
</tr>
<tr>
<td>P070291</td>
<td>Nigeria</td>
<td>HIV/AIDS Response</td>
<td>07/06/2001</td>
<td>FY02</td>
<td>Active</td>
<td></td>
<td>IDA Credit</td>
<td>90.30</td>
<td>90.30</td>
</tr>
<tr>
<td>P072226</td>
<td>Chad</td>
<td>Second Pop. &amp; AIDS</td>
<td>07/12/2001</td>
<td>FY02</td>
<td>Active</td>
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<td>IDA Credit</td>
<td>24.56</td>
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</tr>
<tr>
<td>P072987</td>
<td>Madagascar</td>
<td>Multisectoral STI/HIV/AIDS</td>
<td>12/13/2001</td>
<td>FY02</td>
<td>Active</td>
<td></td>
<td>IDA Credit</td>
<td>20.00</td>
<td>20.00</td>
</tr>
<tr>
<td>P073525</td>
<td>Central African Republic</td>
<td>HIV/AIDS</td>
<td>12/14/2001</td>
<td>FY02</td>
<td>Not Effective</td>
<td></td>
<td>IDA Credit</td>
<td>17.00</td>
<td>17.00</td>
</tr>
<tr>
<td>P073118</td>
<td>Benin</td>
<td>HIV/AIDS Multisectoral</td>
<td>01/04/2002</td>
<td>FY02</td>
<td>Closed</td>
<td>09/15/2006</td>
<td>IDA Credit</td>
<td>23.00</td>
<td>23.00</td>
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<tr>
<td>P074059</td>
<td>Senegal</td>
<td>HIV/AIDS Prevention</td>
<td>02/07/2002</td>
<td>FY02</td>
<td>Active</td>
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<td>IDA Credit</td>
<td>30.00</td>
<td>30.00</td>
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<tr>
<td>P073883</td>
<td>Sierra Leone</td>
<td>HIV/AIDS Response</td>
<td>03/26/2002</td>
<td>FY02</td>
<td>Active</td>
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<td>IDA Credit</td>
<td>15.00</td>
<td>15.00</td>
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<tr>
<td>P074249</td>
<td>Cape Verde</td>
<td>HIV/AIDS</td>
<td>03/28/2002</td>
<td>FY02</td>
<td>Active</td>
<td></td>
<td>IDA Credit</td>
<td>9.00</td>
<td>9.00</td>
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<tr>
<td>P071371</td>
<td>Burundi</td>
<td>HIV/AIDS and Orphans</td>
<td>06/27/2002</td>
<td>FY02</td>
<td>Active</td>
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<td>IDA Credit</td>
<td>36.00</td>
<td>36.00</td>
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<tr>
<td>P073378</td>
<td>Guinea</td>
<td>Multisectoral AIDS</td>
<td>12/19/2002</td>
<td>FY03</td>
<td>Active</td>
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<td>IDA Grant</td>
<td>20.30</td>
<td>20.30</td>
</tr>
<tr>
<td>P003248</td>
<td>Zambia</td>
<td>HIV/AIDS (ZANARA)</td>
<td>12/30/2002</td>
<td>FY03</td>
<td>Active</td>
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<td>IDA Grant</td>
<td>42.00</td>
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<tr>
<td>P078053</td>
<td>Mozambique</td>
<td>HIV/AIDS Response</td>
<td>03/28/2003</td>
<td>FY03</td>
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<td>IDA Grant</td>
<td>55.00</td>
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<tr>
<td>P071374</td>
<td>Rwanda</td>
<td>Multisectoral HIV/AIDS</td>
<td>03/31/2003</td>
<td>FY03</td>
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<td>IDA Grant</td>
<td>30.50</td>
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</tr>
<tr>
<td>P071612</td>
<td>Niger</td>
<td>Support for Multisector HIV/AIDS Program</td>
<td>04/04/2003</td>
<td>FY03</td>
<td>Active</td>
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<td>IDA Grant</td>
<td>25.00</td>
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<tr>
<td>P078368</td>
<td>Mauritania</td>
<td>Multisectoral HIV/AIDS &amp; Endemic Disease</td>
<td>07/07/2003</td>
<td>FY04</td>
<td>Active</td>
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<td>IDA Grant</td>
<td>21.00</td>
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</tr>
<tr>
<td>P071014</td>
<td>Tanzania</td>
<td>Multisectoral AIDS</td>
<td>07/07/2003</td>
<td>FY04</td>
<td>Active</td>
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<td>IDA Grant</td>
<td>70.00</td>
<td>70.00</td>
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<td>P073821</td>
<td>Malawi</td>
<td>Multisectoral AIDS</td>
<td>08/25/2003</td>
<td>FY04</td>
<td>Active</td>
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<td>IDA Grant</td>
<td>35.00</td>
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<tr>
<td>P074850</td>
<td>Western Africa</td>
<td>Abidjan-Lagos Transport Corridor</td>
<td>11/13/2003</td>
<td>FY04</td>
<td>Active</td>
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<td>IDA Grant</td>
<td>16.60</td>
<td>16.60</td>
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<tr>
<td>P082516</td>
<td>Congo (DRC)</td>
<td>Multisectoral HIV/AIDS</td>
<td>03/26/2004</td>
<td>FY04</td>
<td>Active</td>
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<td>IDA Grant</td>
<td>102.00</td>
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<tr>
<td>Project Code</td>
<td>Description</td>
<td>Start Date</td>
<td>Year</td>
<td>Status</td>
<td>IDA Grant</td>
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<tr>
<td>P077513</td>
<td>Congo, Rep. of Guinea-Bissau HIV/AIDS and Health</td>
<td>04/20/2004</td>
<td>FY04</td>
<td>Active</td>
<td>IDA Grant 19.00</td>
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<tr>
<td>P073442</td>
<td>Guinea-Bissau HIV/AIDS Global Mitigation Support</td>
<td>06/02/2004</td>
<td>FY04</td>
<td>Active</td>
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<tr>
<td>P082613</td>
<td>AFR Subregional Regional HIV/AIDS Treatment Acceleration Project (TAP)</td>
<td>06/17/2004</td>
<td>FY04</td>
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<tr>
<td>P082957</td>
<td>Mali Multisectoral HIV/AIDS Project</td>
<td>06/17/2004</td>
<td>FY04</td>
<td>Active</td>
<td>IDA Grant 25.50</td>
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<tr>
<td>P087843</td>
<td>*Lesotho HIV/AIDS Capacity Bldg &amp; TA</td>
<td>07/06/2004</td>
<td>FY05</td>
<td>Active</td>
<td>IDA Grant 5.00</td>
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<tr>
<td>P080406</td>
<td>AFR Subregional Africa Regional Capacity Building Prevention, Network for HIV/AIDS Treatment, &amp; Care (ARCAN)</td>
<td>09/22/2004</td>
<td>FY05</td>
<td>Active</td>
<td>IDA Grant 10.00</td>
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<tr>
<td>P083180</td>
<td>Angola HIV/AIDS, Malaria &amp; TB Control (HAMSET)</td>
<td>12/21/2004</td>
<td>FY05</td>
<td>Active</td>
<td>IDA Grant 21.00</td>
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<td></td>
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<tr>
<td>P080413</td>
<td>AFR Subregional Great Lakes Initiative on HIV/AIDS (GLIA)</td>
<td>03/15/2005</td>
<td>FY05</td>
<td>Active</td>
<td>IDA Grant 20.00</td>
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</tr>
<tr>
<td>P088879</td>
<td>Burkina Faso HIV/AIDS Disaster Response Supplement</td>
<td>05/03/2005</td>
<td>FY05</td>
<td>Active</td>
<td>IDA Grant 5.00</td>
<td></td>
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<tr>
<td>P094694</td>
<td>Eritrea HIV/AIDS/STI, Tuberculosis, Malaria and RH (HAMSET II)</td>
<td>06/30/2005</td>
<td>FY05</td>
<td>Active</td>
<td>IDA Grant 24.00</td>
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<tr>
<td>P090615</td>
<td>Madagascar Second Multisectoral STI/HIV/AIDS Prevention Project (MSPPII)</td>
<td>07/12/2005</td>
<td>FY06</td>
<td>Active</td>
<td>IDA Credit 30.00</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>P088751</td>
<td>*Congo, Dem. Rep. of Congo, Health Sector Rehabilitation Supplement</td>
<td>09/01/2005</td>
<td>FY06</td>
<td>Active</td>
<td>IDA Grant 150.00</td>
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<tr>
<td>P088797</td>
<td>Ghana MAP II</td>
<td>11/15/2005</td>
<td>FY06</td>
<td>Active</td>
<td>IDA Credit 20.00</td>
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<td></td>
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<tr>
<td>P093987</td>
<td>Burkina Faso Health Sector Support &amp; Multisectoral AIDS Project</td>
<td>04/27/2006</td>
<td>FY06</td>
<td>Active</td>
<td>IDA Credit 47.70</td>
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<tr>
<td>P101950</td>
<td>Cape Verde HIV/AIDS MAP Supplement</td>
<td>12/19/2006</td>
<td>FY07</td>
<td>Active</td>
<td>IBRD/IDA (blend) 5.00</td>
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</tr>
<tr>
<td>P104189</td>
<td>Rwanda Multisectoral HIV/AIDS Supplement</td>
<td>02/02/2007</td>
<td>FY07</td>
<td>Active</td>
<td>IDA Credit 10.00</td>
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<tr>
<td>P098031</td>
<td>Ethiopia Second Multi-sectoral HIV/AIDS Projects</td>
<td>03/08/2007</td>
<td>FY07</td>
<td>Active</td>
<td>IDA Credit 30.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total** 1,480.46 1,279.43

*Not funded within the MAP program, but consistent with MAP eligibility principles.*
Introduction to ACTAfrica, Global HIV/AIDS Program, and GAMET

ACTAfrica

To support implementation of its HIV strategy, the Bank established a multi-sectoral AIDS Campaign Team for Africa—ACTAfrica. The team serves as the region’s focal point and clearinghouse on HIV and provides a variety of services, including (1) supporting implementation of the MAP; (2) supporting African countries through knowledge dissemination and exchange; (3) mainstreaming HIV into the Bank’s work in multiple sectors; (4) supporting Bank country teams in addressing HIV in their country assistance strategies; (5) building HIV impact assessment into existing environmental and/or social assessment processes; and (6) strengthening and expanding the Bank’s partnership with UNAIDS, as well as with key agencies, non-governmental organizations, and donors.

The World Bank’s Global HIV/AIDS Program—GHAP

The World Bank’s Global HIV/AIDS Program (GHAP) was set up in 2002 to provide effective, dedicated institutional capacity to respond appropriately to HIV as part of the main development agenda and a corporate priority; to provide the needed specialized expertise on HIV, cross-cutting and multi-sectoral coherence, intensified effort and visibility.

GHAP’s roles include encouraging and supporting HIV mainstreaming in all social and economic sectors; stimulating action in response to HIV globally and within the Bank; sharing information and knowledge on prevention, care, and treatment of HIV across the Bank; serving as a technical counterpart to the Global Fund, representing the Bank in our UNAIDS cosponsor role and interacting with numerous other partners; representing the Bank at national,
regional and international discussions; and, on behalf of the UNAIDS family, hosting the Global Monitoring and Evaluation Team (GAMET), whose task is to improve the quality of HIV/AIDS monitoring and evaluation and build national capacity within countries, and the AIDS Strategy and Action Plan service (ASAP) which responds to country requests for support in developing well-prioritized, evidence-based, results-focused, costed AIDS strategies and action plans.

Global AIDS Monitoring and Evaluation Team—GAMET

The central mission of the Global AIDS Monitoring and Evaluation Team (GAMET) is to improve the quality of HIV/AIDS monitoring and evaluation (M&E) and build national capacity to support the achievement of the third of the Three Ones—one country-led and country-owned M&E system. GAMET works closely with UNAIDS and other global partners, such as other UN agencies, bilateral donors, and the Global Fund to Fight AIDS, Tuberculosis and Malaria. GAMET helps strengthen national M&E capacity through an international team of M&E specialists, based primarily in developing countries. GAMET and partners strive to harmonize their M&E support to national AIDS responses, to use available resources efficiently. Another important role of GAMET is to support the M&E activities of World Bank projects, enhancing country capacity to implement, monitor, and measure progress of the national AIDS response, and to use the information for program improvement and learning.

Results Achieved by MAP Countries in Africa

Table G.1 shows the results achieved by MAP countries in Africa. Results are based on existing data reported in the ISRs, DHS behavioral data, and data from the UNGASS reports. The results are grouped under the HIV service delivery areas defined in box 2.2 of this report. The table also indicates which of the countries had concomitant health sector funding. No outcome-level results were available for Cape Verde, Guinea-Bissau, and Lesotho.
<table>
<thead>
<tr>
<th>Country</th>
<th>WB health sector funding?</th>
<th>Enabling environment</th>
<th>Prevention</th>
<th>Treatment</th>
<th>Impact mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td></td>
<td>National funding for HIV (2001–2005) $8.9 million (UNGASS); nationally approved treatment policies and protocol are implemented (ISR)</td>
<td></td>
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<tr>
<td>Benin</td>
<td></td>
<td>National funding for HIV (2001–2005) $10.9 million (UNGASS); capacity building in about 2,000 communities in 57 of the 77 communes (ISR)</td>
<td>Young men increased condom use with nonregular partner from 34 to 59.5%; young women, 19 to 50.8% (UNGASS); young men reduced sex with multiple partners from 54 to 35% (DHS); % of infected women receiving ARV for MTCT increased from 0% to 18% (UNGASS)</td>
<td></td>
<td>ARV coverage 32.7% (UNGASS)</td>
</tr>
<tr>
<td>Botswana</td>
<td></td>
<td>National funding for HIV (2001–2005) $234.8 million (UNGASS)</td>
<td>Workplace HIV program 70% coverage in 2003 (UNGASS); condom use at last higher-risk sex: men 78%, women 70% (BAIS 2001)</td>
<td></td>
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</tr>
<tr>
<td>Burkina Faso</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005) $35.90 million (UNGASS); capacity building on AIDS activities in more than 2,000 communities—34% of all communities (ISR)</td>
<td>Reduction in sex with multiple partners reduced among young men from 39 to 23% (DHS 1999/2003); improved condom use at last risky sex from 57 to 69% for young men and 39 to 52% for young women (DHS 1999/2003)</td>
<td></td>
<td>ARV coverage 8.9% (UNGASS), 9,538 people on ARV by June 2006 (ISR)</td>
</tr>
<tr>
<td>Country</td>
<td>National Funding for HIV (2001–2005)</td>
<td>PMTCT Coverage Increased from 1.2 to 2.4% (ISR); Annual VCT Increased from 31,000 to 103,951 in 4 Years</td>
<td>ARV Coverage 9.5% (UNGASS); Number of PLWH on ART Increased from 1,200 to 6,416 in 3 Years (ISR)</td>
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<tr>
<td>Burundi</td>
<td>$44 million (UNGASS)</td>
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<tr>
<td>Cameroon</td>
<td>$4.4 million (UNGASS); Number of CSO Receiving Funds from the NAC Went from 0 to 355</td>
<td>% of Young Men and Women with Comprehensive HIV and AIDS Knowledge Increased from 16 to 27.2% (UNGASS); Condom Use with Nonregular Partner Increased from 31 to 55.4% for Young Men and 16 to 42.5% for Young Women (UNGASS); Workplace HIV Program Increased from 0 to 17.6% (UNGASS)</td>
<td>% of People with Advanced HIV Infection on ARV Increased from 1 to 17.8% (UNGASS)</td>
<td>% of Orphans Who Advance from One Grade of Primary School to the Next Increased from 60 to 84% of Estimated Number of Orphans (ISR)</td>
<td></td>
</tr>
<tr>
<td>Central African Republic</td>
<td>$1.3 million (UNGASS)</td>
<td>VCT Coverage Increased from 0 to 60% (ISR)</td>
<td>% of People with Advanced HIV Infection on ARV Increased from &lt;1 to 4.2% (UNGASS)</td>
<td></td>
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</tr>
<tr>
<td>Chad</td>
<td>$1.6 million (UNGASS)</td>
<td>Condom Use by Military Increased from 15 to 67.6% in 5 Years (ISR)</td>
<td>ARV Coverage 4.7% (UNGASS)</td>
<td></td>
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<tr>
<td>Country</td>
<td>WB health sector funding?</td>
<td>Enabling environment</td>
<td>Prevention</td>
<td>Treatment</td>
<td>Impact mitigation</td>
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<tr>
<td>Democratic Republic of Congo</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005) $3.6 million (UNGASS)</td>
<td>40,795 people received VCT (ISR); PMTCT increased from 1.5 to 35% in 2 years (ISR)</td>
<td>% of people with advanced HIV infection on ARV increased from 0 to 2.7% (UNGASS)</td>
<td></td>
</tr>
<tr>
<td>Republic of Congo</td>
<td></td>
<td>National funding for HIV (2001–2005) $4.9 million (UNGASS)</td>
<td>Workplace HIV program 28.3% (UNGASS)</td>
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<tr>
<td>Eritrea</td>
<td></td>
<td></td>
<td>Increased % of respondents with correct knowledge of HIV, from 44 to 88% (ISR)</td>
<td>TB cure rate (% of new smear-positive cases cured) 75%</td>
<td></td>
</tr>
<tr>
<td>Ethiopia</td>
<td></td>
<td>Number of woredas supported by NAC (EMSAP): 266 in 5 years (ISR)</td>
<td>Higher-risk sex reduced among young men from 64 to 37.9% (UNGASS); condom use with nonregular partner increased among young men from 30 to 36.1%, (UNGASS); % of infected pregnant women receiving complete course of ARV increased from less than 1 to 3%</td>
<td>% of people with advanced HIV infection on ARV increased from &lt;1 to 7.1% (UNGASS)</td>
<td></td>
</tr>
<tr>
<td>Gambia, The</td>
<td></td>
<td>National funding for HIV (2001–2005) $5.5 million (UNGASS), 4,000 received grants</td>
<td>MTCT coverage reached 16.6% (ISR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005)</td>
<td>Condom use with nonregular partner increased: young men 33 to 49.6%, young women 20 to 32.2% (UNGASS)</td>
<td>% of people with advanced HIV infection on ARV increased from 1.8 to 5% (UNGASS)</td>
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<tr>
<td>Ghana</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005) $11.8 million (UNGASS)</td>
<td></td>
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<tr>
<td>Guinea</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005) $0.7 million (UNGASS)</td>
<td>Workplace program 30% in 2005 (UNGASS)</td>
<td>ARV coverage 9%</td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td></td>
<td>National funding for HIV (2001–2005) $88.3 million (UNGASS)</td>
<td>% of infected women receiving ARV for MTCT increased from 1 to 9.3%; % of young men and women with comprehensive HIV/AIDS knowledge increased from 26 to 58.3%; higher-risk sex (young men) fell from 92 to 15.5%; condom use with nonregular partner increased: young men 43 to 46.1%, young women 14 to 25.2% (UNGASS); % of young men having sex with multiple partners reduced from 49 to 24% (DHS)</td>
<td>% of people with advanced HIV infection on ARV increased from 3 to 19.7% (UNGASS)</td>
<td>Ratio of orphans’ school attendance compared to other children increased from 0.74 to 0.97 (UNGASS)</td>
</tr>
<tr>
<td>Madagascar</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005) $0.5 million (UNGASS)</td>
<td></td>
<td></td>
<td>Ratio of orphans’ school attendance compared to other children increased from 0.65 to 0.80 (UNGASS)</td>
</tr>
</tbody>
</table>

(continued)
Table G.1 Results Achieved by MAP Countries in Africa (from DHS, ISR, and UNGASS data)  (continued)

<table>
<thead>
<tr>
<th>Country</th>
<th>WB health sector funding?</th>
<th>Enabling environment</th>
<th>Prevention</th>
<th>Treatment</th>
<th>Impact mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005) $32.4 million (UNGASS)</td>
<td>Condom use with nonregular partner increased: young men 38 to 45.6%, young women 32 to 33% (UNGASS); workplace program expanded coverage from 17.5 to 47% (UNGASS)</td>
<td>ART coverage increased from 1.8 to 17% (UNGASS); people on ART: 3,700 (ISR)</td>
<td>Ratio of orphans’ school attendance compared to other children increased from 0.93 to 0.97 (UNGASS)</td>
</tr>
<tr>
<td>Mali</td>
<td></td>
<td>National funding for HIV (2001–2005) $3.5 million (UNGASS)</td>
<td></td>
<td></td>
<td>% of people with advanced HIV infection on ARV increased from 2.5 to 11%</td>
</tr>
<tr>
<td>Mauritania</td>
<td>Yes</td>
<td>CSO’s allocation $37.1 million (2006) (ISR)</td>
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<tr>
<td>Mozambique</td>
<td></td>
<td>National funding for HIV (2001–2005) $2.6 million (UNGASS)</td>
<td>MTCT coverage increased from 1.4 to 3.4% (UNGASS)</td>
<td></td>
<td>% of people with advanced HIV infection on ARV increased from 0 to 7.4% (UNGASS)</td>
</tr>
<tr>
<td>Country</td>
<td>National funding for HIV (2001–2005)</td>
<td>% of infected women receiving ARV for MTCT increased from 7 to 25% UNGASS</td>
<td>% of people with advanced HIV infection on ARV increased from 0 to 35% (UNGASS)</td>
<td>Ratio of orphans’ school attendance compared to other children increased from 0.92 to 0.97 (DHS)</td>
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<tr>
<td>Namibia</td>
<td>National funding for HIV (2001–2005) $73.6 million (UNGASS)</td>
<td>% of infected women receiving ARV for MTCT increased from 7 to 25% UNGASS</td>
<td>% of people with advanced HIV infection on ARV increased from 0 to 35% (UNGASS)</td>
<td>Ratio of orphans’ school attendance compared to other children increased from 0.92 to 0.97 (DHS)</td>
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<tr>
<td>Niger</td>
<td>Yes</td>
<td>795 CSOs approved (ISR)</td>
<td></td>
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<tr>
<td>Nigeria</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005) $12.9 million (UNGASS)</td>
<td>Improved condom use at last risky sex, from 36 to 42% (young men) (UNGASS); median age at first sex rose from 19.4 to 20.3 among young men (DHS)</td>
<td>% of people with advanced HIV infection on ARV increased from 1.5 to 7% (UNGASS)</td>
<td></td>
</tr>
<tr>
<td>Rwanda</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005) $5.7 million (UNGASS)</td>
<td>Number of people receiving VCT increased to about 250,000; 10 million condoms have been distributed (Midterm Review)</td>
<td>Number of people on ART has reached 5,000 (surpasses the appraisal target of 2,350); two-thirds of beneficiaries are poor women (October 2006 estimates); ARV coverage in Rwanda is well over 50%</td>
<td>Number of OVC who received financial assistance for school fees stands at about 25,000, and 38,000 households benefit from access to community health insurance (MTR)</td>
</tr>
<tr>
<td>Country</td>
<td>WB health sector funding?</td>
<td>Enabling environment</td>
<td>Prevention</td>
<td>Treatment</td>
<td>Impact mitigation</td>
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<tr>
<td>Senegal</td>
<td></td>
<td>National funding for HIV (2001–2005) $17.8 million (UNGASS)</td>
<td>MTCT coverage increased from 0.4 to 1.4% (UNGASS)</td>
<td>ARV coverage increased to 52.3% (UNGASS)</td>
<td></td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>Yes</td>
<td>318 small CSOs and 44 large CSOs funded</td>
<td>% of youth using condom for casual sex 14.2% (2005) (ISR)</td>
<td>840 people on ART (ISR)</td>
<td></td>
</tr>
<tr>
<td>Swaziland</td>
<td></td>
<td>National funding for HIV (2001–2005) $6.6 million (UNGASS)</td>
<td>MTCT coverage increased from 1.7 to 11.9% (UNGASS)</td>
<td>% of people with advanced HIV infection on ARV increased from 1.7 to 44.4 % (UNGASS)</td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>Yes</td>
<td>National funding for HIV (2001–2005) $75.5 million (UNGASS); 20 out of 26 line ministries are implementing their respective work plans (ISR)</td>
<td>Premarital sex among young people reduced: 57 to 43% in young men and 39 to 29% in young women (DHS); comprehensive knowledge about HIV and AIDS improved from 26 to 44% (UNGASS/DHS); sex with multiple partners reduced 39 to 33% (young men) and 15 to 5% (young women) (UNGASS); 1,200 headmasters and 995 secondary school teachers trained in life skills training</td>
<td>Ratio of orphans’ school attendance compared to other children increased from 0.9 to 0.98 (DHS)</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>National funding for HIV (2001–2005)</td>
<td>Increase in infected women receiving ARV for MTCT: from 4.6 to 12% (UNGASS); median age at first sex rose from 17.6 to 18.3 years (men) and 16.7 to 17.3 years (women) DHS; condom use at last high-risk sex increased from 36 to 59% (young men) and 20 to 38% young women (DHS)</td>
<td>% of people with advanced HIV infection on ARV increased from 0 to 25% (UNGASS); % of young men and women with comprehensive HIV and AIDS knowledge increased from 25.6 to 40.5% (UNGASS); condom use with nonregular partner increased from 38 to 38.4% for young men (DHS)</td>
<td>Ratio of orphans’ school attendance compared to other children increased from 0.88 to 0.94 (DHS)</td>
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</tr>
<tr>
<td>Uganda</td>
<td>National funding for HIV (2001–2005) $18.8 million (UNGASS)</td>
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<tr>
<td>Zambia</td>
<td>National funding for HIV (2001–2005) $32.0 million (UNGASS)</td>
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<tr>
<td>Zanzibar</td>
<td>39 HIV/AIDS support groups established</td>
<td>Number of health facilities providing PMTC services went up from 6 to 100% of all health facilities</td>
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</tr>
</tbody>
</table>
Generic Results Framework for HIV/AIDS Projects

Generic Results Framework for Generalized Epidemics

**LEGEND**

- **Orange** shading refers to data that should appear in all ISRs for generalized epidemics, provided that World Bank funding supports that HIV service delivery area.

- **Gray** shading refers to data that are already being collected through UNGASS, World Bank, UNAIDS, or other reports and will be compiled by ACTAfrica/Global HIV/AIDS Program (GHAP) for all countries with HIV interventions. Thus, for all gray-shaded data, there is no need for country-level data collection.

- Each MAP project can add additional country-level data at its discretion.

- For all intermediary outcomes, data should come from the national M&E system and should cover the entire national response and not only things funded by the MAP only.
<table>
<thead>
<tr>
<th>Indicator category and indicator</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Demographics</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Total population (million)</td>
<td>World Bank statistics</td>
</tr>
<tr>
<td><strong>2. The Challenge of HIV</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Estimated number of persons living with HIV</td>
<td>UNAIDS Global AIDS Report</td>
</tr>
<tr>
<td>2.2 Estimated number of AIDS-related deaths</td>
<td>UNAIDS Global AIDS Report</td>
</tr>
<tr>
<td><strong>3. Final Outcomes (outcome-level results)</strong></td>
<td>Data source</td>
</tr>
<tr>
<td>3.1 Percentage of infants born to HIV-positive mothers who are HIV positive (UNGASS and MDG indicator)</td>
<td>Calculation, using MoH program data (data also contained in country’s UNGASS report)</td>
</tr>
<tr>
<td>3.2 Higher-risk sex—Percentage of persons who reported that they have not had sex with more than one partner (UNGASS indicator)</td>
<td>DHS or other behavioral surveillance survey (data also contained in country’s UNGASS report)</td>
</tr>
<tr>
<td>3.3 Primary abstinence—Percentage of young people 15 to 24 who reported that they have never had sex (UNGASS indicator)</td>
<td>DHS or other behavioral surveillance survey (data also contained in country’s UNGASS report)</td>
</tr>
<tr>
<td>3.4 Secondary abstinence—Percentage of persons who reported that they have not had more than one partner in the last 12 months (UNGASS indicator)</td>
<td>DHS or other behavioral surveillance survey (data also contained in country’s UNGASS report)</td>
</tr>
<tr>
<td>3.5 Condom use—Percentage of young people who used a condom during last high-risk sex (UNGASS indicator)</td>
<td>DHS or other behavioral surveillance survey (data also in country’s UNGASS report)</td>
</tr>
<tr>
<td>3.6 ARV access—Percentage of persons with advanced HIV infection on ARVs (UNGASS indicator)</td>
<td>Calculation, using MoH program data (data also contained in country’s UNGASS report)</td>
</tr>
<tr>
<td><strong>4. Intermediate Outcomes (output-level results)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>HIV prevention</strong></td>
<td></td>
</tr>
<tr>
<td>4.1 Number of pregnant women reached by PMTCT</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.2 Number of condoms distributed</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.3 Number of persons counseled and tested for HIV</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.4 Number of IEC/BCC events</td>
<td>Country-level M&amp;E system data</td>
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<tr>
<td><strong>HIV treatment, care, and support</strong></td>
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<tr>
<td>4.5 Number of persons reached with community programs</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.6 Number of persons on ARVs</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>Indicator category and indicator</td>
<td>Data source</td>
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<tr>
<td><strong>Impact mitigation</strong></td>
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<tr>
<td>4.7 Number of persons reached with impact-mitigation programs</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.8 Number of income-generating activities</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td><strong>Enabling environment and M&amp;E</strong></td>
<td></td>
</tr>
<tr>
<td>4.9 Number of persons trained in HIV service delivery(^a) in the past 12 months</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.10 Percentage of civil society organizations that are implementing HIV interventions</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.11 Percentage of decentralized government structures that executed an HIV work plan in the last 12 months</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.12 Percentage of organizations that submitted program monitoring forms to the NAC</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.13 Does the country fulfill all Three Ones requirements?</td>
<td>Interview by TTL/GAMET with key informants</td>
</tr>
<tr>
<td><strong>5. Financial Commitments for the Projects</strong></td>
<td></td>
</tr>
<tr>
<td><strong>(input-level results)</strong></td>
<td></td>
</tr>
<tr>
<td>5.1 Number of organizations funded by type of organization</td>
<td>MAP Financial Management Report prepared by the country</td>
</tr>
<tr>
<td>5.2 Percentage of funding for each type of organization by HIV service delivery area</td>
<td>MAP Financial Management Report prepared by the country</td>
</tr>
<tr>
<td>5.3 Country counterpart contribution for HIV/AIDS in US$ (millions)</td>
<td>MAP Financial Management Report prepared by the country</td>
</tr>
<tr>
<td><strong>6. HIV Project Disbursements</strong></td>
<td></td>
</tr>
<tr>
<td>6.1 Amount disbursed by the World Bank for HIV</td>
<td>WB Client Connection</td>
</tr>
<tr>
<td><strong>7. Overall HIV Financing</strong></td>
<td></td>
</tr>
<tr>
<td>7.1 Other development partners’ commitments for HIV/AIDS in US$ (millions)</td>
<td>PEPFAR Web site; GFATM Web site</td>
</tr>
<tr>
<td>7.2 WBG commitments for HIV/AIDS in US$ (millions)</td>
<td>WB Client Connection</td>
</tr>
<tr>
<td>7.3 Estimated investment requirements for HIV/AIDS in US$ (millions)</td>
<td>UNAIDS resource tracking data; development partner Web sites</td>
</tr>
<tr>
<td>7.4 Financing gap to reach HIV/AIDS targets, US$ (millions)</td>
<td>Mathematical calculation</td>
</tr>
</tbody>
</table>

\(^a\) This refers to training that addresses all issues associated with HIV services: planning, financial management, proposal writing, technical skills to deliver HIV prevention; care and support, or impact mitigation services; management or coordination of HIV activities.
Generic Results Framework for Concentrated Epidemics

LEGEND

- Orange shading refers to data that should appear in all ISRs for concentrated epidemics, provided that World Bank funding supports that HIV service delivery area.
- Gray shading refers to data that are already being collected through UNGASS, World Bank, UNAIDS, or other reports and will be compiled by ACTAfrica/Global HIV/AIDS Program (GHAP) for all countries with HIV interventions. Thus, for all gray-shaded data, there is no need for country-level data collection.
- Each MAP project can add additional country-level data at its discretion.
- For all intermediary outcomes, data should come from the national M&E system and should cover the entire national response and not only things funded by the MAP only.
<table>
<thead>
<tr>
<th>Indicator category and indicator</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Demographics</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Total population (millions)</td>
<td>World Bank statistics</td>
</tr>
<tr>
<td><strong>2. The Challenge of HIV</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Estimated number of persons living with HIV</td>
<td>UNAIDS Global AIDS Report</td>
</tr>
<tr>
<td>2.2 Estimated number of AIDS-related deaths</td>
<td>UNAIDS Global AIDS Report</td>
</tr>
<tr>
<td><strong>3. Final Outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>3.1 Percentage of most-at-risk populations (MARPs) that received HIV testing in the last 12 months and know the results</td>
<td>Behavioral surveillance survey for vulnerable groups (data also contained in the country’s UNGASS report)</td>
</tr>
<tr>
<td>3.2 Percentage of MARPs reached with HIV/AIDS prevention programs</td>
<td>Behavioral surveillance survey for vulnerable groups (data also contained in the country’s UNGASS report)</td>
</tr>
<tr>
<td>3.3 Percentage of MARPs that both correctly identify ways of preventing sexual transmission of HIV and that reject major misconceptions about HIV transmission</td>
<td>Behavioral surveillance survey for vulnerable groups (data also contained in the country’s UNGASS report)</td>
</tr>
<tr>
<td><strong>4. Intermediate Outcomes</strong></td>
<td></td>
</tr>
<tr>
<td><strong>HIV prevention</strong></td>
<td></td>
</tr>
<tr>
<td>4.1 Number of persons from MARPs reached with HIV prevention, care and support, and impact-mitigation programs, by type of HIV program and type of MARP</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.2 Number of organizations involved in providing services to MARPs</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td><strong>HIV treatment care and support</strong></td>
<td></td>
</tr>
<tr>
<td>4.3 Number of persons reached with community home-based care programs</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.4 Number of persons on ARV</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td><strong>Impact mitigation</strong></td>
<td></td>
</tr>
<tr>
<td>4.5 Number of persons reached with impact-mitigation programs</td>
<td>Country-level M&amp;E system data</td>
</tr>
</tbody>
</table>

(continued)
## Indicator category and indicator

### Enabling environment and M&E

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.6 Number of persons trained in HIV service delivery&lt;sup&gt;a&lt;/sup&gt; in the last 12 months</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.7 Percentage of civil society organizations that are implementing HIV interventions</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.8 Percentage of decentralized government structures that executed an HIV work plan in the last 12 months</td>
<td>Country-level M&amp;E system data</td>
</tr>
<tr>
<td>4.9 Does the country fulfill all Three Ones requirements?</td>
<td>Interview by TTL/GAMET with key informants</td>
</tr>
</tbody>
</table>

### 5. Financial Commitments for HIV Projects

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Number of organizations funded, by type of organization</td>
<td>MAP Financial Management Report prepared by the country</td>
</tr>
<tr>
<td>5.2 Percentage of funding for each type of organization, by HIV service delivery area</td>
<td>MAP Financial Management Report prepared by the country</td>
</tr>
<tr>
<td>5.3 Country counterpart contribution for HIV/AIDS in US$ (millions)</td>
<td>MAP Financial Management Report prepared by the country</td>
</tr>
</tbody>
</table>

### 6. HIV Project Disbursements

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Amount disbursed by the World Bank for HIV</td>
<td>WB Client Connection</td>
</tr>
</tbody>
</table>

### 7. Overall WBG Finances

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data source</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Other development partners’ commitments for HIV/AIDS in US$ (millions)</td>
<td>PEPFAR Web site; GFATM Web site</td>
</tr>
<tr>
<td>7.2 WBG commitments for HIV/AIDS in US$ (millions)</td>
<td>WB Client Connection</td>
</tr>
<tr>
<td>7.3 Estimated investment requirements for HIV/AIDS in $US (millions)</td>
<td>UNAIDS resource-tracking data</td>
</tr>
<tr>
<td>7.4 Financing gap to reach HIV/AIDS targets, $US (millions)</td>
<td>Mathematical calculation</td>
</tr>
</tbody>
</table>

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<sup>a</sup> This refers to training that addresses all issues associated with HIV services—planning, financial management, proposal writing, and technical skills to deliver HIV prevention; care and support, or impact mitigation services; management or coordination of HIV activities.
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Index

A

Abebech Gobana Children’s Care and Development Organization (AGC-CDO), 74–75
accountability, community leadership, Uganda, 84
ACTAfrica, 21–22, 26, 27, 126, 145
activism, Ethiopia, 69, 71
adaptable program lending (APL), 13
advocacy, 12
Agali Awamu, 79–82
AGAPE Association, 102, 103, 104
Angola, 47
results, 148
Anthony, Khonde, 83, 84, 86
antiretroviral therapy (ART)
   Ethiopia, 66, 67, 69
   Rwanda, 109, 110, 112
   Uganda, 76, 77, 78
attitudes
   Ethiopia, 65–66, 70–71, 74
   Uganda, 91
awareness
   Ethiopia, 74
   Rwanda, 100
   Uganda, 88, 91

B

Balaba, Dorothy, 91
basket funding of drugs, Rwanda, 110
behavior and behavior change, 15, 63–64
   high-risk sex, 51
   Rwanda, 99
   surveillance data, 26
Benin, results, 148
Betelei, Sileshi, 68–70
Binagwaho, Agnes, 113
Botswana, 17
results, 148
Burkina Faso, results, 148
Burundi, results, 149

C

Cameroon, results, 149
campaigns, 16
capacity and capacity building, 14, 46
   community leadership, 84
   Uganda, 84, 90
   World Bank, 12
care. See treatment
Caribbean, results, 149
Index

Chad, results, 149
children, Rwanda, 98–99, 102–103
see also orphans
civil society, disbursements, 33
commitment, FBOs, 106
community-based organizations (CBOs),
   Uganda, 76, 85
community engagement, 63
community initiatives
   Rwanda, 92–93
   Uganda, 90–91
community-led HIV/AIDS initiatives
   (CHAIs), Uganada, 76, 81, 83–86, 87, 88–89
community-level care, 57
community mobilization, 64–65
condom use, 52–53, 76, 120
Congo, Democratic Republic of, 43, 47
   results, 150
context, 1–3, 11–12
contracting, performance-based,
   Rwanda, 110–111
coordination, 19, 45
coordination of activities, Rwanda, 107–108
   FBOs, 106
   M&E, 112–113
coping, 2
Côte d’Ivoire, 52
counseling. See voluntary counseling and testing
Country Director Questionnaire, 26, 27
Country Feedback Forms, 28, 133–141
country needs, 2–3, 6, 8, 116–117

D
Dawn of Hope, 66–68
   executive director, 68–70
decentralization, 45
   Rwanda, 107–113
   Uganda, 87
disbursements, 123
   Generic Results Framework, 159, 162
discrimination. See stigma
District AIDS Committees (DACs),
   Uganda, 82–83, 85–86, 88
drugs, funding, Rwanda, 110
see also antiretroviral therapy (ART)

E
education, 47, 49–51
employment. See income-generating activities
enabling environment
   Generic Results Framework, 159, 162
   questionnaire, 136–137
Eretu, Godfrey, 83, 84, 85, 87
Eritrea, 56
   results, 150
Ethiopia, 44, 49, 57–58
   examples, 65–75
   results, 150
   Ethiopian Orthodox Tewahido Church
      Sunday School Project, 71–73
examples, 63–64
   Ethiopia, 65–75
   Rwanda, 92–113
   Uganda, 75–91

F
faith-based organizations (FBOs)
   Ethiopia, 71–73
   Rwanda, 102–107
Feyisa, Meslin, 68
financial commitments, 123
   Generic Results Framework, 159, 162
financial sustainability, Rwanda, 112
financing, Generic Results Framework, 159, 162
Freedom in the Sun International Center, 104
funding, 8, 18
   allocation, 9
   commitments, 3, 14, 31–33, 34, 35
disbursements, 3, 32, 33–34, 36
distribution, 4
   innovative, 13–14
international, 42
non-MAP, 17

G

The Gambia, results, 150
Gashaw, Zerihun, 70–71
Generic Results Framework, 124
  concentrated epidemics, 160–162
  generalized epidemics, 157–159
genocide, Rwanda, 96–98, 104
Ghana, 44, 45, 46
  results, 127–130, 151
Gisenyi, Rwanda, income-generating
  activities, 100–101
Global AIDS Monitoring and Evaluation
  Team (GAMET), 146
Global Fund to Fight AIDS, Tuberculosis
  and Malaria (GFATM), 18, 42
Global HIV/AIDS Program (GHAP),
  145–146
Gobana, Abebech, 74–75
government allocations/funding, 42
grants, hospital, Rwanda, 111–112
Great Lakes Initiative, 41
Guinea, results, 151
Guinea-Bissau, 56

H

Hajati Nabukenya, Hadijah, 79–82
harmonization. See coordination
  health facilities, 54–55
  HIV transmission, 53
health service delivery, 55–56
herbal treatment, Uganda, 90–91
HIV/AIDS Prevention and Control
  Offices (HAPCOs), 65
HIV status, 52–53
HIV testing, Rwanda, 100, 101, 111
  voucher program, 98–99
holistic care, Uganda, 90
home-based care
  Ethiopia, 73
  Uganda, 88
hope, restoring, Rwanda, 104
hospital grants, Rwanda, 111–112

I

impact mitigation, 6, 7, 38, 56–58
  Generic Results Framework, 159, 161
  questionnaire, 136
Implementation Assessment Review
  (IAR), 125
Implementation Status and Results
  reports (ISRs), 26
incidence, 12, 18
income-generating activities
  Ethiopia, 66–67, 73
  Rwanda, 93–94, 94–95, 100–101,
    103–104
  Uganda, 79–82
indicators, 120
information and its dissemination, 59–60
  Rwanda, 96, 110
  Uganda, 77–79, 91
in-kind support, Ethiopia, 67–68
innovation, Rwanda, 106–107
institution building, 41
Intensifying Action Against HIV/AIDS in
  Africa, 12
international funding, 42
international partnerships, 46
interview guide, 131

J

Joint United Nations Programme on
  HIV/AIDS (UNAIDS), 15

K

Kayitesi, Madine, 99–100
Kenya, 45
  results, 151
knowledge, 12, 47, 49–51
  Rwanda, 100
  Uganda, 84–85
Index

L

legislation, 44
Lesotho, 17

M

Madagascar, 50–51
results, 151
Malawi, 43, 44
results, 152
Mali, results, 152
MAP. See Multi-Country AIDS Program
MAP II, Ethiopia, 66
Mauritania, results, 152
media, 16
monitoring and evaluation (M&E), 6, 8,
17, 23–24, 38, 58–61, 120, 125–126
GAMET, 146
measuring, future Bank-financed
HIV/AIDS programs, 119–124
operationalizing, 58–60
questionnaire, 138–141
Rwanda, 112–113
Mozambique, results, 152
Mugisha, Ereazer, 83, 86
Mukono AIDS Support Association
(MASA), 76–79, 80
Multi-Country AIDS Program (MAP),
13–15
achievements, 115–117
creation, 12–13
data and data sources, 25
evaluation, 16, 22
future, 9–10
impetus, 1, 21–22
Interim Review, 125
limitations and recommendations, 117
methodology, 23–29
model for other programs, 61
objectives, 2–3, 4, 6, 14, 15, 16, 23–24,
115–116
outputs, 5–6
people’s lives and, 63–113
phases, 15
projects, approved, 142–143
purpose, 21–22
research questions, 25
results, 3–4, 9, 16, 34, 37, 39, 117, 120,
147–155
results for the World Bank, 61–62
multisector response, 44–45
Uganda, 82
Murebwayire, Gloriose, 105–106

N

Nabukenya, Hadijah Hajati, 79–82
Nakityo, Margaret, 80–81
Namibia, 17
results, 153
Nantume, Sophie, 88–89
National AIDS Commissions (NACs),
45, 46
disbursements, 33
strengthening, 41–42
Niger, results, 153
Nigeria, 41, 46, 49, 53
results, 153
Niyonsaba, Nicolas, 99, 100

O

objectives, 11–19
Operations Evaluation Department
(OED), MAP evaluation, 125–126
orphans, 56
Ethiopia, 67, 70–71, 73, 73–75
Rwanda, 92, 94, 96–98, 102–103
Uganda, 79–82
outcomes, 7–8, 120, 121, 122
Generic Results Framework, 158, 161

P

partnerships
international, 46
Rwanda, 108, 113
people living with HIV/AIDS, Uganda,
83, 88
performance, Rwanda, 108
examples, 92–113  
genocide, 96–98, 104  
results, 153  
Rwanda National Youth Council, 98–100

S

scale-up, 2, 16, 42–43  
Rwanda, 107–113  
school attendance, 56  
self-sustainability, 57  
Senegal, 46  
results, 154  
Serekebirhan, Aba, 71–73  
service coverage data, questionnaire, 134–135  
service delivery  
definition, 23  
Rwanda, 110  
Sierra Leone, 47, 51, 54, 57  
results, 154  
skills acquisition, Rwanda, 96  
see also training  
social change, 63–64  
social effects of AIDS, 11  
social mobilization, Rwanda, 94  
South Africa, 17  
stigma and discrimination  
Ethiopia, 71  
overcoming, 64  
Rwanda, 99–100, 102  
Uganda, 78, 84–85  
Sub-Saharan Africa, HIV prevalence and incidence, 12  
Swaziland, 17, 46  
results, 154  
systems strengthening, 5, 7, 37, 39

T

Tanzania, 47  
results, 154  
task team leaders (TTLs), 42, 125  
interviews, 28, 131–132  
Questionnaire, 26, 27

Q

qualitative data, questionnaire, 137  
questionnaire, country feedback form, 133–141

R

rapid information system, Rwanda, 110  
Recovery Center, Ethiopia, 67  
reporting, future Bank-financed HIV/AIDS programs, 119–124  
resource  
expansion, 12  
mobilization, 41–42  
response system, Ethiopia, 65–66  
results, 3–4, 9, 34, 37, 39, 117, 120, 147–155  
chain, 23  
Results Framework, Generic, 124  
Results Scorecard, 120–123  
rights, Uganda, 88  
risk behavior, 51–52  
Rwanda, 45, 51, 56  
challenges, 95–96
Index

The AIDS Service Organization (TASO), 87–89
Three Ones, 18, 19, 26, 40–41
data, 27
Tioulong, Saumura, 94
Traditional and Modern Health Practitioners Together Against AIDS (THETA), 90–91
training
Ethiopia, 72–73
Rwanda, 96–98
Uganda, 90
transmission, health facilities, 53
Treatment Acceleration Project (TAP) Evaluation Report, 61
treatment and care, 6, 7, 17–18, 38
Ethiopia, 69, 73
herbal, 90–91
number receiving, 55
questionnaire, 135
Rwanda, 105, 107–113
Uganda, 77–78, 87, 90–91
Turwanye Ubukene Association, 93–94, 95
Tuvugibyayo Association, 101

V
voluntary counseling and testing (VCT), 53, 54
Ethiopia, 69, 73
Rwanda, 98–99, 100
Uganda, 76
voucher system, HIV testing, Rwanda, 98–99
vulnerable and at-risk populations, 51
FBOs, Rwanda, 106

W
Waldesamuel, Serekebirhan, 71–73
widows, Uganda, 79–82
women, empowerment of, Rwanda, 95
World Bank
financial systems data, 26
future HIV/AIDS programs, 119–124
MAP results and, 61–62

Y
youth programs, Rwanda, 98–99

Z
Zambia, 47, 56, 58
results, 155
Zanzibar, 60–61
results, 155
The MAP and the World Bank have made all the difference in the fight against AIDS.

Dr. Peter Piot
UNAIDS Executive Director

The Africa Multi-Country AIDS Program 2000–2006 shows that the funding made available through the World Bank’s Multi-Country AIDS Program (MAP) has dramatically increased access to HIV prevention, care, and treatment across Africa. The book uses extensive data from national surveys and HIV/AIDS programs that show how MAP funding has helped support children and adults affected by AIDS, prevented mother-to-child transmission, helped countries build capacity for expanded and more effective national programs—including providing treatment—and been a catalyst for greatly increased support. Published and unpublished data from 30 countries are compiled to provide the first summary picture of the results to which MAP support in Africa has contributed.

One unique feature of the MAP has been its emphasis on channeling money to communities, grass-roots initiatives, civil-society organizations, and NGOs. Personal stories from people and groups in Uganda, Ethiopia, and Rwanda offer powerful examples of how these grass-roots efforts and sharing of knowledge and experiences among countries have improved health and lives, reduced stigma, and given new hope to people living with and affected by HIV across the continent.

The book also introduces a new Results Scorecard and Framework to better measure and report on results of Bank-financed HIV/AIDS programs in Africa. The results described in this book will be of great interest to readers working in the areas of civil society engagement, public health, poverty reduction, social development, and population and reproductive health, as well as to anyone interested in national and global responses to HIV in Africa.