THE WORLD BANK OPERATIONS EVALUATION DEPARTMENT

Review of National HIV/AIDS Strategies for Countries Participating in the World Bank's Africa Multi-Country AIDS Program (MAP)

Background Paper for the OED Evaluation of the World Bank's Assistance for HIV/AIDS Control

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	anti-retroviral therapy
BCC	behavior change communication
CBO	community-based organization
CSW	commercial sex worker
HIPC	highly-indebted poor country
HIV	Human Immunodeficiency Virus
IEC	information, education, and communication
MAP	Multi-Country HIV/AIDS Program
MOH	Ministry of Health
MTCT	Mother to child transmission
NGO	non-governmental organization
NMSF	National Multi-Sectoral Strategic Framework on HIV/AIDS (Tanzania)
PAD	Project Appraisal Document
PLWHA	people living with HIV/AIDS
STI	sexually-transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	voluntary counseling and testing

Contents

1. Introduction **1**

2. Strategic Approach **2**

Goals *3*

Priorities *4*

Time Sequencing 6
Inclusion or Exclusion of Particular Interventions 6
Costing 7
Detailed Projects or Targets 7
Conclusion on Prioritization 7

Targets and Indicators *8*

Monitoring and Evaluation *9*

Actors and Responsibilities *10*

Cost Estimates and Resource Mobilization *12*

3. Efficiency **13**

Targeting *13*

PLWHA and Affected Families 13
High-Risk Groups 13
Vulnerable Groups 14

Proven Interventions *14*

Economic Efficiency *16*

4. Equity **17**

5. Relevance **18**

Situation and Response Analysis *18*

Stages of the Epidemic *19*

Causes of the Epidemic *20*

6. Feasibility **20**

7. Conclusions **21**

References **25**

Appendix. Summary Tables **27**

Figures

Figure 1. Share of total estimated cost assigned to prevention compared to adult HIV prevalence 19
Figure 2. National strategy estimated average annual cost as a share of MAP project average annual budget (percent) 21

Tables

Table 1. Countries participating in the Africa MAP as of July 2003 2
Table 2. Share of estimated cost of national HIV/AIDS plan accounted for by different areas of focus 7
Table 3. Distribution of estimated costs for preventive interventions (percent of total for preventive interventions) 15
Table 4. Summary of national HIV/AIDS strategy review 22

1. Introduction

1.1 The overall development objective of the World Bank's Multi-Country HIV/AIDS Program (MAP) for the Africa Region is to increase access to HIV/AIDS prevention, care, and treatment programs, with emphasis on vulnerable groups. The specific development objectives of each country project are to be drawn from the national strategic plans. Accordingly, "satisfactory evidence of a strategic approach to HIV/AIDS" is one of four eligibility criteria. This is to be demonstrated by "a coherent, national, multisectoral strategy and action plan for HIV/AIDS prevention, care, and treatment that has been developed through a participatory approach using social assessment techniques. It could also be demonstrated by having a participatory strategic planning process underway, with a clear roadmap and timetable" (World Bank, 2000).

1.2 The project appraisal documents (PADs) for MAP projects typically do not feature substantive discussion of strategic priorities or include policy conditionalities. Indeed, project objectives themselves are largely determined by the national strategic plan. For example, the Ethiopia and Kenya PADs explicitly state that the projects are to fund the implementation of the countries' strategic plans (even though, in both cases, the national strategic plan document had not been finalized). Because they are so important in shaping the MAP projects, an understanding of these national plans is an essential step in evaluating the effectiveness of MAP assistance.

1.3 Accordingly, the objective of this review is to assess the extent to which national HIV/AIDS plans represent a **strategic approach** to addressing the epidemic. Evidence of a strategic approach includes: clear goals; explicit priorities; systematic planning, targets, timeframes, and indicators; clear plans for monitoring and evaluation; clearly specified implementing actors and responsibilities; and cost estimates and strategies for resource mobilization.

1.4 Additional characteristics of a strategic approach are the extent to which plans are efficient, equitable, relevant, and feasible. **Efficiency** in meeting defined goals is assessed by reviewing the extent to which national plans involve targeting of specific groups, rely on proven interventions, and reflect considerations of economic efficiency such as cost-effectiveness and the role of government in addressing aspects of market failure. **Equity** is considered in terms of how national plans address access to services by the poor, and whether HIV/AIDS programs are considered in the context of other health needs in the country. **Relevance** is assessed in terms of the extent to which national plans review and reflect the existing HIV/AIDS situation and response. **Feasibility** is reflected in whether the human and financial resources necessary for implementation of the plans are estimated in a realistic way, and whether implementation and absorptive capacities are considered.

1.5 National HIV/AIDS strategic plans from 21 of the 23 Sub-Saharan African countries participating in the MAP as of July 2003 are reviewed.[1] Table 1 lists the countries, their populations and GNP per capita, estimated HIV prevalence (given in the plans), and timeframes of the plans. Appendix A1 lists the national strategies reviewed.

1. National strategic plans of the Gambia and Sierra Leone were not available.

Table 1. Countries participating in the Africa MAP as of July 2003

	Population (1999) (millions)	GNP per capita (1999) ($US)	HIV prevalence (around 1998) (% adults)	Timeframe of national strategy
MAP 1				
Benin	6	380	4.1	2000-2005
Burkina Faso	11	240	7.2	2001-2005
Cameroon	15	580	7.2	2000-2005
Central African Republic *	4	290	12.9	2002-2005
Eritrea	4	200	2.4	2003-2007
Ethiopia	63	100	7.3	2001-2005
Gambia	1	340	..	..
Ghana	19	390	4.6	2001-2005
Kenya	29	360	13.0	2000-2005
Madagascar	15	250	0.9	2003-2006
Nigeria	124	310	5.9	2000-2003
Uganda	21	320	10.0	2001-2006
MAP 2				
Burundi *	7	120	8.3	1999-2003
Cape Verde	0.4	1330	1.3	2002-2006
Guinea	7	510	4.1	2003-2007
Mauritania	3	380	0.6	2003-2007
Mozambique	17	230	14.5	2000-2002
Niger	10	190	..	2002-2006
Rwanda	8	250	13.0	2002-2006
Senegal	9	510	1.4	2002-2006
Sierra Leone *	5	130	7.0	..
Tanzania	33	240	10.0	2003-2007
Zambia	10	320	20.0	2001-2003

*HIV prevalence estimate from UNAIDS.

Sources are 1999/2000 World Development Report, national HIV/AIDS strategies, and UNAIDS.

1.6 For the most part, the reviewed national strategies are organized similarly to an outline suggested by a UNAIDS (1998) guide to strategic planning (see Appendix Table A2). Description and analysis of the HIV/AIDS situation and current response in the country are followed by statements of overall goals and principles, and descriptions of areas of focus – prevention, care/treatment, mitigation, and enabling environment. Each area of focus is developed, in most cases, in terms of more specific goals, activities, targets, timeframes, indicators, and implementing partners, often summarized in a planning matrix. Separate sections are usually included on the institutional framework and on monitoring and evaluation.

2. Strategic Approach

2.1 Aside from saying that, "a strategy is nothing more than a series of steps designed to move from one situation towards another," the UNAIDS (1998) guide to strategic planning does not give a clear and concise definition. It does, however, specify that the following are features of a strategic approach:

- being situation-specific
- getting to the root of the problem
- anticipating the impact of the epidemic
- dealing with obstacles
- seizing opportunities

- setting priorities
- governments taking the lead
- learning from experience
- planning realistically
- assuring resources
- foreseeing practical management structures
- providing flexibility

2.2 Each of these characteristics is discussed one way or another in the following sections of this review. Key elements of a strategic approach to be assessed are: clarity in goals and priorities, specific targets and timeframes, a basis for evaluation of progress, and clearly assigned roles and responsibilities.

GOALS

2.3 The MAP emphasizes a multisectoral approach to HIV/AIDS, running the risk of planning in terms of sectors instead of focusing on objectives. In general, this has not occurred with the national plans reviewed, in that overall goals and areas of focus come first, and then activities and implementing sectors are specified in relation to the goals.

2.4 At the most general level, the goals of all of the plans, consistent with the overall MAP objectives, are to improve prevention, care, treatment, and mitigation of the HIV/AIDS epidemic, as well to create an enabling environment. This is expressed in different ways. Some state their overall goals in terms of these three or four general objectives, with more specific areas of focus under each objective, similar to the list below.

2.5 For example, the Burundi plan (1999-2003) states that its three overall goals are to: (i) control sexual transmission of HIV; (ii) improve the well-being of people living with HIV/AIDS (PLWHA); and (iii) reduce the impact of the epidemic on affected families. Under each overall goal, a number of more specific areas of intervention are envisioned. Other strategies state overall objectives relating directly to specific areas of intervention. For example, the Benin document lists 14 objectives, covering most of the areas of intervention listed below.

2.6 Regardless of how overall goals and specific objectives are organized, all of the plans envision improvements in most – and usually all – of the following areas.

1) prevention

    - information, education, and communication (IEC)/behavior change communication (BCC)
    - reducing vulnerability of youth, girls, and women
    - condom promotion
    - voluntary counseling and testing (VCT)
    - blood transfusion safety
    - universal safety precautions in health care settings and prevention of other types of blood-borne transmission
    - prevention of mother-to-child transmission (MTCT)
    - diagnosis and treatment of sexually-transmitted infections (STIs)

2) care and treatment

    - medical and psychosocial care for people living with HIV/AIDS

- home-based care
- treatment of opportunistic infections
- policy development/pilot programs for anti-retroviral therapy (ART)

3) mitigation

- support to communities
- support and care for AIDS orphans and affected families
- promotion of rights and reduction of stigma of PLWHA

4) enabling environment

- advocacy
- policy and legislative change
- integration of HIV/AIDS issues in other sectors, in particular poverty reduction
- institutional framework
- epidemiological and behavioral surveillance
- research
- monitoring and evaluation

2.7 That the national strategies would cover most or all of these areas, and often in similar terms and in similar order of discussion, is not surprising, since the list mirrors guidelines included in the MAP documentation, as well as the UNAIDS guide on strategic planning.

PRIORITIES

2.8 Prioritization is a key element of a strategic approach. Just what is meant by this in the context of HIV/AIDS strategies, however, could be a matter of contention. Most of these documents use the term "priority" to describe most, if not all, of the main components of an HIV/AIDS program, without relating it to any ranking according to importance or effectiveness. Almost all of the reviewed strategies include all but a few of the standard areas of intervention listed above, with no discussion of their relative importance (i.e., in terms of a ranking of goals to be achieved) or their relative effectiveness (i.e., in terms of reaching these goals).

2.9 An example can be provided by the Mauritania strategy, where the stated areas of focus for prevention are: IEC/BCC, condom promotion, VCT, STI treatment, prevention of maternal-to-child transmission, blood safety, and universal precautions. With regard to treatment and mitigation, focus areas are psychosocial and medical care, including ART, and community care and economic support for PLWHA, orphans, widows, and affected families. Improving surveillance and reinforcing coordination and management are also goals, as is the general objective of reducing the vulnerability of individuals, families, and communities. This differs little from the list above and there is no discussion of the relative importance of the different goals and areas of focus.

2.10 It could be maintained that all of the standard areas of intervention are equally essential, so that prioritization among them is not necessary or even desirable. The national strategy for Tanzania (2003-2007) makes this point, worth citing at length:

> All major elements of the National Response have to be in place if the response is likely to achieve its desired impact. The NMSF does not attempt to prioritize among those objectives or strategies. It insists on the comprehensiveness of the

> Response, knowing that due to preferences, experiences, resources available etc. priorities will have to be established in distinct areas once Operational Plans and Activities are developed. It is one of the most important tasks of TACAIDS as the main guardian of the National Response to ensure that all areas are covered and balances between the areas are maintained or (re-) established. [2]

2.11 The idea that all types of activities are necessary for success and therefore should not be prioritized is, to some extent, implicit in the MAP's emphasis on a multisectoral approach, so that the lack of prioritization evident in national plans can perhaps be explained by the signals received from the World Bank, UNAIDS, and other international partners. However, the UNAIDS (1998) guide to strategic planning *does* emphasize priority-setting:

> An essential characteristic of strategic planning is that it focuses on priority areas for action. UNAIDS strongly recommends that these priority areas be set initially by how important a contribution various factors make to the spread of the HIV/AIDS epidemic and its negative impact in the country. Other priorities – political, financial, community-related etc. – will be considered when opportunities for successful response are examined later in the planning process.

2.12 Nevertheless, the guide goes on to say that priority areas suggested by UNAIDS are:

- care for people living with HIV/AIDS;
- mitigating the impact on people infected and affected by HIV/AIDS;
- reducing the vulnerability of young people and other specific population groups;
- promoting safer sexual behavior for young people, other specific population groups and for the general public;
- promoting and distributing condoms;
- preventing and controlling STDs;
- providing safe blood supply;
- promoting safer drug injection behavior;
- promoting a supportive ethical legal, and human rights environment.

2.13 This list is quite inclusive. Similarly, the Africa MAP documentation, in which there is little – even rhetorical – emphasis on priority-setting, includes a table listing the standard HIV/AIDS interventions, recommending they should all be "higher priority" in high and increasing prevalence situations – the case in most of the Africa MAP countries. It is only in low and stable prevalence situations that a number of the care/treatment and mitigation activities are said to be lower priority (World Bank, 2000).

2.14 Although the reviewed strategic documents do not set explicit priorities among the HIV/AIDS interventions they envision, implicit priorities may be discerned in four ways. First, one strategy sequences interventions over time, presumably starting with the most urgent priorities. Second, the inclusion or exclusion of certain interventions in some strategies is informative. Third, a number of documents include cost estimates which should in principle reflect priorities. Fourth, a number of strategies are very detailed in terms of specific projects and/or specific quantitative targets, which should implicitly reflect choices and priorities.

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2. Republic of Tanzania. "National Multi-Sectoral Stratregic Framework on HIV/AIDS" (NMSF), p.5.

Time Sequencing

2.15 Although Cameroon's strategy (2000-05) cites similar overall objectives as other strategies, prioritization is evident by specifying a relatively limited number of actions to be taken immediately and in the first two years of the strategy. The stated immediate priorities include development of sectoral plans and formulation of programs for communication and media, blood supply safety, and care for PLWHA. Others are even more specific, such as assigning one full-time staff to the Central Technical Group of the National HIV/AIDS Program, agreeing with the television network on a weekly HIV/AIDS program, and organizing a donor meeting. Priorities for the first two years of the strategy are only two and quite specific: condom promotion among high-risk groups, and establishment of 11 VCT centers. However, the reasons for choosing these interventions over other types are not provided (let alone anchored in the situation and response analysis).

Inclusion or Exclusion of Particular Interventions

2.16 Prioritization may be evident with regard to inclusion or exclusion of anti-retroviral drugs for post-exposure prophylaxis, prevention of MTCT, and treatment of PLWHA. Of the 21 plans reviewed, only seven envision ART on a large scale. Many exclude it altogether, such as those in Burundi (1999-2003) and Mozambique (2000-02), or contain general actions relating to advocacy and policy development, such as those in Tanzania (2003-07) or Cape Verde (2002-06). A few, such as those in Central African Republic (2002-05) and Eritrea (2003-07), envision limited pilot programs. Use of anti-retrovirals for the prevention of MTCT is more common, specified in 17 of the 21 strategies. The cost of ART is obviously an important factor, but this is only discussed in anything more than an oblique way in seven of the reviewed documents.[3]

2.17 Aside from the inclusion or exclusion of ART, differences between plans in terms of envisioned interventions are on the margins. For example, Uganda (2000/1-2005/6) includes vaccine research, an activity not discussed by most other national plans. Seven strategies, such as those in Benin (2000-05) and Burkina Faso (2001-05), emphasize reducing gender vulnerability and include activities to strengthen the rights, education, and literacy of girls.

2.18 Differences in overall goals between national plans are often matters of emphasis. For example, 15 strategies, such as those in Senegal (2002-06), and Mauritania (2003-07), emphasize surveillance and research by including it as a distinct area of focus instead of as part of general discussion of monitoring and evaluation.

2.19 Burundi and Mozambique stand out by excluding, in addition to anti-retrovirals, several interventions found in other plans. In Burundi's strategy, under prevention, blood safety is not included, while under mitigation, only care for orphans is emphasized, leaving out the range of socio-economic support activities discussed in other plans. Mozambique similarly stands out with an overall objective limited to prevention of transmission and medical and psychosocial care to PLWHA and orphans, which excludes a range of support and mitigation activities discussed in other plans. (It is interesting that both countries are affected by conflict and developed their strategies over three years before MAP project approval).

3. See Table A3 in the Appendix for tallies of these and other characteristics of the reviewed strategic plans.

Costing

2.20 The citation above from Tanzania's strategy recognizes that prioritization is inevitable when it comes to more detailed operational planning, in particular budgeting. The ten national strategies that provide cost estimates thus reveal in this way their priorities to some extent. From those national plans (as well as sectoral plans in two cases), Table 2 shows the share of total estimated cost accounted for by different areas of focus. The priorities revealed would not necessarily have been evident from the narrative sections of the plans.

Table 2. Share of estimated cost of national HIV/AIDS plan accounted for by different areas of focus

	HIV prevalence (% adults)	% of total estimated cost of national plan			
		Prevention	Care/ treatment/ mitigation	Enabling / institutional environment	Total
Burkina Faso	7.2	59	24	17	100
Burundi	8.3	49	30	21	100
Cameroon	7.2	39	59	2	100
Ghana	4.6	41	38	21	100
Kenya	13.0	58	25	17	100
Madagascar	0.9	45	39	16	100
Mauritania *	0.6	61	18	21	100
Mozambique	14.5	49	14	37	100
Nigeria	5.9	60	14	26	100
Tanzania *	10.0	25	67	8	100
Uganda	10.0	46	33	21	100
Zambia	20.0	20	70	10	100

* from health sector plan only

Source: Author's calculations based on strategy documents in Appendix Table A1 and Government of Tanzania (2003).

Detailed Projects or Targets

2.21 A number of national strategies provide details on specific planned projects and/or have detailed and specific quantitative targets. Such detailed plans implicitly reflect priorities. For example, among the specific plans in the Central African Republic's (2002-05) strategy are the establishment of 36 VCT centers and ensuring TB treatment for 8,250 patients per year for three years. Presumably, the plan's development involved trade-offs between more or fewer VCT centers and treatment of more or fewer TB patients (among many other things). That is, there must be reasons why 36 centers are planned, and not 20 or 80. The plan is not costed, but once it is, the relative costs of all of the specific interventions will become apparent and underlying choices and priorities perhaps clearer.

2.22 The Mauritania strategy (2003-07) provides an example of a set of specific targets which may implicitly reflect priorities in a similar fashion. For example, targets include the number of HIV-positive cases identified through VCT to be increased by 50 percent and for 90 percent of public health facilities to provide adequate STI care. Again, why a 50 percent increase in positive screening and not 25 percent or 75 percent? Once this plan is budgeted and implemented, the relative costs of achieving such targets, and therefore the presumed choices of the planners, would become clearer.

Conclusion on Prioritization

2.23 Of the 21 documents reviewed, 16 contain details (time sequencing, inclusion/exclusion of interventions, cost estimates, detailed project planning, and/or detailed targets) which implicitly reflect

choices and trade-offs between different areas of focus and types of interventions. Of course, the problem is that priorities are not discussed clearly and up-front, but left to the budgeting and implementation stages. Perhaps this ambiguity is necessary for political reasons, leaving tradeoffs between the desires of different stakeholders to the future or to negotiations over budget allocations. However, this lack of transparency in prioritization undermines the main point of doing strategic planning at all, and is the major weakness of most of these national plans. The practical effect is likely that prioritizing is left to more detailed sectoral plans, and perhaps eventually to the budgeting and implementation of projects such as those in the Africa MAP.[4]

TARGETS AND INDICATORS

2.24 Overall objectives can be translated into quantitative targets and timeframes, and progress can be monitored through indicators – either related to the specific targets or measuring other aspects of the area of focus. Because they provide a clear basis for evaluation of success or failure, these elements – targets, timeframes, and indicators – especially when quantitative, are taken as evidence of serious commitment and planning.

2.25 A distinction between "objective" and "target" should be made. Most of these strategic plans have overall "objectives" (usually relating to the four standard areas of focus – prevention, care, mitigation, and enabling environment) some of which may be expressed in quantitative terms. As well, under each objective, plans may specify a number of quantitative targets and indicators. Although a few plans specify different timeframes for different targets, most assume that the timeframe is the same as that of the overall strategy.

2.26 Of course, an important overall objective for all plans relates to prevention of HIV transmission. Of the 21 documents reviewed, 13 express this in a quantitative way. Senegal's (2003-06) plan for example, aims to stabilize HIV prevalence at under 1 percent, while Kenya's (2000-05) objective is to achieve a reduction in prevalence of 20 to 30 percent by 2005 among the 15-24 age group. In most cases, other overall objectives relating to care, mitigation, and enabling environment are expressed more generally in terms of "improvements."

2.27 Eighteen of the strategies contain at least one quantitative target or indicator (under the overall objectives), but the number of targets and level of detail vary widely. Targets in Benin's (2000-05) strategy are to achieve 100 percent blood safety and reduce the risk of maternal-to-child transmission to less than 15 percent, but others are more general. Burkina Faso's (2001-05) plan, on the other hand, has a number of specific and quantified targets, examples of which include:

- reduce by 25 percent incidence among target groups
- put in place VCT services in 6 regional capitals
- increase condom utilization by 30 percent
- 100 percent blood screening
- put in place prevention of mother-to-child transmission programs in 6 regions
- reduce STI incidence by 25 percent
- 75 percent of political, traditional, and religious leaders to be engaged in HIV/AIDS activities
- integrate an HIV/AIDS component in 60 percent of poverty alleviation programs

4. A quick review of some Africa MAP project documents shows, however, that prioritization between areas of intervention is not explicitly discussed, but only reflected in budget allocation. This is likely where the differences between MAP projects – and therefore real national priorities – will be revealed.

2.28 Some of the strategies include such a large number of targets and indicators that the feasibility of measuring them may be questioned. For example, it is difficult to see how to measure a target listed by the Cameroon (2000-05) strategy: to bring to 90 percent the share of women who use female condoms when their partner refuses the male condom. Examples from the long list of indicators in the Niger (2002-06) plan include: 75 percent of political leaders are to be involved in prevention activities; 100 percent of schools are to introduce HIV/AIDS in their curricula; 100 percent of blood transfusions are to be screened; 80 percent of health workers are to be trained in the care of PLWHA; and 100 percent of hospitals are to offer PLWHA care. In this case, like some others, the ambition of some of the targets suggests that they may be unrealistic, undermining the credibility of the plan.

2.29 Along with indicators referring to specific activities or areas of intervention, a number of strategies provide a more limited list of indicators for the purpose of evaluating progress of the strategy as a whole. Niger, for example, provides a list of 16 overall indicators. Burkina Faso's list is a more reasonable five indicators for prevention and three for care/mitigation. Senegal's plan lists five targets/indicators for evaluation of the overall strategy: HIV prevalence remaining under 3 percent; 7,000 patients receiving ART; regular availability of HIV/AIDS statistics; number of research projects; and number of functional coordination bodies put in place at each level of decentralization.

2.30 A number of strategies do not consider the sources or methods by which their indicators are to be measured. Among those that do, some provide such a long list that the feasibility of monitoring them can be questioned.

2.31 More problematic is a lack of baseline data to allow monitoring of progress towards the targets and change in the indicators. Only seven of the documents provide baseline data for any significant proportion of targets and indicators. Some strategies include in their activities provision for collection of such data, but the longer the list of indicators, the more resources would be necessary for this. More importantly, the lack of information on many indicators leads to the question of how the particular quantitative targets were derived. For example, if one does not know existing STI prevalence or whether it may be increasing or decreasing, how can a certain percentage reduction be specified as a target except by more or less randomly picking a number?

2.32 Only one strategy (Burundi) mentions a quantitative target from previous HIV/AIDS plans and whether or not it was achieved. In this case, 15 percent of PLWHA are stated to currently have access to care, compared to the previous target of 75 percent.

MONITORING AND EVALUATION

2.33 Planning for monitoring and evaluation of these targets and indicators is necessary to an effective strategy. This is emphasized by the UNAIDS guide to strategic planning and is accordingly discussed in separate sections of most of the national documents.

2.34 In 15 documents, epidemiological and behavioral surveillance are treated separately from monitoring and evaluation, and emphasized as specific areas of intervention. In others, surveillance is discussed along with monitoring and evaluation. In many strategies, monitoring and evaluation is discussed in terms of process issues, rather than in terms of assessing impact – in particular on HIV transmission. As discussed below, lack of information on impact, and even presentation of available international studies, is an important weakness in the situation analyses of these documents.[5]

5. This focus on process – coordination, financial disbursement, etc. – is also evident in the Africa MAP documentation.

2.35 Many of the strategies assign responsibility for surveillance to the Ministry of Health (MOH) and monitoring and evaluation to the overall coordination body, often located within the MOH. However, only nine of the reviewed documents clearly assign overall responsibility for monitoring and evaluation to the coordinating body, with many either leaving the issue vague or stating that each implementing actor is to be responsible for monitoring and evaluation of its own program, with reports and evaluation meetings eventually to be coordinated by the central body.

2.36 How the results of monitoring and evaluation are to be used is hardly considered, despite the emphasis on "continuous project rework" in the Africa MAP documentation. The Madagascar plan is one of the few examples which explicitly states that monitoring and evaluation should contribute to ongoing program improvement.

ACTORS AND RESPONSIBILITIES

2.37 Clear specification of actors and responsibilities for implementation, in particular the lead responsibility, is also evidence of serious and realistic planning.

2.38 Of the 21 reviewed strategies, 17 list implementing sectors and/or ministries for each type of envisioned activity. A number of strategies state that the MOH is responsible for medical-related activities, but leaving that aside, only three plans (Burkina Faso, Mozambique, and Uganda) specifically designate a lead implementing actor for all or most areas of activity. Uganda is the best example of this, with a planning matrix which clearly designates a lead agency for each of the 186 listed activities. In a couple of national plans, certain sectors or ministries are designated as responsible for specific target groups. For example, the Mozambique strategy assigns programs targeting youth in school to the Ministry of Education, youth out of school to the Ministry of Youth and Sports, AIDS orphans and vulnerable mothers to the Ministry of Social Action, and STI patients and PLWHA to the MOH.

2.39 Important to the multisectoral approach, and one of the criteria for participation in the Africa MAP, is the existence of a high-level HIV/AIDS coordinating body. Most of the national strategies describe the make-up of such coordination bodies, often consisting of a council with ministerial representation and an implementing secretariat or program. Of the 21 countries reviewed, 11 have coordination bodies under the office of the President or Prime Minister while the other 10 are situated hierarchically under the MOH.

2.40 The role of the MOH is a matter of discussion in many strategies. The general emphasis on a multisectoral approach was part of a reaction to the failure of previous HIV/AIDS programs to stem the epidemic. These programs were often medical-oriented, implemented by Ministries of Health, which became discredited to some extent by the overall failure to address the epidemic. For example, Ghana's document explicitly criticizes the MOH for the lack of effectiveness of previous HIV/AIDS programs. Embracing the multisectoral approach often implied downgrading the role of the MOH, including moving overall coordination responsibility to the office of the Head of State, and was sometimes taken, including in Africa MAP documentation, as evidence of commitment to an effective strategy. Recently, the pendulum seems to have swung back a bit, so that the importance of health sector interventions is again emphasized as an essential part of HIV/AIDS programs. In the case of these 21 national strategies, 16 assign a lead or important implementing role to the MOH, often including overall coordination and monitoring and evaluation. (The exceptions, where the role of the MOH is explicitly or implicitly downgraded, are Ethiopia (2001-05), Ghana (2001-05), Guinea (2003-07), Kenya (2000-05), and Madagascar (2003-06)).

2.41 In general, clarification and development of the institutional framework is a preoccupation in many strategies, and is an area of focus recommended by the UNAIDS guide. For example, the strategies

of Benin and Burundi include organizational changes to improve multisectoral coordination. Eritrea's strategy includes rationalization of the three different existing HIV/AIDS coordinating bodies, and Niger's includes clarification of the role of the MOH, which is stated to have been ambiguous since the transfer of HIV/AIDS coordination to the Office of the President.

2.42 Decentralization and community-based implementation are also important to the approach advanced by the Africa MAP, and emphasized by many national strategies. Some go into more detail than others, but for the most part, specific mechanisms for how regional or local coordinating bodies are to operate is left to future planning. Similarly, the roles of non-governmental and community-based organizations (NGOs and CBOs), including associations of PLWHA, are emphasized in principle in most plans, and they are named as implementing actors for many of the IEC/BCC and care/support interventions. Some strategies, such as Kenya, Burundi, and Rwanda, reflect government's preoccupation with a lack of coordination and control – in particular, over flows of donor funding – of NGO programs with make up the bulk of existing HIV/AIDS interventions. However, specific mechanisms of coordination and support are not often specified. Although some strategies, like Tanzania's, specify that social fund mechanisms are to be set up, most are very general on this issue.

2.43 Similarly, the important role of the private sector is almost universally recognized in principle, but specific strategies on how to encourage this are lacking. In most national plans, the private sector is mentioned as a source of funds, in particular for workplace interventions. In all of the Africa MAP countries, private providers play a significant role in health services, but in only a few of the national plans, like Ghana and Guinea, are private health services mentioned, and in none is there a strategy on how to get them involved in HIV/AIDS activities (or at least recognition that this is a challenge).

2.44 All of the national strategies explicitly or implicitly expect to rely on international partners to finance a large share of the eventual costs. As well, international partners, in particular UNAIDS but also in some cases bilateral donors and the World Bank, were involved in strategy development, including financing the process, in particular consultants. The role of international partners in strategy development is acknowledged in 14 documents, while the participation of the World Bank is mentioned in five.[6] Cameroon and Tanzania are examples where outside consultants and externally-financed studies were used.

2.45 In the documentation for the second round of the Africa MAP (MAP II), the criterion relating to strategic planning explicitly states that PLWHA should be involved in strategy development (World Bank, 2001). Of the 21 reviewed strategies, only nine explicitly mention the involvement or consultation of PLWHA in the planning process (of these, five are funded under MAP II). Although many strategies involved some kind of consultation process, often workshops, exactly who participated is not often specified in the documents. Most of the national plans state that associations of PLWHA should be involved in implementation activities, in particular relating to care and support, but little detail is provided.

2.46 Although they may be self-evident in some cases, criteria for designating particular actors as implementers and/or leads in different areas are not discussed to any extent. Somewhat obvious are the lead roles of the MOH for medical interventions such as STI treatment, or the Ministry of Education's role in implementing IEC activities in schools. On the other hand, the reasons for involving different levels of administration (central, regional, or local), or making government the lead (as opposed to the private sector or NGOs and CBOs), may be implied but are not often clearly discussed. For example, although particular country contexts may oblige government to take the lead in IEC/BCC activities or condom promotion, it is conceivable that other types of actors could be more effective.

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6. The Africa MAP PADs provide more information on World Bank involvement in national strategy development.

COST ESTIMATES AND RESOURCE MOBILIZATION

2.47 Cost estimates and a funding strategy are evidence of a strategic approach because they reflect prioritization and consideration of the realities of the situation, in particular available and potential resources.

2.48 However, only ten of the reviewed national strategies include cost estimates for the envisioned areas of intervention. (These are evenly split between countries with projects under MAP 1 and countries under MAP II). For the others, costing is to be done by future sectoral plans (and eventually by the MAP projects), and indeed the cost estimates for Tanzania and Mauritania in Table 2 come from sectoral plans. In any case, it is not possible to assess whether estimated budgets reflect stated priorities, because, as discussed above, none of the plans clearly state their priorities among the set of standard HIV/AIDS interventions.

2.49 In fact, the bases for the cost estimates that are provided are hardly discussed. The Uganda strategy is an exception, with some discussion of the sources for cost estimates. As well, the Nigeria plan briefly mentions some of the assumptions behind the cost estimates, but these relate to accounting issues such as estimation of rates to be applied to different equipment, supplies, and services.

2.50 Resource mobilization is emphasized by the UNAIDS guide to strategic planning, which devotes one of four modules to the subject. Accordingly, many of the national strategic plans have a separate section on the subject. However, in most cases, the discussion is quite general – limited to statements that government, the private sector, and international donors are to contribute funding. In many cases, concrete strategies for raising resources are limited to plans for a donor round-table meeting.

2.51 A number of strategies specify the envisioned share of costs to be covered from different sources. For example, Burkina Faso's document states that the central government is to provide 10 percent while provincial authorities are to contribute 5 percent. Uganda provides the most detailed projections, comparing expected costs to estimated future total government revenues, specifying that the government is to devote 3.31 percent of its budget to HIV/AIDS, or 0.51 percent of GDP. This is to account for 30 to 45 percent of the total cost of the plan, with the rest coming from communities and private sources, but mostly from international donors. Nigeria's plan also stands out, presenting figures representing apparent commitments by specific donors. Several countries envision resources from debt restructuring (HIPC) to be devoted to funding their HIV/AIDS plans. Cameroon's plan, for example, states that 70 percent of costs should be covered from this source.

2.52 Only a few of the national strategies provide information on funding for existing HIV/AIDS programs. An example is Mozambique, where 85 percent of existing funding is from international sources, 11 percent from government, and 3 percent from service fees.[7]

2.53 Aside from general statements about private and community contributions, specific mechanisms for mobilizing national resources are hardly mentioned. Kenya's strategy is an exception, with mention of the need to restructure private companies' medical and retirement benefits, and to develop health insurance schemes, even though little detail is provided.

2.54 A number of strategic plans, with Rwanda and Tanzania as particular examples, focus on descriptions of envisioned financial management mechanisms (perhaps related to their preoccupation with the fact that most existing donor funding was being channeled directly to NGOs).

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7. Among all the reviewed documents, this is the only mention of fees for publicly-provided HIV/AIDS services, although they are likely in place in other countries.

3. Efficiency

3.1 Efficiency can be defined as maximizing impact/effectiveness within a given budget constraint. Consideration of efficiency can be taken as evidence of a strategic approach and is inherently important to the potential effectiveness of the strategies and actions set out in national plans.

3.2 One aspect of efficiency is to choose interventions and assign resources in a way that reflects overall goals. As discussed above, it is not possible to assess the extent to which this is done because explicit prioritization between the different overall goals – prevention, care/treatment, and mitigation – is not evident.

TARGETING

3.3 Targeting is an important way of improving efficiency by reaching groups most likely to need the services provided.

PLWHA and Affected Families

3.4 With regard to the overall goals of care, treatment, and support for PLWHA, and mitigation of the effects of the epidemic on affected individuals, families, and communities, the target groups are somewhat obvious in principle. However, as some of the situation analyses in strategic plans describe, certain groups and geographic areas are more likely to be affected than others, so that some degree of targeting of certainly limited resources for palliative care and other support is required.

3.5 This is hardly discussed in the national plans. Most plans provide estimates of the numbers of PLWHA, often of their age and sex distribution, and numbers of AIDS orphans. Urban/rural and geographic differences in HIV prevalence are also sometimes presented. However this information is never explicitly linked to any targeting strategies for coverage of care, treatment, and support activities.

High-Risk Groups

3.6 With regard to the overall goal of prevention of HIV transmission, targeting interventions to those groups most likely both to be infected and whose behaviors are most likely to contribute to further transmission, is efficient in reducing overall incidence of infection at any stage of the epidemic (World Bank, 1999a). In Sub-Saharan Africa, transmission is overwhelmingly through heterosexual intercourse, so that targeting groups with the most sexual partners is an efficient preventive strategy. Depending on the context, these groups can include commercial sex workers (CSWs), their clients, STI patients, street children, soldiers and police, long-distance truck drivers, migrant workers, miners, prisoners, refugees and internally displaced, urban professionals, and university students.

3.7 Of the 21 strategic plans reviewed, only one (Uganda 2001-06) does not explicitly mention such high-risk groups as targets for intervention.

3.8 Among the 20 plans that do include targeting of high-risk groups, the degree of emphasis varies, so that only seven refer to high-risk groups in their statements of overall goals and objectives. For example, Madagascar's plan does not mention high-risk groups in its overall goals, and considers only STI patients as a particular group to target. Mauritania lists high-risk groups in its situation analysis, and targeting is implied, but not explicitly planned in the strategy. On the other hand, Mozambique provides an example of a clearly-stated overall objective emphasizing high-risk groups, with a goal to, within three

years, reach with preventive interventions 2.31 million Mozambicans who have non-regular sexual partners.

3.9 Many of the national strategies describe in their situation analyses regional differences in HIV prevalence, but only a few include geographic targeting of preventive interventions. Zambia is an example, with explicit targeting of Lusaka and the Copper Belt region. In Nigeria's plan a number of particular interventions are to be done first in high-prevalence "hotspot" states. Kenya's plan mentions targeting slums and border towns.

3.10 Aside from some prevalence estimates, usually for CSWs, very little data on specific high-risk groups, such as numbers and locations, are presented. Exceptions include Zambia's plan, which states that interventions should reach 24,000 CSWs, 150,000 street children, 3,500 truck drivers, and 13,000 fishermen. Similarly, the Mozambique situation analysis estimates total numbers of different high-risk and vulnerable groups, including 1.6 million men who have irregular sexual relations and 380,000 who are commercial sex clients.

Vulnerable Groups

3.11 All of the reviewed strategies emphasize targeting youth and reproductive-age women as particularly vulnerable groups, echoing MAP documentation as well as the UNAIDS guide to strategic planning. The vulnerability of women due to social, cultural, and economic inequalities related to gender is a subject of much discussion in many of the strategic planning documents. As well, a number of plans focus on children and adolescents as a "window of hope," with the hope being to reach these low-prevalence groups before they grow older and adopt unsafe behaviors. Another vulnerable group sometimes cited in the strategies is formal sector workers (likely because of their economic importance, although this reason is usually not made explicit). Similarly, even though prevalence is higher in urban areas, several plans focus on the vulnerability of rural areas, with the aim of protecting them from the spread of infection. In one or two plans, men in general are also mentioned as vulnerable groups, perhaps reflecting recent concern that the focus on women's knowledge and attitudes may not be effective in situations where men have greatest control over sexual relations. (The notion of targeting becomes somewhat problematic when more and larger populations are added to such lists of "vulnerable" groups).

3.12 The distinction between high-risk and vulnerable groups is sometimes implied, or assumed, but nowhere made clear in the strategies. The difference, of course, is that high-risk groups contribute most to transmission because they have more sexual partners, while the groups considered more vulnerable (youth and women) do not necessarily contribute greatly to expansion of the epidemic. This has clear implications for efficiency in slowing and reversing the epidemic.

3.13 Without more explicit prioritization and/or more detailed costing estimates, it is difficult to discern whether rhetorical emphasis on targeting of high-risk groups is to be matched by resources and action. The available costing estimates do not provide the necessary level of detail, although in general, the impression is that more resources are to be devoted to interventions targeting the large vulnerable groups of youth and women than are to be assigned to those targeting high-transmission groups.

PROVEN INTERVENTIONS

3.14 Two factors limit an evaluation of the efficiency of the mix of interventions envisioned by the national strategies. First, without prioritization between goals, it is difficult to determine whether the package of interventions is appropriate to meet the national objectives. Second, with the exception of

ART and a limited number of specific activities, the national strategies include most of the same interventions.

3.15 Looking at efficiency only in terms of the likely effectiveness of the package of interventions in stemming the overall rate of transmission, we can examine first the priority given to preventive activities. Again, such priorities are not made explicit, but can be discerned from costing estimates from those strategies that provide them. Table 3 shows that the share of total estimated costs devoted to prevention ranges from 20 percent in Zambia to 61 percent in Mauritania. At the lower end are countries which have budgeted for ART, while most range between 50 and 60 percent devoted to preventive services. This is difficult to interpret, since there is no standard cut-off, but it seems – with several exceptions – that significant resources are envisioned to be devoted to prevention.

3.16 Another way of assessing efficiency in reducing transmission is to look for types of interventions which have been proven to be effective, such as the following (Jha and others, 2001).

- targeted condom promotion and access
- CSW peer education
- STI management
- targeting high-risk heterosexual males
- VCT
- anti-retrovirals for prevention of MTCT
- blood transfusion screening

3.17 However, in further evidence of the similarities between these strategies, almost all of them include each of these interventions, with anti-retroviral prevention of MTCT and targeting of male high-risk groups absent in a few cases.

Table 3. Distribution of estimated costs for preventive interventions (percent of total for preventive interventions)

	Burkina Faso 2001-05	Cameroon 2000-05	Ghana 2001-05	Madagascar 2003-06	Mauritania 2003-07	Mozambique 2000-02	Uganda 2001-06	Zambia 2001-03
IEC & condom promotion	*52*	*45*	*57*	*62*	*58*	*77*	*45*	*20*
IEC	10	36	..	45	41	46	24	3
Condom promotion	41	9	..	17	17	30	20	17
VCT	*7*	*19*	*8*	*6*	*9*	*3*	*27*	*40*
STI management	*8*	*8*	*12*	*5*	*1*	*4*	*9*	*11*
Prevention of MTCT	*6*	*1*	*10*	*26*	*5*	*0*	*8*	*26*
Blood safety & universal precautions	*12*	*27*	*12*	*1*	*27*	*16*	*10*	*2*
Blood safety	11	27	4	0	21	6	3	2
Universal precautions	1	0	9	0	7	10	7	0
Address structural factors	*16*	*0*	*0*	*0*	*0*	*0*	*2*	*0*
Total Preventive	*100*	*100*	*100*	*100*	*100*	*100*	*100*	*100*

Source: Author's calculations on the basis of strategy documents in Appendix Table A1.

3.18 The distribution of resources within this package of preventive interventions can be informative. Table 3 provides information from those national plans which include cost estimates. It shows the share of total resources for prevention to be assigned to different types of activities. In general, IEC and condom promotion are planned to receive the most resources, ranging from 45 to 77 percent of the total assigned to prevention. VCT and blood safety draw significant resources in many cases, as does prevention of MTCT in countries where anti-retrovirals are to be used.[8]

3.19 Seven strategies include separate modules designed to address some of the structural causes of vulnerability, in particular relating to gender inequalities. Cameroon and Benin, for example, emphasize improving female literacy, while Madagascar and Uganda include interventions relating to sexual violence, and Benin and Rwanda envision improving women's economic opportunities through revenue-generation activities. In addition, many strategies, citing the multisectoral approach, also emphasize "mainstreaming" HIV/AIDS issues in non-health sectors, in particular poverty reduction.

3.20 Some in the published literature suggest that this blurring of the focus of HIV/AIDS programs, moving quite beyond the core package of proven preventive interventions listed above, is not an efficient use of limited resources (Pisani and others, 2003). Others, like the World Bank's Africa regional strategy on HIV/AIDS, insist that addressing root causes is an essential part of an effective response (World Bank, 1999b). In any case, the lack of explicit prioritization in the national plans makes it difficult to assess the emphasis put on interventions addressing structural factors. The costing estimates shown in Table 3 suggest that for the most part, such interventions do not take up a large share of envisioned budgets, even in Uganda, where structural causes are much emphasized in the strategy text. However, it should also be noted that IEC, the most important component of preventive budgets, usually includes activities which move beyond simply encouraging sexual behavior change and condom use and which could be interpreted as addressing root causes. Examples are advocacy, awareness-raising, policy and legislative change, and rights promotion.

ECONOMIC EFFICIENCY

3.21 Important characteristics of economic efficiency are cost-effectiveness and the extent to which market failures are addressed by government through providing public goods and supporting positive externalities (World Bank, 1999a).

3.22 **Cost Effectiveness.** Cost effectiveness is a key component of economic efficiency. However, the relative costs and effects of different interventions are never mentioned in the national strategies, except for several which note the high cost of hospital care for PLWHA. Similarly, the effectiveness of different types of interventions is almost never discussed, with no reference made either to international evidence or to local experience. An exception is mention in a few strategies that mass communication campaigns done in the past were unsuccessful in significantly changing behaviors. Aside from this, in some cases there are general assertions that past programs have been ineffective. This is attributed to lack of adequate implementation as well as to the lack of a multisectoral approach. As for actions which have been effective, the Tanzania document mentions reduction in prevalence in one district (Mbeya), but notes that the reasons for this cannot be "scientifically" determined. Similarly, the Uganda strategy notes that the causes of a reduction in prevalence in that country cannot be determined.

3.23 This lack of consideration of cost or effectiveness, let alone in combination, is not surprising given the overall paucity of evidence internationally. One review, for example, found only one study

8. Although Cameroon, which budgeted significant resources for ART for PLWHA, seems to have neglected to include in its budget anti-retroviral drugs for pregnant women.

done in Africa on each of the areas of STI management and VCT (Creese and others, 2002). Another problem seems to be a general focus on process and implementation issues, rather than on the impact of programs on HIV transmission. This is evident both in many of the response analyses of the national strategies and in the general MAP documentation. Many national strategies recognize this lack of epidemiological data and analysis, and so emphasize in their planned activities surveillance, research, and prevalence and behavioral surveys.

3.24 **Public Goods.** Filling such information gaps is an example of a public good, a service for which no private market exists but which is important to the well-being of the population and so should be provided by government. Other examples in the area of HIV/AIDS are pilot projects, coordination and regulation, and the institution of universal precautions in clinical settings. All of these are included as responsibilities of government in all of the national plans.

3.25 **Externalities.** Another economic criterion for government involvement is the extent to which an activity or service includes positive externalities, so that the private market will not produce the optimal supply. All effective preventive activities imply the positive externality of reducing the circulation of HIV among the entire population, so that their inclusion in all of the national strategies as government responsibilities is economically efficient on these grounds. Although some of the treatment activities for PLWHA also include positive externalities, by reducing possible transmission of opportunistic infections such as tuberculosis, many cannot be said to have significant benefits beyond the beneficiary and his or her family (although ART, by reducing viral load, is thought to reduce risk of transmission). One argument against this interpretation is that care for PLWHA is an essential – politically-necessary – component of overall HIV/AIDS programs, so that preventive efforts would be ineffective without it.

4. Equity

4.1 Government intervention is also important for promoting equity, in particular relating to the extent to which a necessary activity imposes potentially catastrophic costs on individuals, and the extent to which access by the poor cannot be assured by a private market. Many care and treatment activities, in particular ART but also including drugs for opportunistic infections, would impose catastrophic costs on families in Africa. This is also true of prevention of MTCT with anti-retrovirals. At the same time, in countries where half or more of the population is under the poverty line, access to even relatively inexpensive services, such as health education and condoms, may be restricted for the poorest, requiring government intervention (Creese and others, 2002).

4.2 Access by the poor to services is emphasized explicitly in only a limited way. For example, the affordability of VCT is a particular preoccupation in the strategies of Burkina Faso, Mauritania and the Central African Republic. Other strategies, such as Rwanda's and Tanzania's, mention ensuring access by the poorest as a guiding principle, but it is less clear how this is to be operationalized. Nigeria's strategy stands out in its emphasis on targeting in priority those who are least able to pay. An implicit goal of improving access is more common insofar as extension of service coverage is part of the objectives of many plans.

4.3 Equity in terms of how HIV/AIDS programs are balanced with other health needs should also be an important consideration. It is a particularly obvious concern with regard to the high cost of ART. However, although the resource demands by ART in particular are mentioned in an oblique manner in some plans, the issue is never confronted head-on. Seven of the reviewed documents mention the cost of ART more directly, although there is no comparison with the financial requirements of other health services.

4.4 Many documents mention the existing high cost of hospital care for PLWHA. For example, in Kenya, Burkina Faso, and Burundi, 30 to 70 percent of hospital beds are occupied by PLWHA. Only in the Burundi plan is development of community and home-based care explicitly linked to this need to free up health sector resources, although this is implicit to many other plans.

4.5 Only a few plans mention overall health sector strategies (Mauritania) or existing health expenditures (Benin), and even in these cases there is little discussion of how the HIV/AIDS strategy is to fit in. The Tanzania strategy stands out with explicit statements regarding the need to find a balance between providing HIV/AIDS-related services and meeting other health needs. It also says that such a balance is necessary between ART and other HIV/AIDS interventions. More details on how this is to be done, however, are not provided.

5. Relevance

5.1 The relevance of a national HIV/AIDS strategic plan depends on analysis of the current situation and response, reflecting understanding of the stage and causes of the epidemic.

SITUATION AND RESPONSE ANALYSIS

5.2 Analysis of the current situation and response in order to shape future plans is a key characteristic of a strategic approach, emphasized by the UNAIDS guide to strategic planning, which devotes two of four modules to the subjects. Accordingly, all of the national strategic plans reviewed here have sections on situation and response analysis, and many provide relatively lengthy discussion, although empirical data is often scarce. Exceptions are a few countries, such as Eritrea and Guinea, where HIV prevalence surveys had been done and different risk factors, in particular age, sex, geographic location, and occupation, can be described in quantitative terms.

5.3 Although many are very descriptive, 14 of the strategies reflect an analytical effort by describing conclusions and recommendation flowing from the existing situation and response. For example, 15 such recommendations are listed in the Benin strategy, including the need to revise current IEC messages and methods, and the necessity to target CSWs and migrants. On the other hand, many such recommendations are quite general, and tend to cover most, if not all, of the range of possible HIV/AIDS interventions. The Benin list, for example, refers to IEC in general, IEC in schools, development of local capacities, developing targeted interventions, advocacy of religious leaders, condom promotion, improvement of the status of women, protection of vulnerable children, STI management, care and support for PLWHA, blood transfusion safety, surveillance, coordination, decentralization, and resource mobilization.

5.4 This lack of focus is reflected in the lack of prioritization evident in the objectives and plans. In general, although the situation and response analyses of many strategies are relatively strong, conclusions (if drawn) are general, and there is little evident link between different aspects of the situation and the proposed goals and plans. An obvious example is that many documents refer in their situation analysis to geographic differences in prevalence, but only a few (Nigeria, Mozambique, Zambia) include geographic targeting as a strategy.

STAGES OF THE EPIDEMIC

5.5 Assessing the relevance of the content of these strategies is correspondingly difficult given this lack of focus and prioritization – and the resulting similarity between plans despite widely varying contexts.

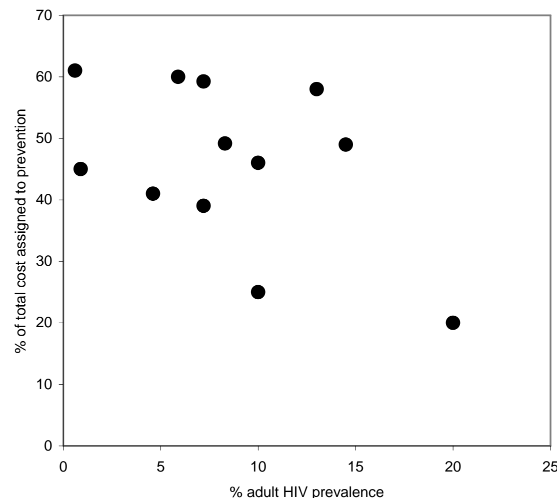
5.6 The World Bank's Africa regional strategy on HIV/AIDS defines two epidemic stages (World Bank, 1999b). The policy prescription when adult prevalence is under 7 percent is to focus resources on reducing transmission among high risk groups, followed by coverage of other vulnerable groups as resources permit. When prevalence is over 7 percent, the prescription is to continue interventions targeting high-risk groups, while at the same time addressing other vulnerable groups, and rapidly adding care and mitigation activities. Epidemic stages can also be characterized as nascent, concentrated, and generalized (World Bank, 1999a). An epidemic is classified as nascent when HIV prevalence is lower than 5 percent among high-risk groups, but as concentrated when HIV prevalence is 5 percent or higher among these groups, but remains lower in the general population. A generalized epidemic is defined as a situation where adult HIV prevalence among the general population is 5 percent or higher. UNAIDS, alternatively, classifies an epidemic as generalized when HIV prevalence among the general population is 1 percent or higher (UNAIDS, 2000).

5.7 According to HIV prevalence estimates provided (with some exceptions) in the plans, four countries can be classified as having nascent epidemics (Cape Verde, Madagascar, Mauritania, and Niger), and five as concentrated (Benin, Eritrea, Ghana, Guinea, and Senegal), with the rest experiencing generalized epidemics.

5.8 This terminology is used in only two of the national strategies, and in none are the standard policy prescriptions clearly spelled out. Again, due to the lack of explicit prioritization, it is difficult to assess the extent to which these strategies are relevant to the stage of the epidemic in each country, although the lack of prioritization itself is inconsistent with the policy prescription of starting with high-risk groups at any stage.

5.9 Lacking explicit prioritization, we must turn to the available cost estimates to provide an idea of implicit priorities. Figure 1 compares the share of total estimated cost assigned to prevention activities with the rate of adult HIV prevalence in the general population. The pattern is very close to random, suggesting that, in general, any standard prescription is not being applied.

Figure 1. Share of total estimated cost assigned to prevention compared to adult HIV prevalence



Source: Author's estimates of share allocated to prevention based on strategic plans.
Note: Actual expenditures may not correspond with what is in the strategic plans.

CAUSES OF THE EPIDEMIC

5.10 All of the reviewed national strategies recognize heterosexual transmission as the major proximate cause of the epidemic, with MTCT and blood-borne infection each accounting for less than 5 percent of cases – although the empirical bases for such estimates are never noted. Most of the documents also review root causes such as poverty, conflict, migration, and gender inequality, and several go into detail on cultural practices and sexual behaviors.

5.11 Again, it is difficult to tell to what extent the strategies reflect these diagnoses, given the lack of explicit prioritization among the standard areas of intervention. However, the distribution of estimated costs of different types of preventive activities given in Table 3 shows that, in general, IEC, condom promotion, VCT, and STI management, which all address sexual transmission, make up the bulk of envisioned budgets, although it is not possible to determine to what extent these are to be targeted at high-transmission groups.

6. Feasibility

6.1 The feasibility of a strategy depends on a number of factors, in particular the extent to which it reflects a realistic understanding of the situation and appreciation of the limits of available resources – financial, human, and institutional.

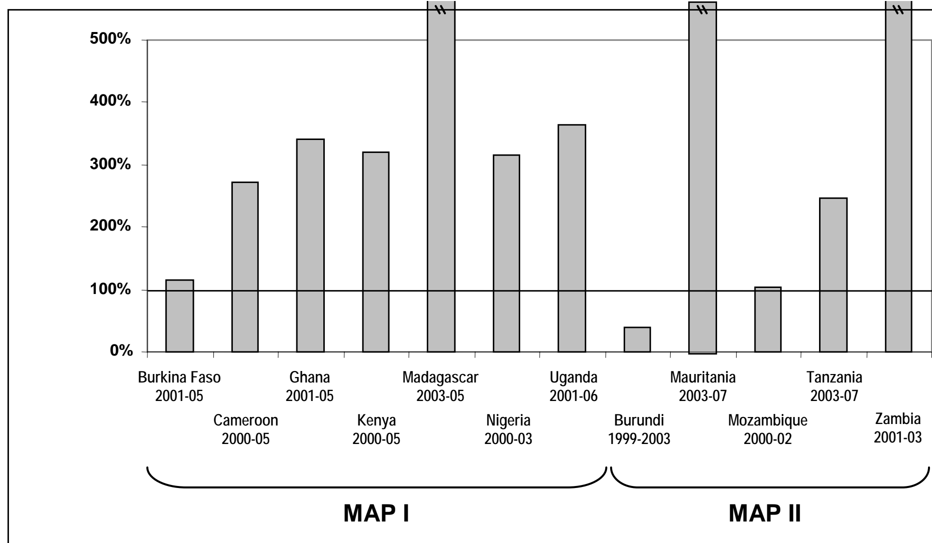
6.2 In general, the lack of prioritization in most of the plans, the lack of costing in half of them, and the lack of details on resource mobilization in most, suggest that more planning work would be necessary before many of these strategies could be considered feasible.

6.3 With regard to human and institutional capacity, there is wide recognition in the national plans of existing weaknesses, so that training and capacity-building – mostly of government structures, but also of NGOs and CBOs – make up significant components of the planned strategies. This can be seen to some extent in Table 2, where planned expenditures under the “enabling/institutional environment” category are significant, usually around 15 or 20 percent of total estimated costs, and largely consist of support for such capacity building.

6.4 For those that provide cost estimates, it is difficult to assess their feasibility without more detailed understanding of each country context. However, on the assumption that such understanding influenced subsequent project development, the annual budgets of the MAP projects can provide a standard by which the feasibility of the cost estimates provided in the national plans can be evaluated.[9] Figure 2 shows the annual estimated cost given by national strategies as a proportion of the average annual budget of each country’s subsequent MAP project. It shows that with some exceptions, estimated budgets considerably exceed what subsequently became available, which suggests that the many of the costings may have been somewhat unrealistic.

9. Note that other sources of funding are not considered, such as the Global Fund.

Figure 2. National strategy estimated average annual cost as a share of MAP project average annual budget (percent)



Source: Appendix Table A3.

6.5 The graph also supports more subjective impressions of the feasibility and realism of some of these national plans. For example, the Burkina Faso, Burundi, and Mozambique strategies, with clear objectives and an understanding of resource constraints reflected in their exclusion of ART, give the impression of being the result of a serious and realistic planning process. Alternatively, the Zambia national strategy, despite a relatively sophisticated situation and response analysis, is very undeveloped so that it is difficult to see the basis on which its attached costing table was produced.

7. Conclusions

7.1 The UNAIDS guide suggests there are three types of strategic plans:

1) a general framework which sets fundamental principles, broad strategies, and the institutional framework, acting as the basis for subsequent operational planning;
2) a general framework plus more detailed strategies and intermediate steps to reach stated objectives; or
3) a general framework plus detailed strategies plus detailed alternatives for each strategy to overcome potential obstacles.

7.2 With perhaps one exception (Zambia 2001-03), the documents reviewed can be considered to provide the elements characterizing the first type: a general framework of broad strategies and an institutional structure. In addition, a third to a half of the reviewed documents (varying in level of detail) specify “intermediate steps,” including envisioned interventions, targets and indicators, implementing actors, monitoring and evaluation, and costing – and so would fit with the second type. It should be noted that a number of the documents reviewed were not finalized before the country’s MAP project approval date (see Table A4 in the Appendix). These are Eritrea, Ethiopia, Central African Republic, Ghana,

Kenya, and Madagascar (and perhaps others).[10] However, like those for which strategic plans were still not available at the time of this study (Gambia and Sierra Leone), the MAP project documents refer to an ongoing process of strategic plan development. (The Zambia document is basically a plan for such a process).

7.3 Thus, almost all the reviewed documents meet this general definition of a “strategy” and could therefore be considered to meet the MAP criterion. As well, those that do not have a strategy document are said to have a strategic planning process in place, so that they also meet the criterion.

7.4 This review considers a set of more specific characteristics of a “strategic approach, however.” A quick summary of the preceding analysis is provided in Table 4. It shows, ignoring differences in degree, that most of the strategies have most of the characteristics considered. However, the most important characteristic that is lacking is statements of clear priorities. This is important with regard to the question of what guidance is provided to the Africa MAP projects by the national strategic plans.

7.5 For the most part, they advocate a standard package of HIV/AIDS interventions (such as the list provided in Section 0 above). With ART as the most significant exception, all of the national strategies set out similar broad areas of focus (prevention, care/treatment, mitigation, and enabling environment) and similar specific types of interventions (i.e., IEC, condom promotion, STI treatment, VCT, community mobilization, etc.). *The overall strategic direction provided by these plans, then, would have differed little from a standard template*.

Table 4. Summary of national HIV/AIDS strategy review

Characteristic	Number of strategies
Strategic approach	
Goals	Most
Priorities	None
targets and indicators	Most
monitoring and evaluation	Most
actors and responsibilities	Most
Efficiency	
targeting	Most
proven interventions	All
economic efficiency	Most
Equity	
access	Few
other health needs	Few
Relevance	
situation and response analysis	All
consider stage of the epidemic	Few
consider causes of the epidemic	All
Feasibility	
costing	Some
resource mobilization	Some
implementation capacity	Some

10. Given the temporal correspondence in many cases between national strategy development and MAP project preparation, it is unlikely that the former was done in isolation from the latter.

7.6 What is lacking is clear and explicit prioritization between the different areas of focus and types of interventions. This need for ambiguity is perhaps due to the requirement to satisfy the large number of stakeholders drawn in by the multisectoral approach (Ainsworth and Teokul, 2000). Indeed, MAP and UNAIDS documents show a similar reluctance to provide explicit guidelines on which interventions should be priorities in which situations. Their resulting recommendation is for priorities to be set according to each particular context – thus the UNAIDS emphasis on situation and response analysis. Many of the strategy documents indeed have relatively well-developed sections on situation and response analysis, but the links between their conclusions and the subsequent strategies are not made clear.

7.7 Three-quarters of the reviewed strategies, however, contain details (cost estimates and/or specific projects and targets) or differences in emphasis (particularly regarding targeting) which at least implicitly reflect choices, trade-offs, and priorities. This, in turn, presumably shapes subsequent budgeting and implementation of MAP projects so that they embody a set of priorities. These priorities likely remain unstated, but they are presumably rooted in each particular country context. Determining whether this presumption is actually the case – that they are really relevant to the situation – will be difficult, requiring close reading of MAP project budgeting and implementation.

7.8 It is also recognized that the national strategies envision further and more detailed sector-specific planning which may provide more explicit prioritization. A brief review of sector strategies from Tanzania[11] and Mauritania for suggests that although more details on interventions and costs are provided, priorities between types of interventions are not discussed.

7.9 Four overall conclusions can be drawn from this review.

- First, the MAP criterion requiring a strategic approach can be said to have been generally met.
- Second, in terms of overall strategic direction, with a lack of clear statements of priorities, overall strategies are so similar that a generic package of HIV/AIDS areas of focus and interventions could have served just as well.
- Third, differences between many strategies are evident in their details, which when costed and implemented, would reflect implicit priorities.
- Fourth, although these implicit priorities may be relevant to each country context (and efficient and equitable), it is not possible to determine this without closer analysis of budgeting and implementation of each case.

11. Government of Tanzania (2003).

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Appendix. Summary Tables

Table A1. Timeframes and dates of national strategies

Country	Title	Timeframe	Strategy date	MAP approval
Benin	Cadre stratégique national de lutte contre le VIH/SIDA/IST au Benin	2000-2005	Dec. 00	Jan. 02
Burkina Faso	Cadre stratégique du plan national multisectoriel de lutte contre les IST/VIH/SIDA au Burkina Faso	2001-2005	Jun. 00	Jul. 01
Burundi	Plan stratégique national de lutte contre le VIH/SIDA et les MST	1999-2003	Oct. 98	Jun. 02
Cameroon	Plan stratégique de lutte contre le SIDA au Cameroun	2000-2005	Sep. 00	Jan. 01
Cape Verde	National Strategic Plan Against AIDS	2002-2006	Feb. 02	Mar. 02
CAR	Plan cadre stratégique de lutte contre le SIDA de la République Centrafricaine	2002-2005		Dec. 01
Eritrea	National Strategic Plan on HIV/AIDS/STIs	2003-2007	Apr. 03	Dec. 00
Ethiopia	Strategic Framework for the National Response to HIV/AIDS in Ethiopia	2001-2005	Jun. 01	Sep. 00
Gambia	not available			Jan. 01
Ghana	Ghana HIV/AIDS Strategic Framework	2001-2005		Dec. 00
Guinea	Cadre stratégique national de lutte contre les IST/VIH/SIDA	2003-2007	Jun. 02	Dec. 02
Kenya	Kenya National HIV/AIDS Strategic Plan	2000-2005	Oct. 00	Sep. 00
Madagascar	Plan stratégique de lutte contre le VIH/SIDA a Madagascar	2003-2006		Dec. 01
Mauritania	Cadre stratégique national de lutte contre les IST/VIH/SIDA	2003-2007	Aug. 02	Jul. 03
Mozambique	Plano estrategico nacional de combate as DTS/HIV/SIDA	2000-2002	Feb. 00	Mar. 03
Niger	Cadre stratégique national de lutte contre les IST/VIH/SIDA	2002-2006		Apr. 03
Nigeria	HIV/AIDS Emergency Action Plan (HEAP)	2000-2003	Jan. 01	Jul. 01
Rwanda	Cadre stratégique national de lutte contre le VIH/SIDA	2002-2006	May 02	Mar. 03
Senegal	Plan stratégique 2002-2006 de lutte contre le SIDA	2002-2006		Feb. 02
Sierra Leone	not available			Mar. 02
Tanzania	National Multi-Sectoral Strategic Framework on HIV/AIDS	2003-2007	Jan. 03	Jul. 03
Uganda	The National Strategic Framework for HIV/AIDS Activities in Uganda	2000/1-2005/6	Mar. 00	Jan. 01
Zambia	Strategic Framework	2001-2003	Oct. 00	Dec. 02

Table A2. Correspondence between national strategy documents and outline recommended by UNAIDS (1998)

	Benin 2000-05	Burkina Faso 2001-05	Burundi 1999-2003	Cameroon 2000-05	Cape Verde 2002-06	CAR * 2002-05	Eritrea 2003-07	Ethiopia 2001-05	Ghana 2001-05	Guinea 2003-07	Kenya 2000-05	Madagascar 2003-06	Mauritania 2003-07	Mozambique 2000-02	Niger 2002-06	Nigeria 2000-03	Rwanda 2002-06	Senegal 2002-06	Tanzania 2003-07	Uganda 2000/1-2005/6	Zambia 2001-03
Description of planning process	1	1	1	1	0		1	0	1	1	0	0	1	1	1	1	1	0	1	1	1
Introduction																					
Situation analysis	1	1	1	1	1		1	1	1	1	1	1	1	1	1	0	1	1	1	1	1
Response analysis	1	1	1	1	1		1	1	1	1	1	1	1	1	1	0	1	1	1	1	1
Strategic framework																					
Guiding principles	1	1	1	0	1		0	1	1	1	0	1	1	1	1	0	1	1	1	1	1
Broad strategies	1	1	1	1	1		1	1	1	1	0	1	1	1	1	1	1	1	1	1	1
Institutional framework	1	1	1	0	1		1	1	1	1	0	1	1	1	1	0	1	1	1	1	1
Priority areas and strategies																					
Specific objectives	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Key initiatives	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Partnerships identified	0	1	1	1	1	1	1	0	1	0	0	0	1	1	1	1	0	1	0	1	1
Resources	0	1	1	1	0	0	0	0	1	0	0	1	0	1	1	1	0	0	0	1	1
Management mechanisms																					
Monitoring & evaluation	1	1	1	0	1		1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Financial accountability	0	0	1	0	1		0	0	0	1	1	1	1	0	1	0	1	1	1	0	0

* Only the planning matrix was available for review.

Note: This table describes the extent to which national strategy documents follow an outline suggested by UNAIDS (1998) in terms of whether separate sections are devoted to each issue. This does not say anything about the content of these sections, which may or may not adequately address the particular issue.

Table A3. Selected data on countries participating in the MAP

Country	Population 1999 (millions)	GNP per capita 1999 ($US)	Total annual health spending per capita 1997 (US$)	HIV prevalence (around 1998) (% adults)	Timeframe of national strategy	National strategy estimated cost			MAP project cost		
						Estimated total cost (US$ millions)	Average annual cost (US$ millions)	Average annual cost per capita (US$)	Total cost (US$ millions)	Average annual cost ($US millions)	Average annual cost per capita (US$)
MAP I											
Benin	6	380	12	4.1	2000-2005	..	..	..	25.4	6.4	1.06
Burkina Faso	11	240	8	7.2	2001-2005	27.0	5.4	0.49	23.5	4.7	0.43
Cameroon	15	580	31	7.2	2000-2005	130.0	32.5	2.17	60.0	12.0	0.80
Central African Republic	4	290	8	12.9	2002-2005	..	..	..	18.0	3.6	0.90
Eritrea	4	200	6	2.4	2003-2007	..	..	..	50.0	10.0	2.50
Ethiopia	63	100	4	7.3	2001-2005	..	..	..	59.7	19.9	0.32
Gambia	1	340	12	..	..	..	..	..	16.2	3.2	3.24
Ghana	19	390	11	4.6	2001-2005	118.9	23.8	1.25	27.8	7.0	0.37
Kenya	29	360	17	13.0	2000-2005	200.0	40.0	1.38	50.0	12.5	0.43
Madagascar	15	250	5	0.9	2003-2006	101.0	25.3	1.68	21.0	4.2	0.28
Nigeria	124	310	30	5.9	2000-2003	182.0	60.7	0.49	96.3	19.3	0.16
Uganda	21	320	14	10.0	2001-2006	181.5	36.3	2.88	50.0	10.0	0.48
MAP II											
Burundi *	7	120	6	8.3	1999-2003	5.7	2.9	0.41	36.7	7.3	1.05
Cape Verde	0.4	1330	34	1.3	2002-2006	..	..	..	9.6	1.9	4.80
Guinea	7	510	19	4.1	2003-2007	..	..	..	22.3	4.5	0.64
Mauritania †	3	380	24	0.6	2003-2007	126.7	42.2	14.08	23.4	4.7	1.56
Mozambique	17	230	5	14.5	2000-2002	40.0	13.3	0.78	64.0	12.8	0.75
Niger	10	190	5	..	2002-2006	..	..	..	27.5	5.5	0.55
Rwanda	8	250	13	13.0	2002-2006	..	..	..	30.5	6.1	0.76
Senegal	9	510	23	1.4	2002-2006	..	..	..	32.2	6.4	0.72
Sierra Leone	5	130	11	7.0	..	..	..	..	15.3	3.1	0.61
Tanzania ‡	33	240	12	10.0	2003-2007	138.5	34.6	1.05	70.0	14.0	0.42
Zambia	10	320	27	20.0	2001-2003	559.9	186.6	18.66	46.0	9.2	0.92

* Estimated cost is for 2 years.
† Estimated cost is from sector strategies and is for 3 years.
‡ Estimated cost is from health sector strategy only.

Table A4. Selected characteristics of national strategies

	Benin 2000-05	Burkina Faso 2001-05	Burundi 1999-2003	Cameroon 2000-05	Cape Verde 2000-06	CAR 2002-05	Eritrea 2003-07	Ethiopia 2001-05	Ghana 2001-05	Guinea 2003-07	Kenya 2000-05	Madagascar 2003-06	Mauritania 2003-07	Mozambique 2000-02	Niger 2002-06	Nigeria 2000-03	Rwanda 2003-06	Senegal 2002-06	Tanzania 2003-07	Uganda 2000/1-03	Zambia 2001-03	Total
Detailed planning for specific interventions	0	0	0	1	0	1	1	0	0	0	0	0	0	0	1	1	0	0	0	1	0	6
specific targets in most areas	0	0	1	1	1	0	0	0	0	0	0	1	1	1	1	0	0	1	0	0	0	8
costing	0	1	1	1	0	0	0	0	1	0	1	1	0	1	0	1	0	0	0	1	1	10
Quantified HIV prevalence goal/objective/target	0	1	1	0	0	0	1	0	1	0	1	1	1	1	0	1	1	1	1	1	0	13
any other quantitative targets and/or indicators	1	1	1	1	1	1	1	0	1	1	0	1	1	1	1	1	1	1	1	1	0	18
baseline data for important targets provided	0	0	1	0	0	0	0	0	1	0	0	1	1	1	0	0	1	1	0	0	0	7
Recommendations/conclusions from situation/response analysis	1	1	1	0	1		0	0	1	1	0	1	1	0	1	0	1	1	1	1	1	14
Coordination under MOH	0	1	1	1	1	1	1	0	0	0	0	0	1	1	1	1	0	0	0	0	1	11
MOH lead/important role	1	1	1	1	1	1	1	0	0	0	1	0	1	1	1	1	1	1	1	1	1	17
Implementing actors specified	0	1	0	1	1	1	1	0	1	0	1	1	1	1	1	1	1	1	1	1	1	17
Lead implementer specified	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	3
Responsibility for M & E specified	0	0	0	0	1	1	0	1	1	0	1	0	0	1	1	0	0	0	1	1	0	9
Surveillance/research as separate focus	1	1	0	0	1	1	1	1	1	1	1	0	1	1	1	0	1	1	0	1	0	15
PLWHA involved in strategy development	1	0	1	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	1	1	1	9
International partners acknowledged in strategy development	1	1	1	1	1		1	0	1	1	0	1	1	0	0	1	1	0	1	1	0	14
World Bank acknowledged in strategy development	0	0	0	0	0		0	0	1	1	0	0	0	0	0	0	1	0	1	1	0	5
High-risk groups targeted	1	1	1	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1	0	1	18
High-risk groups mentioned in overall goals	0	0	1	0	1	1	0	0	0	1	0	0	0	1	0	1	0	1	1	0	0	8
Women & youth targeted	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	21
Non-HIV/AIDS gender interventions (ie. literacy)	1	1	0	1	0	0	0	0	0	1	0	1	0	0	0	0	1	0	0	1	0	7
Large-scale ART planned	0	1	0	1	0	0	0	0	1	0	0	0	1	0	1	0	0	1	0	0	1	7
ART for MTCT planned	1	1	0	1	1	1	1	1	1	1	0	1	1	0	1	1	0	1	1	1	1	17
Cost of ART discussed	0	0	1	0	0	0	0	0	0	0	0	1	0	0	1	0	1	1	1	1	0	7

	Benin 2000-05	Burkina Faso 2001-05	Burundi 1999-20003	Cameroon 2000-05	Cape Verde 2000-06	CAR 2002-05	Eritrea 2003-07	Ethiopia 2001-05	Ghana 2001-05	Guinea 2003-07	Kenya 2000-05	Madagascar 2003-06	Mauritania 2003-07	Mozambique 2000-02	Niger 2002-06	Nigeria 2000-03	Rwanda 2003-06	Senegal 2002-06	Tanzania 2003-07	Uganda 2000/1-2005/6	Zambia 2001-03	Total
Detailed planning for specific interventions	0	0	0	1	0	1	1	0	0	0	0	0	0	0	1	1	0	0	0	1	0	6
Specific targets in most areas	0	0	1	1	1	0	0	0	0	0	0	1	1	1	1	0	0	1	0	0	0	8
Costing	0	1	1	1	0	0	0	0	1	0	1	1	0	1	0	1	0	0	0	1	1	10
Quantified HIV prevalence goal/objective/target	0	1	1	0	0	0	1	0	1	0	1	1	1	1	0	1	1	1	1	1	0	13
Any other quantitative targets and/or indicators	1	1	1	1	1	1	1	0	1	1	0	1	1	1	1	1	1	1	1	1	0	18
Baseline data for important targets provided	0	0	1	0	0	0	0	0	1	0	0	1	1	1	0	0	1	1	0	0	0	7
Recommendations/conclusions from situation/response analysis	1	1	1	0	1		0	0	1	1	0	1	1	0	1	0	1	1	1	1	1	14
Coordination under MOH	0	1	1	1	1	1	1	0	0	0	0	0	1	1	1	1	0	0	0	0	1	11
MOH lead/important role	1	1	1	1	1	1	1	0	0	0	1	0	1	1	1	1	1	1	1	1	1	17
Implementing actors specified	0	1	0	1	1	1	1	0	1	0	1	1	1	1	1	1	1	1	1	1	1	17
Lead implementer specified	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	3
Responsibility for M & E specified	0	0	0	0	1	1	0	1	1	0	1	0	0	1	1	0	0	0	1	1	0	9
Surveillance/research as separate focus	1	1	0	0	1	1	1	1	1	1	1	0	1	1	1	0	1	1	0	1	0	15
PLWHA involved in strategy development	1	0	1	0	0	0	0	1	1	1	0	0	0	0	0	0	0	1	1	1	1	9
International partners acknowledged in strategy development	1	1	1	1	1		1	0	1	1	0	1	1	0	0	1	1	0	1	1	0	14
World Bank acknowledged in strategy development	0	0	0	0	0		0	0	1	1	0	0	0	0	0	0	1	0	1	1	0	5
High-risk groups targeted	1	1	1	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1	0	1	18
High-risk groups mentioned in overall goals	0	0	1	0	1	1	0	0	0	1	0	0	0	1	0	1	0	1	1	0	0	8
Women & youth targeted	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	21
Non-HIV/AIDS gender interventions (i.e., literacy)	1	1	0	1	0	0	0	0	0	1	0	1	0	0	0	0	1	0	0	1	0	7