

APPENDIX H: RESULTS FROM THE MAP SELF-ADMINISTERED QUESTIONNAIRE

OED used a self-administered questionnaire to collect basic data on the preparation and implementation of all 24 country-level African MAP projects approved by December 31, 2003, from task team leaders (TTLs). The survey was sent to those who were TTLs at preparation as well as to the current TTL. A total of 32 TTLs completed questionnaires for the 24 countries, as in several cases the current TTL was the same as the TTL at preparation and in others the same TTL was or had been responsible for more than one country. The questionnaires were distributed in early June 2004. The response rate was 100 percent, although in some instances the TTLs missed or did not answer a question, so the sample size is not uniformly 24. Table H.1 lists the MAP I and II countries covered by the survey.

Table H.1: Country Coverage of the TTL Self-Administered Questionnaires

MAP I (n = 12)	MAP II (n = 12)
Benin	Burundi
Burkina Faso	Cape Verde
Cameroon	Guinea
Central African Republic ^a	Malawi
Eritrea	Mauritania
Ethiopia	Mozambique
Gambia	Niger
Ghana	Rwanda
Kenya	Senegal
Madagascar	Sierra Leone
Nigeria	Tanzania
Uganda	Zambia

a. At the time the questionnaire was distributed, the CAR was in non-ac-crual status and the project's effectiveness had been delayed. The re-sponses on design relate to pre-effectiveness activities, some of which occurred after approval, using funds from other sources.

TTL Background

The technical background of MAP TTLs involved in project preparation has remained fairly consistent: about a quarter of projects had TTLs who are medical doctors and half (which may include the M.D.s) have TTLs with some public health training (see table H.2). However, during implementation only 38 percent of the projects had TTLs with a public health background.

The same pattern is evident with sector affiliation: about 71 percent of projects had TTLs for preparation who were mapped to Health, Nutrition, and Population (HNP), compared to a smaller share (58 percent) among current TTLs. About one in five projects was managed in either preparation or implementation by a TTL affiliated with the Environmentally and Socially Sustainable Development (ESSD) network (including agriculture, rural development, and operations). Overall, 42 percent of MAP projects under implementation have TTLs from a sector other than HNP.

TTLs who prepared MAP I projects had about 9 years of HIV/AIDS experience and in MAP II about 8 years.¹ At the time of the interview, the preparation TTLs for one of the MAP I and four of the MAP II projects had had three years or less of HIV/AIDS experience. Among the preparation TTLs, 54 percent had managed another free-standing AIDS project or one with a major HIV/AIDS component.

The current TTLs for MAP II projects have more HIV/AIDS experience (10 years) than those for MAP I projects (6 years). However, current TTLs of 3 MAP I and 4 MAP II projects had 3 years or less of HIV/AIDS experience. For only a third of MAP I projects did the current TTL have experience managing another HIV/AIDS project, compared with TTLs for about half of the MAP II projects.

On average, TTLs for both MAP I and II projects had a decade or more of Bank experience.

The Bank's AIDS Portfolio in African Countries with MAP Projects

Lending

According to the TTLs, among these 24 countries with multisectoral HIV/AIDS projects, 83 percent also had at least one project in a sector other than health (such as education, transport, or social protection) with an HIV/AIDS component (table H.3). The share of countries with HIV/AIDS components in other sectors has increased between MAP I and II (from 75 percent to 92 percent), as has the mean number of components (from 1.7 to 2.4).

Policy Dialogue

Policy dialogue occurred almost universally in both MAP I and II projects both during preparation and since approval (table H.4).

However, there were some notable differences between MAP I and II countries and between preparation and implementation in terms of the content of policy dialogue (table H.5).

- Overwhelming attention was given to institutional development, including the multisectoral response and role of the Ministry of Health (MOH), during preparation (83 percent of projects). This continued at a lower level during implementation (43 percent—but particularly in MAP I projects, 50 percent).
- There was extraordinarily little attention to: (a)

Table H.2: TTL Characteristics

	Preparation			Implementation		
	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)	MAP I (n = 12)	MAP II (1) (n = 12)	MAP I & II (n = 24)
Training: Percentage of projects with TTLs who studied... ^a						
Medicine	25	25	25	25	33	29
Public health	58	50	54	33	42	38
Demography	17	8	13	17	17	17
Economics	17	25	21	42	25	33
Sector mapping: Percentage of projects with TTLs mapped to... ^b						
HNP	75	67	71	58	58	58
Education		8	4		8	4
Social Protection				17	17	13
ESSD	25	17	21	25	17	21
Infrastructure		8	4		9	4
Previous experience, in number of years: mean [range]						
HIV/AIDS	9.3 [3,18]	7.9 [2,20]	8.6	6.3 [1,18]	10.1 [2,20]	8.2
Bank	11.8 [6,27]	15.9 [7,28]	13.9	10.3 [5,16]	15.4 [4,29]	12.8
Management of other HIV/AIDS projects (percent)	58	50	54	33	50	42

Source: Self-administered questionnaire.

Note: Unit of observation is the *project* (not the individual); some individuals are mapped to more than one project.

a. Other fields of study: nutrition, development studies, urban planning, public policy, sociology, business and law, international relations.

b. HNP (Health, Nutrition & Population), ESSD (Environmentally and Socially Sustainable Development).

strategic discussions (only 17 percent of projects) or (b) technical issues (13 percent prevention, 17 percent treatment) during preparation.

- The most common issue for policy dialogue during implementation was antiretroviral therapy—policy, technical, and implementation issues (56 percent of projects)—among both MAP I and II projects.
- Policy dialogue on technical issues surrounding prevention was very low, both during project preparation and implementation—only one in four countries. And during implementation, prevention discussions were much lower in MAP II (9 percent, where ARV treatment was allowed) compared with MAP I (42 percent, where ARV could only be funded retroactively).

Thus, institutional issues dominated the policy dialogue during project preparation; during implementation, the dialogue on institutions

continued, but technical discussion of anti-retroviral therapy dominated in both MAP I and II projects. Very little policy dialogue was conducted on strategy or on technical aspects of prevention.

Analytic Work

The share of projects for which analytic work was conducted before project approval more than doubled between MAPs I and II, from 17 percent to 42 percent (table H.6). The MAP I countries do not catch up after effectiveness, with a relatively low percentage conducting analytic work.

The main topics for analytic work were:

- Analyses of the HIV/AIDS situation, policy responses, risk behavior (4 countries)
- Analysis of the orphan situation (3 countries)
- Macro- and microeconomic impact of AIDS (2 countries)

Table H.3: AIDS Components in Projects in Other Sectors

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
Percent of countries with at least one project in another sector w/an AIDS component	75	92	83
Percent w/an HIV/AIDS component in an education project	58	66	66
Percent w/an HIV/AIDS component in a transport project	50	50	50
Percent w/an HIV/AIDS component or activities in a CDD or social fund or social action project	0	50	42
Mean [min,max;total] projects with AIDS components per country	1.7 [0,4;20]	2.4 [0,5;26]	1.8 [0,5;46]

Source: Self-administered questionnaire.

Note: This table includes 5 projects in MAP I countries and 6 in MAP II countries that were reported to have AIDS components by the TTL but for which there is no mention of AIDS in the project appraisal document. If these are excluded, then 79 percent of all MAP countries had at least one non-health sector project with an AIDS component, and the mean number is 1.3, 1.9, and 1.6 for MAP I, MAP II, and both, respectively. Other sectors with AIDS components included: urban development (3); emergency demobilization or rehabilitation (2); agriculture (2); rural infrastructure (1).

Table H.4: Percent of Projects in Which Policy Dialogue on HIV/AIDS Was Conducted with Client Government

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
During preparation	92	92	92
Since approval	83	91 ^a	87 ^a

Source: Self-administered questionnaire.

a. Excludes Sierra Leone.

Table H.5: Trends in Policy Dialogue During Preparation and Implementation (percent of projects)

Stage of project cycle	N	Advocacy/ political commitment	Strategies	Institutional development ^b	Monitoring and evaluation	Donor interaction/ coordination	Prevention	Treatment
Preparation								
MAP I Total	12	25	17	75	0	17	8	8
MAP II Total	12	0	17	92	0	17	17	25
Both - Total	24	13	17	83	0	17	13	17
Implementation								
MAP I Total	12	0	17	50	17	0	42	58
MAP II Total	11 ^a	0	9	17	9	17	9	55
Both - Total	23 ^a	0	13	43	13	9	26	56

Source: Self-administered questionnaire.

a. Excludes Sierra Leone.

b. Institutional development includes multisectoral AIDS body, institutional framework and linkages, the health sector role in the multisectoral response, civil society role and mobilization, fiduciary issues, the local response, and monitoring and evaluation.

- Analysis of ARV supply and/or modeling (2 countries)
- Public expenditure analyses of HIV/AIDS programs and of ARV drugs (2 countries)
- Mapping of high-transmission areas (1 country)
- Study of migrants (1 country)
- Child needs assessment toolkit (1 country).

Project Preparation

The share of projects that have benefited from institutional analyses and NGO capacity assessments has increased over time; the share that conducted needs assessments has declined (table H.7).² In any event, analyses of these sorts are only being undertaken systematically for two-thirds to three-quarters of all projects.

About 80 percent of TTLs for both MAP I and II countries reported that the time allowed for

preparation (which was, on average, 7.8 months for MAP I and 16.6 months for MAP II³) was sufficient to ensure national ownership of the project. However, substantially fewer MAP I TTLs at preparation reported that there was adequate time (58 percent) or Bank budget (67 percent) to ensure a quality project design. These figures on adequacy of preparation time and funds have risen to three-quarters in MAP II projects, but still, one in four TTLs of a MAP II project reported that preparation resources were inadequate.

Implementation

Overall, three-quarters of the projects' TTLs reported that the Bank budget funds provided for supervision were adequate to ensure some minimum level of implementation quality (table H.9). The adequacy is much lower for MAP II

Table H.6: Percent of Projects in Which Analytic Work Was Conducted

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
Prior to approval	17	42	29
Since approval	25	17	21

Source: Self-administered questionnaire.

Note: Excluded from "analytic work" are baseline surveys (which are surveys, not analysis, and measured elsewhere in the SAQ); needs, beneficiary, institutional, and NGO capacity assessments (measured elsewhere in the SAQ); and preparation of the national AIDS strategies.

Table H.7: Percent of Projects in Which Preparatory Assessments Were Conducted

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
Institutional analysis	67	92	79
Stakeholder analysis	75	75	75
NGO capacity assessment	58	75	67
Needs assessment	92	67	79

Source: Self-administered questionnaire.

countries (only 58 percent) than for MAP I countries (92 percent).

One aspect of the MAP template that was intended to expedite project implementation where there was limited government capacity was a provision for contracting out key management functions—financial management, procurement, NGO management, and monitoring and evaluation (M&E). The current TTLs for the 24 MAP projects were asked the extent to which these functions had in fact been contracted to others—completely, partially, or not at all.

TTLs reported that roughly half of the projects did not contract financial management or procurement and about 70 percent did not con-

tract out NGO management or M&E (table H.10). MAP II projects were more likely to at least partially contract out financial management, procurement, and M&E, compared with MAP I projects. However, over both MAPs the share that completely contracted out ranged from 4 to 29 percent. None of the projects contracted out all four tasks, while seven did not contract out any of them.

Among the projects that had completely or partially contracted out these tasks, 86 to 92 percent of TTLs reported that the arrangement had accelerated implementation of the project.

The most common reason for not contracting out financial management, procurement, and

Table H.8: Percent of Projects in Which Resources Were Adequate to Achieve Aims

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
Sufficient preparation time for national ownership of project	83	82 ^a	83
Sufficient preparation time for quality project design	58	75	67
Sufficient Bank budget funds for preparation adequate to ensure quality project design	67	75 ^a	71

Source: Self-administered questionnaire.

a. Excludes Mauritania.

Table H.9: Percent of Projects with Bank Budget Funds Adequate for Supervision

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
Sufficient Bank budget funds for supervision to ensure minimum quality	92	58	75

Source: Self-administered questionnaire, as reported by current TTLs.

NGO/civil society management, cited by half or more of TTLs, was that adequate capacity existed to do this in government, including existing mechanisms (table H.11). In contrast, the most frequently cited reason for not contracting out M&E functions was the reluctance of the government (38 percent), including cases in which the government wanted to build its own capacity, and the absence of a suitable contractor (25 percent).

Interventions Supported by the MAP

The African MAP projects are supporting a large number of public sector activities and interven-

tions, according to TTLs from 18 of the 24 projects under study (see figure H.1).⁴ Among these activities, likely a subset of all of the activities supported in multiple sectors, are many that are public goods, prevention interventions targeting the general public or those most likely to spread HIV, care and treatment, and support to mitigate the impact of HIV/AIDS.

- The interventions most likely to be supported are **information and preventive interventions for the general public**, such as STD treatment, prevention of mother-to-child trans-

Table H.10: Extent to Which MAP Projects Contracted Out Key Management Functions (percent)

Function		Complete	Partial	Not at all
Financial management	MAP I	17	33	50
	MAP II	42	17	42
	Both	29	25	46
Procurement	MAP I	0	25	75
	MAP II	33	33	33
	Both	17	29	54
NGO management	MAP I	25	0	75
	MAP II	8	25	67
	Both	17	13	71
Monitoring and evaluation	MAP I	8	17	75
	MAP II	0	42	58
	Both	4	29	67

Source: Self-administered questionnaire, as reported by current TTLs.

Note: Sample size is MAP I (12), MAP II (12), Both (24).

Table H.11: Reasons for Not Contracting Out Key Management Functions (percent)

Management function	Adequate capacity/ existing mechanisms	No suitable contractor	Government reluctant	Other arrangements have been made	Don't know or no answer
Financial management (n = 11)	64	0	18	9	9
Procurement (n = 13)	54	8	8	15	15
NGOs (n = 17)	53	6	24	12	6
M&E (n = 16)	19	25	38	13	6

Source: Self-administered questionnaire.

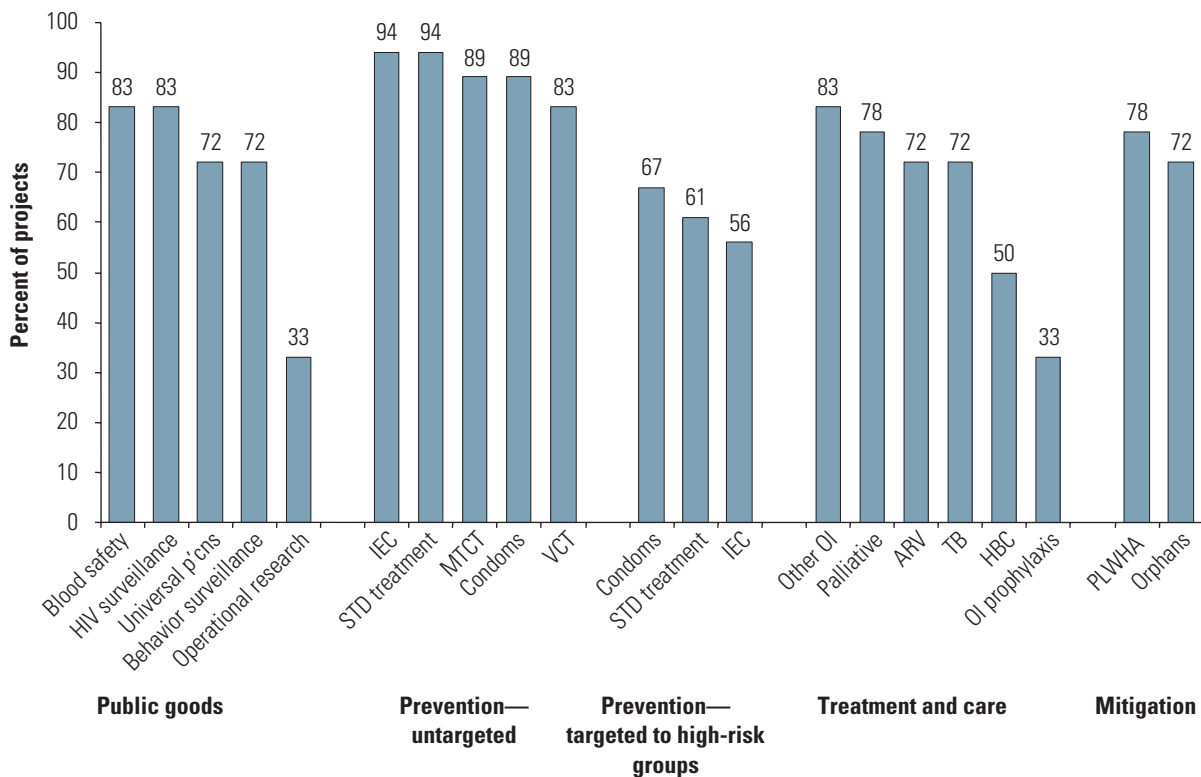
mission (MTCT), condoms (including through social marketing), and voluntary counseling and testing (VCT), all supported by more than 80 percent of projects.

- Financing of **public goods**, such as blood safety, HIV surveillance, universal precautions for health workers, and behavioral surveillance, is somewhat less common. Only a third of projects supported operational research.
- Financing of several types of **care and treatment interventions** was equally as high as financing for public goods. This included treatment of TB and other opportunistic infections (OI), palliative care, and antiretroviral treatment. However, only half of the projects supported home-based care (HBC) for AIDS patients and only about a third supported prophylaxis for TB and other opportunistic infections among HIV-positive people.

- Roughly three-quarters of the projects financed public sector support programs to **mitigate the impact of AIDS** among people with HIV/AIDS (PLWHA) and orphans.
- **Preventive interventions targeted** to high-risk groups (HRG)—those most likely to contract HIV and spread it to others, such as sex workers, transport workers, the military, and police, are, as a group, the least likely to be supported and were covered by roughly half to two-thirds of the projects.

There were important differences in terms of some of the types of activities supported by MAP I and MAP II projects (figure H.2). MAP I countries were about twice as likely as MAP II to support public sector operational research, targeted prevention to high-risk groups, and mitigation of the impact of AIDS to PLWHA. MAP II countries were sub-

Figure H.1: Public Sector Activities and Interventions Supported by African MAP Projects



Source: Current TTLs, 18 African MAP projects.

Note: Excludes CAR, Ghana, Kenya, Malawi, Mauritania, and Senegal.

stantially more likely to finance treatment of TB and other opportunistic infections and slightly more likely to finance public antiretroviral treatment. However, they were less likely to finance palliative care and home-based care for AIDS patients.

Multisectoral Approach

TTLs reported a very large number of ministries or sectors involved in the national multisectoral response supported by the MAPs—an average of 16 ministries in each country, equally high for MAP I and II countries (table H.12). In 10 of the 24 projects, the project was supporting a response of 20 or more ministries, and in two-thirds, 10 or more ministries.

Nongovernmental Organizations and Community-Based Organizations

Overall, a mean of 143 different nongovernmental organizations (NGOs) and 921 community-based

organizations (CBOs) had been financed per project through the civil society components, with substantially more of each financed to date by MAP I projects, compared with the more recently launched MAP II projects (table H.13).⁵ The number of CBOs is some six times larger than the number of NGOs, on average, and ranges from none up to 6,700.

Monitoring and Evaluation

Baseline Surveys

The respondents for three-quarters of projects reported that at least one baseline survey was undertaken during preparation, either financed by the Bank or by others (table H.14).

Governments of three-quarters of MAP I countries and nearly two-thirds of MAP II countries had conducted national risk/sexual behavior surveys, even if not financed by the MAP

Figure H.2: Difference in Support for Key Public Sector Activities, MAP I & II

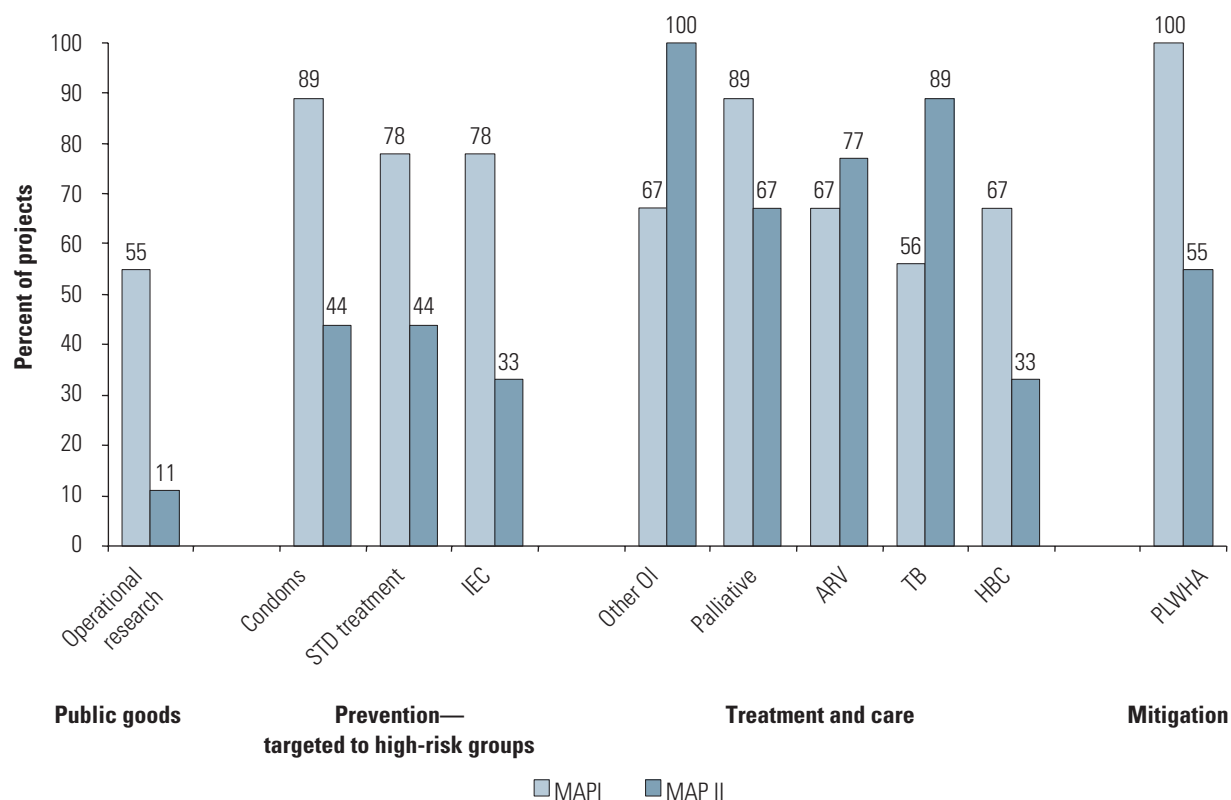


Table H.12: Ministries Officially Enlisted in MAP-Supported Multisectoral Response

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
Ministries officially enlisted in MAP-supported multisectoral response: mean [min,max]	17 [6,30]	16 [4,30]	16 [4,30]
Distribution of projects by number of ministries supported:			
Fewer than 10	3	5	8
10–19	4	2	6
20 or more	5	5	10

(table H.15). Since no additional information was collected, we do not know the extent to which the respondents counted Demographic and Health Surveys, as opposed to those explicitly investigating risky behavior, knowledge of transmission and prevention, and the adoption of preventive behaviors. While more MAP I countries had such a survey than not, one in four still did not. At the time of this survey, most of the MAP I projects had reached or passed the midpoint of the project.

Evaluation of Pilot Projects that Could Be Scaled Up

In both MAP I and II, in 58 percent of the countries, the preparation TTLs cited at least one pilot intervention that had been evaluated in the client country and that was suitable for replication on a larger scale (table H.16). In more than half of these cases (8/14 projects), only a single pilot project was cited. In 5 of the 14 projects, at least one of the pilot projects cited was a community-driven development (CDD) type inter-

Table H.13: The Number of NGOs and CBOs per Project Financed by the Project to Date

	MAP I		MAP II		MAP I & II	
	Mean [min,max]	n	Mean [min,max]	n ^d	Mean [min,max]	n ^d
Excluding double-counts ^a						
NGOs	247 [5,700]	11 ^b	46 [0,120]	11	143 [0,700]	22 ^b
CBOs	1674 [40,6700]	10 ^{b,c}	157 [0,550]	11	872 [0,6700]	21 ^{b,c}
Including double-counts						
NGOs	351 [5,1500]	12	46 [0,120]	11	212 [0,1500]	23
CBOs	1659 [40,6700]	11 ^c	157 [0,550]	11	944 [0,6700]	22 ^c

Source: Self-administered questionnaire.

a. In one country, the TTL could not separate the number of NGOs from CBOs, citing a combined total of 1,500. The top panel excludes this observation and in the bottom panel 1,500 is attributed to both NGOs and CBOs.

b. Excludes Kenya.

c. Excludes Nigeria.

d. Excludes Mauritania.

Table H.14: Percent of Countries in Which Baseline Surveys Were Conducted During Preparation or Implementation

Baseline surveys	During preparation			During implementation		
	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
Any baseline	75	75	75			
→ financed by others	33	67	50			
→ financed by project/Bank	42	33	38	75	50	63

Table H.15: Percent of Governments that Had Conducted National Risk/Sexual Behavior Surveys

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
National risk/sexual behavioral survey (even if not financed by MAP)	75	67	71

Source: Self-administered questionnaire.

vention that did not necessarily deal specifically with HIV/AIDS.⁶ There were, in fact, very few interventions that had been previously evaluated in these countries—in 42 percent of the projects, none, and in the other 58 percent, only 1 to 3 each. OED was not able to establish the quality of the evaluation of the interventions that were cited.

Monitoring

The monitoring indicators in the Project Appraisal Documents (PADs) for 42 percent of all MAP projects had been revised; this was more likely to have happened in the MAP I countries (half of projects) than in MAP II (a third of projects). The mid-term review (MTR) is a major opportunity to do this, though none of the MAP II countries had reached the MTR as of the date of the survey.

Given the way that HIV spreads from people with the highest-risk behavior (who are often the first to be infected) to their sexual partners and children, many national AIDS programs seek to change the behavior and the infection rates among “high-risk groups” (HRG), defined in the questionnaire as “the populations most likely to spread HIV.” Examples include sex workers, transport workers, the military, po-

lice, prisoners, miners, and so on. Prevention and lower infection rates among these groups are not only indicative of the success of project activities aimed at them, but are likely to have a larger impact on slowing infection in the lower-risk population.

According to current TTLs, about 58 percent of governments are collecting HIV prevalence data and 75 percent are collecting behavior information on at least one high-risk group (table H.17). The group most likely to be monitored in both cases is sex workers, followed by the military and transport workers. The share of countries monitoring at least one HRG and the number of groups being monitored was slightly higher in MAP II countries, which showed a greater diversity in the types of groups monitored as well. Nevertheless, 10 countries were not monitoring HIV and 6 were not monitoring behavior in any high-risk group.

Donor Coordination

The MAP I projects differ significantly from MAP II projects in the extent to which the Bank was the major HIV/AIDS donor at the time of preparation. According to TTLs, in three-quarters of the MAP I countries the Bank was the major donor for HIV/AIDS, compared with only 17 percent of

Table H.16: Evaluations of Potentially Replicable Pilot Projects in Client Country

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
At the time of project preparation	58	58	58
Since project approval, have any pilot projects been formally evaluated, even if not by project?	25	8	17

Table H.17: Percent of Governments (Irrespective of Whether Financed by MAP) Monitoring HIV and Behavior among High-Risk Groups and Mean [min, max] Number of High-Risk Groups Monitored

	HIV			Behavior		
	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)
At least one high-risk group	58	58	58	83	67	75
Sex workers	58	58	58	83	67	75
Military	25	33	29	25	42	33
Transport workers	17	33	25	42	25	33
Fishermen	0	17	8	0	17	8
Police	0	17	8	0	17	8
Prisoners	8	0	4	0	8	4
Miners	0	17	8	8	17	13
STI patients	8	0	4	0	0	0
TB patients	0	8	4	0	0	0
Factory workers	0	0	0	8	0	4
Displaced persons (number)	0	0	0	0	8	4
Mean [min,max]	1.2	1.7	1.4	1.7	1.8	1.8
Number of high-risk groups	[0,3]	[0,4]	[0,4]	[0,4]	[0,4]	[0,4]

the MAP II countries, where the Bank was most likely a relatively minor donor (table H.18a). Many of the African countries that had had previous AIDS projects or components were in the MAP I group: Kenya and Uganda (with former STI projects and Uganda with the PAPSCA); Burkina Faso (with an AIDS and population control project); and Benin, Cameroon, Eritrea, Ethiopia, Gambia, Madagascar, and Nigeria (with AIDS components of health projects).

In contrast, none of the MAP II countries previously had Bank-sponsored free-standing AIDS projects and only a few had AIDS components of health projects (Niger, Tanzania, Zambia). This meant that the Bank was really starting

from a much lower level of dialogue on AIDS in the MAP II countries.

Over time, other donors appear to have stepped up assistance to the MAP I countries where the Bank previously dominated, while in the MAP II countries the Bank stepped up its presence relative to other donors. As a result, at the time of the survey, the TTLs reported that the Bank was the major donor on HIV/AIDS in half of the countries of both MAP I and II, and in most of the rest it was one of several major donors (table H.18b).

With respect to coordination with other donors, during preparation the reported extent was very high in half of the countries and only

moderate in a third for MAP I, but by MAP II, the level of coordination at preparation was reported as either high or very high in all countries. This may also reflect the fact that the Bank was coming from a less dominant position in terms of HIV/AIDS assistance in the MAP II countries. In terms of coordination during implementation, TTLs reported on average slightly less coordination with other donors in MAP I than in MAP II. Nevertheless, the TTLs reported for two-thirds of MAP I and three-quarters of MAP

II countries that the level of coordination was high or very high. OED did not interview representatives of other donors in these countries to assess their views on collaboration.

In terms of the change in engagement of other partners over time, the most notable change is the entrance of the Global Fund, which was not named as a donor during preparation of any of the 24 projects, but was reported to be present in two-thirds of the countries at the time of the survey in mid-2004 (table H.19).

Table H.18a: Relative Importance of the Bank as AIDS Donor and Extent of its Consultation with Other Donors at the Time of Project Preparation

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II ^a (n = 24)
Percentage of client countries in which the Bank was...			
...the major donor	75	17	48
...one of several major donors	8	25	17
...a relatively minor donor	8	42	22
...not financing HIV/AIDS activities	8	8	9
...one of several minor donors	0	8	4
Percentage of projects in which consultation was...			
...very high	50	58	54
...high	17	42	29
...moderate	33	0	17

Table H.18b: Relative Importance of the Bank as AIDS Donor and Extent of its Coordination with Other Donors During Implementation

	MAP I (n = 12)	MAP II (n = 12)	MAP I & II ^a (n = 24)
Percentage of client countries in which the Bank is currently...			
...the major donor	50	50	50
...one of several major donors	42	50	46
...a relatively minor donor	8	0	4
Percentage of projects in which coordination has been...			
...very high	33	50	42
...high	33	25	29
...moderate	25	25	25
...low	8	0	4

Source: Self-administered questionnaire.

Table H.19: Number of Client Countries in Which Other AIDS Donors Were Involved at Time of Project Preparation and Currently

	Involved at preparation			Currently involved		
	MAP I (n = 12)	MAP II (n = 12)	MAP I & II (n = 24)	MAP I (n = 12)	MAP II ^a (n = 12)	MAP I & II (n = 24)
African Development Bank				1		1
Belgium				1		1
Canada	2		2			
Denmark	1		1	1		1
EU	1	1	2	2	1	3
France	4	4	8	4		4
Germany	3		3	2	1	3
Global Fund				7	9	16
Ireland				1		1
Italy				1		1
Netherlands	2		2	2		2
Norway	0	1	1			
U.K.	4	1	5	3	1	4
U.N. agencies	7	6	13	5	2	7
U.S.	7	8	15	7	5	12

a. Excludes Sierra Leone.