

APPENDIX I: SURVEY OF TASK TEAM LEADERS—SUMMARY OF RESULTS

Overview of the Methodology and Sample

Over the period June 1–August 12, 2004, the current task team leaders (TTLs) of 19 ongoing African MAP projects—11 MAP I projects and 8 MAP II projects—were interviewed in an open-ended question format. The objective of the survey was to obtain their opinions on some of the main substantive issue of the OED AIDS evaluation, in light of performance to date, and additional insights on the design and future of the MAP as an instrument. This information builds on the results of the self-administered questionnaires reported in Annex H.

The 19 projects and 18 TTLs¹ in this survey included all current TTLs of MAP I projects (as of the time of the interview), with the exception of Ethiopia, which was not covered because OED had conducted a case study in that country. It included all 8 MAP II projects that had been effective for at least a year, as of mid-August 2004.² The countries are listed below. In only four cases (Benin, CAR, Cape Verde, Kenya) was the current

TTL the same as the TTL at the time of project approval, and the CAR project was still not effective as of the end of fiscal year 2004 because the country was in non-accrual status.

Design Issues

What were the main constraints to a more effective national response before the MAP?

Among the 16 countries that responded (9 in MAP I and 7 in MAP II), the most frequently cited constraint was **weak capacity in the Ministry of Health (MOH)**, including a weak or understaffed health system (9 countries, or half), followed by a **lack of political commitment/denial/stigma** in 6 countries (table I.1). TTLs for 6 countries cited lack of activities in other sectors or multi-sectoral institutions. Surprisingly, the TTLs for only four countries (one-quarter) cited **lack of financing** as a constraint; in one country the TTL mentioned that financing was not a constraint, and in one country that the ample financing of HIV/AIDS by many donors was stretching administrative capacity to the breaking point.

Among the nine MAP I countries, the most frequently cited constraint was lack of political commitment/denial/stigma, while for MAP II countries, the majority cited weak MOH capacity as the major constraint. The fact that finance was not mentioned as the major constraint more frequently does not imply that there was sufficient finance to launch a program, but rather that there were other constraints that were more binding.

Are there any specific design features that set this MAP project apart from the MAP template?

The most common special design feature reported by TTLs was the special component—for targeted interventions (Burkina Faso), other com-

MAP I (11 countries, 10 respondents)	MAP II (8 countries, 8 respondents)
Benin	Burundi
Burkina Faso	Cape Verde
Cameroon	Guinea
CAR	Mozambique
Eritrea	Rwanda
Gambia	Senegal
Ghana	Sierra Leone
Kenya	Zambia
Madagascar	
Nigeria	
Uganda	

Table I.1: Main Constraints to HIV/AIDS at Project Preparation

Constraint	Percentage of countries (n = 16)	MAP I (# countries)	MAP II (# countries)
Weak MOH capacity, including weak health system, limited manpower	56	3	6
Lack of political commitment/denial/stigma	38	4	2
Lack of financing	25	2	2
Lack of multisectoral coordination/weak MS institution (like CNLS)	19	1	2
Lack of activities or coordination outside MOH, in other ministries	19	2	1
Lack of coverage of HRG, need to expand pilot programs more widely	13	2	0
Political unrest/conflict	13	1	1
Lack of strategic framework for donor coordination	6	1	0
No operational mechanism for funding non-public sector entities	6	1	0
Don't know	13	2	1

municable diseases (Eritrea), orphans (Burundi), the private sector (Guinea), and treatment (Rwanda) (table I.2). While all MAP II countries were eligible for financing of antiretroviral treatment, two MAP I countries also offered it : Benin for preventing mother-to-child transmission (MTCT) and Cameroon for treatment, with an amendment of the credit agreement.

Did the project design reflect any important country-specific design factors or lessons from previous health/AIDS experience in this country?

In 7 of the 19 projects (37 percent), the TTLs noted no design features that reflected lessons from previous experience in the country (table I.3a).

The TTLs for 12 countries (7 MAP I, 5 MAP II) identified lessons from previous projects that were

Table I.2: Specific Design Features

Design feature	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Special components	26	2	3
<ul style="list-style-type: none"> • Targeted interventions • TB and malaria • Orphans • Private sector • Treatment 			
ARVs in MAP I	11	2	0
Community components using existing CDD or SF mechanisms	11	1	1
Windows or components for different levels of public sector	11	1	1
MAP doesn't fund MOH	5	1	0
MAP funds only MOH	5	1	0
No contracting out	5	0	1
Separate window for CBOs, emphasis on decentralization	5	1	0
More preparation and analytic work than template	5	0	1
None	37	5	2

taken into account in the project design, the foremost, cited for 7 countries (37 percent), were lessons related to **poor implementation capacity or ability to coordinate** in the public sector more generally or in the MOH. In two countries, this resulted in prioritization of sectors within the multisectoral response, in two others to greater reliance on the private sector. In one case, the project administrative unit was put in the Ministry of Finance and, in another, a more gradual implementation strategy was pursued, to avoid exceeding limited capacity. In one additional case, the project design was reported to have taken into account the limited capacity, but to date none of these mechanisms was deemed successful. In contrast, in one country the **relatively good performance of the MOH and local governments** was cited as having contributed to project design.

In four countries (21 percent), the projects were able to use mechanisms or **institutions** developed through previous community-driven development, though in one case this was not working well for political reasons. Also, in one of these countries, the project was able to use a drug procurement agency that was set up by previous projects.

In addition to these lessons, TTLs from five countries noted **country-specific considerations** that did not arise from past projects but that affected project design, including: the early stage of the epidemic; complementarity of activities with an ongoing health project;³ components that were tailored to decentralized government; large refugee and orphan populations; a strong NGO sector; and an ongoing antiretroviral treatment program.

Table I.3a: Lessons from Previous Projects

Lesson from previous project	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Low capacity of MOH, public sector (n = 7)	37		
Stretched too thin to supervise all sectors/ministries; prioritized ministries w/previous WB experience		1	1
Weakness of MOH, bad performance w/previous project led to more private sector role		1	1
Project admin unit in MOF due to past poor experience w/MOH in previous health project		0	1
Gave project time to mature, didn't push beyond capacity		0	1
Lack of capacity to plan and implement; proposed solutions have been ineffective		1	0
Institutions (n = 4)	21		
Previous success w/CDD mechanisms		2	2
Used national drug procurement agency from previous project		0	1
Substantive issues (n = 2)	11		
Lessons from previous STI project, especially regarding government commitment		1	0
Lesson from previous health project on lessons for young people		0	1
Good implementation capacity (n = 1)	5		
Good implementation capacity in MOH and local governments		1	0
None/not answered (n = 7)	37		
None		1	3
Not answered		3	0

Note: Total is more than 19 because some countries gave multiple answers.

Table I.3b: Country Characteristics and Project Design

Country characteristic	MAP I (# countries)	MAP II (# countries)
Complementarity with ongoing health project	1	0
Low prevalence country led to emphasis on prevention, IEC	1	0
Decentralized components	1	0
Large refugee and orphan populations	0	1
Strong NGO sector	0	1
Ongoing ARV treatment program	0	1

Themes of the OED Evaluation

Strategic Approach

The MAP template funds virtually any activity in the national strategy and the latter tend to be exhaustive menus of all that can be done. How is it being decided in [country] which activities will be funded first? What's the prioritization process?

The TTLs for nine countries (47 percent) reported no real prioritization process by government: whatever conforms to the broad national strategy and/or is on the list of allowable activities (or not on the list of what can't be funded) is funded (table I.4).⁴ In four countries (22 percent), some prioritization is enforced by project components on, for example, targeted interventions, orphans, treatment, or workplace interventions. In two countries, plus the public sector of a third, the projects set priorities as a function of what other donors are doing and according to various indicators. In four countries, the TTL reported exerting pressure for specific priorities (behavior change, IEC for high-risk groups, MOH activities) or to be selective.

The TTLs sometimes cited what the revealed priority of governments was (regardless of the process—targeted interventions, prevention, awareness raising) or noted that different levels of government set priorities independently (3 countries).

What, if any, interventions are being financed to ensure that transmission is being reduced among those with high-risk behavior? Is there any aspect of the proj-

ect that assures that this issue will be addressed?

In only four countries (22 percent)—all of them in MAP I—is the highest-risk behavior being systematically addressed by the public sector (table I.5); in nine countries (50 percent) it is only being addressed to the extent that NGOs undertake these activities; in five countries (28 percent) no part of the project ensures that high-risk behavior is systematically addressed (and four of the five are MAP II countries). Thus, to the extent that this is taking place, it is more organized in MAP I countries. It has largely been relegated to NGOs, and the countries in MAP II are less likely to have addressed this at all.

Government Commitment

Respondents were asked to characterize the level of commitment to addressing HIV/AIDS prior to the launch of the project, then—for projects that have been effective for at least 12 months—they were asked whether the level of commitment had risen, fallen, or stayed the same and, if it had changed, the current level. The questions asked about five levels of government: the highest levels; ministry of health; other sectors; parliament/ legislature; and local/regional offices. The responses were on a 6-point scale: very high, high, moderate, low, nonexistent, or hostile. Note that in most cases the respondents were not present during project preparation.

Was there an explicit strategy in the project to raise government commitment? If so, what was it?

The TTLs for only a third of the countries (6) re-

Table I.4: Prioritization Process

Process	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
No prioritization process (n = 9)	47		
There's a list of things that can't be funded or that can be funded, otherwise no prioritization. Whatever is demanded.		3	1
There's no real prioritization process by government; whatever conforms to the broad national strategy is funded.		1	4
Priority enforced by components/project design (n = 4)	21		
Priority to targeted interventions		1	0
Priority to workplace interventions		1	0
Priority to orphans		0	1
Priority on treatment		0	1
Revealed priorities by government decisions (n = 4)	21		
Priority to targeted interventions		1	0
Priority to prevention		2	0
Priority to awareness creation/IEC		0	2
Other prioritization principles (n = 9)	47		
Try to balance prevention and treatment		0	1
Consideration of what other donors are financing		0	2
Provincial/geographic coverage		2	0
All groups are required to set priorities in their own action plans.		2	1
Priority activities based on indicators, in collaboration with other donors		1	0
Pressure from TTL on content (n = 4)	21	2	2
Not answered (n = 1)	5	1	0

Note: Total is more than 19 because the TTLs for some countries gave multiple answers.

ported an explicit strategy for raising government commitment, including activities such as training or study tours for leaders, or advocacy as the objective of Rapid Results Initiative (table I.6). In two of these cases, the strategies were simply development of a national strategic plan and requiring each sector to prepare its own program—pretty standard in all of the projects.

Strategies:

Training for parliament, leaders:	2
IEC, study tours for officials, parliament, religious leaders:	1
Rapid Results Initiative w/advocacy as focus:	1
Development of national strategic plan, committees, after approval:	1
Required key sectors in NAC, preparation of sector programs ⁵	1

If the project has been effective for at least 12 months, to what extent has government commitment risen or fallen since the start of the project among these groups?

At the **highest levels of government**, TTLs reported that political commitment had risen in half of the countries and fallen in one since the start of the project (table I.7a). Commitment at the highest levels primarily rose in MAP I countries (7 of the 8 with an increase were MAP I); in the majority of MAP II countries (5 of 7), commitment at the highest levels was reported to be unchanged. This reflects the lower commitment at the highest level in MAP I countries before the project was launched (2/11 rated very high and 3/11 rated high), compared with MAP II countries (5/8 rated very high before the project launch).

Table I.5: Systematic Attention to High-Risk Behavior

Intervention/policy	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Being systematically addressed by public sector (n = 4)	21		
Major emphasis on targeted interventions to HRG by government		3	0
"Hot zones" identified via mapping exercises and include HRG activities.			
These are the priority		1	0
Not systematically addressed by public sector (n = 9)	47		
Being addressed by NGOs, but no special emphasis		2	2
An area of special emphasis for NGOs		0	1
NGOs, some ministries, a MAP request for one group (prisons), but NAC not addressing them systematically		3	1
Not being addressed (n = 5)	26		
Project is trying to identify high-risk groups		0	1
No part of the project assures that this will be addressed		1	3
Not available (n = 1)	5	1	0

Table I.6: Strategy to Raise Political Commitment

Answer	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Yes	32	4	2
No	58	6	5
N/A	11	1	1

For the *MOH, other ministries, and Parliament*, commitment was reported to have risen in roughly half of the countries, and not differentially between MAP I and II. The level of government with the largest number of countries reporting an increase in commitment is **local or regional government** (10 of 14 reporting), also evenly in MAP I and II.

What is the current level of government commitment?

The current level of commitment at the highest level of government (president, prime minister) and among MOH officials was reported to be high or very high by 14 of the 17 reporting TTLs (82 percent) (table I.7b). Roughly two-thirds reported local/regional government officials and Parliament/legislators to have high or very high commitment. In most countries com-

mitment varied across ministries, with some registering high and others moderate. TTLs for three countries reported that commitment at the highest level and in the MOH was moderate or low, and four that local and Regional government commitment was at these levels. In one country, the commitment of parliament/legislature was characterized as non-existent.

To what extent can these changes (or mitigation of declines) be attributed to the Bank's intervention?

Among the TTLs for the 13 countries that reported a change in commitment during the projects, seven attributed it entirely to the Bank's intervention (of which five were MAP II) and three partially (table I.8). In three cases, the TTLs claimed the changes were not due to the project, of which two were due to changes in government.

Table I.7a: Changes in Level of Political Commitment

Trend	Highest levels			MOH			Other ministries			Parliament			Local government		
	I #	II #	Both %	I #	II #	Both %	I #	II #	Both %	I #	II #	Both %	I #	II #	Both %
Rose	7	1	44	5	3	44	4	3	38	4	3	38	5	5	56
Same	2	5	38	3	3	33	3	3	33	2	4	33	2	2	22
Fell	0	1	6	0	1	6	0	0	0	0	0	0	0	0	0
DK/NA	2	1	17	3	1	22	4	2	33	5	1	33	4	1	28

Note: DK/NA - don't know/no answer.

Table I.7b: Current Level of Political Commitment

Trend	Highest levels			MOH			Other ministries			Parliament			Local government		
	I #	II #	Both %	I #	II #	Both %	I #	II #	Both %	I #	II #	Both %	I #	II #	Both %
Very high	5	5	56	6	2	44	1	1	17	1	2	17	2	4	33
High	3	1	22	2	4	33	4	2	56	5	3	44	4	2	33
Moderate	1	1	11	0	2	11	1	2	17	1	2	17	2	1	17
Low	0	1	6	1	0	6	0	0	0	0	0	0	1	0	6
Non-existent	0	0	0	0	0	0	0	0	0	0	1	6	0	0	0
Hostile	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
DK/NA	2	0	11	2	0	11	2	1	17	4	0	22	3	0	17

Table I.8: Attribution of Changes in Commitment to the Bank

Answer	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Yes	39	2	5
Partially	17	3	0
No	17	1	2
N/A or no answer	28	4	1
Don't know	6	1	0

Multisectoral Response/Institutional Issues

What were the main government institutions involved in the national response to HIV/AIDS before the MAP project?

Eleven of the 17 countries responding (65 percent) initially had an AIDS department in the Ministry of Health, at a low level (3), mid-level (5), or high level (3) (table I.9). Two had a multisec-

toral National AIDS Committee (NAC) based in the MOH and three had one not linked to a ministry, under the president or prime minister. A single country had no institutional arrangement for AIDS before the project.

Has the institutional set-up changed? If so, has it been influenced by the MAP eligibility criteria? If so, in what way?

In all 13 cases where the institutional set-up changed, the TTLs attributed it to the MAP eligibility criteria and, to some extent, UNAIDS recommendations. In two countries where there was already a NAC (and thus no change), it wasn't clear to the TTLs whether the NAC had been the result of Bank activities or pressures (such as a visit from Bank President Wolfensohn) before the project (table I.10a, b).

Comments:

Friction between MOH and the NAC (3)
MOH has been given a major role in the NAC (3):

- Minister of Health is chair of NAC
- Minister of Health is the first vice president of the NAC, Minister of Social Affairs is the second VP

Table I.9: AIDS Institutions before the MAP

Institutional arrangement	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Mid-level department in MOH (*)	26	4	1
High-level department in MOH	16	1	2
Multisectoral unit not linked to a ministry, under the president or prime minister	16	1	2
Low-level department in MOH	16	1	2
Multisectoral NAC in the MOH	11	1	1
None	5	1	0
Both a unit in MOH and multisectoral unit outside MOH	0	0	0
No answer/ NA	5	1	0
Don't know	5	1	0

* This option wasn't offered—it was a write-in, but ended up being the most common.

Table I.10a: Change in Institutions Since MAP Effectiveness

Changed?	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Yes	68	7	6
No	16	2	1
N/A	5	1	0
No answer/don't know	11	1	1

Table I.10b: How Institutions Have Changed

How changed?	Percentage of countries (n = 13)	MAP I (# countries)	MAP II (# countries)
NAC in office of the president or prime minister	92	7	5
Created Ministry of AIDS, NAC secretariat inside AIDS ministry	8	0	1

- Minister of Health is vice-chair of NAC, Minister of AIDS is rapporteur.

Well-functioning MOH program and/or despite NAC (4):

- NAC a strong, credible institution, complementary relation w/NACP—NAC focuses on prevention and NACP on treatment
- NAC strengthened ability to coordinate donors, civil society, local government
- AIDS program in MOH still exists and is an important source for technical support, with many activities still focused on the health sector. The NAC has enabled more autonomy for other ministries and NGOs to design activities and access funding
- MOH program still exists and is implementing a significant health component.

Ineffective NAC (1):

- NAC/NAS not very effective, as doesn't meet often enough.

Other problems noted with or improvements in NAC (4):

- Need to attract better-qualified staff.
- Number of staff rose from 6 to 20 after the MAP.
- NAC has become filled with more dedicated and knowledgeable staff, is now thinking more about developing specific guidelines and implementation policies for issues such as ARV.
- In the MOH, there's a new "national coordinator" for AIDS, plus a MAP person, plus potentially a TAP person, both of whom report to the national coordinator.

NGOs, CBOs, and Civil Society Response

Prior to the project, how conducive was the environment to enlisting NGOs through the government for the fight against HIV/AIDS? Was the government already supporting NGOs? Was there already a mechanism? If not, did the project result in developing one?

In about half of the countries (10, or 55 percent), the government was already funding NGOs through the MOH and/or other sectors (table I.11). In eight (44 percent), the government wasn't funding NGOs or CBOs at all, including one case in which mechanisms existed on paper but had never been used.

In all seven cases where the government was not previously supporting NGOs and there was no mechanism, TTLs reported that the MAP resulted in creating mechanisms for supporting them. In some countries where the government was already funding NGOs to work on AIDS, the project created or strengthened mechanisms for funding CBOs and civil society.

To what extent were there capable local/indigenous NGOs with capacity to design, manage, and evaluate HIV/AIDS programs?

In 11 of the 19 countries (58 percent), the TTLs reported few or no indigenous NGOs with capacity to design, manage, and evaluate HIV/AIDS programs (table I.12).

Table I.11: The Environment for NGOs before the MAP

Answer	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Government wasn't funding NGOs or CBOs	37	3	4
Government was already funding NGOs to work on AIDS	26	3	2
Government was already funding NGOs through the MOH	16	1	2
Government was funding NGOs in health or other sectors, but not AIDS	11	2	0
Non-functional mechanisms existed but they hadn't been used	5	1	0
Don't know	5	1	0

How is it determined what type of intervention will be financed for a given NGO or CBO? Is there any prioritization?

Of the 12 countries for which the TTL answered, in 8 there is no prioritization, with virtually any proposal that passes muster being approved, and in 2 others proposals are approved provided they are on the long list of potential activities in the Project Appraisal Document (PAD) or not on the short list of ineligible activities. In other words, there is no prioritization in 10 of the

12 that answered (53 percent of the total). In one case, the TTL said that priorities were defined at project launch, but the TTL did not explain if these were institutionalized. The respondents for the 7 countries with no response (37 percent) generally explained in detail the approval process but did not address prioritization, or they gave additional information on logistics (table I.13).

Have the implementation/funding mechanisms foreseen by the project been suc-

Table I.12: Extent of Capable Local NGOs

Answer	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Many/some	42	4	4
Few/limited indigenous capacity	42	6	2
No local NGOs for AIDS	16	1	2

Table I.13: Prioritization of NGO Interventions

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
No prioritization; nearly all proposals are approved	42	4	4
Must be on one of the list of activities in the PAD (or not on the list of excluded activities)	11	2	0
Prioritization by districts as a function of work program, prevalence rate, vulnerable groups	5	1	0
Priority activities defined at project launch—HIV/AIDS knowledge; raising commitment; mitigation	5	0	1
Not answered	37	4	3

Table I.14a: Success in Accelerating Funds to Civil Society

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Yes	68	7	6
For big NGOs, but less so for small NGOs	5	1	0
No	11	2	0
Too soon to tell	11	0	2
Not answered	5	1	0

Table I.14b: Bottlenecks in NGO/CBO Financing

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Financial & administrative aspects (n = 8)	42		
Special accounts and cash flow		1	0
Overly centralized disbursement & low administrative capacity		1	0
Poorly developed banking system in periphery		1	0
Slow processing		1	0
Slow replenishment of special acct at central level		1	0
Special account ran out of money		0	1
Adapting Bank procedures for smaller NGOs		1	0
Inadequate staff to enter cost estimates into MIS		0	1
Low NGO capacity/poor results (n = 5)	26		
Building capacity for smaller NGOs		1	0
Results indicators – lack of them introduces delay in approval		1	0
Low quality of NGO proposals ->revisions		0	1
Getting NGOs qualified to receive money		0	1
Poor results		1	0
Selection process (n = 4)	21		
Clarifying the selection process		1	0
Political interference in selection of subprojects		0	1
Long time for subcontracted agencies to review proposals		0	1
Large proposals that need approval from NAS take long time to approve		0	1
No bottlenecks (n = 4)	21	3	1

Note: Total is more than 19 because some countries gave multiple answers.

successful in accelerating funds to civil society?

For the most countries (13) the answer was an unqualified yes, and in one other it was the case for large NGOs. In four cases, the funding mechanisms had not accelerated funds or it was too soon to tell (the latter two both MAP II countries).

What are the bottlenecks, if any?

Only 4 of the 18 projects reported that there were no bottlenecks (table I.14b). The predominant problems were **financial and administrative**, affecting 8 countries (44 percent, including 6 of the 7 MAP I projects that reported bottlenecks)—cash flow, overly centralized disbursement, low administrative capacity, poorly developed banking systems, slow replenishments of the special accounts, problems adapting Bank procedures to project needs. The second most com-

mon bottleneck, mentioned by five countries (28 percent), was **low capacity of NGOs**. A third common complaint had to do with difficulties in the **selection process for NGOs** or their proposals—political interference, long and cumbersome review times, and lack of transparency (4 countries, 22 percent).

AIDS and the Health Sector

What has been the impact of the MAP and the national institutional set-up on the engagement of the MOH?

In half of the 18 active MAP countries TTLs reported that there was some disengagement or tension with the MOH as authority was put in a multisectoral committee outside the MOH: Five initially had displeasure or tension, but this has been neutralized (table I.15). In four there con-

Table I.15: Extent of Disengagement of the MOH Due to MAP Institutional Requirements

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
No disengagement (n = 9)	47		
No disengagement		2	1
Didn't change the institutional set-up		2	0
MOH is still the leader, with other sectors involved		1	0
Excellent ownership because 1/3 of MAP funds are allocated to MOH		0	1
MOH has largest action plan and is leading the treatment program		0	1
MOH is head of NAC.		0	1
Initial disengagement, overcome (n = 5)	26		
Initially MOH was not pleased, now responsible for health operations		2	2
Tension involving lack of clarity between role of MOH/NAC, but Minister is VP of NAC.		1	0
Continued disengagement (n = 4)	21		
Alienated the MOH, both because of NAC and because didn't get another health project		1	0
Very negative effect on MOH, struggles between MOH & NAC, exacerbated by ethnic differences, nationally and at state level		1	0
Adverse impact due to NAC and creation of Ministry of AIDS		0	1
Adverse impact because of rivalry between current health minister and former health minister chairing the NAC		0	1
No comments offered (n = 1)	5	1	0

tinues to be disengagement or tension, due to either institutional or personal rivalries. In the remaining half of the countries, there was no reported disengagement. This was due, in some cases, to the fact that the MOH was still leading the national AIDS response, a special component of the project had been carved out for MOH, the MOH had a leadership role in the NAC, or the institutional set-up of the response was not affected by the MAP.

What has been done, if anything, to address the tensions or problems with the MOH?

TTLs for nine countries responded that they had tensions/problems with the MOH, and eight of them offered solutions. At the top of the list was personal discussions with the TTL or a decision to discuss all health activities directly with the MOH (five countries). In three cases a new minister of health, director of health, or new government came in, solving the problem. In three countries, there was an attempt to raise the project respon-

sibility or authority of the MOH by creating a special account for the MOH or simply giving it more say (table I16.a).

Does the MOH have its own special account?

Most MOHs have accounts with the NAC and some have special accounts from other health projects. However, in only four countries did the MOH have its own special account in a MAP, including in Eritrea, where the government response is led from the MOH. (TTLs for five countries did not respond or did not know, however; table I 16.b).

If there's a concurrent health operation, what is the relation between the MAP activities and the health project (formal and informal)? Are they coordinated? Complementary?

At the time of the interview, seven countries had no concurrent health project and an eighth had a concurrent AIDS and reproductive health proj-

Table I.16a: Solutions to MOH-NAC Tensions

Solution	Number of countries
Personal discussions w/TTL; TTL discusses all health activities directly w/MOH	5
New director of health or minister of health	2
Got MOH its own special account, after MTR.	1
New government and new minister of health	1
Trying to get a treatment committee going and justify a special account on a volume basis	1
More project responsibility given to MOH	1

Table I.16b: Special Accounts for the MOH

Answer	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Yes	21	2	2
No	53	6	4
Don't know/no answer	26	3	2

Table I.17: Relation Between MAP and Concurrent Health Operations

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Good coordination (n = 8)	42		
Counterparts for the two projects are the same		2	1
Bank TTLs or teams are the same		2	0
Projects are supervised together		1	0
Work programs shared between projects and with the Global Fund activities.		1	0
Finance complementary activities		2	0
Pharmaceuticals link the health and MAP projects. MOH reviews drugs.		0	1
Some crowding out of health by MAP (n = 1)	5		
SWAP finances district health plans; a little crowding out by MAP, which tends to top up district health plans by financing treatment.		0	1
Very little coordination (n = 1)	5	1	0
No concurrent health operation at the time of the interview (n = 7)	37	4	3
No response (n = 3)	16	1	2

Note: Total is more than 19 because TTLs for some countries gave multiple answers. SWAP = sector-wide approach.

ect that did not address the entire health system.⁶ Almost all of the remaining countries (8 of 10) reported good coordination through measures such as sharing the same counterparts, joint supervision, and the same TTL for the two operations. The TTL for one country suggested that the MAP had crowded out some of the district health plans financed by a SWAp and one additional

Table I.18: M&E Indicators Being Collected

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Same as in the PAD	37	4	3
Additional indicators being collected	16	2	1
Change in some indicators (some added, some dropped)	42	4	4
Not answered	5	1	0

country reported very little coordination between projects (table I.17).

Monitoring and Evaluation

Are the indicators actually being collected different from the PAD? If so, in what way?

In nearly half of the countries with active projects (8, or 44 percent), some of the PAD indicators had been dropped, and new ones had been added. In three countries, the PAD indicators had been kept but others had been added, and in seven the indicators were the same as in the PAD (table I.18).

What mechanisms are in place to evaluate the effectiveness of interventions implemented by NGOs and CBOs?

The TTLs reported that none of the projects included provisions to evaluate the effectiveness or impact of NGO and CBO interventions. Of the TTLs for 17 countries that answered this question, about a third (6, 35 percent) reported that there were no mechanisms whatsoever for evaluating the effectiveness of interventions by NGOs and CBOs. Others in effect only monitored process and output indicators (8 countries, 47 percent) or subjected them to financial or management audits (4 countries, 24 percent). External evaluations at the MTR and ad hoc field visits were also used (table I.19).

What technical inputs has the project received for M&E? How useful has this assistance been in setting up and implementing M&E for this project?

Table I.19: Evaluation Mechanisms for NGOs and CBOs

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
None (other than, for example, completion reports) (n = 6)	32	4	3
Indicators (n = 8)	42		
Output/process indicators only		0	3
Reporting with core indicators (not clear if they are process or outcome)		3	2
Report cards		1	0
External audits (n = 4)	21		
Technical audits by consultants hired by NAS		1	0
Management & financial audits		1	2
External evaluations (n = 5)	26		
MTR will have an evaluation		2	1
Ad hoc field visits/supervision missions		1	1
No answer or N/A (n = 2)	11	2	0

Note: Total is more than 19 because some countries gave multiple answers.

Table I.20a: Technical Inputs for M&E

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
GAMET	79	7	8
Consultants	21	4	0
Other donors	63		
UNAIDS		3	1
USAID consultant/MEASURE		4	0
Other donors		2	0
CDC	0	2	
Development Economics ^a	5	1	0
None	5	1	0
No answer/NA	5	1	0

a. The Bank's research department.

Table I.20b: Comments on Technical Assistance

Comment	Number of countries
GAMET was very helpful	3
GAMET useful, but reported to someone other than the TTL; M&E expert needs to be part of overall team	1
GAMET not very helpful	1
"Technically they are helpful, but there's no one around to implement recommendations"	1
M&E technical assistance was very useful, part of the 'one system' M&E system that has been set up	1
"There's sometimes been an overload (not necessarily from the Bank), with each donor consultant coming with their own thing. Not too little, just uncoordinated"	1
"Disappointing results" from consultant	1

Most of the projects did get some technical assistance on monitoring and evaluation, often from many sources. GAMET was the most frequently cited source, for 15 countries (table I.20a,b).

What are the key issues in this country for improving M&E and ensuring that these results are used to inform decisions?

The TTLs for only two countries reported that the M&E systems were functioning well. For all of the rest, myriad problems were noted, including: the need to collect and disseminate relevant data for decision-making at the periphery; the need to create incentives; the need to make M&E more results-oriented, as opposed to process oriented; the need to build capacity for M&E at both the center and in decentralized units; the tendency of

each donor to have a different set of indicators; the need to monitor quality as well as coverage of services; the lack of impact evaluation (table I.21).

Impact

(If the project has been active for at least a year) what are the main constraints to improving the national response to AIDS today? Has the MAP project had an effect in easing any of the initial constraints? Which ones?

Low implementation capacity remains the predominant constraint, cited by TTLs in six countries—capacity of the health sector, the NAC, and NGOs, and civil society. Financial resources were cited as a constraint for four countries,

Table I.21: Comments on Key Issues for Improving M&E

Comment	Number of countries
Overall M&E system is not operational	4
Need to provide incentives for data collection and build capacity of provinces for M&E	2
Data go to the center, but there's no guidance or feedback to the local level	1
Lack of power of the NAC over all of the actors; each donor has its own indicators	3
Weak capacity of the NAS M&E unit, more skilled people needed	2
Every indicator needs its own collection system & NAC wants to put them all together themselves instead of supporting other agencies to do it	1
Need M&E for whole program, not just project	1
Need to focus on monitoring quality of services, not just coverage	1
Current M&E systems designed to assist national-level decision makers, which isn't useful for implementers at the local level	1
Simplify M&E and make it relevant to local decision makers, to make it a management tool	1
Too much output-based evaluation; need to focus on results	3
Too many indicators; need to get agreement across agencies/donors	1
Need good impact evaluation methodology and to enter data into system for use	1
Training in GIS to understand spatial coverage	1
M&E system is functioning well right now	2

while in four others the TTLs remarked that the influx of money had outstripped the capacity to absorb it, given the limited skilled manpower for implementation (table I.22).

What has been the impact of the Bank's assistance through the MAP as of today, relative to the counterfactual of no MAP/no Bank assistance, both positive and negative?

It should be kept in mind that the MAP I countries are basically at mid-term review (MTR) or almost closed, while many of the MAP II countries have barely been effective for a year. The main impacts cited by TTLs, relative to the counterfactual of no MAP, were greater political commitment and community mobilization (9 countries, 50 percent); greater awareness of HIV as a problem (8 countries, 44 percent); stronger institutions and capacity, including multisectoral institutions (8 countries, 44 percent); impacts on other donors in terms of attracting money or donor coordination (6 countries, 33 percent); expanding access to treatment/care (5 countries, 28 percent, of which 4 are MAP II); and pro-

ducing public goods in terms of surveys, surveillance, and strategic papers (table I.23). **None of the TTLs cited any positive behavior change, a reduction in new HIV infections (as opposed to changes in HIV prevalence), or lower morbidity or mortality.**⁷ TTLs for three countries reported negative impacts, in terms of the resentment of other donors, antagonisms between the MOH and the NAC, and a lack of transparency in the NAC.

In your judgment, has the MAP been more or less effective relative to a standard investment project (SIP) on HIV/AIDS prepared on a non-emergency basis in this country?

The large majority of TTLs thought that the MAP was effective or much more effective than a standard HIV/AIDS investment project (12 countries), while two thought that they were equally effective, and a third wasn't sure what the difference is between a MAP and a standard investment project. One TTL noted that at the preparation phase the MAP was less effective because the projects held to a template and were unwilling

Table I.22: Current Constraints to the AIDS Response

Answer	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Low implementation capacity (n = 6)	32		
Weakness, low implementation capacity of health sector		2	2
Strengthen capacity at NAC in terms of training, manpower, organizational effectiveness, or dedication		2	0
Lack of involvement of civil society		1	
NGO capacity		0	1
Money – too little (n = 4)	21		
Lack of financing for ARV		2	0
Money is about to run out, lack of money		0	2
Absorptive capacity – too much money in relation to people (n = 4)	21		
Politics surrounding the huge sums of money		2	0
Shortage of human resources/absorptive capacity		0	2
Institutional issues (n = 3)	16		
Isolation of MOH; Relation between MOH and MoHIV/AIDS, which will compromise treatment program		1	1
Institutional and organizational issues, federal, state		1	0
Programmatic issues (n = 3)	16		
Strengthen M&E and link program to results		1	1
Improve targeting/more strategic thinking		1	1
Need a way to make sure critical interventions are “scaled up”		1	0
ARV treatment issues (health facilities, staff training, drug supply)		1	0
Lack of coordination (n = 2)	11		
Scattered, uncoordinated activities		1	0
Lack of coordination within government and among donors, so much money is flowing		0	1
Social issues (n = 1)	5		
Stigma		1	0
No answer or NA (n = 3)	16	2	1

Note: Total is more than 19 because some countries gave multiple answers.

to adapt to local conditions, while they were more effective at the implementation phase because of the ability to adapt the project by amending the development grant agreement. Note that only four of the TTLs interviewed were around at project preparation, when the “template” and emergency preparations were being pushed, so most may not have been as familiar with the preparation phase, especially of the first MAP. The main reasons the MAP projects were believed to be more effective is that they allow a mul-

tisectoral approach to HIV/AIDS and support communities, and that adaptation is possible (table I.24).

The Future of the MAP

Has the availability of new financial resources from the Global Fund or PEPFAR influenced the content of the MAP? If so, how?

Of the 16 TTLs for the 18 active projects, seven (37 percent) remarked that these other sources

Table I.23: Impact of MAP to Date

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Positive impacts			
Commitment, mobilization (n = 9)	47		
Increased political commitment		0	1
Greater community/civil society mobilization		4	3
Empowered local government, local implementers, gave them info, coordination; decentralized		2	2
Greater awareness, acceptance of HIV as a problem		5	3
Institutions (n = 8)	42		
Multisectoral activities		3	1
Stronger institutions/capacity		1	3
Impacts on other donors (n = 6)	32		
Has made program more attractive to fund by other donors		1	2
Enhanced donor coordination, one M&E system		1	3
Treatment (n = 5)	26		
Access of the poor to ARVs, more access to treatment		1	1
Created institutional framework for more access to treatment/care		0	3
Public goods (n = 4)	21		
More information on the epidemic through surveys, surveillance		1	1
Revised strategic framework		1	1
Other (n = 8)	42		
Leveling off in HIV prevalence		2	0
Mobilized lots of money		1	0
More people tested, aware of status		1	0
Activities would not have been on this scale		1	0
Funding of commodities (others fund mainly TA)		1	0
Decreased stigma		0	1
Better medical waste management		0	1
Behavior change		0	0
Negative impacts (n = 4)	21		
Resentment of other donors		1	0
No impact on prevalence, care or behavior		1	0
Antagonism between MOH and NAC		0	1
Lack of transparency		0	1
No answer/ N/A (n = 2)	11	1	1

Note: Total is more than 19 because some countries gave multiple answers.

have had no impact on the content of the MAP to date (table I.25). In some of these cases, the other sources are funding things that the MAP does not finance. The other half (44 percent) said that it has influenced the content (3) or that

they anticipated that it would, once the money started flowing (5). Among those already affected, comments included that the involvement of other financiers has lessened the Bank's financial leverage and forced it to focus on its

Table I.24: Effectiveness of the MAP Relative to a Standard Investment Project

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Much more effective	11	2	0
More effective	53	5	5
The same	11	1	1
Less effective	0	0	0
Much less effective	0	0	0
Don't know – What makes MAP different?	5	1	0
Less effective at preparation phase, because held to “template,” unwilling to adapt to local conditions. More effective at the supervision phase because can be adapted by amending DGA & ACT Africa not involved in supervision.	5	0	1
N/A no answer	16	2	1

Table I.25: Influence of Other Funding on the Content of the MAP

Answer	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
No	37		
No		1	3
No, the others are funding things that MAP doesn't finance, complementing the MAP		2	1
Not yet, because the money hasn't started flowing	26	3	2
Yes	21		
Funding of treatment shifted to others		1	0
Highlights need to prioritize because of absorptive capacity		0	1
Has lessened the Bank's financial leverage		1	0
Has gotten Bank to focus on its comparative advantage		1	0
N/A – No other funding	5	0	1
Don't know	5	1	0
No answer	5	1	0

comparative advantages, that as a result the treatment financing could be shifted to other donors, and that the large amounts of money highlight the need for government and donors to prioritize activities because of limited absorptive capacity.

How has the much broader availability of funds affected the relevance of the MAP? Is the approach still relevant?

There were basically only two answers to this question—still relevant (two-thirds of respon-

dents) and no answer (one third, table I.26). Those that reaffirmed the relevance gave reasons such as the great needs, the MAP's unique approach (focusing on the multisectoral response and the use of local governments and NGOs), and the concern by governments about the predictability and sustainability of other sources (in particular the Global Fund). In two cases, the respondents noted that while still relevant, the other new funders had focused more on treatment and that the MAP needed to return to a strong emphasis on prevention.

In what ways, if any, would you change the design or approach to the Bank's HIV/AIDS assistance in this country in the next round of lending?

A third of the TTLs (4 from MAP I, 2 from MAP II) indicated that changes were needed in the overall approach in terms of greater emphasis on prevention (in the light of other donors' financing of treatment), on policy dialogue and strategy, and on working with the countries to help them find their own solutions (instead of following a template) (table I.27). Five TTLs did not answer the question. Other suggestions touched on country-specific issues that could be grouped roughly into financing (4, 22 percent), multisectoral issues (2, 11 percent), and specific interventions (2).

Were the eligibility criteria for the MAP useful and appropriate?

Nearly half (8, 42 percent) said that the eligibility criteria were useful and appropriate, but an almost equal number did not answer the question (7, 37 percent). Two TTLs dissented, saying that the contracting out should not have been forced in all cases, as in some it was not appropriate, and that the eligibility criteria should have not been imposed without dialogue or explanation.⁸ Two TTLs did not know if the eligibility criteria were useful or appropriate (table I.28).

How should they be revised, if at all, for the next round?

TTLs from only 9 countries answered this question, including two cases in which the respondent was not sure how they should be revised. Comments from the seven responding countries are in table I.29.

How many TTLs have there been for this country since and including preparation?

Only four MAP projects (three MAP I, one MAP II) had retained the same TTL since preparation (table I.30). This is surprisingly low for the MAP II projects, as most were recently approved. In fact, three MAP II projects have had 3 TTLs each in the course of 2 years, and a fourth has had 4 TTLs.

If the TTL is not from the health sector, what have been the difficulties managing this project as someone not based in the health sector? Are there any advantages to have non-health staff managing the project?

Seven of the respondents (39 percent) were not from the health sector. None felt they had any difficulty managing the project. Six of the seven noted heavy involvement of health specialists. One advantage of not being from the health sector is greater credibility in marketing a multisectoral approach (2 responses). Two of the TTLs said that they were able to lend expertise to the community-driven components, which an HNP colleague probably would not have been able to do.

Table I.26: Impact of Other Funding Sources on the Relevance of the MAP

Answer	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Yes	63		
Still relevant		3	3
MAP requirements seen favorably in light of the GF, other donors		1	1
MAP still offers MS approach, use of local governments, and NGOs		3	0
Government & NGOs don't trust sustainability, predictability of GF, others		1	0
N/A	5	0	1
Not answered	32	3	3

Table I.27: Recommended Changes in the Design or Approach to the Bank’s HIV/AIDS Assistance in the Next Round, MAP Countries

Answer	Total – MAP I & II		Number of countries	
	Percent	Number of countries (n = 19)	MAP I (n = 11)	MAP II (n = 8)
Overall approach	37	6		
Greater emphasis on prevention /leave treatment to the other donors			3	
Focus more on the larger response (as opposed to the project); emphasis on policy dialogue, strategy, evaluation of results			1	1
Should change approach – assist country to find its own solution by asking the right questions, sharing experiences, listening to all levels of stakeholders, not a template				1
More country ownership from the beginning				1
Financing	21	4		
Grant instead of credit			1	1
Pooled funding			1	
Reduce counterpart & community contribution requirements (in latter case, especially for mobilization and awareness interventions)				1
Multisectoral aspects	11	2		
Revisit line ministry component – too vertical, not integrated			1	
More sectoral implementation of subprojects in ministry of transport, MOH, etc, using special accounts where there are already Bank operations in that sector				1
Specific interventions	11	2		
More technical support for the MOH				1
More support to PLWHAs before they get sick, with food, etc.			1	
Other	5	1		
If other funding materializes, just focus on the community component			1	
Not answered	26	5	3	2

Any other comments or issues you’d like to raise in this evaluation? (number of TTLs)*Issues to examine*

- How important is it to give money to every ministry? (1)
- What are the most efficient and effective institutional arrangements for NGO financing? (1) Write a paper on “stock-taking” for the community response (1)
- What is the most efficient way to scale up? (1)

- Paper on how to have an impact even when the country is in non-accrual (1)
- MAPs are not dealing well with the orphan problem (1)

Lessons & comments

- “There was a total lack of responsibility of advisers in the MAP on content,” attention only to process. This was “chaotic and irresponsible,” due partly to the haste imposed in preparation. (2)
- There was too much haste—we’re now find-

Table I.28: Usefulness and Appropriateness of Eligibility Criteria

Response	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
Yes, useful and appropriate	42	4	4
Caveat – contracting out not useful/appropriate	5	0	1
Not appropriate – Criteria should have been suggested, not imposed, w/o dialogue or explanation	5	0	1
Don't know/not sure	11	2	0
Not answered	37	5	2

Table I.29: Suggested Revisions for the Eligibility Criteria

Comment	Number of countries
Require good M&E system	3
Criteria should be adaptable to country context, not a cookie cutter	3
More flexibility in procurement procedures by the Bank	1
Provision for ARV needs to be 'more open'	1
Commitment to the "three ones"	1
More program management (vs. outsourcing)	1
Need for substantive technical advice on HIV/AIDS	1
Genuinely strategic plans, with prioritization	1

Table I.30: Number of TTLs to Date

Number of TTLs	Percentage of countries (n = 19)	MAP I (# countries)	MAP II (# countries)
1	21	3	1
2	37	5	2
3	26	2	3
4	11	1	1
Not asked	5	0	1

ing “communities” of five people (1). The preparation of the MAP projects should not have been done as quickly as they were pressured to do. In [country] it didn't make much difference because there was a previous AIDS project. But elsewhere it resulted in low ownership and involvement in civil society, and inability to deal with fraud, corruption, and the experience of previous health projects (1, citing 2 additional countries).

- “Cannot address AIDS without improving health systems.” Need to come back to this focus. (2)
- Most money has been spent on training and workshops, not on implementation (1)
- In smaller countries, where the money is not needed, it may be more appropriate to supply technical assistance (1)
- The huge amount of money coming in from the Global Fund is distorting the policy dialogue,

ownership, and demanding more time of everyone on the ground. If you consider that 75 percent of the MOH budget is salaries, then the amount coming in on AIDS is clearly larger than the non-salary recurrent budget of the MOH. (1)

- Don't understand what the "MAP approach" is. (1)
- Rapid Results Initiative (RRI) is bottom-up but with no agreement from the top to change the rules; the Bank can't waive the guidelines for

local shopping for the 3-month timeline. The Accelerating Results Together (ART) model, used since 1992, also gets results in 100 days (1).

Recommendations

- All TTLs should have two weeks of training on substance (1, TTL not from the health sector)
- Major advantage to having TTL in the field (1)
- MOH is still in need of major assistance (1)
- Keep the next MAP simple (1)