



An Assessment of Ongoing Assistance: The Africa MAP

From September 2000 through the end of June 2004, 29 country-level Africa MAP projects were approved, amounting to roughly \$1 billion in commitments, of which about \$255 million had been disbursed.¹ Since all of these projects are still active and some only recently launched, information on their effectiveness is not yet available. As these projects are completed, OED will evaluate them individually, in depth, through project assessments. This chapter reviews the objectives of the Africa MAP program, the assumptions underlying the rationale, and the validity of the assumptions, based on the evidence from previous chapters. This is followed by an assessment of the program's design and risks, based on available evidence from implementation to date.

The assessment of this chapter uses the findings and lessons from the first generation of completed projects (based on PPARs and case studies) of the previous chapters; a review of program and project documents (including self-evaluations sponsored by ACTAfrica); OED's field-based case study of Ethiopia; data on project implementation to date collected from current task team leaders,² SAP, and other internal data systems; interviews with task team leaders and with country directors on their views of key issues in program design and implementation (see Appendixes I and J); a desk review of national AIDS strategies in 21 MAP and 5 non-MAP countries; and OED's recent evaluation of community-based and community-driven development (CBD/CDD; CDD or CD, as applicable, for the remainder of this review) development (OED 2005a).

The Objectives, Design, and Risks of the Africa MAP

The overarching objective of the Africa MAP is to prevent HIV infection and mitigate its impact. According to design documents, the goal of the first phase of the 10–15 year program of support is “to intensify action against the epidemic in as many countries as possible,” with two explicit objectives: (a) to scale up prevention, care, support, and treatment programs and (b) to prepare countries to cope with the impact of those who develop AIDS over the next decade.³ The development objective of the first envelope of \$500 million (MAP I), approved in September 2000, is to increase access to HIV/AIDS prevention, care, and treatment programs, with emphasis on vulnerable groups (such as youth,

Box 4.1: The Design and Eligibility Criteria of the Africa MAP

The first and second Africa MAPs were each a \$500 million envelope from which individual countries or Regional programs could access IDA resources, provided that each country satisfied certain eligibility criteria. The projects are intended to represent the first phase of a 10-to-15-year commitment of assistance to fight HIV/AIDS on the continent.

The strategy and project template focus on putting into place the machinery to “get things done,” and relatively less on what should be undertaken. The MAP attempts to accelerate implementation through project design that will ensure: enhanced political commitment; multisectoral activities and coordination; a substantial increase in financial resources; creation of the fiduciary infrastructure to accelerate disbursements, with contracting of key project management activities, when necessary; and channeling of a large share of project funds directly to NGOs and communities.

Countries that wish to participate in the Africa MAP must meet four eligibility criteria (World Bank 2000b):

- Evidence of a strategic approach to HIV/AIDS, developed in a participatory manner, or a participatory strategic planning process underway, with a clear roadmap and timetable
- Existence of a high-level HIV/AIDS coordinating body, with broad representation of key stakeholders from all sectors, including people living with HIV/AIDS

- Government commitment to quick implementation arrangements, including channeling grant funds directly to communities, civil society, and the private sector^a
- Agreement by the government to use multiple implementation agencies, especially NGOs and CBOs.

Provided that these are met, the MAP is committed to finance the overall national HIV/AIDS strategy. In an annex, the MAP project appraisal document highlights different priorities for countries with concentrated and generalized epidemics, but there is no attempt to prioritize activities or objectives in implementation; this is already assumed to have occurred in the national strategy. The components in the vast majority of MAP projects are organized around the funding of an implementing entity—the public sector and civil society, for example—rather than the type of intervention or objective. Of the first two dozen Africa MAP projects, only four have components that reflect the type of activity or objective.^b

The purpose of the project template approach is to expedite project preparation. To compensate, the projects are supposed to have a higher budgetary coefficient on supervision, strong M&E (representing 5–10 percent of project costs) that enhances “learning by doing,” and mid-course adjustments.

a. During MAP II, this was strengthened to say that subcontracting of key implementation arrangements would be the norm and that government agrees “to channel grant funds directly to communities, civil society, and the private sector, and to have effective procurement mechanisms in place” (World Bank 2001b, p. 15).

b. The activity-oriented components are: knowledge management (Ghana); targeted interventions (Burkina Faso); orphans (Burundi); and three components in Malawi on prevention and advocacy, treatment, care and support, and impact mitigation. Malawi is also the only MAP with a component exclusively for monitoring, evaluation, and research. (In most of the other projects this function is embedded in the project management or coordination component.)

Most MAP design features and eligibility criteria seek to raise political commitment and mobilization.

women of childbearing age, and other groups at high risk). MAP II, approved in February 2002, had, in addition, the objectives of: (i) pilot testing antiretroviral therapy (ART); and (ii) supporting cross-border initiatives. Each individual country project also has specific development objectives “as stated in national strategic plans.”⁴ The MAP has combined the use of country “eligibility criteria” and a project

design template to meet these goals and objectives (see box 4.1).

The MAP strategy and mechanisms can be related to the elements of development effectiveness used by OED—relevance, efficacy, efficiency, institutional development, and sustainability (see table 4.1).⁵ Most of the eligibility criteria and project design features attempt to ensure broad political commitment and mobilization (affecting both the relevance and sustainability of activities) and to engage civil society and actors in all sectors in implementation (effecting greater access to services). A

Table 4.1: Linking MAP Strategy and Mechanisms to Development Effectiveness

Measure of development effectiveness	Objective	MAP mechanisms to ensure the objective	
		Eligibility criteria	Project design feature
Relevance	Build political commitment	<ul style="list-style-type: none"> • Participatory approach to strategy development • High-level coordinating body • Commitment to quick implementation arrangements and multiple implementing agencies 	<ul style="list-style-type: none"> • High-level policy dialogue • Multisectoral response (commitment from more sectors than health) • Enlist NGOs, CBOs, communities (political mobilization)
	Implement activities that are appropriate to the stage of the epidemic, locally adapted, technically sound, in agreement with policies.	<ul style="list-style-type: none"> • National AIDS strategy 	<ul style="list-style-type: none"> • Learning by doing and strong M&E
Efficacy	Wider coverage of interventions		<ul style="list-style-type: none"> • More finance • More implementers (non-health sectors, civil society)
	Implement the most effective interventions	<ul style="list-style-type: none"> • National AIDS strategy^a 	<ul style="list-style-type: none"> • Monitoring, evaluation, research
Efficiency	Economize on scarce capacity in the short run while expanding it in the long run	<ul style="list-style-type: none"> • Commitment to quick implementation arrangements and multiple implementing agencies • HIV/AIDS coordinating body 	<ul style="list-style-type: none"> • Tap capacity of other ministries, NGOs, CBOs • Capacity-building activities • Contracting out management functions
	Prioritize activities to ensure cost-effectiveness and allocative efficiency (financing public goods, addressing externalities)	<ul style="list-style-type: none"> • National AIDS strategy 	<ul style="list-style-type: none"> • Learning by doing: monitoring, evaluation, research
Institutional development ^b	Improve intersectoral coordination	<ul style="list-style-type: none"> • Multisectoral HIV/AIDS coordinating body 	
	Create mechanisms to enlist civil society	<ul style="list-style-type: none"> • Commitment to multiple implementing agencies 	<ul style="list-style-type: none"> • Capacity building for civil society
	Ensure transparency and accountability		<ul style="list-style-type: none"> • Fiduciary mechanisms
Sustainability ^c	Political commitment and ownership by civil society	<ul style="list-style-type: none"> • [see political commitment above] 	<ul style="list-style-type: none"> • [see political commitment above]
	Financial, economic, technical resilience	<ul style="list-style-type: none"> • National AIDS strategy 	

a. It was also an assumption of the approach that pilot interventions have been shown locally effective.

b. The ability of a country to make more efficient, equitable, and sustainable use of its human, financial, and natural resources through: (a) better definition, stability, transparency, enforceability, and predictability of institutional arrangements and/or (b) better alignment of the mission and capacity of an organization with its mandate.

c. The resilience to risk of net benefit flows over time, including technical, financial, economic, social and environmental resilience, government and other stakeholder ownership, institutional support and resilience to exogenous influences.

The main risks identified by the MAP were slow implementation and low coverage, due to weak commitment and capacity.

number of mechanisms are designed to economize on scarce capacity—improving efficiency by contracting out management and fiduciary functions, for example. To assure technical efficacy, cost-effectiveness, and allocative efficiency, the MAP approach is highly dependent on three criteria and design features—the rigor of the national AIDS strategy, the assumption that pilot projects have been tested, and the implementation of intensive M&E and learning by doing. Unlike previous AIDS projects, the management or coordination of the MAP projects in most cases rests with a multisectoral body, and Ministry of Health activities are financed through that body.⁶

The Africa MAP was classified in design documents as a high-risk program, and efforts were made to mitigate the main risks through eligibility criteria and program design. The main risks were described as slow implementation and low coverage of interventions, due to low political commitment and implementation capacity.⁷ The MAP II proposal also acknowledged a risk that the community-based component could reinforce existing inequalities, particularly with respect to implementation of antiretroviral therapy.

However, several risks with respect to technical efficacy, efficiency, and sustainability were not assessed in the MAP design documents. Among

Other risks to efficacy, efficiency, and sustainability were not addressed in MAP design.

these are the risks that:

- National strategic plans, which are the blueprint for the activities to be financed, may not direct resources to activities with the largest impact or may not have assessed adequately the sustainability of the program. This could result in: (a) allocation of scarce capacity to less effective, efficient, or sustainable activities, including those that are the least politically objectionable and that do not address the main drivers of the epidemic; or (b) support of unsustainable ac-

tivities, with adverse consequences for the long-run support and viability of NGOs and civil society and, in the case of treatment programs, for development of viral resistance.

- Communities may not know “what’s best” in terms of implementation of interventions, and thus select those with low efficacy, that do not exploit any comparative advantage in implementation, and for which they lack the technical expertise. Large transfers have the potential to result in maldistribution of resources within the community, the expectation of further transfers, and elite capture.
- Multisectoral AIDS commissions may attempt to implement rather than coordinate, and increase red tape, slowing the response and institutional development of key ministries that are already engaged, such as the Ministry of Health and the military. Scarce capacity in some sectors may be diverted from important poverty-reduction activities in which they have a mandate and capacity to low-impact anti-AIDS activities in which they have no capacity or comparative advantage in implementation.
- The intensified M&E and supervision that was to compensate for a more thorough technical analysis of activities during preparation may not be implemented—as has been the case in most previous AIDS projects—resulting in little learning by doing and reduced efficiency and efficacy.

Based on the poor performance of past AIDS and HNP projects on implementing M&E, the lack of experience of the Bank in working through multisectoral AIDS commissions,⁸ and the findings of the OED evaluations of CBD/CDD and social funds on effectiveness and/or sustainability, all four of these critical risks should have been rated *high*. There were no design elements of the overall MAP to mitigate these risks, which could theoretically compromise effectiveness even if greater implementation is achieved.

Were the Assumptions Valid?

The focus of the MAP on rapidly scaling up interventions was based on the assumption, first, that past efforts to fight AIDS in Africa had been unsuccessful, and, second, that there are five principal reasons for this failure: (a)

inadequate finance, (b) lack of political commitment, (c) failure to achieve broader coverage of successful pilot interventions, (d) inability to get resources to communities, and (e) too narrow a focus on the health sector as the main actor. Implicit in the third reason is a sixth assumption: that in each country, pilot interventions have been evaluated, found effective, and are suitable for wider replication.

Evidence from this evaluation strongly supports the assumption that the lack of political commitment was the most important constraint to action—not only in Africa, but in all developing regions. The lack of finance and failure to achieve broader coverage of services, cited as separate constraints by the MAP, were also valid, but fundamentally a reflection of low commitment. In the course of researching the Bank's response to AIDS, OED did not find any instance in which a client requested HIV/AIDS assistance and the Bank declined to provide it. Attempts to provide HIV/AIDS assistance to countries where commitment was weak (such as in Indonesia and Zaïre) were not successful. The MAP's heavy emphasis on commitment and political mobilization in design was warranted, based on the previously low success rate of engaging African countries.

However, several other assumptions are not well substantiated. The first of these was that past efforts to control the epidemic in Africa had been unsuccessful. On the one hand, there was not at that time, nor is there currently, much evidence concerning the extent to which the trajectory of the epidemic is different than what might have happened in the absence of government and donor action. Except for a few research settings, HIV incidence and AIDS morbidity and mortality have not been tracked in Sub-Saharan Africa, and there are few population-based surveys that have tracked behavior over time. No studies have convincingly linked outputs of government AIDS programs and donors to these outcomes on a national scale. On the other hand, the Bank's HIV/AIDS assistance in Burkina Faso, Chad, Kenya, and Zimbabwe largely achieved its objectives. Several key interventions were implemented nationwide, though in some cases they were judged not to be sustainable.⁹ Substan-

tial institutional development was built in Burkina Faso (for the AIDS component), Chad, Kenya, and Uganda. There was clearly too little effort to control the epidemic across the continent, but at least in the countries studied by OED where the Bank was engaged on a national scale, usually in collaboration with other donors, it would not be correct to say that efforts have been "unsuccessful."

OED could find no evidence to support the assumption that lack of success in controlling AIDS in Africa has been caused by a failure to get resources to communities. The failure to mobilize political support from communities in some instances in the past may have been a missed opportunity in generating higher-level political commitment; however, most of the case studies of generating high-level commitment do not involve a push from the bottom or funding of communities.

Brazil is the main exception. In that case, the bottom-up political mobilization for fighting AIDS emerged from an indigenous democratization movement of the 1980s; AIDS policy did not precipitate this movement. While there are certainly examples of successful HIV interventions implemented by communities, OED could find no evidence that community-driven AIDS interventions are systematically more effective or more cost-effective than those implemented by NGOs, government, or even the private sector.

Nor does OED find that an over-emphasis on the health sector was a reason for lack of success. While it may be the case that other key sectors could use more resources to fight the epidemic, OED found no evidence that reallocation from health to other sectors would have improved the effectiveness of the response in the countries studied. OED found no instances in which the response of other sectors was as

The MAP correctly focused on the lack of political commitment as the most important constraint to action in Africa.

OED found no evidence that failure to get resources to communities was responsible for lack of previous success in AIDS control.

powerful as that of the health sector, and in most cases health ministries have worked with the most critical government agencies in other sectors.¹⁰ To the extent that the AIDS response is assigned to a low-level unit within the Ministry of Health with weak capacity, it reflects the low priority and political support of AIDS control. Bank assistance to strengthen the capacity of the health sector improved the AIDS response when political commitment was present. OED has not found examples of a strong response that bypassed the health sector or that was led by a sector other than health.

The assumption that there are many pilot activities that have been locally evaluated, found effective, and are suitable for wider replication is not well supported by task team leader interviews. In 42 percent of African MAP countries, the task team leaders were unaware of any previous local pilot testing of an HIV/AIDS intervention suitable for wider-scale replication. In the other 58 percent, they reported that fewer than four interventions had been locally tested. In more than half of these cases, only a single pilot project was cited. In about a third of the cases, one of the pilot projects was a CD-type intervention that did not necessarily directly address HIV/AIDS.

Two constraints to better performance were important in the first generation of assistance and are not among the explicit assumptions in the MAP design documents: (a) severely *limited capacity* within government and civil society; and (b) *conflict, political instability, and governance* problems. The MAP acknowledges capacity constraints by invoking mechanisms to accelerate disbursements and contract out some management activities and through project components that intend to build capacity on a large scale.¹¹ Conflict, political

Fewer pilot projects have been evaluated than assumed by the MAP.

Project preparation was shortened in MAP I, but the delay to effectiveness increased.

instability, and governance problems are responsible for unsatisfactory project outcomes in Haiti and Zaire, and the failure of the fully prepared Nigeria STI project to be negotiated. Among completed projects, there are no examples to date of Bank support for an effective AIDS response in countries with civil conflict or that are in arrears, even though these countries may be those most susceptible to the rapid spread of HIV.

Evidence on Implementation to Date¹²

Project preparation—which normally might have taken one or two years for each project—was considerably shortened, but with consequences for the delay from project approval to effectiveness (see box 4.3). The MAP compensates for rapid preparation through a project design that relies on the technical rigor of the national strategic plan, learning by doing, and more intense supervision.¹³ While more than 80 percent of MAP I and II task team leaders thought that the preparation time was sufficient for national ownership of the project, there is evidence that important activities were squeezed. Only 58 percent of MAP I task team leaders reported that the time was adequate to ensure quality project design, for example. The first joint World Bank and UNAIDS Progress Review in June/July 2001 found that the substantial delays between project approval and effectiveness in MAP I were in part the result of inadequate preparation (World Bank 2001c). The review recommended that operational manuals, first-year implementation programs, and the process for application and review of community grants should be finalized prior to project approval. These and other actions to improve project preparation resulted in a doubling of preparation time between MAP I and II, but a shortening of the time between preparation and effectiveness. MAP II task team leaders were more likely to report conducting an institutional analysis or an NGO capacity assessment during project preparation than were MAP I team leaders. Only 17 percent of task team leaders reported that analytic work was conducted prior to project approval for MAP I, and while this number rose to 42 percent among MAP II team leaders, it was still relatively low.

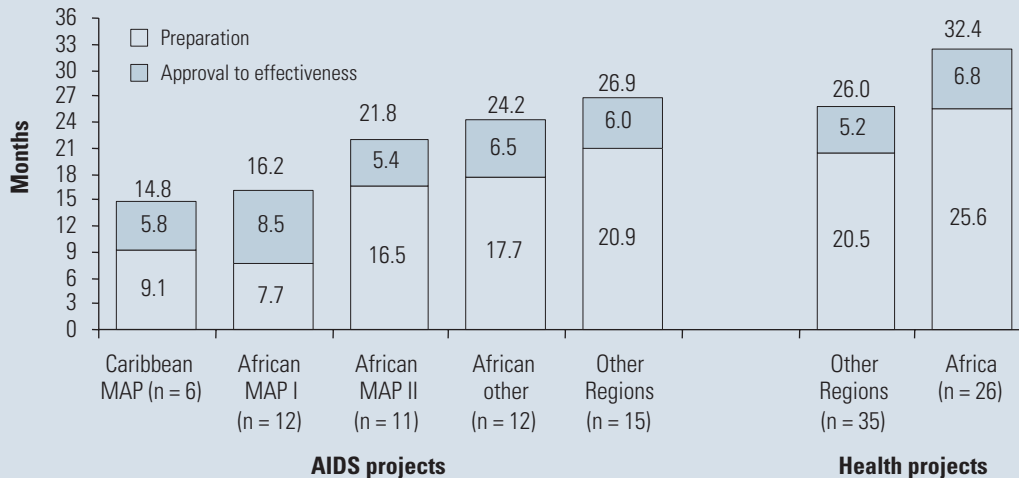
Box 4.2: Did the MAP Reduce Project Preparation Time?

One of the important rationales of the Africa MAP for using a project design template was to accelerate implementation by reducing the time it takes from project identification through Board approval (preparation). OED compared the preparation time and time from approval to effectiveness^a of 56 completed and active AIDS projects (23 of which were Africa MAP projects) with 61 completed or active (non-AIDS) health projects in the same countries.

The six Caribbean MAP projects had the shortest total time from identification through effectiveness (14.8 months), followed by Africa MAP I (16.2 months, see figure). However, total time rose to 21.8 months in Africa MAP II. The 12 African MAP I projects had the shortest preparation time of any group of AIDS projects (7.7 months), but also the longest time from approval to effectiveness (8.5 months). Preparation time doubled during MAP II, to 16.5 months, although this seems to have reduced average time to ef-

fectiveness by about 40 percent. The total time from identification until effectiveness for MAP II projects is only about two months less than other African AIDS projects, and five months less than AIDS projects in other Regions. Three-quarters of non-MAP African AIDS projects were health or social protection projects with an AIDS component, requiring preparation for all activities, perhaps explaining the longer preparation time.

AIDS projects worldwide also had substantially lower total time from identification through effectiveness (21.7 months) than did (non-AIDS) health projects in the same countries (28.7 months, not shown). This is mainly due to a year's shorter preparation time for AIDS projects in Africa (13.9 months, compared with 25.6 months for African health projects). Excluding African AIDS projects and the Caribbean MAP projects, AIDS and health projects elsewhere in the world have roughly the same total time from identification to effectiveness (26–27 months).



a. "Effectiveness" is a legal term that refers to the time when the borrower may begin to draw from World Bank loans. The borrower must approve the loan or credit agreement through its own government procedures, and any special conditions set by the agreement must be met.

It is difficult to say whether or not supervision of the Africa MAP projects has been more intensive than for regular projects.¹⁴ On the one hand, supervision of the MAP I projects from the Bank's budget seems not to have been more intensive than for standard health projects. OED compared the Bank budget supervision expenditures for MAP I projects in 8 countries at one and two years after project

effectiveness with the supervision costs of 11 ongoing health projects in the same countries. On average, supervision costs within the first 12 months were 39 percent higher for the health projects than for the MAP projects.¹⁵ After two years the cumulative supervision costs for the health projects were 10 percent higher than for the MAP projects. Comparing the projects country-by-country, in six of the eight countries

Supervision of MAP I projects has probably not been more intensive than that for other health projects, at least during the first two years.

ACTAfrica team or supervision activities financed from trust funds. Almost all of the MAP I task team leaders nevertheless reported that the Bank budget funds allocated for supervision were adequate to ensure minimum quality; however, only 7 of 12 task team leaders reported that supervision resources were adequate for MAP II countries.

Fewer MAP projects have contracted out key functions than anticipated, but where this has been done, team leaders believe it has accelerated implementation. Task team leaders reported that roughly half of the projects did not contract for financial management or procurement and about 70 percent did not contract for NGO management or M&E. However, among the projects that had completely or partially contracted-out these functions, 86 to 92 percent of team leaders reported that it had accelerated implementation of the project. Streamlined procedures and an operational manual have been developed for the prototype MAP project, with the potential for simplifying and accelerating implementation (Brown and others 2004). A comparison of the disbursement rates of MAP I and health, nutrition, and population projects in 11 countries suggests that, on average, the MAP projects have disbursed somewhat faster, although there is great dispersion around the trend lines for the two groups (see figure 4.1).¹⁶ Comparing the disbursement rates country by country, in 6 of the 11 countries the MAP disbursed at a faster rate than the HNP projects, in 2 countries the disbursement rates were roughly the same, and in 3 countries the results varied depending on the elapsed time.¹⁷

MAP projects have helped to create mechanisms for governments to finance NGOs and CBOs and invested in capacity to

MAP supervision costs since project effectiveness were similar to or less than those for health projects. These statistics do not include supervision from other sources, however, such as support from the

implement HIV/AIDS interventions. Task team leaders reported that in 8 of 19 MAP projects, the government had not been funding NGOs or CBOs before the project, including one case in which mechanisms existed but had never been used. In seven of those cases the MAP reportedly created the mechanisms. Task team leaders for 58 percent of the 19 MAP projects reported that few or no indigenous NGOs had the capacity to design, manage, and evaluate HIV/AIDS programs before the project.

Large numbers of actors have been engaged for implementation. According to task team leaders, an average of 16 ministries are being supported among the first 24 Africa MAP projects; 10 of the 24 projects support between 20 and 30 line ministries, and two-thirds support 10 or more ministries. Further, in line with the Africa Region strategy, more than three-quarters of the African countries participating in the MAP have World Bank-supported projects in other sectors with AIDS activities and components. Most of these are not formal components and therefore are difficult to monitor; supervision resources may not be adequate to ensure their efficacy (see box 4.3). An analysis of AIDS and education projects found that MAP resources for the education sector are more likely to be used in countries that have AIDS components in ongoing education operations, though the supervision of both is weak (Bakilana and others 2005).¹⁸ The number of NGOs and CBOs enlisted in the Africa MAP projects is substantially greater than in the first-generation projects (see table 4.2).¹⁹

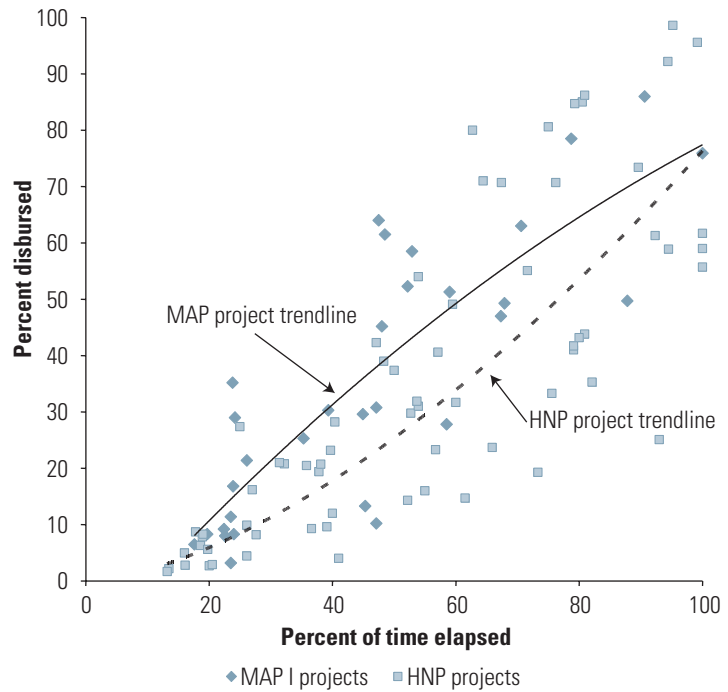
Political commitment is reported to have increased, and it is likely that the Africa MAP played a role in some countries. Many international events since 1999–2000 have influenced political commitment, but the Africa MAP projects have delivered key inputs aimed at raising commitment in most cases. According to interviews with task team leaders and country directors for two dozen MAP I and II projects, the eligibility criteria for commitment were backed up with substantial high-level policy dialogue during project preparation and after approval.²⁰ In 44 percent of 19 African MAP projects, team leaders reported that political commitment at the highest

levels of government has risen since the launching of the projects, and in 56 percent it has risen at the level of local government (see Appendix I). In about half of the cases, the task team leaders attributed the increase in commitment to the Bank’s intervention; in other cases they expressed an opinion that increased commitment was only partially attributable to the Bank or the result of changes in government. According to OED’s case study of Ethiopia, donors credited the Bank with opening up a frank dialogue about HIV/AIDS at the highest levels of government in 1999, including with the president, prime minister, and minister of economy and finance. The government agreed to borrow from IDA, raise the issue in public speeches, and incorporate HIV/AIDS into the Poverty Reduction Strategy Paper (PRSP). Increased awareness and political commitment were cited as the main achievements of the MAP to date by country directors for 82 percent of MAP I and 62 percent of MAP II countries. These reports will be followed up in depth by OED when the projects are completed, to understand whether they can be attributed to the Bank’s actions. However, **the fact that two dozen or more countries have been willing to borrow (or accept a grant) for a national HIV/AIDS response is, in itself, indicative of a significant change in commitment and meets the goal of the first phase of the MAP of “intensifying action in as many countries as possible.”**

Did the Unanticipated Risks Materialize?

Many of the anticipated risks in the project appraisal document linked to implementation—

Figure 4.1: Africa MAP I Projects Disbursed More Quickly Than HNP Projects in the Same Countries, on Average



Source: World Bank data.
 Note: Eleven MAP projects and 14 HNP projects.

such as low commitment and limited capacity—have been reduced through the MAP design mechanisms. However, as noted above, a number of risks affecting the program’s development effectiveness were not assessed

The MAP is reported to have helped increase political commitment in many African countries.

Table 4.2: Number of NGOs and CBOs Supported by Africa MAP Projects, as of July 2004

Projects	Fiscal year approved	NGOs	CBOs
Africa MAP I (10–11 countries) ^a – mean [minimum, maximum]	2000–2001	247 [5,700]	1,674 [40,6700]
Africa MAP II (11 countries) ^b – mean [minimum, maximum]	2002–2004	46 [0,120]	157 [0,550]

Source: PPARs, ICRs, MAP TTL self-administered questionnaire.
 a. Excludes Kenya for NGOs and Kenya and Nigeria for CBOs.
 b. Excludes Mauritania.

Box 4.3: Embedding AIDS Activities in Education and Transport Projects

Adding AIDS activities or components to projects in sectors outside of health is one strategy for ensuring that key sectors become involved. Potential advantages are that they can address policy issues within that sector and may build ownership by the ministry involved over the longer term. However, these AIDS activities are rarely large enough to become a formal project component that can be monitored, and very few have been evaluated. When the activities are “retro-fitted” into an ongoing project, there is often little documentation of the objectives or performance when the project closes.

While there are a few exceptions, supervision of AIDS activities in non-health sector projects also is generally modest. OED identified 18 ongoing projects in the education sector and 16 in the transport sector that mentioned AIDS activities in project design documents; only 4 had formal AIDS components that exceeded \$1 million.^a

In reviewing the most recent status report for these 34 projects, AIDS was rarely mentioned in the development objectives (see table). Fewer than 40 percent reported on the status of AIDS activities and fewer than a third had AIDS indicators. Virtually all of the indicators were in terms of outputs. None of the status reports elicited comments of managers on AIDS.

Seminars, workshops, and analytic work on HIV/AIDS have been launched within the Bank’s education and transport sectors to familiarize staff and government counterparts with AIDS impacts and how the sectors can help alleviate the problem.^b However, in the context of a specific project, supervision resources are often too tight to be able to enlist a technical expert for these small and specialized activities for which the sectors themselves have little expertise. An exception is Ethiopia, where some transport projects have hired the expertise needed to ensure technical quality.

Supervision of AIDS Activities in Education and Transport Projects

Percent of projects for which the most recent Project Status Report...	Sector	
	Education (n = 18)	Transport (n = 16)
Mentioned AIDS in development objectives	11	6
Reported the status of AIDS activities	39	25
Had AIDS indicators	28	31

Source: Appendix C and the most recent Project Status Reports.

a. All of the education projects and 14 of the 16 transport projects are in Sub-Saharan Africa. Three education projects and one transport project have formal AIDS components greater than \$1 million.

b. See, for example, Bundy and Gotur 2002; Valerio and Bundy 2004; World Bank 2003b.

Efforts to date have not been able to avoid unanticipated risks in the MAP design.

and there are no mitigating mechanisms in the design. For example, the MAP relies heavily on the national AIDS strategy and rigorous M&E to

promote learning by doing to ensure technical relevance, efficiency, and efficacy. If the national AIDS strategy is weak or M&E is not implemented, then effectiveness would be seriously compromised. Many of the unanticipated risks became apparent soon after approval of the first MAP projects and have been recognized in internal reviews by ACTAfrica. Additional resources have been brought to bear

to address some of them.²¹ Efforts may also have been made in individual country projects to mitigate these risks through other means. The findings to date, discussed below, suggest that in the aggregate the MAP design has not been able to avoid them.

Most national AIDS strategies do not cost or prioritize activities and are unlikely to ensure the technical relevance, efficiency, or efficacy of the Bank’s assistance without additional analysis.²² A background study for the OED evaluation reviewed the strategic plans of 21 African countries with MAP projects and 5 countries with conventional Bank HIV/AIDS projects. It concluded that, while there were

some important exceptions, overall the strategies resembled a template with a complete or nearly complete menu of standard interventions and no prioritization (see box 4.4). There was also no clear relation between the content of many of the strategic plans and the stage of the epidemic.²³ The strategic plans tend to be oriented around implementation rather than behavioral or epidemiological outcomes. This

suggests that the existence of a national strategy is not an adequate substitute for the standard analysis at project appraisal.

In the absence of strategic advice on prioritization, many of the programs being financed are not sufficiently focused on public goods and reducing high-risk behavior. The task team leaders for only 4 of 19 Africa MAP countries reported that the highest-risk behavior was being

Box 4.4: How Strategic Are National Strategic Plans?

OED reviewed national HIV/AIDS strategic plans from 21 countries participating in the Africa MAP^a and the strategic plans of 5 non-MAP countries that were studied in depth for the OED evaluation—Cambodia, Chad, India, Indonesia, and Russia. Evidence of a strategic approach included: clear goals, explicit priorities; systematic planning, targets, timeframes, and indicators; clear plans for M&E; clearly specified implementation actors and responsibilities; and cost estimates and strategies for resource mobilization. Additional characteristics were the extent to which the plans are efficient, equitable, relevant, and feasible.

Strategic Plans in Africa MAP Countries

In most of the documents, the term “priority” is used to describe most, if not all, of the main components of an HIV/AIDS program, without any ranking according to importance or effectiveness. All of the national strategies set out similar broad areas of focus (prevention, care/treatment, mitigation, and enabling environment). Almost all of the reviewed strategies included all but a few of the standard (two dozen) areas of intervention, with no discussion of their relative importance or effectiveness. The only prioritization occurred around the inclusion of antiretroviral therapy (ART)—only a third of the 21 plans envisioned it on a large scale. Seventeen of the 21 included ART for prevention of mother-to-child transmission (MTCT). Only 10 of the plans were costed. While the overall documents did not prioritize, there were some implicit priorities embedded in the budgeting and implementation stages. But there was a lack of transparency in prioritization. Only seven of the documents provided baseline data for a significant share of targets and indicators. All but one plan (Uganda, 2000/01–2005/6) explicitly mentioned high-risk groups (HRGs) as targets for intervention. But only seven referred to HRGs in the

statement of overall goals and objectives. The costing data did not provide adequate detail to judge whether these plans are really putting resources on HRGs. These strategies generally focused on process and implementation issues, rather than on the impact of programs on HIV.

In terms of overall strategic direction, with a lack of clear statements of priorities, the strategies are so similar that a generic package of HIV/AIDS areas of focus and interventions could have served just as well. This is important with regard to the question of what guidance is provided to the MAP projects by the national strategic plans.

Strategic Plans in Five Non-MAP Countries

The plans for Chad, Cambodia, India, Indonesia, and Russia also tended to have a core set of interventions that are assumed to be of equal importance, so that priorities should not be decided among them. However, all but the Russian document (which was actually a piece of legislation) emphasized targeting of HRGs and included a standard set of preventive interventions to address them. This was in contrast to many of the strategies in African countries with MAP projects, where HRGs are often placed at the same level of priority as large “vulnerable” population groups (such as youth and women) who are at risk of infection, but much less likely to spread HIV, on average. The strategies of the non-MAP countries also have less emphasis on underlying “root” causes and on the need for a multisectoral response, which is recognized but not operationalized to nearly the same extent. However, cost-effectiveness is not considered in any of the non-MAP strategies, nor is capacity treated as prominently. World Bank AIDS projects based in these five countries have clearly articulated objectives and priorities, however, in an attempt to ensure efficacy and efficiency.

Source: Mullen (2003a, b).

a. Plans for Gambia and Sierra Leone were not available at the time of the review, and the Malawi project had not yet been approved.

systematically addressed by the public sector; in half of the countries it is only being addressed to the extent that NGOs undertake these activities;

Many MAP projects do not ensure that public goods and the highest-risk behaviors are addressed.

insufficient support for public goods, especially surveillance, research, and M&E. No baseline data were established on the prevalence and behaviors of the general population in regions or high-risk groups. The under-financing of public goods and interventions for high-risk groups is greater in the more recent MAP II than in MAP I projects: Data obtained from task team leaders showed that MAP I countries were twice as likely as MAP II countries to support public sector operational research, targeted prevention interventions to high-risk groups (HRGs), and activities to mitigate the impact of AIDS to PLWHA. MAP II countries were substantially more likely to finance treatment of TB and other opportunistic infections, and slightly more likely to finance public antiretroviral therapy (see Appendix H). The MAP in only one country—Burkina Faso—has a special component to address high-risk behavior. There is often a strong reluctance to focus funds on the highest-risk behavior in generalized epidemics in Africa, in part because of the difficulty of identifying and reaching those at highest risk of HIV transmission. Recent research suggests that focusing prevention efforts on areas where people go to find new sexual partners may be less difficult than identifying specific risk groups, and more efficient than relying on interventions to the general population (see box 4.5).

The overall record of the Africa MAP in implementing strong M&E to improve

The record of the Africa MAP in implementing M&E to date is weak, and no better than for first-generation AIDS projects.

in 5 cases (28 percent), no part of the project assures that high-risk behavior is systematically addressed. The OED case study on Ethiopia found that the MAP had

“learning by doing” is weak, similar to the M&E record of the portfolio of completed HIV/AIDS projects. If 5–10 percent of project costs had been allocated

for M&E, as proposed in MAP design documents, some \$50–100 million would have been available for M&E in the two rounds of Africa MAP projects. However, except for the one project with a separate M&E component (Malawi, 8.3 percent of project costs), very little is known about M&E allocations, let alone actual expenditure.²⁴ Slow progress in designing and implementing M&E systems was recognized in the first joint World Bank and UNAIDS progress review mission in June/July 2001,²⁵ at which time it was recommended that M&E functions be outsourced and M&E plans be finalized during project preparation. In 2002, a generic M&E operational manual was prepared jointly with UNAIDS (World Bank and UNAIDS 2002) and a Global Monitoring and Evaluation Support Team (GAMET), based at the World Bank, was created to facilitate UNAIDS cosponsor efforts to build country-level M&E capacities and coordinate technical support.²⁶ Despite these additional inputs, the *Interim Review of the MAP* conducted in early 2004 found that most of the six projects visited had developed M&E plans, but in none had the plans been operationalized,²⁷ which made it difficult to assess what had been accomplished. As of the summer of 2004, task team leaders for 24 MAP I and II projects reported that M&E had been wholly or partially contracted out in a third of the projects, although outsourcing for M&E increased between MAP I and II (see Appendix H, table H.10). Team leaders for only two of the projects reported that the M&E systems were functioning well. The OED case study of Ethiopia found that the M&E framework was not developed until the third year of the project. In only a quarter of the Africa MAP countries has there been a national AIDS knowledge and risk behavior survey of the general population within a year of project approval.²⁸ In 9 of 28 countries with MAP projects, there has never been a population-based, nationwide survey to measure the patterns of AIDS knowledge and risk behavior among men and women. The recommendations of the *Interim Review* included making a functional M&E system a condition for future projects, putting it in a separate component with non-fungible resources, and building capacity.

Box 4.5: PLACE: Focusing Prevention Where People Go to Find New Partners

In countries with generalized epidemics where HIV is spreading substantially by casual sexual networks, reaching people with the highest rates of partner change with prevention services can be challenging. Approaches that focus on occupational groups at high risk of HIV transmission may not be sufficient to reach important populations with many casual sexual partners, particularly if the latter are difficult to identify, such as *migrant labor* or *out of school youth*. The PLACE approach—for Priorities for Local AIDS Control Efforts, developed by MEASURE Evaluation—attempts to systematically identify locations where people go to meet new partners, for the purpose of targeting prevention programs to areas that are likely to have high HIV incidence.

In South Africa, for example, the authors found more than 200

sites in each of three townships and 64 sites in one central business district where people go to meet new sexual partners (Weir and others 2003). The male-to-female ratio was 2:1, and almost half of all men and women interviewed had a new sexual partner in the past 4 weeks. Commercial sex was rare in the townships but available at 31 percent of the sites in the business districts. Yet fewer than 15 percent of the township sites and 20 percent of the business district sites had condoms. PLACE has also been applied in Burkina Faso (Burkina Faso PLACE Study Group 2002 and Nagot 2003), India (Bhubaneswar PLACE Study Group 2002), Madagascar, Mexico (Mexico PLACE Study Group 2002), Tanzania (Tanzania PLACE Study Group 2002), and Uganda (Ssengooba and others 2003 and Uganda PLACE Study Group 2002).

However, the experience of completed HIV/AIDS projects suggests that none of these measures is sufficient to ensure that M&E takes place or that the results are used to improve performance. No additional incentives have been incorporated into the MAP program design to overcome these problems. Disbursements, for example, are not tied to the existence of baseline studies or intermediate evaluations.

The MAP projects, like past HIV assistance, are also neglecting to collect HIV and behavioral data on groups most likely to contract and spread HIV. In Ethiopia, where years ago the government was monitoring HIV among sex workers in many different parts of the country, they are no longer monitored; epidemiological surveillance is almost entirely among pregnant women attending antenatal clinics. According to the task team leaders, about 58 percent of governments of the first two dozen African MAP countries are collecting HIV prevalence data and 75 percent are collecting behavioral information on at least one high-risk group. Nevertheless, 10 countries were not monitoring HIV in any high-risk group and six were not monitoring behavior.

The engagement of a large number of sectors in implementation, many of them with no apparent comparative advantage in

addressing AIDS, has increased the complexity and coordination problems of the national response, with substantial risks for efficiency and efficacy. As noted earlier, two-thirds of the first two-dozen Africa MAP projects are supporting the response of 10–30 ministries, according to task team leaders. There are many potential objectives of such engagement (see box 4.6), but in the case of programs supported by the MAP, the objectives for different sectors are not well differentiated. It may be helpful to the objective of *political mobilization* to engage as many sectors as possible, for example, but it is unclear whether widespread engagement in *implementation* will enhance efficacy or efficiency. Although the AIDS epidemic has wide-ranging impacts and societal determinants, this does not mean that all sectors are equally relevant or competent in launching an effective response. Enlisting all sectors in implementation does not use the comparative advantage of sectors that are most critically involved effectively, and it encourages action in areas that are far removed from other ministries' mandates. The *Interim Review of the MAP* found that the implementation engagement of most ministries was around HIV prevention and care of their civil servant workforce, rather than sectoral programs on

Box 4.6: The Objectives and Modalities of Multisectoral Approaches

For well over a decade, the international community, including the World Bank, has emphasized the need for an AIDS response that goes beyond the health sector, with two main objectives: improving the efficiency and effectiveness of programs on the ground and mobilizing the public. To the extent that multisectoral activities were launched in the first phase of the Bank's response, they tended to address the first of these objectives. In the hardest-hit countries, adult mortality from AIDS was affecting all sectors of the economy, generating the need for plans to mitigate the impact. There are also many AIDS activities that require multisectoral collaboration in implementation to be effective. For example, changing the behavior of sex workers requires not only involvement of the Ministry of Health and the acquiescence of sex workers, but the cooperation of law enforcement, brothel owners, and local government.

The Bank's HIV/AIDS assistance has addressed either or both of these objectives through five main approaches: (1) building the capacity of the Ministry of Health to work selectively with other priority sectors;^a (2) supporting establishment of national multisectoral commissions, usually under the president or prime minister, either to coordinate or implement a national multisectoral response;^b (3) supporting a response coordinated by a ministry with multisectoral responsibilities, like planning;^c (4) supporting AIDS components or activities in non-health sectors, such as education, transport, or social protection; and (5) facilitating a dialogue among key ministries.^d

OED could find no evidence to suggest that any one institutional arrangement is more effective or efficient in producing results on the ground than the alternatives, if the political commitment is present. The multisectoral commission model supported widely by the Africa MAP seems to be based on experience in Uganda;^e more than a decade after the formation of the Uganda AIDS Commission, the definition of multisectoral coordination and the best way of pursuing it is still being debated in that country (De Merode and others 2001). The MAP operational manual lists a number of theoretical responsibilities of these agencies but notes that, "in reality, [their] role is often ill-defined" (Brown and others 2004). The first MAP Progress Review noted a strong tendency for the secretariats of National AIDS Councils (NACs) to become implementation bureaucracies, as opposed to coordinating agencies, and reported that "Partner agencies in both the public sector and civil society remain unclear as to [their] responsibility...in supporting the implementation process" (World Bank 2001c, p. 5). The MAP *Interim Review* found that the NAC secretariats had grown to 50–70 professional staff in some countries and had little accountability (World Bank 2004). Evidence to support the effectiveness of institutions to manage the AIDS response outside of the Ministry of Health from the Bank's experience is scant.^f

a. For example, in Bangladesh, Brazil, Cambodia, Eritrea, Guyana, India, Jamaica, Kenya (in the 1990s), Uganda, and Zimbabwe.

b. Most countries of the Africa MAP, as well as several in the Caribbean MAP.

c. For example, in Chad and Indonesia. This has often been the strategy in population programs, which also seek multisectoral action.

d. As in Russia, for example.

e. "Those few countries that have made significant progress in slowing the epidemic (such as Uganda) have placed the coordinating body of national HIV/AIDS efforts under the president's office, where it has the visibility, reach and authority to coordinate and mobilize all stakeholders" (World Bank 2000b, p. 11).

f. As presented in Chapter 3, the Ministry of Health in a number of Bank-supported projects did work successfully with a handful of the key sectors for results on the ground. The Indonesian AIDS project was launched by Bapenas without adequate support of the Ministry of Health, the main implementer. In Chad and Burkina Faso, AIDS and population projects were managed from the Ministry of Plan, which undermined support in the Ministry of Health.

the ground (World Bank 2004). The findings also suggest that activities may be occurring within ministerial "silos" rather than bringing critical sectors together to achieve jointly a specific objective.²⁹

The overarching authority vested in institutions to coordinate the multisectoral response in many cases has resulted in the disengagement of the Ministry of Health, the lead technical agency for the long-run fight against AIDS. Task team leaders for roughly half of the African MAP projects reported

that the Ministry of Health was either initially or continues to be disengaged from the response as a result of the shift in responsibility to a national multisectoral commission. In one-fifth of the countries, the Bank's country director became involved in sorting out tensions between the Ministry of Health and the National AIDS Council or another agency. The experience to date indicates that building the capacity and political support for a strong response within the Ministry of Health is absolutely

essential as the foundation for an effective national response across sectors.

The components for grants to civil society also pose substantial risks for the development effectiveness of the MAP projects.

Considering that the average MAP project allocates 40 percent of resources to the civil society response, roughly \$400 million has been committed for this purpose—from a low of \$0.42 per capita (Ethiopia) to a high of \$5.86 (Gambia, see figure 4.2).³⁰ This includes allocations of \$2.53 per capita in Mauritania and nearly \$1 per capita in Madagascar, both of which have *nascent* epidemics. There are many possible objectives of engaging civil society in general or specific NGOs, CBOs, or communities, including: (a) to improve the relevance, efficiency, or efficacy of service delivery or to exploit a comparative advantage in implementation; (b) to mobilize political support for AIDS control; (c) to empower communities or marginalized groups; or (d) to foster an indigenous, independent civil society response. The objectives and distinction between the roles of these different elements are not clearly articulated in the MAP design documents and will make them difficult to assess.

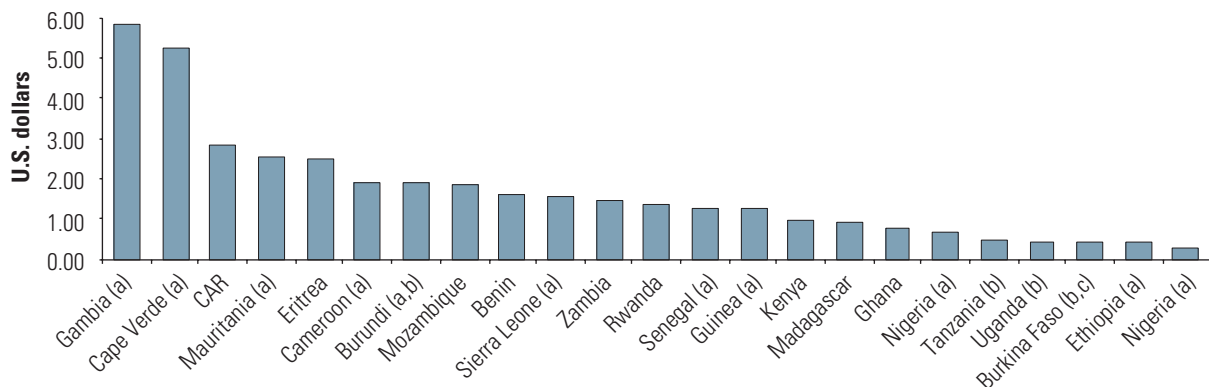
The use of civil society funds is generally demand-driven and, according to task team leaders, is not strategic from the perspective of the needs of the national program.

According to 8 of 12 task team leaders, there is no process for prioritizing which interventions NGOs and CBOs undertake to ensure efficiency. In many if not most instances, any proposal that passes muster is being funded.³¹ NGOs and CBOs can select from a broad menu of eligible activities; there is no assurance of systematic coverage. The OED case study on Ethiopia found that there had been no systematic evaluation of NGO or community projects. The task team leaders for 17 projects reported that none included provisions to evaluate the effectiveness or impact of NGO and CBO interventions. For about a third of the projects it was reported that there were no M&E

The emphasis on engaging all sectors in some cases reduced the engagement of the Ministry of Health.

A large share of MAP resources are for civil society, but the objectives and roles of civil society are not clear in the MAP design.

Figure 4.2: Budgeted per Capita Public Spending on Civil Society AIDS Interventions, Africa MAP Countries



Source: Project appraisal documents and World Bank 2003a for population.

Note: (a) Excludes value of separate capacity-building component with CSO allocation; (b) Excludes other component with partial allocation to CSOs; (c) Combines financing for CSOs and provincial governments,

The impact and cost-effectiveness of community-driven approaches to AIDS were not evaluated relative to alternatives before being widely adopted.

mechanisms whatsoever for the civil society component; others, in effect, only monitored process and output indicators (47 percent) or were subjected to financial or management audits (24 percent).

Financing community-driven development (CDD) approaches for AIDS is a major new element of the MAP for which impact or cost-effectiveness was never formally evaluated before it was widely adopted. A pilot project of the approach was conducted in the Poni region of Burkina Faso in 2000–01, financed by the Population and AIDS Control Project. A process evaluation of the pilot about a year into implementation found that: “confusion persists on the specific objectives of the pilot project. This situation is a result of the lack of formal planning.... Likewise, the anticipated results and the indicators were not clearly specified and it is difficult to know if they were reached. The dominant impression is that each of the actors and promoters had their own version of what the pilot project was or should be and their own expectations in relation to results.”³² In the MAP design, it is unclear whether the objective of sending AIDS resources to communities is political mobilization, service delivery, or empowerment.³³ If some of these activities are being promoted purely to mobilize segments of civil society, there may be less costly, more efficient approaches. There are many ways of ensuring community participation that do not involve transfer of funds, for example.

The recently completed OED evaluation of the Bank’s support for community-driven and community-based development (CBD/CDD) suggests additional risks for the efficacy and efficiency of CBD/CDD projects, a category that includes all of the Africa MAP projects.³⁴ CBD/CDD projects tend to be more successful on quantitative goals, such as infrastructure construction, than on qualitative goals, such as capacity enhancement. The evaluation found that the effectiveness of Bank

CBD/CDD projects in enhancing social capital and empowering communities has varied widely, that the link between CBD/CDD and community capacity enhancement is weak, and that sustainability is lower in CBD/CDD than in non-CBD/CDD projects (OED 2005a). The results of CBD/CDD projects have depended on local political and social conditions, government commitment, and community capacity. They tend to be more successful when they support indigenously matured participatory efforts or when the Bank has provided sustained, long-term support to communities beyond the length of a single subproject. The evaluation also notes that, for the Bank, CBD/CDD interventions have been more expensive to prepare and supervise; for the borrower, there are substantial costs. Weaknesses in M&E (particularly with regard to monitoring progress on qualitative goals) and the short time span of the Bank’s subproject cycle constrain the Bank’s capacity to implement CBD/CDD projects (OED 2005a). Four issues are highlighted for special attention in future CBD/CDD interventions: (a) the need for clear articulation of expected achievements; (b) calculation of costs and benefits, including long-term poverty impact, of undertaking the CBD/CDD approach as a basis for comparison with alternatives; (c) increased focus on sustainability and long-term development; and (d) addressing constraints related to the Bank’s mode of operation, its operational policies, and its M&E systems.

The lack of prioritization and costing in most of the national AIDS strategies also poses risks for the sustainability of the activities and benefits of the MAP projects. There are no eligibility criteria or program design features of the MAP that ensure sustainability of the response, aside from what is mentioned in the national strategic plan. Sustainability is especially relevant to the civil society components and to long-run expenditures on AIDS treatment. The MAP strategy did not specify whether the initial large share of expenditure on civil society was a one-time measure for mobilization or whether it is a permanent feature. The OED evaluation of the Bank’s support to CBD/CDD found that “the

Bank's structure and mode of operation limit its ability to ensure sustainable outcomes from CBD/CDD projects: "...the process must be managed 'close to the ground,' but normally without direct Bank involvement at the local level....with its mode of operation, distance from implementation, and its current M&E system, the Bank has found it difficult to ensure...sustainability of development outcomes from its CBD/CDD projects" (OED 2005a). The MAP operations manual already cites an example in which failure to assess the sustainability of antiretroviral treatment in Nigeria resulted in a three-month lapse in the availability of drugs in 2003, compromising the effectiveness of the treatment and contributing to viral resistance (Brown and others 2004). The 10–15 year commitment of the Bank to these countries does not eliminate the need to consider the long-term sustainability of efforts and to encourage more efficient and effective use of the funds.

To summarize, the Africa MAP has succeeded in enlisting at least two dozen countries to launch major HIV/AIDS initiatives with \$1 billion of new resources and appears to have contributed to heightened political commitment. This alone is an enormous accomplishment, given the lack of demand for AIDS assistance by most of these countries in the 1990s. There is evidence of broad mobilization of civil society, on a greater scale than most (but perhaps not all) of the completed HIV/AIDS projects, and of many more sectors of the economy. Mechanisms have been created to finance an AIDS response from civil society in many countries where this did not previously exist. The objective of scaling up interventions is being pursued.

However, the overarching objective of the MAP is to prevent HIV infection and mitigate its impact; broader implementation and political commitment are a means to that end. Since these projects are all still in the field, it is too early to assess whether this is being accomplished. The MAP approach relies heavily

on the technical and strategic guidance of the national strategic plan, coupled with strong M&E, heavier than normal supervision, and the existence of proven, locally evaluated pilot projects to ensure the efficiency and efficacy of the Bank's assistance. The risks associated with these factors were not assessed during preparation of either MAP I or II, and because of the emphasis on rapid preparation of the projects, less analytic work and fewer baseline assessments were conducted. The strategic input of the Bank—which might have provided some insurance against these risks—was much less than in previous HIV/AIDS projects. While there are no doubt examples of countries in which these risks have been mitigated by project-specific features, the evidence to date suggests that in many cases the national strategic plans are not sufficiently prioritized, that weak M&E has not produced the anticipated learning by doing, and that many activities are being scaled up that have never been evaluated locally. Supervision appears to be no greater than in health lending, while the complexity of the projects and the number of activities are far greater. There is a risk that many of the actors that have been mobilized politically behind the fight against HIV/AIDS are engaged in implementing activities for which they have no technical expertise or comparative advantage, diverting scarce capacity from other poverty-reduction activities and diverting resources from actors that can use them effectively. The mid-term reviews of these projects and the next phase of lending provide an opportunity to develop mechanisms to minimize these risks and improve the effectiveness of the Bank's assistance.

Weaknesses in national AIDS strategies pose risks for the sustainability of MAP activities.

It is too early to assess whether the MAP projects are meeting their objective of preventing HIV infection and mitigating its impact, efficiently and sustainably.