APPENDIX L: MANAGEMENT RESPONSE

Management welcomes the opportunity to comment on this OED report, which provides a very useful overview of the Bank's work on HIV/AIDS and the timelines of key events inside and beyond the Bank. The report aims to assess "the development effectiveness of the Bank's HIV/AIDS assistance against the counterfactual of no Bank assistance," looking at "policy dialogue, analytic work and lending." It describes two phases in the Bank's response to HIV/AIDS: projects and analytic work done from 1985 through 1997, and the hugely increased, and, in management's view, innovative efforts since 1998. The report summarizes prior evaluations of early projects. In addition, although (as the report notes) none of the projects under the Africa Multi-Country AIDS Program (MAP) has closed, it offers assessments, based on OED's reading of the evidence, of their design. The report mentions but does not assess the major efforts management is already making to address many of the concerns raised. (Some of these efforts are noted in the Management Action Record at the end of this response.)

Areas for Comment. Management appreciates the extensive work reflected in this review. Management agrees that it is important to recognize how the early HIV/AIDS projects contributed to greater political commitment to addressing HIV/AIDS, greater efficiency and scale of national AIDS programs, and stronger institutions and national capacity; and management agrees also with the judgment that the Bank's initial response was held back internally, measured against the scale and impact of the epidemic. With respect to the MAP, it is reassuring that many of OED's observations and recommendations echo the findings of management's own three reviews (in 2001 and 2002, and the 2004 independent "Interim Review" that was shared with the Board and is summarized in box L.1). However, management would like to comment on some specific aspects of the report: the methodological difficulties the OED review faced, learning over time and the treatment of Bank support, the review's stance on the role of Ministries of Health, targeting high-risk groups in prevention efforts in generalized epidemics, the role of communities, and monitoring and evaluation.

Key Issues

This section presents management's comments on six key areas of concern it identified in the OED report.

A. Methodology and Evidence Base

Because of its timing, the review does not take into account the extensive evolution that has taken place with regard to Bank assistance. Additionally, management would mention two issues of methodology.

- The OED review of the MAP assesses a broad Bank program at an early stage of implementation.[1] The MAP program has evolved considerably during the more than two years since the OED review began, so that some of the report's findings, of course, do not reflect recent achievements and developments. Specifically, the 2004 Interim Review high-

1. OED notes that the OED review of the MAP encompasses all active MAP projects through the end of fiscal year 2004. Interviews with MAP TTLs and country directors for MAP projects were conducted in the summer of 2004 (that is, in fiscal year 2005).

Box L.1: The MAP Interim Review

In fall 2003, as part of its oversight of the MAP, ACT*africa* commissioned a review of the MAP program as a whole. A team comprising 3 Bank staff, 2 senior consultants, and 3 non-Bank staff (representatives from UNAIDS, a major bilateral HIV/AIDS donor, and a major international NGO) reviewed all MAP program documents, interviewed MAP task team leaders and staff of ACT*africa*, conducted field visits in a roughly representative sample of 6 MAP countries, and obtained input from more than 300 government officials, donor representatives, and stakeholders. The team submitted a draft to ACT*africa* for comment, and then prepared a final draft reflecting management feedback. By prior agreement, management did not edit the report except for clarity and minor factual corrections. The report was presented to the Africa Regional Leadership Team in May 2004 and to the executive directors in August 2004, and thereafter made public. Its conclusions and recommendations are being incorporated into ongoing MAP projects wherever possible, and they directly informed the design of the second generation of MAP projects.

lighted the need for more rigorous strategic planning, greater health sector engagement, better targeting of vulnerable groups, and stronger monitoring and evaluation. While it is reassuring that nearly all of OED's principal observations and recommendations reaffirm the findings of management's own reviews and consultations, management believes that the review would have given greater recognition to the intensive efforts underway to address these issues, which are also prioritized in the draft Global HIV/AIDS Program of Action.[2]

- Management notes OED's extensive use of existing reviews of the earlier AIDS projects, MAP documents, and interviews with task team leaders (TTLs) and country directors, but it also notes two issues with the evidence base used. OED conducted only one field case study of a MAP project—Ethiopia. Management recognizes that the choice of projects was constrained by the early timing of the review; however, as the first MAP project, Ethiopia's is in many ways the least typical, since the MAP has continually evolved since its inception. This project has also been among the more problematic in implementation. The Ethiopia project provided lessons that guided later operations, but it lacks many of the features that are now standard in the MAP.
- Given the importance of the MAP in stimulating a broader response to HIV/AIDS, it is somewhat surprising that, except in Ethiopia, OED consulted no country-level MAP stakeholders (including governments) or others in the donor community or civil society.
- Given the central role of sexual behavior in the HIV/AIDS epidemic and its complex social and cultural dynamics, the OED review might have given more attention to social, social psychological, and community development analysis.

B. Learning over Time and Implementation Support

The review's summary assessment of the nine completed "first generation" HIV/AIDS projects and nine project components is generally positive, noting their contribution to greater political commitment to addressing HIV/AIDS, greater efficiency and scale of national AIDS programs, and stronger institutions and national capacity. Management agrees that these efforts deserve recognition. However, OED's favorable comparison of the early AIDS projects with all health, nu-

2. OED notes that the OED evaluation does not support the finding in the Interim Review that "the objectives, approach, and design of the MAP program have generally been appropriate" (the evaluation finds that several key assumptions underlying the MAP design proved unfounded and identifies a number of critical risks that were overlooked).

trition, and population projects gives little cause for comfort, as there is little direct evidence—outside countries with significantly lower prevalence rates, relative to Africa—of the effectiveness of earlier AIDS projects in preventing infections.[3]

Analytic Work. It would have been useful for the report to include comparators or benchmarks against which to interpret the results of surveys asking Bank staff and African policy makers about key Bank documents on AIDS. Management wishes that more could have been learned from the surveys about how to do better in getting key Bank reports to intended audiences.

Ongoing Implementation Support for MAP. The OED review tends to discuss the MAP as if it were simply a set of traditional projects. The report's reliance on project documents, and in particular its focus on what were explicitly named as risks and constraints at the very beginning of the program, has produced an unduly static picture of the MAP. In reality, MAP projects are more dynamic than standard Bank-supported operations, allowing for ongoing risk assessment, learning, and alterations. In this sense, the design of MAP encompasses more than what is provided for in any individual project. It also includes the larger program of intensive implementation support and cross-country learning led by ACT*africa* and the Global HIV/AIDS Program. In fact, many of the most important aspects of MAP design and implementation have arisen in the course of experience, and have been integrated both prospectively and retroactively into other MAP operations. For instance, the original MAP document may not have singled out weak monitoring and evaluation (M&E) as a risk, or limited capacity as a constraint, but in practice the Bank has recognized these priorities from the outset and has devoted an unprecedented amount of time and resources to strengthening both of these traditionally weak areas. Specifically, MAPs have benefited from:

- Direct support from specialists, including M&E specialists, in ACT*africa* and the Global HIV/AIDS Program
- Country visits from technical support teams to resolve implementation roadblocks
- Workshops for TTLs and country-level practitioners from government and civil society to derive and disseminate lessons of successful experience
- Guidelines and manuals on such subjects as financial management, M&E, and procurement
- Recourse to the Implementation Acceleration Team (IAT), which comprises the heads of all central Bank departments and is charged with removing internal barriers to rapid processing and implementation of HIV/AIDS projects
- The various MAP reviews.

Early Action. This kind of support and flexibility has enabled the Bank to identify and address problems at an early stage. For instance, as the OED review correctly notes, MAP projects frequently encountered delays in implementation, partly because of inadequate attention to institutional factors. When the MAP reviews identified this issue, management decided in 2002 that institutional issues would need to be resolved before any future MAP project could be approved. As a result, preparation time increased, and time from approval to effectiveness fell. Likewise, disbursements in many MAP projects began sluggishly, but concerted attention to the common obstacles has helped accelerate implementation, and MAP projects are now disbursing at or very near their planned ambitious target disbursement rates.

Implementation Support Efforts. The Bank has also been willing to take larger steps. The IAT was es-

3. OED notes that there is insufficient evidence to assess the impact of any Bank lending on HIV incidence because of the failure to collect necessary data. However, there is ample indirect evidence, in the form of behavior change or increased knowledge, of plausible influence of Bank assistance on new infections in Burkina Faso, Cambodia, Chad, India, and Kenya (see Chapter 3, "Outcomes and Impacts" and box 3.5). These are all low-income countries with significant AIDS epidemics. Management notes the relatively low prevalence rates, relative to the Sub-Saharan Africa average, for most of the countries cited by OED.

tablished in January 2003 to improve the Bankwide implementation of MAP and other HIV/AIDS projects. The Implementation Acceleration Team has (a) facilitated changes in and exceptions to Bank policies and procedures; (b) provided project task teams with prompt advice on solving individual and systemic preparation and implementation problems; and (c) worked with the Global HIV/AIDS Program and ACT*africa* to share knowledge and build capacity in project preparation and implementation (including in fiduciary areas) through shared learning by Bank staff and country counterparts.

Similarly, in 2002 the education team in AFR, with ACT*africa* and HDNED, launched an effort to "Accelerate the Education Sector Response to HIV/AIDS" by sharing information among client education teams, providing technical assistance, and supporting clients in accessing education sector and MAP resources for the education sector response. More than 33 ministries of education, along with teams from health ministries and national AIDS commissions, have participated in this program. An evaluation has shown that countries that participate actively in this effort are more likely to access both education sector and MAP support.

Conclusion. In sum, the Bank has in place robust mechanisms to identify and remedy issues that arise during the implementation of MAP projects. While management agrees with OED that implementation needs to improve still further, it knows of no comparable Bank effort in support of a single program.

C. Role of Ministries of Health and the Health Sector

MAP requires that, to be eligible for MAP projects, countries must have in place a high-level multisectoral coordinating body. The OED review states that this requirement has alienated ministries of health (MOHs) in some countries (box 4.6), that MOHs need a more prominent role as the natural lead agency, and that there is no example of a strong response that bypassed the health sector and was led by a sector other than health. On the other hand, the report also notes that "Commitment to fighting AIDS needs to be more widely entrenched across the political and institutional spectrum than in a head of state or Minister of Health" (p. 23). OED disagrees with the MAP premise that "too narrow a focus in the health sector as the main actor" was one reason why earlier efforts were unsuccessful against AIDS, and it does not find "that an *overemphasis on the health sector* was a reason for lack of success."

Role of MOHs. Management agrees that MOHs have a central role in addressing HIV/AIDS, and that their capacity and role need to be strengthened. Nothing in the multisectoral response is meant to supplant the functions that only an MOH can perform. The need to fully engage the health sector was a key recommendation in the Second MAP Review, is an explicit focus in the second generation of MAP projects ("MAP2"), and is emphasized in the *Warriors* manual (Brown, Ayvalikli, and Mohammad 2004). Progress in this area is evident from OED's survey of TTLs: in 18 countries for which TTLs responded on this issue, there was never a problem in 9, the initial problems had been overcome in 5, and problems of MOH disengagement persist in only 4 (Appendix I, table I.15; it is also worth noting that in 1 of the 4, the problems are for personal reasons).[4] In Appendix I, table I.17, for 10 countries with both MAP and health projects, only one TTL reports "little" coordination with MOH, and only one reports "a little crowding out" of MOH-planned activities by MAP activities, while 8 report good coordination. In addition, whatever the institutional frictions have been, they do not appear to have resulted in limits on MOH im-

4. OED notes that countries with no reported disengagement included several in which the MOH was still leading the national AIDS response, a special component had been carved out for the MOH, the MOH had a leadership role in the NAC, or the institutional set-up was not affected. The *Interim Review of the MAP* (2004) found that "Where resources for the Ministry of Health were treated as part of the multisectoral response … rather than as a dedicated component managed by the MOH, the results have been generally poor."

plementation: across all MAP projects, MOHs have received roughly half of all MAP funds channeled to the public sector, and they are expected to have more than 60 percent by projects' end.

Beyond the Health Sector. At the same time, field-based HIV/AIDS experts say there *is* evidence that earlier overemphasis on the health sector contributed to lack of success in several ways. First, MOHs are seldom powerful enough to motivate the highest levels of political commitment, require other ministries to act, or support community responses effectively. While they naturally play a lead technical role in surveillance, treatment, and many key interventions, they have no particular advantage in coordinating other government entities. It seems logical that the necessary multisectoral response could be coordinated better through a high-level multisectoral AIDS authority than through the MOH. Indeed, the first two countries to successfully curb HIV, Uganda and Thailand, had high-level coordinating bodies chaired by a very senior political leader, and promoted multisectoral responses that extended far beyond the health sector (although of course the health sector played a strong role).[5] Second, as box L.2 illustrates and evidence from Uganda demonstrates, an overemphasis on MOHs has in some cases "professionalized" AIDS and discouraged community and religious leadership and involvement. Third, there are examples where health sector leadership has led to an over reliance on health interventions. When the health sector dominated AIDS responses, many programs, including several World Bank-supported projects supported sexually transmitted infection (STI) care as a key intervention to reduce HIV transmission (and did not emphasize promoting changes in sexual behavior). Although one trial had indicated that STI care reduced HIV transmission, several more recent trials have since contradicted that finding, starkly underscoring the dangers inherent in a narrow health sector response that is based on what may be imperfect scientific evidence. By contrast, management believes and relevant literature indicates that the decline in HIV transmission in Uganda was driven by widespread mobilization and behavior change (Low-Beer and Stoneburner 2003). Also, by contrast, expanded health service interventions, including condoms and voluntary counseling and testing, came later, as shown in figure L.1. [6]

Conclusion. The experience of Uganda, the first African country to successfully curb its epidemic, powerfully illustrates the dangers of a narrow, technocentric health sector response to a disease that can only be addressed through sweeping changes in cultural, social, and gender norms. This lesson is not limited to Africa. Throughout large swathes of Central and Eastern Europe and Central, South and South-East, and East Asia, it is becoming clear how important the legal, justice, police, prisons, and social welfare ministries are in creating contexts conducive to effective AIDS responses among injecting drug users, prisoners, and sex workers, the communities most vulnerable to HIV infection in these regions. Crucial as the health sector is, it can be said without exaggeration that the course of epidemics in much of Europe and Asia will depend at least as much on these other ministries as on the health ministry.

D. Reaching High-Risk Groups

The OED review repeatedly comments on the importance and cost-effectiveness of reaching high-risk groups. It takes a strong stand on the need to prioritize preventive efforts among high-risk

5. OED notes that MAP internal reviews and an external review of the Uganda and Senegal experience find significant problems with the functioning of multisectoral AIDS authorities (see box 4.6 of this report and Putzel 2004). Management notes that it does not view that journal article as meeting the standards of a review.

6. OED notes that the PPAR on the Uganda STI Project (Report No. 32600) found that, while some behavior has changed in Uganda, it is not clear to what extent it can be attributed to public policy. It noted that other factors may also have played an important role (high AIDS mortality and personal exposure to AIDS suffering and death).

Box L.2: The Need for a Multisectoral Response

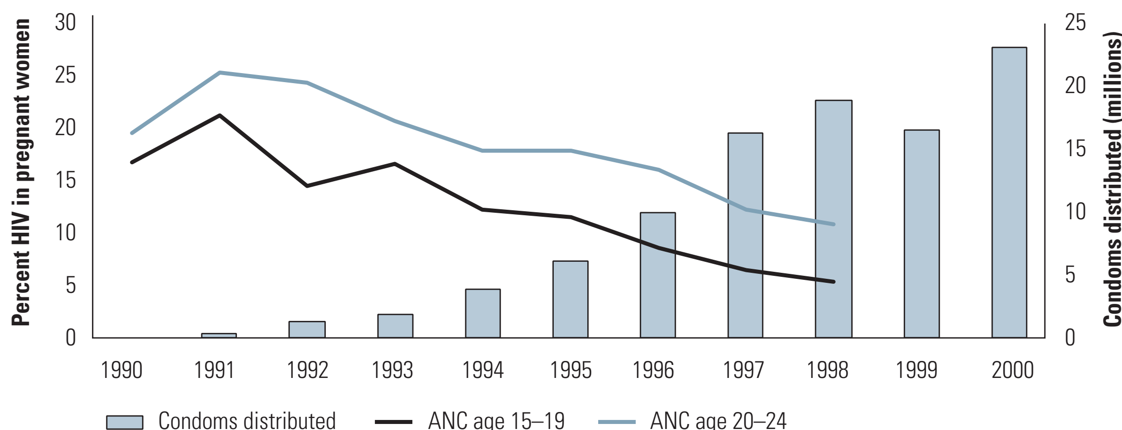
An analysis of the pitfalls of a health sector–led response is the subject of a growing scientific literature.[a] The need for a broader response is movingly captured in a very personal statement by one of the intellectual leaders in HIV/AIDS, Daniel Low-Beer:

> I have just been in Botswana and glimpsed the future of the expensively scaled global AIDS development programme—it scared me. Here was a remote, rural community where everything was scaled up—all the acronyms—routine ARV treatment, PMCT, friendly clinics, STD treatment, VCT, even ABC. Yet the HIV infection rate remains at 25 per cent, despite spending 10 times what Uganda spent since 1991. So I asked the local health worker 'Do you talk to a patient who comes in with AIDS about AIDS, do you confront it?' He said No, a six-week counseling course had told him not to. He had a tick box on a sheet of paper for notifiable conditions that did not include AIDS. Only two out of 10 AIDS patients wanted testing and got treatment. I asked about the village chief—he does not feel qualified to talk about AIDS. I asked about the church, no one mentions it at funerals. AIDS had not gone beyond the headspace of awareness, education and counseling to a lower centre of gravity between the gut and the heart of behavior change.[b]

a. For example, Allen and Heald 2004.

b. Daniel Low-Beer, *Financial Times*, November 28, 2003.

Figure L.1: Trends in Socially Marketed Condoms and HIV Prevalence, Uganda 1990–2000



Source: Stoneburner and Low-Beer 2002.

Note: ANC = women attending ante-natal clinics.

groups even in generalized epidemics, while acknowledging a role, at later stages in the epidemic, for "additional society-wide prevention and awareness measures" and, in mature epidemics for treatment and care of people living with HIV/AIDS and programs and policies to help affected individuals and families (box 3.1). OED's document review concludes that few MAP projects are systematically addressing the highest risk behaviors.

Transmission Dynamics. All AIDS specialists agree with the need to begin by targeting individuals with the riskiest behavior. But the issue is more complex in a generalized epidemic than in a concentrated one. Some commentators argue that interventions among high-risk groups are always more cost-effective. But as the 1993 *World Development Report* notes, the cost-effectiveness of prevention declines as prevalence rates rise, and what has proven cost-effective in one setting

is not necessarily transferable to others (box 3.1). Moreover, while it might always be more cost-effective in a narrow sense to target interventions to high-risk groups, the smaller the percentage of new infections for which these groups account, the less the impact targeting can have on the epidemic.[7] To understand the *specific* transmission dynamics in each context, it may be most important to first ask, What proportion of HIV infections arises from different populations and, more specifically, what proportion of infections may be attributed to high-risk groups?

Different Models. Behavioral and biological evidence and models for several African countries suggest that traditional risk groups may constitute a relatively small source of infections in highly generalized epidemics in Southern Africa; in East Africa, where mixed epidemics predominate, infections may arise roughly equally from traditional risk groups and the wider population; and in West Africa, sex workers and their clients undoubtedly play a major role in HIV transmission. In Swaziland, for example, as figure L.2 shows, behavioral data from the highly generalized epidemic suggest that most new infections arise from casual, rather than commercial, sex (there are similar data from Lesotho). These data are reinforced by other mapping and population estimation studies in numerous southern African countries, which have identified very small numbers of sex workers. They are also consistent with two recent studies estimating the contribution of high-risk sex to HIV transmission in Zimbabwe and Zambia (Cowan and others 2005; Cassalls 2005): in Zimbabwe, only 11 percent of adult male infections were likely to have arisen from commercial sex; and in Zambia, only about 2 percent of new adult HIV infections could be ascribed to traditional high-risk groups such as sex workers, truckers, and soldiers, and about 97 percent of new infections appeared to have occurred in the general population among groups not considered to be at high risk (figure L.3).

Appropriate Targeting. Thus, the many major AIDS initiatives that have targeted sex workers in Swaziland, Lesotho, and elsewhere in Southern Africa have addressed behaviors that seldom happen and so are unlikely to contribute significantly to HIV transmission. Epidemiological data and models from highly generalized epidemics in southern Africa suggest that a Ugandan-type response, which focuses on sweeping changes in sexual norms and in the widespread adoption of safer sexual behaviors, may be vital. It is significant that Uganda's AIDS response during the decisive phase in the late 1980s, when incidence began to fall, emphasized behavior change in the general population and did not specifically target high-risk populations (Green 2003). There is no evidence that focusing primarily on high-risk groups has curbed generalized epidemics anywhere.[8] Indeed, evidence from Uganda, and to some extent, specific cities and regions in Ethiopia, Kenya, and Rwanda, suggests that significant and widespread reductions in the number of sexual partners among men in the general population was primarily responsible for declines in HIV prevalence and incidence. [9]

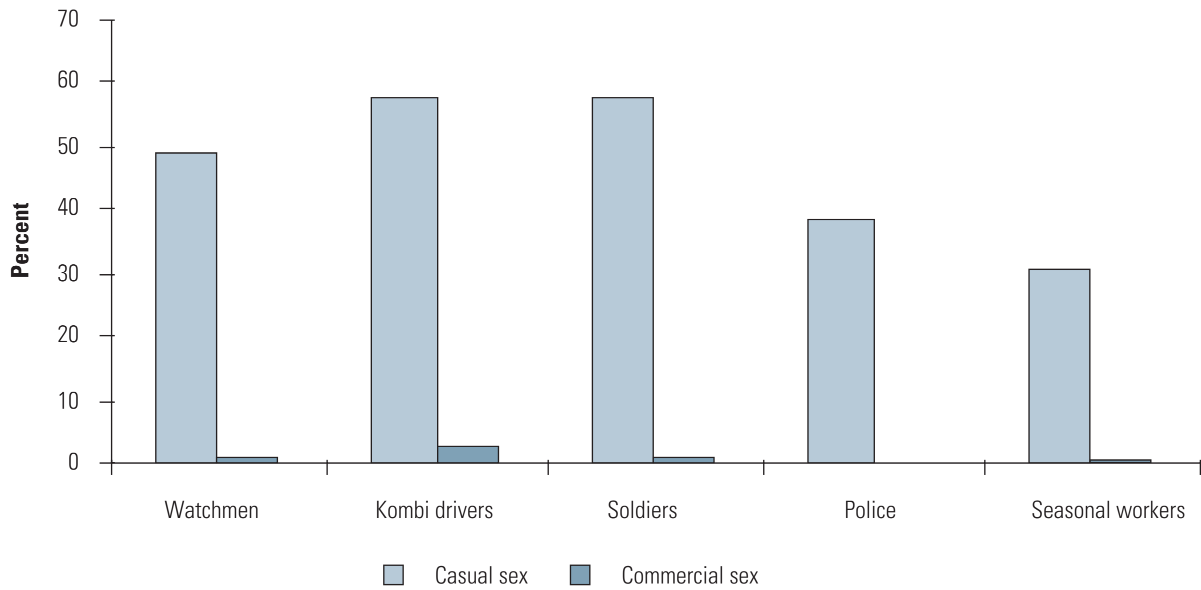
Relevance to the MAP. Since most of the population of MAP-supported countries, and most of MAP money, is in countries with generalized epidemics, the above findings are of particular rel-

7. OED notes that the OED evaluation neither states nor implies that it is always more cost-effective to target interventions to high-risk groups, nor does it recommend that programs focus primarily on high-risk groups in generalized epidemics.

8. OED notes that the OED report does not suggest that programs focus primarily on high-risk groups in generalized epidemics, but rather that coverage of high-risk groups be assured.

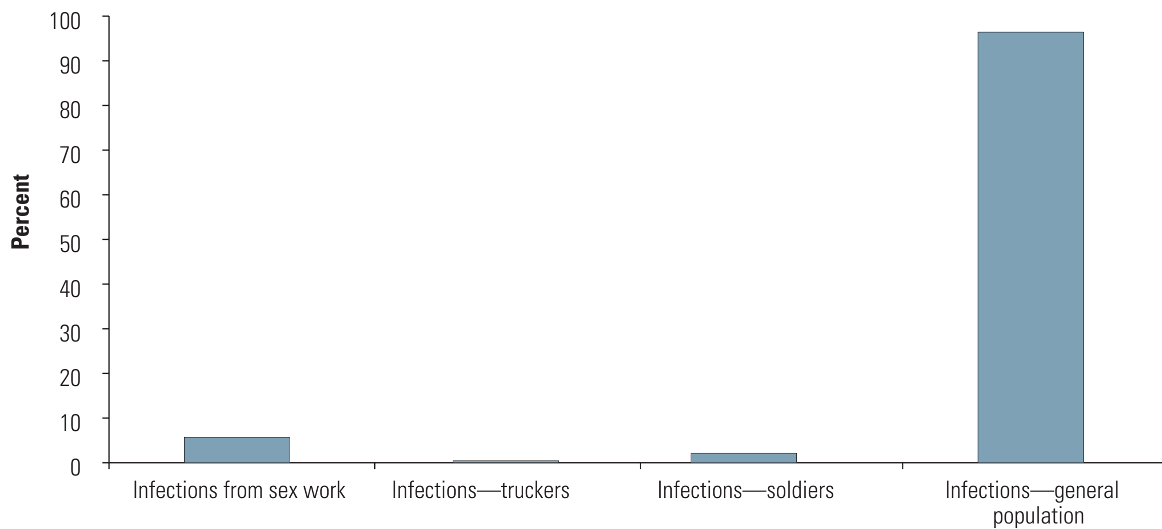
9. While OED agrees that there has been a decline in HIV incidence in Uganda, it notes that the article by Shelton and others (2004) referenced by management does not discuss any change in HIV outcomes in either Kenya or Rwanda, and only mentions evidence of a decline in HIV *prevalence* in Ethiopia. As noted in box 3.4 of the OED report, trends in HIV prevalence are not meaningful as an indicator of prevention success in mature epidemics.

Figure L.2: Sex Partnerships in Swaziland



Source: Family Health International, Behavioral Surveillance Survey, 2002.

Figure L.3: New HIV Infections in Zambia, 2004



evance to the MAP.[10] Management suggests that OED's position does not reflect recent improved understanding of HIV transmission dynamics in different contexts and effective responses in generalized epidemics. While the MAP must undoubtedly sharpen its emphasis on understanding transmission patterns and adjust programming accordingly, its focus on changing sexual norms through large-scale social and community mobilization is consistent with this body of analysis and evidence—far more so than programs targeting narrowly defined risk groups.[11]

Who Can Reach High-Risk Groups? The review notes the important role played by nongovernmental organizations (NGOs) and community-based organizations (CBOs) in expanding access to prevention and care among high-risk groups in many of the completed projects, but it cautions that "NGOs may not always be better placed than government to work with high-risk groups" and cites an example from Indonesia to illustrate that some government agencies have regular contact with sex workers. However, even in Indonesia, much of the most important work among injecting drug users and prisoners, who have considerably higher HIV rates than sex workers, is done by NGOs. In Thailand government agencies have also played an important role in prevention among sex workers, but have been less effective in reaching injecting drug users. Government agencies in most countries lack the expertise needed and the channels through which to reach sex workers, injecting drug users, prisoners, and men who have sex with men. Such groups tend to avoid (and sometimes fear) many government agencies. Moreover, it is often formal institutions such as health facilities and schools that have the most difficulty overcoming the stigma and social barriers to dealing with socially sensitive issues surrounding AIDS (Campbell 2003).

Context-Specific Strategy. The issue, therefore, is how best to reach high-risk populations and areas, in different contexts. For example, in Africa most sex workers do not work in establishments or clearly identified red-light districts, where they would be relatively easy to identify and target on a large scale. Government-led programs to promote 100 percent condom use in sex establishments, which helped to check HIV infection in Thailand and to a lesser extent in Cambodia, are much harder to introduce in Africa, India, or anywhere sex work is largely informal and widely dispersed. One way to reach widely dispersed informal and part-time sex workers, as well as highly sexually active men and most men who have sex with men and do not identify themselves as gay, is by prevention campaigns for the entire population in which it is not necessary for them to self-identify. Given the importance that high-risk behaviors play in driving the epidemic, it is essential to reach as many people as possible who engage in them. The OED review weighs whether it is better to rely on government agencies or on NGOs, but clearly both have important roles to play to ensure comprehensive coverage.

The PLACE Methodology. OED comments on the PLACE methodology, which asks people where others go to meet new sexual partners, and develops lists and maps of locations where efforts could be focused. It is an interesting new effort, but there are caveats. In Andhra Pradesh and West Africa, for example, it is unlikely that PLACE populations have rates of partner changes, STIs, and HIV near the levels confirmed among sex workers. PLACE studies in Central Asia exaggerate the importance of sexual transmission and divert crucial attention from injecting drug use. Nor is there any rigorous evidence of the effectiveness of interventions based on the PLACE

10. OED notes that two-thirds of the countries participating in the African MAP have levels of HIV prevalence in the general population of less than 5 percent.

11. The importance of changing social norms in the general population as a foundation for more specific and focused action is well illustrated by lessons from other health promotion and behavior change fields. For example, the smoking cessation literature underscores the importance of changing overall social norms as an essential prerequisite for more targeted behavior change campaigns. See also Cassalls 2005 and Pisani, Garnett, and Grassly 2003.

method, or reliable indications of the size of populations identified by the PLACE methodology. OED's statement about the possible efficiency of the approach is too strong for an unproven methodology.

Conclusion. Management agrees that the MAP must do more to support improved understanding of national transmission dynamics, as it is doing in current MAP operations. But the MAP principle that each AIDS response must be nationally owned and rooted in an understanding of the distinctive character of each epidemic remains wholly valid. As the OED report notes, there remains "great uncertainty and rapidly changing information about a totally new disease." Emerging research has cast into question some earlier articles of faith and research findings that inform some of the assumptions and judgments in the OED review.

E. The Role of Communities and Civil Society

The OED review contains several statements on the role of NGOs, CBOs, and other civil society groups—a role emphasized in the MAPs and other AIDS projects. For example, it states that "there is little evidence about the conditions under which NGO service delivery is more cost-effective than government services;" "Communities may not know 'what's best'…and …may select (interventions) with low efficacy… and for which they lack the technical expertise;" "there is 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." The review also calls for precise delineation of the roles of various nongovernmental entities, in order to focus on those with the "expertise" to implement "activities with a direct impact on the epidemic." Management does not see in the OED review evidence that civil society activities pose "substantial risks" and it would like to raise four issues in this regard.

1. Limited Role of Formal Interventions

In management's view, adopting all of OED's conclusions would require a presupposition that there are clear, proven, tried, and tested interventions to reduce HIV infection in the generalized epidemics in which many MAP projects operate. Management does not believe that the weight of evidence supports this presupposition. Uganda's national experience, the clearest positive example, underscores the central importance of political commitment, community engagement, and sweeping normative and behavioral change. In contrast, the evidence for specific interventions in generalized epidemics is remarkably weak: many first-generation Bank AIDS projects were STI projects and owed their inspiration to a single STI trial in Mwanza, Tanzania, in 1992 (Grosskurth and others 1995). A few years later, three major trials all found that STI treatment had no effect on HIV transmission (Wawer and others 1995; Kamali and others 2003). Similarly, voluntary counseling and testing is widely promoted as a prevention priority. It is obviously important as a platform for treatment, but the only rigorous trial of the approach found no evidence of any impact on STI or HIV markers, and a recent meta-analysis concluded there was little evidence that it reduces HIV transmission (Weinhardt and others 1999; Wolitski and others 1997). A recent adolescent sexual health trial in Mwanza, Tanzania, found that intensive education and health sector interventions did not reduce pregnancy, STIs, or HIV among adolescents, and it concluded that the failure to engage the wider community and in particular to change sexual norms and behaviors among older men, as Uganda had done, may have been a major reason for the trial's failure to achieve biological impact (Obasi 2003). Campbell's rigorous evaluation of why an intensive, carefully designed intervention among sex workers and their clients in South Africa had so little impact on new infections reached a similar conclusion (Campbell 2003). These findings caution against excessive reliance on formal interventions and underscore the centrality of the community engagement and normative changes championed by the MAP projects.

2. Role of Communities and Institutions

In management's view, the review does not give sufficient weight to the central role that com-

munities and their institutions play in creating the enabling environment to foster behavior change. Communities have a unique function that no other entity can perform, and that is not intervention-based. Most of the determinants of sexual behavior are deeply rooted in cultural norms, beliefs, roles, and practices that are established, maintained, enforced, and amended at the local level; they cannot be influenced by government alone. Stigma and silence, in particular, can be overcome only where civil society contributes to a deeply participatory process of social empowerment and social diffusion. In this realm of social change, knowing "what's best" is not a matter of technical expertise, but of local knowledge and local involvement. By definition, this can be supported—but not directed—from the outside. This is what some leading HIV/AIDS researchers have concluded:

> *The likelihood that people will engage in health-promoting behaviors is influenced by…the extent to which they live in a supportive social environment. [Campbell 2000.]*
>
> *Individuals cannot change their behavior in a vacuum, but are heavily influenced by their social networks and group norms. Their very perceptions of risk are ordered and nurtured by the peer group and social context within which they operate. [B]ehaviors have to be supported and reinforced by the value system of the society within which [people] function. [Ray and others 1998.]*

Supportive Environment. The best-designed technical interventions cannot succeed if the social environment is unsupportive. In treatment programs around the world, for instance, it is common for a significant share of people diagnosed with HIV to decline antiretroviral treatment, even when it is free of charge. Quite literally, they would rather die than face the stigma or social isolation of admitting their HIV status. The most influential theories of behavior change recognize the centrality of community influence. For example, social diffusion theory (an outgrowth of diffusion of innovation theory in agriculture) notes that individuals are more likely to be positively influenced by the testimonies and examples of close, trusted neighbors and friends than external experts. Thus, it is vital to work with and through communities (box L.3).

MAP Model. Many of the mechanisms by which social norms evolve are unforeseeable, organic, and even ineffable. This is why the MAP has adopted a demand-driven model for civil society support. Management acknowledges that this approach poses a challenge to monitoring, and agrees that MAP projects should do a better job of supporting local assessments of impact. But embracing uncertainty is part of the unprecedented challenge of addressing AIDS, which the Bank must do. As the leading technical agencies

Box L.3: Experience of Uganda

In Uganda, social communication at the community level helped to pierce denial, promote personal risk perception, instill personal proximity to the epidemic, and thus change community norms and reduce HIV transmission. Activities were locally led by political, religious, and community leaders who promoted changes in community norms, not just individual actions, and created enabling and protective environments long before the concept gained currency. The involvement of faith-based communities is especially noteworthy: the founding leaders of Uganda's AIDS Commission were Catholic and Anglican bishops. All of this was accomplished without large-scale involvement by specialist agencies, and most of the country's gains preceded the growth in formal HIV services. As a result, even today, surveys reveal far more openness about AIDS in Uganda than in neighboring countries, where people are just as likely to personally know someone who has died as a result of AIDS. The cumulative effect of this cultural shift ultimately had a far greater direct impact on the epidemic than did any specific activities.

working on AIDS have recently stated, "All the components of a national response cannot be measured easily. For many components, such as reducing stigma and protecting human rights, indicators are still being developed and tested." (USAID and others 2004).

3. Competition with Government Services

The OED review states that it could find no evidence that community-driven AIDS interventions are systematically more effective or more cost-effective than those implemented by NGOs, government or the private sector. Management believes that international experience in contexts as diverse as San Francisco, Rio de Janeiro, and Rakai shows the vital role of communities in complementing government initiatives (McKusick, Horstman, and Coates 1985). No government can meet all the prevention, care, support, and treatment needs of the HIV-affected population, especially in countries with widespread epidemics. Even in middle-income countries, households and communities provide the vast majority of care and support. While a few services are so technical that they should be undertaken only by specialist institutions, many of the basics of HIV/AIDS interventions are well within the competence of even small organizations, with proper oversight.

Example. In the Poni pilot in Burkina Faso, for example, the OED report does not cite the evaluation's finding that more than 60 percent of the population of the province in all 500 villages received face-to-face HIV/AIDS education, and more than 2,000 people were trained. By contrast, the previous reproductive health project had trained fewer than 100 people in the provincial capital and was planning to reach no more than 20 villages. The use of community-based mechanisms helped expand this coverage substantially, relative to classical health projects.[12]

There is wide agreement that coverage is both a critical proxy for overall program implementation and a prerequisite for behavior change.

4. Community Mobilization

The OED report underestimates how much work has been done to prepare and guide community mobilization and to evaluate and document impact. The report *Rural Workers' Contribution to the Fight against AIDS: A Framework for District and Community Action* (Royal Tropical Institute and others 2001) laid the foundation for the community mobilization process, presenting objectives, costs, and lessons from 10 years of experience in Tanzania and elsewhere. It was reviewed by 400 workshop participants from 30 African countries and facilitated by a global authority on participation. Participants visited communities that had taken actions against AIDS, revised the paper, and used it as a basis for a strategy for community mobilization against AIDS. They then assessed the cost-effectiveness of community action compared to action by NGOs, government, and the private sector. Various other reports also assessed the impact of community mobilization, as did the MAP *Interim Review,* many supervision missions, and technical support missions (for example, Delion, Peters, and Bloome 2004). [13]

Results. The actions undertaken by communities and some of their concrete results are beginning to be documented. A growing number of communities are conducting situation analyses, using community maps to identify where the epidemic is spreading and reflect on factors within the community's control. Such actions have closed brothels and bars near secondary schools in Benin, changed the village laws to punish men who force girls to have sex in Tan-

12. OED notes that the *cost-effectiveness* of the Poni pilot project has not been rigorously evaluated. An interim external evaluation remarked that even if effective at raising awareness, the project may be more costly than alternatives and less sustainable (CCISD 2001). It also questioned the wisdom of linking community mobilization to transfer of funds.

13. OED notes that Working Paper #79, referenced above (Delion, Peters, and Bloome 2004), also states that "While communities can measure some progress, such as the number of people tested, … and the number of people cared for, there is a need to develop instruments to compare impact of local response between different communities and regions, including a cost-effectiveness analysis"(p. 16).

zania, and organized "food baskets" each week at the market to support chronically ill patients. As one community member reported:

> *Before [the MAP] nobody was really speaking of AIDS, outside information meetings. Now everybody talks about it, inside families, schools, shops, etc. Before, nobody dared to be tested, now many people were tested, testing is the normal thing to do. Before, nobody knew exactly what to do in case of AIDS, now many families have People Living with AIDS, there are many associations of PLWHA.*

Measuring Results. Simple instruments and indicators are being used to measure results, and M&E tools have been developed to assess results and insert lessons systematically into operations. For example, "report cards" are being used in Benin and Cameroon. As a result of these assessments, many communities have made significant changes in their community action plans.

F. Monitoring and Evaluation

The OED evaluation states that "notwithstanding the piloting of innovative monitoring approaches in several countries, the overall record of the Africa MAP in implementing strong M&E to improve 'learning by doing' is weak, similar to the M&E record of the portfolio of completed HIV/AIDS projects." Management agrees that MAP M&E needs improving, but wishes to highlight two additional points (a) the review does not adequately acknowledge the ongoing intensive efforts to improve M&E that are beginning to achieve considerable improvement on the ground, although this is a difficult and slow process; and (b) it cannot be assumed that learning by doing does not occur in the absence of formal M&E, as the MAP was intended to provide small amounts of funding to huge numbers of actors with latent capacity, to enable them to learn by doing while executing their own small projects.

MAP Approach. Given the Bank's experience with weak M&E in projects in Africa, including in previous AIDS and health projects, the Bank decided within the first year of MAP implementation to assist TTLs and country counterparts by (a) developing an operational guide for program M&E (drafted in 2001, widely reviewed by stakeholders and technical partners, and published in 2002); and (b) creating special M&E country assistance capacity in the World Bank. One of the first things the Global HIV-AIDS Program did was create the Global AIDS Monitoring and Evaluation Team (GAMET). By early 2003 GAMET had three full-time staff paid by the Bank and 15 M&E consultants in the field,[14] helping countries with and without MAP projects to establish and maintain program M&E systems. By April 2005, GAMET's consultants had made 115 M&E support visits to 33 countries, about 75 percent of which were in Africa. While this effort has taken some time to show results on the ground, the latest assessment of M&E frameworks in MAP countries (attached as Annex A) shows a much more promising picture than the OED report.

Harmonization and M&E. Having one program M&E system for a country supported by all donors, rather than many separate systems, is one of the "Three Ones," a major harmonization effort led by UNAIDS that the Bank helped to launch in September 2003, and that was endorsed by all the major financial donors in Washington in April 2004.[15] The Bank has reinforced this approach by toughening its MAP access criteria with regard to M&E for second-generation MAP projects.

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14. GAMET had its own budget line item in the 2004/05 UBW of $2.1 million that will increase to $3.66 million in 2006/07.

15. On 25 April 2004, UNAIDS, the United Kingdom and the United States co-hosted a high-level meeting at which key donors reaffirmed their commitment to strengthening national AIDS responses led by the affected countries themselves. They endorsed the **"Three Ones" principles**, to achieve the most effective and efficient use of resources, and to ensure rapid action and results-based management: **One** agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners. **One** National AIDS Coordinating Authority, with a broad-based multisectoral mandate. **One** agreed country-level Monitoring and Evaluation System. Accessible at www.unaids.org.

Conclusions. The lessons learned are that getting M&E established on the ground takes multifaceted special efforts (which the Bank has supported), and that it takes time. And it takes even more time to ensure that the monitoring turns into evaluation that affects program decision making. It also requires incentives to ensure that M&E is considered to be as indispensable as, for example, sound financial management and reporting. This is a long-standing issue in Bank-supported projects, noted in numerous other OED evaluations, and it will be interesting to see what future OED evaluations of completed MAP projects find, and what broad lessons can be drawn from GAMET efforts. Management would welcome more specific suggestions from OED on how to improve M&E.

OED Recommendations

Management agrees with the principles and broad goals underlying most of OED's recommendations, and indeed is already implementing some of them. For example, the Global HIV/AIDS Program of Action that is now being prepared singles out greater support for country strategic planning and prioritizing, for implementation, and for monitoring and evaluation as priority areas. However, management notes problems with some of OED's recommendations (a) some are relatively general and sweeping; (b) they relate to challenges that the Bank has long been grappling with that are intrinsically very hard to fix; (c) they require concerted action with other donors, and cannot be addressed by the Bank alone; and (d) they are not amenable to quick, top-down fixes, but require the long, slow process of building capacity in countries. The attached Management Action Record provides detailed responses to OED's recommendations.

Annex: GAMET Monitoring and Evaluation Status, by Country, April 2005

		M&E framework	M&E plan	M&E costed plan/ budget	M&E NAC staff	M&E implementation staff	M&E in country TA	TWG/ M&E working group	Database active	Surveillance—biological captured in ANC	Surveillance—behavioral	Surveillance—health facility	Program activity monitoring	Evaluation research	Evidence decision making
Country	Classification	Written doc presented to stakeholders: Conceptual plan	Operational plan with Gannt Chart with responsibilities mentioned		Central NAC staff	Decentralized staff	Enlisted local TA through TWG or consultant		National Indicator Dataset: output, outcome	Already processed data	DHS, BSS, MICS, LQAS	Anything to do with quality	Grantees reporting in a structured format on outputs	Targeted assessments to improve programming	Using data for decision making
Angola	3														
Benin															
Burkina Faso	2	YES	YES	YES	YES	INT	INT	YES	NO	YES	INT	YES	YES	YES	NO
Burundi	1	YES	YES	YES	YES	YES	NO	NO	YES	YES	YES	NO	YES	NO	YES
Cape Verde	1	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
CAR	3	YES	NO	NO	YES	N/D	N/D	YES	NO	YES	N/D	N/D	NO	NO	NO
Congo Brazaville	2	YES	YES	YES	YES	NO	YES	YES	NO	NO	NO	NO	NO	NO	NO
Congo, D. R.	3	YES	YES		YES	NO	YES	YES	NO	NO	NO	NO	NO	NO	NO
Côte d'Ivoire	2	YES	YES	YES	YES	NO	INT	YES	NO	YES	YES	INT	INT	INT	NO
Ethiopia	1/2	YES	YES	YES	YES	YES	NA	YES	INT	YES	YES	YES	INT	YES	INT
Gambia	2	YES	YES	YES	YES	NO	NO	YES	YES	YES	YES	NO	YES	NO	NO
Guinea Buisau	3	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	
Guinea	2	YES	YES	YES	YES	INT	YES	YES	INT	YES	YES	YES	YES	NO	NO
Kenya	2	YES	YES	NO	YES	NO	YES	YES	NO	YES	YES	YES	YES	NO	NO
Lesotho	3	NO	NO	NO	YES	YES	YES	YES	NO	YES	YES	NO	NO	NO	NO
Madagascar	1	YES	YES		YES	YES	YES	YES	YES	YES	YES	N/D	YES	YES	YES
Malawi	1	YES	YES	YES	YES	INT	YES	YES	YES	YES	YES	YES	YES	NO	YES
Mali	3	INT	NO	NO	YES	INT	YES		NO	YES	YES	INT	NO	N/D	NO
Mauritania	2	YES	NO	NO	YES	NO	YES	YES	NO	YES	YES	N/D	N/D	N/D	N/D
Mozambique	2	YES	NO	NO	YES	INT	NO	YES	INT	YES	YES	NO	INT	NO	NO
Namibia	1	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	INT	YES	NO

(*Continued on the following page.*)

Annex: GAMET Monitoring and Evaluation Status, by Country, April 2005 (continued)

		M&E framework	M&E plan	M&E costed plan/ budget	M&E NAC staff	M&E implementation staff	M&E in country TA	TWG/ M&E working group	Database active	Surveillance—biological captured in ANC	Surveillance—behavioral	Surveillance—health facility	Program activity monitoring	Evaluation research	Evidence decision making
Country	**Classification**	**Written doc presented to stakeholders: Conceptual plan**	**Operational plan with Gannt Chart with responsibilities mentioned**		**Central NAC staff**	**Decentalized staff**	**Enlisted local TA through TWG or consultant**		**National Indicator Dataset: output, outcome**	**Already processed data**	**DHS, BSS, MICS, LQAS**	**Anything to do with quality**	**Grantees reporting in a structured format on outputs**	**Targeted assessments to improve programming**	**Using data for decision making**
Niger	3	INT	INT	NO	YES	YES			NO	INT	YES	N/D	NO	NO	NO
Nigeria	2	YES	YES	NO	YES	YES	YES	YES	NO	YES	YES	INT	NO	YES	NO
Rwanda	1	YES	YES	YES	YES	INT	YES	YES	YES	YES	YES	NO	YES	YES	YES
Senegal	1	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO
Sierra Leone	2	YES	YES	YES	YES	NO	NO	YES	YES	YES	YES	NO	YES	NO	NO
Swaziland	2	INT	INT	NO	YES	INT	INT	YES	NO	YES	YES	NO	INT	NO	NO
Tanzania	2	YES	YES	YES	YES	NO	INT	YES	NO	YES	INT	NO	INT	NO	NO
Togo	3	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO	NO
Uganda	2	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	INT	YES	YES
Zambia	3	YES	YES	YES	YES	YES	YES	YES	NO	YES	YES	YES	INT	NO	NO
ARCAN	2	YES	YES	YES	YES	YES	N/A	N/A	NO	N/A	N/A	N/A	INT	NO	NO
GLIA	2	YES	YES	YES	NO	YES	YES	N/A	NO	YES	Pilot Done	NO	INT	NO	NO
IGAD	1	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NO
LACP	2	YES	N/D	INT	YES	YES	YES	N/A	N/D	N/A	N/A	N/A	N/A	N/A	N/A
TAP	3	YES	NO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	YES	YES	N/D

1 = Successfully attained overall: framewrk doc., database populated, active operating program monitoring.

2 = Partially attained:national framewk adopted, database defined and partial developed, indicators agreed, system not operating properly.

3 = Not attained.

INT = in transition, N/D = no current data, ARCAN = Africa Regional Capacity Building Network Project, GLIA = Great Lakes Initiative on HIV/AIDS, IGAD = Inter-Governmental Authority on Development, LACP = Pan-Caribbean Partnership Against AIDS, TAP = Regional HIV/AIDS Treatment Acceleration Project.

Management Action Record

OED Recommendation	Management Response
For All Bank HIV/AIDS Assistance 1. **Help governments to be more strategic and selective, to prioritize, using limited capacity to implement activities that will have the greatest impact on the epidemic.** In particular, the Bank should ensure that public goods and prevention among those most likely to spread HIV are adequately supported. a) The Bank should help governments prioritize and sequence the implementation of activities likely to have the greatest impact and that enlist sectors and implementers according to their comparative advantages to work collaboratively toward specific epidemiological outcomes. Costs, cost-effectiveness, impact, equity, human resource requirements and sustainability of alternative AIDS prevention, treatment, and mitigation strategies should be assessed. b) Projects in countries at all stages of the epidemic should be systematically mapping high-risk behavior; monitoring HIV and behavior in populations most likely to contract and spread HIV; assuring high coverage of information and preventive interventions to them; and taking action to reduce stigma and legal barriers to prevention and care among marginalized groups. A country-by-country assessment of the extent to which this is currently taking place and an action plan to improve performance would satisfy this recommendation. c) In high-prevalence countries the Bank should work with government and other partners to assess the costs, benefits, affordability, sustainability, and equity implications of different types of treatment for AIDS patients, on the basis of which to make rational decisions in the allocation of health resources. This should be a priority even if Bank resources will not be financing this care. A population-based HIV prevalence survey is critical to understanding the scope and distribution of demand for treatment and for designing efficient treatment and care strategies in hard-hit, low-income countries.	1. Management believes that action on this recommendation must be and will be taken jointly with partners. Effective impact requires harmonized coordinated efforts with major partners in our support for country HIV/AIDS programs. Intensive efforts to help governments to be more strategic and selective, to build capacity to collect and analyze data on behaviors and HIV status in key groups, and to prioritize on the basis of epidemiological and programmatic data are key priorities in the draft Bank Global HIV/AIDS Program of Action (GHAPA) and in collaborative work with partners, including the Global Task Team (GTT), and reflect the "Three Ones" principle. The final report of the GTT includes a set of specific actions (and accountabilities) to help countries develop prioritized "AIDS action plans that drive implementation, improve oversight, emphasize results…and are rooted in broader development plans and planning processes." The Global HIV/AIDS Program (GHAP) and UNAIDS will work with other major partners to set up a Strategic Planning Facility by September 2005, to assist countries to develop strategic prioritized national plans. Improved behavioral monitoring requires concerted international efforts to which the Bank is contributing significantly. Improved bio-behavioral surveillance is a core part of a good national M&E system and, with partners, the Bank is helping countries to strengthen bio-behavioral surveillance to enable them to identify and effectively address proven drivers of HIV transmission. (This is the core work program of GHAP's GAMET team. Country-by-country status is summarized in Annex A.) Analytic work to support decisions on resource allocation has been done in Africa as part of several national AIDS investments and two regional projects (the African Regional Capacity Building Network for HIV/AIDS Prevention, Care, and Treatment and the Treatment Action Program). In Asia, analysis has been done in India and Thailand and is planned in China. The GHAPA includes plans to support further work in selected additional countries. Management disagrees with the statement on the critical role of a population-based HIV prevalence survey: (i) HIV prevalence data give no information on the state of individuals' infection and eligibility for treatment; (ii) these data would measure potential demand, not effective demand, which is mediated by access and cost, clinical eligi-

OED Recommendation	Management Response
	bility, physiological tolerance of the drugs, commitment to adhere to the regimen. Specifically, internal and international processes to monitor progress on national strategies already exist within the framework of GHAPA, the GTT, and UNAIDS governance. The Bank agrees to continue to use these processes and to ensure that the relevant reports of these agencies are made available on a timely basis to Executive Directors during the upcoming three years.
2. **Strengthen national institutions for managing and implementing the long-run response, particularly in the health sector.** a) Bank assistance should distinguish between institutions and strategies for raising political commitment (mobilization) and those for efficient and effective implementation of activities on the ground. Both objectives have been shown to be critical, but experience shows that a single institution may not be able to satisfy both objectives efficiently. b) Bank HIV/AIDS assistance needs to consider strategies for building, broadening, and sustaining political commitment in specific settings. c) Greater use of institutional and political analysis should be made to enhance the local relevance and effectiveness of national and sub-national institutions (including multisectoral institutions and those in the MOH) in relation to local capacity, political realities, and the stage of the epidemic.	2. Strengthening institutions is a long-term and challenging task with which the Bank and many development partners are grappling. Bank efforts to strengthen the health sector are much broader than the Bank's AIDS work, but within HIV/AIDS projects, it is already standard practice to include components to strengthen health sector service delivery capacity (unless a complementary HNP project is already doing this), and to build the capacity of the National HIV/AIDS authority. Management disagrees that effective implementation and mobilization are necessarily dichotomous. In fact, good implementation is often among the most effective means of achieving mobilization. For example, when communities are given funding to organize themselves to take care of AIDS orphans, this is both mobilization and implementing an "activity on the ground." Broadening political commitment has been a major objective in many countries and specifically of the first phase of the MAP Program. OED notes this as a major achievement of the MAP (and has also been important outside of Africa). Likewise institutional and political analysis is already being done in many Regions and in MAPs. Support for strengthening national institutions is a harmonized partnership activity. Management will use the UNAIDS governance process to report on progress on strengthening institutions and will provide the relevant documentation to Executive Directors on a timely basis during the next three years.
3. **Improve the local evidence base for decision-making.** The Bank should create incentives to ensure that the design and management of country-level AIDS assistance is guided by relevant and timely locally-produced evidence and rigorous analytic work. a) The Bank should launch immediately – within the next 6 months—an in-depth inventory and assessment of the	3. Improved national Monitoring and Evaluation (M&E) to inform decisions is a key goal of the "Three Ones" (the Bank agreed in this context with other donors and clients that there will be only one country-level M&E system for all donors) and a centerpiece of GHAP's work, in the context of its partnership in UNAIDS and with other major players. GHAP's GAMET team provides extensive field support for developing M&E ca-

OED Recommendation	Management Response
extent of implementation of all planned M&E activities and the availability and comparability over time of input, output, and outcome data relevant to assessing program effectiveness, in all countries with freestanding HIV/AIDS projects and significant components. This assessment should serve as the basis for a time-bound *action plan* to improve the incentives for monitoring and evaluation in the Bank's HIV/AIDS assistance, with explicit targets in terms of improved monitoring and periodic use of evaluation to improve program effectiveness. b) Ongoing projects and those in the planning stage should pre-identify a program of commissioned research and analytic work on issues of priority to the AIDS program. c) Pilot programmatic interventions should be independently evaluated before they are replicated or expanded; those that have been scaled up without the benefit of evaluation should be evaluated within the next 12 months as a condition for continued finance. d) The Bank should become an "AIDS knowledge bank" by: maintaining a central database of Bank-sponsored or managed analytic work on AIDS – including evaluations – that is complete, up to date, and accessible to staff, clients, researchers and the public; developing a mechanism for the routine dissemination of findings from the Bank's analytic work on AIDS to internal and external audiences; translating key products; and investing in priority cross-national analytic work and research that is an international public good.	pacity and systems, and work is underway in most regions and countries. Annex A summarizes the status of M&E system development in highly affected countries. MAP repeater projects already include stringent requirements on M&E. Management believes that this level of intensive support for M&E is unprecedented in a Bank portfolio (notable given widespread difficulties with M&E in Bank projects) and expects that it will show results, but this will take time. With regard to research and analysis, more is needed, but not all can or should be pre-identified.[1] It is critically important to assist countries to identify and address their own research priorities. The bigger challenge is to ensure that planned research and analytic work is in fact carried out. Additional research and analysis of issues of priority are included in the draft GHAPA. With regard to independent evaluation of pilot interventions, there are major cost, cost-benefit, and feasibility concerns. Management agrees that large-scale interventions ought to be evaluated, but would not make this a pre-condition of financing of high-priority operations. Management agrees to continue its extensive efforts, in close partnership with key donors, to assist countries to strengthen M&E. With regard to the Bank's knowledge base, a senior Knowledge Officer has been recruited by GHAP. The draft GHAPA outlines what management agrees to do in knowledge development and GHAP's FY06 work program includes this knowledge development program. Management will report on progress with regard to M&E in client countries and in its knowledge base efforts in the next update of the GHAPA.
For the Africa MAP **4.** The Africa MAP is designed to mitigate risks concerning political commitment and implementation, but there are few structural mechanisms to assure efficiency or efficacy. These risks can be reduced through the following actions (in addition to the recommendations above, which apply to all projects): a) **A thorough technical and economic assessment of national strategic plans and government AIDS policy and an inventory of the activities of other donors should become a standard part of MAP project preparation.** When national strategic plans are found inadequate as a basis for prioritization and sequencing of activities, the Bank should engage government in strategic discussions, informed by analytic work, to identify programmatic priorities that reflect the stage	Consistent with the recommendations of the MAP *Interim Review* of 2004, assessments of national HIV/AIDS plans, and taking account of other donor support, are already part of project preparation and regular and joint reviews of MAP projects. The GHAP Program of Action and actions detailed in the GTT Final Report give high priority to strengthening country strategic planning and better harmonizing, aligning and coordinating among donors, and list specific actions (with accountability) and have established a process and timetable for monitoring progress. As noted above, management does not agree with a stark distinction between political mobilization and implementation. While more evaluation of results is needed, management does not

1. OED notes that its recommendation is not suggesting that all research be pre-identified or that the countries not be involved in the pre-identification process.

OED Recommendation	Management Response
of the epidemic, capacity constraints, and the local context. Follow-on projects should be structured to ensure that those priority activities, including public goods and prevention among those with high-risk behavior, are pursued. b) **The objectives of the engagement of different segments of civil society need to be clearly articulated, to distinguish between the actors enlisted for purposes of political mobilization and those with the expertise and comparative advantage to implement activities with a direct impact on the epidemic.** The results of ongoing CDD-type AIDS activities should be rigorously evaluated with respect to their effectiveness in changing behavior or mitigating impact before they are renewed, in line with the recommendations of the OED CD evaluation. The complementarity or competition between CDD AIDS activities and the decentralized public sector response should be assessed as part of this effort. c) **The Bank should focus support for implementation on the sectors whose activities have the greatest potential impact on the epidemic and with some comparative advantage in implementation—such as the Ministry of Health, the military, education, transport, and others, depending on the country – and ensure that the resources to supervise their activities are forthcoming.** The objectives of multisectoral action against AIDS –particularly in terms of political mobilization and implementation—also need clearer articulation; the key actors with respect to each of these two objectives need to be more clearly defined. A country-by-country assessment of the relation between MAP support for line ministries and the AIDS activities in non-health sector assistance and their relative effectiveness should be conducted, with an eye on improving their complementarity and using supervision resources efficiently.	agree with the specific sub-recommendation; "rigorous evaluation" of all the many thousands of CDD-type activities, which is not feasible or affordable. Following early experience with MAP projects and the MAP Interim Review of 2004, a shift has already been made to focus on key sectors with potential for greatest impact on the epidemic (also reflected in the GHAPA). Education is a key example, and is the focus of ongoing special efforts by HDNED and GHAP. Under the MAP, management agrees to a rigorous analysis of national strategic plans—taking into account other donor support—and, as noted above, is already acting on this. It has also moved to support key sectors. Management will report on progress in the context of the MAP update.