

Experience in Scaling up Support to Local Response in Multi-Country Aids Programs (map) in Africa

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Abstract

This paper is the first in a series of efforts to facilitate exchanges on methodologies of local response interventions inside the World Bank's Multi-Country HIV/AIDS Program (MAP) for Africa. In its design, the MAP is unprecedented in its flexibility, coverage and the emphasis it places on local, community-driven initiatives responding to the HIV/AIDS crisis. Supporting these local response initiatives took time. In most MAP projects it took one to three years to develop scaling up approaches and to mobilize the population. Research is just starting to gather evidence that local response does work, but methodologies to scale up community mobilization are still new and there are very few publications on practical instruments that have been successfully applied at the national level. The central question of this paper is: What lessons can be learned from the implementation of the Local Response Components under the MAP programs to improve results of future programs against HIV/AIDS? The paper draws lessons from Burkina Faso, Cameroon, Central African Republic, Chad, Ethiopia, Eritrea, Gambia, Ghana, Kenya and Uganda.

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**ESSD Regional Program on HIV/AIDS in collaboration with AIDS Campaign Team for
Africa (ACTafrica)**

Jean Delion , Pia Peeters, Ann Klofkorn Bloome

December 2004

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Preface

This paper takes stock of methodologies in scaling up local response components supported by the World Bank's Multi-Country HIV/AIDS Program (MAP) in Africa. The paper draws lessons from, among others, Burkina Faso, Cameroon, Central African Republic, Chad, Ethiopia, Eritrea, The Gambia, Ghana, Kenya, and Uganda. It focuses on experiences of countries that have succeeded in scaling up their local response programs within two to three years, the processes involved and the lessons learned.

The paper is one step in an ongoing effort from the Environmentally and Socially Sustainable Development (ESSD) network for Sub-Saharan Africa to disseminate lessons learned in supporting local responses against HIV/AIDS. Experience from the past four years demonstrates that social mobilization at community level is a powerful instrument in fostering sustainable behavioral change, treatment, care and support in the fight against HIV/AIDS. In 1998, ESSD Africa supported a regional program called "Rural AIDS" to contribute to the World Bank's multi-sectoral AIDS effort. Based on a review of social mobilization approaches from various NGOs in Africa, RAIDS developed a proposed framework for action at the national, district, and community level to support and sustain a social mobilization process. Validated in a Pan-African workshop in Tanzania in June 2000, this framework provided an important input to one of the key features of the MAP program in Africa: the direct support to community organizations, NGOs, and the private sector for local HIV/AIDS initiatives through local response components.

Research is starting to document the positive impact of local responses. In Uganda, three Demographic and Health Surveys suggest that local response activities created a context that allowed people to dare to talk about sex, AIDS, the use of condoms, and access to tests, care and support. But methodologies to scale up community mobilization are still new, and there are relatively few publications featuring practical instruments that have been successfully applied at the national level. This paper aims to contribute to that literature by highlighting key features of successful local responses, and lessons learned in scaling them up. These lessons could be of particular value for other regions where local response initiatives in the fight against HIV/AIDS are not yet as developed as they are in Africa.

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Abbreviations and Acronyms

ACTafrica	AIDS Campaign Team for Africa
AIDS	Acquired Immune Deficiency Syndrome
APL	Adaptable Program Lending
ARI	Accelerated Results Implementation
ARV	Antiretroviral
BAFROW	Foundation for Research on Women's Health, Productivity and the Environment
BCC	Behavior Change Communication
CACC	Constituency AIDS Control Committees
CAP	Community Action Plan
CAR	Central African Republic
CBO	Community Based Organization
CDD	Community Driven Development
CHAI	Community-led HIV/AIDS Initiatives
CHW	Community Health Workers
CMR	Community Managed Response
CPC	Community Project Committee
CSO	Civil Society Organization
CSW	Commercial Sex Workers
CTG	Central Technical Group
DFID	Department for International Development – United Kingdom
DFP	District Focal Person
DHAC	District HIV/AIDS Committee
EAF	Emergency HIV/AIDS Fund
ESSD	Environmentally and Socially Sustainable Development
FBO	Faith Based Organization
GAC	Ghana AIDS Commission
GAMET	Global HIV/AIDS Monitoring and Evaluation Team
GARFUND	Ghana AIDS Response Project
HAMSET	HIV/AIDS, Malaria, STDs & TB
HARRP	HIV/AIDS Rapid Response Project
HFO	HIV/AIDS Facilitation Officer
HIV	Human Immunodeficiency Virus
IDA	International Development Association
IEC	Information, Education and Communication
ILO	International Labor Organization
KADRE	Kenya AIDS Disaster Response Project
LR	Local Response
M&E	Monitoring and Evaluation
MAP	Multi-country AIDS Program
MOU	Memorandum of Understanding
NAC	National AIDS Committee or Council
NACC	National AIDS Control Council
NACP	National AIDS/STD Control Program
NAS	National AIDS Secretariat
NGO	Non Governmental Organization
OVC	Orphans and Vulnerable Children
PAD	Project Appraisal Document
PCT	Project Committee Team
PLWHA	People Living with HIV/AIDS

PMU	Project Management Unit
PPF	Project Preparation Fund
PTG	Provincial Technical Group
RAIDS	Rural AIDS
RRI	Rapid Results Initiative
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAP	Treatment Acceleration Project
TB	Tuberculosis
TOR	Terms of Reference
ToT	Trainer of Trainer
TTL	Task Team Leader
UAC	Uganda AIDS Committee
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counseling and Testing
WAC	Woreda AIDS Committee

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EXECUTIVE SUMMARY

Introduction and objectives

Sub-Saharan Africa is disproportionately affected by the HIV/AIDS pandemic. With about 10% of the world's total population, Sub-Saharan Africa accounted for three-quarters of AIDS deaths worldwide and up to two-thirds of all people living with HIV/AIDS in 2003. African leaders, the World Bank, and the international community at large have recognized the need for quick, forceful, and sustained action against the pandemic. Guided by these principles, the Bank and its partners designed the Multi-Country HIV/AIDS Program (MAP) for Africa, to scale up national multi-sectoral HIV/AIDS initiatives. As of July 2004, 28 African countries and three regional programs have received US\$1.1 billion within the MAP approach, and MAP projects are being prepared in another ten countries and for regional programs.

Until the end of the 1990s, HIV/AIDS prevention and control activities in many countries used a predominantly bio-medical approach and focused on top-down information, education and communication messages. To move from individual awareness raising and sensitization to the promotion of behavioral change, a successful social mobilization program needs the full participation of people in the communities, starting with an analysis of their risk and vulnerability to HIV infection. With this goal in mind, MAP projects channel about 40% of their funds to local response initiatives. These initiatives are multiple strategies developed at the local level to fight HIV/AIDS, with many countries making the community the focal point of action. Social development plays a crucial role in ensuring that local response investments lead to effective behavioral change and provide support to affected members.

When the Bank designed MAP, rural development staff experienced in Community Driven Development (CDD) and a Rural AIDS (RAIDS) strategy brought their skill in community mobilization to help change behavior and support infected and affected people. As a result of lessons learned in CDD and RAIDS, a key feature of MAP projects is direct support to community organizations, NGOs, faith based organizations, and the private sector for local HIV/AIDS initiatives.

In its design, the MAP is unprecedented in its flexibility, coverage and the emphasis it places on local, community-driven initiatives responding to the HIV/AIDS crisis. Supporting these local response initiatives took time. In most MAP projects it took one to three years to develop scaling up approaches, and to mobilize the population.

Research is just starting to gather evidence that local response does work, but methodologies to scale-up community mobilization are still new and there are very few publications on practical instruments that have been successfully applied at the national level. This paper is the first in a series of efforts to facilitate exchanges on methodologies of local response interventions inside the MAP programs. The central question is: "What lessons can be learned from the implementation of the LR components under the MAP programs, to improve results of future programs against HIV/AIDS?"

Main Findings

The paper draws lessons from Burkina Faso, Cameroon, Central African Republic, Chad, Ethiopia, Eritrea, Gambia, Ghana, Kenya and Uganda. It focuses on the experiences of countries that have succeeded in scaling up their local response programs within two to three years, the processes involved and the lessons learned. The application from a lesson of one country to

another depends heavily upon each country's existing situation, including the extent of the epidemic, the available funds for HIV/AIDS and past experiences with HIV/AIDS activities, CDD and social funds.

The main lessons learned of the report are:

- When a country has an advanced and strong decentralization system and/or a well functioning social fund system in place, using these existing structures can (a) facilitate the rapid scaling up of implementing the local response activities, and (b) eliminate the need to create a new framework.
- Thoughtful preparation before implementing the local response component includes the development of guidelines, building consensus on methodologies, identifying partners, and training at the national and subnational levels. While this preparation can be time consuming, it can result in fast scaling-up once local response activities are launched.
- Communities need easy access to simple information on how to access MAP funding for local response activities, especially for community organizations, smaller NGOs and faith-based organizations.
- “Open” Action Plans can be tailored to a country's needs and experiences. While the issue of open, unlimited initiatives to be funded at the local level can be a big challenge, through the “learning by doing” approach of the MAP, countries adapt the rules according to the identified difficulties. Given the flexibility of local communities in the development of their local HIV/AIDS Action Plans, an in-depth situational analysis is essential to avoid superficial and inefficient action plans.
- The quality of Community Action Plans for the fight against HIV/AIDS through the fast scaling-up process can be limited at the beginning, but the process opens up the debate on HIV/AIDS in the communities.
- Short term, results-based initiatives can strengthen the implementation and scaling up of the local response components.
- An NGO- or supply-driven process is costly and may be hard to scale up, especially in rural areas. A balance must be sought between larger NGOs, and community organizations. The level of involvement of larger NGOs and faith-based organizations depends on local capacity. Ascertaining this capacity should be part of the in-depth social assessment during project preparation.
- The involvement of the private sector in local response activities remains a challenge.
- Communities have to take responsibility to ensure results and quality activities at the local level, using simple M&E indicators and methodologies.
- Making the shift to promoting behavioral change and service delivery to support families affected by HIV/AIDS can be challenging for local communities. They will require more technical assistance and larger NGOs need to be part of the referral system.
- Combining social mobilization at the community level with increased access to Voluntary Counseling and Testing and Antiretrovirals has proven to be successful.

- Simplified reporting in fiduciary matters is needed for the small budget used by local communities. There is also a need for affordable, financial control of small grants. Each country must find a balance between various tools, such as self-evaluation tools at community level and external controls. Using external firms for financial management, monitoring and evaluation accelerates disbursement and facilitates financial control of resources.

Part 1: Overview of Scaling up Local Response Components in the Multi-Country HIV/AIDS Program in Africa

1. THE MULTI-COUNTRY AIDS PROGRAM (MAP) IN SUB-SAHARAN AFRICA

1. Sub-Saharan Africa is disproportionately affected by the HIV/AIDS pandemic. With less than 11% of the world's total population, Sub-Saharan Africa accounted for 76% of AIDS deaths and up to two thirds of all people living with HIV/AIDS in 2003. The numbers pertaining to sub-Saharan Africa are stunning¹:

- 25 million of the estimated 38 million people living with HIV/AIDS;
- 12 million children orphaned by the pandemic;
- As many as 18 million orphans by 2010; and
- Over 70% of the young people infected worldwide.
- On average, there are 13 infected women for every 10 infected men, and 75 % of young people infected are girls and women.
- In 2003 alone, an estimated 3 million people in the region became newly infected, while 2.2 million died of AIDS.

2. African leaders, the World Bank, and the international community at large have recognized the need for quick, forceful, and sustained action against the epidemic. Guided by these principles, the Bank and its partners designed the Multi-Country HIV/AIDS Program (MAP) for Africa, to scale up national multi-sectoral HIV/AIDS efforts with greater partnership with Civil Society Organizations (CSOs), and to support sub-regional HIV/AIDS initiatives. In September 2000, an initial amount of US\$500 million in credits was approved by the Bank for the MAP program, and an additional US\$500 million in grants was approved in 2002 for the second stage of the MAP program.

3. The MAP funds are available to any low-income African country that meets the following eligibility criteria:

- Satisfactory evidence of a strategic approach to HIV/AIDS, developed in a participatory manner;
- 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 for HIV/AIDS activities directly to communities, civil society, and the private sector; and
- Agreement by the government to use multiple implementation agencies, especially NGOs/Community Based Organizations.

4. The overall goal of the MAP is to increase access to HIV/AIDS prevention, care, and treatment programs, with emphasis on vulnerable groups (such as youth and women of childbearing age). The MAP seeks to enlist all development sectors in the fight against HIV/AIDS, recognizing that the health sector can no longer bear the full burden of the epidemic alone. The MAP is built on a "program support" model, meaning that assistance is comprehensive, flexible, and adaptable. MAP projects are characterized by: (a) learning by

¹ UNAIDS, *2004 Report on the Global AIDS epidemic, 4th global report*, June 2004. For more information on the pandemic in Africa: www.unaids.org, and <http://www.worldbank.org/afr/aids/>.

doing; (b) multiple targets in prevention, care, support, and treatment; (c) multiple sectors, stakeholders, and implementation channels; (d) attention to gender issues;² and (e) a focus on capacity building, knowledge sharing, financial management, and monitoring and evaluation. At the same time, the specific objectives of MAP projects reflect the priorities of the individual National HIV/AIDS Plans.³

5. As of July 2004, 28 African countries and three regional programs have received US\$1,088,200 within the MAP approach and MAP projects are being prepared in another ten countries and for regional programs.

6. Overall, MAP projects channel about 38% of project funds to Local Response (LR) initiatives⁴ (see Table 1 below). In its design, the MAP is unprecedented in its flexibility, coverage and the emphasis it places on local response. Local response corresponds to multiple strategies developed at the local level to fight against HIV/AIDS, with many countries making the community the focal point of action. MAP's demand-driven design allows implementing agencies in the public and private sector and civil society to decide what activities in prevention, care and treatment, and mitigation should be undertaken. In the four years of MAP, more than 28,000 CSOs and communities have received roughly US\$105 million in grants for HIV/AIDS programs, and more are in the process of receiving grants. The objective of this effort was to reach out and mobilize the majority of the population, bringing messages adapted to the local context and inviting people to confront HIV/AIDS.

Table 1: Examples of World Bank funding for Local Response in MAP projects⁵

Country	Total MAP funding in country, US\$ million	MAP funding for Local Response (LR), US\$ million	LR as a percentage of total funding
Burkina Faso	22	4.8	21.8%
Cameroon	50	27	54%
Ethiopia	59.7	26.4	44%
Ghana	25	15	60%
Kenya	50	30	60%
The Gambia	15	7.5	50%
Uganda	47.5	20	42.1%

7. Supporting these local response initiatives took time. In most MAP projects it took one to three years to develop scaling up approaches, and to mobilize 20% to 50% of the total population. On average, MAP financed about 10,000 local initiatives per year. It is too early to measure the outcome of this mobilization. However, the concerned communities can measure signs of change: the health services can measure continuous increase in demand for tests, and more recently, for Antiretroviral drugs (ARVs); and Demographic and Health Surveys (DHS), using

² For more information on Gender and HIV/AIDS, see *Integration of Gender Issues in Selected HIV/AIDS Projects in the Africa Region: A baseline assessment*, World Bank, March 2004, <http://www.worldbank.org/afr/hd/wps/Rep%2067%20-03042004.pdf>.

³ For more information on the MAP program: <http://www.worldbank.org/afr/aids/map.htm>.

⁴ According to MAP questionnaires collected by the World Bank's AIDS Campaign Team for Africa (ACTAfrica) during January-February 2004.

⁵ Source: Respective Project Appraisal Documents.

biological data (random tests), can report changes. As various interventions are being carried out in parallel, it is hard to isolate the direct impact of the Local Response activities. Still, the DHS in Uganda, for example, shows correlations between strong social mobilization and reduction of the prevalence rate, over five to ten years. Local response activities seem to be successful in creating a context for people to talk about HIV/AIDS, to change their behaviors, and to access tests, care and treatment.

8. These first few years of MAP were a first phase of the fight against HIV/AIDS, moving from isolated niches of good practices to national mobilization, in all villages and towns, against HIV/AIDS. With a large portion of the population now mobilized, some countries are moving to another step: connecting the health services with the communities, rehabilitating the importance of Community Health Workers (CHWs) (often volunteers with a bike or a motor bike, a cellular phone, receiving a small monthly allowance) and asking them to focus on HIV/AIDS.

9. Following approaches used by Médecins Sans Frontières in South Africa,⁶ many countries are now trying to integrate the dynamics of thousands of communities with the health services. A CHW on HIV/AIDS builds on the initial mobilization phase, accompanies people who want to be tested (before and after tests), helps people access antibiotics and improve their nutrition if they are sero-positive, assists them in accessing ARVs, and in adhering to ARV treatment. If death is coming, CHWs assist the patients and their families to protect the family assets, to plan for the future orphans and then CHWs follow the orphans after the death.

10. These CHWs on HIV/AIDS are now linking communities with health services. This is going far beyond mere sensitization. Leaders of Local Response components can quickly learn from the most innovative experiences and move beyond the initial social mobilization to accompany the dozens of millions of people living with HIV and the hundreds of millions of family members to access care and treatment, to adhere to this treatment and to live positively. This seems to be the challenge for the next phase of MAP.

11. This paper is the first in a series of efforts to facilitate exchanges on methodologies of local response interventions inside the MAP programs. Other papers will follow, reflecting the richness of an action research process taking place in many countries. All the papers will try to answer the general question: "What lessons can be learned from the implementation of LR components under the MAP programs, to improve results of programs against HIV/AIDS?" The present paper is focusing on the experience of countries that succeeded in scaling up their programs within two to three years, the costs involved and the lessons learned.

⁶ Cowley Geoffrey, *Medicine without Doctors*, in: Newsweek, July 19th, 2004.

2. LOCAL RESPONSE COMPONENTS AT THE HEART OF THE MAP

2.1. Social Development Objectives and the MAP ⁷

12. In the overall context of the World Bank's commitment to poverty alleviation, social development objectives are expressed in terms of inclusion, empowerment and security. The *regional social development strategy* for Sub-Saharan Africa emphasizes the critical need for a social and institutional perspective to understand the role of stigma, power, gender, identity, networks and kinship systems in the spread of and response to HIV/AIDS. MAP projects contribute to social development in the following ways:

- They aim to minimize the stress on core social structures (households, kin groups, communities, public agencies and productive organizations) caused by illness, death and requirements of care for HIV/AIDS victims;
- They promote inclusion of marginalized groups by reaching out to involve such groups in program planning, giving them “voice” and bringing them within the sphere of public social responsibility;
- They aim to increase the security of the poor (and the public in general) by providing adequate resources to support the delivery of needed information and services, including prevention services and goods such as condoms and medical and palliative drugs and supplies;
- They aim to empower the poor (and the public in general) by involving them in the design and delivery of services and in monitoring and evaluating project activities;
- They aim to build capacity and partnership in social institutions at all levels, from local communities to the national government; and
- They confront the need for cultural changes in gender relations, conflict resolution, governance, and recognition and respect for human rights, which are all fundamental to achieving sustainable social development in Africa.

13. Social development plays a crucial role in ensuring that local response investments lead to effective behavioral change and provide support to affected members. Social analysis provides a framework for examining social factors contributing to the propagation of HIV/AIDS, assisting in the design of social mobilization processes through creating community-based diagnostic tools, facilitating psycho-social methods to confront HIV/AIDS, establishing indicators to be used by communities, conducting and scaling up pilot projects, constructing communications components, and assessing the social impact of interventions.

14. Recent guidelines from the World Bank's AIDS Campaign Team for Africa (ACTAfrica) stress the need for good social analysis as a prerequisite for behavior change. In-depth social

⁷ This paragraph is partly based upon: Cynthia Cook, *Multisectoral HIV/AIDS Projects in Africa: A Social Analysis Perspective*, Social Development Papers, no. 43, June 2003, [http://lnweb18.worldbank.org/ESSD/sdvext.nsf/60ByDocName/MultisectoralHIVAIDSProjectsInAfricaASocialAnalysisPerspective/\\$FILE/SDPaper4322Jul2003.pdf](http://lnweb18.worldbank.org/ESSD/sdvext.nsf/60ByDocName/MultisectoralHIVAIDSProjectsInAfricaASocialAnalysisPerspective/$FILE/SDPaper4322Jul2003.pdf).

analysis should be part of the preparation of MAP programs, especially for specific programs in prevention, care, treatment, support and mitigation, and for monitoring and evaluation.⁸ Currently, however, social analysis is not yet a routine part of preparation for MAP operations.⁹ Since MAP is an emergency response, such analyses were not mandatory for project approval, in order to save time during project preparation and to respond speedily to country needs. Some countries conducted assessments once the project was underway and basic institutions were equipped. Ongoing MAP projects can use MAP 1 or 2 funds to conduct such studies; new countries may use Project Preparation Funds (PPFs) or any other trust fund, as needed. MAP3 is under preparation, and such assessments will most likely become a requirement.¹⁰

2.2. Social Mobilization identified as a key feature of successful HIV/AIDS programs

15. Until the end of the 1990s, HIV/AIDS prevention and control activities in many countries were centered on the predominantly bio-medical approach and the repeated use of top-down Information, Education and Communication (IEC) messages, without any national HIV/AIDS policy or strategy in many countries. Despite impressive awareness raising efforts in many countries, it is clear that minimal behavior change has occurred. To move from individual awareness raising and sensitization to the promotion of behavior change, a successful social mobilization program needs the full participation of people in the communities, starting with an analysis of their risk and vulnerability to HIV infection.

16. Based upon this analysis, communities can plan actions that stimulate behavior change and improve care and support for people living with HIV/AIDS, their caretakers, orphans, and other vulnerable groups. Ideally, such a social mobilization program builds on locally available resources, in addition to those channeled from higher levels, and improved health and development structures.¹¹

17. During the last decade many African countries used *Community Driven Development* (CDD) approaches to support local initiatives in poverty alleviation programs.¹² CDD corresponded to a radical shift in approach to poverty reduction and development, by transferring the control of decisions and actual management of resources to the community level, with community groups being called to work in partnership with demand-responsive support organizations and service providers including elected local governments, the private sector, NGOs, and central government agencies. CDD was mainly used to build community infrastructure, to develop services, and to organize economic activity and resource management. CDD empowered poor people and improved governance.

⁸ Ibid.

⁹ World Bank, *Turning Bureaucrats into Warriors, Preparing & Implementing Multi-Sector HIV-AIDS Programs in Africa, Preparing and Implementing Multi-Sector HIV/AIDS Programs in Africa*, 2004, <http://www.worldbank.org/afr/aids/gom/gom.htm>.

¹⁰ Email from Nadeem Mohammad, Sr. Operations Officer, ACTAfrica, AFRHV, 7/20/2004.

¹¹ Research Triangle Institute, World Bank, Tanesa, UNAIDS, *Rural workers' contribution to the fight against HIV/AIDS: a framework for district and community action*, UNAIDS, 2001.

¹² For more information on CDD: <http://lnweb18.worldbank.org/ESSD/sdvext.nsf/09ByDocName/CommunityDrivenDevelopment>.

18. Lessons from previous CDD projects (from water and sanitation to microfinance and health) having gone through the scaling up process are relevant to MAP countries' challenge of scaling up support to local response. Previous CDD experience identifies two crucial conditions for successful scaling up: political commitment and well-designed decentralization.

- Political commitment: Strong political commitment is indispensable for power to actually shift from top to bottom. While institutional change might be necessary, political commitment is directly dependent on an enabling environment, i.e. a lively and empowered civil society, free media, and strong NGOs.
- Well-designed decentralization has three key dimensions – political, administrative and fiscal. While key stakeholder participation and some sector programs can be scaled up without waiting for all three dimensions, full national coverage will at some point require all elements to be in place.

19. When the Bank moved to a multi-sectoral approach against HIV/AIDS, rural development staff experienced in CDD brought their skill in community mobilization to contribute to change behavior and to support infected and affected people. In 1998, ESSD Africa supported a regional program called “Rural AIDS” (RAIDS) to contribute to the World Bank’s multi-sectoral AIDS Campaign Team (ACTAfrica) for the rural sector. Based upon a review of social mobilization approaches from various NGOs in Africa, RAIDS developed a strategy paper presenting a framework for action at the national, district and community level to support and sustain a social mobilization process.¹³

20. The framework for action identified relevant actors at the community, district and national level and clarified their respective roles. Broadly speaking, the process involves (i) the sensitization of social actors based on social and cultural conditions facilitating the spread of HIV/AIDS, and (ii) support for their efforts to change these conditions. The strategy paper emphasizes that social mobilization at the community level is a key ingredient in fostering behavioral change, and in general to support the fight against HIV/AIDS.

21. As a result of lessons learned from the CDD approach and the RAIDS strategy, a key feature of the MAP projects is direct support to community organizations, NGOs, and the private sector for local HIV/AIDS initiatives through the Local Response Components. Local response activities in the fight against HIV/AIDS represent a total investment of about US\$350 million from the MAP program. Successful implementation of local response activities should stimulate behavior change among community members.

2.3 Local Response Component in MAP

22. Local response (LR) components of country-specific MAP projects are defined somewhat differently in each country. The LR approach can be defined, for example, as *Support to the Response of Civil Society* (Benin), *Support for Local Responses* (Cameroon), *Emergency HIV/AIDS Fund* (Ethiopia), *Communities and Civil Society Initiatives* (The Gambia), *Support to*

¹³ The strategy paper was discussed and validated during a Pan African workshop on community participation and HIV/AIDS, held in Mwanza, Tanzania in June 2000. This workshop resulted in the strategy paper: RTI, World Bank, Tanesa, UNAIDS, *Rural workers' contribution to the fight against HIV/AIDS: a framework for district and community action*, UNAIDS, 2001.

implementation of initiatives from civil society, private sector, and research institutions (Kenya), and Sexually Transmitted Infection (STI)/HIV/AIDS Prevention and non-medical Care-Taking Activities Fund (Madagascar).

23. Whatever the name, all MAP projects recognize the need to directly support communities and CSOs initiatives. MAP projects (i) support community involvement through capacity building and through the establishment of HIV/AIDS grant facilities and suitable institutional frameworks that bring resources closer to the communities, and (ii) provide grants to finance CSO initiatives. CSOs represent a wide range of actors outside government and the for-profit sector, including non-government organizations (NGOs), faith-based organizations (FBOs), professional associations, trade unions and community-based organizations (CBOs), and vulnerable groups (e.g. commercial sex workers (CSWs), orphans and vulnerable children (OVC), People Living with HIV/AIDS (PLWHA)).

24. CSOs range in size and scope, from national level organizations such as national or international NGOs or professional organizations, to grassroots groups, such as women's savings groups.¹⁴ The following categories of organizations can be recognized as playing a direct role in driving the implementation of local response components: NGOs, professional associations and trade unions, Faith Based Organizations (FBOs), and community-based organizations (CBOs).

25. *NGOs.* The NGO-driven process has been widely used to scale up in MAP countries, because many NGOs have the capacity to add or mainstream HIV/AIDS within their existing activities. However, this approach is often supply-driven, costly and difficult in rural areas: while in urban centers transport and travel costs make NGO scaling up possible, such a strategy cannot be applied to rural areas where those costs are much higher. If the NGO-driven process is adopted in rural areas, it runs the risk of doing so as an unsustainable 'boutique' model, and not being truly community driven.

26. Nevertheless, NGOs cover wider geographical areas and offer service delivery with a comprehensive spectrum of HIV/AIDS care, prevention and treatment, as well as providing technical support and advisory services to the communities. Many NGOs have had experience with proposal writing and reporting to donors in international languages, which can be an advantage to a community through a quick response to a request for proposals. In addition, consortiums of NGOs collaborating to present larger projects together have proven successful, as in the case of The Gambia and the *Crossland Group*.¹⁵ This option alleviates the burden of time and procedure, fills the gaps where the public sector lacks capacity, and eases disbursement.

27. *Professional associations and trade unions.* These vocational organizations are made up of members of associations or unions advancing their occupational interests, typically by setting occupational standards, providing accreditation, negotiating compensation and developing a public position on matters of common interest. Their great strength is in the size of their membership, and they represent a greatly underused and promising channel to reach thousands of employees and their families in all sectors and levels of employment.

28. In some countries, professional associations are already making a difference -- for example, in Kenya the Association of Trade Unions is making a major difference by adapting the

¹⁴ World Bank, *Turning Bureaucrats into Warriors, Preparing & Implementing Multi-Sector HIV/AIDS Programs in Africa*, 2004.

¹⁵ For The Gambia Case Study, see Part II: Country Case Studies.

International Labor Organization (ILO) policy of having one person in ten qualified in First Aid knowledge to having one person in ten with comprehensive knowledge of HIV/AIDS care, prevention and treatment. Similarly, the Cameroon private sector businesses (e.g. Agro industry), under MAP financing, cater for the communities around their factories at various locations.

29. *Faith-based organizations.* These organizations are religious affinity groups whose aim is to provide spiritual teaching and guidance, but are also enjoined by faith to undertake a social mission that includes teaching, care and welfare. FBOs have numerous adherents, an unrivaled rural reach and many have an umbrella structure, in which local religious communities, such as parishes, are linked to provincial structures, such as dioceses, which in turn are linked to a national secretariat. FBOs offer an opportunity to channel resources and training through a national secretariat to an entire province or country. The cases of Uganda and Senegal particularly prove this potential.¹⁶

30. *Community-based organizations.* Communities can get organized and establish a committee against HIV/AIDS, or they can use existing committees¹⁷ or CBOs to directly represent the ultimate beneficiaries.

31. LR components can be implemented through these different types of actors, with different average funding allowances per actor. For example, community groups typically seek a small level of support, such as for printing a few hundred brochures to hand out in village markets and at role-play or music performances, or in-kind donation of posters, brochures, and condoms. These groups play the crucial role in home-to-home sensitization activities and home-based care of PLWHA, and care of OVCs. Community-based CSOs typically request fairly modest sums to support their activities; they might seek some funding to expand their existing sensitization program or to offer more rapid response to their HIV testing and counseling services and home-based care. NGOs, because they normally have paid staff and complex activities, usually request fairly extensive sums to support their activities in communities throughout a district, region, or nation. An NGO's efforts, therefore, could cost many times more than efforts by communities or charitable organizations.

32. MAP recognizes the uniqueness of the HIV/AIDS pandemic and the need for multi-sectoral and multi-partner rapid response, which sometimes translates into a need for higher administrative costs to wage war on the disease. Therefore, MAP supports the balance of supply- and demand-driven approaches to suit a country's needs. As Table 2 below shows, some local response components focus entirely on small grants (for example Burkina Faso, Cameroon, Ethiopia), others combine small grants for funding of CAPs by communities with larger grants for CSOs (for example Benin), while others provide the most extensive part of their funding to CSOs (for example Madagascar).

¹⁶ For the Uganda Case Study, see Part II: Country Case Studies.

¹⁷ Supported by Social Development Programs, e.g. The Gambia MAP.

Country	Community grants	CSO grants
Benin	US\$1000-US\$3,000	US\$35,000
Cameroon	US\$280-US\$5,250	US\$280-US\$100,000
Ethiopia	US\$1,000	National level maximum: US\$500,000 Regional level maximum: US\$200,000
The Gambia	Up to US\$150,000	US\$150,000 to NGOs, US\$500,000 to NGO consortiums
Ghana	US\$500 at district level	US\$500 – US\$ 2,500
Madagascar		Proposals around US\$100,000

¹⁸ Source: Project Appraisal Documents.

3. OVERVIEW OF DIFFERENT APPROACHES TO SCALE UP LOCAL RESPONSE ACTIVITIES: VARIATIONS, FROM QUICK PILOT PROJECTS TO LONG STRUCTURED PROCESSES

33. Since 2000, twenty-eight MAP countries have started implementing national HIV/AIDS programs. Many of them include ambitious outreach indicators, e.g. that between 30% and 50% of the total number of communities should prepare CAPs, receive small grants as incentives to conduct social mobilization activities, implement these CAPs with transparency and good governance, and achieve results against HIV/AIDS. These programs recognized that some psychosocial changes needed to fight HIV/AIDS could be triggered by widespread “social mobilization” inside small social groups.

34. The scaling up process was envisaged on the basis of some experience in social funds and CDD projects. Only a limited number of countries had experience in providing small grants to 10% to 20% of their communities within five- to seven-year projects. As such, each MAP faced the challenge of implementing support to local response and finding ways to reach a large number of communities within two years.

35. *Many projects used a “pilot” approach.* During project preparation in some countries, the first six months of implementation were identified as risk-taking in funding pilot activities. Such countries, such as Ethiopia, awarded the block-grant money to sub-districts, giving communities the freedom to decide which projects to finance. Other countries, like Burkina Faso, directly allocated grants to communities.

36. While this first phase of CAPs had weaknesses, the programs learned from them. Project teams made corrections and adopted a pragmatic approach to scale up based on lessons learned, the main theme of MAP implementation. Gradually, these projects produced guidelines and began using more structured approaches. In Ghana, for example, guidelines led to “service” contracts signed with community groups on deliverables (not on expenses), giving more flexibility to the implementing CSO.

37. *Other projects used a more structured “cascade” approach from the beginning.* These projects invested most of their first year in building consensus on a first set of community mobilization guidelines, based on previous experience from pilot activities done by churches, NGOs, UN agencies or other organizations. They identified the best organization in the country to provide an initial training and then they conducted a cascade capacity-building approach. After two to three years, some MAP countries, such as Cameroon, were able to reach 2,000 to 3,000 communities.

38. Countries using this structured approach supported a first group of a few hundred to one thousand communities and then expanded to a few thousand communities. Through capacity building, local organizations assisted first communities to assess their situation vis-à-vis HIV/AIDS and to prepare their sub-project proposals or CAPs. Those plans were approved and financed as pilot sub-projects.

39. Most MAP countries used a combination of the above two approaches. Some countries moved very slowly, aware of the risks of such massive community mobilization processes vis-à-vis financial sustainability issues, unsure about effectiveness, and because of Monitoring and Evaluation (M&E) concerns.

4. OVERALL SCALING UP LOCAL RESPONSE LESSONS LEARNED

40. These lessons are arranged by theme, and are meant to be illustrative, as the present document is only the first contribution to a series. The application of a lesson from one country to another depends heavily upon each country's existing situation as far as infrastructure, the extent of the epidemic, the available funds for HIV/AIDS, and past experience with HIV/AIDS activities, CDD and Social Funds. These lessons learned are based upon country case studies, which are developed in more detail in Part 2.

Structural Lessons Learned

41. *When a country has an advanced and strong decentralization system in place, using these existing structures can (a) facilitate the rapid scaling up of implementing the local response activities and (b) eliminate the need to create a new framework.* For the last ten years, Ghana has undertaken an intensive decentralization process to the district assemblies. This existing decentralization process was successfully used for scaling up of the local response. In addition, Burkina Faso needed no new structure to implement the local response component, which proved to be cost efficient. Small scale local subprojects have been appraised, financed and monitored from the local administrative levels, resulting in rapid geographical coverage and ownership. On the other hand, Kenya is still struggling to identify a suitable decentralization structure for HIV/AIDS programs.

42. *If a good social fund system is in place, using this structure can facilitate the scaling-up of the HIV/AIDS local response component.* Benin, for example, used the financial agency that implements a social fund project. Implementation of the local response component was a natural extension of the social fund activities. This proved to very cost effective and allowed a fast scaling up of local response activities, well integrated in social development activities at the community level. On the other hand, in Sierra Leone, social fund management is assigned to manage all larger grants above a certain financial threshold.

Timeframe

43. *Thoughtful preparation before implementing the local response component can result in fast scaling-up once local response activities are launched.* While some MAPs took longer than others to prepare the implementation of local response activities -- involving development of guidelines, building consensus on methodologies, identifying partners, and training at the national and lower levels -- once launched nationwide, they succeeded in scaling-up rapidly.

44. *Quality of CAPs through the fast scaling-up process can be limited at the beginning, but the process opens up the debate on HIV/AIDS in the communities.* Fast scaling-up subprojects may have limited quality and efficiency at first, but they allow communities to start thinking about HIV/AIDS, discuss the issue in the community and inside the family, and set the stage for more elaborated actions by the community.

45. *Short term, results-based initiatives can strengthen Local Response.* Short-term, results-based initiatives were undertaken, among others, in The Gambia (Accelerated Results Implementation, or ARI) and Eritrea (Rapid Results Initiative, or RRI). While both countries used the approach to strengthen and accelerate the implementation of the overall project, in areas where the short-term, results-based initiatives were undertaken, the approach helped to strengthen the implementation and scaling up of the local response components. The initiatives also

reenergized the commitment and support of the highest level of leadership to the fight against HIV/AIDS.

Implementing Organizations

46. *A NGO- or supply-driven process is costly and may be hard to scale up, especially in rural areas.* The use of NGOs, as compared with direct support to communities can be costly and expensive when a program is scaling-up at the national level. Experience has been different in various countries with some NGOs building capacities and stepping out and others trying to implement activities by themselves, asking for more resources to supervise CAPs. In many countries, NGOs have only been used as facilitators, and not as intermediates to manage resources for communities themselves. Later, each community can include some costs to pay local service providers of their choice, but communities are not forced to work with a given organization.

47. *Balance must be sought between larger NGOs and community organizations. The level of involvement of larger NGOs and FBOs depends on the capacity of local communities and local NGOs. Ascertaining this capacity should be part of the in-depth social assessment during project preparation.* In Chad, a two-tier approach was used because of the weakness of community organizations and local organizations to reach all communities nationwide. Nine NGOs were contracted to provide technical assistance and supervision of activities in local communities. The resources for the activities themselves, however, go directly to the communities. In Uganda, the partnership with FBOs in scaling up local response initiatives was instrumental due to the FBO's unequaled outreach in rural areas. In The Gambia, NGO-driven implementation has increasingly been favored since it proved to be more time and cost effective, providing support to communities that would not be available otherwise.

48. *Engaging religious bodies and FBOs in the national response to HIV/AIDS can lead to greater influence on behavior and social influence, and care and support activities.* FBOs possess the moral authority to influence behavior change, have access to a broad audience on a regular basis, have grassroots involvement, and a holistic approach to the HIV/AIDS epidemic in providing both physical, psychosocial, and spiritual solace and as such should be partners in the fight against HIV/AIDS.¹⁹ They are also major providers of health services. FBOs are very much involved in community services and are often eager to integrate health and community aspects of the fight against HIV/AIDS. Many MAP countries provided grants to FBOs to support health or/and integrated health and community services on HIV/AIDS. In Uganda, for example, the involvement of FBOs and religious leaders in the national response to HIV/AIDS was a deliberate national policy. As a result, FBOs have been a crucial partner in the scaling up of local response, since, among others, the outreach of FBOs in rural areas is unequaled. In Ghana, a Catholic Pastoral Outreach Center has been a crucial ally to provide support for orphans and care and support activities for PLWHA.

49. *The involvement of the private sector in local response activities remains a challenge.* In most MAPs, the involvement of the private sector has been challenging. Private firms were hesitant, as they did not know how to work with the national AIDS programs. However, private firms are now increasingly mobilizing their own resources, and are mainly asking the National

¹⁹ World Bank, *Turning Bureaucrats into Warriors, Preparing & Implementing Multi-Sector HIV-AIDS Programs in Africa, Preparing and Implementing Multi-Sector HIV/AIDS Programs in Africa*, 2004.

AIDS Committees to create a supportive context, to provide clear national strategies for example on access to ARV. Many firms are now well ahead on prevention, care and support for their staff and the MAP projects can use these best practices present in all countries as examples for other private firms.

50. *Communities have to take responsibility to ensure results and quality activities at the local level, using simple M&E indicators and methodologies.* In Cameroon, for example, the Bank Task Team introduced "report cards," for the community to evaluate the usefulness of activities, grant management, and quality of services from supporting organizations. These often resulted in changes to CAPs. In Eritrea, where the Rapid Results Initiative was introduced, very simple M&E indicators were created, due to the need for a baseline to track results (and not activities). By pushing down the level of accountability to the local level, the increased feeling of ownership helped unleash local capacity.

Action Plans

51. *"Open" Action Plans can be tailored to a country's needs and experiences.* The issue of open, unlimited initiatives to be funded can be a big challenge, but through the "learning by doing" approach, countries adapt the rules according to the identified difficulties. In Cameroon, some limitations on the type of activities that can be funded (e.g. Income Generating Activities except for PLWHA Associations) have been introduced, without imposing too many restrictions, and guidelines were provided on the most effective activities. In Ghana, priority areas are announced for each round of invitations for proposals. In The Gambia, action plans are open: a beneficiary can prepare a plan for a year or more, and funds are disbursed based on reports and M&E. Fiduciary monitoring is based in quarterly reports and the next disbursement is not done unless the recipient accounts for the previous quarter.

52. *An in-depth situational analysis make CAPs more successful.* Given the flexibility for local communities in the development of their local HIV/AIDS Action Plans, a participatory situation analysis -- identifying the real causes of HIV/AIDS, needs and possibilities of the community to decrease the propagation of HIV/AIDS and mitigate its impact -- is essential to avoid superficial and inefficient action plans. As such, intensive and refresher training in participatory situation analysis is crucial and should be the part of government action plans.

Activity Content

53. *Making the shift from activities in the area of IEC to behavioral change and service delivery to support families affected by HIV/AIDS can be challenging and will require more technical assistance.* Initial mobilization of local communities to respond to the HIV/AIDS epidemic using IEC has been relatively easy, such as in Burkina Faso, Ethiopia, Ghana, Kenya, and The Gambia. Moving towards behavioral change and care and support activities, however, requires more technical assistance and new incentives for the selection process of community subprojects. In The Gambia, for example, to increase behavioral change and service delivery activities, the golden rule of two new subprojects on behavioral change and service delivery activities for every sensitization project has been adopted. In Burkina Faso, a curriculum for social workers (Auxiliaire sociale) is being developed to ensure increased, but affordable, technical assistance to the local communities for, among other things, needs assessments related to services for the community to support PLWHA and their families.

54. *When moving from IEC to Behavior Change Communication (BCC) and care and support services, larger NGOs need to be part of the referral system.* While local communities

often can implement IEC activities themselves, they need continuous support from larger NGOs when moving to BCC activities and care and treatment services, such as providing support for HIV/AIDS orphans and ARV treatment. Larger NGOs and governmental services need to be part of the referral system to complement the absorbing capacity of communities, both at the technical and financial level. (See for example the Burkina Faso case study in Part 2).

55. *Combining social mobilization at the community level with increased access to Voluntary Counseling and Testing (VCT) and ARV has proven to be successful.* In Burkina Faso, for example, the community mobilization process was not conducted in isolation: the project also increased access to VCT and ARVs at the same time. The social mobilization process prepared community members for access to condoms, VCT and ARV, and these were readily available. In fact, the availability of condoms, VCT and ARVs reinforced the mobilization: people saw a way out of AIDS, because there was access to prevention methods and treatment. The relative success of some MAP projects can be attributed to the combination of improved access to tests and ARV with massive education, sensitization and mobilization to use these new health services.

56. *It is important to consolidate the linkages between the community actions plans and the health services.* National AIDS Committees are increasingly calling for an integration of health and community activities. For example, community health workers can serve as a link with communities, accompanying people to access VCT and ARV, following patients' adherence to treatment, assisting orphans and vulnerable children, and assisting families in coping with sick members.

57. *Currently, most developing countries have been reluctant to scale up treatment on a large scale.* To encourage greater attention to this issue, the International Development Association (IDA); the Joint United Nations Programme on HIV/AIDS (UNAIDS); the Global Fund to Fight AIDS, Tuberculosis and Malaria; and major bilateral donors have recently committed to increasing treatment. In addition, the WHO has declared access to ARVs a global health emergency, setting a target of treating three million people in developing countries by the end of 2005 (the "3 by 5 initiative"). In support of these overall goals and the "3 by 5" objectives particular, the World Bank is piloting the feasibility of scaling up existing treatment initiatives in three Africa countries (Burkina Faso, Ghana, and Mozambique) through a first major grant from the Regional HIV/AIDS Treatment Acceleration Project (TAP).

58. TAP will be patient-centered, to meet the treatment needs of PLWHA and their families within a continuum of five comprehensive elements, including community care and support, prevention of mother to child transmission and opportunistic infections, and ARV therapy. Specifically, TAP would strengthen the foundation for treatment and increase the number of persons being treated through: (a) the development of services provided by associations of PLWHA in Burkina Faso; (b) the extension of company treatment benefits to include all members of the surrounding communities in Ghana as well as by the associations of PLWHA and NGOs; and (c) the expansion of treatment services provided by international NGOs within public sector health facilities in Mozambique.²⁰

Financial Lessons

²⁰ Source: Project Appraisal Document, *Africa Regional HIV/AIDS Treatment Acceleration Project (TAP)*, World Bank, May 2004.

59. *Simplified reporting back in fiduciary matters is needed for the small budget used by local communities.* Some MAPs established a threshold under which no receipts are needed but in which expenses are required to be reflected in an accounting book that is checked and confirmed by the community HIV/AIDS Committee. Ghana, for example, uses results-based contracts, i.e. service contracts signed with community groups on deliverables, making it more flexible for communities to implement their activities. In Burkina Faso, norm-based financing is used, at US\$1/person. A community will receive US\$1/person living in the community to implement its community action plan.

60. *Using external firms for financial management, monitoring and evaluation accelerates disbursement and facilitates financial control of resources.* In Kenya, for example, a local accounting firm was hired for financial management, monitoring and evaluation of the Community Initiative Fund, increasing and accelerating disbursement rates and improving financial control of resources. In Ethiopia, the lack of reliable accounting firms has contributed to the unattainable monitoring of resources of more than 7,000 woredas (districts) and kebeles (communities). It is evident that the countries that adopted such exceptional measures -- contracting out routine tasks – have performed better and more efficiently in fiduciary management.

61. *Communities need easy access to simple information on how to access MAP funding for local response activities, especially for CBOs and smaller NGOs and FBOs.* In some countries, a discrepancy in access to information exist between organizations (often bigger NGOs) familiar with project proposals, and other local, usually smaller, organizations with little experience on project proposals. Local organizations' proposals might not be selected due to procedural issues, although their proposals might be more valuable to the communities than larger, better presented proposals. In Ethiopia, for example, local HIV/AIDS committees post announcements about available funds in the communities themselves. On the other hand, in Ghana, the National AIDS Committee uses nationwide newspapers to ensure wide access to information about access to MAP funding.

62. *There is a need for affordable, financial control of small grants.* Some MAPs contract private firms to implement random audits of small community grants, while above a certain amount, budgets are automatically audited. Other countries introduced internal control systems such as report cards to control disbursed funds to the Community AIDS Committee and to improve effectiveness of the community action plan. Each project must find a balance between various tools, such as self-evaluation tools at community level and external controls. The use of penalties can be necessary in case of misuse of funds. Communication (for example on radios in Benin) on best practices provides benchmarks against which community members can assess their own performances.

Next steps

63. This first phase of MAP, which is still ongoing, focused on the “how to” question and on the process of creating the necessary institutions at all levels, including at the local level. The second phase of MAP will more directly focus on outcomes, on the measurement of real behavioral change, on increased access to VCT and ARV, and on integration of local responses and health activities. Health services will need community agents to monitor adherence to treatment and to create a supportive psychosocial and economic context for PLWHA.

64. While this paper focuses on the lessons learned of the implementation of scaling up local response, a next step will be to find instruments to measure the impact of local response in the

fight against HIV/AIDS. While communities can measure some progress, such as the number of people tested, including pregnant women, and the number of orphans cared for, there is a need to develop instruments to compare impact of local response between different communities and region, including a cost-effectiveness analysis.

65. Other steps that should be undertaken in the near future are to stimulate exchanges between practitioners, in MAP, on the most effective tools in local response; continue to mainstream HIV/AIDS in other products of the World Bank, such as PRSPs; and continue research on measuring the impact of local response on behavioral change, including cost-benefit analysis of behavioral changes.

Part II: Country Case Studies: Examples of scaling up approaches in MAP projects

1. BURKINA FASO: NORM-BASED FINANCING DIRECTLY TO VILLAGES

Context

66. Burkina Faso has the second highest HIV prevalence rate in West Africa – 7.2% in 2002.²¹ Prevalence is significantly higher among the female population, especially among younger women. The government estimates a loss of \$25 million per year due to AIDS, roughly 0.5% of GDP for the past five years.²²

67. A community driven model to cover all villages and urban neighborhoods in one province was piloted under a Bank project completed in 2002. In the pilot project, provincial and local authorities demonstrated the capacity and commitment to mount an initiative of major scale, moving away from boutique approaches to HIV/AIDS. Communities proved capable of preparing, implementing, and managing funds put directly into their hands.²³ In nine months, the pilot funded close to 600 micro-projects worth US\$175,000 and covered over 90% of the population in Poni province.

68. A major innovation was the commitment to cover all ten departments and all villages and urban neighborhoods of the province and to use the government's own deconcentrated administration to coordinate, manage and follow up the project. A pivotal feature of the community driven approach was the fact that proposals for village-level projects were based on a very simple questionnaire and given a maximum ceiling. This innovative pilot is now being replicated in thirteen provinces under the follow-up HIV/AIDS Disaster Response Project, the Burkina Faso MAP. Approved in July 2001 and effective in March 2002, the Burkina Faso MAP has a budget of \$22 million to assist the government in implementing its 2001-2005 HIV/AIDS Strategic Plan, 21.8% of which is designated to the Local Response (LR) component.²⁴

The Local Response Component

69. Burkina Faso's MAP is the closest expression of a MAP country applying the CDD approach. The CDD approach was chosen primarily because the largely rural population has proven difficult and costly to reach with larger NGO-driven interventions. The LR relies entirely on local actors and existing decentralized institutions, emphasizing community empowerment via training and quick disbursement.

70. Burkina Faso used "beneficiary assessment" in its MAP preparation, to assess the value to the community of planned and ongoing activities. Beneficiary assessment is a tool for improving the quality of development operations; its objective is to assess the value of an activity, as the affected people perceive it. Beneficiary assessment combines qualitative and quantitative techniques, deriving data from observation, conversation and open-ended discussions with groups

²¹ World Bank, "Burkina Faso: A Community-Driven Approach to HIV/AIDS," *Findings* #213, August 2002.

²² Country Brief, June 2004.

²³ World Bank, "Burkina Faso: A Community-Driven Approach to HIV/AIDS," *Findings* #213, August 2002.

²⁴ Project Appraisal Document, Burkina Faso HIV/AIDS Disaster Response Project, June 2001.

of beneficiaries and other stakeholders. Attempts are made to provide balance by ensuring that the responding population constitutes a representative sample of relevant interest groups.²⁵

Implementation arrangements of local response component

The Burkina Faso MAP project is managed by the Project Management Unit (PMU) based in the Ministry of Economy and Finance, which has a proven track record in managing disbursement. Villages send proposals to a provincial HIV/AIDS technical team with multi-sectoral representation. There are also ten departmental, 600 village and twenty sectoral committees to assist the approval and execution of micro-projects.

A PMU committee issues an order of payment directly to local committees' accounts. Despite skepticism at the national level regarding local capacity, the Bank insisted on direct disbursement of funds to village communities and urban neighborhood committees. The PMU contracts local organizations to train village committees in situation analysis, project planning and implementation, and training of trainers.

71. The Community HIV/AIDS Sub-Projects component aims to empower local communities in their IEC, care, OVC and activities for other vulnerable groups, particularly women. The component also funds training and technical capacity building. The LR component includes social mobilization, in which specifically selected community representatives attend LR training. After this training, the community representatives prepare and ensure community support for sub-projects, which are then submitted to their provincial AIDS committee. Funds then flow bi-annually to communities from the central level.

Scaling Up

72. By May 2003, HIV/AIDS committees had been set up at the provincial, departmental and village level in the twelve participating provinces, with 15,000 people receiving cascade training on STIs/HIV/AIDS and preparation of sub-projects. A year after the effectiveness date, communities from three provinces had submitted and received funding for sub-projects.²⁶ By December 2003, 2,000 sub-projects in eleven provinces had been funded.²⁷

Costs

73. According to the Project Appraisal Document (PAD), sub-projects should cost between US\$0.60 and US\$1.00 per capita annually. As of May 2003, 20.4% of the total IDA credit had been disbursed.²⁸ As of November 2003, 37% had been disbursed.²⁹

²⁵ Source: Cook, C., Multisectoral HIV/AIDS Projects in Africa: A Social Analysis Perspective, ESSD Network Paper No. 43, June 2003.

²⁶ Project Status Report 5/23/2003.

²⁷ TTL Timothy Johnston, BTOR and Aide Memoire 12/2003.

²⁸ Project Status Report 5/23/2003.

²⁹ TTL Timothy Johnston, BTOR and Aide Memoire 12/2003.

Lessons Learned

74. The following lessons were learned during scaling up:
- Innovation, creativity and initiative among project coordinators at different levels provoked a learning cycle and ongoing search for effective solutions adapted to the local situation.
 - Sidestepping intermediaries and disbursing money directly to villages avoided high costs and empowered communities. Learning from the pilot project helped address delays in disbursement in the subsequent expansion to thirteen additional provinces.
 - The community-based process was made smoother by clear norms regarding the selection of trainees and committee members. Communities also clearly understood the guidelines for the selection of projects, with the use of a simplified questionnaire as the application form and straightforward budget limits.
 - Crucial to the structure and success of this project was reliance on existing political and administrative authorities and institutions at the central, provincial and district levels.

2. CAMEROON: THE CASCADE APPROACH

Context

75. Cameroon's first AIDS case was reported in 1983. The latest HIV/AIDS surveillance results (September 2000) indicate an HIV prevalence rate of 11% among the sexually active population, representing an estimated 937,000 infected people.³⁰ In 2004, an estimated 650 people are newly infected with HIV in Cameroon every day. The Cameroon MAP is a large project (\$50 million over four years) in a medium-sized country (15 million inhabitants). The project, as part of the first round of MAP projects, was prepared starting in 2000 and became effective in October 2001. After a concerted effort to work with and prepare participants, scaling up of local response took place in 2003.

The Local Response Component

76. The LR Component represents over 50% of the MAP investment, with an objective of reaching at least 300 CSOs and 3,000 communities in four years. The LR component has the same objectives as most MAPs: to support communities' efforts to prevent the propagation of HIV/AIDS and to mitigate its impact. The PAD strongly emphasized community mobilization and the use of participatory tools in the preparation of CAPs, with inclusion of all groups (and special emphasis on traditionally vulnerable groups such as commercial sex workers, inmates, street children, and PLWHA) in planning and implementation of the activities.

Scaling up: The cascade approach used in Cameroon

77. The cascade approach used in Cameroon trained trainers who each trained more trainers, who then assisted communities in preparing and initiating their HIV/AIDS CAPs. The process started with the initial training of NGOs at the national level, then training of local NGOs at the provincial level, after which fifty NGOs in the ten provinces of Cameroon supported community mobilization. These communities in their turn supported the expansion of community mobilization to neighboring communities.

78. Contracted NGOs have only transitory technical assistance mandates, so they step aside once capacity has been developed at each respective level. The training NGOs are paid by the project, as an initial investment. Local organizations provide follow-up services -- the communities pay for these follow-up costs using up to 10% of the resources provided by the project under CAP annual grants.

79. The main actors are:

- A LR Specialist and his team of three staff in the NAC Secretariat.
- One LR specialist in each of the ten provincial units of the NAC,

Implementation arrangements of the local response component

The Cameroon MAP project is implemented by a specific public agency under the National AIDS Committee (NAC), chaired by the Ministry of Health; it includes a Central Technical Group (CTG), 10 Provincial Technical Groups (PTG) -- covering all provinces -- and a plan for 336 District Focal Points. At the national level, a section chief for local response and three senior staff are responsible for the local response component. At the provincial level, there is one provincial coordinator for support to local response, with responsibility for the development and implementation of HIV/AIDS strategies at the grassroots level. Facilitation of community participation is subcontracted to organizations already established in the field.

³⁰ Project Appraisal Document, Cameroon Multi-Sectoral HIV/AIDS Project, December 2000.

- Contracted NGOs at the national and provincial levels, and
- Community AIDS committees.

80. *Step one (3 months, starting January 2002): building a consensus on a first set of guidelines for community mobilization, and training lead NGOs at the provincial level:*

- The Local Response Specialist³¹ in the NAC prepared draft guidelines for community mobilization against HIV/AIDS. He based this draft on (i) experience from existing pilot activities by churches, NGOs, UN agencies, NAC itself (during project preparation) and other organizations; (ii) studying HIV/AIDS community mobilization programs in other countries; and (iii) exchanges with the Bank task team.
- The LR Specialist prepared terms of reference (TORs) for a lead national NGO. He also prepared TORs for ten provincial lead NGOs to launch the community mobilization process at the provincial level, and published an invitation for expression of interest.
- The LR Specialist and the Lead National NGO organized a workshop, inviting experienced and interested organizations, including NGOs, Faith Based Organizations, associations of people living with HIV/AIDS, and other CSOs experienced in community development and contributing to the fight against HIV/AIDS.
- At the workshop, the participants adapted participatory methodologies already well known in Cameroon to the case of HIV/AIDS and to various socio-economical settings, such as villages, urban neighborhoods, prisons, and unions. The participants finalized guidelines for community mobilization, as “version number 1,” recognizing that the guidelines would evolve through learning-by-doing. After the workshop, the local response specialist at the national level finalized the selection of lead provincial NGOs to launch the community mobilization process in each of the ten provinces, in parallel. As the Lead National NGO had completed its technical assistance contract, it stepped aside after the workshop.

81. *Step 2 (9 months): training NGOs and other organizations at the provincial level and launching the community mobilization process in 500 first communities, nationwide:*

- The ten lead provincial NGOs launched the community mobilization process in their provinces, with each organizing a one-week workshop for 80-120 participants, including local NGOs interested in supporting communities, local leaders and many organizations involved in the fight against AIDS.
- After their provincial workshop, each lead provincial NGO started supporting five first communities and, after two to three months, continued with another five communities. The activities in these ten first communities in each province were used as references, with good situation analysis, detailed action plans and performance indicators.
- Within a month after the provincial workshops, each PTG signed contracts with five provincial NGOs, to follow the models implemented by the lead provincial NGO. Each provincial NGO was to support twenty communities -- ten over three months and ten more over the following three months. At this point, most Lead Provincial NGOs had completed

³¹ Vincent Ngwet, Senior Rural Development Specialist, who already had a long experience in community development.

their technical assistance contracts and stepped aside, though some of them continued as implementing NGOs.

82. By following these steps, at the end of year one 500 communities had prepared action plans based on a participatory process, had received their funds and were implementing their action plans.

83. *Step 3 (the 12 months of 2003): community mobilization in over 3,000 additional communities.* The provincial local response specialists signed contracts with roughly ten additional NGOs per province, to launch community mobilization in twenty to thirty communities per NGO, in a gradual process of about ten communities per quarter. As a result, the total number of communities implementing action plans with the assistance of the project grants rose from 500 to over 3,000 communities by the end of 2003.

Direct Financial Support for CAPs

Communities received direct financial support from the program to assist with the implementation of their action plans after they: (a) went through the participatory process, (b) established their Local HIV/AIDS Committee, (c) elaborated their action plans, (d) obtained legal status, and (e) opened a bank account. The amount of support varies between US\$280 and US\$5,250 annually, depending upon a standard formula which takes into account the number of community members and their level of vulnerability to HIV/AIDS.

84. *Step 4: controls, consolidation, quality enhancement:* At the end of Year 2 (2003), the project and the World Bank team conducted a mid-term review. On the basis of this review, the provincial units slowed their expansion and are focusing during Year 3 on controls, consolidation and quality enhancement. The Year 3 objective is to move from 3,000 communities to 5,000 communities. The team revised the guidelines through learning-by-doing, and the following actions were taken:

- Putting in place a district AIDS focal person. As planned in the PAD, the NAC asked each district to appoint an AIDS focal person. By the middle of year one, the PTG used project funds to provide a motorbike and a small monthly allowance (for gas and small lump sum per diem) to 260 first focal points. The PTGs are planning to support focal persons in all 336 districts before the end of Year 3. The focal persons will support all kinds of local response initiatives, inside a coherent district HIV/AIDS action plan. The focal persons assist communities by linking them with health services and various programs such as food for people living with HIV/AIDS.
- Focusing on effective activities, based on simple result indicators used by the communities themselves. The national Local Response Specialist organized workshops every six months with the provincial local response specialists and lead provincial NGOs, where they consolidated the guidelines for community mobilization. They noted that some communities were not achieving results, for example in IEC or income-generating activities, so they introduced some limitations on the type of activities that can be funded, rejecting for example income-generating activities except for PLWHA Associations.
- They focused on concrete support to i) encourage community members to access voluntary counseling and testing, ii) provide home based care to chronically ill patients

and their families, orphans and widows, and iii) facilitate access to ARV.³² Simple indicators used by communities include the number of people tested for HIV; the number of patients, orphans and widows receiving support; the number of persons living openly with HIV; the number of deaths per year; and the number of pregnant girls below fifteen years old during the last two years.

- Using radio as a mass education tool to disseminate good practices of CAPs and build capacities. The provincial units (GTP) signed small contracts with local radio stations in all ten provinces, to broadcast weekly examples of communities achieving results in their HIV/AIDS activities. Then the national radio station broadcasted the best cases. The program is used to build a culture of transparency (in participatory processes in managing the grants) and “achieving measurable results.”
- Introducing "report cards" at the Community level. The Bank task team brought examples of report cards used elsewhere, and the LR specialist contracted a NGO with this experience in another country for a workshop. The participants designed a report card system for Cameroon, and immediately tested it with communities, with support from a Bank social accountability consultant. The provincial teams then trained the district focal persons, who assist their communities in organizing a community report card “voting session” every six months. The report cards evaluate the usefulness of CAP activities, grant management, and quality of services from supporting organizations.
- Experience from the first communities that conducted the vote is that communities quickly make changes in the often-weak first year committees and prepare more effective action plans for the following six months. The use of report cards appears to be a crucial ingredient in the scaling up methodology: with thousands of communities involved, it is hard to ensure good governance and results on the ground from outside; communities have to take more responsibilities at their level. From this point of view, rapid scaling up forced the pace of transfer of responsibilities to communities.
- Increasing controls: using penalties against problem communities and incentives for successful communities. At the beginning of Year 3, the NAC President (the Minister of Health) asked all levels of NAC staff to increase controls of CAPs. The project decided to stop funding about 20% of communities, to indicate that the community grants will only be used in communities using a participatory process. The external financial auditor, the financial management firm, the local response staff, and the focal persons are involved in this supervision effort. The NAC (or local authorities) have sent some NGOs or community leaders to court in cases of clear misuse of funds.
- In addition, the NAC allowed its provincial units to make small increases in the grants (maximum 20%), for communities striving to achieve results in a participatory way.

85. The combination of the above measures should improve capacities and achieve more results under the next CAP round. It is expected that many communities will mainstream their activities using their own resources, for example through “market provisions for the sick,” collected in kind in each market.

³² Both tests and ARV are subsidized by the project to facilitate access and are to be mainstreamed in the Global Fund Program by the end of 2004.

Costs

86. MAP Cameroon's initial investment was larger than other MAPs that immediately started to fund hundreds of communities. The main costs were:

- initial contract with one lead National NGO (one month, two senior staff)
- initial contract with ten lead provincial NGOs (six months in each of the ten provinces)
- initial contract with five NGOs in each province (total fifty NGOs)

87. During Year 1, the allocation for provincial NGOs was through a lump sum/result based contract for a NGO team (including PLWHA), for US\$600 per community that had received its CAP grant and started to implement it. This was only to launch the process, with most NGOs stepping out after launching the communities' action plans.

88. During Year 2, the process was launched, the methodology was clearly established as a reference and the NAC decided to reduce the amount of the contract to US\$200 per community. In isolated rural communities, the provincial units were allowed to continue the community allocation up to US\$600. Around the first communities other communities formed their committee and prepared their proposals without assistance from NGOs contracted by the NAC. These second-stage communities benefited from the support of relatives, friends or community workers involved in communities already implementing their CAP. This “snowball effect” was encouraged by the NAC -- community workers who initiated the process could provide follow-up services to the community for a small fee.

89. All above costs were only for initial start-up. Once a community starts implementing its CAP, the project only provides general follow-up by the focal person at the district level. The Community AIDS Committee can use up to 10% of its annual grant (average US\$200) to provide financial incentives to various external specialists to help to implement the CAP -- generally a nurse or community development worker. Furthermore, the Committee can allocate a maximum of another 10% to provide small allowances or awards to volunteers (not committee members) implementing the CAP.

Lessons learned

90. *“Open” Action Plans: some limitations are needed and an in-depth situational analysis is crucial.* The issue of open, unlimited initiatives to be funded proved to be the biggest challenge, but gradual improvement is tangible. Some limitations on the type of activities that can be funded (rejecting for example Income Generating Activities except for PLWHA Associations) have been introduced, without creating too many restrictions. Given the flexibility for local communities in the development of their local HIV/AIDS action plans, a participatory situational analysis -- identifying the real causes of HIV/AIDS, needs and possibilities of the community to decrease the propagation of HIV/AIDS and mitigate its impact -- is essential to avoid superficial and inefficient action plans. As such, intensive training in participatory situational analysis is crucial.

91. *Long preparation at the beginning of the project resulted in fast scaling up once local response activities were launched.* While the project took a long time to prepare its take-off, because of guidelines; building consensus on methodologies; identifying partners and training at the national, provincial, and district level; once launched nationwide it succeeded in scaling up rapidly in all ten provinces. After only two years of implementing the local response component, over 4,000 communities are currently implementing their CAP.

92. *Quality of CAPs through the fast scaling up process was limited at the beginning, but the process opened up the debate on HIV/AIDS in the communities.* Fast scaling up may limit quality and efficiency, but it allows communities to start thinking about HIV/AIDS, discuss the issue in the community and inside the family, and “set the stage for more elaborated actions by the community.” The adaptations of implementation manuals, increased controls on problem cases, incentives and penalties developed after two years of implementation of the local response component improved the quality of CAP.

93. *Combination of social mobilization at the community level with increased access to VCT and ARV was successful.* The community mobilization process was not conducted in isolation: the project also increased access to VCT and ARVs at the same time. The social mobilization process prepared community members for access to condoms, VCT and ARV, and these were readily available. In fact, the availability of condoms, VCT and ARVs reinforced the mobilization: people saw a way out of AIDS, because there was access to prevention methods and treatment. The relative success of MAP Cameroon can be attributed to the combination of improved access to tests and ARV with massive education, sensitization and mobilization to use these new health services.

94. *An NGO-driven process is costly and may be hard to scale u,p especially in rural areas.* The use of NGOs proves costly when intensive and thus can be difficult to scale up. In the case of Cameroon, the experience has been variable, with some NGOs transferring knowledge and stepping out as prescribed, and others trying to ask for more money.

3. ERITREA: THE RAPID RESULTS APPROACH TO ACCELERATE IMPLEMENTATION

Context

95. The HIV/AIDS prevalence rate among adults in Eritrea is estimated at 2.7%,³³ but this relatively low infection rate could rise exponentially.³⁴ The Eritrea HIV/AIDS, Malaria, Sexually Transmitted Diseases (STDs) & Tuberculosis (TB) program (HAMSET) is a \$50 million project over four years in a small sized country (4.3 million inhabitants). The project, as part of the first round of MAP projects, was prepared starting in 1999 and became effective in March 2001. In contrast to other MAP projects, the Government of Eritrea decided to combine Malaria and HIV/AIDS into one project.³⁵

The Local Response Component

96. The LR component, *Community Managed Response (CMR)*, represents 17% of the overall project. The component aims at identifying and validating community-managed, affordable, effective mechanisms for minimizing the transmission and impact of HIV/AIDS, Malaria, STDs and TB. Validated mechanisms will be replicated in other similar areas in Eritrea. The component consists of two sub-components: (a) Community Counseling and Support Groups, and (b) Community-Managed Response.

97. *Using the Rapid Results Initiative (RRI) approach to scale up project implementation.* The Rapid Results Initiative (RRI) is a management and implementation tool to jump start and scale up project implementation activities. The RRI concept is to take a large project and split it into a series of mini-projects, usually with a 100-day implementation period, with the completion of any one of these mini-projects constituting a measurable success. Implementation teams of RRI differ from traditional implementation teams in three fundamental ways: rather than being partial, horizontal and long term, they are results oriented, vertical and fast (see box below).³⁶

98. Per the request of the Government of Eritrea, the RRI approach was used to jump-start Eritrea's revised five year strategic HIV/AIDS Plan. The Bank Task Team introduced RRI in the Eritrea MAP with the aim of accelerating the implementation of the CMR component.

33 These numbers are based upon interim numbers from the Government of Eritrea.

34 World Bank, Eritrea, Malaria/HIV/AIDS, Project Appraisal Document, November 2000.

35 Ibid. The integration of HIV/AIDS and malaria was considered necessary for two major reasons: (i) as a means of achieving economies of scale; and (ii) disease-specific programs face a higher risk of failure when implemented in parallel.

³⁶ For more detailed information on the RRI, see Ronnie Hammad, et.al, *Turbocharging the National HIV/AIDS Strategic Plan in Eritrea: the Rapid Results Approach*; Nadim F. Matta and Ronald N. Ashkenas, *Why Good Projects Fail Anyway*, Harvard Business Review, September 2003; and Africa Region Debriefings Program, *Eritrea Rapid Results Initiative*, CD-ROM.

Basics of the RRI approach

Results Oriented The goal of a RRI is a measurable result, rather than recommendations, analyses, or a partial solution. This results orientation is important because (i) it allows project planners to test whether the activities in the overall plan will add up to the intended result and to alter plans if needed, (ii) it produces real benefits in the short term, and (iii) being able to deliver results is more rewarding and energizing for teams.

Vertical Project plans typically unfold as a series of activities represented on a timeline by horizontal bars. In contrast, a RRI encompasses a slice of several horizontal activities, implemented in tandem in a very short time frame. The term vertical also refers to a cross-functional effort, since different horizontal work streams usually include people from different parts of an organization. The vertical orientation is key to reducing “white space risk” (some required activities not identified in advance, leaving gaps in the project plan), and “integration risk” (that the disparate activities won’t come together at the end). RRI are not vertical programs in the sense of being run by just one Government Ministry – they are as multi-sectoral as activities in other National AIDS Plans.

Fast RRI generally last no longer than 100 days. While the RRI deliver quick wins, the more important value of these initiatives is that they change the way teams approach work. The short time frame fosters a sense of personal challenge, ensuring that team members feel a sense of urgency right from the start.

Scaling up

99. The main actors in Eritrea are:

- The Ministry of Health;
- Other line Ministries, including Education, Labor, Tourism, and Transport;
- Head of the Community Managed Response Component;
- Technical leadership provided by the head of the Central Zoba (a district);
- International consultants contracted to launch the RRI and give continuous support; and
- Local RRI coaches and implementation teams.

100. *Step 1. Identifying a senior political champion.* The RRI was initiated because the Task Team was concerned about the slow progress of the Community Managed Response Component. For example, in Central Zoba (one of 6 districts in Eritrea), only 7 out of 50 projects approved had been disbursed. The Bank team approached the Minister of Health and the head of the CMR to introduce the RRI to accelerate implementation of the CMR component and scaling up nationwide.

101. The Minister of Health had reservations about rapidly increasing the CMR component, since he perceived it as “throwing money at the community.”³⁷ However, the Government had recently approved a revised five-year Strategic HIV/AIDS Plan and the Minister of Health was impatient to see results and willing to take risks. As such, the Task Team and the Minister of Health decided to shift the focus of the RRI towards launching the newly developed Strategic HIV/AIDS Plan. The RRI initiative thus aimed to translate the focus areas in the National HIV/AIDS strategic plan into action through setting and achieving rapid results within the context of longer term strategic planning activities.

³⁷ Ronnie Hammad, et.al, *Turbocharging the National HIV/AIDS Strategic Plan in Eritrea: the Rapid Results Approach*.

102. Once the government agreed, a team was assembled with support from the Bank's Global HIV/AIDS M&E Team (GAMET) and the Multi-Sector Team Learning Initiative. External international consultants were hired to launch the RRI initiative in the country. As such, the 100-day initiative became the means to launch the strategic plan.³⁸ RRI are designed in waves (or rounds) to (i) achieve real results, (ii) build confidence and momentum, and (iii) facilitate the implementation of the overall strategic plan.³⁹

103. *Step 2: Launch the RRI in one district.* In February 2003, a two-day workshop was organized to launch the RRI in Asmara. Workshop participants included those who developed the strategic plan, those who would play a role in implementation, those influencing its directions and those who would be affected by it. They included representatives from various Ministries; religious groups; People Living with HIV/AIDS; students; vulnerable groups (e.g. commercial sex workers); and external partners such as UNAIDS, UNICEF, USAID, UNDP and the World Bank.

104. Workshop participants identified some priority areas to start implementing the Strategic Plan, with the idea of having some success in some areas before scaling up. Priority areas included (i) HIV prevention among high risk groups (CSWs and truck drivers), (ii) HIV/AIDS education for school children, (iii) expanding VCT services, (iv) safe injection practices, and (v) provision of home based care for PLWHA.⁴⁰ Self-selected teams were assembled to translate each area of focus into an initial 100-day-result-oriented goal, and a workplan to achieve it.

105. In between the start-up week and the 100-day mark, the local RRI coaches and strategic leaders participated in periodic video and/or telephone conferences to receive ongoing support and coaching from the international consultants to implement their respective RRI.

106. *Step 3: Scaling up the RRI.* In October 2003, the RRI approach was introduced in the Northern Red Sea (Massawa District) and in February 2004 in the Debub Zoba. In Debub Zoba, the process was orchestrated entirely by local coaches, with guidance from the National HIV/AIDS director and support from others who had spearheaded the RRI in Asmara and Massawa. While the project continues to receive occasional support from international consultants, the RRI approach has been institutionalized in the project and new RRI initiatives are supported by local consultants who facilitate the start-up of the initiatives.

Costs

107. The establishment of the RRI required the intervention of external catalysts. These costs can not be covered by the Bank Budget foreseen for project preparation and supervision. As such, the Task Team looked for external funding, such as support from GAMET and trust funds.

³⁸ Ronnie Hammad, et.al, *Turbocharging the National HIV/AIDS Strategic Plan in Eritrea: the Rapid Results Approach.*

³⁹ Aide memoire, Eritrea: HIV/AIDS Malaria, STDs, and TB Control Project (Cr. 3444-ER), Supervision Mission Jan.12-Feb 6, 2004 Aide Memoire, draft.

⁴⁰ Ibid.

Examples of Goals and Results from the first 100-day RRI	
Goals	Results
VCT Increase by 25% the number of users rating at least 8 on scale of 1-10 in terms of satisfaction with quality of services.	Weekly average number of VCT users jumped 80% 95% level of satisfaction of users.
Commercial Sex Workers Out of 100 CSWs, ensure that 20 occasional safe sex practitioners consistently practice safe sex and 25 of the others adopt and consistently use safe sex practices.	70 became regular users of female condoms, 35 have started using VCT services.
Safe Injections Eliminate all unprotected exposures (needle pricks, sharp objects and contaminated materials) among care givers in one hospital.	“Zero-tolerance” achieved, and 95% of staff received training in occupational safety.
Home Based Care Ensure that 25% of PLWHAs and their affected family members in two communities are provided with holistic home based care.	The Orthodox and Catholic churches provided home-based care to 132 PLWHA.

Lessons learned

108. *A limited number of local facilitators might delay the scaling up of the community-managed response.* In one region of the Eritrea HAMSET project, there were only two facilitators to cover a population of 800,000 and around 1,000 communities, resulting in a delay of scaling up of the local response component.⁴¹

109. *RRI can strengthen the Local Response Components.* While the RRIs did not focus on the Community Managed Response Component, the approach has nevertheless helped to strengthen the implementation and scaling up of the CMR component in areas where RRI have been undertaken.

110. *RRI fosters the need for simple, concrete M&E indicators.* The RRI created the incentive to develop simple and concrete M&E indicators. In order to track the results of each RRI, a baseline needed to be created. Each result from the RRI became an indicator in itself. In contrast to other, more abstract M&E indicators, RRI monitors indicators of results and not of activities (such as number of people trained, number of VCT centers built, etc.).

111. *RRI increases the feeling of ownership and helps unleash local capacity.* By pushing accountability down from the central level, local teams implementing RRI feel more responsible and express increased ownership of the local projects. As a result of increased accountability and feeling of ownership, capacity in the client system at the local level is often unleashed, which before was not used.

⁴¹ Aide memoire, Eritrea: HIV/AIDS Malaria, STDs, and TB Control Project (Cr. 3444-ER), Supervision Mission Jan.12-Feb 6, 2004, draft.

4. ETHIOPIA: BLOCK GRANTS TO SUPPORT LOCAL RESPONSE

Context

112. In 2000, one of every eleven people living with HIV/AIDS worldwide was an Ethiopian. With approximately 2.9 million adults and 150,000 children living with HIV/AIDS, Ethiopia has the third largest population of people living with HIV/AIDS in the world, after South Africa and India. Adult HIV prevalence rose from an estimated 3.2% in 1993 to about 10.6% by the end of 1999 – and about 5,000 Ethiopians became infected each week of the year 2000. If incidence does not drop, one-third of Ethiopians now aged 15 could die of AIDS.⁴²

113. Ethiopia was one of the first two MAP countries -- the US\$59.7 million Ethiopia MAP project received Board approval in September 2000. The project finances a three-year component of the Government's 2000-2004 HIV/AIDS Strategic Plan, and includes US\$28 million for community-driven HIV/AIDS initiatives.⁴³

The Local Response Component

114. Local Response (LR) features centrally in the Ethiopia MAP, reflecting the philosophy of the MAP overall, and serving as a reference to countries that later joined the Program. The LR component in Ethiopia comprises 46.9% of the project, with a first-year aim of both capacity building and expanding and accelerating existing prevention and mitigation programs. Since community-level management and disbursement of funds was largely untested, the Ethiopia MAP chose the "learning-by-doing" approach, with continuous on-the-job implementation lessons and scaling up of ongoing HIV/AIDS activities.

115. Relations between local government structures and local community governance structures are strong in Ethiopia. Local government consists of "woredas," district equivalents with a population of 100,000 people, made up of an average of twenty "kebeles" of 1,000 families (5,000 people) in each woreda. Woredas and kebeles are often used for governmental mobilization campaigns, and served as the basis for the HIV/AIDS local response component. Both woredas and kebeles have elected representatives, including a financial officer.

116. To provide grants for HIV/AIDS activities to communities, NGOs and the private sector, the project created an Emergency HIV/AIDS Fund (EAF) under the Project Coordination Unit of the National AIDS Secretariat (NAS). The aim of the demand-driven EAF is to expand the response of communities, NGOs and the private sector by channeling funds for multi-sector HIV/AIDS activities directly to them. The EAF has two windows: one for woredas, and one for NGOs and the private sector.

117. In order to receive a block grant from the EAF, a woreda needed to take the following steps:

- Attend an introductory workshop held by the NAC to explain the project and their participation in it;
- Form a Woreda AIDS Committee (WAC);
- Conduct a workshop for all of its kebele administrations;

⁴² PAD, August 2000.

⁴³ PAD: The overall project cost is US\$63.4 million, with US\$59.7 million from IDA. The Emergency HIV/AIDS Fund is allocated US\$28.1 million of the total amount, with US\$26.4 million coming from IDA.

- Appoint an HIV/AIDS Facilitation Officer (HFO), who would attend an introductory workshop organized by the Regional AIDS Committee or the EAF; and
- Send a representative to attend a second national workshop on financing.

118. The PAD outlined an expectation that at least ten percent of the country's 550 woredas will be added to the project each year, thus reaching 165 woredas (30%) during the three years of project implementation ending in 2004. The speed at which new woredas could be added to the project was to largely depend on their demand for assistance and capacity, i.e., if more woredas took part in the project, the pace of expansion was to be quickened

Scaling Up

119. The national launch workshop was held in February 2001, after which the NAS held regional introductory workshops for woreda administrators and health officers. Each woreda, with the support of the NAS and regional secretariat, trained an HIV/AIDS Facilitation Officer (HFO), who then trained Kebele AIDS Committees. Follow-ups of all the trainings were held when needed, with the process being repeated for new woredas and kebeles.⁴⁴

120. Woreda AIDS Councils and Kebele AIDS Committees informed communities of the existence of community funds and encouraged communities to submit an application, which required a broadly defined community, members who would be accountable for funds, and a broad proposal for the use of the funds. Applicants were required to present their application at community forums. Applications were approved by woredas, after which communities were required to submit a financial statement; keep basic receipts; and make regular, public updates at community forums. Project work is inspected by the Regional AIDS Secretariat. Through this simple mechanism, 2,000 communities were mobilized and received grants in the first 18 months of program implementation.

121. Through the process of introductory workshops, HFO trainings and kebele trainings, Ethiopia scaled up successfully during its three years -- as of June 2004, 263 woredas have been reached, and the 263 HFOs are working with 7,316 kebeles. Thus, the Ethiopia MAP was successful in reaching 54% of the estimated 13,500 kebeles at the end of three years. In addition, 73 nationally funded and 200 regionally funded NGOs are implementing their proposals through the second window of the EAF.

Costs

122. Kebeles are advanced \$1,000 in two tranches, as a start-up for project preparation through their respective woreda. Once approved by the woreda, a proportion of kebele funds, as determined by a work plan, are transferred from the NAS to the woreda, which passes these to the kebele. After the start-up funds, the kebeles prepare an annual HIV/AIDS plan of action. Upon approval by the WAC, funds are released in four tranches dependent upon the submission of quarterly reports to the WAC.

Lessons Learned

123. *Process management and accountability proved to be major challenges.* The Ethiopia MAP has had a problem of accountability in terms of tracing funds to their actual use. In particular, the monitoring of over 7,000 kebeles has been unattainable. This includes a difficulty

⁴⁴ Dr. Gebreselassie Okubagzhi, Senior Health Specialist, AFTH4, AFMET, in email of 6/9/2004.

with reporting, as well as a lack of trained accountants. In Ethiopia, there is a limited presence of international accounting firms, in contrast to the situation in other African countries.

124. *Government is reluctant to collaborate with NGOs.* Ethiopia's history of independence (no colonization) has led it to be wary of donors and international NGOs. NGOs have been used for technical support, and religious organizations have been especially important, but the relationship has been strained and time consuming.

125. *Disbursement was unsatisfactory and will be hard to complete before the project's closure.* The Ethiopia MAP retains \$25 million to disburse, including \$20.2 million from the EAF.

5. KENYA: HIV/AIDS COMMUNITY INITIATIVE ACCOUNT

Context

126. As of August 2000, close to 300 people in Kenya died daily because of AIDS – 80% of them between age 15 and 49 years. Throughout the mid-sized country, about 14% of all adults (15-49) were infected with HIV, with the prevalence rate rising above 20% in some districts. Of the roughly 2.2 million infected Kenyans, 106,000 are children under the age of five. At least 700,000 children have been orphaned through the loss of their mother or both parents.⁴⁵ Particularly distressing is the prevalence rate among young women, with 24% of women aged 15-24 infected.⁴⁶

127. The Kenya MAP was one of the first two MAP projects. Along with the Ethiopia MAP, the Board approved the Kenya MAP in September 2000, and Kenya was the first country to access funds, with the project becoming effective in January 2001. The Kenya MAP – named the Kenya AIDS Disaster Response Project, or KADRE – contributes US\$50 million to the partnership against HIV/AIDS in Kenya by supporting the Government's National HIV/AIDS Strategic Plan, with US\$30 million (60%) directed towards community initiatives.

The Local Response Component

128. The first two MAP projects introduced a new approach for addressing HIV/AIDS: supporting and strengthening community-based responses to the epidemic. Support to the implementation of initiatives from civil society, the private sector, and research institutions make up the third project component (for US\$30 million), with a specific aim of prioritizing community-driven activities. Three of the five priority areas of the National HIV/AIDS Plan – Prevention and Advocacy, Care and Support, and Mitigation of the Socio-Economic Impact -- include community mobilization for social change.

Local Response Implementation Structure: HIV/AIDS Community Initiative Account

The Government of Kenya declared AIDS a national disaster and established the National AIDS Control Council (NACC) in December 1999. Constituency AIDS Control Committees (CACCs) have the responsibility of coordination at the community level.

In addition to CACCs, NACC established an HIV/AIDS Community Initiative Account to increase community access to financial and human resources for sub-projects that the communities identified, prepared, and maintained themselves. All 210 constituencies in 68 districts have been eligible for support from the account, through a standard application form submitted to the CACCs, which have approval authority for projects valued up to US\$5,000 equivalent. A Technical Committee of the NACC Secretariat helps review the community proposals that have a higher monetary value. The financial management, monitoring and evaluation of the account were contracted to a Kenyan accounting firm.

Communities manage the sub-projects themselves, supported by NGOs, CBOs, PLWHA groups, and religious organizations.

⁴⁵ Project Appraisal Document (PAD), August 2000.

⁴⁶ 1998 Demographic and Health Survey, cited in the PAD.

Scaling Up Local Response

129. Partly because it was the first MAP, the process of starting up an effective community initiative component in Kenya took over eighteen months. The single most important reason was the lengthy procurement process of a Finance Management Agency prior to the operationalization of the component. Nonetheless, as of June 2004, the Kenya MAP disbursed funds to over 1500 CBOs and NGOs throughout the 210 constituencies, with the total grant amount reaching US\$8.8 million.

130. Many NGOs and CBOs are involved in the fight against HIV/AIDS in Kenya, and the Kenya MAP is also addressing the capacity of communities to plan and manage their own HIV/AIDS activities through training of community members in appropriate service delivery, e.g. home-based care and counseling. With the help of DFID, USAID, and UNAIDS, Kenyan NGOs, CBOs and Faith-Based Organizations have been trained at least twice in the areas of Policy Awareness, how to apply to the Community Initiative Account, financial and procurement Management, and monitoring and reporting.⁴⁷

131. The community initiative component was completely demand driven and no additional efforts were initiated to mobilize communities. However, very quickly after the start of the project it became clear that demand for financial support by far exceeds the supply, mainly because of cash flow limitations. This is most pronounced in high prevalence areas and in areas where community initiatives have been financed in the past through other agencies. In low prevalence areas and places where such initiatives have not been financed in the past have a much slower rate of uptake and scale up (especially the Northern Province, North Eastern Province and the northern part of Rift Valley Province).

132. Although the community initiatives are spread throughout the country and each constituency, challenges remain for the scale up of the community program. Apart from the number of community initiatives, these challenges relate to the geographic coverage of initiatives, the lack of focus on some high priority areas (e.g. the prevention of HIV infection among young girls), and the quality of the community interventions.

133. With the transformation of CACCs from a volunteer structure into an entity with a permanent and enumerated secretariat it is expected that these changes will provide better opportunities to address these challenges.

134. *Close monitoring and evaluation:* The Kenya MAP is designed to have intense implementation support and supervision, with additional assessment through a formal semi-annual program review by the NACC. Key performance indicators for the 210 constituencies at the community level include:

- The proportion of constituencies submitting at least three proposals to the Community Initiative Account (with an aim of increasing the number between Year 2 and Year 4); and
- Desired increases in assistance in care of PLWHAs and orphans, peer education, and VCT.

An evaluation of the distribution of the content and expenditures of the financed community proposals is done on a regular basis and data are published in two major national newspapers every six months.

⁴⁷ Voetberg, Albertus, BTOR 10/11/2002.

Lessons Learned

135. The following lessons were learned during scaling up:
- The NACC in Kenya has worked well as a conduit for financial support to community initiatives.
 - The partnership with the Kenyan accounting firm for the financial management, monitoring and evaluation of the HIV/AIDS Community Initiative Fund to a Kenyan accounting firm was successful. The firm received requests once the community proposal was approved – this system proved to be efficient.
 - The Community Initiative component of the Kenya MAP has been instrumental and very successful in “breaking the silence” on HIV/AIDS and expanding the involvement of civil society in the national response to HIV/AIDS.
 - With a countrywide involvement of CSOs in substantial numbers the issues of transparency and accountability can only be effectively dealt with at decentralized level.
 - The experience of the involvement of Members of Parliament in mobilizing communities to respond to the epidemic is mixed. While their potential and leadership in this regard is recognized and appreciated in some constituencies, in others their involvement has been interpreted as interference.
 - The initial mobilization of communities to respond to the HIV/AIDS epidemic is, in relative term, easy. To improve both the quality of the initiatives and the co-ordination of the civil society response is a far more complicated challenge.
 - It takes leadership and guidance from the NACC to have stakeholders, including communities, to focus on high priority areas such as HIV prevention among young girls, OVCs and HIV prevention and counseling among married couples.

6. UGANDA: THE ROLE OF FAITH-BASED ORGANIZATIONS

Context

136. Adult HIV prevalence in Uganda declined significantly over the last decade, from about 18% in the early 1990s to 6.2% in 2003.⁴⁸ Uganda stands out as one of the few African countries that have reversed the spread of HIV. However, it remains one of the worst affected countries, with over 800,000 deaths and 1.1 million orphans since the start of the epidemic.⁴⁹

137. As with other MAP countries, Uganda's MAP supports the HIV/AIDS National Strategic Framework, with nearly half of the funding providing for Local Response -- of US\$47.5 million, \$10 million finances District initiatives and another \$10 million supports community initiatives. The LR component in Uganda is called CHAI, for Community-led HIV/AIDS Initiatives. At its start in January 2001, the Uganda MAP project was envisioned as a "war-like" effort: a scale up of activities far beyond previous small incremental efforts.⁵⁰

Local Response

138. Operational since July 2003, CHAI was designed and implemented to specifically assist communities to identify and address their needs in relation to HIV/AIDS: the aim of the component is to enhance community competence to develop and manage sub-projects within their means. Implementation and management of the CHAI sub-component involves a range of actors at national, district and community levels:

- The Project Committee Team (PCT) of the Uganda AIDS Commission (UAC);
- District HIV/AIDS Committees (DHACs), with a District Focal Person (DFP);
- CSOs; and
- Community Project Committees (CPCs).

139. With 20% of the project's funding, district initiatives contain training activities for community-based staff and leaders, including teachers, home-care givers, counselors, traditional healers and birth attendants, and rural extension workers. DHACs are charged with selecting, financing and supervising the community-led initiatives. In each district, a lead CSO promotes CHAI to community beneficiaries.

140. With another 20% of the funding, CHAI supports activities directly carried out at the community level. The CHAI Manual includes a list of eligible sub-projects, with streamlined approval and financing for a list of standard projects. Communities present their proposals to their DHAC, or to the PCT. The project is being implemented incrementally, starting in districts that already have HIV/AIDS workplans and scaling up after strengthening capacities. (The Bank had a District Health Services Project in Uganda from 1995 to 2001.) In addition, the project left \$5 million unallocated at the start, to be allocated to Districts or CHAI based on progress review and project needs.

Scaling Up

141. Faith-Based Organizations have been a crucial partner in Uganda's scaling up of Local Response. The outreach of FBOs in rural areas is unequalled -- communities in Uganda have a

⁴⁸ www.worldbank.org/ug/ctry_brief, 6/22/04.

⁴⁹ Project Appraisal Document, December 2000.

⁵⁰ Ibid.

long and strong tradition of community associations and community-led initiatives, and many FBOs are part of this tradition, with robust national umbrella organizations, and experience with donor-funded projects.⁵¹

The Role of Faith-Based Organizations in Uganda in the Fight Against HIV/AIDS



TB, STI and opportunistic infection management.

Most private not-for-profit (PNFP) health providers in Uganda are faith-based. They account for a sizable proportion of the health services delivered in the country and have as their prime concern the provision of services to the poor. This sector has expanded substantially, especially in rural areas, providing services at subsidized prices, thanks to the solidarity of sister churches and denominations. These providers are coordinated through umbrella organizations, such as the Catholic, Protestant, and Muslim Medical Bureaus and the Uganda Community Based Health Care Association.

As community leaders, FBOs and interfaith groups have committed themselves to support efforts already undertaken by governments and NGOs to provide information, prevention, and care. The *2004 World Development Report* suggests that with altruistically motivated providers the inherent pro-poor ethos can be banked upon if combined with regulation and support. Umbrella organizations can collect and make use of information to strengthen the pro-poor ethos and enhance self-regulation. They can also provide the much-needed additional managerial capacity so often wanting at the implementation level in a resource constrained environment.

Uganda involved religious leaders early on in the planning and implementation of national AIDS strategies, a mobilization that has been instrumental in the significant changes in the course of the epidemic. FBOs are acutely aware of the complex nature of the infection and the root causes that have fueled the epidemic (fear, ignorance, global socio-economic inequalities, marginalization of vulnerable people, poverty and gender issues).

142. CHAI necessitates training facilitators in participatory processes so that they in turn support CPCs in preparation, implementation and management of their sub-projects on a regular basis. As of April 2004, all districts had nominated and submitted to PCT three persons to be trained as ToTs, and all CPCs sampled for the mid-term review reported that they had been trained and that the training had improved their implementation and management capacity. In December 2003 (after two years), the CHAI had disbursed to 894 sub-projects in 30 districts. This increased by February 2004 to 1,937 CHAI sub-projects in 30 districts. An additional 55 Phase 2 CHAIs were funded by the end of March 2004.

143. However, by mid-term the CHAI had disbursed only 25.6% of the allocated funds, and the number of sub-projects was far below the PAD target. There is an increasing demand for services provided by community sub-projects (condoms, VCT), yet CPCs do not yet have the capacity to provide additional services.

⁵¹ Much of the below text box owes reference to: Hutchinson, Paul, 2001, "Combating Illness," in *Uganda's Recovery: The Role of Farms, Firms, and Government*, Ritva Reinikka and Paul Collier, eds., World Bank.

Lessons Learned

144. *Equity in funding and disbursement have been challenging.* While equity is one of the principles of CHAI, it was established that the funding mechanism has no inherent formula that evenly allocated funds -- to the thirty districts or to different types of community organizations. Thus, some districts are better trained and -- because they are assisted by local accountants and NGOs/CBOs -- are over-advantage in their project bid, although this allocation of grants does not reflect the real needs of the given districts. In particular the divide between the rural and urban districts is clearly reinforced. In addition, political limitations have limited the MAP team's approach due to politicization of the districts' choice.

145. Group discussions with CPCs and DHACs during the mid-term review found that the CHAI subcomponent supports three different types of community groups: a) previously existing CBOs, some of which are associated with larger NGOs; b) informal community groups; and c) newly formed community groups, many with political connections. The review showed that the CHAI appraisal process favors the well-organized CBOs and well-connected newly formed groups, at the expense of the smaller informal groups.⁵² In the mid-term review, CPCs stated that it takes an average of eight months to requisition and receive funds for the second installment. This delay seriously undermined community participation and initiatives.

146. *Problem with reporting back in fiduciary matters.* The Uganda MAP has had difficulty with 'adapting' flexibility, i.e. how to account for direct and indirect costs for which no receipt is provided. To remedy this, a \$1,000 threshold was established, below which no receipt was required. Instead, expenses are reported in an accounting book, made available for accountability upon request.

147. *Training is central for consistency in coverage, but needs to be improved.* CPCs have been trained in improved implementation and management capacity. However, trainings do not adequately address service delivery skills for home based care and psychosocial support including nutrition, counseling, and parenting. In addition, the duration of the training is too short considering the low literacy levels of CPCs, and there is a general lack of follow-up trainings. Moreover, those trained have not been able to adequately pass on the acquired knowledge to the rest of the members on the CPC.

148. *Technical supervision and monitoring strains District Focal Persons.* DHAC members -- particularly the DFP -- often provide technical support to CPCs concerning sub-project implementation and management, and this support has been given at all times and anywhere, even at funerals. This huge community demand has increased the workload of DFPs and negatively affected their performance.

⁵² Mid-Term Review of UACP, Draft Abstract on CHAI Program Component, December 2003.

7. GHANA: WIDE COLLABORATION

Context

149. In 1999, Ghana's National AIDS/STD Control Program (NACP) estimated Ghana's adult HIV prevalence rate at 4.6%. However, rates among commercial sex workers are as high as 82% in some areas. The Project Appraisal Document for the Ghana MAP shows an estimate of 126,000 orphans in Ghana, with the figure predicted to rise to over 250,000 by the end of this year (2004).⁵³

150. The Ghana MAP, called the Ghana AIDS Response Project or "Garfund," is contributing US\$25 million to finance four years (2001-2005) of the Government's Strategic Framework for HIV/AIDS. Garfund covers all activities not within the Ministry of Health's mandate, because the Ministry of Health has an ongoing Health Sector Program Support Project. Garfund's aim is to intensify multi-sector activities.

151. Lessons learned from past HIV/AIDS and STD projects were reflected in the Garfund design. One of the lessons was learned from Uganda, where political leadership was a key factor in the success of the program. Garfund conducted a communications campaign early on to inform potential actors about its objectives and strategy. A coordinated multi-sector approach has also been found to be the most effective in addressing the epidemic in other countries, and so was used in Ghana.

The Local Response Component

152. The largest component (US\$18.9 million) of Garfund is for Prevention and Care Services, with 75% of the component (US\$15 million) earmarked for non-governmental and community-based initiatives. Access to the Prevention and Care funds, for the financing of proposals, is available through three windows: a) line ministries; b) CSOs including NGOs, CBOs, trade and professional organizations; PLWHA associations; and Districts; and c) small CBOs and associations. The first two windows can fund projects up to US\$100,000, while "Window C" provides seed money up to US\$2,500.

Local Response Implementation Arrangements

The Ghana AIDS Commission (GAC) oversees Garfund, with responsibility for semi-annual proposal selection through a technical subcommittee, and for overall performance monitoring. The Secretariat implements the GAC's decisions, with responsibility for finances and administration, including the contracting of technical support. District AIDS Committees recommend Window C proposals to the Secretariat.

Scaling Up

153. Approximately 11% of the Prevention and Care funds are available for funding small contracts under Window C. The GAC has approved a total of 1,912 proposals to date.

154. *Step One: Capacity Building.* US\$2.4 million of Garfund was allocated for building capacity and enhancing the technical and managerial capacity of implementing entities to

⁵³ Project Appraisal Document, December 2000.

implement projects as well as sustain the process of scaling up. The training was subcontracted to pre-approved NGOs, who were monitored through beneficiary feedback and random site visits. All of the over 400 NGOs and CBOs currently involved in HIV/AIDS related activities have benefited from capacity building in the areas of financial management, basic procurement, proposal and report writing, monitoring and evaluation, as well as communication/behavior change. This has been done with considerable support from the Support to International Partnership against AIDS in Africa (SIPAA) program financed by DFID.

155. *Step Two: Calls for proposals.* Proposals from Window C required a statement of intent, a guarantee in the form of a declaration of joint liability signed by at least five unrelated community members, and some very basic information. The details of the requirements are spelled out in the General Operational Manual for MAPs. Three calls for proposals were given. By November of 2002, 339 proposals for a total of US\$484,520 had been approved. The 3,161 proposals in response to the second call for proposals were returned to the districts for approval and financing. Over 600 were financed, followed by 960 in the third call. This structure allowed for a phased implementation, and for a more rapid start-up, by allocating resources to projects ready to go. It also allowed the flexibility to modify funding priorities each cycle to reflect the perceived needs.

156. The basis of transparency under the community response is very good. Calls for proposals are advertised in newspapers with national circulation, and the GAC also publishes the names of the grant recipients. The districts are required to advertise the names of the beneficiaries at public places, while the CBOs are expected to publicize the receipt of the funds.

157. The MAP emphasizes a participatory approach in preparation of sub-projects. To insure that participation is broad in all cases, NGOs and consultants are being used as catalytic agents where necessary.

158. *Step Three: Approval and Disbursement.* Due to the high volume of work, it was agreed that technical and financial reviews would be outsourced to members of the project review and approval committees. Standardized screening formats based on the Bank-wide general operations manual for MAP were distributed to the district M&E focal points to help them process Window C proposals efficiently.

159. The GAC was advised that when a proposal includes significant procurement, the proposal should include a very simple procurement plan for the items for carrying out the activities. After initial problems with delays, the GAC agreed that, based on simple service standards, the approval process would not exceed 10 working days.⁵⁴

160. *Step Four: Implementation.* A number of issues have been ironed out since implementation began. The first had to do with delays in acquiring goods and services for projects. Under the project, the CBOs and NGOs were considered “grant recipients” and were required to follow good public procurement procedures. In the past, even after obtaining initial project approval for procurement, the CBOs sent individual purchase orders to the GAC, which approved them and sent an order to a bank. There was usually a big delay at this point. It was also noted that this system put an emphasis on the inputs for carrying out the activities rather than on the deliverables expected from the CBOs. The procurement requirements for small amounts (under \$2500) to CBOs have therefore been waived.

⁵⁴ Aide Memoire, October 2003.

161. CBOs sign Memos of Understanding (MOU), as do district chiefs. It was agreed that, where appropriate, these MOUs with community groups should be based on output/performance based contracts with: (i) a clear statement of activities to be carried out; (ii) Quality Assurance Plan and (iii) appropriate incentives and sanctions which encourage good and timely performance and discourage unsatisfactory performance. The TTL gave the GAC a sample of a service contract for their guidance.

162. Project review also noted a problem with inconsistency in IEC messages and the concern was that they would be confusing and send mixed signals. Garfund put in place a “clearing house” for approval of IEC materials. A third issue in implementation was the concern that social aspects of beneficiary communities were not being fully taken into account. To address this, a social assessment is underway. Lastly, review indicated needed next steps: scaling up implementation will involve prioritizing high prevalence areas, and moving toward care for OVCs and toward BCC over IEC.

163. *Step Five: Monitoring.* Over the course of the project, allegations of corruptive practices arose. Although investigation revealed that 95% of funds were used for their intended purposes, additional measures were put in place to discourage corruption. First, the financial audit for 2002 included detailed audits of a quarter of the implementing stakeholders under the first call for proposals. To further suppress corruption, the GAC trained and fielded a group of inspectors to assure that the implementing stakeholders existed and were carrying out activities funded from the Project. The GAC ensures that corrupt stakeholders are prosecuted efficiently to the fullest extent of the law.

164. About 70% of Ghana’s population has been reached through Garfund activities. The project’s success is due in part to a good 2001-2005 Strategic Framework, developed by the Ghanaian government in partnership with the Bank, and to good collaboration with partners. The CDD approach in Window C was untried but the government proved open to its use.

8. SUMMARY OF OTHER CASES: THE GAMBIA, CHAD, CENTRAL AFRICAN REPUBLIC

8.1 The Gambia: Results orientation and supporting self-empowerment

165. HIV prevalence rates in The Gambia are at 1-2% and a Behavioral Sentinel Surveillance (BBS) survey conducted in 2002 showed a high level of knowledge about HIV/AIDS in the population. At present the focus within the local response component of the HIV/AIDS Rapid Response Project (HARRP) is on shifting from IEC to BCC and service delivery. The most recent Project Status Report (May 2004) suggested a new “golden rule” of “two new projects on behavioral change for every sensitization project,” and committed to empowerment where vulnerability contributes to transmission, as in the case of women. (See box.⁵⁵)

Women Take Charge: A NGO begins with empowerment

In 1991, a group of women recognized the gender dynamics in health services. Beginning with only a one-room clinic and their own personal networks for communication, they organized themselves to improve health outcomes for women and later to combat the HIV/AIDS epidemic in their village. Today the Foundation for Research on Women’s Health, Productivity and the Environment (BAFROW) supports itself as a fee-for service network of clinics in three districts, with additional monies from grants, donations, and research contracts, and plans to replicate its programming in an additional three districts.

BAFROW offers services and preventive care to women, men and youth, with support systems that focus on economic and emotional well-being through entrepreneurial education, the use of culturally sensitive materials, and the active participation and involvement of beneficiaries. BAFROW describes its work as “multi-sectoral, multi-dimensional, holistic, participatory and people-centered,” and the Bank HARRP Task Team attests to the inspirational experience of witnessing ordinary citizens organizing and empowering themselves to make a difference in their communities from the grassroots up.

166. Local Response represents half of the total US\$15 million credit for HARRP activities. Of the US\$7.5 million credit allocated to LR, US\$3.5 has been disbursed and/or committed (43%). The LR component disburses through three tiers: 1) grants of about US\$500,000 each to three large consortiums of NGOs, 2) grants of about US\$150,000 each to nine medium sized NGOs, and 3) hundreds of smaller grants to small associations and CBOs. Proposals are approved by the NAS through coordinators who liaise between NAS’ Deputy Director and seven division/municipality committees.

167. In the Gambia MAP, scaling up is “everything needed to get the project faster than the epidemic.”⁵⁶ The need to scale up is pressing given the amount of funding as yet unspent. With a local currency drop against the US dollar, additional funds committed by the government, and Global AIDS Funds at US\$28 million requiring disbursement through the NAS body, expanding absorptive capacity is urgent.

168. As in other cases described in this study, low organizational capacity and unskilled human resources present a bottleneck in the fight against AIDS. The NAS will be hiring consultants to help strengthen its leadership role and operational capacity, and adding support

⁵⁵ Executive summary of proposal “Well Woman’s Clinic: HIV/AIDS Prevention” from BAFROW to the NAS.

⁵⁶ Interview with TTL John May, June 16, 2004, Washington DC.

staff to assist the coordinators. Other missing pieces that will receive attention in scaling up include: encouraging a culture of competitiveness, results orientation, and adequate monitoring and evaluation.

8.2 Chad: the Role of Microfinance

169. HIV rates seem to be declining in Chad,⁵⁷ and knowledge of the epidemic is at 97%. The fight against AIDS is therefore aimed at maintaining that edge through a focus on behavior change. The Second Population and HIV/AIDS Project builds on previous population work because many population activities, such as promotion of women's economic independence and reproductive health empowerment, address some key determinants of HIV transmission.

170. Although not part of the MAP, the Chad project, at US\$24.56 million, is structured similarly, with components focused around social marketing, strengthening the capacities of key ministries, supporting the implementation of the National Population Policy, and a local response initiative (the Social Fund) that disburses over a third of the total funding (US\$8.87 million) through a classic microfinance scheme as well as through grants.

171. Because Chad is twice the size of France with only 500 kilometers of hard-top road, a weak communications system, and three Project Unit Social Fund employees, the Chad project works under a two-tier system. The Project Unit sub-contracts with nine local and international NGOs with experience in different parts of the country (e.g. CARE and World Vision), which are paid for technical service such as supervision, project development and other technical assistance. A separate budget line funds community activities. Thus, no overhead goes to the NGOs, which has lowered the overall cost of activities and kept overhead costs to about 15%.⁵⁸

172. Research on microfinance shows that women have a track record of high rates of repayment. Approximately 5,000 women, equipped by training agencies, have benefited from a small loan (from the Chad Social Fund, or FOSAP), and 3,000 more have been enrolled. Though many projects recognize the empowerment of women as a key determinant in transmission rates, this project directly addresses the economic vulnerability that forces women to abdicate control of their sexuality.

173. About 50,000 people have been reached through the 380 grants disbursed for micro-projects. The government convenes an annual priority-setting workshop to determine which types of projects will be solicited, for example, projects which target high-risk groups such as youth, women and truckers through peer education, condom distribution, or care and support for PLWHA.⁵⁹

174. Communities are assigned NGOs (*projects dynamisateurs*) to supervise and assist them through the process. A central management committee made up of government ministries, NGOs and civil society representatives approves projects; money is kept in a bank account when one is available, and eventually is disbursed by hand, due to the lack of financial infrastructure.

⁵⁷ At least this is true where measurement has occurred – in the army (between 1995, 1998 and 2003) and at the nineteen sentinel sites (since 2001) where pregnant women come for care. A behavioral study is planned to determine why, and the government is planning its own national survey.

⁵⁸ Telephone interview with TTL Michele Liroy, 7/12/2004.

⁵⁹ A federation of fifteen associations created by PLWHA are now receiving support from FOSAP for income-generating activities and for the provision of counseling and prevention for other groups.

175. This project has helped educate and empower a post-conflict society whose capacity to organize and address its problems had disintegrated. Training, on a) incorporating as an association or CBO, b) opening a bank account, c) preparing a project proposal and balance sheet, and d) conducting peer education and cooperating in groups, has laid the groundwork for future development efforts in a country where human resources are scarce.

176. Because scaling up is a matter of hiring more people into the ranks of the six international and two local experienced NGOs, building human resource capacity is the main front in the fight against HIV/AIDS in Chad.

8.3 Central African Republic: Peer counseling and Community Health Workers

177. Local Response in the Central African Republic (CAR) has not yet been scaled up, but the country is nevertheless a good example of the fact that MAP has experience now that the World Bank did not have when MAP started in 2000. The CAR case shows that MAP has become more efficient, cost-effective and sustainable. CAR also highlights a rare combination of scaling up with quality, despite very scarce resources.

178. CAR is in non-accrual. Nonetheless, funded by a small (US\$15,000) grant mobilized by the National AIDS Committee (NAC), a youth peer counselor training project is in progress. NAC is working with ten women's associations with a nearly nationwide reach. The US-based organization, Advocates for Youth, has collaborated on the project – showing the kind of work in which NGOs are currently involved.⁶⁰

179. The question in CAR has been how to ensure quality results. NAC decided that in order to do this, they wanted to borrow the methodology of the best project in the world to change behaviors among the youth. They chose to emulate the Girl Guides in Kenya, a project that received an award at the 2002 International AIDS Conference in Barcelona, Spain. The NAC asked the Kenya Girl Guides to prepare a specific manual.

180. The objective of the youth peer counselor project is to build social capital through 5,000 girl community leaders, who will protect themselves against HIV and will support those already infected. The secondary aim is for the girls to act as community role models.

181. In this youth peer counseling project, NAC emphasizes high-quality, sustainable work – paraphrased by the CAR MAP TTL as, "we have very scarce bullets so we need a high-value result."⁶¹ Unfortunately, due to war, this planned project has not yet been fully implemented. All the participants have been chosen, and the main trainer is hired and standing by.

⁶⁰ See Advocates for Youth's website, www.advocatesforyouth.org.

⁶¹ Interview with CAR MAP TTL, Jean Delion, June 16, 2004.

Steps and Costs:

1. Training twenty Trainer of Trainers (TOTs) from ten womens' associations, mainly groups of people living with HIV/AIDS, and commercial sex workers. This phase costs \$7,000, for the training in the capital, and is subsidized by a gender fund grant (from the Bank and Norway).
2. Each pair of women from each association form twenty new pairs of Lead Peer Counselors, by training youth in their area who have been carefully selected from the associations' existing youth members. Ten associations thus multiplies into 200 Lead Peer Counselors. With a cost of \$500 per workshop, this phase costs \$5,000 – a lump sum is paid to each association as an advance, with final payment after the completed trainings.
3. Each lead pair forms five groups of peer counselors – the groups are located in different communities, so that they can act as catalysts and fill in their region as they spread their work. HIV prevention is taught like a self-defense course, with a self-defense kit, including a t-shirt for community acknowledgement. The lead pairs receive a small lump sum for their five groups (\$2 each, \$10 total). Each group is designed to be self-sustainable.

182. CAR also innovated in putting in place Community Health Workers to “accompany” community members to access and properly use care and treatment.⁶² Caritas (Catholic Relief Services) was already providing social support to the poorest in and around Bangui, using social workers, working through community associations around the Catholic Church. A small group of social workers, around Father Gauthier, were deeply shocked by the increased number of mothers dying due to AIDS, leaving many orphans behind them. As soon as Father Gauthier learned that some patients had been able to access ARV, he launched a pilot project to try to save some mothers presenting signs of HIV/AIDS, members of the communities in and around Bangui. With very few resources available, the Father concentrated the project on access to ARV. He mobilized the existing social capital (lively associations around the church in the communities); he trained three social workers on HIV/AIDS. The Church and Father Gauthier were initially very hesitant to start putting some mothers living with HIV/AIDS under ARV as they were not sure that they would receive enough donations to continue the treatment. But in September 2003, after the sister of a nun died, leaving eight orphans, the Father decided that the Church should not wait longer, he should start doing something.

183. The social workers became “accompagnatrices,” agents accompanying the patients and their families, and they gradually developed the following methodology:

- Identify the sick mothers with symptoms looking like AIDS. The nuns, mainly, identified sick mothers, while the Father disseminated messages of hope and solidarity at Church.
- Provide home based care and gradually prepare the sick mothers and their families, explaining that it is now possible to live positively with HIV.
- Accompany the mothers to meet with competent doctors, helping them to access food supplies (provided by the World Food Program that quickly mobilized large stocks of food for families of PLWHA), good treatments for opportunistic infections and, when needed, to access ARVs.
- The Father and the Church were able to use funds from Catholic Relief Services and local donations to pay for antibiotics, medical exams (very expensive for local people) and ARVs

⁶² The present case is based on notes provided by from the leader of this initiative, Father Yves Gauthier, in charge of CARITAS operations in Bangui. The authors are thankful for his willingness to share his notes and his experience at the early stage of his program.

for the first poor mothers. In mid-2004, as the Global Fund program was starting its support in CAR, access to care and treatment became easier.

- Visit the mother nearly everyday, mainly during the first months of treatment, to create a positive atmosphere in the family, to help the sick mothers to adhere to treatment and to follow up secondary effects (accompanying the mothers to meet the doctors, using portable phones to call the doctors in case of emergency).
- Assist the sick mothers to reinsert themselves in the community, including increasing their income, using small income generating grants.

184. By the end of 2003, the Father and the social workers were supporting twenty mothers, with 75 kids. By mid-2004, they were supporting fifty mothers, with 180 kids. With very limited funds to support some pilot activities, the local response team of the MAP project identified this project as a promising example, well inserted in existing social capital. The MAP is now supporting only key limited expenses: purchase of motorbikes for the three social workers, and provision of small monthly allowances (gas and small incentives). Other donors are contributing to the project: the World Food Programme continues to provide food supplies to the sick women for their families, the Global Fund is starting to provide access to tests and ARVs, Caritas continues to support the basic salary of the social workers and collects donations.

185. This type of approach illustrates the linkage between community mobilization and access to care and treatment: such initiatives allow mothers to access care and treatment, which has a direct impact on attitudes regarding HIV/AIDS, leading to behavioral changes. Like other interventions, these activities, alone, will not be enough to change all behaviors. But they are very cost effective in protecting many people's lives (mothers and their kids) and in creating role models of "living positively with HIV/AIDS." MAP support is limited to key expenses, allowing the MAP to scale up such support and reach thousands of communities (in countries where the MAP is fully effective, which is not, unfortunately, the case of CAR).

ANNEX 1: GUIDELINES FOR COMMUNITIES

Below is a list of MAP Task Team Leaders (TTLs) and Government officials who can be contacted for further information, or for copies of the listed documents on Local Response in each country. In addition, this paper's task team, led by Mr. Jean Delion, AFTS2, (and with the help of country teams) collected and can make available hard copies of Local Response component guidelines for the following countries:

Sierra Leone (35 pages in English)	Madagascar (65 pages in French)
Ethiopia (10 pages in English)	Nigeria (18 pages in English)
Chad (a total of 90 pages in French)	Djibouti (65 pages in French)
Mozambique (a total of 64 pages in English)	
Uganda (over 150 pages in English, including implementation and evaluation forms)	

Burkina Faso

WB Task Team Leader: Timothy Johnston, johnston@worldbank.org

Local Response Document:

"Manuel d'Exécution du Projet d'Appui au Programme National Multisectoriel de Lutte contre le Sida et les infections sexuellement Transmissibles," Novembre 2001, Ministère de l'Economie et des Finances, Projet d'Appui au Programme National Multisectoriel de Lutte Contre le Sida et les Infections Sexuellement Transmissibles Unité de Gestion (PMLS)

Contact: Monsieur Seydou Kabre, Coordonnateur du PA-PMLS, pmls@cenatrin.bf,

Cameroon

WB Task Team Leader: Jean Delion, jdelion@worldbank.org

National AIDS Committee Chair: Dr Leopold Zekeng, cnls@camnet.cm

Head of Local Response Unit in NAC: Marcel Bela, mbela78@hotmail.com

Local Response Document:

"Mise en œuvre du Processus Participatif de Lutte contre le VIH/SIDA par les Communautés a la Base; Guide Méthodologique de Formation des Formateurs," Ministère de la Santé Publique, Comité National de Lutte contre le SIDA Groupe Technique Central, Section Responses Locales.

Contact: Jean Delion, jdelion@worldbank.org

Chad

WB Task Team Leader: Michele Liroy, Mliroy@Worldbank.org

National HIV/AIDS Program Representative: Dr Hamid Djabbar, jabarhamid2003@yahoo.fr

Head of Local Response Unit in NAC: Habib Mahamat Abdel-Aziz, FOSAP (Social Fund) Administrator, fosap@intnet.td,

Project Coordinator, Project Coordination team: M. Mahamat Saleh Idriss

Local Response Documents :

- “Programme d’Activités Annuel (P.A.A.) Janvier-Décembre 2003,” Octobre 2002, Ministère de la Santé Publique, Direction Générale, Projet d’Appui au Secteur de la Santé, Crédit 3342 CD-IDA.
- Decision tree for navigating the health system for people living with HIV and AIDS [--under development]
- “Manuel de Procédures, Fonds de soutien aux activités en matière de population, (FOSAP),” Ministère de la Promotion Economique et du Développement.
- "Plate-forme d'initiation a la vie, Fonds de soutien aux activités en matière de population (FOSAP)," Ministère de la Promotion Economique et du Développement.

Contact: Michèle Liroy, Mlioy@Worldbank.org

Djibouti

WB Task Team Leader: Sameh El-Saharty, selsaharty@worldbank.org

National AIDS Committee Representative: Omar Ali, Executive Secretary, Executive Secretariat, omaryabeh@yahoo.fr

Head of Local Response Unit in NAC: Safia Houmed, Head of Unit for the Community Interventions Support, shoumed@yahoo.fr

Local Response Documents:

- “Unite d’Appui aux Interventions Communitaires, Manuel de Procédures, ” Comité Technique Intersectoriel de la Lutte contre le Sida, le Paludisme et la Tuberculose, Secrétariat Exécutif de la Lutte contre le Sida, le Paludisme et la Tuberculose.
- Decision tree for navigating the health system for people living with HIV and AIDS

Contact: Sameh El-Saharty, Sr Health Specialist, MNSHD, selsaharty@worldbank.org

Ethiopia

WB Task Team Leader: Anwar Bach-Baouab, Abachbaouab@worldbank.org

Local Response Document:

“List of Eligible Activities”

Ghana

WB Task Team Leader: Eileen Murray, emurray@worldbank.org

Local Response Documents:

- New form for proposals
- Approval checklist for proposals in disbursement manual

Kenya

WB Task Team Leader: Michael Mills, Mmills@worldbank.org

National AIDS Control Council: Dr. Margaret Gachara, Director

Madagascar

WB Task Team Leader: Nadine Poupart, npoupart@worldbank.org

Local Response Document:

“Elaboration de la liste des “meilleures pratiques” pour la lutte contre les IST/VIH/SIDA et détermination de leur niveau optimum par zone d’intervention, Juin 2003,”
Gouvernement de Madagascar Programme Multisectoriel de Prévention des IST/VIH/SIDA (PMPS).

Mozambique

WB Task Team Leader: Jacomina de Regt, Jderegt@worldbank.org

Local Response Documents:

- “Conselho Nacional de Combate ao HIV/SIDA (CNCS), Grant Management System Operational Manual”
- “Proposal Guidelines”

Contacts: Paul L. Janssen, janssen@xs4all.nl, CNCS Rua António Bocarro 106-114
Maputo, Mozambique, www.cncs.org.mz, T (1) 495 604/5 F (1) 485 001.

Nigeria

WB Task Team Leader: Francois Decaillet, fdecaillet@worldbank.org

Local Response Document:

“Guidelines with initial indicators for preparation of an operational manual; Operational Manual for the community mobilization fund; a component of the Multi-Sectoral HIV/AIDS program in Nigeria.”

Sierra Leone

WB Task Team Leader: Malonga Miatudila, Mmiatudila@worldbank.org

Local Response Document:

“Community and Civil Society Initiatives; Guidelines for the Community Groups,” Sierra Leone HIV/AIDS Response Project (SHARP) May 27, 2002.

Uganda

WB Task Team Leader: Dr. Peter Okwero, Pokwero@worldbank.org

National AIDS Committee Chair: Dr. David Kihumuro Apuuli, Director General, Uganda AIDS Commission, uac@uac.go.ug

Head of Local Response Unit in NAC: Mr. Stephen Kiirya, CHAI Implementation Specialist, Uganda HIV/AIDS Control Project, uacp@infocom.co.ug

Local Response Documents:

- "An operational framework for countrywide implementation of responses to HIV/AIDS, submitted to UNAIDS by the NAC on the District Response Initiative.”
- "CHAI handbook" (Community-led HIV/AIDS Initiatives)

ANNEX 2: GENERAL RESOURCES

Alliance, Reports, www.aidsalliance.org/docs/index_eng.htm

“Prevention: What makes it work”

“Enhancing the involvement of people living with HIV/AIDS”

“Training Material and Guides”

Behavior Change toolbox, The Change Project, www.changeproject.org

Center for Communications Program, Johns Hopkins University, Reports, www.jhuccp.org

“Reaching Youth Worldwide”

“Impact of the HEART Campaign: Findings from the Youth Surveys, 1999 and 2000”

“Managing Fear, Giving Hope: HIV/AIDS and family planning behavior change communication guidelines for urban youth”

Family Health International, Publications, www.fhi.org
<http://www.fhi.org/en/HIVAIDS/Publications/FactSheets/index.htm>

[Surveillance and Assessment Reports”](#)

[BSS Guidelines for Repeated Behavioral Surveys”](#)

[FHI/UNAIDS Best Practices in HIV/AIDS Prevention Collection”](#)

[HIV/AIDS Rapid Assessment Guide”](#)

“Behavior Change Communications Handbook”

“How to Create an Effective Peer Education Project”

“Assessing and Monitoring BCC Interventions”

“Meeting the Behavioral Data Collection Needs of National HIV/AIDS and STD Programs: a joint Impact/FHI/UNAIDS Workshop: Report and Conclusions”

“Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries”

“Findings from Behavioral Surveillances”

“Behavior Change: A summary of four major theories”

“HIV/AIDS Prevention and Care in Resource-Constrained Settings”

“HIV/AIDS Prevention, Care and Support Across Faith-based communities; An annotated bibliography of resources”, Faith-Based Organizations CD-ROM, To obtain copies: info@e-alliance.ch

Management Science for Health, <http://erc.msh.org/>

“The Health Manager’s Toolkit,” Manager’s Electronic Resource Center
erc.msh.org/mainpage.cfm?file=1.0.htm&module=toolkit&language=english

MEASURE Evaluation, Reports, www.cpc.unc.edu/measure/

“National AIDS Programmes: A guide to monitoring and evaluation”

“A New Tool to Focus and Monitor AIDS Prevention Efforts: The PLACE method”

“Monitoring National Progress with Composite Indices”

“Indicators for Monitoring and Evaluation of AIDS Programs”

“A Framework for the Evaluation of National AIDS Programmes”

Population Council, www.popcouncil.org

“The ABCs and Beyond: Developing an Operations Research Agenda and Comprehensive Behavior Change Approaches for HIV Prevention: Report from a Technical Meeting”

“The Impact of Life Skills Education on Adolescent Sexual Risk Behaviors”

Horizons AIDSQuest: HIV/AIDS Survey Library

Youth Survey Question Bank

“Peer Education and HIV/AIDS: Past experience, future directions”

UNAIDS, Reports, www.UNAIDS.org

localresponse@unaids.org

“Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on construction of core indicators”

UNAIDS Monitoring and Evaluation on-line Library

Summary Booklet on Best Practices Issue 2: “The International Partnership against AIDS in Africa”

“Surveys on Sexual Behavior”

“Sexual Behavior Change for HIV/AIDS; Where have the theories taken us?”

Paper on community mobilization, includes list of resources, published 1997.

http://www.unaids.org/en/other/functionalities/ViewDocument.asp?href=http%3a%2f%2fgva-doc-owl%2fWEBcontent%2fDocuments%2fpub%2fPublications%2fIRC-pub03%2fCommMob-TU_en%26%2346%3bpdf

“HIV, Health and Your Community; A guide for action,” by the authors of “Where there is no doctor”

http://www.unaids.org/en/other/functionalities/ViewDocument.asp?href=http%3a%2f%2fgva-doc-owl%2fWEBcontent%2fDocuments%2fpub%2fPublications%2fExternal-Documents%2fHHYC-Hesperian_en%26%2346%3bpdf

“An operational framework for countrywide implementation of responses to HIV/AIDS,” November 2000, The District Response Initiative (DRI), Proposal submitted to UNAIDS by Uganda AIDS Commission.

University of Kansas Community Tool Box www.ctb.ku.edu

USAID, www.usaid.org

“The ABCs of HIV Prevention: Report of a USAID Technical Meeting on Behavior Change Approaches to Primary Prevention on HIV/AIDS”

“Handbook of Indicators for HIV/AIDS/STI Programs”

World Bank, <http://www.worldbank.org/afr/aids/>

“Turning Bureaucrats into Warriors, Preparing & Implementing Multi-Sector HIV-AIDS Programs in Africa, Preparing and Implementing Multi-Sector HIV/AIDS Programs in Africa”

“Integration of Gender Issues in Selected HIV/AIDS Projects in the Africa Region: a baseline assessment”

“Local Government Responses to HIV/AIDS:A Handbook”

“National AIDS Councils Monitoring and Evaluation Operations Manual”

<http://www.worldbank.org/afr/hd/wps/Rep%2067%20-03042004.pdf>

http://www1.worldbank.org/hiv_aids/

http://www1.worldbank.org/hiv_aids/docs/M&E%20Manual.pdf

“A Social Analysis Perspective, Paper No. 43,” June 2003, WB Social Development Papers, Cynthia Cook in Collaboration with ACTAfrica Multisectoral HIV/AIDS Projects in Africa

http://imagebank.worldbank.org/servlet/WDSContentServer/IW3P/IB/2004/04/22/000090341_20040422095206/Rendered/PDF/282860SDP043.pdf

“Tools for Community Participation: A Manual for Training Trainers in Participatory Techniques”

<http://wbln0023.worldbank.org/Networks/PREM/PREMDocLib.nsf/58292AB451257BB9852566B4006EA0C8/A519A6B01CB325C4852567130004B6E6>

“Village Participation in Rural Development; Manual, Tools,” The African Network on Participatory Approaches -- Contact ACTAfrica for hard copy, khansen@worldbank.org

“Workshop on the Local Response to MAP, December 5, 2002; Intensifying Action Against HIV/AIDS in Africa” CDROM

“Seminaire du MAP Programme Plurinational de Lutte contre le VIH/SIDA en Afrique (PPS), Dakar Senegal, du 21 au 24 janvier 2003,” CDROM -- Contact: Bachir Souhlal,

Lead Social Development Specialist, MNSRE, BSouhlal@WorldBank.org

Community Driven Development:

<http://lnweb18.worldbank.org/ESSD/sdvext.nsf/09ByDocName/CommunityDrivenDevelopment>

Decision tree for assisting PLWHA, used by implementing CBOs in community projects

Contact: Michele Lioy, Sr Population Specialist, AFTH3, mlioy@worldbank.org

“Self-assessment framework for AIDS competence”

Contact Jean Delion for hard copy, jdelion@worldbank.org

World Health Organization

“Essential List of Laboratory Equipment and Supplies for HIV Testing,” 2002, Regional Programme on AIDS, World Health Organization, Regional Office for Africa.

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