Chapter 11

Scaling up Multisectoral Approaches to Combating HIV and AIDS

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Introduction

The AIDS pandemic is a global crisis with impacts that will be felt for decades to come, demanding massive responses at many levels. Such responses need to continue to be grounded in the three core pillars of prevention, care and treatment, and mitigation. But these responses need to be much larger in scale, far more broadly based, and better connected so as to better match the scale, breadth, and interconnectedness of the pandemic's causes and impacts.

Alarmingly, programs aimed at preventing the spread of HIV reach fewer than one in five people who need them (UNAIDS 2004a). Fewer than 12 percent of the 6 million people estimated to be in immediate need for treatment are receiving it (WHO 2005). Only a tiny fraction of households that are affected by the pandemic are receiving any kind of support. Programs aimed at combating the epidemic generally tend to be concentrated in urban areas.

This deplorable situation is not caused by lack of knowledge of what needs to be done in prevention, care and treatment, and mitigation. On many of these issues there are well-codified scientific and operational guidelines. A few such examples include guidelines on combating the epidemic among men having sex with men (Anyamele et al. 2005; UNAIDS 1998) and HIV/AIDS care and treatment guidelines for resource-limited settings (WHO 2004). Several small- and medium-scale programs are successfully addressing many other issues, such as home-based care for people living with HIV (PLWHAs) or support to street children.

The first part of this chapter focuses on challenges to scaling up. The second part discusses World Bank's experience with scaling up its multisectoral HIV/AIDS

initiative. The final part of the chapter illustrates models for scaling up multisectoral prevention and social protection programs to combat HIV and AIDS with a focus on the role of community-driven development.

If It Is So Urgent, and So Much Is Known, Why Is So Little Happening?

Is It the Excessive Cost of Scaling Up?

The annual global costs of scaling up such programs has been estimated by UNAIDS to be around US$12 billion in 2005, and perhaps doubling over the next 20 years in real terms (UNAIDS 2004b, 2005).[1] This compares to annual global military expenditures of $852 billion in 1999, of which developing countries spent $245 million. The annual total cost of agricultural subsidies of OECD countries, including the cost of OECD agricultural policies to their consumers, amounts to an additional $300 billion (OECD 2003). The issue of financing the expenditures to combat HIV/AIDS is not, therefore, a question of affordability but a question of willingness of the national governments of affected countries, and of public and private donors, to pay for the costs of fighting HIV/AIDS. Or to say it differently, there is a lack of political will.

HIV/AIDS: A Slow-Onset Disaster

Amartya Sen has long demonstrated that catastrophes that develop gradually do not elicit the same response as sudden catastrophic events (Sen 1981). Willingness to pay for dealing with the former is much more limited than for the latter, as the public and private responses to the 9/11 attacks and the tsunami in the Indian Ocean amply demonstrate. Other slow-onset catastrophes where action has been slow include hunger and malnutrition, global warming, loss of tropical forests, and depletion of a number of marine fisheries. On global warming, for example, the Kyoto protocol proposes only very modest action in developed countries, does not bind developing countries to any action, and has been rejected by the current U.S. administration.

Stigma

To understand the lack of political will in responding to the spread and impacts of HIV/AIDS, one must also look to the stigma associated with HIV/AIDS and to the religious controversies over sex education and the use of condoms to account for the lack of truly scaled-up action. Stigma systematically impedes scale up of effective HIV/AIDS response strategies. Stigma is internalized by stigmatized people,

preventing them from taking action when they could help themselves to deal with the epidemic (Aggleton 2000). More specifically, external and internal stigma:

- contribute to the spread of fear and false information
- prevent many people from seeking the knowledge they need
- impose untold psychological stress and suffering on people who are potentially or actually infected by the virus, on their families, and on their surviving orphans
- reduce the willingness of people to assist people living with HIV/AIDS (PLWHA) and may even lead them to inflict additional harm
- prevent many people from accessing the support, care, and treatment programs that already exist and therefore contribute to additional unnecessary deaths[2]

Stigma thus exercises its influence at the global, national, community, and individual levels and in the hearts of those infected and affected. Even after 25 years of the epidemic, stigma is still rampant, hindering implementation and scaling up of systematic harm reduction approaches. This has and will clearly lead to easily preventable infection with a deadly disease and therefore has and will continue to lead to a large number of clearly preventable deaths from AIDS.

The Challenges Posed by the Program Complexity and the Multisectoral Nature of the Fight against HIV/AIDS

The multisector nature of the HIV/AIDS response,[3] including provision of antiretroviral treatment (ART), poses a challenge to scaling up. As emphasized in the AIDS treatment guidelines of the World Health Organization (WHO), implementing even a treatment program involves many actors and organizations beyond the health professionals and clinics and hospitals for a comprehensive treatment strategy with the following components (WHO 2004):

- Voluntary counseling and testing (VCT) for HIV and regular monitoring of all who are infected
- Healthy living and survival skills, psychosocial support, nutrition, and so on.
- Prevention and treatment of opportunistic infections

- ART and the associated adherence support to the patients

- Prevention of mother-to-child transmission (PMTCT), including treatment of the mothers and infected family members (MTCT-Plus)

Even where ample financial resources for scaling up treatment have been provided, as in the case of Botswana, health sectors find it very difficult to do so on their own (WHO 2003). The most successful treatment programs, such as the one in Brazil, have mobilized capacities both inside and outside the public sector, in the private sector, and NGOs. And they have decentralized the financial resources all the way to the municipal level (Bacon et al. 2004).

The complexities of multisectoral development initiatives are widely recognized and well understood. The lessons from the integrated rural development approach have now paved the way to decentralized and participatory mechanisms of planning and execution, including a much broader range of actors from national to local levels (Box 11.1).

At the 2004 World Bank conference on local development, a consensus emerged that stresses that local development is a coproduction among communities, local governments, the sector institutions, and the private sector (World Bank 2004). Central governments and donors need to find ways to energize and help finance the local arena, so that these various actors can collaborate and be effectively coordinated. A step-by-step approach to scaling up such programs can be found in Binswanger and Nguyen (2006) (also see Box 11.2).

Such local and community-driven development programs have successfully been scaled up to national levels in Mexico, to the entire Northeast of Brazil, and to about half of Indonesia and are growing rapidly in many parts of Africa. And the approach has been integrated into the Multicountry AIDS Program (MAP) for Africa, in which more than half of the resources go to so-called community funds (World Bank 2004).

Scaling Up under the World Bank HIV/AIDS Programs in Africa

Funding and Disbursement

The Multicountry AIDS Program (MAP) of the World Bank for Africa was initiated in early 1999, with the first US$500 million tranche of the program approved by the Board of the World Bank in September 2000.[4] At the end of 2004 the MAP

Box 11.1 Lessons from Multisectoral Integrated Development Projects

Under the leadership of the World Bank in the 1960s, "Integrated Rural Development Projects" became a popular attempt to deal with multiple institutions and sectors involved in rural development until about the mid-1980s. The integrated rural development projects tried to create synergy between the different components of rural development. They relied on central sectoral agencies (such as agriculture, infrastructure, education, health) for the execution of the multiple components of the programs, which were designed in an integrated fashion by design teams rather than by the sectors. The approach failed all over the world and has been abandoned (World Bank 1988).

The first serious weakness of this centralized model was that it failed to mobilize the significant latent capacities at the local and community level and in the private sector. Subsequent decentralized and community-driven programs all over the world have demonstrated that latent capacities available at these levels are indeed very large (World Bank 2002).

Each of the sectors already faces formidable challenges in ensuring that its services reach the widely dispersed populations of their countries. They also have priorities of their own. When they were asked to implement additional projects for which they themselves did not develop priorities, they tended to use the additional resources to help implement their sectoral activities.

To coordinate integrated rural development projects, and to ensure that the sectors would implement the priorities agreed on at project preparation, central project units were set up and given strong powers to manage the financial resources to be used by the involved sectors. But coordinating complex programs in thousands of localities from the center posed nearly insurmountable information problems. It created additional bureaucratic layers, which slowed the disbursement of project resources and implementation to a crawl. The lesson from integrated rural development, therefore, is that it is difficult to scale up multisectoral programs by coordinating central sector agencies for implementation.[a]

In rural development, such centralized approaches have now been replaced with decentralized and participatory mechanisms of planning and execution, including a much broader range of actors. At the community and local levels, there are no insurmountable information problems. What needs

to be done and how to do it are often readily apparent, and the cross-sectoral coordination problems are reduced to manageable proportions. Moreover, accountability of service providers and contractors to local populations is easier to achieve than with distant agencies. Responsibility for setting priorities, planning, and execution is transferred to local development committees, which are usually associated with local governments and communities. Local governments and communities plan and execute their own projects using locally available implementation capacities, labor and materials, and matching grants from donors or their own governments. Communities and/or local governments are provided with block grants and/or conditional grants, which they have to match with their own resources in cash and in kind. They obtain training and technical services from government agencies, the private sector, and NGOs. The need for strong central support from the various sectors does not disappear, but the role shifts to the setting of policies and program parameters, standard setting and controls, cofinancing of the programs, facilitation and training, monitoring, and evaluation (World Bank 1997).

[a] At the same time that "integrated rural development programs" were in the ascendant, the multisectoral nutrition-planning paradigm was also dominant. Though advances were made in recognizing the multiple causality of malnutrition, the prescription of a single nutrition-planning unit with a mandate to somehow orchestrate the sectors in top-down, highly planned, multisectoral action plans that required complex coordination also failed.

supported national HIV/AIDS programs in 34 African countries. Total approved funding was US$1,088 million as subsidized International Development Association (IDA) grants and subsidized credits, of which about US$300 million had been disbursed by 2005. MAP has adopted the following principles:

- Empower stakeholders with funding and decisionmaking authority
- Involve actors at all levels, from individuals and villages to regions and central authorities
- Provide support in the public and private sectors and in civil society
- Encompass all sectors and the full range of HIV/AIDS prevention, care and support, and mitigation activities (World Bank 2004)

Box 11.2 Scaling Up Community-Driven Development (CDD): Key Lessons

- Overall, keep in mind and build on country context, institutional arrangements, capacity, and the triggers and different processes of scaling up. Build a library of well-documented context-specific experiences through good monitoring, evaluation, and operational research. Use these to advocate for improvements in the contextual environment.
- To sustain CDD, anchor it within existing contextual systems (government), frameworks (e.g., PRSP), and processes (decentralization), even where these may be imperfect. Ultimate aim is to weave and embed sustainable CDD in the national social, political, cultural, and institutional fabric. Donors and governments need to focus more on the institutions and processes to manage CDD programs (not the project per se) and on transformation or transition (not exit strategies). Community-driven is citizen-driven, not client-driven.
- Capacity is pivotal and is more than simply resources; it includes institutional arrangements, motivation, and commitment, which necessitate appropriate incentives at all levels. Capacity development takes time and resources but is an essential investment. The capacity and commitment of local governments, facilitators, and local leaders is particularly important.
- Learn by doing and by communicating, monitoring, evaluating, and changing. Learn from failure, but learn faster from success. Start with the positive (what is working) not the problem (what is not) and build on that. Be adaptive, flexible, and open to change. Anticipate and address trade-offs. Apply realistic time horizons (10- to 15-year, not 5-year, cycles).

Source: Gillespie (2004).

In each country, the IDA resources support the implementation of the national HIV/AIDS strategy and program. Financing can be used for any of the national program components and virtually all categories of expenditures including community grants, salaries, vehicles, condoms, and HIV/AIDS drugs. IDA resources can therefore be used by national HIV/AIDS programs to fund unfunded or underfunded components; that is, IDA acts as a funder of last resort.

The program finances both HIV/AIDS programs of central ministries and decentralized expenditures of NGOs, faith-based organizations, the private sector, local governments, and communities. Most programs have two separate funds, a "sector fund" and a "community fund," with the community funds typically accounting for more than 50 percent of the planned expenditures.

From the beginning it was recognized that one of the main objectives of the program had to be to develop the funding and implementation mechanisms that would allow the transfer of resources to thousands or tens of thousands of implementing organizations while maintaining financial accountability and ensuring quality programs. Fully developing the disbursement and procurement mechanisms that would be able to do this has been the major objective as well as a major challenge during the first years of program implementation. Based on the experience so far, a comprehensive generic operational manual has been produced that summarizes the best practices for designing and implementing a scaled-up response (World Bank 2004).

The community funds have typically been designed using the following principles:

- Build on available culturally adapted models. In most countries, and on virtually all components of the fight against HIV/AIDS, existing small projects and programs have had many years to develop culturally adapted best practices. Their staffs and volunteers can provide their insights during the design phase and training during the scale-up phase of programs.

- Identify all existing and latent capacities, design the programs so that they can participate, and obtain the necessary financial resources. These include local or district governments, government agencies and services, private firms, persons living with HIV/AIDS, community-based organizations such as PLWHAs associations, churches, producer associations, local chambers of commerce, and NGOs.

- Facilitate learning by doing rather than insist on fully developed capacities before granting funding.

- Rely on community participation and decentralized coordination. Within broad guidelines and priorities defined by national AIDS councils, local and district stakeholder AIDS committees plan and coordinate local programs. The committees assign responsibilities and resources for different program components as well as to local implementers such as communities, organizations, and services.

- Provide the HIV/AIDS funds to local coordinating committees as fungible block grants or envelopes that can be used for all components of the fight against HIV/AIDS.

- Once their proposals have been approved, directly transfer funds into bank accounts of all implementing organizations.

- Use simplified procurement mechanisms.

- Promote accountability. Transparent budgeting, disbursement, and accounting procedures need to ensure accountability to end users of the services and to the government.

- Encourage additional resource mobilization by providing resources as matching grants to implementing organizations and communities.

A recent interim review of the MAP finds that in less than four years, just over US$1 billion has been committed to 28 countries in Sub-Saharan Africa: one subregional project and eight additional country projects are in the final stages of approval (World Bank et al. 2004).

Implementation Experience

The review finds that in its concept and design, MAP has been a major achievement: It is the largest single commitment to HIV/AIDS ever undertaken by the World Bank. Disbursement levels under the program approach those of other health and social sector projects financed by the World Bank, but they are not nearly as fast as would have been necessary in the case of the HIV/AIDS crisis or as anticipated at the inception of the program.

Implementation experience has been mixed. The decentralized community components and the NGO components have been the most successful part of the program. "Community-based and targeted interventions managed by civil society organizations and visited by the review team were often inspiring" (World Bank et al. 2004, p. 16).

Over 50,000 communities in Africa have now been reached with financial resources. Significant capacity exists in civil society and the private sector to implement the program. Echoing the disappointment in integrated rural development, the sectoral components have been disappointing with almost identical action plans by the ministries focusing on the initial stages of workplace programs rather than on beneficiaries.

Other principal findings of the review were as follows:

> The objectives, approach, and design of the MAP Program have generally been appropriate. The original objectives are in the process of being realized. Experience with implementation of individual projects and subprojects has been mixed and often disappointing. However, most projects are new and need time to mature. The context for dealing with the HIV/AIDS epidemic in Africa has changed significantly since the Program was launched in 2000. Consequently, the future MAP program will need to become more strategic, collaborative and evidence-based. (World Bank et al. 2004)

The interim review stresses that most MAP projects are new. The six projects visited have an average age of 12.5 months. Perhaps the most important objective in the coming period will be to allow the new institutions and mechanisms created by the governments with Bank support to mature, ensuring that the fundamental mechanisms and systems are in place as noted above. In other words, the first priority is to stay the course (World Bank et al. 2004, p. 12).

The report notes that since MAP started four years ago the context has significantly changed, with other funders having committed significant resources.

> Under these changing circumstances, the future approach of the MAP Program will need to be more strategic. While retaining the very positive aspects of the current approach—flexible, client-driven, community-based and delivered through the civil society—the future Program should be an instrument to reinforce the national approach advocated by UNAIDS, referred to as "The Three Ones"—one national authority, one strategic framework, and one monitoring and evaluation system to manage the HIV/AIDS response. The MAP program is operating within this framework, and should encourage others such as the Global Fund and PEPFAR to adopt this approach. Working with other development partners, it can assist national authorities to build a more effective, accountable authority, revise the strategic framework and introduce a simple, manageable and useful M&E system for HIV/AIDS. (World Bank et al. 2004, p. 7)

Scaling Up Prevention

The desired outcomes of prevention programs include changes in sexual practices toward fewer partners, a single partner, delayed initiation of sex by youth, or absti-

nence and adoption of safer sex techniques, in particular condoms.[5] They also may include changes in community norms of male dominance and tolerance, violence, and abuse.

Parents and communities must accept that their children be provided with thorough sex and prevention education enabling them to protect themselves as and when they start to have sex. For women it involves giving them the self-confidence to demand condom use by their regular partners or husbands. Global experience suggests that AIDS education and awareness programs, although clearly necessary, rarely bring about behavior change without intensive participation by those whose behavior is to be changed (UNAIDS 2004a, Chapter 4). In rural areas of Africa, the most successful interventions required not only interpersonal communication but participatory involvement of whole communities, such as the model of TANESA, which was scaled up to all villages in an entire district.[6] As the following list of 10 elements of a comprehensive prevention program illustrates (UNAIDS 2004a), prevention programs not only need to approach behavior change from many different angles, but also include a number of additional elements:

- AIDS education and awareness
- Behavior change programs, especially for the young, those at higher risk of HIV exposure, and people living with HIV
- Promoting male and female condoms
- Voluntary counseling and testing
- Preventing and treating sexually transmitted infections
- Prevention of mother and child transmission
- Harm reductions programs for injecting drug users
- Measures to protect blood supply safety
- Infection control in health care settings
- Community education and changes in laws and policies to counter stigma and discrimination, and vulnerability reduction through social, legal, and economic change

Although it includes highly targeted interventions, MAP financed by the World Bank has taken a whole-population approach to prevention interventions. For this it has recently come under criticism, both by internal evaluations and outside publications (World Bank et al 2004; Mallaby 2004). The internal evaluators in particular stress that there are enormous variations in the nature and extent of the AIDS epidemic, that the qualities of the subprojects it supports are very mixed, and that the program could be improved by better taking these variations into account and focusing more on interventions that have the highest payoffs. Now that many countries are coming closer to having the implementation and financial mechanisms in place for scaling up the HIV/AIDS response, MAP has to deal with these criticisms. Without abandoning prevention efforts for the population at large, the third tranche of MAP became more adaptive and evidence-based in the choice of interventions to be favored.

There are a number of examples of prevention effort under MAP that have gone beyond mass communication and achieved coverage of other prevention methods to a significant scale, including in Ethiopia, Kenya, Ghana, and Burkina Faso. Within the broad MAP principles discussed above, they use somewhat different implementation mechanisms.

Design of a Community-Driven Multisectoral Prevention Initiative: Scaling Up in Burkina Faso

Burkina Faso has developed an approach for covering all villages and urban neighborhoods within each province with intensive prevention efforts including interpersonal communication and community participation. Under the Burkina Faso approach, provincial authorities have set up HIV/AIDS committees at the provincial level (as a subcommittee of the general provincial development committee), district level, and community levels (i.e., village or urban neighborhood level). Membership in these committees involves all stakeholder groups from government, the private sector, and civil society. At all levels membership in the committees is based on demonstrated interest of individuals to serve on them and on selection of the committees by actors at that level (CCISD 2002). After a successful initial pilot project in the particularly poor province of Poni in 1990, the program has been expanded to the 13 provinces with the highest populations. Eight thousand communities have received training and funds and used them primarily for prevention efforts.

Training the community committees in submission of proposals, setting up a bank account, financial management, monitoring, and the ABCs of HIV/AIDS and its prevention took a training course of two weeks. The volume of training required is huge. From each community two men and two women have been trained, and among them one adult and one youth. For the 8,000 communities already

trained, this meant training 32,000 community members. In addition, NGOs that want to support the program, local staff in the public and private sector, and all members of the district and provincial committees have to be trained, perhaps 300 people per province, or another nearly 4,000 people so far. Scaling up to the 44 provinces of Burkina Faso will therefore imply a total training effort of between 80,000 and 100,000. In the provinces covered so far, the resulting logistics problem was solved by cascade training, with a team of trainers of trainers at the provincial level, and training teams in each district. The provincial and the district committees put in place these training teams and supervise their work. The training teams usually consist of retired teachers and other government officials, educated spouses, and educated youth. In order to minimize travel and transport costs, they are all recruited in the district in which they work. It is a testimony to the significant latent capacities at this highly decentralized level that it has not been difficult to find good people to do this work on a part-time basis. All committee and training team members are volunteers and are paid a unified and low per diem for their training or workdays. They can be mobilized again for subsequent training efforts.

Once trained, community HIV/AIDS committees were given a budget envelope of US$1.00 per capita. They submitted a simple project proposal for funding to the district committee for a preliminary approval. The district committee then sent the set of approved community proposals to the province level for inspection and final approval. The same process was used for proposals from NGOs, the private sector, and local offices of government agencies such as education and health. Once approved, the provincial authorities gave their bank a disbursement order to transfer the approved budgets to the communities and other implementing entities.

The process evaluation of the pilot program in the province of Poni (CCISD 2002) has concluded that this novel approach has functioned well and indeed has been able to cover practically all communities in the pilot province. The cost of reaching one person with face-to-face HIV/AIDS and prevention education via this approach was about US$0.60 and that between 60 and 100 percent of the population was reached. There is as yet no evaluation available for the Burkina Faso approach of its impact on behavior and HIV transmission.

Scaling Up Social Protection

Many impacts of HIV and AIDS are revealed through the responses that individuals, households, and communities adopt. Some of these responses are examples of resilience, but many derive from distress. The first line of defense has been communities, many of which have responded in very innovative ways. Documented responses include labor sharing, orphan support, community-based childcare,

community food banks, credit schemes for funeral benefits, and new ways of reducing the time and energy of domestic tasks, such as fuel and water collection and food preparation (Mutangadura, Mukurazita, and Jackson 1999; Donovan et al. 2003; Drimie 2003; NAADS 2003; Gillespie and Kadiyala 2005).

Social protection interventions to combat HIV/AIDS can be targeted at vulnerable communities, families, or individuals. They include interventions to make them less susceptible to HIV infection as well as interventions to deal with the consequences of the disease itself. Examples include support to the production and income generation of vulnerable individuals and households so that they are less likely to have to engage in sex work or are able to recover from the loss of working-age adults, food and nutrition interventions, home-based care, assistance with schooling and health needs of orphans and other survivors, and outright cash transfers.

To maximize food and nutrition security in the context of HIV/AIDS the overriding dual principle should be to (1) augment community and household resistance and resilience as far as possible and (2) ensure there are safety nets in place for those who are unable to "cope" otherwise. The emphasis in mitigation strategy needs to be on strengthening resilience, the ability of households and communities to adapt livelihood strategies so as to bounce back from the shock of HIV/AIDS. Policy needs to draw on what is working already in communities where proactive responses are under way. Where households' and communities' capacity to "cope" has been exceeded, a broad-based social security system offering minimal benefits or specifically targeted welfare programs may in the short and medium term be important for mitigation. There is a need to move from an "individual-infected" model to a "community-affected" one and to focus on strengthening community capacity.

Thus, understanding community responses and capacities is a crucial first step in developing a long-term, comprehensive, and expanded strategy for social protection. Although there are several studies of community-driven responses to HIV/AIDS (Mutangadura, Mukurazita, and Jackson 1999; Foster 2002; Hamazakaza and Kauseni 2002; Hsu, Du Guerny, and Marco 2002; Silomba 2002; White 2002), there are only limited analyses of experiences in scaling up such initiatives (Phiri, Foster, and Nzima 2001; Hunter 2002; International HIV/AIDS Alliance 2002; Kadiyala 2004).

Although most social protection programs have been narrowly focused and adopt a service delivery model, the paradigm is slowly shifting. Kadiyala (2004) discusses how the Scaling Up HIV/AIDS Interventions through Expanded Partnerships (STEPs) initiative, supported by Save the Children U.S.A. (SC), in Malawi has evolved from a service delivery model to provide material support to orphans into a scaled-up community-driven multisectoral initiative (Box 11.3).

Box 11.3 Scaling Up HIV/AIDS Interventions through Expanded Partnership (STEPs)

Supported by USAID and Save the Children U.S. (SC), STEPs started in 1995 (then called COPE, Community-based Options for Protection and Empowerment) as a service-delivery program in one district in Malawi to assist children affected by HIV/AIDS. Through evaluations, SC realized such an approach was not sustainable, cost-effective, or scalable.

On the basis of recommendations from the evaluations and the field experience, the program revitalized the dormant decentralized AIDS committees (at the district, community, and village levels) and their technical subcommittees under the National AIDS Commission (NAC), in the Namwera community in Mangochi to mobilize collective action to combat the epidemic. Based in turn on the positive experience in Namwera, the program changed its initial strategy to that of an external agent for change, assisting communities with community mobilization and capacity building so that communities become empowered to act collectively to address their own problems.

Village AIDS Committees (VACs) identify the vulnerable and plan responses on the basis of the nature and magnitude of vulnerability within the villages, the needs of the vulnerable, and the capacity within the villages to respond. They also monitor the program's activities and mobilize resources. Because the needs of the most affected communities are multiple, the program has evolved into a truly multisectoral program, offering prevention, care, support, and mitigation activities. Through its experience with STEPs, SC has also influenced national policies related to HIV/AIDS and children. For example, it played a critical role in drafting National Orphan Care Guidelines and coordinated Malawi's first national child abuse study in partnership with the National Task Force on Child Abuse. Save the Children was also instrumental in formation of the Wills and Inheritance National Task Force. It actively monitors the orphans, widows, and widowers component of the National Strategic Framework. Through partnerships and training, other NGOs and CBOs (community-based organizations) in the program approach of community mobilization and facilitating collective action, STEPs, and similar models aim to cover 75 percent of Malawi's population.

Source: Kadiyala (2004).

Contextual factors that are critical for scaling up this community-driven model include an enabling policy environment with a strong commitment of the current government, especially NAC, to a multisectoral approach to combating HIV/AIDS. Organizational factors enabling scaling up include a well-trained and motivated staff; adoption of a community mobilization model through capacity building of district, community, and village AIDS committees; commitment to documenting and disseminating lessons learned; and reaching more affected populations through partnerships. Factors specific to communities include leadership within the community, whether the communities are urban or rural (rural communities are easier to mobilize), the nature of livelihoods, and the history and culture of the communities with respect to collective action. Planning along with the communities for a phasing down of SC's presence and scaling up of the role and responsibilities of the AIDS committees and funding mechanisms have also been identified as critical in enabling and sustainably scaling up collective action (Kadiyala 2004).

Important factors that threaten or limit the scaling up of STEPs include the magnitude of the epidemic, which is eroding community resources; recurrent food crises, which divert resources to sheer survival; the gap between the resources that communities need and what they have, which undermines the spirit of volunteerism; weak commitment of donors to a truly community-driven multisectoral response; and the overall context of poverty and underdevelopment, which makes it more difficult to mobilize communities and build their capacities to respond to the multiple challenges of the AIDS epidemic (Kadiyala 2004). The STEPs experience shows that scaling up multisectoral, community-driven responses to HIV/AIDS is possible but highly challenging. Building such responses in high-HIV/resource-poor settings is both resource- and time-intensive. But promoting community ownership and building local capacity is essential for action to be sustained. Using similar principles as the STEP program discussed above, Burkina Faso is currently preparing a social protection pilot for a truly scaled-up community-driven approach (Box 11.4).

Conclusions

There is significant consensus on how to prevent, mitigate, and treat HIV and AIDS, well summarized in recent guidelines and best practice papers of UNAIDS, WHO, UNICEF, and other organizations. Nevertheless, scaling up of actions recommended in these documents has been slow. In this chapter we conclude that the slow speed cannot be explained by absence of the required knowledge or by the prohibitively high costs of scaling up; scientific consensus exists in many areas, and the world could well afford the funding needed. Instead, explanations must be sought in the slow-onset nature of the catastrophe, the enormous stigma surrounding

Box 11.4 A Burkina Faso Proposal for Scaling Up Social Protection

When the Burkina Faso community-driven prevention program was first set up, communities were allowed to put in place social protection components. Few ever did, and it became clear that communities would not be able to do so on their own. Several barriers to community management of the social protection efforts need to be resolved. A learning-by-doing program to cover the entire province of Sanmatenga is currently in the design phase and trying to overcome these barriers.

1. Communities and individual families are already part of an informal, if inadequate, social protection system. But they do need additional resources and support to expand these informal mechanisms into a more systematic effort. These resources should be provided as matching grants to the communities, with the latter providing the matching resources in cash or in kind. Rural communities that are provided with cash to assist with health and education expenses will be asked to provide the food needed for their most vulnerable members, either in kind or in cash.
2. Although communities all over Africa are able to identify vulnerable families and classify them by degree of need, they are not able to carry out proper needs assessment for these families, a task that normally is done by a social worker. In Sanmatenga there are nearly 300 villages and urban neighborhoods but only three trained social workers, and there is no way the Ministry of Social Welfare can hire enough social workers to assist communities to do this job. The learning-by-doing program will therefore ask communities to select one or several members to be trained in basic family needs assessment and supervision skills, and they will then be remunerated via daily allowances for their work out of the community grants. The ministry is currently developing a curriculum and training program for them.
3. Assisting the chronically ill, orphans, and the families that take care of them will require significant additional training of enough community members to manage the tasks. These community members cannot work as volunteers for a long period of time and need to be provided with modest remunerations, such as per diems for every day they work or home visit they make.

4. The community members will encounter situations that they and the community as a whole cannot handle, such as medical emergencies or child abuse. To deal with these cases requires the putting in place of proper referral systems so that difficult cases can be handled by health professionals, social workers, or educators with the required skills. These same specialists need to be involved in designing and delivering the training and to be available for facilitation and training on demand.
5. The same committee structures that were used for prevention at the provincial, district, and community level, the same training teams, and the same financing mechanisms can be reinforced and used to coordinate, manage, and monitor the social protection program. In particular, the committees can coordinate and provide financial resources to the NGOs and local offices of the respective government services so that they can become the facilitators, trainers, and referral system.

Source: Hans Binswanger, personal observations.

HIV/AIDS, and the multiplicity and complexity of the actions required in the areas of prevention, care and treatment, and social protection.

Regarding the latter, we show that implementation of parallel vertical intervention by different central sector agencies is not a practical way of scaling up. Integrated rural development is the classic example of the failure of such a strategy. It floundered on the lack of real participation and buy in from the beneficiaries, the impossibility of centrally coordinating local actions of different sectors, the inability or unwillingness of sector agencies to deliver services locally according to an agreed and coordinated program, and the prohibitive cost of parallel service delivery mechanisms and personnel. The approach has been supplanted by local and community-driven development approaches in which implementation and coordination of many actions are delegated to communities and development committees associated with local governments, with the assistance of sector agencies and the private sector. Information at the local level is much more readily available, and therefore coordination at that level becomes feasible. The deep involvement of communities and existing local implementers sharply reduces cost, increases willingness to cofinance the interventions, and improves commitment and understanding of the programs.

The community funds of the Multicountry AIDS Program financed by the World Bank in around 30 countries of Africa have been designed along the lines of

this model. Early implementation experience, although not yet conclusive, shows that such implementation mechanisms can mobilize significant local capacities in communities and at local levels and can be scaled up at more affordable costs. Impact evaluation, however, lags behind. The WHO treatment guidelines for HIV/AIDS also incorporate principles of decentralization and strong community participation. A social protection program in Malawi and a scaled-up prevention program in Burkina Faso provide additional examples of affordable and feasible community-driven implementation strategies.

It is urgent that such strategies for scaling up be subject to further evaluation, of the scaling up mechanisms involved, how to further improve them, as well of the impact on slowing down the epidemic and dealing with its health and socioeconomic consequences. Research along these lines will require that researchers participate early on in the design of the monitoring and evaluation systems, the required baselines, sampling and data collection strategies for impact evaluation, and the continuous feedback of research results back into the programming environment.

Notes

1. These figures include the cost of comprehensive prevention effort and care and support of people living with HIV, including ART for about half of those in need of treatment, it being assumed that all those in need cannot be reached.

2. ACT-UP, the coalition of AIDS activists that over the past 20 years has put enormous pressure on governments to fight AIDS, has often used the slogan "Stigma=Death," and rightfully so. The most dramatic illustration of internalized stigma is well known by treatment practitioners in the field: A significant number of AIDS patients refuse to acknowledge their status and, as a consequence, fail to seek treatment for AIDS. Hans Binswanger has personally witnessed the death of seven people, three of whom were employees of the World Bank, who knew perfectly well that they could be treated but failed to seek it or even refused it.

3. This section draws on Binswanger (2000).

4. For extensive documentation on the program, see http://www.worldbank.org/afr/aids/map.htm.

5. In addition, prevention includes blood and injection safety and prevention of mother-to-child transmission (MTCT). Because the standard for MTCT programs has come to include antiretroviral treatment of the mother and her infected family members, the latter is discussed as part of the treatment section.

6. For information on the TANESA program, see http://www.kit.nl/projects/pr_sheets/pr_sheet17.asp and www.kit.nl/projects/resource/pub/87.mht.

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