What We're Learning

Effectively Combating HIV/AIDS Pandemic

No. 5
March 2004

Performance Review Branch

An infectious killer with global consequences

Combating the HIV/AIDS pandemic constitutes a global challenge of staggering proportions. Over 40 million people live with HIV/AIDS, three million affected people died in 2003 alone, and the rate of new infections continues to rise.

HIV/AIDS is pushing nations into destitution and despair as households disintegrate, labour forces weaken, incomes degenerate, and assets diminish. In concert with armed conflict, natural disasters and/or crop failures, this disease will continue to destabilize countries without a formidable, effective human response.

HIV/AIDS predominately affects developing countries. While sub-Saharan Africa is most severely affected, the disease is gaining strength in Latin America, the Caribbean, Asia and Eastern Europe. The challenge of building a formidable response is exacerbated by the pandemic's inherent complexity, and propensity to evolve. Moreover, what works in one context may not be a viable option in another. Often, lessons are found to be situation–specific.

To this end, CIDA endorses a multi–faceted 'combination prevention' programming response. The Agency's 'HIV/AIDS Action Plan (2000)' commits Canada to working with its development cooperation partners to achieve specific results and targets. To date, CIDA has contributed to over 250 HIV/AIDS–related projects and programs.

Stiles Associates Inc. was retained by Performance Review Branch (PRB) to review the past ten years of CIDA's HIV/AIDS programming. This distillation of what was learned from the Review sets out the key lessons identified, in turn providing opportunities for making improvements in development cooperation activities.

'Combination prevention' methods include: communications, political dialogue, condom use strategies, treatment of sexually-transmitted diseases (STIs), voluntary counselling, testing, safe blood supply, reducing mother-to-child transmissions (MTCT), family-planning counselling for HIV-positive couples

Learning in Progress

Learning is a progressive and continuous process. As we learn more about what works (and what doesn't), our capacities for working effectively are enhanced and refined.

This series is produced to promote information sharing and encourage discussion. Each issue sets out what we're learning from PRB's performance measurement and reporting experiences about a selected topic or issue.

Canada

Programming Overview

The Review found that CIDA's HIV/AIDS investments ranged from core funding to international organizations for large–scale initiatives to support for community–based projects. CIDA contributed to the 'Global Fund to Fight AIDS, TB and Malaria'. The 'Canada Fund for Africa' supported research on the development of a new HIV vaccine. The 'Canada AIDS Russia Project' functioned at national/regional levels in four pilot regions to increase the capacity of government and non–government organizations to respond to the threat of HIV/AIDS.

A $7.3M, five–year project in Haiti focused on STI control and community mobilization to support those affected by HIV/AIDS, especially children. In Brazil, 'Promoting Sexual and Reproductive Health for Women and Youth' built school capacity for conducting sexual and reproductive health sessions. The 'Baltics HIV/AIDS Local Initiatives Program' supported small local projects, including the 'Live and Let Live' educational project in Latvia. CIDA's 'Small Grants Program' capitalized on the experience of Canadian organizations by applying their resident HIV/AIDS expertise in developing countries.

Other key programming characteristics included:

- While prevention and capacity building represented a major focus, few programs addressed the treatment and care component
- A high proportion of CIDA–funded initiatives concentrated on HIV/AIDS prevention and management among vulnerable populations (e.g. migrant workers, police, commercial sex workers)
- CIDA programming reflected a move towards regional programs that brought together partners from government, private industry, civil society and academia (and from different sectors)
- Although still in its early stages, mainstreaming was becoming more evident with the growing realization that an HIV/AIDS focus had to be integrated into development priorities outside the health sector

While gender equality was identified as a priority, there was little to demonstrate that it was being effectively applied.

The Agency spent more than twice as much on HIV/AIDS programming over the past three years, as it did in all previous years combined ($139M versus $67M). UNAIDS core funding was recently increased to $5.4M annually from $3.4M.

About the Review

The review carried out by Stiles Associates Inc. comprised:

Assessing documentation for 50 CIDA-supported HIV/AIDS investments

Identifying lessons and good practices set out in international publications

Analyzing of pertinent information from CIDA's electronic databases

Interviewing more than 20 key informants (mostly CIDA health specialists, development officers)

What We're Learning

LESSON	WHAT IS WORKING
1 Inclusive local ownership and strong partnerships are fundamental to effective programming and the achievement of results.	The Review found that HIV/AIDS programming is more likely to succeed when: 1) local ownership arrangements embody recipient country priorities/plans, and 2) strong partnerships (between CIDA, host country governments and/or local organizations/institutions) are defining elements. Internationally recognized 'good practices' underscore the importance of inclusion. A guiding principle in CIDA's 'HIV/AIDS Action Plan (2000)' is to support partnerships between Canadian and developing country organizations in combating HIV/AIDS. Effective partnerships were characterized by: a shared responsibility and accountability for results; a common vision and mutual understanding of what worked well; and good communications and information sharing. If the project is to be sustainable, partnerships must respond to the perceived needs of each organization. The Review also found that: ⊙ Local partners needed to have adequate institutional capacity from the outset ⊙ Host country partners that demonstrated sound financial management enhanced program/project sustainability ⊙ Community–based work should be linked to government health service providers It was critical to have the commitment of high–level government officials in recipient countries to what is being carried out. The 'Kenya AIDS Control Program' demonstrated that long-lasting partnerships and high levels of trust contributed to positive results, and strong partnerships can act as a catalyst leading to other development cooperation opportunities. 'Enhanced Support to HIV/AIDS in the Caribbean Program': CIDA recognized that locally defined strategies were neither feasible nor technically sound. Local ownership can be undermined by institutional infighting and competition among partner organizations, including the donors themselves. The 'West African Program to Combat AIDS' found that results are enhanced with broad-based stakeholder collaboration between donors, central/ regional organizations, NGOs, groups and associations.

LESSON	WHAT IS WORKING
2 Donor coordination, while essential in theory to develop effective responses to the multi-faceted HIV/AIDS pandemic, can be difficult to implement.	CIDA's 'Policy Statement on Strengthening Aid Effectiveness (2002)' identified donor coordination as one of the principles of effective development cooperation. Recipient countries are called on to bear the main responsibility for coordinating their development cooperation initiatives with other countries and institutions. However, the Agency's HIV/AIDS programming experience showed that such donor coordination can be difficult to achieve. Why is this the case? The Review found that donor coordination becomes more challenging under the following conditions: 1) a multi–donor scenario (particularly with one donor having far more money than the others), 2) a multiple project scenario (especially if projects are working at cross purposes), 3) ongoing competition for local implementing partners, 4) limited capacity among governments and donor agencies, and 5) an insufficient commitment to collaboration. Other constraints can include donors competing for project ideas, and lending agencies competing to disburse funds. The 'Enhanced Support to HIV/AIDS in the Caribbean Program' demonstrated that donor coordination is particularly challenging when a large number of donors are developing new HIV/AIDS programming with partner countries, and where some donors are not compelled to collaborate. CIDA's ability to improve donor coordination was strengthened by an enhanced field presence in the region.
3 While the practice of engaging local participants would appear to be advantageous, their full participation may be difficult to achieve, and the value of participatory approaches has yet to be adequately substantiated.	Many lessons related to the benefits of participatory processes, particularly those that engage civil society and the people expected to benefit from HIV/AIDS initiatives (e.g. people living with AIDS and their family members). Experience from the field showed the merits of engaging program participants at all stages: from early planning through to monitoring and evaluation. While managers and practitioners agree that bottom–up, participatory approaches worked best in HIV/AIDS programming, the Review indicated that full participation can be difficult to achieve. Time requirements can be considerable. Some individuals consider their participation to be threatening. More assessment is required to identify the value of various participatory approaches. "It is important to involve people living with AIDS, their families and other community members from the design stage onward because they have an insider's perspective on conditions, needs and possible solutions." (Highway 4/5 STAR Project, Cambodia)

LESSON	WHAT IS WORKING
4 Capacity building needs to be broad–based and innovative, mobilizing and strengthening resources inside and outside core government departments.	CIDA's 'Policy Statement on Strengthening Aid Effectiveness (2002)' described enhanced capacity as being vital for sustainable development. Capacity building dedicated to strengthening organizations and individuals was found to be a critical element in most CIDA–funded HIV/AIDS programming. Nevertheless, capacity building can be extremely complex and challenging, with the resources of host governments often being thinly stretched. A UNICEF project dealing with mother-to-child transmissions of HIV reported that donor-funded programs are overly reliant on government health care providers who are often already excessively burdened. As a mitigating strategy, UNICEF trained lay counsellors and traditional birth attendants to provide services normally provided by health department staff. Strengthening the mobilizing and management capacity of NGOs and community-based organizations attracts large numbers of activists/volunteers who can be enlisted to address HIV/AIDS and other social development issues. (Southern Africa AIDS Training Program, Phase I) Organization-to-organization mentoring is practical, endogenous, hands-on, highly contextualized and culturally appropriate. (Southern Africa AIDS Training Program, Phase I) Integrating subjects such as STI/HIV management into pre-service training curricula at medical colleges helps to curb the high cost of constant training. (Kenya AIDS Control Program, Phase II)
5 Coordinated multi–donor programming (under the direction of national governments) can be enhanced by the establishment of a common reporting framework, and a strong donor field presence.	CIDA funded relatively few HIV/AIDS responses that were tied to programming approaches such as Poverty Reduction Strategy Papers (PRSPs) and Sector–Wide Approaches (SWAps). The move toward more responsive, coordinated initiatives was found to be most prevalent in the Caribbean and parts of sub–Saharan Africa. Debate on the merits of such approaches continues within CIDA. Some suggest it may not be prudent to abandon individual projects that are innovative and responsive to the needs of specific groups. The Review identified the need to establish a common reporting framework for this type of programming (particularly if several national governments are involved), and to increase CIDA's presence in the field by strengthening human resources. Funding a diverse number of partner organizations through a small, responsive project fund increases the program's reach, multiplies its outputs, and increases its impact. (Southern Africa AIDS Training Program, Phase I)

LESSON	WHAT IS WORKING
6 Developing multi-country programming and regional linkages is logistically complex and takes a great deal of time.	Regional programming appeared to be well established and on the rise. Examples included the West African Program to Combat AIDS, the Regional AIDS Training Network (Africa), the Canada-South East Asia Regional HIV/AIDS Program and the Caribbean HIV/AIDS Project. Regional programming typically involved linkages and networks that crossed linguistic, cultural and political boundaries. The mid-term evaluation of the 'West African Program to Combat AIDS' identified complications ensuing from linguistic differences, cultural diversity and varied sensitivities to gender equality. CIDA's experience in the Caribbean demonstrated difficulties in influencing policy when there are many donors involved, some with much larger investments. It is advisable to limit the number of Canadian organizations and institutions involved, and to deal with a few, well-established partner organizations, institutions and networks in the host regions (as identified through CIDA's regional projects in Africa). The experience of the 'South African AIDS Training Program' suggests the need for country-specific strategies and approaches, reflecting the political map of each country's civic culture, rather than a blanket strategy for the region.
7 Comprehensive HIV/AIDS programming should include: 1) the participation of public and private sector organizations, 2) prevention and care as part of the continuum, and 3) a supportive environment and comprehensive health care for people living with HIV/AIDS.	CIDA's support for comprehensive approaches was found to be consistent with international 'good practices'. The implementation of a series of simultaneous responses proved to have value: for example, legal reforms to protect against discrimination, changing the attitudes of health professionals, improving STI diagnosis/treatment and promoting safe sex. Projects need to create an environment where disclosure of positive HIV status does not jeopardize employment, and allows for active community involvement without discrimination. Integrated programming should embody prevention, testing, counselling, home care and care of children to provide enhanced opportunities for people living with HIV/AIDS to become informed and seek care. Approaches such as syndromic management of STIs can be successful and cost effective. Also, community clinics can contribute to a reduction in STI prevalence when governments provide quality assurance and build in low, sustainable costs for services. Locating testing services in local health centers may be a viable strategy.

LESSON	WHAT IS WORKING
8 Integrating gender equality, while fundamental to CIDA programming, is often constrained by a lack of expertise, and needs to be strengthened so that lessons can be identified and applied.	There were clear indications that most programs/projects struggled with gender issues. There was evidence that executing agencies and CIDA project officers were generally ill–informed about the application of CIDA's 'Policy on Gender Equality (1999)'. Gender equality was not well integrated into most evaluations of HIV/AIDS programming (as noted by the absence of gender equality results, gender–sensitive indicators). Few Agency programs demonstrated an in–depth understanding of the complex gender dimensions of behavioural change. Relatively few CIDA projects adequately addressed the more challenging aspects of gender equality in relation to HIV/AIDS (such as power relationships between men/women, risk and vulnerability, youth issues, and gender dimensions of people living with HIV/AIDS). Good, qualitative social research sometimes generates surprising results. Research on the role of Vitamin A in reducing AIDS in Zimbabwe found that men played a major role in deciding on methods of infant feeding. This led to more counselling of men. Women and girls are more vulnerable to HIV infection than men where the epidemic is a gendered expression of poverty, economic insecurity, educational and employment discrimination and violence against women. (Southern Africa AIDS Training Program) The main reason for HIV transmissions was not dealt with: the behaviour of male clients. (Kenya AIDS Control Program)
9 Information, Education and Communications (IEC): More needs to be understood about effective approaches for changing how people: 1) perceive their exposure to risk, and 2) make appropriate preventive choices in their day–to–day lifestyles.	CIDA's HIV/AIDS IEC experience appeared to be largely rooted in behavioural change models, while agencies such as UNICEF had begun to focus on highly participatory, rights–based approaches to communication. Feedback from the field called for more attention to be paid to capacity building since IEC was found to be common to many investments (yet was often weakly implemented). Resourcing for community awareness and support for preventing HIV/AIDS is as important as allocations for clinical services. (Evaluation of Kenya AIDS Program) Multi–media, multi–channel approaches work best as indicated by the effectiveness and popularity of theatre, video and road signs. However, educational initiatives were not sufficient to change the habits of truckers and forestry workers. Employers should provide other activities to divert and engage workers in their off hours. (HIV/AIDS Prevention Among Truckers in Cameroon)

LESSON	WHAT IS WORKING
10 Working with vulnerable groups proved to be an effective programming strategy.	The Agency's programming documentation indicated that considerable success had been achieved in reaching out to people living with HIV/AIDS and those groups considered more vulnerable to the pandemic (including sex workers and youth). HIV/AIDS programming should target youth as early as possible, certainly before becoming sexually active. Youth friendly clinics, and school/peer education are essential. Youth should be involved in the development of education/communication materials and activities. Prevention programs aimed at high-risk groups must be sustained over a long period of time. Behavioural relapses are common. (Highway 4/5 STAR Project, Cambodia) Home care for people living with AIDS must also include economic development assistance (not only the provision of medical and health care). This is necessary to address the extreme poverty and ill health of affected individuals and their families. (Highway 4/5 STAR Project, Cambodia) Interventions aimed at female sex workers are inherently empowering, with benefits that can go far beyond initial preventative objectives. Dramatic increases in self-esteem often spark notable advancements in people's lives (e.g. micro-enterprise development, community preventative programs). (Kenya AIDS Control Program, Phase II) Mobile programs with low visibility can be effective when dealing with marginalized groups such as commercial sex workers. Sensitive programming needs the support of the police and politicians (e.g. needle-exchange programs). (HIV/AIDS Community Clinics Network, Vietnam) The participation of the poorest and most vulnerable populations should be structured to augment the dignity, skills, social status and confidence of individuals. (South African AIDS Training Program, Phase II)

This series is prepared for the sole purpose of promoting learning within the international development cooperation community.

The information put forward should, in no way, be viewed as defining or modifying CIDA Policy.

We welcome any suggestions to improve our work.

Please e-mail us at: dger_prb@acdi-cida.gc.ca