SUCCESS ON THE ROAD: REVERSING THE SPREAD OF HIV/AIDS IN WEST AFRICA

The Story of the Abidjan-Lagos Corridor HIV/AIDS Joint Regional Project

THE WORLD BANK

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ALCO	Abidjan-Lagos Corridor Organization
ART	Antiretroviral therapy
ARV	Antiretroviral drug
BCC	Behavior change communication
CSO	Civil Society Organization
CYP	couple years of protection
ECOWAS	Economic Community of West African States
EU	European Union
GFATM	Global Fund for AIDS, Tuberculosis, and Malaria
GTZ	German Agency for International Cooperation
HIV	Human Immunodeficiency Virus
ICT	Inter-Country Team
IEC	Information, Education and Communication
IRIN	Integrated Regional Information Networks
MAP	Multi-Country HIV/AIDS Program
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MTR	Mid-Term Review
NAC	National AIDS Commission
NAP	National AIDS Program
NAP+WA	West African Network of People Living with HIV/AIDS
NGO	Non-governmental Organization
PAD	Project Appraisal Document
PDO	Project development objective
PLHIV	People Living with HIV/AIDS
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWG	Transitional Working Group
UEMOA	West African Economic and Monetary Union
UNAIDS	Joint United Nations Program on HIV/AIDS
VCT	Voluntary Counseling and Testing

HIV/AIDS along the Abidjan-Lagos Corridor

For some, the issue of HIV/AIDS in Africa has been overblown. For the millions of Africans directly impacted by it, the millions who feel its effects more indirectly, and the millions more who recognize its impact on national and regional development, nothing could be further from reality. For those who live, work, and travel along Africa's main east-west transport route—the Abidjan-Lagos Corridor, stretching from Abidjan in Côte d'Ivoire to Lagos in Nigeria—HIV/AIDS is an important everyday consideration.

Long-range ground transport is a major route for the spread of HIV in Africa. Drivers and their assistants overnight along their way and can spend days at border crossings waiting to clear customs and other border formalities. These rest stops and delays provide multiple opportunities for sexual encounters that can transmit HIV and other sexually transmitted infections (STIs). This puts truck drivers, other mobile workers, sex workers, and the people who live along the route at increased risk for HIV. About 30 million people live along the corridor, and 14 million people travel along the corridor each year. The route is essential to the region's socioeconomic development.

In 2001, estimated HIV prevalence rates among adults in the five countries linked by the corridor were 9.7 percent in Côte d'Ivoire, 6.0 percent in Togo, 5.8 percent in Nigeria, 3.6 percent in Benin, and 3.0 percent in Ghana. Prevalence rates among truck drivers and sex workers in large cities along the corridor were multiples higher. For example, surveys conducted in 1992 found that 33 percent of truck drivers and 80 percent of sex workers in Lomé, Togo, were HIV positive.

As funding for HIV/AIDS programs tightens due to the global economic crisis and realignment of global health priorities, treatment efforts are stagnating, and prevention efforts may also suffer. In an era of "doing more with less," it has become especially important to identify and expand the reach of proven HIV/AIDS prevention, care, and treatment strategies. Along West Africa's main highway, the Abi-

djan–Lagos Transport Corridor Joint Regional HIV/AIDS Project reduced HIV risk among some of the region's most vulnerable populations and therefore provides a good model for beginning to reverse the spread of HIV/AIDS in Africa and maximizing opportunities for and the benefits of care and treatment of those living with HIV. This was one of the first projects in Africa to develop a regional approach to the fight against HIV/AIDS and remains one of only a few that actually ensures services across borders.

Financed through the World Bank's Multi-country HIV/AIDS Program (MAP), the Corridor Project achieved solid results: better knowledge of how to prevent HIV, more diagnosis and treatment of STIs, greater condom availability and use, and greatly increased voluntary HIV counseling and testing. The project accomplished this through careful planning and effective monitoring, strong government commitment, cooperation among local government authorities and the health and transport sectors, community participation and ownership, and targeted technical support. The Corridor project brought together five countries, working with different stakeholders in various locations to benefit truck drivers, sex workers, travelers, border communities, and military and customs officials.

This report highlights project results and explores five key factors leading to the Abidjan-Lagos Corridor Project's remarkable achievements:

- Ownership by key stakeholder groups
- Harmonization and strengthening of services
- A harmonized communication strategy
- Use of Cross-Border HIV/AIDS Committees
- An intensive and responsive approach to project management

Key Project Events

July 2000:	First meeting with UNAIDS support in Accra
May 2001:	First Bank preparation mission
July 2001:	First meeting of the Ministers of Health of the five countries, facilitated by UNAIDS, which established a working group and a provisional secretariat in Benin, and reached a consensus on the institutional framework for the project
April 2002:	Joint Declaration of the five Heads of State
March 2003:	Negotiations of the grant
Nov. 2003:	Approval of the project by the Board of the Bank
Dec. 2003:	Launch of the project by the President of Benin
Feb. 2004:	Effectiveness of the grant
August 2004:	Signature of the Headquarters Agreement
Feb. 2006:	Mid-term review

A Turning Point in STI/HIV/AIDS Control along the Corridor: Overview of the Abidjan-Lagos Corridor HIV/AIDS Project

Responding to unmet need: project rationale and goals

HIV prevention can be especially effective when carried out in places where risky behavior occurs. So in 2001, development began on a joint regional HIV/AIDS Project in the Abidjan–Lagos Transport Corridor, the first sub-regional project under the World Bank Multi-country HIV/AIDS Program (MAP).

The project aimed to increase access to HIV prevention, basic treatment, support, and care services

by underserved vulnerable groups, with particular attention to transport workers, migrants, sex workers, customs and immigration officials, and the local populations living and working along the corridor—especially at the border towns.

The project was expected to contribute to reducing the spread of HIV and to mitigating adverse social and economic impacts of HIV along the corridor. UNAIDS was the key technical support partner. The implementation of the three-and-a-half year Abidjan-Lagos Corridor Project (February 2004—December 2007) was a turning point in STI/HIV/AIDS control along one of Africa's most important highways.

Abidjan-Lagos Corridor Project Quick Facts

$16.6 million	IDA grant
$1.3 million	Country contributions
1,022 km	Corridor length
87	Implementing agencies
3,762	People trained
21	Organizations received support to care for PLHIV or vulnerable children
20	Automatic condom dispensers installed
625	Condom sale points established
8.8 million	Condoms distributed
16	VCT centers established
27,639	People used VCT centers
14,202	Received STI services
36	Health facilities refurbished
9	Incinerators installed
539	PLHIV accessing ART via project
30 million	People sensitized
2,978	Radio commercial airings
54	TV commercial airings

A simple and carefully considered design

This was the first regional HIV/AIDS project aiming to reduce the impact of HIV on the transport sector and the transport sector's contribution to the spread of HIV. It was designed to complement national HIV/AIDS programs and transport sector projects. The project development team comprised high-level country representatives from the health and transport sectors and national AIDS programs, World Bank and UNAIDS staff, PLHIV, transport union representatives, donors, and a private sector coalition. The project was defined by a participatory process that engaged a variety of stakeholders. These stakeholders, from all five countries and including civil society and public sector representatives, participated in a series of project design workshops. This approach built strong stakeholder ownership, from the heads of state down to the community level and incorporated a wide variety of needs, concerns, perspectives, and experiences. The project objectives and design were realistic, simple, and based on known conditions in the target area and the desired outcomes.

The intended beneficiaries were clearly identified, and the project kept its focus on those target groups throughout implementation. The project incorporated strong commitment to regional cooperation, objectives matched to regional capacity, clear delineation and coordination of the roles of national and regional institutions, accountable governance arrangements, and planning for sustainable outcomes.

Three key components: prevention, care and support, and coordination and training

The project's prevention component focused on condom social marketing, information, education and communication (IEC) and behavioral change com-

munication (BCC). Interventions were tailored by audience and included radio programs, forming support groups for people living with HIV (PLHIV), peer education, improving service providers' interpersonal communication skills, distributing educational materials, community outreach, and promoting male and female condoms. The project established 625 condom sales points along the corridor, increasing the distribution network to 784 points of sale.

The care and support component included voluntary counseling and testing (VCT), diagnosis and treatment of STIs and opportunistic infections, community-based care and support, safe medical waste disposal, and antiretroviral therapy (ART), added after the mid-term review. The project trained staff and renovated and equipped eight health centers at border posts and eight reference hospitals to bring them up to standard in VCT.

The project also trained health center staff to provide better medical diagnoses and treatment, contracted civil society and private sector organizations to provide community-based care, and developed and implemented a medical waste management plan (including training, materials, equipment, and awareness-raising).

The third component was inter-country coordination, training, and policies. This work facilitated and harmonized work across borders, creating effective public-private and civil society groups and partnerships to implement and assess project activities. It also aimed to reduce the amount of time spent at border crossings, by undertaking checkpoint studies and observation to understand the bottlenecks, as well as advocacy, IEC, training, and other measures to address delays.

Building on international lessons learned

The project design, planning, and implementation reflected lessons learned **from international experience in responding to HIV/AIDS, specifically the need to:**

- Address regional and cross-border determinants and implications of HIV
- Seek strong political leadership and commitment at the highest levels
- Focus on factors affecting risk and vulnerability
- Empower local communities
- Work across and with several sectors
- Acknowledge and plan for complexity implicit in cross-border endeavors
- Use participatory processes
- Provide critical technical assistance
- Sequence interventions to match implementation capacity
- Build a robust monitoring and evaluation (M&E) system.

Solid Results

The investment in laying the foundations for success paid off. As shown in Table 1, knowledge of how to prevent HIV increased in primary target populations from 50-68 percent pre-intervention to 83-88 percent post-intervention. Reported use of a condom at last encounter with a client or non-regular partner increased from less than 60 percent to over 70 percent for sex workers and to 79 percent for truck drivers. By 2007, nearly 28,000 people along the corridor had accessed VCT services, and 8.8 million condoms had been distributed. All of the process and output indicators were exceeded by large amounts. Very substantial progress was made towards the ambitious outcome targets.

The project also had a contraception benefit—the condoms distributed through the social marketing component over two-and-a half years were enough to provide 109,319 couple years of protection (CYP) compared to 9,778 CYP for condoms distributed in 2003, prior to the project.

Table 1 Select Project Indicators

Indicator	Baseline (2005)	Target	Value (2007)
Outcome indicators			
Behavior change			
Percent of truck drivers who report using a condom in last act of sexual intercourse with a non-regular partner in the previous 12 months	59.3 percent	90.0 percent	78.8 percent
Percent of sex workers along the corridor who report using condoms with their clients of the previous week	58.8 percent	80.0 percent	70.5 percent
Prevalence of gonorrhea amont sex workers along the corridor	8.9 percent	4.5 percent	3.8 percent
Knowledge			
Percent of commercial vehicle drivers who can identify at least two ways to prevent HIV	68.0 percent	90.0 percent	82.7 percent
Percent of 15- to 24-year olds residing along the corridor who can identify at least two ways to prevent HIV	50.4 percent	90.0 percent	84.4 percent
Percent of sex workers along the corridor who can identify at least two ways to prevent HIV	59.5 percent	90.0 percent	87.9 percent
Output indicators			
Number of condoms distributed through social marketing along the corridor	0.97 million	1.46 million	8.8 million
Number of people who use VCT centers along the corridor	1,000	1,500	27,639
Percent of health facilities along the corridor that report adequate supply of antibiotics for treating STIs over the previous six months	30 percent	90 percent	100 percent
Number of checkpoints per 100 km along the corridor	9	3	5
Average time (minutes) for trucks to clear border formalities	180	90	128
Process indicators			
Train border town residents as key community HIV/AIDS IEC activists	37	500	1,460
Percent of total disbursements to sub-projects made through civil society organizations	0 percent	40 percent	66 percent
Staff of health facilities along the transport corridor trained on basic management of HIV	0	50	287

Source: Abidjan-Lagos Corridor Organization (ALCO).

These results and the project's continued success are due largely to the five critical factors described below. Without them, it is doubtful that such achievements could have been made. The project's focused attention to them provides an example well worth considering as funding priorities shift yet HIV/AIDS continues to take a heavy toll. A collaborative and comprehensive approach to them made real and sustainable results possible.

Success Factor 1: Shared Ownership

This is the first time we have a project that listens to us. I came because what we say matters here.

HIV-positive woman

Perhaps the single most important factor in the project's success is that it was able to engender and maintain a deep and broad sense of ownership among its constituents. The project had multiple owners from the beginning.

Project management and the approach to coordination were highly participatory at all stages from project concept inception to the project completion. Reviews and action planning were done in consultation with the stakeholders. Agreements were reached for implementation priorities. In a stakeholders' workshop in Cotonou, Benin, in July 2001, it was recognized that specific institutional arrangements would have to be put in place in view of the regional dimensions of HIV/AIDS along the Abidjan-Lagos transport corridor. The transitional working group (TWG) formed at this meeting was given the mandate to review a number of institutional options to carry out the basic intentions of the project. The TWG was composed of high level staff from the five countries, including secretaries of the national AIDS commissions, and Directors of Transportation. This group later became the Project Governing Body.

National and international stakeholders

Participation by donors and development partners

In the context of the Bank's regional strategy, the Bank had started working with the West African Economic and Monetary Union (UEMOA) and ECOWAS on an action plan to support trade and transport facilitation in West Africa. The Bank had also begun funding or preparing MAPs in the five countries and helping them establish national AIDS councils.

As part of the West Africa Initiative, a UNAIDS team carried out extensive assessments of vulnerable groups along the Abidjan-Lagos corridor, finding high HIV prevalence rates in the border towns especially and almost no HIV/AIDS services there. The studies highlighted that border areas were not adequately taken into account in national programs. These findings were shared across countries and with development partners, including the World Bank, and the Bank used the findings to begin conceptualizing a project to complement national programs by filling critical gaps.

The Bank invited other partners, including French Cooperation, the United States Agency for International Development (USAID), AWARE, WHO, and others, to participle in the project preparation.

As noted above, the five governments, several partner agencies, and civil society engaged with the World Bank in an inclusive, highly participatory year-long project development effort. UNAIDS ICT provided both human and financial resources to support project preparation, including financial support for the operations of the Interim Executive Secretariat and for some meetings of the Governing Body. USAID helped fund the July 2001 workshop which launched project preparation. The EU, GTZ, UNICEF, and the World Health Organization also played important roles by providing technical assistance and sharing experiences.

Country commitment

Representatives of the governments of the five corridor countries agreed in principal on August 2, 2001

to the following: (i)to develop and coordinate HIV/AIDS prevention and care policies and strategies in the cross-border areas; (ii)to develop a multisectoral HIV/AIDS program targeting the vulnerable population in that corridor; and (iii)to strengthen STI/HIV/AIDS care and health social infrastructure in that corridor and to commit themselves to develop an HIV/AIDS project along the Abidjan - Lagos transport corridor. In October 2001, the Governing Body, approved the detailed institutional arrangements for the project. The presidents of the five countries signed the joint declaration on April 30, 2002, confirming their commitment to joint action to fight HIV/AIDS along the corridor.

Consensus was reached on the project's basic principles and detailed institutional arrangements, including each country's contribution of $50,000 per year to the project. Despite the political crisis in Ivory Coast and Togo, all the countries fulfilled their financial commitments. The Bank and UNAIDS also committed fully to the project, ensuring adequate financial, policy, and technical support, including strong continuity of the World Bank task team.

Each of the five countries had identified HIV/AIDS as an issue requiring Bank support. They agreed that the Corridor HIV/AIDS project should complement the country-specific projects and address the cross-border HIV/AIDS issues that are not easily addressed through country-specific projects.

Shared ownership through ALCO

The Abidjan-Lagos Corridor Organization (ALCO) was established to implement the project. Creating a new organization helped ensure shared ownership among the five countries. It also made the project easier to manage. No single country owned it, and working through ALCO avoided conflicts of interest that might have arisen if an existing local, national, or regional organization had taken on the role.

The Executive Secretariat (seated at ALCO headquarters) and World Bank organized a joint project launch to solidify the Corridor project's standing in the region and each country.

The transport sector

By engaging the transport sector on issues already important to them—such as reducing the time wasted at checkpoints and border crossings—the Corridor Project created an opening for transport workers to understand their risk of contracting and spreading HIV.

Observatories were installed at all borders for direct monitoring of behavior of various target groups as well as sample recording of time required to clear the border formalities. Observatories were critical in a constant data flow allowing ALCO management to focus on the areas requiring more attention.

The sector—including unions and ECOWAS—embraced the project and now has workplace HIV/AIDS programs that provide information and services to their constituents.

Civil society

CSOs (community organizations, NGOs and the private sector) were key implementing partners for the project. They carried out two distinct implementation tasks: (i) mobilization and empowerment of communities along the corridor to address HIV/AIDS; and (ii) providing HIV/AIDS-related services to various community groups along the corridor. The commercial drivers set up a coordination body supported by ALCO including the various unions along the corridor to undertake HIV/AIDS awareness campaigns to sensitize their truckers which are the most vulnerable people. Some religious chefs also played in important role by conveying the prevention messages to their communities and setting examples, e.g., the religious chef of

Hillacondji's border invited all his wives to be tested for HIV/AIDS.

PLHIV

The project partnered with the West African Network of People Living with HIV/AIDS (NAP+WA) to provide psychosocial and nutritional care and support to people infected and affected by HIV, and to help reduce HIV stigma and discrimination along the corridor. The project also supported five national PLHIV networks and 17 local PLHIV associations. Counselors were trained, support groups were set up, ambassadors from the national networks were named, and NAP+WA helped develop the harmonized policy on STI/HIV/AIDS prevention, treatment, care, and support.

According to project managers at the Project Secretariat and the World Bank, engaging PLHIV in the project to the point where they felt it belonged to them contributed to the project's success in many ways.

"They feel they are in the driver's seat," noted Abidjan-Lagos Corridor Organization (ALCO) Project Manager Justin Koffi.

The general public

In 2004 and 2006, the Corridor project mounted the month-long Love Life Caravan with support from the World Bank, UNAIDS, and the Coca Cola Africa Foundation. A convoy centered on a large truck outfitted with a sound stage and movie screen, the Caravan stopped at sites from Lagos to Abidjan, attracting over 160,000 participants along the corridor in 2004 and nearly three million in 2006. Broad regional and international media coverage extended its reach even further. The Caravan used celebrities, politicians, and entertainment to draw large crowds at each stop. It raised awareness of the Corridor project, educated about HIV/AIDS, fought stigma, demonstrated male and female condom use, and spread positive messages about avoiding HIV and living positively with it. Importantly, the Caravan fostered greater community engagement and a sense that the project was for them.

The project's great success led to even broader ownership. The project now receives support from the Global Fund for AIDS, Tuberculosis, and Malaria (GFATM) in the form of a $45 million five-year grant (2007–2012).

Ownership lessons for others

- The project design and its approach to project coordination were highly participatory at all stages from project concept inception to completion. Reviews, action planning, and prioritization were undertaken in consultation with the stakeholders. Participatory processes and stakeholder engagement play a key role in creating strong ownership and responsibility among the stakeholders and partners.
- The Bank played a catalytic role in supporting an innovative initiative by taking high risks. Strong partnership between the Bank, the governments, UNAIDS, and others was critical to the design and delivery of the project. Strong partnership must be built prior to initiating project design.
- Establishing the institutional framework for program implementation during project development requires time, particularly in a regional program. Government ownership and leadership is a core requirement for successful institutional arrangements and project implementation. Participating member governments should be in the forefront of decisions related to which country houses the headquarters, and how its management will be staffed to ensure openness, transparency and equal opportunity to all nationalities. Project responsibilities were successfully shared by all the five countries.

Strengthening Health Systems

The Corridor project is a good example of health system strengthening for disease control. The health centers used technical and financial support from the project to develop and adopt a standardized reference document and continuum of care approach to ensure good-quality service at border towns and other popular stopping points along route. The project helped improve national procurement systems to reduce stock-outs, put good financial management tools in place, and provided needed supplies and equipment. Through coordinating mechanisms such as an Inter-country Facilitation Committees and Cross-Border AIDS Committees, the project also helped create an enabling environment for dialogue between public sector health centers and NGOs/civil society. Both learned to work together with community members to educate and motivate the general population and members of the target groups.

Factor 2: Strengthening Health Systems and Harmonizing the Continuum of Care

Harmonization is the process of bringing disparate things or systems into agreement or establishing common standards. In the context of the Corridor project, harmonization entailed building the capacity of health centers serving the corridor to provide a minimum level of HIV/AIDS prevention and care that is easily accessible to people living and traveling along the corridor, no matter which partner country they find themselves in. Harmonization and health system strengthening were treated almost as one in this project. Harmonization would not have been possible with strengthening health care services and the systems on which they rely, and health system strengthening without harmonization would likely have created imbalances resulting in increased friction among country actors and a possible breakdown of the project.

The importance of harmonization

Migrants generally do not benefit systematically from the social welfare system of the country where they reside and thus may not receive social services or information that may be available to local populations, even if those services are quite limited even for locals. Because people using the corridor may spend long periods away from home, it is critical that they be able to, for example, obtain counseling, STI treatment, or ARVs even if they are not in their home country. Migrants, including sex workers who may prefer to work far from home and family, did not have easy access to local services prior to the project. Even services in their country or town of origin could be very limited. In STI/HIV/AIDS prevention and care, it is also important for people to get information, treatment, or supplies when the need is recognized, rather than having to wait and risk loss of interest, courage, or opportunity.

In addition, migrant populations along transport corridors often live in an economic and social environment which hampers them from obtaining similar information on HIV/AIDS as the local populations. Furthermore, messages about HIV/AIDS may differ considerably among countries.

A key impetus for the harmonization effort was to make quality care, including ART, available to corridor users. It was felt that this would help reduce STI transmission and extend the lives (and quality thereof) of people living with HIV.

Level of harmonization achieved

By the end of World Bank funding in 2007, the project had achieved a remarkable level of harmonization and systems improvement. Based on the findings

Situation Analysis

- Data collection form for central level on national HIV/AIDS strategy
- Data collection questionnaire for peripheral level (health center directors, service providers, NGOs) on services and facilities available
- Interviews with directors of AIDS Commissions, Pharmacy, Public Health
- Interviews with thematic group sponsors
- Literature review

of a health services situation analysis and consultations with governments and the other stakeholders, the consultants developed a Consensus Technical Framework (summarized in Annex 1) to guide the harmonization effort. A reference guide was developed with the five countries to harmonize their approach to the continuum of prevention, treatment, care, and support services along the corridor. The guide and consensus technical framework helped ensure equal access to quality care.

Finding harmony through analysis, capacity building, and strengthening systems

The project retained consultants from the five participating countries to conduct a detailed situation analysis of border health options and make recommendations for harmonizing and raising the level of services available. Prior to the Corridor project, health facilities (public sector hospitals, clinics, or dispensaries) near border crossings and checkpoints provided few if any HIV/AIDS-related services and generally had very limited capacity. Table 2 shows what personnel, facilities (utilities), and HIV/AIDS-related services were and were not available during the situation analysis visit to the eight border health centers selected to pilot the harmonization effort. Only two of the centers had a physician (Aneho Hospital in Togo and a private VCT center in Hillaconji, Benin). All had at least one nurse or midwife, and five of the eight had a medical assistant (including one that had a physician as well). Most had running water and electricity. Medical diagnosis capacity was extremely limited, as was treatment for opportunistic infections. None of the centers provided ART; three provided VCT services.

The study also cross-referenced national policies with local practices, local realities (such as severe shortage of doctors who would normally carry out key medical tasks/procedures), and characteristics of local target populations (including their mobility). It then recommended policies and standards to both accommodate differences and raise the overall quality of care.

Using findings and recommendations from the situation analysis, the countries reached consensus on a number of issues/in key areas.

- The prevention and care services that should be provided regarding STIs and HIV/AIDS;
- The status of eight health care centers in the border areas;
- Current methods of procuring and distributing drugs, reagents, supplies, and condoms—including agreement to charge government-recommended prices for ARV drugs;
- The dire need for training of personnel at the selected sites—health care providers, social service staff, NGOs, PLHIV associations, and family members of PLHIV;
- Close coordination among government agencies charged with leading the HIV/AIDS response (MOH, NAC, NAP); involvement of other government agencies, the private sector, NGOs, civil society, religious organizations, and PLHIV; and development of national and international partnerships;
- Follow-up of ARV patients via patient records kept with the patient for use at any participating health center;
- Standardized M&E indicators and data collection forms with coordination, oversight, and analysis by a third party; and

Table 2 Possibilities of Health Care Delivery in Visited Health Centres

	Côte d'Ivoire	Ghana		Togo		Benin		Nigeria
Facilities	Noe	Elubo	KCH	KVK	Aneho	HLC	Krake	Seme
Staff, competence								
• Physicians	0	0	0	0	+	+	0	0
• Nurses, midwives	+	+	+	+	+	+	+	+
• Medical Assistant/counsellor	0	+	+	+	+	0	0	+
Local Facilities								
• Electricity	+	0	0	+	+	+	+	+
• Pipe born water	+	0	0	+	+	+	+	+
• Communication (telephone)	0	0	0	0	+	+	+	+
Diagnosis and follow up								
• Serology of HIV for VCT	0	0	0	+	0	+	+	0
• CD4 counting	0	0	0	0	0	0	0	0
• Kirol blood content	0	0	0	0	0	0	0	0
• Hemogramme (haemoglobin)								
• Glycemie, crea, ASAT/ALAT	0	0	0	0	0	0	+	0
• Parasitology	0	0	0	0	0	0	+	0
• Chest X-ray	+	+	+	0	+	+	+	+
• Screening of TB (spit)	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0
Treatment of OI								
• Health care as regards STIs	0	0	+	0	0	+	+	+
• Chimioprophylaxy Cotrimo	0	0	0	0	0	0	0	0
• Treatment anti- tuberculosis	0	0	0	0	0	0	0	0
Treatment of Other OI	0	0	0	0	0	+	+	0
Treatment by ARV								
• Chimioprophylaxy	0	0	0	0	0	0	0	0
• PTME (ZDV, NVP)	0	0	0	0	0	0	0	0
• HAART (tritherapy)	0	0	0	0	0	0	0	0
Other activities								
• VCT	0	0	0	+	0	+	+	0
• Promotion of condoms	0	0	0	0	0	+	+	0
• Waste management	0	0	0	0	0	0	0	0

Source: Harmonization of continuum of care and policy of access to treatment of STI/HIV/AIDS patients in the 5 Abidjan-Lagos Corridor Countries, Final Report, February 2005.

Table 3 Training to improve health care

Content	Profile	Number
Syndromic management of STIs	Health center providers	101
Medical care of OIs	Health center providers	80
Voluntary Counseling and Testing	Health center providers	100
MTCTP	Health center providers	97
Psychosocial care and support services for PLHIV	Health center providers	97
Laboratory	Health center providers	35
Prescription of ARVs	Health center providers	93
Health Care Waste Management	Medical doctors, nurses, pharmacists, lab technicians, traditional birth attendants, artisans	348
Psychosocial advisers for community care and support services for PLHIV and OVCs	Members of PLHIV associations and PEC NGOs	223

- Terms of reference for operationalizing institutional framework for implementing STI/HIV/AIDS prevention and treatment along the corridor. This involved agreeing to identify and employ consultants to train and provide technical assistance in a variety of areas and agreeing on what was needed to bring prevention and care up to par.

Strengthening systems, improving services

Border towns tend to be small and far from national capitals—a sort of "no man's land" when it comes to services other than customs and immigration. Because of this, the project was not seen as interfering with the national HIV/AIDS response but rather extending the national response beyond governments' immediate ability to reach those areas. The health ministries in the participating countries helped design, supported, and participated in the project.

Assessing and addressing the situation on the ground

In the end, the project conducted facility assessments and substantially improved capacity at 36 public and private health facilities. It financed staff training, equipment, furniture, supplies, and reagents and drugs to diagnose and treat STIs, opportunistic infections and common ailments.

Health center training focused on integrated care—prevention interventions, VCT, follow-up, ART, PMTCT in some centers, laboratory services, treatment of STIs and opportunistic infections, and medical waste management (table 3). Health center staff received training to improve the quality of service provision. In addition to the basics, training paid particular attention to making sex workers feel welcome at the centers so that they would not avoid seeking treatment. To ensure continuity of care for mobile people, the project adopted a single medical file for following up drivers and other patients who accessed services in more than one center. Mobile clients carried their medical record with them as they traveled. The project gave funds and capacity building support to NGOs and associations of PLHIV to provide community-based care.

A major focus of improving health services at the borders and at key points along the corridor was improving the diagnosis and treatment of HIV/AIDS, other sexually transmitted infections, and opportunistic infections. Better management of HIV/AIDS and STIs would contribute to reductions in HIV transmission. Provision of ART in particular required improving procurement, accounting, and M&E systems. It also required improving standards of care, staff-to-client ratios, staff training, and other professional development. Table 4 outlines the full scope of health system capacity building in the border towns.

Table 4 Standard Indicators for Building Site Capacity

Description	Activity, Objectives, Target	Means, Intervention of Expected Result
Biology laboratory	• HIV serology, blood screening • CD4 counting • Hematology • Saliva bacteriology • Biochemistry • Reagents + consumables	• Rapid test • Alternative method: Dynabeads • Cyflow, white cells, HB rate, plaquettes • BAAR test (tuberculosis) • Glycemy creatininemie, transaminases
Blood transfusion security	• Support of creation of blood collection center • Authorization for storing blood in nearby government-owned blood depot	• Screened blood • Screened blood extract, other facilities available at borders
Training	• Health professionals, social actors	• Decent health care, psychological and spiritual supports, income generating activities
Imaging (medical test)	• Chest X-ray • Scanning (abdomen)	• Chest X-ray (tuberculosis) • Adenopathis exploration (tuberculosis)
Universal precautions	• Hospital waste management	• Incinerators available
Drugs	• Purchase of ARV through pharmaceutical depot	• Regular supply of drugs
Mother-to-child transmission prevention activities	• Setting up voluntary counselling and testing centers • Health staff training	• Follow up of HIV-positive pregnant women • HAART for women after child delivery
Promotion of condoms	• Mobilization, BCC sessions, social marketing	• Sensitization of sexually active people, setting up condom Kiosques
Communication	• Telephone, fax, Internet	• Follow up patients
Collaboration	• Follow up of activities • Supervision of activities	• Insure Corridor Project + PNLS or others • Insured by National AIDS Control Programme, + District Health Director + Corridor project, others
Impact management	• Social mobilization • Orphans	• Home-based care, IGA, social integration and education (orphans)
Sustainability	• Government • Resource mobilization	• Long-term activities
Visibility in respect of road	• Signalization/corridor axis • Road opening	• Putting in place signboards, posters

To improve standards of care, the project worked with local governments, service providers, and national programs to correct deficiencies in accommodation, counseling, blood screening, psychological support, diagnosis, and other aspects of care.

Integrating prevention and care

The harmonization effort also sought to reinforce integration of prevention and care. Prevention centered on:

Taking VCT to New Heights

In a single year (2005 to 2006), the number of people accessing VCT at centers along the corridor rose 50 percent. The total number of people tested rose from around 1000 at project inception to 27,639 by 2007, with 90 percent returning for their test results. Use of the health centers rose by up to 200 percent over the life of the project.

- STI diagnosis (including syndromic) and treatment to lower transmission risk,
- Voluntary HIV counseling and testing to raise awareness about personal status and to know how and why to prevent getting infected or infecting someone else,
- Provision of condoms during the VCT visit,
- Universal precautions to prevent infection by/to health workers (training, infrastructure, and supplies),
- Blood safety,
- Prevention of mother-to-child transmission,

"This capacity building programme should enable retained medical centres to develop efficient preventive actions as well as decent care services for HIV positive patients migrating along the Abidjan-Lagos corridor. It is all about integrating prevention with health care, acknowledging that easy access to quality health care is a way of reinforcing preventive action, reducing the stigmatization of people living with HIV/AIDS and promoting voluntary HIV testing."
Harmonization Study Final Report

- IEC materials,
- And referral to support services and groups

Harmonization was possible because the project carved out a niche that was not being addressed and formed an inter-country advisory committee with representatives from HIV programs and the Ministries of Health, Transport, Uniformed Services (and Customs) of each participating country. Members of this committee informed project management about what was and was not being done in the target areas, helped determine what the interventions would be,

Table 5 Select Health Service Indicators

Indicator	Baseline (2005)	Target	Value (2007)
By end of 2006, each border crossing point of the corridor has at least one voluntary counseling and testing (VCT) center on either side of the border.	3	8	16
By end of 2005, at least 90 percent of the health facilities along the corridor report adequate supply of antibiotics for the treatment of antibiotic-sensitive sexually transmitted infections, over the previous six months	30 percent	90 percent	100 percent
Process Indicators			
By the end of 2004, all the countries along the transport corridor have adopted a common HIV/AIDS strategy for the transport corridor.	0	5	5
By 2006, increase by at least 50 percent, compared with first year of the project, the number of trained HIV/AIDS counselors working in voluntary HIV/AIDS counseling and testing centers along the transport corridor.	4	8	173
By 2005, at least 50 staff of health facilities along the transport corridor have been trained on basic management of PLHIV	0	50	287

Source: ALCO. Thre three output indicators for transport facilitation are not strictly those of the PAD.

and ensured compliance with national laws. They also ensured fairness in distribution of resources and attention. Taking the time to negotiate with this key constituency gave the project the information and buy-in needed for success, as did transparency and effective documentation of project decisions. Table 5 provides an indication of how much health services improved in just two years.

How Do You Harmonize Prevention and Treatment across Borders?

1. Identify health facilities along and near the corridor.
2. Assess the health facilities.
3. Analyze usage patterns (who uses the facilities, for what concerns, how often).
4. Compare relevant national policies and strategies.
5. Convene country partners to review findings, discuss any plans that might impact what is adopted, and agree on a common framework. Engage national, district, and local levels in this discussion.

How challenges to systems strengthening and harmonization were met

Border areas and checkpoints along the Corridor had almost no HIV interventions when the project started. The need for training, materials, supplies, systems, relationship development (across the various types and levels of groups that needed to be involved) and virtually everything else was staggering. The project invested heavily from the beginning to improve the odds for success. Specifically:

- Although the project's Governing Body facilitated the process, operational-level harmonization of clinical aspects and the ARV referral system were difficult. Subcontracting financial management and M&E allowed the Secretariat to focus on programmatic and thematic harmonization. As such, the Secretariat was able to develop synergy among the national HIV/AIDS programs and the sub-regional Corridor project.
- The Executive Secretariat and project managers fostered close collaboration between NACs and MOHs.
- To improve access to ART for mobile people when outside their own country, ALCO negotiated a referral system with all countries. Patients were issued a referral slip through which they could access ART in any member country. Referral records were consolidated monthly, and ALCO reimbursed countries that provided ART to non-citizens along the corridor. The system also helped Ministries of Health harmonize ART for mobile populations and non-citizens and helped national AIDS programs better plan for ART services.
- Harmonizing M&E required long-term investment and vision. The project built solid links with country M&E systems to minimize risk of duplication, and fed data into national systems.

Lessons and recommendations for others

Inadequate staffing remained a challenge for the project despite major improvements. Governments must be convinced and helped to find resources to employ the additional staff needed to provide good, consistent services. Communities, the private sector, and CSOs could consider helping to support one-to-two additional staff at health centers, for example.

Factor 3: A Harmonized Communication Strategy

An integrated regional IEC/BCC strategy was developed, validated by the five countries and widely

disseminated. The Corridor project's BCC strategy provided a common BCC framework for the five project countries. It enabled partners at all levels to help meet the HIV/AIDS-related needs of border communities and mobile populations through a coherent, coordinated, and harmonized approach.

The common framework was tailored to the partners involved in a targeted regional response. By coordinating essential BCC programs and activities, the framework enabled partners within and across borders to improve access to information, prevention, care, and support services for priority groups along the corridor.

Methodology

The communication strategy was developed by a team from the Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs assisted by consultants from each of the five participating countries. Their methodology consisted of:

- Reviewing documents related to the project and the results/findings of technical assistance carried out by others on topics such as continuity of care, national HIV/AIDS action plans, and establishment of Border HIV/AIDS committees.
- Conducting an inventory and review of existing HIV/AIDS materials available in the five countries.
- Meeting with key partners in the public and private sector, NGOs, development partners, and IEC/BCC workers.
- Visiting the border areas to conduct community mapping, focus group discussions, and individual interviews with members of the project's target audiences

These activities allowed the team to better understand the target audiences' socioeconomic realities, analyze the causes of increased risk of HIV/AIDS, identify ongoing IEC/BCC activities, identify constrains and opportunities, and organize a communi-

Table 6 Overview of the Abidjan-Lagos Corridor Project Communication Strategy

Strategic Focal Point	Strategy #1	Strategy #2	Strategy #3
Promoting good communication practices among the various organizations working along the Corridor	Develop a common understanding of STI/HIV/AIDS BCC among the players	Involve local authorities, opinion leaders, and community leaders in the planning and coordination of communication activities	Strengthen journalists' capacity for STI/HIV/AIDS communications
Giving vulnerable groups, border communities, and migrant populations ownership of STI/HIV/AIDS interventions	Through various communication channels, increase education, participation, and protection of vulnerable groups, communities living in border areas, and migrant populations to take responsibility in meeting the HIV/AIDS challenge	Mobilize NGOs, community-based organizers, and civil society organizations to carry out BCC interventions	n.a.
Involving social workers, health workers, and peer educators to deliver quality services	Strengthen capacity of service providers to treat and prevent HIV/AIDS	Improve peer educators' skills to carry out BCC activities	Develop job aids for social/health workers and peer educators

Note: n.a = not applicable.

The Love Life Caravan

In 2004 and 2006, the Corridor project mounted the month-long Love Life Caravan with support from the World Bank, UNAIDS, and the Coca Cola Africa Foundation. A convoy centered on a large truck outfitted with a sound stage and movie screen, the Caravan stopped at sites from Lagos to Abidjan, attracting over 160,000 participants along the corridor in 2004 and nearly three million in 2006. Broad media coverage extended its reach even further.

The Caravan used celebrities, politicians, and entertainment to draw large crowds at each stop. It raised awareness, educated, fought stigma, demonstrated condom use, and spread positive messages about avoiding HIV and living positively with it. It even fostered greater community engagement and interagency collaboration. Importantly, the Caravan educated and motivated young people to get involved in the battle for life.

Powerful testimony by PLHIV and others affected by HIV/AIDS helped put a human face on the epidemic. PLHIV associations helped prepare speakers to tell their stories, and provided support to help them handle any negative reaction to going public. They also created support groups at each border, and people testing positive at VCT centers were referred to those support groups. These activities seem to have contributed to a gradual reduction in stigma and discrimination against PLHIV.

Remarked one truck driver in Ghana who participated in the Caravan: "Thanks to this Caravan, I have understood that we can eat with someone infected with HIV without any risk."

The Love Life Caravan has become a recognized brand. Information kiosks at project sites sport the Caravan logo, and the Caravan continues annually with Global Fund and other support.

cation strategy development and consensus building workshop.

Strategy overview

The project's communication strategy is founded on qualitative and quantitative research that identified target audience demographic and socio-cultural characteristics; their knowledge, attitudes, and practices relevant to HIV/AIDS; and where they get information and services. It lays out communication objectives, communication channels, message concepts, M&E indicators, and partnership mechanisms for implementing the strategy. It takes into consideration the social and cultural context of the different countries, the changes desired in each segment of the target population, and the appropriate use of various communication approaches (such as BCC, community mobilization, social marketing, and advocacy).

Table 6 provides an overview of the communication strategy. The full strategy specifies intended audiences and key activities for each strategy. It also defines the roles of the various sectors and partner categories (e.g., health sector, transportation ministries, NGOs, Cross-Border HIV/AIDS committees, religious leaders, and others).

Implementation

Several factors influenced implementation of the harmonized communication strategy.

Decentralization of activities: While the Executive Secretariat played a coordination and technical support role, activities had to be planned by stakeholders on the ground. This included but was not limited to NGOs, CSOs, CBOs, NACs, and communities. Their plans were then integrated into the overall plan harmonized and coordinated by the project.

Multi-sectoral and cross-border coordination: Multi-sectoral coordination ensured synergy of interventions along the Corridor. Coordination of

interventions on both sides of borders ensured the harmonization and continuity of activities and facilitated documentation of good practices.

Coordination and strengthening of social and health centers: The communication interventions developed under the project contributed to strengthening health centers and promoted access to quality prevention and treatment services. Health and social service personnel were trained and were encouraged to refer to materials appropriate to the audience segment.

Use of common indicators on performance contracts: Participating organizations were encouraged to use the same indicators to measure the progress of their activities.

Strengthening communication capacity: The project provided training and technical support to implementing partners to strengthen their strategic planning skills as well as the technical skills required to implement and monitor communication activities.

Community participation and empowerment: As noted in the section on ownership, participation of PLHIV and affected communities in the development and implementation of communication interventions and strengthening local capacity helped empower them to take responsibility for themselves.

IRIN: A Vehicle for Change

Engagement of IRIN allowed the project to reach millions of people. The project worked with IRIN to:

- Create a radio station on the Benin-Nigeria border.
- Report on topics relevant to travelers, such as traffic accidents, documents needed to cross borders, and where to get HIV/AIDS services.
- Advertise the Love Life Caravan.
- Provide a venue for corridor users and residents to express their concerns about HIV/AIDS and road issues.
- Hold numerous call-in shows with a range of experts.

Communication challenges

The sheer number of different groups involved and the previous lack of engagement on HIV in the targeted areas made capacity building extremely difficult, time consuming, and costly.

Considering five countries, two national languages, several local languages, multiple cultures, conflict in Côte d'Ivoire, and Togo's ineligibility for World Bank funding, the project was impressive in developing a sub-regional communications strategy including standardizing key terms and messages along the border. The impact of the harmonized communication strategy is evident from behavioral surveys and direct observation.

- Border areas are estimated to have prevalence as high as twice the national figures. Changing behavior in the mobile population is more difficult than the settled population. Special strategies and approaches are required to stimulate behavior change in mobile populations.
- Building grassroots capacities has been exhaustive and should not be underestimated. Changing behavior, especially in CSWs, to alternate income generation opportunities is equally difficult without a longer term vision and consistent support.

Innovations

The project created a special brand of male and female condoms—Migrant and Femigrant—that could be sold all along the Corridor (instead of different brands being sold on each side of the border as required by licensing regulations). This was the first project to develop a single condom brand across countries. Having a single brand greatly simplified messaging, reduced advertising costs, and facilitated M&E.

Localized radio channels. Through IRIN (Integrated Regional Information Networks, a service of the UN Office for the Coordination of Humanitarian Affairs) Radio, partnerships were established with 32 radio stations for the five countries—national radio stations as well as community radio - for the production and broadcasting of radio programs in 17 local languages. In 15 months of activities, over 30 million people were sensitized through the radio programming approach. The initiative resulted in significant increase in demand for VCT. The established radio coverage can be used to promote awareness on PMTCT, TB/HIV, and other topics.

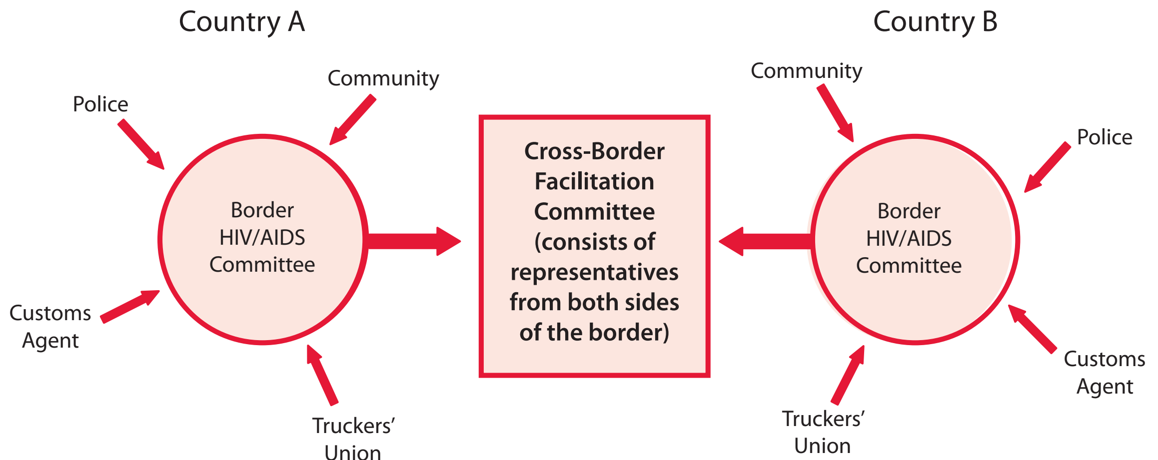
Factor 4: Cross-Border Facilitation Committees Played a Crucial Role

During and after project development, transport workers, police, customs agents, and communities identified the need for a mechanism to address complaints about border crossing and t inform travelers of what is required to cross borders. Complaints came from both corridor users and corridor officials. Drivers complained about the number of checkpoints (up to 36 per 100 kilometers, versus the recommended three per 100km), long delays (typically four hours for passenger vehicles and two or more days for vehicles carrying goods), and inconsistency of demands at different times and different posts. Officials complained that drivers and passengers tried to cross without the proper documents or carrying restricted loads. Even police often were not aware of documentation needed or national and regional regulations. The diversity of people using the corridor added to the complexity and confusion.

If the project was going to reduce delays at borders and checkpoints, it was crucial to bring police, transport workers, customs officials, and immigration employees together to discuss problems, identify solutions, and create action plans.

After the project was approved, two workshops were held in Lomé, Togo—one with representatives of transport workers and another with border con-

Figure 1: Composition and interaction of Cross-Border Facilitation Committees



The Togo–Benin Border Facilitation Committee won the Best Committee Award for undertaking activities such as:

- Introducing signage to direct travelers where to go at border patrols (for example, drivers of personal cars have a specific area at which to show their drivers license)
- Organizing an annual World AIDS Day event
- Developing IEC and BCC campaigns for specific target audiences
- Organizing in-service training for new border agents (on regulations and STI/HIV/AIDS)
- Organizing training and condom distribution with border hotel staff

The Côte-d'Ivoire–Ghana Facilitation Committee:

- Held monthly meetings with border agents to share complaints
- Decided to work with the agents toward a zero-complaint goal
- Determined what information transport workers need in order for this goal to be achieved
- Convinced drivers of commercial passenger vehicles to sensitize passengers on documentation needed to cross borders and to have their driving assistants check passenger documentation before allowing passengers to board.

trol agents from each of the border areas. During a third workshops bringing the two groups together, ECOWAS representatives presented ECOWAS regulations, and participants agreed on the roles of the Border Facilitation Committees:

- Arbitration
- Collecting data on border crossings and hindrances thereof
- Organizing training in ECOWAS regulations
- Helping to ensure that transport workers and passengers were aware of and traveled with the documentation needed to cross borders
- Improving relationships between border users, communities, and border officials
- Creating and overseeing implementation of action plans

The committees' overall charge was to eliminate hindrances to crossing the borders and to sensitize border employees and others on behaviors that put them at risk of HIV infection. The meetings also made clear the need to involve additional categories of stakeholders, so community representatives were invited to join.

Cross-Border Facilitation Committees drew their membership from border committees on either side of the border. Each Border Facilitation Committee operated according to its capacity and the needs of the border communities, including migrants and border employees. The typical committee had five officers: two police/customs/immigration representatives, two transport workers, and one community member. The project supported the committees with funding and capacity building (ECOWAS regulations, project design and management, IEC, mediation skills, HIV/

Table 7 Border Control Outcome Indicators

Indicator	Baseline (2005)	Target	Value (2007)
Number of checkpoints per 100 km along the corridor	9	3	5
Average time (minutes) for trucks to clear border formalities	180	90	128

AIDS prevention, and so forth). Members of the Committees were given the right to cross the border freely to discuss or resolve border crossing issues.

During the project, waiting times at borders decreased, as had the number of checkpoints between borders. Awareness of border crossing requirements increased significantly. Much more needs to be done, but because of the success of the Abidjan-Lagos Cross-Border Facilitation Committees, ECOWAS now requires its regional projects to institute cross-border committees.

Challenges

- While crossing times decreased overall, not all borders showed improvement, and two borders continued to close from evening until early morning, forcing vehicles to remain overnight.
- Language and cultural barriers remain an issue at borders where one country uses French and the other uses English.
- Turnover among border control employees necessitated additional training for new staff

Innovations

Establishment of border committees and training them for peer-to-peer learning. Border communities were mobilized and trained for community mobilization and awareness. ALCO coordinated the training not only to support the community level subprojects but also for peer-to-peer learning. This approach proves to be cost efficient and giving a clear mandate and operational objective to the committee members.

Lessons for others

- Involve high-level local officials in Cross-Border Facilitation Committees to increase ownership and commitment to change.
- Education and prevention activities must be almost constant in order to reach new people crossing or settling down at the borders.
- The committees must be flexible and adapted to the local conditions and populations.

Factor 5: Managing to Effect

Making this project work required an enormous number of people and a clear organizational framework. The inherent complexity of a multi-country, cross-border HIV/AIDS project demanded that institutional arrangements be as straightforward as possible.

A streamlined implementation framework to accommodate many actors

A Governing Body of heads of national HIV/AIDS programs and Transport Directors from each country adopted annual action plans, supervised their implementation, and liaised with the national HIV/AIDS programs. The Executive Secretariat coordinated project implementation by civil society organizations (CSOs) and public sector organizations. An Advisory Body, with half of its members from private sector organizations, provided technical and policy advice to the Governing Body. Community-based border HIV/AIDS committees coordinated the local response to HIV/AIDS. Inter-country Facilitation Committees, with representatives from all stakeholders, helped provide training on HIV prevention and implementation of Economic Community of West African States (ECOWAS) regulations on the free movement of people and goods, and oversaw or implemented IEC activities. An operational manual spelled out roles and responsibilities and guided project implementation.

The five participating governments agreed on shared project responsibilities, including which country housed the headquarters and how it would be staffed to ensure openness, transparency, and equal opportunity to all nationalities. Countries led different aspects of project management:

- Nigeria: Presidency of the Governing Body
- Ghana: Vice-Presidency of the Governing Body
- Benin: Host of the Secretariat headquarters and grant recipient on behalf of the other countries
- Côte d'Ivoire: Executive Secretariat
- Togo: Advisory Body Chair

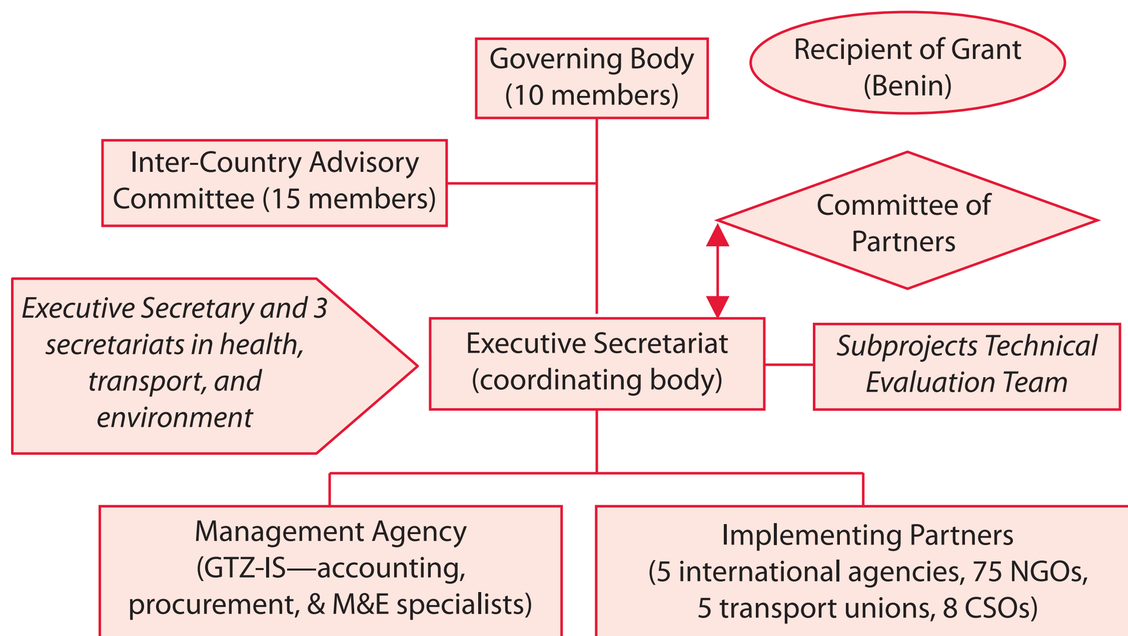
Project countries alternated in hosting the Governing Body meetings held two-to-three times per year. Government representatives, the Executive Secretariat, Bank staff, and others as appropriate attended these meetings.

Institutional arrangements

Given the size and complexity of the project, institutional arrangements and management models also had to be lean and flexible. On the ground in West Africa, this meant:

- Establishment of ALCO to create true joint ownership of the project by all participating states and to coordinate and implement the project rather than separate coordination bodies in each country
- Use of an Executive Secretariat not housed in a participating government agency or in a pre-existing regional organization.
- Agreement that the Government of Benin, which had volunteered, would house the ALCO headquarters and finance the overhead of the Executive Secretariat, which would be seated at ALCO headquarters. Benin's government also offered

Figure 2: Corridor Project Organization Chart / Institutional Arrangements



to receive the project funds on behalf of all five countries, including Togo (which was in non-accrual status with the Bank) and Côte d'Ivoire (rapidly slipping into conflict).

- Facilitation and coordination vs. command and control: To avoid confiding too much power in any one entity, the Corridor project Executive Secretariat contracted out much of the work, reducing the risk of the Secretariat becoming a command and control institution. The Executive Secretariat was supported by an experienced management firm that dealt with fiscal management, procurement, and M&E, which also enabled the Secretariat to focus on coordination, collaboration, and capacity building.
- Creation of conditions for beneficiaries' involvement.
- Robust M&E: The M&E plan was developed through a participatory process since a number of partners would be involved in M&E activities according to their areas of expertise. Sufficient resources and skills had to be made available for M&E. The Corridor project initially contracted out M&E to ensure adequate attention to both M&E and implementation.
- Hiring country-level NGOs (one per country) to coordinate reporting and M&E in that country and then supply the information to the Executive Secretariat.

Within the Bank this meant:

- A supervision budget adequate to staff regular visits by supervision teams: Supervision teams drew on the resources of partners, particularly bilaterals and other stakeholders. The composition of the supervision teams was multisectoral.

Subcontracting critical but routine tasks paid off in terms of time and money, especially for a new organization (ALCO) in a complex setting. Contracting a lean management group with routine accounts management, procurement management, and M&E system development expertise proved to be cost efficient and effective. The contracting out of accounts management and M&E on a build-operate-transfer (BOT) basis worked well. By the time World Bank funding ended, ALCO successfully took over the fiduciary and M&E roles. With project objectives well defined and target groups well identified, it was comparatively easier for the institutions to focus on the deliverables.

Management structure within the Bank

The project management structure within the Bank was typical of other projects except that at the regional level a single team of specialists (financial management, health, and procurement), based in Benin, provided technical support instead of having a team in each country. This proved to be cost-efficient and ensured a broad view of the entire project instead of a primarily country-level perspective. Like the creation of ALCO, having a single team for the five countries fostered progress toward an overall objective instead of individual objectives (and success) for each country. This team and the task team based in Washington kept the Bank's staff in each country informed about the project, including expected visits and their outcomes. As with other regional projects, the task team conducted at least three visits each year. Visits, always in conjunction with the Executive Secretariat, typically began in Benin and then proceeded to one or more countries with key activities or with issues needing resolution.

Sustainability, the Bank's role, and partnership

The Corridor project confirms that Bank can play a catalytic role, undertake high risks, build effective institutions, attract substantial financing and

deliver results. The Bank played a catalytic role in supporting an innovative initiative by taking high risks. The project documents indicate that at initiation, with the exception of UNAIDS, other development partners did not show interest in joining the project. UNAIDS provided extraordinary technical and financial support to bring the project concept to fruition. Strong partnership between the Bank and UNAIDS was a critical factor in the design and delivery of the project. After the Mid-Term Review, ALCO qualified to receive $45 million from the Global Fund over five years.

Challenges

Project coordination was highly labor intensive with significant diplomatic and political risk. Coordination among five countries (1022km of corridor) was difficult due to two national languages, multiple cultures and local languages, multiple religious beliefs and beliefs on traditional and spiritual healing, and engagement of five Ministries of health, transport, and uniformed services.

Management lessons learned

- Establishing the institutional framework is an essential step during the preparation phase and requires time, particularly with a regional program, but it is time very well spent. The same is true of high-level political engagement in participating countries. Once there is a political consensus, operational and institutional aspects of the projects are easier to develop and implement. Government ownership and leadership are also crucial for successful institutional arrangements. Participating governments should decide which country will house the headquarters and how it will be staffed to ensure openness, transparency and equal opportunity to all nationalities. The responsibilities of the project were successfully shared by all the five countries. Benin's offer to provide office space for the Executive Secretariat greatly facilitated reaching agreement. Also important: the institutional arrangement was simple and lean despite the inherent complexity of the project.
- The Executive Secretariat focused heavily on facilitation and coordination of community engagement, training staff, and disseminating management tools. All stakeholders appreciated this, and it helped ensure empowerment of civil society organizations.
- Contracting certain management responsibilities to a lean management group with routine accounts management, procurement management, and monitoring and evaluation system development proved to be cost efficient and effective. The firm operated on a build-operate-transfer basis, and ALCO successfully took over the fiduciary and M&E roles by the end of the Bank-funded project.
- In order to allow for flexibility, it is better to keep financing expenditure categories to a minimum in complex projects. Expenditure categories need not be elaborate—maximum amounts may be allocated to an unallocated category so that the project can benefit from flexibility and allocate resources based on the previous 12 months of implementation progress.

Key recommendations for other regional projects

Creating management structures that facilitate and encourage ownership of the entire project can help ensure overall project success in addition to country-level success.

- Regional projects should consider the benefits of using a single or joint project management unit across countries instead of having such a team in each country.

- Likewise, project managers should work hard from the beginning to ensure that each country is concerned about and invested in the success of the other participating countries.
- Having one project appraisal document for the project instead of a separate project appraisal document for each country involved in the project can also help all involved stay focused on the common goal.

In addition, project managers must help stakeholders be clear about expectations, conditions, and limitations, and they must help stakeholders focus on a topic, analyze it from various perspectives, and reach consensus on how to address it. This requires that stakeholders be represented and heard in the decision-making process.

More Lessons Learned

In addition to the lessons specific to the five factors highlighted, the Abidjan-Lagos Transport Corridor HIV/AIDS Project generated the following lessons that may be useful for future sub-regional HIV/AIDS projects, from project design to implementation to evaluation.

Mainstreaming in the Transport Sector. The project provides an impressive example of mainstreaming HIV/AIDS in the transport sector in World Bank operations. It has significantly raised awareness of the impact of HIV on the sector's development and of the sector's contribution to the spread of the epidemic. The ministries of transport in all five countries recognize the challenge and have been fully engaged in the project (evident from stakeholder consultations). However, evidence of key results delivered by the transport ministries in terms of improved partnership with the border entities to streamline customs formalities and facilitating traffic flow has not been sufficient. It is critical to actively engage the transport sector, customs and uniformed services to further reduce the amount of stagnant traffic at the borders. Without adequate parking facilities and infrastructure, as well as access to basic health services and information –mobile populations may be contributing not only to the spread of HIV but also to the spread of other diseases including TB and respiratory infections. Bank-financed transport infrastructure operations should address such challenges as a safeguard issue at the borders as well as in-country main road arteries. Future operations should be designed with critical thinking that transit facilitation (including infrastructure and customs clearance) are key to the success in curtailing the epidemic.

Easing the flow of persons and goods across borders. While this project provided an excellent example of mainstreaming HIV/AIDS in the transport sector, accelerating border clearing formalities may not be sufficient to reduce significantly the time spent by trucks in front of a border—a major contributor to risky behavior. Addressing the root causes of the chaotic conditions prevailing at some borders requires a comprehensive program combining physical investment and regulatory and behavior change. Ministries with relevant responsibilities such as customs duties and security concerns should be engaged in solution-finding, and ECOWAS should play a more active role in pushing the regional integration agenda. The objective of addressing different border closing policies at different borders and several check points on the 1022km corridor (especially in Côte d'Ivoire during the conflict) was not achieved. According to the border security agencies, such initiatives would have compromised the national security. Nevertheless, the border agencies fully cooperated in the dissemination of the IEC interventions.

Complementing national AIDS programs. Regional HIV/AIDS programs are most useful when they complement national programs, focus on border areas, and target vulnerable groups associated with the trucking industry. The Governing Board greatly facili-

tated the process of developing synergies between the five national AIDS programs and the regional program. A program combining the fight against HIV/AIDS with trade facilitation offers strong opportunities for synergy, though it is easier to reach a consensus among governments on the former than on the latter.

Project design. This was the first regional HIV/AIDS project addressing the threat of HIV on the transport sector and the transport sector's contribution to checking the spread of the epidemic. The project incorporated strong commitment to regional cooperation, objectives matching regional capacity, clear delineation and coordination of the roles of national and regional institutions, accountable governance arrangements, and planning for sustainability of outcomes. The project design was innovative and relied heavily on a participatory process that engaged a variety of stakeholders. This approach resulted in strong ownership from the heads of state to the community level. The objectives and design were realistic, simple, and based on both known conditions in the target area and the desired outcomes. The beneficiaries were clearly identified, and the project kept its focus on those target groups throughout implementation. The project design was realistic, simple and based on the key results to be delivered in prevention, care, treatment and coordination. A simple project design that is focused on outcomes and well defined target groups results in successful implementation—I including better monitoring. However, a simple project design does not warrant less preparation effort and budget, rather, it requires a larger preparation budget for gathering evidence on which to base the design.

Sustainability. Planning and implementation must take place with sustainability in mind. Knowing that the project grant had a real end-date, project partners worked quickly to demonstrate the value of the approach and begin to identify potential new partners and donors. Based on the Mid-Term Review, the Global Fund awarded ALCO $45 million for a five-year follow-on project, allowing the work not only to continue, but also to expand.

The Project Development Objective (PDO), Strategic Alignment and Focus. The PDO was realistic, simple, and developed based on evidence and recognition of the complexity of the challenge to address HIV/AIDS in the mobile settled populations along the Abidjan-Lagos corridor, especially at the border areas. The PDO was based on assessments done in 2001 at the border areas that estimated about 300,000 HIV positive persons traveling across the borders annually and the time to clear cargo trucks at the border areas that resulted in delays from a few days to months, in some cases. Considering that the corridor provided about 65 percent of trade facility to the five West African countries involved, the effect of HIV on the mobile populations and settled populations along the corridor was likely enormous. Stakeholders recognized that the traffic flow must be improved, number of checkpoints should be reduced, and customs clearance procedures be streamed lined. These challenges were considered during the PDO design. However, considering that the improvement of traffic flow, customs clearance and border security issues, which engaged several agencies and sensitive border policies—the project design team did not include traffic facilitation as one of the objectives in the PDO but addressed this challenge in the project implementation as a project activity. The PDO should be developed based on evidence and well informed estimates of what can be realistically achieved. Objectives that are critical but their achievement is too risky can still be part of the project design but do not necessarily be part of the overall PDO. A wider and earlier stakeholder consultation in the development of the PDO and KPIs is critical. The project narrowly identified the target groups and beneficiary populations and kept its focus on the target throughout its implementation.

Monitoring and evaluation across borders. Developing an M&E program from scratch for the corridor, considering that only a few countries had a

national M&E system, was a daunting task. Bringing five countries to agreement on the M&E standards, software, data collection and reporting took time in the beginning. It also was very challenging to conduct surveillance of mobile populations. With mobile groups, it is even more difficult to have absolute data. Monitoring of new incidents in settled population is feasible but monitoring mobile populations requires high investment, an implementable methodology, and consistent financing over the medium-to-long term.

Behavior change among mobile populations. Border areas are estimated to have prevalence as high as twice the national figures. Changing behavior in the mobile population is more difficult than the settled population. Special strategy and approach is required to make behavioral change interventions in the mobile populations.

Building capacity where little capacity exists. Building grassroots capacities required very large amounts of human and financial resources. The cost and time needed should not be underestimated.

Conclusion

The Abidjan-Lagos Transport Corridor HIV/AIDS Joint Regional Project made considerable progress toward reducing the risk of transmitting HIV/AIDS and other STIs along this major West African highway. The project documented notable improvements in knowledge about STI/HIV/AIDS prevention. Access to VCT services increased many-fold. More than100 health care providers were trained to provide STI/HIV/AIDS clinical and counseling services, 223 staff and members of NGOs and PLHIV associations were trained to provide prevention, support, and care services. Anti-HIV stigma was attacked directly. Access to ART was ensured for over 500 corridor users.

From a systems perspective, clinic and hospital facilities and training were greatly enhanced. Medical waste management was instituted. Border employees became better informed about transportation, customs, and immigration policies as well as STI/HIV/AIDS. Border crossing times and the number of checkpoints were reduced. Greater collaboration took place between sectors involved (in particular health, transport, police, and customs and immigration).

This project has made a real and lasting difference along the Corridor. Such major gains would have been unlikely if not impossible without joint ownership by all five countries and the other project stakeholders. A comprehensive approach to systems strengthening and harmonization of health services in some ways laid the foundation for change—adequate services must be available to encourage, reinforce, and support behavior change. Tested, consistent communication strategies and programs reached million of people—both adding to the foundation for change and supporting change once initiated. Work across borders was also critical, serving to reduce certain barriers to change. Finally, the project's development of, and reliance upon, streamlined but broad-spectrum management structures facilitated joint project development, quick identification and resolution of problems, and innovative approaches for regional programs.

Many factors led to the Corridor Project's success. It is hoped that the information provided here will assist those developing or managing other regional projects (on HIV/AIDS or any topic) to be at least as successful. The Corridor Project continues to operate with government and GFATM funding and various types of partner support. In March 2010, the World Bank Executive Directors approved a new Abidjan-Lagos Corridor Project that will focus on transportation issues and includes support to expand the HIV/AIDS activities already underway.

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Annex:
Consensus Technical Framework

Annex Consesnus Technical Framework

Intervention Area	General Objective	Operational Objectives	Strategies	Indicators	Expected Results	Sample Results
1. Program Implementation	Create strong awareness of the Corridor Project	1. Inform constituents of the existence of the program. 2. Reinforce the adherence of involved actors in the program. 3. Create a favorable framework for program management.	1. Information and sensitization campaign regarding program implementation, stigmatization, and support for PLHIV	Number of sessions or informational meetings Number of NGOs involved in meetings	Communities informed NGOs involved Management committee in place	75 NGOs became implementing agencies Border and cross-border committees established
2. STI/HIV/AIDS Prevention						
2.1 Behavior change	Reduce STI/ HIV transmission via condom use	1. Reinforce prevention of STI/ HIV/AIDS for a change in habits 2. Reinforce participation of affected people in interventions 3. Improve access to quality information, encouraging abstinence, faithfulness, and condom use	1. Community mobilization for behavior change 2. Condom social marketing and distribution	# of sensitization sessions conducted # of people sensitized # of STI patients # of STI kits sold # of condoms sold	Sensitization carried out Adoption of risk-reduction behaviors Training of leaders Assured availability of condoms	More than 30 million people sensitized 625 people trained for condom distribution 8.8 million condoms distributed 14,202 treated for STIs
2.2 Blood transfusion	Ensure that blood and extracts are safe	1. Support creation of and equip blood collections centers at borders 2. Organize blood donation campaign in collaboration with national program 3. Ensure trained technical staff available at transfusion centers 4. Create depots for screened blood at government-owned facilities near corridor	1. Enhance blood and blood extract protection system using government facilities 2. Create blood collection centers along corridor 3. Ensure equipment, training, IEC to discourage unnecessary or unsafe transfusion	# of blood collection centers established # of tested blood centers in place # of voluntary blood donors # of useable tested blood sachets available	Functional blood products protection system in place	Blood banks established at all corridor health reference centers

3. Improvement and integration of health services provided to PLHIV	Create optimal conditions for multidimensional health care delivery integrating counseling and testing, psychological support, and drugs	1. Equip centers and improve access roads 2. Improve laboratory capability and supply management 3. Ensure staff training 4. Enhance STI care and support 5. Enhance counseling and blood screening in health centers 6. Develop drug protocols for opportunistic infections, HAART, and PMTCT 7. Develop nutrition activities 8. Facilitate cooperation among all in health service delivery and follow-up	1. Equip and rearrange health centers 2. Enhance lab and imaging center 3. Train health care providers 4. Manage STIs 5. Implement VCT 6. Ensure procurement of drugs, reagents, and consumables 7. Provide food assistance to PLHIV 8. Set up working partnerships		Trained staff Norms and standards established Drugs available Working partnership with other teams	1,174 participants in training on STI syndromic management, opportunistic infection care, VCT, MTCTP, psychosocial support, laboratory, ARV proscription, medical waste management Standards agreed Drugs provided
4. Improvement of psychosocial care for PLHIV and their families	Organize psychosocial care and economic support for PLHIV	1. Fight stigmatization 2. Organize social services to fight stigmatization and discrimination 3. Organize support groups for PLHIV	1. Set up community-based network of partners to sensitize other partners and engage them in anti-stigma and anti-discrimination activities 2. Create social service area within health centers for support, meetings, discussions, VCT 3. Create PLHIV support groups	# of NGOs involved in health care delivery # of patients getting psychological and/or financial support	Support for set-up network	Project supported 21 organizations to provide support to PLHIV and OVC.

Annex Consesnus Technical Framework (continued)

Intervention Area	General Objective	Operational Objectives	Strategies	Indicators	Expected Results	Sample Results
5. Reduction of socioeconomic consequences of HIV/AIDS	Propose appropriate solutions to reduce social impact of HIV/AIDS	1. Enhance patient follow-up and home-care delivery 2. Create income-generation activities for socio-economic support 3. Enhance support to HIV/AIDS orphans	1. Organize home monitoring and care 2. Develop income-generation activities for PLHIV and their families 3. Provide material assistance to AIDS orphans	# of institutions with a social solidarity system # of workers treated by the system	Solidarity system in place Functional anti AIDS Committee	ARVs provided for 539 PLHIV Care and support provided to 1,246 PLHIV and 1,084 OVC Border HIV/AIDS committees established, trained, equipped, and operating
Control of HIV/AIDS in companies	Develop global care of HIV+ employees in their place of work	1. Sensitize staff to establish mutual assistance system 2. Train teams of educator on STI/HIV prevention 3. Provide counseling, blood screening, condom distribution, STI treatment, and ART available at companies	1. Convince leaders, trade unions, or workers to establish a mutual assistance system funded by monthly contributions based on salary in order to provide ART to workers and their family members	# of workers identified as seropositive	Employees treated for HIV	Trained 97 police, customs, immigration, and transport union staff on HIV prevention and customs regulations
Agency for sample collection system and feedback/ evaluation	Measure the impact of the intervention put in place or strengthened by program activities	1. Reinforce qualitative MIS system for STI/HIV/AIDS 2. Establish sentry supervision system and supervision of STI/HIV/AIDS 3. Encourage quality behavioral studies regarding migrants 4. Establish a feedback/ evaluation mechanism for all program interventions	1. Strengthen institutional capacities and local competencies 2. Revitalize epidemiological supervision 3. Set up an MIS	# of functional sentries # of feedback/evaluation missions Supervision reports	Establish management system leading to knowledge of the position of STI/HIV/AIDS at the borders and the taking of appropriate and relevant decisions	Comprehensive M&E system established Observatory set up at each border crossing [verify]

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