Multisectoral HIV/AIDS Projects in Africa:

A Social Analysis Perspective

Cynthia Cook
in collaboration with ACT Africa
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# Contents

Introduction

Social Development Objectives in MAP Projects

Relationship to the Regional Development Strategy

Changing Perspectives on HIV/AIDS

HIV/AIDS in the African Social Context

Poverty

Gender Relations

Age Differences

Ethnic Diversity

Conflict and Violence

Weak Institutions

Poor Governance

Africa’s Assets

Social Analysis for MAP Projects in Africa

Country Strategy

Project Identification

Project Preparation

Project Appraisal

Social Diversity and Gender

Social Institutions, Rules and Behavior

Stakeholder Analysis

Participation

Social Risks

Institutional Arrangements and Sustainability

Social Analysis After Appraisal

Monitoring and Evaluation

Conclusion

Bibliography
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INTRODUCTION

HIV/AIDS poses a tremendous development challenge in Africa, a continent in already difficult circumstances. Africa contains a large (and growing) share of the world’s absolute poor. Its eroding share in the world economy, declining exports, limited diversification into new lines of business, and massive flight of financial and human capital, have posed serious threats to social development. Armed conflict and other forms of violence are increasingly used to appropriate political power and redistribute resources. The failure of post-colonial states to provide a level of living commensurate with, if not better than, that experienced during the colonial and pre-colonial past evokes in many Africans diffused rage based on rising and unsatisfied expectations. In addition, the productivity of women, who provide much of the region’s labor, is hampered by a culture perpetuating the isolation of women from knowledge and other assets.\(^1\) All of these factors are closely linked to the fact that Africa exhibits the most rapid spread of HIV/AIDS and the highest vulnerability to and from it. Twenty years after the disease first appeared in Africa, it continues to take a deadly toll. It has reached every country and has infected and killed millions.

HIV/AIDS is not just a medical but a crucial socio-economic issue. The social, economic and welfare challenges posed by HIV/AIDS are unprecedented. The illness reduces productivity, depletes scarce public and private resources and human capital, raises the cost of doing business, exacerbates gender inequality, deepens poverty, diminishes school enrollment, challenges health systems and pension schemes. The disease has already orphaned 12 million African children, a number likely to double by 2010. This demographic change has already pushed up dependency ratios and poses difficulties for families to cope with the extra expenses. AIDS often sickens and kills the family breadwinner, leaving widows and orphans, often sick themselves, and elderly persons without any support. All these factors have led to increased and sustained impoverishment combined with increased state expenditure and economic decline. Despite growing national and international efforts, the situation has been slow to improve.

In response to this challenge, the Africa Region of the World Bank has developed a strategy to stimulate awareness of the epidemic and its potential

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\(^1\) This paragraph is taken in part from the Summary of Can Africa Claim the 21st Century? World Bank, Washington, 2000.
consequences for development among high level decision makers, and to provide financial resources and technical support for actions to address HIV/AIDS across all sectors of its operations. It works in partnership with other donors through the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the International Partnership Against AIDS in Africa (IPAA). These programs assist African countries to develop and implement national strategies to combat the spread of HIV/AIDS and to provide care, support and treatment for Persons Living with HIV/AIDS (PLWHA). As part of this strategy, the Region has developed a new lending instrument, the Multi-Country AIDS Program (MAP), which permits the rapid processing of country projects meeting the following criteria.2

- **Satisfactory evidence of a strategic approach to HIV/AIDS.** In principle, this should be demonstrated through a coherent, national, multi-sector strategy and action plan that has been developed through a participatory approach using social assessment techniques. In practice, the urgency of making resources available to fight HIV/AIDS has led to projects being designed and approved while the strategic planning process is still ongoing.

- **A high-level HIV/AIDS coordination body has been established,** including broad representation of stakeholders, including PLWHA. This criterion aims to ensure continuing stakeholder involvement throughout project implementation.

- **Government has agreed to use appropriate implementation arrangements to accelerate project implementation.** This is aimed at facilitating rapid disbursements while ensuring transparency and accountability. This often requires officials to implement procurement practices which they do not support.

- **Government has agreed to use and fund multiple implementation agencies,** including community-based and non-governmental organizations. This criterion is intended to ensure the full mobilization of available resources to design and carry out HIV/AIDS programs.

Twenty-four (out of 45) African countries have received support through MAP projects through FY02, and many more are receiving or about to receive aid in FY03. MAP projects are multi-sectoral in nature. They focus on minimizing and mitigating the impacts of HIV/AIDS on a country’s entire economy and society.

The new approach to HIV/AIDS has posed many challenges to project task-team leaders and social scientists in assessing social dimensions and in developing, together with borrowers and other donors, a process of ongoing social analysis from project identification through project evaluation. This process is ideally expected to continue under the leadership of the borrowing country after the project is completed. This paper aims to support this process by providing a social development perspective on possible approaches and key factors.

This paper first discusses the social development objectives of MAP projects in the context of the World Bank’s Africa Region development strategy. The paper then looks into aspects of African societies and cultures which contribute to make the region more vulnerable to HIV/AIDS. Finally, it suggests an approach to social analysis of MAP projects in Africa. The paper is based on a review

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of the literature on HIV/AIDS in Africa and elsewhere, as well as a review of available project documents for MAP projects.

**Social Development Objectives in MAP Projects**

In the context of the World Bank’s commitment to poverty alleviation, the social development objectives are expressed in terms of inclusion, empowerment, and security.³ Achievement of these objectives is primarily the responsibility of the borrower. The World Bank provides assistance through country policy dialogue, support for the participatory preparation of poverty reduction strategies and other national and sector strategies, and lending operations. Country-specific objectives and targets are articulated through country Economic and Sector Work (ESW) as well as through the national and sector strategy formulation process. However, often the objectives and targets for the fight against HIV/AIDS are not well defined at a national level when HIV/AIDS projects are in preparation. The process of social analysis can help establish such objectives and increase the effectiveness of HIV/AIDS programs in promoting positive social outcomes.

**Relationship to the Regional Development Strategy**

The strategy for the new millennium set out for Africa and supported by the World Bank recognizes HIV/AIDS as “a new menace” threatening to undermine human health and welfare, reduce savings and investment, and stress the social fabric in many African countries.⁴ The strategy does not focus on fighting HIV/AIDS but on the need to develop participatory approaches to facilitate consensus, include marginalized groups and to strengthen Africa’s institutions. The strategy trusts the capacity of African communities to manage development programs, and the ability of governments to provide an environment attractive to private investors. This is based on an understanding that economic growth without simultaneous social and institutional development (or “nation-building”) does not necessarily lead to inclusion, empowerment and poverty reduction.

In this context, the Africa Region is preparing a Social Development Strategy to guide the social analysis of country programs and projects. This strategy proposes that the social development goals for Africa should include:

- Development that promotes inclusive and equitable societies which recognize and protect human and civil rights, and support the dignity of all social groups and individuals;
- Development that promotes eradication of poverty by first recognizing and scaling up local people’s own internal production structures, and then ensuring that the benefits of increased productivity are distributed equitably within society;
- Development that promotes strong, effective, responsive and transparent institutions, and good governance.⁵

The strategy recognizes Africa’s problems – poverty, inequality of access to resources (especially gender inequality), social exclusion, insecurity and conflict, environmental degradation, vulnerability to natural hazards, ineffective formal organizations and poor governance. It also recognizes Africa’s assets:

³ See, for example, the 2000/2001 World Development Report on Poverty.
underutilized productive capacity, strong local institutions, shared community values and solidarity, cultural diversity and indigenous knowledge. The strategy calls for country programs that will promote accountability and institutional change through civic engagement, build cohesive and resilient societies that can prevent and manage conflict, and promote socially responsible development and investment. One purpose of the present paper is to show how the goals of the regional development strategy, including its social development component, can be addressed through HIV/AIDS projects, which constitute a significant share of the regional lending program.

The goals of MAP projects in Africa are to intensify action against HIV/AIDS in order to avert future infections, alleviate human suffering, and help preserve national development prospects. Expressed in social development terms, the expected project outcome is improved security (health and welfare), empowerment and inclusion, especially for vulnerable groups, among both the poor and the non-poor. Projects aim to ensure equitable access to project benefits and often tackle issues of exclusion and stigmatization. A major focus in most projects is capacity building (empowerment) at the community level, in government agencies, and in civil society. The projects also aim at preserving prospects for economic growth, which is essential to poverty alleviation.

MAP projects contribute to regional social development in the following ways:

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

Changing Perspectives on HIV/AIDS

Action to address HIV/AIDS has been exceptionally difficult to initiate and sustain, in Africa and elsewhere, because of the deeply personal and private nature of behavior associated with the spread of the disease, and strong social and cultural constraints related to issues of sexuality, illness and death. These matters are not easily discussed or objectively analyzed in any culture. The first challenge to the social analyst/researcher is to overcome his or her own reluctance to deal with these issues on a personal level, and to identify the limits on understanding imposed by his or her own background and perspective. It is tempting but limiting to “simplify” the issue by defining it as a medical problem or a problem of communication, rather than as a fundamental problem in human and
social relations. Resistance to a broader
definition has often been found among
borrowers and donor agencies, precisely
because of the political, cultural and
personal sensitivity of the issue.

Knowledge and understanding of
the HIV/AIDS epidemic, in Africa and
elsewhere, is new and is constantly
evolving. Initially, it was seen as prima-
arily a health problem. Given the initial
prevalence among marginal groups
(male homosexuals and drug users), it
was not seen as a major concern even for
African health care professionals. Once
the magnitude of the problem was recog-
ized, however, African health care
systems tended to respond in terms of a
biomedical model, with programs to
protect the quality of blood transfusions,
improve diagnosis and treatment of
STDs, and intervene to prevent mother-
to-child transmission (MTCT). As over
time the limitations of these approaches
became clear, a public health approach
was added. It focused on providing more
information to groups at risk and the
general public, in the hope of inducing
the behavioral changes needed to slow
the spread of the epidemic.

At this point the World Bank began
to recognize HIV/AIDS as a key chal-
lenge for development in Africa. Its
economic arguments and simulation
models were effective in convincing
national leaders to acknowledge the
existence of HIV/AIDS and to devote a
significant share of national resources to
prevention and care programs. In other
respects, the Bank needed to learn from
colleagues in the donor community how
to tackle the problem. Early interventions
focused on IEC (information, education,
communication) campaigns and “social”
(i.e. subsidized) marketing of condoms in
order to overcome the many “market
imperfections” believed to explain “irra-
tional” risky behavior. Soon, however, it
was recognized that individual choice
was also constrained by social, economic,
and cultural factors, and that measures to
alter social norms, reduce the stigma
attached to vulnerable groups, raise the
status of women and reduce poverty
were necessary.6

In recent years, substantial sociologi-
cal and anthropological research on
HIV/AIDS has been carried out, in Africa
and elsewhere. It has led to a better
understanding of the social and cultural
context of HIV/AIDS programs. African
research institutions have been actively
involved in this work, and are well
positioned to provide leadership and
guidance to project teams. The emerging
concept is that the structural and cultural
context of a country or community consti-
tutes the “enabling environment” for
individual behavioral change.7 This
context can be modified through actions
that can be incorporated in broad spec-
trum of World Bank and other donor-
financed projects. Such projects include
legal and policy change, economic incen-
tives, participatory approaches, and
capacity building activities that capital-
ize on existing social and cultural assets.

A recent OED review summarizes the
findings relevant to HIV/AIDS projects.
Several of these findings have implica-
tions for the institutional design of
projects, especially for components that
expect to rely on NGOs or CBOs for
implementation. However, these findings
do not reach deeply into the social and

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7 Baylies, Carolyn, “Perspectives on Gender and AIDS in Africa.” In Baylies, Carolyn, and Janet Bujra, eds.,
AIDS, Sexuality and Gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia, Social Aspects
The weak performance of completed projects in monitoring and evaluation means that we still have limited understanding of the impact of World Bank assistance on HIV/AIDS outcomes. Completed HIV/AIDS projects do not have adequate indicators that are systematically collected over time — for disease incidence and prevalence, service delivery and quality, and behavior — at both the project and program levels.

Strengthening political commitment to HIV/AIDS is a long-term process; the Bank has tended to overestimate political commitment during project design.

Rapid project preparation in response to a public health “emergency” — without sufficient attention to capacity, political commitment, and institutional constraints — is likely to contribute to implementation delays.

The implementation of many HIV/AIDS interventions depends on effective functioning of the health sector at both national and district levels. Decentralizing project activities to the district level can improve implementation, but needs to be matched by giving districts sufficient authority to incur expenditures, improving financial flows to districts, strengthening accountability, and building capacity for planning and management.

Project and program design must strike a balance between comprehensiveness and avoiding excess complexity relative to local capacity.

Projects that increase drug availability in the short run may not necessarily improve treatment outcomes or sustainability after project completion.

Findings on NGOs:

- The demand for partnerships with NGOs/CBOs often exceeds the supply of willing and able partners.
- Too often NGO/CBO involvement is not clearly conceived during project design, involvement progresses slowly, and M&E are either poorly designed or not done at all.
- NGOs can potentially be used to reach groups at high risk of contracting and transmitting HIV, but NGO activities are not always directed to the highest-priority interventions.
- Governments may view NGOs as competitors for donor funds; thus, limited disbursement to NGOs may reflect a lack of commitment as much as administrative difficulties.

Social development was recognized for the first time by the world community as a key issue in understanding both the causes and the consequences of HIV/AIDS transmission at the 2002 World Conference on HIV/AIDS in Barcelona.

**HIV/AIDS in the African Social Context**

Certain features of African societies render their people particularly vulnerable to the spread of HIV/AIDS. These include widespread poverty, gender relations, age structures, ethnic diversity, conflict and violence, weak institutions and poor governance.

**Poverty.** While the epidemic originally affected the better-off segments of society which could travel and could afford multiple sexual partners, it soon “trickled down” to the poor and vulnerable, who are least able to bear its costs. Current evidence seems to suggest that the better educated and wealthier African
elite has been more successful in stemming the spread of the disease, while its ravages are more and more extensive among the poor.\textsuperscript{8} Poverty in Africa is related to generally poor nutritional and health status and to inadequate access to education, particularly for girls, increasing vulnerability to the spread of the disease. AIDS itself has been an important factor in impoverishing many families, not only through the illness and death of the breadwinner but also through the generation of widows and orphans, often sick themselves, who require support, as well as elderly parents left without the support of their children. Caring for the sick and dying draws women away from food production and family maintenance activities and may force children, especially girls, to drop out of school. Family and community solidarity, the traditional “safety net” of the poor, has mitigated the economic impact of AIDS to some extent, but needs for social support far exceed the capacity of such systems in countries where HIV/AIDS prevalence has reached epidemic levels.

\textbf{Gender relations.} Unlike other parts of the world, HIV/AIDS in Africa is mainly spread through heterosexual contacts, including but by no means limited to commercial sex. The probability of male to female HIV transmission is estimated at two to four times that of female to male transmission. As a result, Africa is the only continent in which a higher proportion of women than men are HIV-positive. This fact has dramatic implications for a society in which women are held to be responsible for family food production (as well as most other family welfare functions), child care, elder care, and care of the sick and disabled.

Due to their traditional role in society, women are less likely than men to seek or receive treatment for sexually transmitted diseases (STDs). Untreated STDs greatly increase the likelihood of HIV transmission.\textsuperscript{9} They can also have a negative effect on fertility, leading women to engage in more sexual activity. In extreme cases, infertility can lead to dissolution of a marriage, which places a woman at greater risk. In addition, women have less education and lower literacy levels than men. Consequently, they are likely to be less well informed about STDs and HIV/AIDS. They are also less likely to interact directly with agents of government (e.g., agricultural extension workers) or NGOs who could provide them with information. The vulnerability of women is rooted in strong cultural patterns of male dominance and decision-making in sexual and other matters, both inside and outside of marriage. These patterns are reinforced by traditional socialization processes and belief systems. They constrain the power of women to negotiate agreement with their partners on “safe sex,” and make it easier for men to blame women for the consequences of their own behavior. Raising questions about a man’s HIV status or about the use of condoms can be seen as a violation of trust or as evidence of a woman’s evil acts or intentions. Practices such as “divorce at will” (for men), “wife inheritance,” and “property-grabbing” from widows illustrate women’s vulnerability and reinforce their dependency on sexual relations. Impoverished women are likely to be driven into commercial sex or other occupations and relationships (including marriage) which place them at high risk of HIV/AIDS.

\textbf{Age differences.} Young women (15-24 years) are particularly vulnerable, and HIV prevalence rates in this category are exceptionally high. Their vulnerability is

\textsuperscript{8} Baylies, Carolyn, \textit{op. cit.}
partly physiological and partly due to limited information, reinforced by behavioral norms that restrict them from seeking either information or care. Their sexual education traditionally takes place in the context of initiation rites, which may have lost their effectiveness and/or relevance, transmit inaccurate information, and in some cases (e.g., genital mutilation) pose a direct hazard of HIV transmission. There are often strong taboos against discussion of sexual matters between generations. Young women are also at greater risk of becoming victims of “non-consensual sex.”

Sexually active young women tend to have older partners, who are more likely than men of their own age to be infected with HIV. As a result, women under 25 represent the fastest growing group with HIV/AIDS in Africa. Among men, the prevalence rates remain relatively low until after the age of 30. This unequal age-based relationship poses a problem for young men, who find their chances of finding an uninfected partner sharply reduced. Overall, the illness and deaths of men and women in their most productive years has increased the already high dependency ratio in Africa, depressing further the standard of living and prospects for future saving and investment.

**Ethnic diversity.** While a great deal of research is done on HIV/AIDS prevalence and incidence rates and related social and cultural variables in African societies, there is little research that explicitly links variations in HIV outcomes to such variables. Consequently, little is known about the ways in which ethnicity, in the African context, may affect HIV/AIDS transmission or its effects on society and the economy. For “nation-building” reasons, most governments do not collect or release health data by ethnic origin. Experience shows that Muslim, Christian, and animist communities (and most countries are a mixture) are likely to react differently, depending on the degree of information and interest of local religious leaders. People living in isolated and/or “closed” communities (e.g., indigenous peoples) may be at somewhat less risk than those in communities open to the outside world. On the other hand, since isolated communities have less access to information and services, the local effects of HIV/AIDS may be more severe.

**Conflict and violence.** Africa is unfortunately prone to war and civil conflict, as well as less organized forms of violent behavior. Violence creates conditions in which physical power provides the only effective constraint on behavior and the influence of cultural norms and social controls is greatly reduced. Violence may be accompanied by an exalted emotional state that defies risk and ignores potential consequences. This context makes rape and (more or less) consensual sex between strangers common, especially in war-torn or occupied areas and in refugee camps. Conflict conditions also make it difficult if not impossible to provide preventive services, diagnosis, care and treatment for HIV/AIDS victims. Finally, the loss of life and lack of hope for the future associated with conflict drastically reduces the value of human life, and consequently the motivation to engage in life-saving behavioral changes. Overall, HIV/AIDS awareness and action requires a longer time perspective than that which tends to prevail in a conflict situation. When people are preoccupied with day-to-day survival, they are not likely to make decisions based on what might happen to them in ten years.

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10 It has been reported that most African girls have their first sexual experience in a non-consensual context.
Weak institutions. Africa’s governmental institutions are notoriously weak, and their national health services are among the weakest of all. Quality care has often been concentrated in the cities, in a small number of world-class facilities serving the well-off elite. Despite the hard work of many dedicated and competent practitioners, the human and financial resources devoted to health services have generally failed to meet the needs of the poor. The distribution of pharmaceuticals, especially under an official monopoly, has often been scandalously mismanaged. These constraints, combined with the many other killer-diseases (e.g. malaria, tuberculosis, cholera) competing for resources, have limited the capacity of the public health care systems to respond to the challenge of HIV/AIDS. The needs for new infrastructure, equipment, and supplies, for training of new staff and re-training of existing staff, and for delivering preventive, diagnostic, and treatment services to vastly increased numbers of clients, far exceed the absorptive capacity for assistance these institutions have shown in the past. While governmental health care services certainly need to be strengthened as part of any program to combat HIV/AIDS, alternative ways to provide adequate health care to the public at large need to be found. There are already successful examples in this direction.

HIV/AIDS is not an isolated problem of the health system. Public education, for example, plays a crucial role. The success of such programs depends upon the effectiveness of the education services, more specifically their effectiveness in reaching young girls and women. Ministries of labor and justice have specific responsibilities to ensure respect for the economic and human rights of people living with HIV/AIDS, and they are often ill-equipped to fulfill these responsibilities. In most African countries, the ministries of social affairs, youth, or women’s affairs are particularly weak in terms of budget resources (except for national sport teams – which can be an important resource in HIV/AIDS programs) and in influence on national decision-making. The staff of stronger sector ministries such as agriculture, mining, transport, and industry often have limited contact with the workers they represent, and both the staff and the workers they meet are almost exclusively male.

In recent years, Africa has seen a flourishing growth of national and local NGOs in response to the failure of public institutions. Many have addressed themselves to the needs generated by the HIV/AIDS epidemic. Most NGOs have excellent intentions, and some have skilled staff capable of providing services to the poor. But they have only a tenuous legal existence, varying of course from one country to another, and unless they have international sources of support, their resources are usually very limited. NGOs often experience difficulties in obtaining information and communicating with their clients and donors. Starting with a hands-on, mission-oriented group of staff, they often have trouble in “scaling up” to larger operations with a more complex administrative structure. Community-based organizations (CBOs) have been formed to deal with all kinds of problems, but they also depend heavily on outside resources and expertise. Often their informal structure (no “mission statement” or bank account) is a barrier to obtaining outside support. In addition, CBOs often work only as long as members feel they can continue to contribute without undermining the welfare of their own families.

Poor governance. African public institutions frequently fail to respond to the real, felt needs of the people they are supposed to serve. This is partially a failure of economic growth, since African
countries have not been able to generate the revenues that would put these institutions on a more sustainable footing. However, available revenues have often been misallocated, and those allocated for real public purposes have often been misspent or simply unspent because of cumbersome procedures or actual malfeasance. This record means that international donors will be particularly cautious in tracking the ways that their funds are used, and require strong reporting and accounting skills of the organizations that implement their programs. Transparency and accountability requires that programs include strong monitoring and evaluation systems, including provisions for full public disclosure and feedback to project management. Such systems need to focus not only on financial management questions or even only on health outcomes, but also on tracking the economic and social consequences of the programs and making this information available to the public, including program participants, in real time.

Involving a broad range of stakeholders in the design of the national strategy, and involving affected groups in the design of particular programs, is a good beginning for better governance in the implementation of MAP projects. However, it is necessary to recognize the skill requirements for meaningful stakeholder participation, to plan for the needed training and supervision, and to allow sufficient time for the participants, including NGOs and CBOs, to master these skills before large amounts of money start flowing. To demonstrate good governance, programs have to be sensitive and responsive to the needs and concerns of the many different social groups towards which their interventions are directed. This often requires not only “paper work” skills but attitudinal training (or “bureaucratic reorientation”), especially on the part of public agencies.

**Assets.** Africa’s greatest strength may be its remarkable resilience in the face of many development challenges, rooted in the strength of its “base communities.” Shared values of family and community solidarity and strong local institutions promote equity in the distribution of even meager resources. These values and institutions have often been in contradiction with economic growth imperatives, and over the last fifty years many have been weakened by development. Despite their key role in providing safety nets and building local social capital, these values and institutions sometime militate against broader social development in the sense of nation-building. The social development challenge of HIV/AIDS in Africa is to transform these mechanisms for survival at the community level into systematic approaches for achieving security, inclusion and empowerment in HIV/AIDS programs across entire countries.

**Social Analysis for MAP Projects in Africa**

There is a growing recognition that the success of MAP projects in achieving their objectives could be greatly improved by an understanding of the social and cultural context of each project and of the agendas, capacity and constraints of the various actors to be involved in implementation. MAP projects are investment in programs designed to induce behavioral change and to alter the agendas and activities of social institutions. Success in stemming the spread of HIV/AIDS requires fundamental changes in household, community, and organizational norms and modes of behavior. As a result, MAP projects include a complicated mix of activities: national, regional, and local coordinating activities, programs carried out by sector agencies, private sector and NGOs, community-based initiatives, and training and capac-
ity building at all levels. Introducing social analysis into the project cycle presents a significant opportunity to make MAP projects more effective: “a process of permanent social impact assessment and stakeholder consultation to ensure that HIV/AIDS programs reach beneficiaries directly, quickly, and with maximum impact on the ground.”

Technically, MAP projects rarely generate significant risks related to the Bank’s social safeguard policies, and formal social assessments are not required. Good practice suggests, however, that social assessment and analysis can be very beneficial to such projects, from the initial policy dialogue with borrowers, through project formulation, implementation and evaluation.

Country strategy. Social analysis can start even before a project is identified, by helping to establish and prioritize the social development objectives for the country. These objectives would draw from the country’s Poverty Reduction Strategy and the Bank’s Country Assistance Strategy to identify specific social assets and constraints to development.

The Government’s strategic framework and action plan for HIV/AIDS is a key element in the social analysis of MAP projects. UNAIDS has prepared guidelines for the strategic planning process which provide a sound foundation for assessing the social development consequences of future projects. The guidelines start with a situation analysis which “puts the HIV epidemic in its social, economic, and cultural context.” This analysis identifies the stakeholders who may create opportunities or constraints, and provides baseline data against which progress toward the goals of the strategic plan will be measured.

Next is a response analysis which looks at all relevant initiatives for HIV/AIDS prevention, treatment and care, including those undertaken by communities, NGOs, the private sector and the formal health care system. Based on this information, the country develops a strategic framework and an action plan to address barriers and “scale up” successful initiatives.

Project identification. At project identification, the government’s strategy and action plan should be reviewed by a World Bank social scientist. This review would form the basis for a dialogue with project personnel and the donor community on the social dimensions of the HIV/AIDS program and how these relate to the country’s larger social development agenda. Review of the national strategy should cover the following issues:

- How participatory has the planning process been? Have the relevant stakeholders (or their representatives) been really involved (or just “consulted”)? Has the process been one which is likely to generate future commitment to help implement the action plan?
- How adequate are the baseline data, particularly in light of the future measurement of social development outcomes? Can it be disaggregated by gender and by small administrative unit? Does it cover medical data only (incidence and prevalence indicators, STDs and other associated diseases, etc.) or does it also describe the social and cultural situation in different communities? What is known with respect to the baseline for indicators that will later be used to measure progress in social development?
- Has the strategy succeeded in identifying all the relevant stakeholders?

Are there any groups that have been excluded (intentionally or unintentionally) from the planning process?

- Does the situation analysis explore prevailing social structures and cultural values that may affect the response of individuals and communities to planned HIV/AIDS programs? Does it demonstrate gender sensitivity?
- Does the response analysis present an unbiased view of the advantages and disadvantages of different organizations delivering health care services? Does it cover a broader range of responses, including social protection for affected families, care for orphans, and compensation for disabled workers? Does it address legal and regulatory issues regarding human rights?
- How does the strategy envisage the coordination of activities to be undertaken by a multiplicity of actors, including sectoral agencies, NGOs, and CBOs? Is there a regional (i.e., decentralized) dimension to this coordination? Does the strategy provide a clear description of the responsibilities of each type of actor and show how these are interlinked?
- How does the strategy assess (or plan to assess) the capacity of the different actors involved in program implementation? Will this assessment (and the resulting training plans) address inclusion, empowerment, and security issues?
- What activities are included in the proposed action plan? Do these activities have social development objectives? How will these activities contribute to (or constrain) the achievement of desired social outcomes?
- What proposals are made in the action plan for program monitoring and evaluation? Are social development outcomes defined and measured through readily obtainable indicators? What research will be undertaken to establish the necessary baseline?

Based on this review, the project team can determine if there is a need for additional social assessment to be carried out during project preparation. Of course, there is always more relevant work that could be done. The minimum requirements for social assessment are to establish the social information required to link project objectives and activities with social development goals, to evaluate the social risks related to project activities, to design and implement risk mitigating actions, and to incorporate social concerns into project monitoring and evaluation.

Project preparation. The situation becomes more complicated when a country does not have a national strategic framework and action plan. In this case, a full social assessment is necessary as part of the MAP project preparation process. This includes carrying out a situation and response analysis for the country, identifying strategic priorities and the program of activities to be supported by the Bank project, assessing social risks and constraints, designing mitigating actions, and planning for the inclusion of social dimensions in project monitoring and evaluation. Although carrying out the social assessment is the Borrower’s responsibility, and can often be done by local consultants, this extensive work program should engage members of the project preparation team and the national steering committee on the Borrower’s side, as well as Bank staff, other donors, international consultants and research institutions. Properly planned and carried out, such work can make a considerable contribution to the national strategic planning process, as well as to building local capacity for social assessment.

The needs and agendas for MAP social assessments vary widely across
Box 2: Building Local Capacity Through Social Assessment

During preparation of the MAP project for the Central African Republic, a social assessment (SA) was carried out by a team composed of an international consultant (anthropologist), a local consultant (sociologist), and the head of the Planning, Programming, and Research Department of the Ministry of Social Affairs. The objectives were to understand local people’s perceptions about HIV/AIDS, its causes and consequences, and to assess their capacity and constraints for community mobilization. The team, with the support of the Task Manager, approached the SA as the first step in an ongoing participatory process, focusing on capacity building at both institutional and community levels.

The assessment involved four weeks of field work using an action-research approach. Before the field work began, a reference library on HIV/AIDS was assembled for the local team. Field work was carried out in urban and rural communities, and with special groups who could not express themselves freely in a community discussions, such as commercial sex workers, street children, junior wives, widows and orphans. Local NGO staff working with these groups were also interviewed. In addition, the field work essentially piloted a participatory approach to deepen understanding of HIV/AIDS issue and to develop capacity and commitment to design and implement a community action plan.

Based on the results of the assessment, the team developed a training manual. Thirty local facilitators were trained in participatory techniques to assist communities in analyzing their situation and developing a socially and culturally appropriate community action plan. One output of this training program was the development of a second module for use by the community facilitators in training key community members to conduct a local situation analysis. The community mobilization process tested during the SA was to be “scaled up” by the local facilitators during project implementation.

This SA focused on the diagnosis and development of capacity for community action planning. In addition to the community-based component, the project includes support to government agencies and civil-society organizations (religious, professional, business, NGOs) engaged in the fight against HIV/AIDS. The project preparation team also assessed the capacity of selected government agencies and civil-society organizations to prepare and carry out action plans. The Task Manager, a social scientist, and the project’s Implementation Specialist, also with a social-science background, applied social analysis at the appraisal of all project components.

The involvement of the SA team did not end at appraisal. Based on the findings of the social assessment, the team helped to draft an Operational Manual for the community response component, specifying eligibility criteria and channels for communities and sub-community groups to access project funds. The manual includes suggested indicators for program activities, individual behavioral change, and growth of social capital at the community level. Criteria for the selection of government agencies and civil society organizations and funding of their action plans are also set out in the Operational Manual.

Africa. In some countries, e.g. Zambia and Uganda, a great deal of work has already been done by other donors and local researchers. In other countries, government leadership has been lacking until recently and little is known about the HIV/AIDS situation and its socio-cultural context.

**Project appraisal.** The social analysis should show how the project serves the World Bank strategic objectives of inclusion, empowerment and security, as well as regional and country-specific social development objectives. Social analysis allows evaluation of the proposed MAP program in relation to the core elements of social diversity and gender, social institutions, stakeholders, participation, social risks, and project institutional arrangements and sustainability. The social analysis also determines the relevant social development indicators to be included in project monitoring and evaluation, the methods by which this information would be obtained and disseminated, and the resources for this purpose to be provided by the project.

(a) Social diversity and gender. This section describes the patterns of HIV/AIDS incidence and prevalence among different social groups, as well as available information about their HIV-related knowledge, attitudes, and behavior, and their social and cultural environment. This assessment is initially based on medical data (sentinel surveys) and on the “Knowledge, Attitudes, Practices” (KAP) surveys which are now standard practice in AIDS program planning. It is used to identify priority target groups for prevention and care programs. Typically high-risk groups are those who are highly mobile (transport workers, miners, migrant workers, rural-urban migrants, service providers working outside their home communities), and those professionally engaged in multiple sexual relations (commercial sex workers). So far, there has been relatively little focus on male homosexuals and intravenous drug users as target groups in Africa, although these may be relevant in some locations. People living in single-sex accommodations (military, prisoners) or vulnerable to exploitation by dominant groups (refugees, street children) are particularly at risk. Many of these groups are already marginalized by the mainstream society. In a situation of severely limited resources, a focus on such target groups can be justified by cost-effectiveness considerations; indeed, many small-scale interventions do just that. However, there is a danger in drawing attention to such groups as being at high risk for HIV/AIDS. There is a strong tendency for people to react by “blaming the victims” and seeking to exclude them from support rather than to help them.

High-risk groups often have their own subcultures, means of communication, and mutual support networks. Successful programs to reach vulnerable groups are usually designed with intensive involvement of the intended beneficiaries, in order to respond to their own perceptions of their needs. Because HIV/AIDS is so closely related to intimate personal behavior, a level of trust between service provider and client is essential in order for programs to be effective. This is often best accomplished by asking members of these groups to design and implement their own programs. For example, peer counseling has been a successful technique with many marginalized groups.

Because of the risks of publicly stigmatizing target groups and driving risky behavior even further under-

ground, many national programs prefer to blend these initiatives into a broadly based information campaign aimed at the general public. In Africa, given the alarmingly high prevalence rates in many countries, this approach is especially useful. The aim is to equip as many individuals as possible with the knowledge and resources they need to make and implement appropriate decisions. Better information and understanding also improves the economic, social and cultural “enabling environment” for such decisions to be made and implemented. The only danger is that an undifferentiated approach to the general public may have the unintended effect of exacerbating existing inequalities and sharpening traditional social tensions. Program designs that take these inequalities and social tensions into account are more likely to ensure equitable distribution of resources and to encourage people to work together across religious, ethnic, class, age and gender boundaries.

Section II has shown the significance of gender inequality in Africa, both in terms of vulnerability to HIV/AIDS and as a broader constraint to economic growth and poverty reduction. Therefore, it is particularly important for project social assessment to explore gender dimensions of the social and cultural environment. Expectations about the participation of women and girls should take into account the many other demands placed on them in African societies. The risks of sexual exploitation faced by young women deserve special attention, as well as the risks faced by older women in and outside of marriage. There may be a need to challenge customary beliefs about premarital and marital behavior, as well as the normative roles of women and men in family maintenance and care of the sick. The goal should be to move beyond gender-based recriminations to a recognition of shared rights and responsibilities in dealing with the HIV/AIDS epidemic.

(b) Social institutions, rules and behavior.
Relevant social institutions can be classified as formal (government structures, the legal system, public health system, education system, social protection system, private employers, Islamic brotherhoods, churches, NGOs etc.) and informal (family and kin groups, neighborhood or community groups, traditional health care practices, traditional socialization processes, traditional forms of governance, traditional religious beliefs and practices). The distinction between formal and informal institutions is not always clear, and often informal social institutions have more influence on the daily lives of people than the formal ones. Such institutions also evolve over time, with informal institutions often showing greater flexibility and ability to adapt to new needs than formal institutions. However, international assistance usually flows first through formal institutions, and adjustments may be needed on both sides to bring informal institutions into the process.

Both formal and informal institutions are characterized by rules of behavior, explicit or implicit, that affect how members relate to each other and to non-members. These rules, or norms, are “ideal types” that describe desired behavior; they are not always respected in practice. In Africa, there is often considerable tension between the behavioral norms espoused by formal institutions and those prevailing in traditional society. In particular, formal schooling, increased mobility, and the market economy have done much to undermine traditional mechanisms of social control, leading in many cases to a wide divergence between community norms and actual behavior, especially by young people. This in turn leads to social tensions within and between communities that can be significant constraints on the
Box 3: Identifying and Addressing Gender Issues

Knowledge of gender issues is critical to an understanding of the HIV/AIDS epidemic in Africa and to the design of effective interventions for prevention, treatment, and support. There are significant gender-based differences in risk and vulnerability to HIV/AIDS for women and men, reflected in different prevalence rates and age profiles. These differences in risk and vulnerability arise from deeply rooted cultural norms regarding relations between family members and sexual behavior. Typically, those most at risk are younger women who are ill-informed and vulnerable to advances by older men in positions of wealth and power. Older, married women are also at risk, mainly from their husbands, with whom they are powerless to negotiate issues such as fidelity or safe sex. Young men are relatively less exposed, but lack information and are culturally encouraged to engage in sex with multiple partners. Older men have the greatest power to control their exposure to HIV/AIDS, but often experience this as a challenge to their masculinity.

As part of the preparation of the Madagascar MAP project, a special study of “Gender and Sexual Behavior” was carried out by local consultants. The study aimed at clarifying the socio-cultural, economic, and political factors linked to vulnerability to HIV infection, as well as identifying gender differences in knowledge, attitudes, and practices related to HIV/AIDS. It began with a review of prior historical and sociological studies. This review revealed much existing information on gender relations in anthropological monographs and consultant reports, as well as health and education statistics. It helped to frame the analytic approach as well as the key questions and target groups to be addressed in focus group discussions.

Focus groups were established in three regions of the country having different historic and sociocultural characteristics. The groups were also divided according to gender, age and economic status. Additional interviews were carried out with key informants in the communities visited. The group discussions were recorded, transcribed and subjected to content analysis, using a matrix developed from the findings of the literature review.

Classical Malagasy society was characterized by matriarchy and great sexual freedom, only partially suppressed by colonization and the introduction of Christianity and Islam. Today, peer pressure encourages early sexual activity, often abetted by alcohol. Sexual relations are accepted as a means of obtaining money, gifts or favors, particularly by young women. Marriages are delayed, fragile and easily abandoned. Female heads of households, whether abandoned wives or unmarried mothers, are most economically vulnerable, most likely to depend on transitory relationships for support and most likely to be victims of domestic violence. Young unemployed men in urban areas also appear to be at risk.

The study recommends making information more available to these vulnerable groups, as well as providing financial and technical assistance to enable them to become more independent. It is particularly important to find ways of reaching out-of-school youth and children who are vulnerable to sexual exploitation. Positive social values which could be reinforced by such campaigns include a strongly rooted belief in gender equality, and social ambition, which could encourage young people to postpone sexual relations and older people to preserve matrimonial fidelity.

success of HIV/AIDS programs.

Community norms define socially acceptable and socially deviant behavior, based on the collective experience and wisdom of the community. HIV/AIDS is a new and troubling phenomenon, and most communities do not have ready-made ways of dealing with it. Common reactions are first to deny its existence, then to blame it on foreigners or people who travel outside the community, and finally to isolate and stigmatize the victims as deviant community members. People infected with HIV and their families often share these views, experiencing denial, depression, guilt, shame and rage, as well as grief and fear of the consequences of future illness and death. These reactions create additional stress for persons living with HIV/AIDS and their families, encourage those affected to conceal their status, and discourage others from learning the truth and, if necessary, seeking treatment.

One major goal of MAP projects should be to help communities and other institutions re-negotiate the rules of behavior by and towards HIV-positive people and AIDS patients and their families. Work may also be needed to redefine broader norms of sexual behavior, gender and age-group relations. The social assessment can help establish baseline conditions and, in consultation with project planners, set targets for improvement under the project. Also, attitudes and behaviors are often shaped by the country’s legal framework. Thus, part of the agenda of a MAP project is often to put in place and enforce the legal guarantees of human rights and equitable access to treatment for HIV/AIDS victims. Achieving this goal requires both capacity and political will in governing institutions at the national and local level, both formal and informal. Project design needs to take into account the presence or lack of such commitment.

(c) Stakeholder analysis. Good stakeholder analysis is particularly important for MAP projects because of the sensitivity of the objectives, the complexity of the design, and the innovative implementation procedures. Although there may be broad agreement on the desirability of project objectives, stakeholders may have vastly different views on the best ways to achieve these objectives and what they actually require in terms of behavioral and social change.

The national strategic planning process can be a point of departure for identifying relevant stakeholders. Groups represented in the steering committee or coordinating council are obvious stakeholders. Persons living with HIV/AIDS are the primary stakeholders and beneficiaries. The general public benefits if the spread of HIV/AIDS is reduced, because fewer people become ill and die, and because the cost of caring, which must in one way or another be borne by the general public, is lowered. Immediate family members and members of “communities of concern,” specifically including the sexual partners of those in high-risk groups, are also key stakeholders.

Government agencies called on to participate in prevention and care programs, including the Ministries of Health, Education, Social Affairs, Youth and Sports, and perhaps others, are also key stakeholders. They are crucial to project success and usually have strong views on how the issues need to be approached. Employers in both the public and the private sector are concerned about the impact of HIV/AIDS on the productivity of their labor force, the rising costs of training due to fast turnover of workers, and skyrocketing welfare costs (health insurance, compensation for orphans and widows, funeral costs etc). Churches and other religious groups usually have relevant and per-
haps conflicting views about appropriate responses to HIV/AIDS. Their role is often key as they tend to be widely present and trusted at the community level. Secular NGOs seek to mobilize resources to make a contribution suitable to their skills.

Traditional authorities, including chiefs and elders, traditional health care practitioners, and leaders responsible for traditional education, have key roles to play in accepting and promoting cultural and behavioral change at the local level. Experience shows that without the support of the chiefs and the traditional healers, the impact of HIV/AIDS programs is low in rural areas. In many African countries, practices and beliefs supported by the traditional leaders may even increase the risks of infection (e.g., female circumcision). Finally, country action plans are usually supported by a number of donors and it is important to take into account the role and expectations of the international donor and research community.

Stakeholders may be classified into several groups:

(i) National policy makers. Key players at the national level are the national AIDS committees, which need to be set up as a condition for approval of any MAP project. Policy makers in the Ministries of Economic Planning and Finance are among the most interested parties, the first because of the implications of HIV/AIDS for economic development, the second because it is a key player in facilitating the flow of funds through the MAP project. Policy makers and civil servants in the Ministry of Health are responsible for planning and executing a large part of the national action plan. The staff of the Ministry of Education will need to address difficult issues such as HIV/AIDS and sex education in schools and adult education programs. The attorney general, parliament and the Ministry of Justice may need to draft, approve and enforce legislation on human rights and other relevant issues (e.g., inheritance rights for women and children). The national police also have a role to play in human rights enforcement. National opinion leaders, including the president, other political figures, and national celebrities such as sports stars can help information outreach and serve as role-models. Some of these stakeholders may be reluctant to acknowledge the importance of HIV/AIDS or to make the often difficult political choices. At the same time, because of their visibility and influence, these stakeholders can to some extent be held accountable for their actions (or lack of action) by the general public.

(ii) Staff of implementing agencies. MAP programs are generally implemented by a wide variety of public and private agencies, including NGOs and CBOs. All of these agencies have their own pre-existing agendas. It is beneficial for project design to understand how different elements of the HIV/AIDS action plan can be grafted onto these agendas, based on potential complementarities or conflicts. Newly formed agencies to assist in project implementation are likely to need capacity building and take time until they become operational. Within public agencies (and some NGOs), strong professional views may prevail on the “right” way to approach the problem. Too often this perspective is elitist, top-down, even authoritarian. National NGOs and CBOs are more flexible in designing programs that respond to local priorities, but their level of technical knowledge, planning and management skills, and ability to mobilize and deploy resources, is likely to be less than that of more professional groups. Between public sector agencies, NGOs and CBOs, there is likely to be strong competition to access project
Box 4: Involving Service Providers in Community Response Programs

The Africa Region Rural Development Divisions have supported efforts to engage rural development workers (agricultural extension agents) in the planning and implementation of HIV/AIDS prevention and mitigation activities. Through its Rural AIDS program, it has fielded local consultants in seven countries and supported local rural development staff in other countries to work with national extension services and other national agencies on HIV/AIDS. The lessons of this experience were reviewed by a consultant team from the Royal Tropical Institute (KIT) and the Tanzania-Netherlands Support Program on AIDS (TANESA), with the aim of developing a framework for scaling up such efforts to the national level.

The report points to the failure of efforts based on a bio-medical approach combined with awareness-raising campaigns to effect needed behavioral change, and stresses the need to address the social and cultural determinants of behavior as well as information deficits and structural impediments. It emphasizes that successful social mobilization can only be carried out at the community level, based on the full participation of all members. The socio-cultural environment needs to offer well-functioning care and support structures. It also points out that interventions need to be gender-sensitive and age-appropriate. Finally, it stresses the importance of coordinated action by service providers from all sectors under the responsibility of decentralized district authorities.

The proposed framework for action includes the creation of an enabling environment for community mobilization at the national level, through advocacy, sharing of best practices, provision of financial resources, and monitoring and evaluation activities. At the district level, it is proposed that district councils provide leadership and coordination through District AIDS Action Committees. These committees should include, in addition to district representatives of sectoral agencies, local authorities and parliamentarians, as well as representatives of NGOs and civil society. The District Committees provide a forum for the sharing of locally successful best practices and is the linchpin for “scaling up.” In line with their coordination role, the District Committees should control and disburse funds for local interventions. At the community level, a similar committee could be responsible for overseeing the development and implementation of the community action plan.

The report suggests the following roles for rural extension workers: (1) All staff should be given training and counseling to confront HIV/AIDS in their personal lives, in order to serve as role models; (2) Promotion of rural infrastructure, including access improvements and health centers, and development and dissemination of new agricultural technologies appropriate to the changed social situation in rural communities; and (3) Participation (on a selective basis) in the social mobilization process at the district level. Rural extension workers have an important contribution to make due to their extensive contacts with rural communities and their professional ability to assess and help mitigate the consequences of HIV/AIDS for household and national food security.

resources.

(iii) Intended beneficiaries. This covers a broad spectrum of stakeholders: PLWHA and their families, a range of high-risk groups (differing from one country to another) and society as a whole. The concerns of PLWHA are central and need to be understood and accommodated at an early stage of project planning. This is best done through the PLWHA participation in the development of the national strategy and action plan. This may not be easy to accomplish if the general public is still demonstrating fear and denial and PLWHA are stigmatized.\(^{15}\) Even if a few brave (and highly visible) individuals are participating actively in project planning, there will likely be a need to encourage broader openness and involvement of PLWHA throughout the project, especially in community action planning. This requires that resources be made widely available for people to ascertain their HIV status and to receive appropriate counseling in a confidential setting. Programs may use formal organizations and informal networks to encourage, inform and mobilize support for PLWHA and their families.

Depending on the profile of HIV prevalence and risky behavior in a particular country, target high-risk populations may be identified in the country strategy and action plan: for example, commercial sex workers, drug users, members of the armed forces, prison

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\(^{15}\) It is important to understand that stigma is not only something that is imposed on its victims by outsiders, but is also internalized by the victims, causing them to feel unworthy, “unclean,” frustrated and powerless. Such feelings easily lead to depression and withdrawal, or to rage and violent behavior likely to place other people at risk.
Box 6: Involving NGOs in Program Implementation

The social assessment for the Second AIDS and STDs Control Project in Brazil (FY99) focused on lessons learned from the “civil society” component in the previous project (FY94). It concluded that the AIDS I project succeeded in involving and training civil society but also created expectations of continued support from NGOs and their clients. The number of NGOs involved in the program expanded rapidly, from 14 in 1989 to over 175 funded by the AIDS I project. More than half of the NGOs were created during this period, and more than half had issues other than HIV/AIDS as their primary concern. It proved difficult to distinguish the impact of the project in strengthening civil society from the more general growth of NGO involvement in civic affairs over this period, as well as to distinguish the impact of project finance from that of other sources of NGO finance, such as private foundations.

The assessment was based on the results of a tripartite seminar (government, donors and civil society) organized by a working group in which the author participated, as well as on focus group discussions with selected NGOs involved in implementing AIDS I. Prior to the seminar, communication between government, donors and NGOs had mainly been in the form of information-sharing about the project. The seminar provided an opportunity for NGOs to share their own learnings, build an internal consensus, reflect on obstacles and develop common approaches. It was seen as a good first step in the process of deepening civil society participation in AIDS II.

The focus groups revealed a lack of trust between the NGOs and the committee charged with selecting proposals for funding, which the NGOs viewed as “too academic.” They noted unrealistic bureaucratic requirements that added to their costs. They felt the government’s NGO coordinating unit was more interested in managing project funds correctly than in helping the NGOs to build capacity. An excessive focus on meeting quantitative targets was seen as missing the main point of NGO interventions. The NGOs would prefer a more decentralized selection and project monitoring process, but fear the consequences if such a process is not accompanied by strong capacity building at the state and local level. They did not have a clear understanding of how their efforts fit into the overall program strategy, and felt that the government program monopolized the media at their expense. They objected to the program’s “one size fits all” approach, and felt that the project’s refusal to provide support for core funding weakened newlycreated NGOs and limited the ability of all NGOs to supplement project funds from other sources.

The assessment recommended that AIDS II:
- Provide multiple windows to reduce competition for available funds;
- Add selection criteria concerning the organization’s mission, total resources spent on HIV/AIDS, and relation of the proposed HIV/AIDS project to the overall program;
- Restructure the NGO unit to provide more support to NGOs;
- Place even greater emphasis on institutional development and training;
- Provide greater visibility to NGO activities and encourage sharing of experience; and
- Provide clear guidelines for participatory project monitoring and evaluation.

The assessment concluded that it was unwise for the Bank to state categorically that there would not be an AIDS III. This approach would discourage the addition of new partners and would do little to strengthen those already involved. Rather, the AIDS II project should promote a more participatory analysis of decentralization and sustainability and the best ways to attain these goals.

Source: Jane Galvao, “Analise Social - Project AIDS II,” consultant report (in Portuguese), May 1998. For more information, contact John Garrison, LAC.
inmates, migrant workers, truckers etc. HIV-positive women at risk for mother-to-child transmission of the disease may also form a target population, particularly as they are relatively easy to identify and reach through maternal and child health services, and treatment options are available. The challenge is to make services available and to involve these target groups in project planning without attaching additional stigma to their status. Finally, because HIV/AIDS can potentially affect everyone, and in many African countries there are few communities untouched by HIV/AIDS, the society as a whole needs to be regularly informed and involved in planning and evaluating project activities.

(iv) (Potentially) adversely affected persons. Project activities, however well meaning, may have negative consequences for some individuals if not carefully planned preferably with their participation. In the case of MAP projects, the major issue is how to manage programs aimed at empowering women and young people without generating a backlash among older people and men. Children and the elderly are particularly at risk for bearing the burdens of care without adequate resources, and for impoverishment as a result of AIDS-related deaths among men and women in their productive years. There are practical obstacles to the participation of children and elderly people in project activities, and their needs may need to be articulated by trained advocates. Indigenous minorities are particularly vulnerable to sexual and other forms of exploitation. They are also vulnerable to HIV/AIDS because of their generally poor health, due to malnutrition, other diseases (STDs, tuberculosis) and lack of access to health care. Successful programs to address HIV/AIDS among indigenous peoples have been based on their participation, using their own methods of communication, and responding to the unique features of their culture.

(v) Organized interest groups. Professional groups may have a specific contribution to make to MAP project planning and implementation, based on their specialized knowledge and ability to mobilize resources. Examples include doctors, lawyers, journalists, labor leaders, entrepreneurs and religious groups. All these groups share an interest in keeping the HIV/AIDS epidemic under control and in maintaining the pace of national economic growth and poverty reduction. Through formal or informal associations, they offer networks through which information may flow and resources may be mobilized to support national programs. Because of the elite nature of such groups, they may be well placed to influence policy as well as programs.

(vi) Civil society. The term is generally used to describe those formal or informal associations which are non-governmental but directed toward public purposes. It includes both national level NGOs and community-based organizations. For the purpose of MAP project social assessment and analysis, it also includes local-level institutions, such as traditional authority structures, traditional health practices and traditional socialization patterns, all of which are likely to be controlled by local elites. These groups, associations and institutions, together with families and kin groups, form the web of social relationships within which individual behavior is generated and controlled. An important question is the degree of legitimacy accorded to these institutions by those whom they would serve. Another issue is the ability of these associations to absorb external resources and meet donor demands for formal reporting and accounting.

(vii) Donors and other external stakehold-
Support for national HIV/AIDS strategies and action plans is provided by a variety of donors, bilateral and multilateral, each with its own agenda. The “Partnership Consultation” conducted by the World Bank in preparation for MAP 2 highlighted the need to build trust with other donors and become more involved in international aid coordination groups. The aim is to capitalize on the comparative advantage of each partner in supporting national action plans. Several donors have been active in the field longer than the World Bank and have accumulated valuable experience which should be more widely shared within the donor community. A great deal of research on HIV/AIDS in Africa has been carried out by African and European institutions and it can inform World Bank dialogue with country policymakers. The design of project monitoring and evaluation systems should be linked to generation and dissemination of global knowledge to advance the fight against HIV/AIDS.

(d) Participation. The preparation of a national strategy and action plan represents the beginning of a participatory process. The project social assessment and/or social analysis should evaluate the quality of this process and assess how it can be carried over or extended
into the project implementation period. It may be useful to compare this process with that used to prepare Poverty Reduction Strategy Papers or other strategies that may have been supported by the Bank or other donors (e.g., Environmental Action Plans). The success of the national team in identifying and involving all of the relevant stakeholders should be assessed, and remedial actions identified if necessary. The role of PLWHA in strategy formulation and project planning is particularly crucial.

MAP projects generally envisage participation structures that include a national coordinating committee, district-level coordinating committees, and community-level action planning leading to the utilization of grant funds destined for community groups. The national coordinating committee is likely to be made up of highly visible leaders representing powerful stakeholder groups. Democratic methods of decision making, and transparency in the management of resources, will be essential to the success of this group in facilitating program implementation. Coordinating committees at the district level need also to be carefully chosen to ensure balanced stakeholder representation (especially of women, youth, NGOs, and the private sector), and members need to have both skills and incentives for transparent and cost-effective management of project resources. It will be important to ensure participation in such committees by PLWHA and others who will be motivated to maximize results on the ground.

Community participation is at the very heart of the MAP programs, especially the grant components which are to be implemented by community groups. Although awareness of HIV/AIDS may be raised by the national strategy formulation and action planning process, many communities will find it difficult to believe that action against HIV/AIDS is a local priority. Participatory rural appraisal (PRA) techniques can be used to help communities recognize and diagnose their HIV/AIDS problems and propose feasible solutions. Communities usually take a long time to consider the new information and decide what to do about it. Discussions may be needed within families or in small homogeneous groups before large public meetings can be held. The involvement of local health workers, teachers and religious leaders may be important to legitimize discussions in more formal settings such as schools, churches and clinics. It is likely that this process will surface information that members of the community have been hiding from each other, and this will have to be dealt with. Even when there is general agreement on the nature of the problem, the development of a community action plan can still be a lengthy and complex process. It may also take a long time to establish or change local social structures so that the action plan can be carried out.

It is important to ensure the participation of all relevant stakeholders in community problem identification and action planning. In some cases it will be useful to start with small groups differentiated by age and gender, before bringing the different proposals together to generate a community action plan. The process often needs to be supported by trained facilitators who can recognize the presence of different stakeholder groups and create the conditions under which they can effectively participate, empowering those whose voices are less likely to be heard: young women, children, “strangers” etc. Community participation should lead to a commonly accepted and understood action plan in which all members have a role to play. Structures involving all stakeholders and established at the community level are also best placed to monitor and modify as needed the implementation of the plan.
Box 8: Incorporating Traditional Healers and Indigenous Knowledge

The spread of the HIV/AIDS epidemic in Africa has placed great strains on the medical profession, whose numbers were already limited in relation to the population needing medical services. The majority of the population in Africa, especially the rural poor, must depend upon the services provided by traditional healers. Even those who have access to formal medical care may prefer these more culturally appropriate and acceptable services, alone or in combination with modern medical care. The use of traditional healers is consonant with broad cultural concepts, prevalent in Africa, of predestination and supernatural forces at work in determining human health. Traditional healers also offer non-judgmental care, working within a context of culturally accepted behaviors such as multiple sex relationships prior to marriage. A number of national HIV/AIDS programs have included outreach to traditional healers, both men and women, to provide information, improve the quality of traditional health care, and encourage their involvement in developing strategies for community care and support.

Traditional medicine makes extensive use of local resources, particularly plants, some of which have been shown to be effective in treating AIDS symptoms. The knowledge of these plants and how to use them is part of the cultural heritage of local communities. However, many plants are disappearing due to the pressures of development and commercial demand. The knowledge of how to use them is also disappearing as traditional socialization practices are replaced by modern education.

A regional task force on traditional medicine and AIDS in eastern and southern Africa was established in 2000 to share information and coordinate activities. Its secretariat is provided by the Ugandan NGO THETA (Traditional and Modern Health Practitioners Together Against AIDS), based in Kampala, Uganda. The Zambian and Zimbabwean national associations also participate, and groups from Ghana, Nigeria and Cameroon are involved as observers. The task force is also linked to UNAIDS, WHO and the Global Initiative for Traditional Systems (GIFTS) of Health. GIFTS will develop a research program based on an intellectual property rights framework that will protect the rights of local knowledge holders, and will promote sustainable horticulture for priority plant species.

Under the Bank-supported Environmental Support Program in Zambia, a program has been developed with the Traditional Health Practitioners Association to protect and promote sustainable use of biodiversity with medicinal value. It includes the establishment of botanical gardens, forest reserves and a herbarium for medicinal plants; HIV/AIDS training for traditional healers; and development of a plant database and materials published in local languages for use in communicating this knowledge more widely. The program also includes literacy training for healers to promote medical record keeping and the documentation of indigenous knowledge. A similar program is being introduced in Ghana under the GEF-financed Northern Savanna Biodiversity Conservation Project.

The social assessment may include the preparation of a “participation plan” for the project, based on what is proposed in the national strategy and agreed by the authorities in consultation with the donor community. The plan should consider participation at the national, district and local level, and participation in all phases of program execution, from diagnosis and design to monitoring and evaluation. It should include balanced participation by all stakeholder groups, recognizing that active participation has costs that some groups may find difficult to bear. The plan should allow adequate time for people to internalize the project and to bring forward their own solutions, as well as the need to deliver promptly on resources once well-considered plans are made. In addition, the plan should consider how to ensure participation of clients in planning by service providers, participation of workers in planning by employers, and beneficiary participation in planning by NGOs.

(e) Social risks: The spread of HIV/AIDS constitutes a major risk for economic growth in Africa, for the development of social and human capital and for poverty reduction. Thus, MAP projects aim at minimizing social risks. They do this by (i) promoting the inclusion of marginal groups in education, prevention, treatment, and care programs, (ii) supporting the social protection of vulnerable groups like orphans and refugees, (iii) promoting more equitable treatment and empowerment of women and (iv) strengthening the coping skills of individuals, households, CBOs, and civil society.

Generally, the Bank’s social safeguard policies (resettlement, cultural property) are not triggered by MAP projects. However, the policy on indigenous peoples may be relevant. Indigenous peoples, especially those living in remote areas, may be relatively untouched by HIV/AIDS and, for a variety of reasons, may be particularly vulnerable to new infections. Their social structures and cultural values may be different from those of the dominant society, calling for different solutions to the HIV/AIDS challenge. It is therefore important in the case of indigenous communities to ensure that HIV/AIDS action plans are developed in a participatory way. The indigenous community should also be empowered to control the implementation of plans developed for them by others, such as health care providers or NGOs.

Social risks related to HIV/AIDS projects include, at the national level, the risks of conflict and/or poor governance drawing project resources away from the target groups and activities. At the community level, there may be risks of project activities having negative effects on individuals or vulnerable groups. One risk is an increase in violence against women as they attempt to negotiate greater control over sexual decision-making and behavior. Another is the risk of further stigmatization of groups that are revealed as being at high risk for HIV/AIDS, or of individuals who choose to acknowledge their HIV-positive status. A variation on this risk is the expression of “AIDS rage” by people who learn they are HIV-positive and engage in anti-social behavior out of frustration and fear or in hope of effecting a cure. Strong differences on appropriate responses to HIV/AIDS, especially if rooted in ethnic or religious differences, may exacerbate social tensions and undermine social
Box 9: Assessing the Needs of Indigenous Minorities

In preparation of the HPSP HIV/AIDS Prevention Project, the World Bank commissioned a “Social Assessment of HIV/AIDS in Bangladesh.” The objectives were to (a) compile and synthesize existing studies on unsafe behavior and socio-cultural constraints among different high-risk groups; (b) identify areas for further research; (c) summarize lessons learned from existing interventions and (d) recommend needed interventions to bring about behavioral change. The consultant team was drawn from the academic community (Research Evaluation Associates for Development, READ) and the NGO community (CONCERN Bangladesh). In addition to carrying out this study, the consultants worked with the Family Planning Association of Bangladesh to carry out a special study of conditions in the Chittagong Hill Tract region, mainly inhabited by “tribal” groups.

Given the remarkably low level of HIV prevalence in Bangladesh, the national study focuses on identifying high-risk groups: male and female sex workers, transgendered individuals (hijras), street children, (international) migrant workers, professional blood donors, intravenous drug users, truckers and transport workers, prisoners, and pregnant and lactating women. The study identifies many deficiencies in the support services provided and the lack of a coordinated strategy for Behavioral Change Communication. The report stresses the need for socio-cultural sensitivity in designing such strategies and targeting them to specific high-risk groups. It encourages identification of HIV/AIDS as a development problem and the integration of HIV/AIDS programs with general poverty-alleviation programs.

Research with the tribal groups in the Chittagong Hill District started with a participatory rapid assessment involving government officials and NGO staff familiar with the area and the issues. The research team itself was largely made up of professionals of tribal origin. Data were then collected through focus group discussions and interviews with service providers, representatives of a trucker association, NGOs, and key informants from the local power structure.

The study found that high-risk behavior was relatively unknown (or unacknowledged) among the tribal groups, compared to the migrant Bengali laborers and settlers in the area. Alcohol and marijuana use is prevalent among the tribal groups, but the use of intravenous drugs is not known. Little information was available on STD prevalence, but it was believed to be low and mostly found among women. The few known HIV-positive cases were migrant workers returned from abroad.

The study recommended working through tribal leaders to disseminate information based on the need for people to protect themselves against possible HIV infection. Use of radio and posters in local languages, as well as the development of folksongs, was also recommended. Reproductive health and sex education for young people was encouraged. The messages were expected to be well accepted given the general concern of the tribal population about maintaining good health.

capital. The best way to mitigate these social risks is to proceed with caution, allowing plenty of time for people to adjust to new ideas and behaviors, and ensuring that the action plans are prepared in a participatory way and are acceptable to all stakeholders.

(f) Institutional arrangements and sustainability. MAP projects typically foresee a complex set of institutional arrangements, with an apex coordinating council at the national level served by a technical secretariat, allocating resources to sector agency programs and national level NGO and private sector programs, while a large share of the resources is reserved for allocation to community initiatives approved by district coordinating committees. The project-related structures are ad hoc and destined to disappear at the end of the project. This fact will affect the motivation of their members. Over time, these structures are likely to become bureaucratized and to seek to perpetuate themselves. The sector agencies, the private sector institutions, and the national NGOs are more permanent and have vested interests other than the success of the project. The social analysis needs to assess the characteristics of these institutional actors and the system in which they are expected to work together, in order to maximize the chance of successful project implementation. Where implementing agencies are not already identified, the social assessment could assess the range of potential agencies (NGOs and CBOs) and project plans for evaluating and building their capacity as part of the process of awarding grants or contracts.

The social assessment and analysis need to evaluate the skills, attitudes, and behavior of staff in the potential implementing agencies with respect to social development objectives such as inclusion, empowerment and security. The work of the social development specialist should be complemented by an institutional assessment that focuses on whether or not the agencies have the practical skills and the motivation to design and carry out programs in accordance with donor and government requirements. Where such skills are lacking, the MAP project should include specific capacity-building measures, adequately resourced, and the project timeline should allow adequate time for these capacity-building activities before project resources are expected to flow to community groups.

The project’s technical secretariat is designed to serve a variety of stakeholders, including the national coordinating committee, the government, the donors and the international research community. In addition to providing technical leadership, this group will have a key role to play in donor coordination and in coordinating the activities of different branches of government. It will be responsible for the design and implementation of the project’s M&E system, as well as for the reporting, dissemination and disclosure of information related to the project. This group needs proper equipment and training to perform the variety of functions.

A key role in the implementation of MAP projects is played by community development facilitators. The ability to “scale up” interventions and have a wide impact across communities depends very much on the creation of a cadre of skilled professionals who take pride in their work and in building strong, lasting relationships with particular communities. Community development facilitators must transmit accurate information and correct misperceptions, assist communities in acknowledging HIV/AIDS as a problem, create conditions in which the views of every person can be expressed, direct discussions towards constructive solutions and, at the appropriate time,
help identify external resources for the implementation of community plans. This role should create a long-standing bond of trust between the community and facilitator. Thus, facilitators should not be asked to serve a large number of communities or to produce a great many plans in a short time. They require extensive training, field support and supervision to carry out their mission successfully.

The World Bank social scientist can help to locate and integrate the HIV/AIDS project in the broader context of the country strategy for poverty reduction and the country assistance program. Such projects will not only promote the health and welfare of individuals but will also alleviate a potential drain on the resources of families, communities and governments. They also help to strengthen local institutions, build community cohesion, empower local authorities and sector agency staff, support civil society initiatives and their collaboration with government, provide attention and services to marginalized minorities, valorize indigenous knowledge, and challenge cultural norms and values that are counterproductive for development.

Another important area in which a Bank social scientist can contribute to MAP project ex-ante analysis is by linking the project activities to social development outcomes in the project logframe, establishing the corresponding performance indicators and sources of data, as an input to the design of the project monitoring and evaluation system. Indicators may be expressed in quantitative or in qualitative terms. Planning for the collection of these data requires an ongoing commitment to well-designed social research, including the establishment of a baseline during project preparation and periodic reassessments of project outcomes from the perspective of different stakeholders and beneficiary groups.

Social analysis after appraisal. The project social analysis conducted prior to appraisal aims to identify key issues that need to be addressed through policy change, program design, or “rules of the game” for project implementation. Key policy concerns should be addressed during discussions with the Borrower at appraisal, and can be strengthened through project conditionality where necessary and appropriate. When the World Bank and the Borrower cannot agree on policy, the best approach is to agree with the Borrower on the desired outcome and on carrying out a program of research to determine what policy is most likely to achieve this outcome. Without a sense of ownership and commitment, policy changes are unlikely to achieve much or last long.

Issues that can be addressed through program design and “rules of the game” should be described briefly together with the proposed mitigating actions in the appraisal report. However, to ensure that these proposals are actually translated into effective action on the ground, the World Bank social scientist has to participate in the review of the project Implementation Manual prepared by the Borrower, and contribute to it as needed. During implementation, the social scientist should review relevant Borrower reports and engage in discussions with Borrower staff, project partners, and beneficiaries in order to maintain the focus on social development outcomes and to assure a continuous learning process both within the Region and across its boundaries. To this end, it would be useful for the social scientists working on MAP project teams, whether in Washington, in the field offices, or in local firms or institutions, to share information and experiences through a common network, and to interact regularly with counterparts in other donor or
Monitoring and evaluation. Typically, MAP projects foresee monitoring and evaluation of three types: physical and financial monitoring of project processes and project outputs; technical monitoring of HIV/AIDS incidence and prevalence and those of related diseases; and periodic evaluation of project outcomes, often using qualitative techniques such as beneficiary assessment.

These types of research are useful for determining the degree to which a project is implemented according to plan, monitoring its impact on the spread of the disease itself, and assessing its secondary effects on different beneficiary groups. However, to achieve the current goal of implementing “a process of permanent social impact monitoring,” something more is needed. Such a process would:

- Assess the degree to which programs have been inclusive and have fostered more inclusive behavior at the household, community, and service-provider level;
- Assess the degree to which programs have empowered individuals, households and communities with the knowledge and other resources needed to adopt safer practices and to provide better care for HIV/AIDS sufferers, as evidenced by the adoption of these practices and the provision of such care;
- Assess the socio-cultural factors underlying the success or failure of programs and changes in the perception and treatment of marginalized groups; and
- Assess progress in establishing and protecting the livelihoods and human rights of PLWHA and their families.

Early selection of relevant indicators in relation to project social development objectives is critical in order to ensure that valid baseline data, and reliable, replicable measurement methods, are established before the project gets underway. During project implementation, ongoing social assessment can use a mix of qualitative and quantitative techniques to measure these same parameters at different points in time. It will be useful to link the social M&E planning to the participation plan so as to involve beneficiaries to the greatest extent possible, while minimizing demands on their time and resources. Some of the needed data may be obtained from other sources such as sentinel surveys and KAP surveys, especially if these can be modified to address social development concerns (such as the disaggregation of data by relevant social groups). However, in-depth studies in selected communities will also be needed to fully understand why programs succeed or fail, and to monitor changing perceptions of and behaviors toward HIV/AIDS victims and vulnerable groups. These activities should be planned in advance, described fully in the project Operational Manual, and contracted out to national organizations, universities, or NGOs with the capacity for continuing observation on the ground.

Many African countries have limited capacity for designing and carrying out such research. Some African institutions (and NGOs) have developed specialized expertise in this area and can share this expertise with others through South-South technical assistance.18 Because the skills applied to evaluating the social development outcomes of MAP projects are equally relevant to other projects and programs, extensive public investment in

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18 For example, the Institute of Social Research at Makerere University, Uganda, or the School of Social Work at the University of Zambia.
Box 10: Using Beneficiary Assessment Techniques

Beneficiary assessment is a tool for improving the quality of development operations. Its objective is to assess the value of an activity as it is perceived by the affected people. Beneficiary assessment combines qualitative and quantitative techniques, deriving data from observation, conversations and open-ended discussions with groups of beneficiaries and other stakeholders. Attempts are made to provide balance by ensuring that the respondent population constitutes a representative sample of relevant interest groups. However, the sampling procedures used do not lend themselves to detailed statistical analysis. The data provided by beneficiary assessment provides a useful complement to surveys and other forms of data collection that are more amenable to mathematical manipulation.

Beneficiary assessment is being used in the preparation of the Burkina Faso and Niger MAP projects. Groups covered include young people (urban and rural, male and female), men in uniform (military, police), prisoners, secondary schools (students, teachers, and parent-teacher associations), commercial sex workers, gold miners, seasonal farm laborers, truck drivers, Persons Living with HIV/AIDS and community opinion leaders. The Interview Guide covers perceptions and knowledge of HIV/AIDS, personal experience with the disease, attitudes towards affected persons, attitudes toward testing and discovery, beliefs about prevention and cure, factors influencing sexual behavior and effective channels of communication. Information is obtained through direct observation (by trained observers), conversational interviews and focus group discussions with 6 to 12 persons. In addition to seeing the issues from the respondents’ point of view, the study will improve understanding of how the different groups interact and what social actions could be taken to motivate behavior change.

The recently completed *ex-ante* Beneficiary Assessment for the HIV/AIDS project in Niger involved interviews with over 4,000 respondents representing fifteen different social groups at risk. It reveals a wealth of relevant perceptions and beliefs and shows why previous approaches to these groups have been relatively ineffective in inducing behavior change. It stresses the link between poverty and vulnerability to HIV/AIDS, especially for women, but also for men who must travel far in their search for work. Silence, denial, and stigma are still major obstacles to action. The BA recommends that the Niger MAP take a more community-based approach to build on the capacity of local institutions, stressing the integration of HIV/AIDS actions in community development plans.

The success of a beneficiary assessment depends critically on the capacity of the research team to establish trust and elicit confidence in the study subjects, particularly in discussing such a highly sensitive subject as HIV/AIDS. Reports suggest that the study teams met with strong initial resistance. Additional training may be needed, as well as the development of a longer-term relationship with informants, demonstrating to intended beneficiaries that their views can affect the shape of national programs to combat HIV/AIDS.

training and capacity building for social research may be justified on a regional basis. Such investment could be made in the context of strengthening the capacity of selected regional institutions of higher learning, similar to programs the World Bank has sponsored in the past to develop national capacity for statistical data collection, economic analysis, and environmental management. Until domestic capacity is developed, however, international technical assistance may be required to mount social research on the scale that is needed to properly monitor and evaluate the social outcomes of MAP projects.

Special care should be given to sample design in order to ensure adequate coverage of the different socio-cultural contexts found in any one country, in order to facilitate future aggregation of findings from the community to the district and national level. For in-depth information, purposive sampling or over-sampling of high risk populations may be more useful than national random sample surveys. Data collection techniques may include participant observation, conversational interviews, focus group discussions, community meetings, and use of quantitative survey techniques where appropriate. Community development facilitators trained to assist communities in developing their HIV/AIDS action plans may also provide regular feedback on progress in implementing these plans, including the identification of local socio-cultural factors contributing to or constraining their success.

Most important of all is the participation of those affected by project activities in monitoring and evaluating their impact. This means that PLWHA should help to assess the effectiveness of legal and policy changes that are intended to improve their condition; health care providers should consult with their clients, as well as with those who remain outside of the health care system; parents, teachers, and students should be involved in evaluating the impact of educational programs; employers (including public agencies) should provide opportunities for feedback from their workers; NGOs should seek systematic feedback from program beneficiaries; and community leaders should listen to the voices of vulnerable individuals. These forms of feedback and self-correcting mechanisms should be built into project activities, without waiting for formal mid-term reviews and end-of-project evaluations. More structured and systematic M&E activities should be carried out at defined intervals in order to provide information that can be widely shared among all stakeholders. It will be important also to train program managers and coordinating committees to interpret this information and make appropriate changes as the project proceeds.

With a widely accepted conceptual design for this process of permanent social impact monitoring, interpreted in terms of locally appropriate indicators for each country, it should be possible to cumulate knowledge across countries and to contribute to the body of work already being carried out by other institutions on the social dimensions of HIV/AIDS in Africa. The World Bank is becoming involved in this process rather late and there is much to be learned from partners with greater experience in this field. The World Bank, on the other hand, has a contribution to make because of its growing understanding of the links between economic and social development, and its ability to mobilize both financial resources and political commitment for programs to succeed at the country level. Improved performance will enhance the quality of Bank contributions to economic growth and poverty reduction in Africa.
CONCLUSION

MAP projects provide large amounts of resources that, properly used, could have a tremendous impact on capacity building in government agencies, NGOs and community-based organizations. Such capacity will enable these institutions not only to deal with HIV/AIDS, but also to diagnose broader development needs and to design and implement programs to meet those needs. There is, of course, a conflict between the priorities of many organizations and the demands of the MAP projects that interventions focus on HIV/AIDS prevention and care. As the links between the development challenge in general and the HIV/AIDS challenge in particular become better understood, improvement can be expected: sector agencies, NGOs and CBOs may become more willing to take on the fight against HIV/AIDS as a development priority, and MAP project managers may become more willing to fund a variety of development interventions as a way of fighting HIV/AIDS.

A major byproduct of a successful MAP project should be the building of trust between government and non-governmental actors, and improved coordination and efficiency, as each group learns to work effectively with a wider range of partners. This important benefit of trust-building extends to the relationships between NGOs and communities, between community leaders and marginalized groups, and between individuals within communities across gender and age-group lines. The result should be a significant contribution to social capital formation and “nation-building,” key elements for sustainable socio-economic development in the future.
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